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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS
- -x
and ,
Plaintiff,
-against-
, M.D.,
, PLLC,
and HOSPITAL,
Defendants.
- -x

New York, New York
October 3, 2007
11:15 A.M.

EXAMINATION BEFORE TRIAL of
, M.D., one of the Defendants in the above-entitled action, held at the above time and place, taken before Gretchen A. Milton, a Notary Public of the State of New York, pursuant to Order and stipulations between Counsel.

* * *

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APPEARANCES:

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BY: , ESQ.

* * *

STIPULATIONS

IT IS HEREBY STIPULATED, by and among the attorneys for the respective parties hereto, that:

All rights provided by the C.P.L.R., and Part 221 of the Uniform Rules for the Conduct of Depositions, including the right to object to any question, except as to form, or to move to strike any testimony at this examination is 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 to, the trial of this action.

This deposition may be sworn to by the witness being examined before a Notary Public other than the Notary Public before whom this examination was begun, but the failure to do so or to return the original of this deposition to counsel, shall not be deemed a waiver of the rights provided by Rule 3116, C.P.L.R., and shall be controlled thereby.

The filing of the original of this deposition is waived.

IT IS FURTHER STIPULATED, a copy of this examination shall be furnished to the attorney for the witness being examined without charge.

* * *

MR. OGINSKI: Please mark these as Plaintiff's Exhibits 1 and 2.

(The office record of Dr.

for the patient
was
hereby marked as Plaintiff's Exhibit 1
for identification, as of this date.)
(The Hospital chart was
hereby marked as Plaintiff's Exhibit 2
for identification, as of this date.)

,
one of the Defendants herein, having first
been duly sworn by the Notary Public, was
examined and testified as follows:
EXAMINATION BY
MR. OGINSKI:
MR. OGINSKI: Counsel for the
Defendant, Dr. , has
indicated, off the record, he will
accept service for Dr. at the
appropriate time.
MR. : So stipulated.
Q. Please state your name for the
record.
A. .
Q. Please state your address for the
record.
A. , New
York .
Q. Good morning, doctor.
A. Good morning.
Q. Do you perform urethroplasty?
A. Yes.
Q. In your career, since you have

, M.D.
been in private practice, can you estimate
how many urethroplasties you have
performed up until the present time?
A. A dozen.
Q. What is a urethroplasty?
A. A urethroplasty is a repair of a
urethral stricture.
Q. Are you familiar with the term
known as buccal mucosa urethroplasty?
A. Yes.
Q. What is that?
A. That is when they use a graft of
skin from the mouth to put in the urethra
to replace the strictured area.
Q. Is there a subspecialty of
urology that would actually perform
urethroplasties on a regular ongoing
basis?
MR. : Objection to the
form.
You can answer over objection, if
you know, doctor.

MR. OGINSKI: Everything is only if you know.

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A. It can't be answered the way it was asked.

Q. If a patient of yours needed to be sent to a specialist for reconstructive urethroplasty, and for whatever the reason you chose not to perform it, who would you typically send the patient to?

MR. : In 20 ?

MR. OGINSKI: Yes.

MR. : Over objection, you can answer.

A. There are certain people that have a particular expertise in the area.

Q. Can you tell us who? If you recall, can you tell me the names of some of those people that you would send such a patient to?

A. Sure.

Q. Go ahead.

A. If I were to refer a patient, I would probably use Dr. , .

Q. Do you know where Dr. practice is?

, M.D.

A. Yes.

Q. Where?

A. Hospital.

Q. Are there any other physicians with similar qualifications or similar credentials who you would feel comfortable sending a patient to, to perform a urethroplasty?

MR. : In 20 ?

MR. OGINSKI: Correct.

Q. Doctor, all these questions today are going to be related to the treatment time period of 20 until and unless I indicate otherwise.

A. Okay.

Q. So going back to the previous question, can you give me any other names of physicians that you would feel comfortable referring to with the same type of qualifications or credentials as Dr. has?

MR. : He is not asking about the procedure. He is asking about the relationship.

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A. I like Dr. 's approach,

his ability to do this type of a procedure.
Q. Am I correct that when you treated , you never referred him to the type of specialist like Dr. at any time while he was under your care?
A. Yes. Correct.
Q. Can you tell me, from the time that you went into private practice, after completing your medical training, up until the present time, how many UroLume stent insertions you would say you have done?
A. Several dozen.
Q. Can you be any more specific than "several dozen"?
A. If 12 is a dozen, several dozen would be more than 30 or 40.
Q. Less than 50?
A. Perhaps.
Q. Are you familiar with the term, "urethral stricture"?
A. Sure.

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, M.D.
Q. Can you tell what that term means?
A. It's a stricture of the urethra.
Q. Can you be any more specific as to what a stricture is?
A. A stricture is a narrowing.
Q. Can you tell me generally what the etiology is of a urethral stricture?
A. No.
Q. Are there common etiologies that you are familiar with, from most common to least common, that you would be able to describe for me?
A. There are many known etiologies.
Q. Can you tell me what you would consider to be the most common cause for urethral stricture?
MR. : That is a general question?
MR. OGINSKI: Yes.
MR. : Objection, but if you can, answer it.
A. There are many common causes of stricture.

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, M.D.
Q. Can you give me examples of the most common ones?
A. Some of the more common ones would be trauma or infection.
Q. At any time while you were treating , did you ever come

to have the opinion, or did you come to the conclusion, that Mr. had suffered some type of trauma to his penis and his urethra?
A. In his case, what the cause of the urethral stricture was, I don't recall.
Q. Can you make a conclusion as to its etiology?
MR. : Objection.
MR. OGINSKI: Let me ask the question a different way.
Q. At any time while you were caring for Mr. , did you ever determine that the reason for his urethral stricture disease was infectious in origin?
A. As I previously stated, I did not come to the conclusion as to the precise

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, M.D.

etiology of his stricture.
Q. Am I correct, doctor, that in the course of your career, you have had occasion to treat many urethral strictures?
A. Correct.
Q. Would you feel comfortable --
MR. OGINSKI: Withdrawn.
Q. And over the course of your career, doctor, have you become familiar with the treatment methods available to treat urethral strictures?
MR. : Objection to the form.
A. Yes.
Q. Would it be fair to say that in your medical career, and medical school, and during your residency, and in your postgraduate training, that you learned how to treat urethral strictures?
A. Yes.
Q. What is a urethrotomy?
A. A urethrotomy is the term used to describe opening the stricture.

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Q. Is it a surgical procedure?
A. It is a surgical procedure.
Q. How many urethrotomies have you done in your career?
A. Well over a thousand.
Q. Doctor, do you have an opinion, to a reasonable degree of medical probability, as to how many urethrotomies a 35-year-old male with recurrent stricture disease would need before being sent to specialist for a urethroplasty?

MR. : Objection to the form. Rephrase.

Q. Do you have an opinion, doctor, within a reasonable degree of medical probability -- and by the way, all of my questions whenever they are asking for your opinion, are always to within a reasonable degree of medical probability -- with respect to a 35-year-old male, how many recurrent urethrotomies or repeat urethrotomies such a patient can have, before he needs to be sent to the specialist for a

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, M.D.

urethroplasty?

MR. : Objection to the form. Over the objection, if you want to stand on the question, he can answer.

You are presuming that there comes a point where the patient does need have to a urethroplasty after repeat urethrotomies.

MR. OGINSKI: Correct.

Q. Is there -- let's go to this specific patient and talk about treating strictures.

MR. OGINSKI: Withdrawn.

Q. What is a UroLume stent, doctor?

A. A UroLume stent is a device designed to prevent recurrence of the stricture.

Q. How does it do that?

A. It basically prevents the stricture from restricturing.

Q. Before placing a UroLume stent, are there certain indications, that you must be aware of, that the patient must

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have in order to determine whether this particular patient is an appropriate candidate for this particular stent?

A. Yes.

Q. Tell me what those indications are.

A. The indications are variable depending on the particular case.

Q. Can you give me generally what the indications are for the use of the UroLume stent?

A. In general, when a patient has several recurrent strictures in a particular position of the urethra where it would be worth placing such a stent.

Q. Are there other indications that

would require the use of or, which could recommend the use of, a UroLume stent?
A. Where there are cases, for instance, of urinary retention secondary to prostatic hypertrophy.
Q. Are there any other indications?
A. Those would be it for many cases.
Q. Did Mr. have evidence of

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, M.D. urinary retention secondary to prostatic hypertrophy?
A. No.
Q. Doctor, in learning how to use the UroLume stent, did you have occasion to read the manufacturer's instruction manual at some point?
A. It was many years ago, but, sure there are some instructions involved prior to using the device.
Q. Were there other types of stents similar to the UroLume stent that were available to you in 20 ?
A. Not that I'm aware of.
Q. In the course of your training and during your career, have you been exposed or had experience using other types of stents, other than the UroLume stent?
MR. : In the same time frame?
A. Not personally.
MR. OGINSKI: Yes.
Q. Where did you learn how to you

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, M.D. use the UroLume stent?
A. I can't tell you where I was at the time when I learned to use it, but it wasn't in my residency, but in some manner, somewhere or other, somehow that came about. I did learn how to use the stent. When there is a device in urology that is commonly used, one is obligated to learn how to use these things when they are available.
Q. Let me narrow the question.
MR. : Listen to the question. He's asking for a time frame now.
Q. While doing your residency, did you learn to use the UroLume stent?
A. I don't think they were available while I was in residency.
Q. After you were in private practice, at some point, did you learn these stents were now being used; is that

correct?
A. Yes.
Q. In order to learn how to use it,

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did you take a seminar, a continuing medical education seminar? Did you see an exhibit? Did a company rep come to you and explain to you that it was now available and tell you about it? How was it that you came to learn how to use this device?
A. I can't recollect specifically the circumstances under which I learned to use it.
Q. Have there have been occasions when --
MR. OGINSKI: Withdrawn.
Q. Have there been times, during the time you have used the UroLume stent, that you have had a company rep present in the room with you at the time you have used it?
A. Yes.
Q. What was the purpose of your having a company rep present at the time you used that device?
A. I mean there are several reasons that someone might be present.

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Q. Can you tell us how many times a rep has been present when you used the UroLume stent?
A. No.
Q. Was it more than ten?
A. I don't know.
Q. More than 20?
A. I don't know.
Q. Can you give me any sort of estimate?
A. I don't keep track of that; however, the reps are there --
Q. However often they are there, are there occasions that they are there when there is a particular reason for them being present?
A. Yes, sure.
Q. What is the reason --
A. There are several reasons. One might be, for instance, if a stent device doesn't work properly, they could provide a new one for the hospital.
Q. Have you ever had an occasion when you have encountered a stent that

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didn't work properly?
A. All devices --
Q. I'm talking about a UroLume stent.
A. I can't tell you that it has ever happened with a UroLume.
Q. Have you ever had a company rep assist you, guiding you, in the placement of a UroLume stent?
A. No. The rep is not there to assist in surgery. Reps aren't there to assist in surgery.
MR. : Off the record.
(Discussion held off the record.)
Q. Are there times when you have asked for assistance, either as a verbal assist or written assistance, from a manufacturer's rep in the insertion and placement of a UroLume stent?
MR. : Over objection to the form, it is asked and answered, but, doctor, you can answer.
A. I think it's asked and answered.
MR. : Off the record.

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(Discussion held off the record.)
(A recess was taken.)
MR. : What is the answer, doctor?
THE WITNESS: Please read the question back.
(The requested portion of the record was read.)
Q. Do you want to answer the question?
MR. : Over objection, you can answer.
A. When the rep is in the room, they often offer advice, sure.
Q. Other than offering advice, have you specifically asked for assistance or information from the company rep during the placement of a UroLume stent?
MR. : Let me make an objection to the form, to the word, "assistance." Are you asking did the doctor ask the rep to physically participate in the operation?
MR. OGINSKI: In any fashion.

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MR. : I am not sure what you are at getting with this, but if you want to stand on the question, you can answer over objection.
A. There is, as I said, conversation

going on sometimes. I can't give you a specific incident or time where I asked for anything specific.

MR. : Listen to the question. He's not asking about conversations. He's asking if you ever asked the rep to participate in the procedure. That's the question.

THE WITNESS: No.

Q. What is Dr. 's speciality?

A. He's a urologist.

Q. What is a cystoscope?

A. A cystoscope is the device used when you look inside the bladder with a scope.

Q. Can that procedure be done in your office?

A. Yes.

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Q. Am I correct that it can also be done in a hospital setting?

A. It can be done in the hospital setting.

Q. In a urethrotomy, typically, is the stent placed through the urethra and, a after period of time, the skin overgrows the actual stent?

A. No.

Q. How does the stent actually stay in place?

A. Well, after the stent is placed, there is a reepithelization over the stent.

Q. What is reepithelization? Can you tell me what that means?

A. The layer lining the urethra has to grow over the stent.

Q. So what is to prevent the stent from moving?

A. The union of the lining.

Q. In of 20 , did you have a choice of using any other type of stent to place in Mr. , other than the UroLume

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stent?

A. No.

Q. On 10, 20 , when you placed one or more UroLume stents into Mr. at Hospital, was a company rep in the room at that time?

A. I don't recall.

Q. If a company rep had been present

in the room, would you customarily have made a note of that person's presence in the room?
A. No.
Q. Would you, in general, make a note of that somewhere in the written portion of patient's hospital record, an indication that a rep was present in the room?
A. No.
Q. Is there anything that might assist you in refreshing your recollection as whether to or not the company rep was present in the operating room on 10, 20 , when you were putting in the UroLume stent?

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A. I don't know.
Q. Is there anything -- any notes, or a diary, or a calendar that you use on a regular basis -- in which there may be a notation that was made about a particular individual from the company being present in the room during the procedure?
A. No.
Q. To your knowledge, does anyone at Hospital keep track of company reps that enter the operating room?
A. In what sense?
Q. If they come in --
MR. OGINSKI: Withdrawn.
Q. Do you know of anyone who keeps track of other participants to the surgery, such as a company rep, who may be present in the operating room?
A. I'm not aware.
Q. In the course of your review of the patient's chart from Hospital, did you see any notation about a company rep being present in the operating room on 10th?

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MR. : Look at the chart in order to answer the question.
A. I don't recall any such notation.
Q. Did you have a particular individual from the company that made the UroLume stent who you were familiar with?
MR. : Like the rep who got him the stents?
MR. OGINSKI: Yes.
A. We deal with different reps.
Q. In 20 , who did you deal with?
A. There were several different reps we dealt with.

Q. Do you remember any of their names?
A. Their names? Sure.
Q. Who?
A. .
Q. What company did Mr. work for?
A. American Medical Systems.
Q. Is he still a rep for American Medical Systems, as far as you know?
A. As far as I know.

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Q. Does he still come to your office periodically?
MR. : Over objection to the form.
You can answer.
A. Sure.
Q. Was Mr. ever present in the operating room when -- during the insertion of a UroLume stent?
MR. : Objection to the form. You are not talking about the case?
MR. OGINSKI: No. This is in general.
A. Yes.
Q. Were there any other company reps whose names you recall who were ever present in the operating room during a UroLume stent insertion?
A. I don't recall.
MR. OGINSKI: I may ask for the rep's contact information at a later time.
MR. : We will take all

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requests under advisement. I will certainly ask you to put it in writing.
MR. OGINSKI: Sure.
Q. Doctor, during the 20, 20 procedure that you performed on Mr. at Hospital, was a company rep present during the insertion of the UroLume stent?
A. I don't know.
Q. Is there anything in your notes, or anywhere else, that would refresh your m as to whether or not someone was present from the company?
A. Nothing --
MR. : On 20th?
MR. OGINSKI: Correct.
A. (Continuing) Nothing that I saw.

Q. Do you have an independent m
of Mr. as you sit here now?
A. Yes.
Q. Do you remember what he looks
like?
A. Generally.

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Q. Do you remember certain
conversations you had with him during the
course of the time he was under your care?
A. Not specifics, but I do remember
talking to him, sure.
Q. Did you ever meet Mr. 's
wife --
A. I don't know.
Q. -- ?
A. I don't remember.
Q. Did you ever meet with any other
friends or family member of Mr. ,
other than himself and, possibly, his
wife?
A. Not that I recall.
Q. When you would examine a patient
in your office, did you have a particular
assistant or someone in there with you,
other than yourself?
A. Not typically.
Q. When you would perform a
procedure in the office, would you
typically have an assistant present in the
room to either help you, or to observe, or

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just to be there?
A. It's possible.
Q. If you had an assistant helping
you, would you expect to make a note of
that in your notes about who was present
for the procedure?
A. No.
MR. : You are talking
about an in-office procedure?
MR. OGINSKI: Yes.
Q. Let's talk about the UroLume
stent, doctor.
What are the indications for use
of the UroLume stent?
MR. : Objection to the
form.
Q. When you are using a UroLume
stent, is it important to measure the size
of the patient's stricture in order to
determine whether or not the UroLume stent
is appropriate for that particular
patient?
A. Yes.

Q. Why?

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A. Because there are different stents and -- I am sorry -- there are different sized stents that might be appropriate.

Q. Are you aware of the manufacturer's instructions or guidelines that tell you the indications for the size of the stricture in which the UroLume stent can be used?

MR. : Objection to the form of the question.

You can answer over my objection, if you want to stand on the question, Jerry.

MR. OGINSKI: Okay.

A. Is the question you are asking me am I aware how large a stent you need for a particular sized stricture?

Q. Yes.

MR. OGINSKI: Let me rephrase the question.

Q. Does the manufacturer put out information that says: In order to use the stent, the stricture may be no longer

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than "X" centimeters?

A. You would have to show me the literature for me to make a comment on it.

Q. Are you aware of any literature or documents that are put out by the manufacturer of the UroLume stent that say: In order to use the stent, you should use it only for patients whose strictures are of this size or less?

MR. : I want to place on the record a continuing objection to this line of questions concerning literature put out by the manufacturer, just for admissibility purposes.

Go ahead, if you know, if you familiar with the literature, you can answer.

A. Well, at the time that the UroLume stent came out, there was lots of discussion about it. So it was like we were all aware at the time of which size stent needs to used for which size stricture.

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Q. Let me ask you this in a different way, and I am sorry if I wasn't

clear: When the manufacturer comes out with a product -- in this case it was American Medical Systems --

A. Yes.

Q. -- they make the UroLume stent?

A. Yes.

Q. Is there certain information that is put out for the benefit of doctors who are going to use the product?

MR. : Objection to the form.

A. Correct.

Q. Did you ever become familiar with, or learn from the manufacturer, their requirements for their use, their indications for using this particular stent?

To be specific, did you ever learn or become aware of the manufacturer saying: Look, if you want to use this stent, this stent can only be used on a patient whose stricture is of this size or

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less?

MR. : Over objection to the form, doctor, you can answer.

A. Yes. The indications are available.

Q. What is your understanding as to what the manufacturer was indicating the intended use for the UroLume stent was as far as size of stricture?

A. The manufacturer's indications are relayed in various manners, not always written.

Q. I'm asking you only about written material that you learned of or were you made aware of.

A. Physicians don't use written materials when making these determinations, so I can't answer the question the way it is being asked.

Q. I will ask the question in a different way, doctor.

A. Okay.

Q. In the materials that the manufacturer did put out, were you aware

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of anything in that material that said: If you want to use this device, this device is only to be used for patients with a stricture of the following size, and then they go ahead and list the sizes they felt appropriate it to use the stent for?

I'm now asking specifically about the manufacturer's written documents.

MR. : Note my objection to the question.

A. You can't separate out what information they disseminate verbally from what's in written form, so I can't answer it.

Q. I'm not asking about verbal communications.

I am asking: At any time when you learned about the UroLume stent, did you read anything written -- did you learn from any written material put out by the manufacturer about this device -- did you ever learn what size strictures they were telling you, meaning doctors, to use this

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device for in terms of the size of the stricture?

MR. : Objection to the form.

If you understand it, you can answer.

A. I'm trying to explain this to you. Written material is used in conjunction with things learned from other sources, so the question can't be answered specifically.

MR. : Listen to the question. All he is asking you now is: Did you ever read something from the manufacturer -- forget verbal advice or your clinical experience -- he's asking you: Did you actually read something that said: Don't use the stent if the stricture is "X" centimeters long, or only use the stent with strictures this number or numbers of centimeters or less?

MR. OGINSKI: Exactly.

MR. : I object to the

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question for a number of reasons.

If you can answer it in such a form, you can tell him.

A. I can't remember everything I've read. It's over ten years ago that the stent was first introduced.

Q. What was your understanding as to the size of the stricture that the patient would need in order for you to use the UroLume stent?

MR. : Objection to the question, only because of the form.

