SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK
Index No.

- - - - - - - - - - - - - - - - - - - x
, as Administrator of the Estate of , Deceased, and , individually,

Plaintiff,

- against -

, MD, , , MD, , MD, , MD, , MD, , MD, , MD and ,

Defendants.

- - - - - - - - - - - - - - - - - - - x

January 19, 2010
11:44 a.m.

DEPOSITION of DR. , a Defendant herein, taken by the Plaintiff, pursuant to Order, held at Broadway, New York, New York, before Kim Auslander, a Notary Public of the State of New York.

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

THE LAW OFFICE OF GERALD M. OGINSKI, LLC
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Attorney for Plaintiff
BY: GERALD M. OGINSKI, ESQ.

, LLP

Attorneys for the Witness,
DR.
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Attorneys for Defendant,
NEW YORK
BY: , ESQ.

IT IS HEREBY STIPULATED, by and between 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 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 of the C.P.L.R., and shall be controlled thereby.

The filing of the original of this deposition is waived.

IT IS FURTHER STIPULATED, that a copy of this examination shall be furnished to the attorney for the

witness being examined without charge.

D R . after having first been duly sworn by a Notary Public of the State of New York, was examined and testified as follows:

NOTARY PUBLIC: Please state your name for the record.

THE WITNESS: .

NOTARY PUBLIC: What is your present business address?

THE WITNESS: New York, New York.

MR. OGINSKI: Off the record.

(Discussion held off the record.)

MR. OGINSKI: Defense counsel has agreed to accept service on behalf of Dr. .

MR. : Just as I said, if there is any issue in that regard I will let you know.

MR. OGINSKI: Sure.

EXAMINATION BY

MR. OGINSKI:

Q. Good morning, Doctor. What is sepsis?

A. Sepsis is a condition where there's body alterations and changes possibly associated with shock or infection.

Q. What are the symptoms that you typically would see in a patient who has sepsis?

MR. : Note my objection as to form.

It was broad, but I guess you are asking in a broad sense, right?

MR. OGINSKI: Yes.

A. There are many symptoms you might see: Low blood pressure, mental status changes, possibly fever, poor respiratory function, poor renal function.

Q. Anything else?

MR. : Are we talking about clinical or laboratory?

MR. OGINSKI: Just clinical right now.

A. Alterations in cardiac function.

Q. How do you diagnose sepsis?

MR. : Note my objection to form.

Are you asking him in his specialty area?

MR. OGINSKI: Correct.

A. It's a clinical judgment.

Q. What diagnostic tools do you have available to assist you in coming to a diagnosis that a patient has sepsis?

A. You can look at laboratory tests.

Q. Like what?

A. White blood cell count, called CBC, complete blood count.

Q. Anything else?

A. You can look at vital signs, clinical exam.

Q. Can a person die from overwhelming sepsis?

A. Yes.

Q. What is septic shock?

A. Septic shock is a part of sepsis when the patient cannot maintain their blood pressure.

Q. Are you aware of the mechanics that would cause the inability to maintain blood pressure in light of sepsis?

MR. : On a cellular level?

Q. On any level. If you can just tell me.

A. Not specifically.

Q. What symptoms would you expect a patient to have if they were in septic shock? Again, I'm talking generally.

A. General --

MR. : I think he was asked and answered that; low BP, mental status.

MR. OGINSKI: I will rephrase it.

Q. Doctor, you told me what sepsis was and the symptoms of sepsis.

In your opinion, is sepsis the same as septic shock?

A. No.

Q. Tell me the difference.

A. Shock might be when there's --

shock is the -- when you have some of the symptoms of sepsis but also with the profound low blood pressure.

Q. How do you treat septic shock?

A. Depends on what the cause is.

Q. How do you determine what the cause is?

MR. : Objection. That's overbroad.

MR. OGINSKI: Withdrawn.

Q. In order to make a diagnosis of sepsis, you use clinical laboratory tests, correct?

MR. : You may?

A. Right.

Q. One of the factors you use to assist you in coming to a diagnosis that a patient has sepsis is clinical laboratory tests, correct?

A. Correct.

Q. You also use clinical examination?

A. Correct.

Q. And you may also feel the need

to do various diagnostic tests, such as a CT scan or an MRI scan, correct?

A. Not necessarily.

Q. Are there instances where you will obtain a CT or an MRI to evaluate or rule out the patient who has sepsis?

A. To rule in or out if the patient has sepsis?

Q. Yes.

A. Not necessarily.

Q. To evaluate or come to a diagnosis that a patient has septic shock, what tests do you use to come to the conclusion that a patient has septic shock?

A. I think you would look at their vital signs, many of the things I mentioned; their mental status, look at their urine output. That's some of the clinical findings and laboratory findings.

Q. Are there ever instances where you will use or order a CT scan or an MRI scan to assist you in evaluating a patient who you believe may have septic shock?

MR. : That's overbroad.

Ever instances? He is not going to go through every scenario he has ever been confronted with.

MR. OGINSKI: Withdrawn.

Q. When you are evaluating a patient and you suspect that the patient may have septic shock, have there been instances in your career where you have ordered or requested that a CT or MRI scan be performed?