You are assuming that there is a size where it is indicated or contraindicated.
Over objection, doctor, you can answer.
A. Everything has to be individualized for the particular patient. People's urethras are different lengths. Strictures are different lengths. If a proper size stent couldn't be used over the stricture, you may not want use it. For instance, if the stricture is over

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four centimeters. But certainly everything is individualized to a particular case.
Q. Why wouldn't you use a stent for a stricture over four centimeters?
MR. : Over my objection, I think the response was that you may not want to use it.
A. One example, one reason, might be that the re-stricture rate might be too high.
Q. Did you ever learn from reading any material from the manufacturer of the UroLume stent that the stent was not to be used for strictures greater than three centimeters?
A. No. I never read such material.
Q. Did you ever read any literature, medical literature, published papers, or medical texts, indicating that, with respect to the use of the UroLume stent for strictures greater three centimeters, they were not to be used?
A. No.

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Q. In Mr. 's case, on 10, 20 , am I correct, that you actually measured the length of the stricture?
A. Yes.
Q. You estimated its length to be between three and a half to four centimeters; correct?
A. Correct.
Q. You did that by visually observing the stricture?
A. Yes.
Q. Did you have any tools or devices available to you with which you could measure the length of the stricture accurately?
A. Yes.

Q. What device was available to you to actually measure the length of the stricture accurately?
A. The markings on the cystoscope.
Q. Did you in fact use that particular device to measure Mr. 's stricture on 10th?
A. Yes.

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Q. Can you tell me how you came to that estimation instead of a more precise number as to the length of the stricture?
MR. : Objection to the form.
A. Yes.
Q. Please tell me.
A. There is no way to do it absolutely precisely. It's always an estimate.
Q. Were you aware of the manufacturer's --
MR. OGINSKI: Withdrawn.
Q. Were your aware of any materials that were put out by the manufacturer of the UroLume stent regarding the age at which a UroLume stent should not be used?
MR. : Over continuing objection.
Over objection, you can answer.
A. No.
Q. Did you learn from the manufacture's written materials that, with respect to the use of a UroLume stent in

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patients under age 30, they are not be used?
MR. : Again over objection.
A. No.
MR. : Do you have the particular year for the manufacturer's material you are referring to, or are you just asking generally?
MR. OGINSKI: Just in general.
MR. : Over my objection.
Q. Did you ever learn that the manufacturer, when they came out with the UroLume stent, did not have sufficient data to support the use of the UroLume stent in otherwise healthy males that were under the age of 30?
MR. : Over objection.
A. Not that I recall.
Q. When was the last time that you reviewed the instruction manual for the

UroLume stent?
A. I can't tell you that. I just don't recall.

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Q. I'm asking going from the present time all the way back to when you began your private practice.
A. Well, probably ten years ago or longer.
Q. What was your reason for reviewing or reading the instruction manual at that time?
A. It was around the time that I first used the device.
Q. When you first used the device, was it in an operating room setting, or was it at some type of seminar where you were learning to use the device?
A. The first time I used it was in the operating room.
Q. Before actually using the UroLume stent in the operating room, in terms of actually learning how to use it, was that done in a seminar setting where someone was teaching, or was the company rep in the room watching throughout the time you were in operating room using it?
MR. : Or something else?

0043

, M.D.
A. Something else.
Q. What was it?
A. It involved reviewing the materials to learn the indications and gaining familiarity with how the device works. This is usually done in the office or clinic setting.
Q. What was your understanding, doctor, of the size of the stricture the patient needed to have in order to use a UroLume stent?
MR. : Again, over objection.
A. In general, if it was well contained within the bulbar urethra and less than four centimeters, it was an appropriate choice for the patient with recurrent stricture.
Q. Now, you raised an issue when you answered a question a few minutes ago --
MR. OGINSKI: Withdrawn.
Q. If the patient's condition exceeded the manufacturer's requirement --
MR. : Are you talking

0044

, M.D.

about stricture length?
MR. OGINSKI: Yes.
Q. -- about whether or not you could use a UroLume stent, were there still instances where you felt it would be appropriate to use a UroLume stent, despite anything the manufacturer may have had said in their instruction manual or guidelines?
MR. : I have an objection to the form, but go ahead and answer.
A. It's always possible that the representatives have information that is not available in printed company literature.
Q. Was there anything you learned about in the year 2004 or 20 that changed your knowledge about the use or indications for use of the UroLume stent?
A. Sure.
Q. What did you learn in that time period that changed your knowledge about the UroLume stent and indications for its use?

0045

, M.D.
A. As with all surgical procedures, always, the more familiarity you have with certain procedures, the greater the knowledge you have about the particular procedure and how the device should be used.
Q. I am asking specifically: If you can tell me, what specific knowledge did you learn in the year 2004 or 20 that you didn't know in the year 2002 or 2003 or earlier?
A. I don't know specifically. It's just the knowledge I gained over time.
Q. Did the size of the stricture --
MR. OGINSKI: Withdrawn.
Q. Did the manufacturer's recommendations about the size of the -- about the size of the patient's stricture -- change in the year 2004 or 20 , before you performed the procedure on Mr. in of 20 ?
MR. : Over objection, you can answer.
You are asking about the

0046

, M.D.
manufacturer's recommendations?
MR. OGINSKI: Right.
A. I can't --
MR. : Over objection.

A. (Continuing) I can't answer that. I'm not at liberty to comment on whatever the manufacturer's particular suggestion was at that time.
Q. I am only asking if you knew or if you were told that this manufacturer's recommendations had changed, based on anything the company reps had told you in the year 2004 or 20 .
A. No. I was not told about anything.
Q. Did you have an understanding from any published literature --
A. No.
Q. -- that the indications for using the UroLume stent had changed in the year 2004 or 20 compared to years earlier?
A. Not that I'm aware.
Q. How about a patient's age, how did that affect the use or your decision

0047

, M.D.
to use a UroLume stent, if at all?
A. It may have affected it.
Q. How?
A. In very young patients, you may, when putting in an implantable device, have to adjust for how much longer it has to stay in there.
Q. Was that something of concern to you such that you may not want to put it in a young patient?
A. Well, there have been reports of particularly young patients and pain and discomfort or...
Q. When you say, "particularly young patients," can you be specific as to the age you are referring to?
A. For instance, I would never put one in a teenager.
Q. Can you tell me any more specifically a range of ages of patients that you consider to be young patients?
MR. : In terms of the use of a UroLume stent?
MR. OGINSKI: Correct.

0048

, M.D.
A. Every case has to be judged on an individual basis, but in the teens and twenties, you want to may consider other options.
Q. Such as what?
A. Such as, well, there is a whole paradigm when you are presented with stricture. For instance, depending on the size and position of the stricture, the

treatment maybe something as simple as dilation.
Q. Are you familiar with the term known as "an off-label use"?
A. Yes.
Q. What does that mean to you?
A. The FDA will generally set the guidelines for the particular medication, for instance. Yet, in many instances, there are desirable effects that aren't particularly outlined in their packaging inserts, and many medications are used for other purposes based on the other effects they might have.
Q. Are there instances where you

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, M.D.
have used the UroLume stent in a patient where you felt there were indications for using it, and it did not exactly correlate with the manufacturer's requirements, if you felt a patient would benefit from the stent?
MR. : Over objection, you can answer.
A. No.
Q. Have you ever used the UroLume stent in an off-label manner?
A. No.
Q. Is it your opinion, doctor, that on each occasion you have used the UroLume stent, you have done so, using it, according to the manufacturer's recommendations and the FDA guidelines?
MR. : Over objection to the form.
A. To my knowledge, yes.
Q. When you insert a UroLume stent, is it your intention, and hope, and desire that the stent does not move and does not migrate?

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, M.D.
A. Yes.
Q. Are there occasions when the stent has been known to move or migrate?
MR. : As a general proposition now?
MR. OGINSKI: Yes.
A. Yes, I have seen... I have heard of that happening, yes.
Q. How does that happen?
A. There are several proposed mechanisms. It's thought that prior to epithelialization, it's possible that the stent could move or migrate. There are cases where the patient has been

catheterized and that has moved the stent.
Q. Before epithelization?
A. Prior to -- prior to epithelization.
Q. How long does it take for epithelization to occur after placement of the stent?
A. Epithelization may take up to several weeks.
Q. Once there is epithelization, do

you know, either in your own practice or from practice in the community, or from the published literature, of instances where a stent has migrated even though there has been epithelization?
A. I don't know of such a specific case after epithelization.
Q. In your experience, doctor, in the number of times that you have inserted UroLume stent, which you noted was may be 30 to 40 times, have you ever observed the UroLume stent to move after you have placed it?
A. Not to my knowledge.
Q. Let's talk about how you place a UroLume stent.
Can you explain to me how the process is accomplished and what you do?
A. Not every case is the same. Would you like --
Q. In general.
A. In general, you visualize the stricture. And often the stricture has to be opened. Sometimes the stricture has

been previously opened. That's either done prior to the procedure, or at the time of the procedure.
Then the length of the stricture is measured. And the appropriate size stent is placed with a particular device that comes from the manufacturer to place the stent in the particular position under direct vision.
Q. How do you know where to place the stent?
A. The stent is placed across the stricture.
Q. And the device that is used to actually put the stent into the urethra, is that when -- are you familiar with the term, "discharging the stent"?
A. Yes.
Q. What is that? How does that

happen?
A. Basically that's the device that's housing the stent. A scope is used to place it. Using the scope, you to place it directly through the device, and

, M.D.
there is a handle that is pressed that discharges the device.
Q. When this stent is actually loaded onto this device, it's coiled tight; is that right?
A. It comes preloaded.
Q. Once it is discharged, then it releases and springs out, opens up?
A. Yes.
Q. Is it ever acceptable, doctor, to place this stent in any part of the penis?
A. I can't answer the question the way it was phrased.
MR. OGINSKI: I will rephrase.
Q. You told me earlier that you typically place the stent in the bulbar urethra?
A. Correct.
Q. Anatomically, when going into the penis from the head, there is a length of tube or -- what you call that part that you enter into the penis?
A. Meatus.
Q. Generally that's the length

, M.D.
before you reach the end of the penis; correct?
A. Before, before you reach the beginning of the penis, it's not the end, the meatus.
MR. : Starting with the distal end going back?
THE WITNESS: Right.
Q. Where does the urethra begin?
A. At the bladder.
Q. Where does it end?
A. The meatus.
Q. Where in the actual penis itself is it appropriate to place a stent within the length of the actual penis?
A. If you are referring to the part of the urethra, if you are referring to the pendulous or penile urethra, the answer is: No, it would be never placed in that position.
Q. If a doctor such as yourself placed a UroLume stent within that particular portion of the penis, would you consider that to be a departure from good

, M.D.

and accepted medical cure?

A. No one would do that.

Q. To follow up, it would be a departure to put it there; correct?

A. If somebody did it, theoretically, yes.

MR. : You are asking if a doctor knowingly, okay, knowingly placed it there intentionally, would it be a departure?

MR. OGINSKI: Yes.

Q. Let's talk about treating strictures.

What are the methods that are commonly acceptable to treat a urethral stricture?

A. There are volumes written about this. It all depends on the size of the stricture, the position of the stricture, and there are many other factors involved. No general...

Q. Does the age of the patient play a role?

A. That may play a role.

, M.D.

Q. In treating a patient with a stricture, do you use any type of algorithm, or text, or literature to tell you, or a decision-making tree that says, if the patient does this, you do X, Y, Z; if he does that, you do A, B, C?

MR. : Are you asking about something in particular?

MR. OGINSKI: We can have it read back.

(The requested portion of the record was read.)

Q. Do you have an algorithm you use to decide on what treatment to give to the patient who is suffering from urethral stricture?

A. There are algorithms that give you general guidelines. Depending on the actual circumstances, you make the appropriate adjustments.

Q. Where do you have that algorithm that you use?

A. In my brain.

Q. Are there any written algorithms

, M.D.

that you use, other than your own knowledge and experience?

A. No.

Q. What is the most common type of treatment that is used to treat a urethral stricture?
A. Dilation.
Q. That's something that you can do in the office; correct?
A. Or the patient sometimes self-dilates at home.
Q. Is that something you would teach the patient to do?
A. That is possible, yes.
Q. After dilation, what is the most common or most commonly accepted method used treat a stricture?
A. Again, it depends on the actual circumstances of the particular case.
Q. Let's start with medical treatment.
What are the available treatments for urethral stricture; nonsurgical treatments?

, M.D.
A. There are, to my knowledge, no highly effective medical treatments or medications that treat strictures.
Q. What surgical procedures are available to treat urethral strictures?
A. Dilation, urethrotomy, placement of a urethral stent, and open urethroplasty.
Q. In deciding which choice of procedure to recommend to a particular patient, is it important for you to know whether or not this patient has a recurrent stricture that you have treated in the past?
A. Yes.
Q. Why is that important?
A. Because if one particular method doesn't seem to work, you might want to try something different.
Q. After stricture occurs the first time, is the acceptable treatment, the first acceptable medical treatment to treat a stricture a urethrotomy?
A. Yes.

, M.D.
Q. If the stricture occurs a second time, is it acceptable to do a repeat urethrotomy?
MR. : Again, you are speaking in general terms?
MR. OGINSKI: In general.
A. Yes.
Q. If a stricture recurs a third

time, is it appropriate to do a repeat urethrotomy?
A. It may be.
Q. If there is a recurrence of the stricture a fourth time, is it acceptable to perform another, a repeat urethrotomy?
A. It may be.
Q. When is it no longer acceptable to perform a repeat urethrotomy instead of a different procedure?
MR. : If ever.
A. It's not general. It's -- there's no absolute on when not to do a repeat urethrotomy.
Q. When is it appropriate to refer to a specialist --
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, M.D.
A. There is no absolute.
Q. Did Mr. need a urethrotomy to cure his condition?
MR. : When?
Q. At any time when he was under your care in 20 , did he ever --
MR. OGINSKI: Withdrawn.
Q. Am I correct that urethrotomy is a temporary cure used for recurrent stricture disease?
A. Not necessarily.
Q. In your experience, is it your opinion that urethrotomies can be permanent, can permanently cure recurrent stricture disease?
A. I have seen many cases. Absolutely.
Q. Are you also familiar with occasions when repeat urethrotomies do not cure recurrent stricture?
A. I'm familiar with those as well.
Q. At any time while caring for Mr. , did you ever feel that performing a uroplasty for his condition
0 1
, M.D.
would cure his physical condition?
A. Not at the time I was seeing him.
MR. : Note my objection to form of the last question.
Q. In a 35-year old man, such as Mr. , and I am asking a general question, is it acceptable to place a UroLume stent in order to treat a recurrent stricture?
A. Yes.
Q. In a young man with good erections, and good erectile function, is it acceptable to place a UroLume stent to

15 treat recurrent stricture?
16 MR. : Define "young" in
17 that question.
18 Q. In a 30-year male with good
19 erections and good erectile capacity, is
20 it acceptable to place a UroLume stent in
21 order to treat recurrent stricture?
22 A. There is no absolute
23 contraindication.
24 Q. Is the answer yes?
25 A. The answer is there no absolute

1 , M.D.
2 contraindication.
3 Q. In an otherwise healthy male who
4 is 35 years of age, the fact that a
5 patient --
6 MR. OGINSKI: Withdrawn.
7 Q. When placing a UroLume stent,
8 what effect, if any, will it have on an
9 individual with good erections and with
10 good erectile capacity?
11 MR. : Objection to the
12 form. Again you are asking these
13 questions in a vacuum? You were not
14 referring specifically to Mr. ?
15 MR. OGINSKI: I am asking in
16 general sense, if he can tell me.
17 MR. : Rephrase.
18 Q. Is it necessary to have good
19 erectile capacity --
20 MR. : Are you repeating
21 the question?
22 MR. OGINSKI: I'm rephrasing.
23 Q. Does the insertion of a UroLume
24 stent in a 30-year-old male have an effect
25 on a person's ability to have an erection?

1 , M.D.
2 A. Not absolutely.
3 Q. Have you seen instances, have you
4 ever seen instances where it does?
5 A. No.
6 Q. Are there instances in the
7 literature that you are aware of where
8 there is an erectile problem as a result
9 of a stent placement?
10 A. I have seen patients who did not
11 have the ability to achieve an erection.
12 Q. Are you familiar with the phrase,
13 "the gold standard"?
14 A. Yes.
15 Q. What does that phrase mean to
16 you?
17 A. It is the generally accepted
18 practice.
19 Q. What is the gold standard for

treatment of recurrent stricture disease?
A. Urethrotomy.
Q. After a failed urethrotomy, what is the next gold-standard treatment for recurrent urethral strictures?
MR. : Over objection to the form, you can answer, doctor.
A. There are several options.
Q. What are they?
A. Repeat urethrotomy, or urethrotomy via a different method, or urethrotomy followed by self-dilation, or periodic dilation, or placement of a UroLume stent, or an open urethroplasty. There are many options available at this time.
Q. At what point do you say: We are going to do an open urethroplasty?
A. It all depends on the particular case.
Q. Is there any particular reason --
MR. OGINSKI: Withdrawn.
Q. When treating Mr. , am I correct, that you performed more than one urethrotomy for his recurrent stricture?
A. Yes.
Q. After the second time you performed a urethrotomy, when he came back with additional complaints, is there any particular reason why you did not send him out to a specialist to treat his ongoing condition?
A. Yes.
Q. What was the reason?
A. I have treated many cases, a multitude of similar cases, and a second urethrotomy often takes care of the problem.
Q. When the second urethrotomy did not take care of the problem and he required a third procedure, is there a reason why you did refer him out to specialist to address the issue?
MR. : A specialist in what?
MR. OGINSKI: In the field of urology.
Q. Either a colleague of yours or someone who has an additional specialty such as Dr. .
MR. : Jerry, a specialist for what? He has performed an open urethrotomy. He does the stent

placement. He does the urethrotomy.

, M.D.

Why would he need to send him to a specialist?

Q. After the second failed urethrotomy for Mr. , did you perform another urethrotomy, or did you perform an open urethroplasty?

A. After the second failed urethrotomy, I believe Mr. and I had a discussion in the office about various options. At that point, the options included another urethrotomy, performed by a different methodology, placement of a stent versus an open urethroplasty.

Q. When did you have that conversation?

A. May I refer to the chart?

Q. Of course, and tell me the date of that note, please.

A. May 12, 20 .

Q. What is in that note that you are looking at or reading that refreshes your recollection?

A. This was after the second urethrotomy. Visually the patient had a

, M.D.

very slow stream.

Q. What did that suggest to you, if anything?

A. That perhaps the second urethrotomy had failed and the stricture had recurred. At that point I discussed options with him as I have outlined before.

Q. Is there anything within your note that indicates that you had a discussion with Mr. about the options?

A. Yes. Because we came up with a plan.

Q. Other than writing, "Plan," and actual words, "UroLume stent PG," is there anything else in your notes that indicates that you had such a conversation with Mr. ?

MR. : Objection to the form. He also told you what was indicated to him by the patient.

MR. OGINSKI: I am asking if he specifically wrote down anything about

, M.D.

the conversation.

MR. : Are you asking if

there's something in the note that says: I had a conversation with him?

MR. OGINSKI: Yes.

MR. : That's a different question.

Q. Is there anything in your note to say that you actually had a conversation with him about his options?

A. Well, when the plan is written. The plan cannot be made without discussing with the patient what the plan is. The plan is not created in a vacuum. So this was absolutely discussed, as is my custom and practice. I discussed procedures, to come up with a plan, in conjunction with the patient.

Q. Is there anything in the note to indicate what the actual options were that you discussed with him, other than the UroLume stent option?

A. They are not outlined.

Q. Is there anything in the note

, M.D.

that would indicate specifically that the risks and benefits were discussed regarding the treatment options?

A. As I previously explained, when a plan is come up with, the risks of all options and the benefits of all options are discussed with the patient.

Q. Is there anything in your note to indicate that you discussed the specific risks and benefits with this patient?

MR. : Are you asking him if he listed them in his note?

MR. OGINSKI: Or noted that he discussed them.

MR. : Is there a note on the risks and benefits? Do you have a list that you wrote out?

THE WITNESS: No, there is nothing listed here.

Q. Do you have an independent m , as you sit here now, of that conversation you had with him on May 12, 20 , regarding his options?

A. On that specific date, no.

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, M.D.

Q. Other than the plan to try the UroLume stent, do you recall what you said to him about the performance of open uroplasty, of what you said and what he said?

MR. : He is asking for an independent recollection.

Q. I am not asking about custom and practice. I'm asking if you have a specific recollection --
A. No.
Q. Was Mr. alone or did he have anybody with him at the time you had this discussion?
A. I don't recall.
Q. Was anyone from your office in the room at the time you had this discussion?
A. I don't recall specifically.
Q. Did you customarily record your discussions with patients concerning risks and benefits or plans in any form, either by audio recording, or video, or something else?

0071

, M.D.
A. No.
MR. : Objection to the form. He already told you what he discussed in those areas.
Q. Regarding use of the UroLume stent, did you record the conversation by any means, audio or video, that you had with the patient regarding use of the UroLume stent?
A. No.
Q. Have you lectured to any physicians about the use of UroLume stents?
A. No.
Q. Have you ever contributed to any portion of any textbooks regarding the use of UroLume stents?
A. No.
Q. Have you done any research on behalf of the company that manufactures the device for them?
A. No.
MR. : Please read that back.

0072

, M.D.
(The requested portion of the record was read.)
MR. OGINSKI: Strike that.
Q. Have you ever performed research on behalf of a manufacturer of some type of device you use in your practice, over the course of your career?
A. A device, no.
Q. Is there any type of product where you have done research on behalf of the manufacturer that made a product that you use in your practice?

A. No.
Q. Doctor, when you were learning how to use the UroLume stent, was there a requirement by the manufacturer that you take a course of study in order to learn how to use the device?
MR. : Over objection, you can answer.
A. I don't recall.
Q. Did you watch any videos made by the company before using the device?
A. I don't recall.

0073

, M.D.
Q. Whenever it was that you learned to use the device, did you see any videos regarding use of the device?
A. I don't recall.
Q. When you actually started --
MR. OGINSKI: Withdrawn.
Q. What is prostatitis?
A. Prostatitis is --
Q. Again we are starting with in general.
A. -- inflammation, pain in the prostate, in some cases possibly more serious than others.
Q. Turning to the notes on Mr. , specifically, in 2003, you made a diagnosis that Mr. was suffering from prostatitis. If you would look at the consult report dated December 2, 2003 please.
(Witness complies.)
A. Yes.
Q. The impression is that he had prostatitis?
A. Yes.

0074

, M.D.
Q. What led you to conclude that he had prostatitis at that time?
A. Because the prostate was, quote, very tender.
Q. Was a urinalysis done before coming to your conclusion on December 2, 2003?
A. Urinalysis is not necessary to make that diagnosis.
MR. : He asked you whether one was done: "Yes" or "no"?
THE WITNESS: I don't know.
Q. Is there anything in your notes to suggest that a urinalysis was done before coming to the conclusion that Mr. was suffering from prostatitis in December of 2003?

A. No.
Q. Where did you go to medical school, doctor?
A. .
Q. From when to when?
A. I graduated in the class of 2000 -- sorry -- graduating class of .

, M.D.

Q. You started medical school when?
A. I started medical school in 1981.
Q. What did you do after graduating from ?
A. I did my residency.
Q. Where?
A. Two years of general surgery at , followed by three years of urology at Hospital in New York.
Q. When did you complete your residency training in urology?
A. .
Q. Did you do any type of fellowship after completing your urology residency?
A. No.
Q. Did you do any additional postgraduate training after completion of your urology residency?
A. Are you talking about conferences and --
Q. No.
MR. : Any further formal training?

, M.D.

MR. OGINSKI: Yes.
Q. I am asking about any further formal training done in a hospital setting, in accredited, approved programs, other than a fellowship. I'm not talking about CME training.
A. No.
Q. After completing your residency in urology, did you go into private practice?
A. Yes.
Q. Where did you do your undergraduate studies?
A. .
Q. From when to when?
A. Graduating class of .
Q. You started what year?
A. .
Q. Now, going back to , did you go to for all four years?
A. No.

Q. Tell me where you went for the first couple of years before graduating

0077

, M.D.

from .

A. I want to school at .

Q. When did you attend medical school in ?

A. 19 to 19.

Q. After 19 you then transferred to

A. Yes.

Q. -- where you continued from to ?

A. Yes.

Q. When you graduated from medical school, it was with a degree from ?

A. Correct.

Q. Are you licensed to practice medicine in the State of New York?

A. Yes.

Q. When did you become licensed?

A. I believe 19 .

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

A. Yes. Urology.

0078

, M.D.

Q. When did you become board certified in urology?

A. 19 .

Q. When you took the boards, what board organization certified you?

A. American Board of Urologists.

Q. Am I correct that that board examination consisted of a written and an oral examination?

A. At separate times, yes.

Q. When you took the board's oral examination, did you have to take it more than once?

A. No.

Q. When you took the written part of the examination, did you take that part more than once?

A. No.

Q. Are you required to become recertified in urology?

A. Yes.

Q. After how many years?

A. After ten years.

Q. Did you become recertified in

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, M.D.

20 ?

A. Yes.
Q. How long is that recertification good for?
A. Until 20 .
Q. Are you board certified in any other field other than urology?
A. No.
Q. Are you licensed to practice medicine in any state besides New York?
A. No.
Q. Has your license to practice medicine ever been suspended?
A. No.
Q. Has your license to practice medicine ever been revoked?
A. No.
Q. Tell me the hospitals you are currently affiliated with.
A. All of them?
Q. Yes.
A.
Hospital, ; Hospital, New York; Hospital in .

0080

, M.D.
I think that's recently changed its name to . It's possible. Hospitals frequently change names... , it's now called Hospital in .
Hospital in .
Hospital in . Those are the ones I can recall off the top of my head.
Q. In 20 , when you were treating Mr. , were your hospital affiliations the same?
A. Yes.
Q. Currently, what is your hospital affiliation with each of these facilities? What is the nature of it?
A. I'm affiliated. I have privileges.
Q. Are you an attending physician --
A. Yes.
Q. Are you an attending in the Department of Urology?
A. Yes.
Q. Do you have privileges to perform

0081

, M.D.
surgery at any of these particular hospitals?
A. Yes.
Q. At any time before the year 20 , were your privileges at any one of those hospitals ever suspended, other than for

medical-record issues?
A. No.
Q. Were your privileges to admit and treat patients at any of these hospitals ever revoked for any reasons related to patient care?
A. No.
Q. In the course of your career, doctor, have you ever published anything under your name?
MR. : Peer review journals?
MR. OGINSKI: Correct.
A. Yes.
Q. How many articles have you authored or coauthored?
A. I think it's .
Q. Were they done while in your

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, M.D.

residency?
A. Yes.
Q. Can you tell me, can you recall the topic of either of those articles?
A. It's been so long, I can't, I can't remember. I am sorry.
Q. Are they listed in your CV? Does your CV list those two articles?
A. It may or may not.
Q. Does either of those articles relate to the treatment of patients with recurrent urethral stricture disease?
A. No.
Q. Have you published, as an author or coauthor, any portions of textbooks in the field of urology?
A. No.
Q. Have you given any lectures to any national bodies of urologists at any national conferences?
A. No.
Q. Have you ever testified before?
A. Yes.
Q. How many times?

0083

, M.D.

A. A few.
Q. Can you tell me what you mean by, "a few"?
A. I have been asked to be an expert on several occasions.
Q. On those occasions when you asked to be an expert, have you --
MR. : When he has been asked to be an expert?
MR. OGINSKI: When he has been asked.

Q. -- have you testified in court as an expert?
A. Yes.
Q. How many times?
A. Several times. It's not anything I keep track of.
Q. You can tell me an estimate?
MR. : Can you approximate how many times?
THE WITNESS: Five.
Q. When you testified as an expert, was it on behalf of the patient, the doctor, or someone else?

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, M.D.
A. Both.
Q. Can you give me breakdown on that, if you remember, how many times you testified for a patient, how many times for the doctor or the hospital, or someone else?
A. Well, I suppose more for a patient with a complaint against the hospital, but that wasn't always the case.
Q. Let me rephrase the question.
On any of the occasions that you testified as an expert, was it testifying in a medical malpractice matter?
MR. : Whether for a patient or for the defense?
MR. OGINSKI: Yes.
A. Yes.
Q. In those medical malpractice matters where you have testified as an expert, how many times did you testify on behalf of the patient or the plaintiff?
A. Twice I believe.
Q. And how many times on behalf of, other than medical malpractice --

0085

, M.D.
MR. OGINSKI: Withdrawn.
Q. Have you ever testified on behalf of another doctor or a hospital in a malpractice matter?
A. Yes.
Q. How many times?
A. Once or twice.
Q. For those times that you have testified on behalf of another doctor or hospital, what types of cases were those?
A. Not urethral stricture.
MR. : Off the record.
(Discussion held off the record.)
A. (Continuing) Accident, medical malpractice; that would cover all those.
Q. Other than the times when you

testified as an expert on behalf of one side or another, have you had occasion to testify as a defendant, similar to what we are doing here today --

MR. : Over objection, you can answer these questions.

Q. -- where you have been sued?

A. I have been to EBTs, yes.

0086

, M.D.

Q. Can you tell me how many times you have been to an EBT in a case where you have been involved as a person who has been sued?

MR. : Again, over objection.

A. I don't know.

Q. More than ten times or less than ten time?

MR. : Over objection, you can answer.

A. Less than ten.

Q. More five or less than five?

A. Less than five.

Q. When did Mr. first come to see you for the very first time?

A. I believe it was December 2, 2003.

Q. What office did he see you in?

A. I believe it was the office at .

Q. That is in ?

A. Yes.

Q. Over the course of time, did you

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, M.D.

continue to see him at that office?

A. To best of my recollection, yes.

Q. Can you tell me how it was that you came to perform surgery on at Hospital in or of 20 , as opposed to any of the other hospitals you were affiliated with at that time?

A. Yes. I operate there commonly.

Q. What was it about Hospital that made you choose to perform the procedure there as to opposed to any other hospital?

A. I can't tell you what went into the specific decision-making process on that particular occasion, but I perform most of my surgeries at that hospital.

Q. Do you have any title at Hospital, other than attending?

A. Yes.

Q. Any administrative title?
A. Yes.
Q. What is that?
A. I am .

, M.D.
Q. When did you get that title?
A. Years ago.
Q. How many urologists are in the department?
MR. OGINSKI: Withdrawn.
Q. In the year 20 , did you hold that title?
A. Yes.
Q. What does that title confer upon you upon in terms of administrative duties and other things you are required to do as ?
A. I sit on the medical board of the hospital. I'm on certain committees. I'm involved in the credentialing or recredentialing of urologists applying for privileges.
Q. How many urologists were affiliated with Hospital in the year 20 ?
A. Approximately .
Q. How long had you been the as of 20 ?
A. Several years before that.

, M.D.
Q. Do you hold that title --
MR. OGINSKI: Strike that.
Q. Do you have a similar title at any of the other hospitals you are affiliated with?
A. I have other titles.
Q. Are you at any other hospital?
A. No.
Q. Are you , or of any urology department at any of the other hospitals you are affiliated with?
A. No.
Q. Do you recall having a conversation --
MR. OGINSKI: Withdrawn.
Q. Did you have a conversation with in the year 20 that's not concerned with your records?
MR. : After your last care and treatment.
A. I don't recall the specific date.
Q. At some point after a request for

records had been made to your office, did you contact Mr. to see how he was doing and what was happening with him?

MR. : Did he contact Mr. as opposed to Mr. contacting him?

MR. OGINSKI: Correct.

MR. : In the year 20?

MR. OGINSKI: Correct.

A. Again, I don't recall specifically when, but I did have a conversation with Mr. after my last visit with him on .

Q. About how long did that conversation last --

MR. OGINSKI: Withdrawn.

Q. Was it a conversation in person, by telephone, or by some other means?

A. By telephone.

Q. Tell me how that conversation came about.

A. Mr. had called the office and I returned his call.

Q. Did you learn from him why he was

calling your office?

A. Yes.

Q. What did he tell you?

A. He said he had called the office to bring me up to date on what was going on with him and to talk.

Q. Did he call and ask for copies of his medical records?

A. I don't recall discussing records.

Q. Did he advise you that someone on his behalf had requested medical records from your office?

A. I don't remember.

Q. Did he tell you why the medical records had been requested from your office?

A. No, not that I recall.

Q. Do you recall what season this conversation was in? Was it winter, spring, summer, fall?

A. I don't recall the particular season.

Q. Were you in your office at the

time you spoke to Mr. ?

A. Yes.

Q. Was it during normal working

hours?
A. I would think so.
Q. As a result of your conversation with him, did you make notes of that conversation?
A. No.
Q. When you have a conversation with a patient, do you typically make a note in the patient's chart indicating you have spoken to the patient? Do you make a note of what you spoke about?
MR. : Over objection. In the circumstances when the patient is no longer seeing him, or as a matter of custom and practice?
MR. OGINSKI: I will rephrase.
Q. In general, when a patient under your care calls you to discuss a particular problem, when you speak to the patient during office hours, would you make a note in the chart of patient Jones

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, M.D.
called, that you spoke to him, and note that this is what we said?
A. Not always.
Q. If a patient called to speak to you outside of office hours, whether at home or somewhere else, on the weekend, are there times or instances when you will, at a later date, make an entry in the patient's chart saying that you spoke to him and this is what you spoke to him about?
A. Not necessarily.
Q. When you reviewed Mr. 's office chart, did you see any notations you made about a conversation with him after of 20 ?
A. There is no note in the chart.
Q. Tell me what specifically Mr. said to you about his condition at the time of your conversation.
A. He told he had moved to , and that he had undergone some sort of extensive surgery that took six or eight hours. He couldn't give me more details.

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, M.D.
Q. Was there anything else that he told you?
A. That was most of what we talked about.
Q. Did he inform you that the surgery involved, that the surgery was something involving his urethra?
A. Yes.

Q. What, if anything, did you ask him based on the information he gave you?
A. I asked him if -- there were several things I asked him -- if the doctor wanted to have any information from me, or if he wanted his doctor to give me a call so I could tell him what my findings were.
I talked to him about, if he were in New York, that I would happy to continue on being his physician.
Q. What was Mr. 's response when you made these suggestions to him?
A. At the time he said, you know, that's a good idea. I think you should talk to the doctor. I will talk to you

0095

, M.D. when I'm in New York. Yes, I would like to see you.
Q. After that specific conversation, did you speak to any of Mr. 's doctors who were treating him in ?
A. No.
Q. Do you know who Dr. is?
A. No.
Q. Have you seen records from a urologist named Dr. ?
A. No.
Q. Do you know a Dr. at ?
A. No.
Q. Have you seen or read anything about him in the literature in the field of urology?
A. No.
Q. Did you ever have any communications, written or otherwise, with Dr. regarding Mr. ?
A. Not that I recall.
Q. Did any physician ever request

0096

, M.D. copies of Mr. 's medical records before you had this conversation with Mr. ?
A. I don't recall.
Q. After that conversation --
MR. OGINSKI: Withdrawn.
Q. I want to be clear, doctor: Did that conversation with Mr. take place in the year 20 ?
A. It was sometime after 20, .
Q. As you sit here now, do you recall if that conversation took place in

20 --
A. I can't tell you the exact date.
Q. If I told you that that conversation took place in , would that refresh your m ?
A. Again, I can't give you an exact date. I just remember speaking to him one time after the last time I had seen him.
Q. Did you ever talk to Mr. again after that conversation?
A. Not after the conversation.

, M.D.
Q. Did you receive any written correspondence from Mr. about his ongoing condition after that conversation?
A. No.
MR. OGINSKI: We can take a break here.
(A recess was taken.)
Q. Doctor, I want to talk about the insertion of the UroLume stent in regard to its placement in the bulbar urethra.
Does that cause pain or can it cause pain?
MR. : Objection to the form. Are you asking as a general proposition? Is that what you are asking?
Q. Generally, is it one of the side effects of placement of the UroLume stent in the bulbar urethra --
A. Yes.
Q. -- that it causes pain?
A. It could. There are many different reasons for pain. Some patients just, you know, have temporary pain after

, M.D.
placement of a stent which gets better over time.
Q. Are there occasions, that you are aware of, where a patient who has had UroLume stent placement in the bulbar urethra experiences pain when they have erections? Does that cause them pain?
MR. : Over objection to the form, you can answer.
A. Yes.
Q. Is that type of pain any different than the pain they might experience after the insertion of the stent?
A. No. The patient complains of the same type of pain.
Q. You told me earlier that you did not insert a stent in young man typically,

you said, in his teens or early twenties. Are there --

MR. OGINSKI: Withdrawn.

Q. Of the 30 to 40 times you have used the UroLume stent, how many times have you inserted a UroLume stent in a

0099

, M.D.

male less than age 35?

A. I can't recall off the top of my head.

Q. Are there other --

MR. OGINSKI: Withdrawn.

Q. In the times that you have inserted a UroLume stent, have you ever inserted a UroLume stent in a patient who has been 35 years old, other than Mr. ?

MR. : He was 37.

Q. Or about 35?

A. Yes.

Q. Are you aware of any literature that supports the use of a stent for recurrent urethral stricture --

MR. OGINSKI: Withdrawn.

Q. Are you aware of any literature supporting the use of stents for recurrent urethral strictures?

A. The actual indication for use of the UroLume stent is specifically for urethral stricture.

Q. Are you aware of literature that

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, M.D.

supports the use of a stent to treat recurrent urethral stricture?

MR. : Objection. Any literature?

MR. OGINSKI: Any article or text.

MR. : Over my objection, can you cite any particular article?

THE WITNESS: No.

Q. From the time --

MR. OGINSKI: Withdrawn.

Q. Do you have various textbooks on the treatment of the urethra that you keep either at home or in your office that you consult and look at from time to time?

A. Yes.

Q. In addition to your textbooks, do you also receive publications and medical journals, such as The Journal of Urology and other journals --

A. Sure.

Q. -- related to your field of practice?

A. Yes.

, M.D.

Q. Doctor, are there any specific textbooks that you consider to be authoritative in the field of urology?

MR. : Over objection to the form, you can answer.

A. "Authoritative," is too general a term.

Q. Are there textbooks that you consult with, with regard to the use of -- with regard to the treatment of urethral stricture that you deem to be authoritative?

A. There's no one volume that is authoritative on this particular subject matter.

Q. Are there certain chapters of certain textbooks that you consider to be the standard textbooks or portions of textbooks that you have used over the course of your career, that you use from time to time to review or consult with?

MR. : Over objection to the form, you can answer. Do you have portions, or specific areas, or

, M.D.

chapters of textbooks that you use that you consider to be authoritative is what he's asking you.

This is a discovery deposition so, over objection, you can answer.

A. There are textbooks in my office that I consult from time to time.

Q. Are there specific textbooks that you consult with that you consider to be authoritative on the issue of treatment of recurrent urethral stricture disease?

MR. : Over objection.

A. I don't recall considering any one text to be authoritative on any subject.

Q. Are there specific journals or specific articles that you would consider to be authoritative that deal with the issue of treatment of urethral stricture disease?

MR. : Over my objection, you can answer.

A. There could be.

Q. When treating Mr. in the

, M.D.

year 20 , did you consult any textbooks for purposes of treating Mr. ?

A. Not that I recall now.
Q. Did you consult with or use any journals or articles for purposes of treating Mr. ?
A. For his specific treatment, not that I recall.
MR. : Off the record.
(Discussion held off the record.)
Q. Are you aware of any medical literature, doctor, indicating that a second dilation and urethrotomy for recurrent stricture disease has limited value?
MR. : Objection to the form.
Q. Are you aware of any medical literature that says a second dilation and urethrotomy has no long-term effect?
A. No.
MR. : Over objection, you can answer. He's asking you if somebody, somewhere, somehow published

in the literature an article that showed that stricture may recur after a second urethrotomy.
MR. OGINSKI: That's not the question.
MR. : Then rephrase.
Q. I'm asking whether you are specifically aware of any literature that addresses that issue.
A. Who knows? I may have read something that showed that over the years. It's possible.
Q. I'm not asking if it's possible. Do you know --
A. I do not.
MR. : Can you cite any specific literature that says that?
THE WITNESS: (Indicating).
Q. Are you aware of any medical literature that indicates that a third repeat dilation and urethrotomy has no value?
A. I can't cite anything specific.
Q. Can the UroLume stent irritate

the bladder?
A. It shouldn't.
Q. Can it?
A. If it migrates into the bladder, then theoretically it could.
Q. If it stays within its location in the bulbar urethra, can it cause

irritation to the bladder?
A. It should not.
Q. Can a stent be uncomfortable?
A. Yes, it can be.
Q. You have told me that it can cause pain.
Can stent use cause urinary tract infection?
A. With any patient undergoing any urological procedure, that patient is at risk for developing a urinary tract infection, so that's correct.
Q. Once you place a stent into a patient, how often do you tell them to come back to the office for follow-up?
A. It depends on the case.
Q. Typically what do you tell the

, M.D.
patient?
A. Usually the patient is seen in a one- to two-week period of time.
Q. What is the purpose of seeing them postoperatively in that time frame?
A. Any patient postoperatively should be seen to ask them about their condition, how do you feel, first and foremost.
Q. After that one to two-week follow-up period, when do you ask them to come back for you to monitor the stent?
MR. : This is a general question? You are not asking about Mr. ?
MR. OGINSKI: Correct.
A. It's individualized. If a patient doesn't feel it's a faint stream, if it's strong, if he doesn't have any other complaints, I might see him two weeks later, a month later. It depends on the particular patient and the circumstances.
Q. Are you familiar something called

, M.D.
a --
A. No.
Q. Are you familiar with a product called ? Is that anything that you aware of or that you use in your practice?
A. Not that I recall.
Q. Have you done any studies concerning a product known as ?
A. This is what? It's a type of oil that's used?
Q. Might be. I don't know.

A. It sounds vaguely familiar.
Q. Nothing you recall?
A. I can't give you any specific details.
Q. When you perform an open urethroplasty to treat recurrent stricture disease, does that cure the disease?
A. Could it cure the problem of recurrent stricture? It can.
Q. When you perform open urethroplasty for recurrent strictures --
A. Yes.

0108

, M.D.
Q. -- does the procedure itself cure the condition?
MR. : In other words, are you asking does it completely cure it, meaning that the patient never has another recurrent stricture?
Q. That you are aware of, that's what I am asking about.
A. No, of course not --
Q. Can you tell me --
A. -- there are many, many complications associated with the procedure.
Q. Other than complications which occur, can an open urethroplasty, does it cure the recurrent stricture that the patient has?
A. One, you can't separate the complications from the procedure --
MR. : That is not the question. He didn't ask you that.
Q. Tell me, when you say that there are complications that can occur from the procedure, what you are referring to?

0109

, M.D.
MR. : Meaning with an open urethroplasty?
MR. OGINSKI: Correct.
A. Yes. Potential complications include infection, prolonged catheterization, bleeding, necrosis of the graft, recurrence.
MR. : Recurrence of what?
THE WITNESS: Of the stricture.
A. (Continuing) Then there are other associated complications particular to each type of procedure, of which there are a plethora for open urethroplasty procedure.
Q. What do you do in an open urethroplasty?
And again this is only relating

to recurrent stricture disease.
A. You usually remove that portion of the urethra, the area -- it all depends on the particular procedure -- and then typically you reconstruct the urethra.
Q. You are familiar with the type of procedure that actually removes a section

of the urethra that's involved in the stricture and then re-anastomose two sections together; is that one type of technique?
A. Sure.
Q. You are familiar --
A. Yes.
Q. Are there occasions when you have performed a urethroplasty that you have used that particular technique at any time in the procedures, in the dozen or so of these procedures you have performed?
A. Sure. I suppose I have done that.
Q. When you use that type of technique, do you use, does it --
MR. OGINSKI: Withdrawn.
Q. When performing that particular technique, where you cut out the area that has the recurrent stricture and then anastomose the two ends of the urethra together, does that cure a recurrent stricture?
MR. : Objection. For the

rest of the patient's life?
A. There may be a risk of a recurrent problem that I am not aware of.
Q. I'm not asking about any other problems. I am asking specifically about recurrent stricture.
A. They can form new stricture. Absolutely they are at risk.
Q. I'm not talking about a new stricture. All I am talking about is the place in the urethra, the part you removed, and then attached together again.
MR. : Note my objection.
Q. If you are removing a part of the urethra, you have to replace that; is that true?
MR. : Note my objection.
Are you asking if the portion that has been removed -- which is no longer there -- can be reanastomosed and used to create a new urethra?
MR. OGINSKI: Let me rephrase.

Q. Is the performance of open urethroplasty considered to be a cure for

0112

, M.D.

recurrent stricture disease?

A. No. It's treatment.

Q. Is that treatment -- does it have longer or better cure rate for recurrence than urethrotomy?

MR. : In terms of a recurrent stricture?

MR. OGINSKI: Correct.

A. It all depends on the particular case. Every patient's treatment is planned for the individual. There are risks and benefits associated with each of these procedures.

Q. In terms of long-term treatment of a recurrent stricture, is an open urethroplasty the gold standard in order to treat recurrent stricture?

A. Not always.

Q. In some cases, could it be?

MR. : Over objection to the form.

A. It is not generally --

Q. Are you saying that that statement is inaccurate?

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, M.D.

MR. : Objection.

Q. Are there some instances in which the performance of an open urethroplasty has greater benefit than a performing a repeat urethrotomy?

A. It may be at a certain point where that inevitably is achieved.

Q. How do you know when you reach that point?

A. Again, every patient is treated individually and --

MR. : Let him finish.

Q. Are you finished?

A. I was going to say every patient's treatment is individualized.

Q. What indications would you need to see in order to be able to make a determination as to whether or not urethroplasty is the procedure of choice rather than a repeat urethrotomy?

MR. : Objection to the form. You are ignoring all other possible modalities of treatment, such as dilation, stent placement?

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, M.D.

MR. OGINSKI: Correct.

MR. : If you want to stand on that question, he can answer. But I have an objection to the form.

Q. What is the basis for the decision to perform a repeat urethrotomy, doctor, to treat recurrent stricture disease?

Do you always have to go in lockstep fashion starting with dilation, then urethrotomy, then stent insertion, then self-catheterization, then open urethroplasty? Is that the formula that you use to treat patients with this type of disease?

MR. : Objection.

A. No. The treatment plan is always individualized to the particular patient.

Q. Are there occasions, when you are treating a specific individual, that you keep off a particular treatment option and go straight to something is that maybe more invasive or significantly medically?

A. Sure, that's possible.

0115

, M.D.

Q. What sizes does the UroLume stent come in?

A. I don't think I have a list of all the different available sizes.

MR. OGINSKI: Again I should rephrase.

Q. As a rule, in --

MR. OGINSKI: Withdrawn.

Q. All my questions relate to in or about 20 . At that time, what sizes did the UroLume stents come in?

A. At one point, they were available as a three-centimeter stent, I believe a two- and a two-and-a-half centimeter stent as well.

Q. Is the UroLume stent --

MR. OGINSKI: Withdrawn.

Q. Is the use of the UroLume stent --

A. You keep using that term. What do you mean by use of a UroLume stent?

Q. Is a UroLume stent intended to be used relieve urinary obstruction?

A. Yes.

0116

, M.D.

Q. Is that obstruction typically -- in order to use the UroLume stent, does it have to be determined to be in the bulbar urethra?

A. No.

Q. Are there other places that you

can put the UroLume stent which are considered acceptable, other areas than the bulbar urethra?
A. Yes. We reviewed this before. They are accepted for use in treatment of benign prostatic hypertrophy.
Q. Is it proper for the UroLume stent to be used for strictures that are greater than three centimeters in length?
A. Sure.
MR. : Note my objection. It's already been gone over in the deposition, Jerry. No offense, but we spent a great deal of time on this at the beginning of the deposition.
MR. OGINSKI: Okay.
Q. Is the UroLume stent supposed to be placed distal to the external

0117

, M.D.

sphincter?
A. Not always. We previously discussed placing it elsewhere.
Q. Since Mr. did have the condition, as you told me, when it's used to treat recurrent stricture, was it intended to be used distal to the external sphincter --
A. Yes.
Q. -- and proximal to the bulbar scrotal junction?
A. Yes.
Q. Is the UroLume stent intended as a temporary stent? Is it considered to be a temporary measure?
A. No.
Q. Is it intended to be used as initial treatment for bulbar urethral stricture?
A. Absolutely.
MR. : Please note my objection as to this entire line of questions.
Q. What about when the patient comes

0118

, M.D.

in with a bulbar urethral stricture?
MR. : Recurrent, not the first stricture?
MR. OGINSKI: Correct.
A. No, that would not be a good use.
Q. Is the UroLume stent intended to be used for treatment of strictures outside the bulbar urethra, related to recurrent strictures?
A. No.
Q. I would like to ask you some

questions about --
MR. OGINSKI: Withdrawn.
Q. When performing a -- is a dilation the same thing as a urethrotomy?
A. No.
Q. How are they different?
A. A dilation -- well, there are many different ways to do dilation, but the simplest way to explain it is that you have to insert a device into the penis and you gradually dilate -- you gradually dilate the strictured area.
Q. How do you do a urethrotomy?

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, M.D.
A. A urethrotomy is done under direct vision.
Q. In order to perform stent insertion, is it true that you have to be able to open up the stricture to at least a 24-French catheter as the way to do the insertion of the stent?
A. That's the ideal way, yes.
Q. If you could not dilate the stricture to 24-French, would insertion of a UroLume stent be contraindicated?
A. Not contraindicated, but it might not work as well.
Q. If the stricture developed externally, would it be contraindicated to use a UroLume stent?
A. Yes.
Q. If the patient has an active urinary tract infection, would the use of the UroLume stent be contraindicated?
A. Yes.
Q. Why?
A. Well, you don't do any urological procedure on a patient with an active

0120

, M.D.
urinary tract infection.
Q. Why not?
A. Because if there is already the presence of infection, the patient could become septic postoperatively.
Q. Let's talk about the risks of the UroLume stent. Is -- I think you said discharge was one of the possible risks; correct?
A. Yes.
Q. What about postvoid dribbling; is that one of the risks?
A. Yes.
Q. What causes that to occur, postvoid dribbling?
A. It's been theorized that there

might be pooling in the stent itself. Ultimately it gets better by itself over time.
Q. Hematuria, is that a risk of stent placement?
A. Yes.
Q. What about urgency?
A. Yes.

, M.D.
Q. How do you define "urgency"?
A. Urgency could be defined many different ways.
Q. How do you define urgency?
A. The need to go to bathroom as reported by a patient.
Q. Is nocturia a potential risk with the UroLume stent?
A. Not particularly.
Q. The risks we have just been discussing, do most of them resolve spontaneously?
A. Yes.
Q. What happens if the UroLume stent is actually placed in the external sphincter when it's being used to create an operative stricture?
A. If the stent were placed across the sphincter, it may prohibit function of the sphincter.
Q. Can it cause incontinence?
A. It could.
Q. Is that ever a problem with placement of the UroLume stent when it is

, M.D.
used to treat recurrent stricture of the bulbar urethra?
MR. : Asked and answered.
Note my objection again. We have gone over this.
You can answer it again.
A. No.
Q. If the stent had -- I asked the question about the stent being placed in the penis before, but what actually happens to the penis if the stent is actually placed there?
MR. : Again over objection to form. We discussed placement in the penis. Is it the penile urethra you are referring to?
MR. OGINSKI: Yes, thank you.
A. The stent would not be placed in the penile urethra.
Q. If for some reason it is placed in that location, what typically happens?

What can happen?
A. This is all theoretical. I have never seen it placed there.

, M.D.
Q. Have you read any literature about having placed a stent --
A. No. Most literature tells you it shouldn't be done.
Q. Can a UroLume stent that's inserted into the bulbar urethra shorten?
A. I don't know anything about shortening of stents.
Q. Is there a risk in the placement of the UroLume stent where it can shorten?
A. The stent is supposed to go longer.
(Indicating).
Than the stricture.
Q. I am going to get into that, but I am asking now, specifically, is it able to, if has one to, actually shorten?
MR. : Over objection to the form, you can answer. Are you asking about care and treatment once it's placed?
MR. OGINSKI: Yes.
A. Further in there I think it can contract a little bit.

, M.D.
Q. If the stent actually contracts, what happens to the stricture that it is designed to cover it? Can you get a recurrence?
A. Probably not because we put in a device that is longer than the stricture to account for that.
Q. What happens there? Can you be more specific?
MR. : Objection to the form.
A. I previously answered the question.
Q. I will rephrase it.
For instance, if the stricture is four centimeters long, how much longer a stent do you put in, in order to cover that stricture?
A. Probably I wouldn't treat a stricture that long.
Q. Why not?
A. Once they get too long, it gets... you may run into problems with it. You have to use it cover too great an

, M.D.

area, and there is a greater risk a recurrence.
Q. What size stricture do you feel that could occur with?
A. The size, I think the standard is four centimeters or less.
Q. That is a standard --
A. Yes.
Q. Is that something that you read that is written somewhere?
MR. : Over objection. You started the deposition by going through all this with the doctor.
Over my objection.
A. Sure. The standard is established by the standard of care that everyone goes by.
Q. Is that written down somewhere? Did somebody document that when you use these stents on patients, when placement is done on the stricture in the patient, that the placement can used for strictures of four centimeters?
MR. : Objection to the

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, M.D.
form. "Four centimeters or less," is what he said.
MR. OGINSKI: I am trying to find out where the standards are described, how he ascertained the standard.
MR. : Over objection.
A. The device is used in that fashion in general by urologists. That is how the standard is established.
Q. I'm asking: Is there any written documentation, either in the literature, or in the manufacturer's instruction, a manual or guidelines, or FDA guidelines, or anything else -- that you are aware of -- that sets that standard down on paper?
A. Again --
MR. : Listen to the question. He's specifically asking you: Is there anything that is contained within your office that sets the standard down somewhere in written fashion?
A. I can't cite a specific article.

0127

, M.D.
Q. Once a stent has been placed, can you reposition it?
A. It all depends.
MR. : Objection to the form.

Q. Once you place a stent, finish the procedure, and the patient is experiencing problems and comes back to you and tells you they are having problems, can you go in -- at a later time, can you go back in, and reposition that stent?
MR. : Objection to the form.
A. That depends on the situation and how long it's been in.
Q. Tell me what you mean by that.
A. If it's been a long period of time and the stent has reepithelized, it's difficult to move now.
Q. If the stent has reepithelized, if you are going in to take a look, what would you now see?
A. You would see reepithelization --

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, M.D.
Q. Would you see skin?
A. There is no skin inside the urethra.
Q. Would you actually be able to -- if there was reepithelization of the stent, would you be able to visualize the actual stent?
A. It is always, again, highly variable.
Q. Are there times when you can see it and other times you are not able to see it?
A. There are times, after a long period, that it may be completely epithelialized, yes.
Q. Are you aware of contraindications by the manufacturer with respect to repositioning the stent during the same setting you have placed it in?
MR. : Objection to the form.
Q. In other words, just to be sure my question was clear: You do the procedure. You put the stent in. Before

0129

, M.D.
finishing the procedure, you don't like the place it's in.
Can you then move the position of the stent at that point?
MR. : Over objection to the form.
A. At that point, you may be able to move it slightly, but it's difficult. I mean once it's discharged, it's usually pretty much set in that position.

Q. What makes it difficult to move?
A. It's way it's designed. The device is not designed to be moved.
Q. In the number of cases where you have used or inserted the UroLume stents, putting aside Mr. for the moment, have you ever had to remove a UroLume stent in a patient who had the stent placed there for an --
A. No.
Q. -- extended period of time?
A. No.
Q. Did you ever remove a UroLume stent in Mr. ?

, M.D.

A. Yes.
Q. Why did you remove Mr. 's UroLume stent?
A. After the placement of the first stents, his complaints were such that I was concerned about the stents and possible migration. That's stents: That should be plural.
MR. OGINSKI: Please read that back.
(The requested portion of the record was read.)
Q. What was it about Mr. 's complaints which you caused you to be concerned about possible migration?
If you are referring to your note, please tell me what date you are looking at.
A. On , it was approximately two weeks after placement of the first stents, he said that he was feeling much better, although he did have a complaint of some postvoid dribbling and a little bit of incontinence.

, M.D.

Q. What, if anything, did that suggest to you?
A. It suggested several possibilities. Most of all, postvoid dribbling and incontinence, after stent placement, you sometimes have incontinence as I have described. Maybe I was a little concerned that either the stents were interfering with his normal urination or that he had what's called gallbladder instability.
Q. What does that mean?
A. That means that the bladder muscle contracts at times and the patient is now trying to urinate.

Q. Is it similar to spasm?
A. Yes.
Q. What is it in your note that suggests to you that his kind of incontinence was different than what you would expect to see normally, postoperatively, after the insertion of a UroLume stent?
A. I started him on medication for

0132

, M.D.
treatment of bladder spasm and instability.
Q. My question though relates to what it was about his complaints -- what did you write about his complaints specifically that you made believe that his complaints were different than what you would expect to commonly see following a UroLume stent insertion?
A. The type of incontinence he complained of.
Q. What type of incontinence did you note? Was it minimal incontinence --
A. I wrote specifically that he had postvoid dribbling. It's a different type of incontinence. Minimal incontinence is different than a postvoid dribble. That's why I prescribed medication. Because it could be a case of bladder instability.
Q. What is the medication you prescribed?
A. Ditropan, D-I-T-R-O-P-A-N, XL.
Q. What made you believe or what raised the concern that possible migration

0133

, M.D.
of the stent was attributable to his complaints?
A. Because the type of incontinence he described was unusual.
Q. You write underneath in your plan: Will try moving the UroLume stent slightly distally; is that correct?
A. Actually what it says is: If Ditropan NC, then we will try moving it slightly -- Ditropan XL -- if no change -- meaning, if the patient's symptoms didn't improve substantially with treatment, one thing to do would be to try and move the stent slightly distally, if it was found to have migrated proximally.
Q. In your experience in putting in UroLume stents, have you had occasion when you would move a UroLume stent?
MR. : Prior to this case?
MR. OGINSKI: Yes.

A. No.
Q. Did you have an opinion for the possible success of actually being able to move the UroLume stent at some later time

0134

, M.D.
if his condition did not change?
A. Yes.
Q. What was your opinion?
A. I thought it would be difficult or impossible.
Q. Did you tell Mr. that?
A. Yes.
Q. What, if anything, did you say?
A. When?
Q. When you discussed what you intended to do for his condition and you said you couldn't move it.
A. The answer is remove it and replace it.
Q. How much time did you intend to wait before coming to a decision as to whether that would be needed?
A. Probably a few weeks.
Q. During that few-week period of time, did you expect to see reepithelization on the stent you inserted on ?
A. Yes, well, that's why I only waited a couple of weeks as opposed to

0135

, M.D.
longer period of time. The hope was that maybe it wasn't completely epithelialized.
Q. Is there any way clinically to determine, without taking the patient back into the operating room, whether the stent has migrated?
A. Sure.
Q. How?
A. If the stent has migrated distally, it would be palpable or could be palpable.
Q. If it moved proximally?
A. I can't feel that.
Q. On , 20 , did you conduct an examination, a physical examination, of Mr. ?
A. Which date are you referring to?
Q. The same one you told me about, .
A. I don't recall if I did.
Q. Doctor, if the patient comes to you with complaints, do you customarily, in addition to talking to them, examine them; correct?

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A. It all depends on the particular circumstances of the visit.

Q. If they come in postoperatively with a particular complaint, do you typically examine them?

A. It all depends on the particulars of the complaint and the particulars of the situation.

Q. If in fact you did examine the patient, would you agree it's customary, after conducting an examination, to make notes on the patient's chart about your examination?

MR. : You are asking if it was customary for him?

MR. OGINSKI: Yes.

A. If there was some finding.

Q. My question is: If you deem if necessary to do a physical examination of the patient, is it good and accepted medical practice to make a note of that, of the fact you had done an examination, in the patient's chart?

MR. : Objection to form.

Once again it's asked and answered.

He said if there was a finding.

A. I already said that in response to that question. No. 2, record keeping is different. It's not good medical practice, necessarily. I could note it at that time. I can dictate a note...

Q. Would you agree it's important to keep good and accurate medical records of a patient's complaints and of the treatment rendered to them?

A. Again record keeping is a separate issue from taking care of the patient.

Q. Is it correct that in medical school you learned to take notes about your examination of a patient?

A. Yes.

Q. In your residency training, did you learn that it was important for you to make notes about the treatment that you rendered to particular patients?

A. Yes.

Q. In the course of your private

practice, do you keep patient records in your office? When patients come to see you, do you make notes in their charts?

A. Yes.

Q. What is the purpose of doing that?
A. There are many purposes for that.
Q. What are they?
A. Just, for instance, in cases for billing.
Q. What else?
A. To refresh my m .
Q. If information is not contained within the record of the patient, if you are a poor historian, how do you know how you treated the patient, if you don't have a history, on prior occasions?
A. Well, there is always a plan.
Q. If you don't record a plan or if you don't report information about your prior examinations of the patient, how then do you know what the treatment should be or what your findings were if it's not recorded?

0139

, M.D.
A. You are not listening --
MR. : Over objection.
Objection to the form.
A. (Continuing) If no history were recorded, it would be difficult to decide what the next step would be.
Q. Doctor, as a general matter, is it good practice to keep complete and accurate records in order to know what treatment you rendered to patients in your office?
A. Again recording keeping and taking care of patients are often very different things.
Q. I'm asking you: Is it good practice to keep accurate records of whatever treatment you rendered to your patients?
A. Again, it depends. We are talking apples and oranges. You are talking about keeping records and I am talking about patient care, which are two different arts.
Q. I'm now asking about standard

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, M.D.
practice, not treating a particular condition. I'm talking now about making notes in the patient's chart.
Is it good practice, when a patient comes in to see you, that you record their complaints?
A. It's not related to practice. You are not talking about practice.
Q. How can that affect patient

care --
MR. : Objection.
Q. Is it good record-keeping practice to record the patient's complaints? Is it standard practice --
A. It's standard practice.
MR. : But you said that's apart from the practice of medicine?
THE WITNESS: Medical record keeping is aside from the practice of medicine. That is different than keeping records.
Q. Is it good practice to chart in the patient's record whatever a patient comes in complaining of? Do you make a

0141

, M.D.
note of that?
A. Complaints are very important to know, absolutely.
Q. Why?
A. Because you want to compare your treatment and see if the complaints have improved.
Q. If in fact you perform a clinical examination of a patient, is it important for you to make a note of the fact that you performed an examination, so that at a later time, your partner or anybody else who looks at the chart is going to be able to look at the chart and say: Oh, yes, he did an exam, and then to know what you have done?
MR. : Objection. That is a different thing than documenting findings. Are you asking if it's good practice to note the fact that he did an examination?
MR. OGINSKI: Yes.
MR. : As opposed to findings being recorded?

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, M.D.
MR. OGINSKI: Correct.
MR. : Over objection.
A. I think if I have findings, yes, they should be noted.
Q. Why is it important to note particular findings?
A. Again, when the patient comes back you want to compare and see if your treatment was effective.
Q. Please look at the 27, 20 note for Mr. .
(Witness complies.)
A. Yes.
Q. What is it in your note that

would tell you whether or not you performed a clinical examination on that date?
A. I'm looking at the note here, and there specifically is a complaint -- a specific complaint is addressed with the plan. That's all I can see from looking at the note.
MR. OGINSKI: Let me try to rephrase because I wasn't clear.

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, M.D.

Q. Is there anything in the 27th note that you looked at that tells you that you performed a clinical examination of Mr. on that visit?
A. There is no documentation of a clinical exam at that visit.
Q. If you had performed a clinical examination, would you have expected to bill for that exam?
A. Not strictly apart from the visit, no.
Q. Is it your custom, when you perform an examination, that you make a note of that exam, whether or not you have findings, in the patient's chart?
A. Not always.
Q. If there are any findings, do you, in the regular course of your examination -- are you supposed to make a note of that in the patient's chart?
A. Yes.
Q. The fact that there is no notation that appears about any findings on the exam in 27, 20 note, does

0144

, M.D.

that suggest to you, doctor, that you did not perform a clinical examination of Mr. on that date?
A. It's suggests one of two things: Either there was no finding or he wasn't examined that day.
Q. Is it there any way at this point for you to determine from that note, or from anything else that's in the record of Mr. 's visit, whether a clinical examination was done of this patient on that date?
A. No.
Q. If the patient came in complaining of pain in the area of the penis or somewhere behind the penis, in the bladder area, would you have expected to make or conduct a clinical examination?

A. The patient had no such complaint.
MR. : Objection to the form. Rephrase.
Q. If he complained about pain postoperatively, would you have made a

, M.D.
note of that on that date?
A. Yes.
Q. And would you have expected to do a clinical exam --
A. But the patient did not complain of pain on that particular date.
MR. : He is asking a hypothetical question now, doctor, and it calls for a particular answer. To your knowledge, if the patient complained to you of pain on the date of this entry, he is asking if you would have undertaken a physical examination. That is what he's asking you.
MR. OGINSKI: Right.
A. Yes. If the patient complained of pain.
Q. Did you see Mr. in your office before re-operating on him on
20, 20 ?
MR. : After the 27th visit?
MR. OGINSKI: Yes, thank you.

, M.D.
A. No.
Q. You scheduled him for the repeat surgery at the 27th visit, or you asked him to contact your office to see whether his condition had improved, stayed the same, or was getting worse?
A. No, he was supposed to contact me and let me know if the medication was working.
Q. Did he contact you?
A. I believe so.
Q. Is that something you have a m of?
A. (Indicating).
Q. And how is it that you recall he did contact you to let you know whether his condition had changed or improved?
MR. : He said he didn't recall. He believes so.
Over my objection.
Q. Other than ultimately doing the surgery on 20th, is there anything

else to help you refresh your m that says: The patient called me, and I spoke

, M.D.
to him, and we decided on the procedure; something along those lines?
MR. : Something in the chart?
MR. OGINSKI: Yes.
A. Yes. First of all, he would never have been scheduled for surgery without discussing exactly what was to be done, No. 1.
No. 2, I recall several conversations with him regarding his problem.
Q. After 27, 20 ?
A. Yes.
Q. Can you tell me how many conversations you had with him after that visit before the 20th surgery?
A. At least one or two.
Q. Were those conversations with Mr. initiated by him to you or did you call him?
A. In all likelihood, he called me.
Q. Tell me about the first conversation you had with him, after

, M.D.
27, 20 , about his ongoing condition.
A. Well, he must have not improved --
MR. : He's asking if you have a specific recollection.
A. (Continuing) There is no specific recollection.
Q. As you sit here now, do you have a specific m of speaking to Mr. twice before the 20th surgery between 27th --
A. It could have been three.
Q. During any of those conversations, do you remember specifically what you said to Mr. and Mr. said to you?
A. No, I don't recall specific quotes now.
Q. Other than the fact that you did the procedure on 20, did Mr. tell you specifically that his condition was not improved?
A. Yes.

, M.D.
Q. Did he tell you whether he was

taking the medication you had prescribed?
A. Yes, he was.
Q. Did you increase the dosage of the medication in order to see whether that might help his condition?
A. I don't recall.
Q. If he had asked --
MR. OGINSKI: Withdrawn.
Q. If you had determined it was necessary to increase the dosage of his medication, how would you have increased the dosage? How would you have actually accomplished that in terms of calling the pharmacy or Mr. going to the pharmacy, would you call; how would that actually be accomplished?
A. It could be done any number of different ways, but generally the pharmacy would be called.
Q. In your notes for Mr. , is there anything in the chart to indicate to you that you increased the dosage of the Ditropan at any time between 27th and

, M.D.

20?

MR. : Look through your chart. Look at the chart.
(Witness complies.)
A. There doesn't appear to be anything in the chart that documents a change in the patient's dosage.
Q. In your opinion, doctor, was Mr. a compliant patient?
A. Not always.
Q. Tell me what you mean.
A. He missed appointments.
Q. In the year 20 , was he compliant?
MR. : In terms of appointment keeping?
MR. OGINSKI: Yes.
A. No.
Q. Tell me why you say that.
A. Well, he never came for his postoperative visit after the surgery of 20, 20 .
Q. From the beginning of 20 , up until his last procedure

, M.D.

with you on 20th, was he compliant?
A. Yes.
Q. Do you deem a patient to be compliant if they have come to all of the visits that were scheduled?
A. That's a component of compliance.

That is one thing. There are other things.
Q. Other than appointment keeping, from 20 up until 20th 20 , was Mr. otherwise compliant with your instructions?
A. As far as I could tell.
MR. OGINSKI: We can break for lunch here.
[Whereupon, after a luncheon recess was taken, the following was had:]

A F T E R N O O N S E S S I O N

BY MR. OGINSKI:
Q. Doctor, are you aware of any studies of males under the age of 40 with

0152

, M.D.
regard to the affects of the UroLume stent?
A. I can't cite literature.
Q. When putting in two stents to treat a particular stricture, how do you prevent the first stent from dislodging while putting the second one in?
A. There is no particular way that you prevent it from happening.
Q. When you put two UroLume stents in, are they supposed to overlap?
A. Yes.
Q. Why?
A. The company recommended it.
Q. What is the distance -- the minimal distance -- that is required for overlaps when putting in two UroLume stents?
A. Approximately one and half centimeters.
Q. When you place a UroLume stent -- and I am going back to talk about the risks again of stent placement -- are you aware of a percentage of patients who

0153

, M.D.
experience postvoid dribbling?
A. Actual percentages, not being -- I wouldn't know because I am not necessarily a statistical person.
Q. That you are aware, regarding complications and/or risks of placement of a UroLume stent, what percentage of patients experience pain?
A. In my personal experience, maybe a handful.

Q. Can you be any more specific statistically?
MR. : Are you asking for national statistics or in his experience?
MR. OGINSKI: I didn't make that clear.
MR. : Objection.
Q. I'm making a distinction for the purposes of these questions about statistical likelihood regarding experiencing certain risks or complications --
MR. OGINSKI: Withdrawn.

0154

, M.D.
Q. Are you familiar with any statistics, other than from your own personal experience, for a percentage of patients who have experienced pain following the insertion of the UroLume stent?
A. Yes. But I can't quote you a number.
Q. Are you familiar with a percentage of patients who experience incontinence following UroLume stent insertion?
A. Not that I can quote you as a statistic.
Q. Are you familiar with the percentage of patients who experience testicular ingrowth following UroLume insertion?
A. No.
Q. Or the percentage of patients who experience hematuria?
A. No.
Q. Are you familiar with the percentage of patients who experience a

0155

, M.D.
new stricture following UroLume stent insertion?
A. I'm not familiar with the statistics.
Q. Are you familiar with any statistics regarding patients who experience erectile problems following insertion of the UroLume?
A. Other than that it's known to occur on occasion, no.
Q. Or the percentage of patients who experience pain during sexual activity following UroLume insertion?
A. Not specific percentages.
Q. Are you familiar with percentages

related to additional insertion procedures needed, a statistical percentage?
A. I don't have the statistical percentage, no.
Q. Are you aware of any statistical percentages for patients who experience pain on ejaculation following the insertion of the UroLume stent?
A. No, I don't know.

Q. Do you know what the statistical percentage is of patients who experience positive urine culture following insertion the UroLume stent?
A. No, I don't have the statistics.
Q. Do you know statistically --
MR. OGINSKI: Withdrawn.
Q. Do you know the statistical indications for patients who experience resection, surgical resection, following of the insertion of UroLume?
A. No.
Q. Do you know the percentage of patients who need catheterization following the insertion of the UroLume stent?
A. No.
Q. Or who experience retention problems with the stent following the placement?
A. Are you asking about the possibility that it's expelled?
Q. Are you aware of that or have you heard of instances where it has been

expelled?
A. Expelled completely, no.
Q. Do you know the percentage of patients who experience migration of the UroLume stent after insertion?
A. Yes, I have heard of that.
Q. Other than hearing of it, do you have the statistical percentage of that event occurring?
A. No.
Q. What about the percentage of patients who experience urine leaks with migration following insertion of the UroLume?
A. I don't know.
Q. How about the percentage of patients that experience decreasing stream following the insertion of the UroLume?
A. Not the specific percentage.
Q. Are you aware of the percentage

of patients who experience retrograde ejaculation following insertion of the UroLume stent?
A. No.

, M.D.
Q. Or the percentage of patients who experience hematospermia?
A. No.
Q. Or the percentage of patients who have experienced erection changes following the insertion of the UroLume stent?
A. No.
Q. Do you know of any statistical studies done involving patients with a UroLume stent insertion that have developed squamous metaplasia?
A. No.
Q. Are you familiar with the term, "encrustation"?
A. Yes.
Q. What does that mean?
A. When something is covered.
Q. Is testicular pain a risk of the UroLume stent insertion?
A. I've never heard of that.
Q. Is curvature of the penis a risk of insertion of the UroLume stent?
A. Never seen it.

, M.D.
Q. Let's talk about informed consent.
What is the purpose of providing a patient with information sufficient so they can make a decision with respect to their care and treatment?
A. It's mainly, of course, to provide the patient with sufficient information to make a decision about their treatment plan and options.
Q. Would you agree, doctor, that it is important to give patients sufficient information so they can make an intelligent decision on what their options are?
A. Yes.
Q. If a doctor -- and this is a general question -- if a physician did not provide the patient with sufficient information so that the patient could make an intelligent decision on what their treatment options were, is that a departure from good care; is that correct?
MR. : Objection to the

, M.D.
form. Obviously there are certain provisions of the consent statute that allow for not providing consent to the patient, but over my objection.
Q. As a general proposition.
A. No, that's incorrect.
Q. Tell me what you mean by that. Why is it incorrect?
A. First and foremost, what my attorney just pointed out; that there are many circumstances in which no consent at all is given. And there are many circumstances under which consent could have been gotten from a third party.
Q. If there was a situation where the patient is going to the doctor and the doctor is recommending a surgical procedure to the patient, would you agree that almost every such instance involves some sort of process where the patient is made consciously aware and cognizant of the surgical procedure, and that informed consent should be provided by that patient in deciding what the options are?

0161

, M.D.
MR. : Objection to the form. "Informed consent," is a legal term.
A. If a patient is cognizant and aware, then consent should be discussed with the patient, yes.
Q. Postvoid dribbling may occur in the weeks following insertion, correct? You have told me that?
A. Yes.
Q. Is a failure to inform the patient about the risks of a procedure a departure from good and accepted practice?
MR. : Over objection to the form.
A. Not necessarily.
Q. Why not?
A. We usually discuss significant risks with the patient. Things that may be self-limited and known to occur and be part of the procedure are not always discussed.
Q. If there's a situation where you intend to place a UroLume stent in a

0162

, M.D.
patient for recurrent strictures, would telling the patient that they could experience postvoid dribbling be something that you would consider to be significant?

A. It all depends. In caring for particular patients, sometimes that particular item may be discussed and sometimes it might not be discussed.
Q. Did you consider postvoid dribbling following insertion of the UroLume to be a particularly significant risk that the patient should be told about?
A. Actually it's not. I wouldn't consider it a risk at all.
Q. Is it something that you would tell the patient about, postvoid dribbling they may experience, following insertion of the stent?
A. Yes.
Q. Do you consider it a departure from good and accepted practice to fail to provide the patient with that information?
MR. : Objection, asked and

0163

, M.D.
answered.
You can answer it again.
A. Absolutely not.
Q. You told me that hematuria may occur following insertion of the stent?
A. It can, yes.
Q. Is that something you tell the patient about who is going to have a UroLume inserted?
A. Usually.
Q. Would the failure to tell the patient that he could experience hematuria following insertion of the stent be a departure from good care, in your opinion?
A. No.
Q. Why not?
A. Because they might not experience it, and you would have gotten him worried unnecessarily.
Q. Is it a significant --
MR. OGINSKI: Withdrawn.
Q. Are there instances where the fact that the patient may develop hematuria is something you feel should

0164

, M.D.
disclose to the patient?
A. Sure. Sometimes it's worthy of discussion and sometimes it's not.
Q. How do you know when is it or isn't?
A. When it's likely to occur in a patient when I am going to insert a UroLume. Every patient's case is individualized, and every discussion with

the patient is an individualized discussion.
Q. In a patient who is going to have a UroLume stent inserted, are there certain risks associated with the procedure?
A. Correct.
Q. I will get into the specific risks we are talking about in a little while, but my question right now is: If the patient is going to have a procedure, would you agree, as a general principal, that it is important to disclose those risks to the patient?
A. Yes.

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, M.D.
Q. One of the reasons that is important is so that patient can make an informed decision about whether the procedure is right for them?
A. Yes.
Q. If one or more those risks is not disclosed to the patient -- and I'm asking this as a general question -- would you consider it to be a departure from good care, if the patient is not told that they could experience hematuria?
MR. : Objection, asked and answered.
Q. Do you tell patients that, following a UroLume stent insertion, they might have to have a transurethral catheter or other transurethral procedure done for weeks until the reepithelization covers the stent?
A. I don't necessarily describe it in terms of a reepithelization. I might say something else. I might explain it in simpler terms, but we do explain to patients, as with any urethral procedure,

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, M.D.
the risk of catheretization.
Q. What I am asking you is this: Is that a significant thing for you to inform the patient about?
A. Yes.
Q. Is it -- if you fail to advise the patient of that particular risk factor, would that be a departure from urologic good care?
A. If somebody, theoretically, didn't do that, yes.
Q. If that information is not provided to the patient, would that patient have sufficient information

necessary for him to make an intelligent decision on whether to go ahead with the procedure?

MR. : Objection to the form. You are asking him to put himself in the mind of the patient that he is advising.

Q. Do you tell patients, following the insertion of a UroLume stent, that they are not to engage in sexual activity

, M.D.

for a certain number of weeks after the procedure?

A. No, I usually tell them that beforehand.

MR. OGINSKI: Let me rephrase the question. Thank you.

Q. Do you tell the patient -- at some point when discussing the UroLume stent insertion -- do you tell them they are not to have sex for a period of time following the procedure?

A. Yes.

Q. Why?

A. Well, because it could lead to pain, discomfort.

Q. Could it cause the stent to migrate?

A. It may.

Q. Would the failure to tell a patient about this potential problem be a departure from good urological care?

A. Yes.

Q. Can bleeding occur during the insertion of the UroLume stent?

, M.D.

A. Yes.

Q. Do you tell them that, if bleeding occurs, they will need a catheterization and possibly hospitalization to address that issue?

A. Again these things are highly individualized, and we try to avoid catheterization after these types of procedures unless there is no other option.

Q. My question is: Do you discuss with the patient the possibility that bleeding can occur, and that they might have to be catheterized and hospitalized, and, at some later time, they will have to come back to have the stent put in?

A. We discuss all these things with the patient, sure.

Q. When deciding on what to discuss

with a patient regarding insertion of the UroLume stent, would it be a departure from good care not to discuss that possibility with them?

MR. : Objection to the

0169

, M.D.

form.

You can answer.

A. Well, to start discussing with patient the possibility that an outpatient procedure that will take 15 minutes might be needed somewhere down the line and, theoretically, hospitalization, is usually not part of the general discussion, if that is what you are asking.

Q. You don't consider that to be a significant risk, the likelihood of that occurring down the line?

A. Correct. It's not highly likely to occur.

Q. What about the possibility of infection, do you discuss that with the patient prior to a UroLume stent insertion?

A. Yes.

Q. Is that a significant factor that the patient needs to be aware of in deciding whether or not to have the procedure?

A. It is an important factor for the

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, M.D.

patient to know, yes.

Q. Is the failure to discuss the fact that the patient might suffer an infection a departure from good care?

MR. : Are you asking in a UroLume stent insertion or for any urethral procedure?

MR. OGINSKI: I am only asking about the UroLume stent.

A. UroLume stent insertion would be no different than any other transurethral procedure. They all carry the risk of infection, and yes, if the physician failed to disclose, to discuss, that possibility with the patient, I would consider that wrong.

Q. After placing a UroLume stent, is there a possibility that an obstruction would cause the need to apply, at a later time, a suprapubic tap to drain urine?

A. That's a remote possibility.

Q. But have you ever seen that situation occur in your entire career with an insertion of a UroLume stent?

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, M.D.
A. No.
Q. Do you ever discuss with the patient the possibility of that occurring?
A. No, because that would be so remote that it could happen. Any time with a stricture we could see that, but I have never seen it after a Urolome.
Q. Tell me specifically what you told Mr. regarding the risks of a UroLume stent when the decision was made that you were going to put in the stent.
A. What we discussed --
Q. I am sorry for interrupting. I'm not asking in general. I am asking for specifics.
MR. : You are asking for his independent recollection?
MR. OGINSKI: Yes.
MR. : Do you have an independent recollection of what you told him as opposed to your custom and practice?
THE WITNESS: No.
Q. What do you typically tell a
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, M.D.
patient when you discuss the risks of a UroLume stent insertion?
A. Each patient's discussion is individualized, but typically we discuss recurrent strictures of the bulbar urethra. And I explain to him there are other options including another urethrotomy, perhaps a more prolonged period of catheterization. Perhaps I discuss with them the need to catheterize themselves for a period of time or self-dilation, as we discussed previously. We also discuss other options including insertion of the UroLume stent, and open urethroplasty.
Q. What do you tell them about another urethrotomy's success rate?
MR. : Do you mean the chance of the success of another urethrotomy?
MR. OGINSKI: Yes.
MR. : In terms of, like Mr. , a patient who has had two urethrotomies?
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, M.D.
MR. OGINSKI: Yes.
A. A patient who has had several urethrotomies is likely to have

recurrence. The risk can be very high. Some patients are willing to take that risk and just in come every few months for dilation -- that's all right for some people -- and some people say they want a more permanent choice, and those people would be offered either the UroLume stent or a open urethroplasty.

Q. Is the placement of the UroLume done as an outpatient procedure?

A. The patient is not subjected to prolonged anesthesia. In fact we do it very often under local with sedation. And after that, if that doesn't work for them, they have the option of another urethroplasty, an open procedure.

Q. Do you disclose that --

A. I am going to state, with urethroplasty, again, I would explain to the patient that it's a more much involved procedure, a procedure that is much more

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, M.D.

prolonged, and that it is a procedure with greater risks and more potential complications.

Q. Do you explain to the patient that with an open urethroplasty there is a greater success rate long-term than with a repeat urethrotomy or a UroLume stent insertion?

A. It depends.

MR. : Note my objection to the form of the question. It carries a presumption.

A. There is no presumption that it is a better option for every patient in the long term.

Q. In discussing risks with the patient, do you say to the patient: Look, we have a greater chance of curing your condition by going in and doing a urethroplasty than with the other procedures that you talked about?

A. Sure.

Q. What are the risks of undergoing repeat urethrotomy?

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, M.D.

A. Basically the greatest risk is recurrence, theoretically, and the risks of the procedure, the risks associated with the procedure itself.

Q. What are the risks of self-dilation?

A. Again if the patient is properly taught, very minimal.

Q. What are they?
A. The patient may have the risk that he would not be able to do this. They don't have the manual dexterity for this. And not doing it is a problem. They could cause damage to the urethra. But most patients I have taught the procedure to do very well on that type of regimen.
Q. Did you offer the opportunity to Mr. to self-dilate or self-catheterize?
A. No.
Q. Why not?
A. With it this proximal to the bulbar layer, the stricture is a little

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, M.D.
tricky. Patients don't benefit from that.
Q. What risks of insertion of the UroLume do you discuss with the patient?
A. In general, we talk about the fact that they may have recurrent stricture; that this device is made specifically to prevent re-stricture from recurring, but that re-stricture is always a possibility.
We discuss with the patient the risk factor of a urinary tract infection; that it is a risk, as with any type of urological procedure, and it can occur with this device as well.
We talk with them about possible migration, and possible problems with pain after the procedure. With that and with hematuria, I communicate that it's a concern, but they shouldn't be worried about it.
We tell them occasionally there is a risk of incontinence occurring, but that it is usually self-limited incontinence.

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, M.D.
Q. Is there anything else you tell the patient?
A. Again I tailor these discussions to the patient's individual needs. But that's the general outline of what we would discuss.
Q. In such cases, are there any other risks that you deem to be significant enough that the patient should know about that particular problem prior to the UroLume stent insertion?
A. Often we discuss that if this type of procedure doesn't work, that

either the stent has to be replaced or they might be a candidate for open urethroplasty at that point.
Q. Do you give them the statistical information about the likelihood for the need for stent replacement if it doesn't work?
A. No. The general rule is I avoid all statistical information. I don't quote people statistics. People are individuals. Events will occur. Your

concern is the individual, regardless of any type of published statistics.
Q. Did you tell Mr. how many UroLume stents you had previously inserted when discussing with him the plan to use the UroLume with him?
A. I don't generally go into how many procedures I have done with patients.
Q. Did you disclose to Mr. how many urethroplasties you had done prior to 20 ?
A. Like I said, it's not standard practice to give patients that type of statistical analysis when doing a procedure.
Q. I'm only asking whether you did.
A. No.
Q. What are the -- did you mention that an open urethroplasty is a more involved procedure, a more prolonged procedure, and that there are greater risks of complications?
A. No.
Q. What are the risks associated

with urethroplasty?
A. I believe that when we discussed urethroplasty, I mentioned that those risks include prolonged hospitalization, those risks include prolonged anesthesia, those risks include problems with the graft, such as graft ischemia and graft necrosis, long-term, the possibility for the potential for incontinence. These are the types of the things I would discuss with the patient undergoing open urethroplasty.
Q. Before Mr. actually agreed to go ahead with the UroLume procedure on 10th 20 , tell me how you came to the conclusion or made the recommendation that the UroLume stent was appropriate for

him.
A. He was a perfect candidate, with a three and a half-centimeter stricture of the proximal bulbar urethra with recurrent stricture.
Q. Before 10th did you measure the length of his stricture?

, M.D.
MR. : Are you asking him to refer to the chart?
MR. OGINSKI: Yes.
MR. : Refer to the chart, doctor, if you want.
Q. In other words, before doing the first UroLume stent insertion or 10, 20 --
A. Yes.
Q. -- had you ever measured the length of his stricture?
A. He had two previous urethrotomies. Yes. I scoped him twice before that. Specifically, in and also .
MR. : Were those occasions in you are referring to?
THE WITNESS: Yes.
MR. : Also, in the record for the hospital in , it says you scoped him previous to the 31st procedure; correct?
THE WITNESS: Yes.
Q. During that procedure, did you

, M.D.
make a note in the record as to the length of the patient's stricture?
A. Yes.
Q. What did you note regarding the length of the patient's stricture?
A. It says three and half centimeters mid to -- mid to -- proximal bulbar stricture.
Q. Is that in the information on the procedure you performed?
A. Yes.
Q. What is underneath that? You wrote greater than?
A. Thirty minutes. I think it's how long it took me to get it round.
Q. Were you able to dilate to an 18-French catheter?
A. Yes. It says an 18-French council catheter was placed.
Q. The next time you did the procedure was 13, 20 at Hospital; correct?

A. Yes.
Q. That was also a UroLume stent;

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, M.D.
correct?
A. Yes.
Q. What did you do on that day, on
that specific day, as opposed to in
when you did the previous
procedure?
MR. : Objection to the
form.
Q. Was this a different type of
procedure than the first procedure, or was
it a similar procedure?
A. When a procedure has failed, I
generally try to change techniques and see
if a different technique will work.
Q. What, if any reason, was the
particular reason that the urethrotomy on
3rd was going to take place at
Hospital as opposed to another
hospital?
A. No particular reason. I
scheduled the urethrotomy at the hospital
because I usually do my urethrotomies
there.
Q. During the course of that

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, M.D.
urethrotomy on 13, 20 , did you
measure Mr. 's stricture?
A. I don't know.
Q. Can you look at the record --
A. There is no notation of the size
of the stricture.
MR. : He didn't ask you
that.
Did you measure it?
THE WITNESS: Not that I
documented it.
A. (Continuing) I can't recall that
I measured it.
Q. Is there anything in the note to
indicates that you measured it?
A. No.
Q. Other than looking in the typed
operative report for Hospital,
would you have a note anywhere else in
chart, or anywhere else in your records,
that would indicate that you had measured
the size of the stricture?
A. On that particular date, no.
Q. The fact that there is no

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, M.D.
notation about your measuring the size of

stricture, does that indicate that a measurement of the stricture was not done?
A. No.
Q. Do you belive that a measurement could have been done but not recorded?
A. Yes.
Q. Could it also mean it was not done; correct?
A. Correct.
MR. : Objection.
Q. As you sit here now, do you remember measuring the size of the stricture on 13, 20 ?
A. No.
Q. When you performed the UroLume insertion on 10th, you told me earlier that, in the operative report, it's noted that you measured the stricture to be three and a half to four centimeters in length; correct?
A. Yes.
Q. In comparison to your 31st examination, it would appear

, M.D.
to have lengthened in size; correct?
A. Perhaps.
Q. Tell what you mean by that answer.
A. We previously covered this. Because all measurements are approximate.
Q. In the 31st note, after your procedure, I noticed that you did not put a range or an approximate value, that, instead, you wrote specifically: Three centimeters.
Does that indicate that it was an exact measurement or is it still, in your opinion, an approximate measurement?
A. These measurements are all approximate. Always.
Q. When you approximated the size of the stricture on 10th to be three and a half to four centimeters, is it possible, doctor, that the size of the stricture could have been longer than the four centimeters that you had approximated?
A. No.

, M.D.
Q. Is possible that it was shorter than the three and a half centimeters you had approximated?
A. Yes.
Q. Tell me why, in your opinion, it could have been longer than four

centimeters?
A. Because if I noticed that it was definitely four centimeters or longer, I probably would have suggested to the patient, at that point, that we do not proceed with the UroLume; that we work under anesthesia, that we do, under general, a urethrotomy, and leave the catheter in, and then discuss further options with the patient at a later date.
Q. Going back to the risks and options that were available to patients who were contemplating UroLume stent insertion, would you agree that failing to disclose or failure to tell the patient about the option of urethroplasty would be a departure from good and accepted practice?

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, M.D.
MR. : For recurrent stricture disease?
MR. OGINSKI: Yes.
MR. : Objection to the form.
Over objection, you can answer.
A. It's a good thing to discuss with the patient that it's one of the available options, absolutely.
Q. Would it be a departure from good practice not to disclose or discuss with the patient that urethroplasty was an option?
MR. : Objection to the form.
MR. OGINSKI: I will rephrase.
Q. You told me that it would be good practice to discuss with the patient the option of urethroplasty?
A. Yes.
Q. Would not discussing that --
MR. : Objection.
Q. -- option with the patient be a departure from good care?

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, M.D.
A. That seems to me like a legal question.
Q. In your opinion, doctor, if another doctor were to have a discussion about the options involved here, including UroLume stent insertion, and in the discussion of the patient's other alternatives, if the doctor omitted that option in the discussion with the patient, in your mind, would that be a departure from good medical care?

MR. : Over my objection to the form. That's asked and answered.
You already asked him if it would be considered a departure from good practice not to discuss that option.
Q. Is not offering that option, is that a departure --
MR. : Objection.
MR. OGINSKI: I'm turning the question around.
MR. : You are asking the same question again. I'm objecting to the form, it's asked and answered,

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, M.D.
counsel. Let's move on.
Q. When you had the discussion with the patient --
MR. OGINSKI: Withdrawn.
Q. Did you ever recommend to the Mr. that he should have a urethroplasty?
MR. : As to opposed stent placement?
MR. OGINSKI: Correct.
A. That was discussed.
MR. : Listen to the question. He's not asking about options now. Did you discuss with him having a urethroplasty as opposed to anything else?
Is that the question?
MR. OGINSKI: Something to that effect.
A. I still don't understand.
MR. : Listen to the question.
(The requested portion of the record was read.)

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, M.D.
Q. Would you agree that, when discussing options with patients, you will often make a recommendation as to what procedure or plan of treatment you think is appropriate to the patient?
A. Correct.
Q. And the reason for doing that is because you have specialized knowledge about the risks and benefits associated with each of the procedures, which the patient generally does not have; is that not correct?
A. That is correct.
Q. Did you ever tell Mr. :
Look, it's my recommendation, it's my feeling, that you would be better off

having a urethroplasty?
Did you ever say words to that effect to him?
A. No, not to my knowledge.
Q. Did you ever tell Mr. that you recommended he have repeat urethrotomy and UroLume stent insertion?
A. When are you talking about

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, M.D.
chronologically?
MR. : After the two others?
MR. OGINSKI: Yes.
A. Yes.
Q. When did you have that conversation with him?
A. After the second urethrotomy, the stricture recurred, and it was time to discuss further options with the patient.
Q. Did you recommend a repeat UroLume stent insertion?
A. We discussed options.
Q. Is that because patients are able to think for themselves and make choices based on what you present?
MR. OGINSKI: Rephrase.
MR. : If he doesn't understand, he will tell me.
A. I don't understand.
MR. : He is asking you: Did you specifically recommend one form of treatment over another at the time of the third urethrotomy?

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, M.D.
You said you did recommend urethrotomy for the third time as your preferred method of procedure. Did you discuss anything other than urethrotomy?
THE WITNESS: I can't recollect specifically recommending one over another.
Q. Did you tell Mr. it was possible, even after the UroLume stent is inserted, that he may need to have it removed and another one put in?
A. Yes.
Q. Do you remember Mr. 's response?
A. No.
Q. Now I'm going to refer to a form that appears in your office records titled: "AMS UroLume Endoprosthesis Patient Information." I'm going to ask you to take a look at that.

(Witness complies.)
A. Okay.
Q. Have you seen that form before,

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, M.D.
doctor?
A. I don't think so.
Q. Is that a form that you filled out for use with a UroLume insertion?
MR. : He said he hadn't seen it.
A. No.
Q. Is that a form that someone from your office would typically fill out?
A. No.
Q. Do you know if anyone from the hospital is required to fill out that form when you perform a UroLume stent insertion?
A. No.
Q. Is any portion of that form, to your knowledge, in your handwriting?
A. No.
Q. Before today, have you ever seen that form?
A. No.
Q. Does your signature appear anywhere on that form?
A. No.

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, M.D.
Q. Do you have a form just like that for the 10, 20 procedure that you performed on Mr. ?
Because this one apparently relates to the 20th procedure.
A. I don't know.
MR. : Look through your records, doctor.
Off the record.
(Discussion held off the record.)
A. No.
Q. Directing you attention to the bottom of the preprinted form, do you see the indications for using various boxes to check off?
A. No.
Q. Doesn't it say that on the bottom half? It says: Reason for stent insertion, and that it has a checkmark at the box for urethral stricture: Do you see that?
A. Yes.
Q. Underneath it, it is asking for the etiology of the stricture; do you see

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that?
A. No.
Q. It says: Stricture etiology, and then there are a bunch of boxes that are available to check off?
A. Okay.
Q. Do you know why none of those boxes were checked off?
MR. : Objection to the form.
A. I have never seen this form before. I have already answered you. I don't know anything about it.
Q. In your opinion, doctor --
MR. OGINSKI: Withdrawn.
Q. As of 20, 20 , did you form an opinion whether Mr. 's etiology for recurrent stricture was as a result of instrumentation?
A. No.
Q. Did you form an opinion that, in your opinion, it was not because of instrumentation?
A. I did not.

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Q. Did you ever form an opinion as to whether the etiology of the stricture was as a result of catheterization?
A. No. I did not form an opinion.
Q. Do you have an opinion as to whether the stricture's etiology was congenital?
A. No.
Q. Did you form an opinion that his stricture was a result of trauma?
A. Possibly.
Q. You ever inquire or ask Mr. about trauma to any part of his testicles or his genitals?
A. Usually that's one of the first questions that I ask: Was it a result of trauma.
Q. What was his response?
A. I don't know.
Q. If Mr. had advised you that it was, that he had had some sort of trauma, would you have expected to make a note of that?
A. Yes.

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Q. In your review of the patient's chart, did you see any evidence in any notation anywhere indicating that

Mr. had suffered some type of trauma that could possibly lead to a stricture?
A. No.
Q. Please turn to the note of the 10, 20 procedure that you did.
MR. : Off the record.
(Discussion held off the record.)
Q. The top paragraph on page 1 of the operative report indicates the stricture was three centimeters.
A. Yes.
Q. Where did you place the UroLume?
A. It was placed in excellent position proximally; that would be in the bulbar urethra just distal to the sphincter.
Q. Did you indicate in your note where you placed the UroLume stent?
A. Yes.
Q. Where do you say that, other than saying it was placed in an excellent

position proximal?
A. It says it was placed in excellent position proximally.
Q. Does that indicate to you the precise location where it was put in?
A. Yes.
Q. Where is proximal from the bulbar urethra; how far from the external sphincter was the UroLume placed?
A. Half a centimeter.
Q. How far was it from the pendulous urethra?
A. Several centimeters.
Q. Was it your intention to place two stents during that procedure?
A. Yes.
Q. That was to cover the length of the stricture; correct?
A. Yes.
Q. Was it your intention that the stent would exceed the length of the stricture by one centimeter I think you said?
A. No. Probably half a centimeter;

a millimeter to half a centimeter, as necessary.
Q. I may have asked you this already, but why did you want to exceed the length of the stricture?
A. For several reasons. The stricture may actually be a little longer

than you measured, and the UroLume may contract slightly.
Q. The second stent you chose was a 1.5-centimeter stent?
A. Yes.
Q. When you inserted it, how much of an overlap did you have between the first and second stents?
A. A few millimeters.
Q. Is that indicated anywhere on the operative report, the length of the overlap?
A. No.
MR. OGINSKI: Let's take break here.
(A recess was taken.)
Q. Are you aware of any literature

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, M.D.
that requires, when using two UroLume stents, that the overlap should be at least five millimeters?
A. Specific literature? I can't quote any specific manufacturer's instruction or guidelines that were put out, but I'm aware of it, yes, because we do discuss these things all the time at conferences with reps.
Q. From your knowledge and understanding, that overlap should be at least five millimeters?
A. No. Usually a few millimeters. Up to five millimeters, in the range, for the stent, from three centimeters to one and a half centimeters.
Q. There can be an overlap of a half centimeter I think you said, am I correct, if the stricture is four centimeters long?
A. Yes.
Q. If in fact a patient's stricture was four centimeters in length, now, with a stent that is four centimeters in length, is that sufficient to cover the

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, M.D.
stricture?
MR. : Objection to the form.
A. Not by those measurements, no.
Q. In fact if the stricture is at the low end of the range you measured, three and a half centimeters, and you know the stent is four centimeters in length, would that be sufficient to cover the stricture?
A. Yes.
Q. What do you do in an instance

where the overlap created is a shorter length that doesn't cover fully the stricture?
A. Well, you use a different size stent.
Q. In this case, when you put in the stent, with the one and half centimeter overlap, was it your opinion there was sufficient excess covering this wound, beyond the actual length of the stricture; correct?
A. Yes.

, M.D.
MR. : Objection to the form.
MR. OGINSKI: I will rephrase.
Q. If you place a stent -- two stents -- and you realize that it is shorter than the actual length of the stricture, and you have discharged both stents into the bulbar urethra, what do you do in that instance?
A. Hopefully, I figure that out before I discharge and just put in the appropriate size stents.
Q. Is there anything you do if you have in fact discharged both stents and then realize that the length of the stents is not in excess of that one and half centimeters you talked about and that it should extend beyond the length of the stricture?
MR. : Objection to the form. He just asked you a completely hypothetical questions. He's asking you, if that ever happened, what would you do.

, M.D.
Over my objection to form, you can answer the question.
A. If that ever happened, I would try and pull it out and put in the appropriate size stent. I wouldn't leave the stent that was too short in place. There is also the possibility that I could just add a third stent that was, you know, but it's... I've never seen that.
Q. You have never done that, put a third stent in?
A. No.
Q. Is there any risk of destroying the UroLume stent when discharging and placing it? Can you actually remove it and then place it again in the right place?

A. Once it's completely discharged, it's pretty difficult to remove... that's true.
Q. If you try to attempt to move one, would another risk be that you can tear it, and it may break apart, so you have a problem?

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, M.D.
A. Yes.
MR. : Objection to the form, to the word "problem." Other than that, it was fine.
Q. Let's turn, please, to the 20, 20 procedure, and specifically to your typed operative report.
A. Okay.
Q. Did you have assistance during the procedure?
A. No.
Q. On the 10, 20 insertion of the UroLume, did you have an assistant?
You can keep the page open. Can you see in your operative --
A. I don't have to look. Thank you. There is no assistant listed.
Q. On 20, 20 , did you measure the stricture?
A. Yes.
Q. What was the size of the stricture on 20th, approximately?
MR. : Objection to the form of the question.

02

, M.D.
Go ahead and answer.
A. It's not noted here.
Q. Then how do you know the size of the stricture as you sit here now?
A. Because the stricture has to be measured in order to put in the appropriate size stent.
Q. What's the size of the stricture on 20th?
A. The size of the stricture is not written here, but I have to presume it was same as it was three weeks earlier.
Q. Had it grown?
A. No.
Q. Enlarged?
A. No.
Q. Had it shortened?
A. No.
MR. : Off the record.

(Discussion held off the record.)
(A recess was taken.)
THE WITNESS: There is a problem with the question because there was no stricture on . It happened

, M.D.
with the previous stent. When I was answering it, in my mind, I was unclear of the question.
Q. When you performed the 20th procedure, before --
MR. OGINSKI: Withdrawn.
Q. On 20th when you did that procedure, did you observe if the urethra, specifically in the area of the bulbar urethra, was occluded?
A. Prior to this procedure?
Q. During the procedure.
A. During the procedure?
Q. Yes. Before putting in the UroLume stent, did you make an observation as to whether or not the urethra was occluded in any fashion?
A. Yes.
Q. What was your observation?
A. My observation was that it was not.
MR. : This is 20th?
MR. OGINSKI: Yes.
Q. Where was the first stent located

, M.D.
that you initially put in on 10th?
A. It would be proximal -- distal -- which one are you referring to?
MR. : The first one you put in.
A. The proximal stent was in the proximal bulbar urethral.
Q. Did that stent migrate from 10th to 20th?
A. Not to my knowledge.
Q. Where was the second stent that you put in?
A. In the bulbar urethra which was distal to the first stent.
Q. Were they still overlapping?
A. Yes.
Q. Had this second stent migrated at all?
A. No.
Q. Did you observe any shortening of the first and second stents?
A. No.
Q. Did you observe any

reepithelization of either the first or
0208
, M.D.
the second stent?
A. A little bit.
Q. Were you able to pass an instrument through the existing stents?
A. Yes.
Q. Did you remove a stent during that procedure?
A. I removed both stents during the procedure.
Q. Tell me what the indications were for the removal of the stents.
Do you have them listed anywhere in the typed operative report?
A. They are not in the report, no.
Q. Is there any reason why an indication for the removal of the stents does not appear in the operative report?
A. A reason, I don't... I guess some things are missing from the operative report.
Q. In your operative report, is it in any way indicated that you actually removed the UroLume stents?
A. Not in this report, no.
0209
, M.D.
Q. Can you tell me why that information is not contained in the dictated and typed operative report?
A. I have a theory as to why that is.
Q. I am asking if you know specifically.
A. Pretty much...
Q. What is your answer?
A. The dictation system. It appears on that date that it not was performing, and it was dictated at a later time.
Q. At the bottom left side of the page, it has abbreviation for dictation, time dictated, and under it, there's the date of 20, 20 : Do you see that?
A. Yes.
Q. The "T" there represents the abbreviation for transcription?
A. Yes.
Q. Was it dictated and transcribed the same day?
MR. : Was it done the same day?
0210
, M.D.
A. Yes, well, I don't know -- I

couldn't comment on the practices of the transcription services.

MR. : Do you know that the system was down that day?

THE WITNESS: (Indicating).

Q. Your attorney has shown me the preoperative report and pointed out to me something that wasn't mentioned in the postoperative and discharge note for 20th in the Hospital record. There is a notation at the bottom left. It says: Dictating system down.

Is that your handwriting?

A. Yes.

Q. It says that you, at some point, received a copy of the dictated operative report; is that correct?

A. Yes.

Q. And do you know when that made its way into your office record?

A. I don't know when that was but...

MR. : Did you get a copy?

THE WITNESS: Yes.

0211

, M.D.

Q. At some point after the report is transcribed, is it customary for you to review and to sign it; correct?

A. Correct.

Q. Once you dictate a report -- I'm looking at the hospital chart now -- I see a signature which appears at the bottom of that.

A. Yes.

Q. Does that tell you when you signed that operative report?

A. I don't know. It's not dated.

Q. It was at some point after the report was dictated and read that you signed it; correct?

A. Incorrect.

Q. Please tell me what you mean.

A. I mean very specifically that these reports are dictated reports.

Q. How does your signature appear on this particular report in this particular hospital chart?

A. They are dictated, signed and not read.

0212

, M.D.

Q. Is it your custom and practice to sign things that you don't read?

A. Yes.

MR. : Over objection to the form.

Q. Why did you sign it?

A. You are made to. It's hospital policy.
Q. What is the significance of signing something if you are not reading it? Why bother doing it?
A. I asked the same question.
Q. In fact you are at that hospital?
A. Correct.
Q. Is there a policy that says if the doctor signs an operative report they assume they have read it and that everything is accurate?
MR. : Are you asking about written policy?
MR. OGINSKI: I am asking about the policy for doctors at the hospital.

0213

, M.D.
A. No.
Q. Are you aware of any hospital policy, any written material which is put out by the Department of Urology, or anywhere else in the hospital, that requires physicians to read, to review, and to sign their operative reports?
A. I don't know of any policy that requires you to read anything about anything.
MS. : Are you asking about anything with his signature, or the electronic signature?
MR. : His actual signature.
Q. Are you aware of any hospital policy that says you should date every signature for every report you sign at Hospital?
A. No.
Q. Did you ever review this operative report for accuracy?
MR. : When?
MR. OGINSKI: At any time.

0214

, M.D.
Q. Whenever you got it.
A. Not until...
Q. Unrelated to this lawsuit.
A. Until the lawsuit, absolutely I never did.
Q. Did you receive a copy of this report when it made its way into the patient's office record? Did you read it then to see if it was accurate?
A. No.
Q. Did you have any difficulty

removing stent No. 2 on 20th?
When I say, "stent No. 2," I am referring to the one more distal.
A. The stents were difficult to remove.
Q. They were or were not?
A. They were.
Q. Was any damage done to the patient's urethra related to the removal of those stents?
A. No.
Q. What was difficult about their removal?

0215

, M.D.
A. The epithelization had started, and it took an extra few minutes to remove the stents.
Q. At the time you were referring to, when you removed them, when that was actually occurring, was the tissue that contained it being destroyed, did nothing happen to it, or something else?
A. Well, the stent doesn't come out whole. So you are pulling out pieces. It's sort of like pulling a thread out of a piece of material. The material's still holding, even if one thread has been pulled out.
Q. Was there bleeding associated with the removal of the stents?
A. Not significant bleeding, no.
Q. In your opinion, did you expect that there was no scar tissue as a result of the removal of those stents?
A. He had scar tissue as a result of having the recurrent urethral stricture. It was a fair amount of scar tissue.
Q. Would you have expected

0216

, M.D.
additional scar tissue from the removal of these stents?
A. It's possible.
Q. Did you observe any scar tissue in the area where the stents were located?
A. Nothing out of the ordinary.
Q. Did you observe any unusual coloration in the area where the stents had been?
A. Nothing unusual.
Q. After removing both stents, were the stents sent to pathology --
A. Yes.
Q. -- which identified what they are?
A. Excuse me?

Q. Is there a pathology report that identified what was taken out?
A. Yes.
Q. When you remove something from a patient and intend to send it to pathology, do you indicate where that specimen came from?
A. That information is relayed to a

0217

, M.D.
nurse who is supposed to write down what the physician says.
Q. Did the pathology report dictated the following day describe what it was that you removed; correct?
A. Yes.
Q. If you would look at the pathology report, please.
(Witness complies.)
Q. Doctor, are you looking at the surgical pathology report date 22nd?
A. Yes.
Q. It indicates that coil fragments in the length of five centimeters were removed or observed; correct?
A. "Up to five centimeters," it says, yes.
Q. At the bottom, it indicates, it says that the diagnosis was foreign body (coiled wire) said to be from urethral stricture; do you see that?
A. Yes.
Q. Does Hospital keep specimens for any period of time?

0218

, M.D.
A. I don't know their policy.
Q. Does this specimen still exist at Hospital?
MS. : Objection.
Q. Do you know if it still exists?
A. I have no idea.
Q. When you inserted --
MR. OGINSKI: Withdrawn.
Q. When you spoke to Mr. on 27, 20 and discussed his options with him, and as you told us, you have a note that you were going try to move the UroLume stent distally, did you tell him what you would do if you were unsuccessful in being able to move the stents?
A. Yes.
Q. What did you say?
A. I relayed that it was possible.
Q. What did he say in response?
A. He must have agreed, because he

went through with the procedure.
Q. When you removed both stents and sent them to pathology on 20th and decided to put in another stent, what size

0219

, M.D.
UroLume stent do you use?
A. The same as before.
Q. Which is what?
A. Three and 1.85.
Q. To be clear, this typed operative report does not indicate the size of the stent you used?
MR. : Objection to the form of the question.
You can answer.
A. Yes.
MR. : Off the record.
(Discussion held off the record.)
Q. What benefits did you expect to achieve by putting in other two UroLume stents on 20th?
A. At that time I was concerned because the patient had complaints, after the first insertion, and I was concerned about them, and I thought that perhaps repositioning would help. Repositioning was not possible, so I put in new ones, which was thought to be the best way to help him.

0220

, M.D.
Q. You told me earlier that you were concerned, after Mr. made these specific complaints of incontinence and postvoid dribbling, with the possibility that the stent had migrated. On 20th, when you are now visualizing and observing the location and placement of the stents, you determine they had not migrated.
Can you tell me why you still elected to remove those stents and to put in two, two new stents?
A. I observed that where they were can cause pain and discomfort and can cause something maybe you can't see visually. I thought maybe a new stent in a slightly different position, maybe slightly distally, would help with what I expected to achieve or accomplish with this patient.
Q. But having put the two new stents in, wasn't that in a similar area to where the stents would have been, had they not migrated?

0221

, M.D.
MR. : Objection to the form, to migration. Moved distally --
MR. OGINSKI: I will rephrase.
Q. You told me that on 20th you thought the original two stents had migrated slightly; that was your original concern, and that you were thinking it might be causing his problems, and that you were going try to move them distally.
When you realized on 20th that their location was the same as it was when you had put them in, what specifically suggested to you that, by putting in new stents in a slightly distal area, it would alleviate his problems?
MR. : That is the same exact question as the last question. It is asked and answered.
Q. Why did you feel that by removing the stents and putting in two new stents slightly distally it would change the problems he was experiencing?
A. There is more to practicing medicine than just what you see and what

0222

, M.D.
you learn. It is an art. If something doesn't work, you try to maybe do it slightly differently, and perhaps the result will be better the second time.
Q. Did you observe any damage to the urethra at all after you took out the two original UroLume stents and before you put in the two new ones?
A. No more than one would expect from having several previous procedures.
Q. Did the two new UroLume stents have --
MR. OGINSKI: Withdrawn.
Q. Did you place the two UroLume stents a little more distally than the original two stents?
A. Yes.
Q. Did you move them a little more distally to cover the entire length of the stricture plus some?
A. Yes.
Q. How much more did they cover? In other words, how much more of the stents --

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, M.D.
MR. OGINSKI: Withdrawn.
Q. How much additional length did the stents cover in comparison with the length of the stricture?

A. I don't recall specifically.
Q. How much overlap did you have between the first and second stents?
MR. : The two new ones on 20th?
MR. OGINSKI: The two new ones on 20th.
A. I don't have the specifics.
Q. The overlap you have told us about, would it have to be at least a few millimeters more than one and half centimeters; correct?
A. Possibly a little more, depending on the size of the stents used. Those are the guidelines.
Q. Where did you actually place them more distally when you placed the two new stents in comparison to the first two original stents?
A. Likely further away from the

0224

, M.D.
sphincter.
Q. How far away was the first stent you placed from the sphincter?
A. It was a few millimeters to a half a centimeter and it was slightly distal to the sphincter.
Q. Are you aware of any literature that supports the use of repeated and consecutive stents to treat recurrent stricture disease?
A. I can't quote the literature.
Q. Are there manufacturer's guidelines that support the use of repeat and consecutive stents to treat recurrent stricture?
A. I wouldn't be able to quote from the manufacturer's guidelines.
Q. Did you use any electrodes or surgical loops to remove the epithelialized tissue?
A. No.
Q. Did you use any type of device, other than maybe a grabber, to grab the stents to remove them?

0225

, M.D.
A. No. Just the grabber.
Q. Did you use any type of device to stem bleeding that may have occurred while you were pulling out the remnants of the stents?
MR. : Over objection to form.
A. No.
Q. Did you use an endoscope to

visualize all the wire filaments of the original one and two stents that had to be removed?
A. No.
Q. Did you look through the fluoroscope to see if all the wire filaments had been removed?
A. No.
Q. Did the fluoroscope allow you to see if you needed to remove, anything --
MR. : Objection.
Q. Was there anything other than the threads or remnants that you thought it was necessary to remove?
MR. : Objection. That was

0226

, M.D.
asked and answered.
Q. You didn't feel that was necessary?
A. No.
Q. Before you removed the two original stents, had you tried to reposition them?
A. No.
Q. In your 27th note, it was noted, as you said, that it was your intention to try to reposition them.
Why are you telling me now that you did not try to reposition the stents on 20th?
A. At the time of the 20th procedure, it didn't seem feasible because of the urethroscopic observation.
Q. That was an observation of what?
A. When there's a little bit of reepithelization occurring already, it's not going to be possible to move the stents.
Q. Are you a Fellow of the American College of Surgeons?

0227

, M.D.
A. No.
Q. Are you aware of any instances of iatrogenic causes that could lead to urethral stricture?
A. Yes.
Q. In your opinion, did Mr. have an iatrogenic condition that caused his urethral stricture?
A. Prior to my treating him.
Q. Would you agree, doctor, that the use of UroLume stents is best reserved for patients who are medically unfit to have lengthy open urethral reconstructive procedures?

A. That might be one indication.
Q. In your opinion, was Mr.
medically unfit to have a lengthy open
urethral reconstruction?
A. No.
Q. If you were to perform an open
urethroplasty at any one of the hospitals
you were affiliated with, did you need to
have a separate credential in order to do
that procedure at the hospital, other than

0228

, M.D.
your privileges?
A. No.
Q. Would you agree that overall
stricture length dictates surgical
technique used --
A. No, not all the time.
Q. Tell me what you mean.
A. A lot depends, again, on the size
and position of the stricture, in
particular, the age of the patient, the
patient's wishes, the patient's
life-style. There are multiple factors
involved when making the decision on which
treatment is the appropriate treatment for
each case.
Q. In making a decision on treatment
of the patient's disease, in recommending
what the appropriate procedure is, does
the size of the stricture primarily
dictate what surgical technique you are
going to use?
A. Not primarily, no. Many factors
are involved.
Q. I may have asked you this

0229

, M.D.
already: If the stricture is greater than
four centimeters in length, is it your
opinion that the patient would benefit
most from an open urethroplasty rather
than the UroLume stent procedure?
MR. : Objection. It was
asked and answered multitudinous times
today.
MR. OGINSKI: Sorry.
Q. When you formulate a treatment
plan for a patient and the options on how
to treat recurrent strictures, would you
agree that an important question to answer
is whether or not the treatment is a
temporary treatment or a long-term
treatment for the condition?
A. Yes.
Q. Is it the general view that
stricture management should be a cure not

temporary management? Would you agree with that?

MR. : Objection to the form.

A. It depends. All cases are

, M.D.

different. In managing each patient's case, management goals always depend upon the particular case. Nothing is so general as to say you always want achieve a cure.

Q. Putting aside the patient's actual desire, from a medical standpoint, when recommending a particular procedure, is the general goal, in making a recommendation to treat recurrent stricture disease, primarily one of cure and not necessarily of temporary management?

A. Yes.

Q. The goal is always to do your best to prevent recurrent stricture, to do a procedure that will last a prolonged period of time?

A. Yes.

Q. Are you aware of a study by someone named Pansodoro, P-A-N-S-O-D-O-R-O, published in The Journal of Urology in 1996 that reports that a 58-percent recurrence rate after

, M.D.

the first year of the study of the 142 patients in the study; are you familiar with that study?

MR. : Note my objection because you know it's not proper to ask that, but over my objection, if you are familiar with that study, you can answer.

A. No, not off the top my head.

Q. Are you familiar with a study by Dr. Hussain, H-U-S-S-A-I-N, appearing in The Journal of Urology in 1998 involving a study of 210 patients regarding recurrent stricture disease treatment?

MR. : Same objection.

You can answer over objection.

A. I have no independent recollection of that case or that study.

Q. Are you successful with a urethrotomy if it was palliative and not curative? Is that a successful urethrotomy?

A. In many cases, yes.

Q. What are the indicators for

0232
, M.D.
predicting long-term success of urethrotomy?
A. There are a multitude of factors.
Q. What are the most important ones that you consider predicting, in recurrent stricture disease, the surgery's long-term success?
A. There are so many factors that can be predictive of success in a urethrotomy: Age of the patient, the position and size of the stricture, and, in some cases, whether or not infection is involved. There are so many factors for determining it.
Q. The fact that a patient has a single stricture as opposed to multitude strictures a predictive factor of success?
A. Yes.
Q. What about having a length of stricture which is longer than one centimeter; is that predictive?
A. Which kind of stricture?
Q. I'm talking about a new urethral stricture, not a recurrent stricture.
0233
, M.D.
Would the length of a stricture of less than one centimeter be a predictive factor in determining the success rate of repeat urethrotomies?
A. In general, shorter strictures do have a higher success rate.
Q. If I were to ask the same question but as to the nature of the stricture -- not just its length but the type of stricture -- is the success rate greater with a less dense stricture than it is with a stricture of greater density?
A. Yes. There's more success with less dense strictures.
Q. Did you discuss with Mr. whether he would be a candidate for urethroplasty?
MS. : Over objection to the form.
A. No. The actual goal of the second procedure was to try to prevent him from needing an open urethroplasty.
Q. Did you tell Mr. , after doing the first urethrotomy on
0234
, M.D.
31st, what the success rate would be for the procedure?
MR. : Objection to the

form.
A. I told you I don't discuss percentages or success rates with patients because they are all individuals. I don't want to put a number in their head to think about.
Q. Before doing the urethrotomy at Hospital, did you tell Mr. that he had 50 percent or greater likelihood for recurrent stricture -- with a repeat urethrotomy -- with relation to his problem with recurrent stricture? Did you tell him what his chances were of getting a repeat stricture?
MR. : Objection to the form.
A. My philosophy is not to discuss specific percentages with patients because they tend to dwell on these things. No good comes of it.
Q. Other than using actual

0235

, M.D.
statistics or numbers, did you tell Mr. what the possibilities were about the likelihood it would come back, and that he would need another procedure?
MR. : Objection to the form. Do you mean did he say it was more likely than not; that sort of thing?
MR. OGINSKI: Yes.
A. We discussed that possibility, yes. Stricture disease is a recurrent phenomena and I said that eventually -- I have patients that we have followed for 15, 20 years that come in for periodic dilation or urethrotomies, and maybe he may need further treatment. So, yes, it is known to be a recurrent phenomena; that maybe a patient will do well just for a certain period.
Q. Are you aware of a study in The Journal of Urology published in 1994 which suggested that repeat urethrotomies are to be avoided because it's been documented they are futile in the prevention of

0236

, M.D.
recurrent stricture disease and suggested that the more effective treatment is urethroplasty?
MR. : Objection to the form. I don't think that the doctor should answer that. He hasn't even seen what you are reading from. Are they making this suggestion for anyone

a physician might treat? Plus you are talking about an 11-year time period before he even treated this patient.

Q. Are you aware of a study that discussed the use of repeat urethrotomies and the implications for future urethroplasty?

MR. : Over my objection, are you aware of such a study?

A. Are you asking me about something that was written 13 years ago? I would have to read the article. It's an impractical question.

MR. : So that's the answer.

A. (Continuing) It's an impractical

0237

, M.D.

question. That is my answer to the question.

Q. Are you aware of statistics for the success rate on insertion of the UroLume stent in achieving relief of recurrent stricture problems that patients have had it for?

A. I don't quote statistics.

Q. Even if you don't quote statistics, I'm asking you: Do you know what they are?

A. No. I am not quoting them. I don't quote statistics.

Q. Do you know what the statistical success rate is for insertion of the UroLume stent to cure recurrent stricture disease?

A. I can't give you an exact number.

Q. Do you have that information somewhere in your office, whether it's in a journal, or a textbook, or somewhere else?

A. If you are asking me whether I have references that I can look something

0238

, M.D.

up in, the answer to the question is, yes, I suppose.

Q. In preparing for today's deposition, did you review any literature?

A. No.

Q. Did you reference any textbooks in preparing for today's deposition?

A. No.

Q. Did you review Mr. 's deposition transcript?

A. No.

Q. Did you review Mrs. 's deposition transcript?

A. Mrs. was deposed?
MR. : So I assume, since you didn't know she was deposed, the answer is no?
A. (Continuing) No. Correct.
Q. Did you review Mr. 's medical records from anyone he saw and treated with in ?
A. No.
Q. Other than the notes that appear in the hospital record and in your office

, M.D.
record which you have brought today, do you have any other notes in any other place or any billing records about Mr. ?
A. No.
Q. Was your use of the UroLume stent on 20th considered an off-label use?
A. No.
MR. : Objection to the form. That calls for a legal conclusion.
Q. Are you familiar with a study published in 2002 in The Journal of Urology by T. S. Wilson called, "UroLume Stent Lessons Learned"? Are you familiar with that study?
MR. : Over objection.
A. I don't have an independent recollection of that particular study.
MR. : Are you aware of any conclusions reached in that particular study: "Yes" or "no"?
THE WITNESS: No.
I want to say --

, M.D.
MR. : Just answer the questions.
Q. Are you familiar with a study done by Dr. Hussain at the Institute of Urology in London in 2004?
A. No.
MR. : Over objection.
Q. Are you familiar with any of the conclusions reached by Dr. Hussain or any of the coauthors involved in that study?
A. No.
Q. Did you have a conversation with Mrs. about the options available to her husband before inserting the UroLume stent?
MR. : The first time?
MR. OGINSKI: Yes.
A. Not that I recall.

Q. Did you ever meet Mrs. at
Hospital?
A. I don't recall.
Q. Did you ever speak with
Mr. 's primary care physician about
his ongoing care and treatment in the year
0241
, M.D.
20 ?
A. There were communications, I
think, in writing.
Q. Other than the information that
appears in your notes, do you recall any
phone conversations or in-person
conversations with the patient's primary
care doctor?
A. No, none specifically.
Q. Do you remember that his primary
care doctor was Dr. ?
A. I think so.
MR. : Off the record.
(Discussion held off the record.)
Q. Let's go please to the notes,
doctor. Let's start with the
21, note.
MR. : Off the record.
(Discussion held off the record.)
Q. Doctor, I am going to ask you to
read the notes, and then if there are
abbreviations, tell me what they are when
you are done reading the note.
(Witness complies.)
0242
, M.D.
A. Decide what stent size. Scope
stricture. Plan laser treatment.
Q. Am I correct, he did not have
laser treatment on that date?
A. Correct.
Q. What is the next date, please?
A. 31st.
Q. That is in 20 ?
A. Yes.
Q. Would you read the note, please.
(Witness complies.)
A. Three centimeters mid to proximal
bulbar stricture. Greater than
30 millimeters. Tied with 18-French
council. Plan DC follow one week.
Q. Discontinue?
A. Yes.
Q. The patient was going to have a
Foley, an indwelling Foley for one week?
A. Yes.
Q. What was the purpose of the
indwelling Foley?
A. After a urethrotomy, it's the

standard in most situations to have an

, M.D.

indwelling Foley after an internal urethrotomy.

Q. Why?

A. It's actually controversial, but I can tell you why I do it.

Q. Why do you do it?

A. I do it because it's more common to leave one in than to do without it.

Q. Why did you leave it in after performing the urethrotomy, in this case?

A. I thought the patient would do better with a Foley after the procedure than without.

Q. What is it designed to do, the Foley?

A. Several things. No. 1, as the stricture heals, to keeps the scar down.

No. 2, any bleeding, it could bleed, and if there's anything from the cut, it also eases any dysuria, which is trouble that the patient might have voiding, after a procedure.

Q. Let's go to the next note, which is 7th. Can you read that note,

, M.D.

please.

(Witness complies.)

A. DC Foley. Discontinue Foley. Plan: Return in one week. Check postvoid residual.

Q. Did Mr. make any complaints that day?

A. No.

Q. If he had made a complaint that day, would you have made a note of it?

A. Yes.

Q. Did you remove the Foley at that point?

A. Yes.

Q. He returns the following week; correct?

A. Correct.

Q. Could you read the note of 15?

(Witness complies.)

A. Urethrometry done. Status post IOU, postvoid residual 12 millimeters.

Q. Is that normal or abnormal?

A. That's pretty good... that's

, M.D.

within normal range.

Q. Please continue with the rest

your note.
A. That is the note.
Q. Under "Plan"?
A. Plan: Uroflow postvoid residual...
Q. To be done.
A. ... to be done at next visit.
Q. Did Mr. have any specific complaints on that visit?
A. No.
Q. When is the next time you saw him?
A. March 22, 20 .
Q. Would you read that note, please.
(Witness complies.)
A. Status post internal operative urethrotomy, 31, 20 - doing well until two weeks ago. Uroflow 7.2 millimeters per second. Peak flow/average flow, 3.1 millimeters per second. 1-7 millimeters voided.
Q. Was that normal flow?

0246

, M.D.
A. No.
Q. Would you describe it as abnormal?
A. Very slow stream.
Q. Go ahead.
A. Positive urge, positive straining.
Q. Does that mean he was straining to urinate?
A. With urgency.
Q. Postvoid residual, 29 millimeters; is that normal?
A. That's standard, about... within normal range. Assessment and plan: IOU in hospital.
Q. The next note is dated ; correct?
A. Right.
Q. Please read what you wrote.
(Witness complies.)
A. PG, which stands for General.
Q. You saw Mr. --
A. Yes.

0247

, M.D.
Q. This indicates that you saw and treated him on that date at the hospital?
A. Yes.
Q. When did you next see him in the office?
A. .
MR. : Do you want him to

read the note?
MR. OGINSKI: Yes.
(Witness complies.)
A. Status post IOU: Had hematuria, now clear. Plan: DC Foley/trial of void.
Q. What does that mean?
A. Tried a trial of void.
MR. : What does, "trial of void" mean?
THE WITNESS: It means a trial of urinating.
Q. Did Mr. tell you he was having difficulty urinating following the procedure?
A. No. The Foley was removed in that setting.
Q. Did he have any complaints?

0248

, M.D.
A. His complaint that he had hematuria was clear --
Q. Did he express --
A. -- which was cleared.
Q. Did he express any complaints of pain on the 18th of ?
A. No.
Q. When you saw Mr. on March 22nd, you had the plan of performing another urethrotomy at Hospital?
A. Yes.
Q. Did you tell him that you needed to catheterize his penis at that time or words to that effect?
A. Yes.
Q. Do you remember having a specific discussion with him about the risks of a repeat urethrotomy?
MR. : He's asking you specifically if you have a recollection now.
A. No, not a specific recollection.
Q. When was the next time you saw Mr. ?

0249

, M.D.
A. .
Q. Please read that note.
(Witness complies.)
A. Status: Post IOU (second one).
Q. "IOU" stands for internal operative urethrotomy?
A. Yes.
Q. Please continue.
A. Okay now. Complaining of slowing of stream again. Uroflow peak flow four millimeters per second. Voided volume 204

millimeters; less postvoid residual, 35 millimeters.
Q. Was he performing normally, abnormally, or something else?
A. Abnormal.
Q. What, if anything, did that suggest to you?
A. Together with his other complaints, that it was possible that he was restricturing.
Q. Was this the first time that you had a discussion with Mr. about

0250

, M.D.
insertion of the UroLume stent?
A. Yes.
Q. Was anyone with him on this particular visit?
MR. : Objection, asked and answered.
You can answer it.
A. Not that I recall.
Q. Did you provide Mr. with any written materials, pamphlets, documents, drawings, about the UroLume stent?
A. Pamphlets, no, but drawings, I generally do do drawings for patients.
Q. Did you keep a copy of the drawing -- did you --
MR. OGINSKI: Withdrawn.
Q. Do you have a specific m of making a drawing for Mr. on March 22nd --
A. No.
Q. -- regarding the UroLume stent?
A. Not on that specific date, no.
Q. Do you have a model in your

0251

, M.D.
office that you use to show patients you intend to put the UroLume stent into as to what the thing looks like?
MR. : Objection to the form of question.
A. I do not have a UroLume stent model, no.
Q. Do you have the actual device, so to speak, to show how they are inserted, what it looks like, and how it's discharged or inserted?
A. Actually, I just answered that. I do not have a model of the UroLume stent.
Q. Other than a model, I am asking if you have the actual device.
MR. : Isn't that a model?

MR. OGINSKI: I am asking about having either the device or the discharge device, did he have either one of those.

MR. : "Yes" or "no."

A. I don't understand what the difference is between the model and the

0252

, M.D. device.

Q. I am asking about the actual device.

You are familiar with certain anatomic models; correct?

A. Yes.

Q. As I am sure you are aware, some doctors use models to show how these things work; correct?

A. Right.

Q. Aside from an anatomic model, did you have a actual UroLume stent device in your office in --

MR. : May 20 .

Q. -- that you would show to your patients when you intended to perform a UroLume insertion?

A. I did not generally show the device to the patient before this type of procedure.

Q. Did Mr. tell you he was having postvoid dribbling after either of the two urethrotomies, the first one in or the second one in ?

0253

, M.D.

A. No.

Q. On 10, 20 , he goes to Hospital, where you did a UroLume insertion; correct?

A. Yes.

Q. You followed him in your office on 27, 20 ; correct?

A. Yes.

MR. : Off the record.

(Discussion held off the record.)

Q. Did you prescribe Ditropan for the patient between 31, 20 and 27, 20 ?

A. Prior to 27th, not to my knowledge.

Q. After the 10th insertion of the UroLume, did Mr. complain of excruciating pain?

A. No.

Q. Did he ever call you to tell you he was having excruciating pain after

23 10, 20 ?
24 A. Up through the last visit or...
25 Q. Before 20th.
0254
1 , M.D.
2 A. It's certainly possible.
3 Q. But there is nothing in your
4 notes to indicate such a phone
5 conversation; is that correct?
6 A. Correct.
7 Q. Did Mr. ever tell you that
8 he had to use or that he tried adult
9 diapers when he was having dribbling and
10 incontinence?
11 A. If he said that at the visit of
12 , it would have been noted with the
13 other complaints.
14 Q. At any time after 27th, did
15 you ever learn that he had to use adult
16 diapers to control leaking from the
17 postvoid dribbling and incontinence?
18 A. Not that I specifically recall.
19 Q. Do you remember what, if
20 anything, he was using to stop the urine
21 from leaking out and not soiling his
22 clothing, whether it was pads, or a
23 napkin, or something else?
24 A. I don't recall what he was using.
25 Q. After 20, 20 , when
you
0255
1 , M.D.
2 performed the removal and the reinsertion
3 of the new UroLume stents, did you have a
4 conversation with Mr. , by telephone,
5 after the procedure, where he called and
6 said that he had pain following the
7 procedure?
8 A. No. Not to my recollection.
9 Q. Did you ever tell Mr. --
10 MR. OGINSKI: Withdrawn.
11 Q. Do you recall Mr. calling
12 one particular morning before office
13 hours, or paging you, or paging your
14 service, about complaints he was
15 experiencing following the procedure?
16 MR. : Over objection to
17 the form, you can answer.
18 A. No, I have no recollection of
19 that.
20 Q. Did you ever tell Mr. or
21 someone from his family not to call too
22 early in the morning, before office hours,
23 because you had a problem returning phone
24 calls at that hour?
25 A. Absolutely not. I absolutely
0256

, M.D.
encourage all my patients to call whenever they have a question or a problem.
Q. Did you ever tell Mr. that he might have experience painful erections with the stent --
MR. OGINSKI: Withdrawn.
Q. On 20th, did you speak to Mr. after the procedure was done?
MR. : In the hospital?
MR. OGINSKI: Yes.
A. I have no independent recollection of the conversation.
Q. This was an outpatient procedure; correct?
A. Correct.
Q. The patient left the hospital the same day?
A. Yes.
Q. Is it your custom, with an ambulatory procedure, that you talk to the patient following the procedure?
A. Yes.
Q. Did you have a conversation with Mr. while you were still in the

0257

, M.D.
hospital after the procedure was complete?
A. I'm sure.
Q. Do you remember the specifics of that conversation?
A. No.
Q. Did you tell Mr. , either before 20th or on 20th, that he could experience pain with the new stents --
A. I am certain we discussed the risks and benefits of the particular procedure. I am sure that was covered.
Q. On 27th when you saw Mr. , and you indicated you were going to try and move the stents distally, did you ever tell him that you would remove the stents if you couldn't do it and put in new ones?
A. Absolutely.
MR. : Objection, asked and answered.
Q. Did you tell him before -- did you tell Mr. after the procedure was done that you had to use more than one

0258

, M.D.
stent?
MR. : This is the 20th procedure?

MR. OGINSKI: Yes.
A. I don't recall the specific conversation with the patient.
Q. Would you have expected to tell him that you had to use two stents?
A. I have no particular reason to recall it.
Q. Did you ever come to learn that one or both of the stents came to rest in a section of his penis after 20, 20 ?
MR. : Over objection, obviously, other than in conversation with counsel.
MR. OGINSKI: Yes.
Q. I'm not talking about anything you discussed with your attorney.
After 20th, did you learn from any doctor that one or more of the stents you had placed was ultimately located in the penis?

0259

, M.D.
A. No.
Q. In your experience, and based upon your knowledge of the UroLume stent, can the stent placed into the bulbar urethra migrate to the penis?
MR. : Do you mean the pendulous urethra?
MR. OGINSKI: Yes.
A. Yes, it's possible.
Q. Could they actually migrate?
A. They could move per the epithelization. Theoretically they could move.
Q. What would cause it to move?
A. I don't know if I can tell you that with a hundred percent accuracy. Theoretically, if the patient is catheterized, for instance, it might dislodge a stent. Some other type of trauma. Sexual trauma. Perhaps an emergent reason. They could just migrate when a patient is urinating, is straining to urinate.
Q. Assuming that there was no

0260

, M.D.
trauma, no instrumentation trauma, no catheterization trauma, can a stent migrate due to the force of urine coming out?
A. Apparently, it can.
Q. Are you aware of any studies that document that such cases, or a report?
A. I have never seen a published

report specifically addressing that question, no.
Q. If you intend to use a stent in an off-label manner, would you agree that you should tell the patient you are using it in an off-label manner?
MR. : Objection to the form.
Q. Would you agree --
A. It's possible --
MR. : If you can answer the question, answer.
A. (Continuing) I don't think it applies.
Q. If, for whatever reason, you choose to use a stent in an off-label

0261

, M.D.
manner, not in conformance with the manufacturer's guidelines, would it be appropriate for you to have told the patient: Look, I'm thinking of using it this way. I think it will help you. This is why we are using it? Would that be appropriate for you to tell the patient?
A. I might. As a general principle, if we are using something for a purpose that it's generally not designed for, or a medication, we commonly explain to the patient: This isn't what it's designed for, but we can use it for this other purpose, and we can apply or use the device this way as well.
Q. Is it your practice to tell patients about that, if you are going to doing something like that?
MR. : Objection.
A. Sure, it if's an off-label use, I might. One might tell the patient about it.
MR. OGINSKI: Please mark this as Plaintiffs' Exhibit 3.

0262

, M.D.
(The document entitled "UroLume Instructions For Use," dated 7/28/04, was hereby marked as Plaintiffs' Exhibit 3 for identification, as of this date.)
Q. Doctor, I'm going to show you a document which was marked as Plaintiffs' Exhibit 3. It is titled: "UroLume Instructions For Use," and at the top there is a date on there of 28, 2004. That is a 16-page document. I'm going to ask you to look at page 6 and, specifically, at paragraph 4 first. Take

a look at the document, doctor. Can you look please at page 6, doctor and --

MR. : Let him read it first.

A. Yes.

Q. Specifically, paragraph 4, read paragraph 4.

MR. : Objection. That's not appropriate for him to read it into the record.

MR. OGINSKI: Okay.

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, M.D.

Q. First, have you ever seen an instruction booklet like this regarding the UroLume?

A. No.

Q. Have you ever read an instruction manual like this one I'm showing you by American Medical Systems?

A. Not that I'm aware of.

Q. Turn to page 6, under "Precautions," paragraph 4: The prosthesis should be used for treating strictures no longer than three centimeters. Safety and effectiveness of the device in strictures longer than three centimeters has not been fully established.

Were you aware of those manufacturer's guidelines, and, specifically, the quotation I just read to you, were you aware of that?

MR. : I am going to object to the extent case law and legend mandates that manufacturer's inserts or the Physician's Desk Reference

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, M.D.

cannot be used to identify standard practices of care. I do not want to block the question, because it's a discovery deposition, but I think you should re-ask the question. Also, No. 2, he has stated he has never seen the insert before as far he was aware. And No. 3, he has answered this now multiple times.

MR. OGINSKI: It's not an insert, it's not guidelines. It's a specific instruction manual for the use of the device.

Q. I'm only asking whether you are aware of the written instructions for the UroLume stent.

MR. : The one in your hand? The one you just marked?

MR. OGINSKI: Correct.
MR. : Over my objection, were you aware of that? You can answer it. Were you aware that it was printed in a booklet, not what it's discussing.

0265

, M.D.

A. I was not aware of that; that it was in a booklet.

Q. Were you aware of material that has been published which specifically indicates that UroLume stents were not to be used in a patient who had a stricture of greater than three centimeters?

MR. : Objection to the form, objection to the characterization. Over my objection, you can answer that question.

A. Actually I'm familiar enough with the device to make the statement that there is no absolute contraindication in those cases anywhere.

Q. Would the use of the UroLume stent for strictures greater than three centimeters be considered, in your opinion, an off-label use?

A. Absolutely not.

Q. I'm reading from the same page, under the heading "Stricture," paragraph 11. Removal of the prosthesis for any reason after --

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, M.D.

MR. : Objection.

Q. -- could result in significant trauma to the urethra. After, if there is ingrowth over the prosthesis, it must be resected before the prosthesis is removed or the prosthesis may unravel.

Are you familiar with that?

MR. : Objection. Same objection.

Q. Were you familiar with that --

MR. : Is he familiar with that text printed in the booklet?

MR. OGINSKI: Or was he aware of the concept.

MR. : First, were you aware this was printed?

THE WITNESS: No, I was not aware that that was printed in that booklet.

Q. Are you aware of the general concept that, when removing a UroLume stent that has been placed for a prolonged period, it could cause trauma and damage to the urethra?

A. No.

, M.D.

Q. What is your knowledge and understanding with respect its removal?

A. After complete epithelization, it may be necessary to resect tissue first before removing the stents.

Q. Could that result in trauma to the urethra?

MR. : In cases where there's complete epithelization, could removing the stent cause trauma to the urethra?

MR. OGINSKI: Yes.

MR. : Over objection, you can answer.

A. Anytime something's inserted and removed from the urethra, it can cause trauma.

MR. : Off the record.

(Discussion held off the record.)

Q. I want to direct your attention to the manufacturer's statement on page 5 of the instruction booklet: Recurrent bulbar urethral strictures under the heading, "Indications For Use," quote --

, M.D.

MR. : Objection.

Q. -- the device is intended for use in men to remove urinary obstruction, to remove benign bulbar urethral strictures that are less than 3.0 centimeters in length, located distally to the external sphincter and proximal to the bulbar scrotal junction.

Were you familiar with this manufacturer's statement about the indications for use of this device?

MR. : Over objection to the form and to the authority.

A. I told you this previously. I already stated I have never seen this booklet before.

Q. Did you ever learn, during the course of your training in the use in the UroLume stent, that it was to be used only for strictures less than three centimeters?

A. No.

Q. Please go to your billing records.

, M.D.

MR. : Let's take a break first.

(A recess was taken.)
Q. Before we get to the billing records, doctor, did you understand from Mr. that he worked for an ?
A. I believe so.
Q. Did you learn, at some point during your treatment of him, that he had gone down to and had been seen by the emergency room or by an emergency room physician because of continued complaints he was experiencing?
A. I'm not aware of that.
Q. Did you ever tell Mr. that you didn't think he was drinking enough water, when he was complaining to you of being unable to urinate?
A. I don't recall that.
Q. Other than recurrent stricture disease, what else can cause a patient to have decreased urinary flow, or in Mr. 's case, virtually no flow --
A. Are you talking about BPH, which

0270

, M.D.
means benign prostatic hypertrophy? There are lots of other conditions.
Q. What are the most common?
A. Any sort of bladder dysfunction, benign prostatic hypertrophy, and stricture.
Q. Do you recall telling Mr. to return from , to come to New York, so that you could see his problem and see what else you could do for him?
MR. : Over objection to the form, doctor, you can answer.
A. Are you referring to the conversation we had after 20th?
Q. No, this is before. This is sometime around of 20 .
A. I don't recall a specific conversation.
Q. Did you ever tell Mr. , after the second urethrotomy, that you didn't know why he was still having complaints because you cut the area wide enough?
A. It's possible I said that to him.

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, M.D.
Q. Did you ever tell Mr. he should try sitting down to urinate to help with his complaints of difficulty in urinating?
A. I don't recall saying that, no.
Q. Did you tell Mr. that using a UroLume stent will help him urinate?

A. Yes.
Q. Let's to go to the billing records, please, for 20th 20 procedure.
Am I correct you billed $5,000 for the cystourethroscope and UroLume stent?
A. Can I say one thing? I am absolutely uninvolved in the process of billing in my office. If you would like to ask my office manager those questions --
MR. : This doesn't involve other people. You are looking at the billing records. Can you tell him whether that is what's billed?
THE WITNESS: No. I cannot do

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, M.D.
that.
Q. Please look at the computer printout.
A. I don't even have that.
Q. I've given it to you. Your attorney provided it to me.
A. Okay.
Q. Doctor, at some point before this lawsuit was started, there was a request for records that was submitted to your office. Do you recall that?
A. No, I don't recall that.
Q. In any event, at some point a request for Mr. 's records was made after the start of the lawsuit.
Did you provide copies of his chart; do you recall that?
MR. : Over objection. The doctor's office provided you with copies, not the doctor.
Q. Were you consulted about which records were to be provided?
A. No.
Q. Did you learn at any point in the

0273

, M.D.
year 20 whether or not Mr. 's complete office records were provided to his counsel?
A. No.
Q. If you look at the billing records, does the billing record indicate that $5,000 was billed for the 20th procedure?
A. I have to say I really don't know how read this. This is the first time I have ever even seen something like this.
Q. Can you tell from those records

how much you were ultimately paid for the procedure done on 20th?
A. No, I cannot.
Q. Who best in your office is able to interpret those notes?
A. Whoever does the billing. I guess Emma.
Q. Does Emma have a last name?
A. I don't know it.
Q. Is she in the Lawrence office or is she in another office?
A. The Lawrence office.

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, M.D.

MR. OGINSKI: Off the record.
(Discussion held off the record.)
Q. How long did it take for you to do the UroLume stent insertion on 10th?
I am asking for an approximation, not for the exact length of time.
Are you looking for the anesthesia record, doctor?
A. Yes.
Q. I'm asking for your best approximation of how long it would take to do this procedure --
A. Ten or 15 minutes.
Q. -- on 10th.
Is the same true for the 20th procedure?
A. No.
Q. How long did that procedure take?
A. That would have been longer because it was more extensive.
Q. Can you estimate approximately how long that procedure took?
Are you looking for the

0275

, M.D.

anesthesia record?
A. Yes.
That appears to be a little over an hour, about an hour.
Q. Is it your opinion that the procedure performed on 10th was done in accordance with good and accepted medical practice?
A. Yes.
Q. Was it your opinion that the procedure done on 20th was done in accordance with good and accepted medical practice?
A. Yes.
(Continued on the next page to allow for signature line and jurat.)

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, M.D.

MR. OGINSKI: Thank you very much. I have nothing further.

MS. : I have no questions.

(TIME NOTED: 4:20 P.M.)

_____

, M.D.

_____
Subscribed and sworn to
before me this _____
day of _____,
2007.

_____
Notary Public

0277

I N D E X

WITNESS

, M.D.

E X H I B I T S

REQUESTS AND INSERTIONS

DESCRIPTION	PAGE	LINE
AMS rep contact Information	27	10

0278

CERTIFICATION

I, GRETCHEN A. MILTON, a Notary Public for and within the State of New York, do hereby certify:

That the witness whose testimony as herein set forth, was duly sworn by me; and that the within transcript is a true record of the testimony given by said witness.

I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 19th day of October, 2007.

_____
GRETCHEN A. MILTON

0279

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M.D.

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THIS____ DAY OF____,20

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