A. Occasionally.

Q. For what purpose would you use that? I'm asking generally.

A. General, if there's no obvious -- or if you are searching for a cause of septic shock.

Q. How do you treat septic shock?

A. Usually you will give antibiotics.

Q. Would that be IV antibiotics?

A. IV antibiotics.

Q. Is there any other way to treat it?

A. Support, whether that be

cardiac support, ventilatory support.

Q. Is there anything else that you do for septic shock?

A. Those are the first two components that you would establish; make sure their circulation is adequate and airway is adequate.

Q. Do you have a memory of this patient, Mrs. ?

A. I have a memory.

Q. Do you remember what she looks like?

A. Specifically?

Q. Yes.

A. No.

Q. In preparation for today's question and answer session you reviewed the patient's chart, correct?

A. Yes.

Q. Did you review the husband's deposition testimony that he has given in this case?

A. No.

Q. Did you review any medical

literature in preparation for today?

A. No.

Q. Did you review any notes that you may have separate and apart from what's contained within these charts?

MR. : Yes. We brought something for you. I made a copy of it. This, right?

THE WITNESS: Yes.

MR. OGINSKI: Okay.

Q. Other than the page that your attorney just provided to me, did you review any other notes that are not contained within the records that you reviewed for today?

A. No.

Q. In the course of your career, Doctor, you have performed bowel resection with anastomosis, correct?

A. Yes.

Q. The surgery you performed on , 2007 on Mrs. , that was a ventral hernia repair, correct?

A. It was an exploratory

laparotomy and ventral.

Q. The primary purpose was to fix the hernia, correct?

A. No.

Q. What was the primary purpose of the surgery?

A. Explore the patient.

Q. Did you have access to the patient's prior surgical records at the time that they first came to see you for evaluation?

A. Yes.

Q. Did you review the patient's prior surgical records, either at the first visit or at some time shortly before you performed surgery on th?

MR. : In what respect? How in depth?

Q. Did you review it in any regard?

A. I seem to recall I reviewed it.

Q. Do you know Dr. ?

A. Do I know her?

Q. Yes.
A. Yes.
Q. How do you know her?
A. She is another surgeon at
.
Q. Had you worked with her in the past?
MR. : What does that mean? Operated with her?
MR. OGINSKI: Let's start with that.
Q. Have you ever operated with her in the past?
A. Yes.
Q. In what regard? What relationship? As attendings who participated on the same case, as a consultant, something else? You tell me, doctor?
A. I can't recall exactly what role I operated with her, but I have operated with her in the past.
Q. Did you train with her as a resident?

A. I trained as a fellow under her.

Q. Did you have any discussions with her specifically about this particular patient prior to performing your surgery on , 2007?

A. I don't recall.

Q. Is there anything in your office records to suggest or indicate that you had spoken with her, Dr. , prior to performing surgery on Mrs. on , 2007?

MR. : You mean from the timeframe that he first started seeing the patient up until then?

MR. OGINSKI: Yes.

MR. : Could you repeat the question?

MR. OGINSKI: I will rephrase it.

Q. Doctor, from the time you first started seeing and treating Mrs. up until , 2007, had you ever spoken with Dr.

about this particular patient?

A. I don't recall.

Q. Is there anything within your notes specifically that would suggest or indicate to you that you had a conversation with Dr. about this particular patient?

A. Not that I can recall.

Q. In the course of your career before , 2007, had you ever had a situation where you performed a bowel resection with anastomosis that later broke down?

A. Not that I can recall.

Q. As far as you understand, as far as you recall, was this the first time that you had a bowel resection where the anastomosis failed?

A. That I can recall specifically of my patients?

Q. Yes.

A. Yes. The first time are you saying?

MR. : He asking with

certitude, so if you're not sure, say you are not sure.

A. I can't recall.

Q. Before , 2007, had you ever performed a bowel resection with anastomosis that had broken down where the patient ultimately died as a result of sepsis?

A. Not that I can recall.

Q. When there is a breakdown in a bowel anastomosis, what causes irritation to the abdominal cavity? Is it the fecal contents?

A. Typically.

Q. What causes infection when you have a breakdown in anastomosis?

A. The fecal contents.

MR. : Off the record.

(Discussion held off the record.)

Q. In a patient who has an anastomotic breakdown, what symptoms would you expect to see in such a patient?

A. You can see abdominal pain, you can see abdominal distension, fever.

Those are some of the symptoms you can typically see.

Q. What type of clinical findings -- what kind of laboratory findings would you expect to see in a patient who has an anastomotic breakdown?

MR. : I object to form.

Expect to see? I'm not sure if that means will see or can see or may see.

MR. OGINSKI: Okay.

Q. In a patient who suffers an anastomotic breakdown of bowel, if you run lab tests on the patient; blood tests, CBC, what would you typically expect to see? Again, as a general question.

A. You can see an elevation in white blood cell count. You might not see any of these clinical symptoms that I had mentioned.

Q. In the course of your career, have you had occasion to see and treat patients who have had an anastomotic breakdown?

A. Yes.

Q. Have you had occasion to evaluate patients postoperatively where you suspect that a patient has had an anastomotic breakdown?

A. Yes.

Q. Have you also had occasion to reoperate on one or more patients who have had what you believe to be a breakdown of the anastomosis?

A. Yes.

Q. In addition to those symptoms that you just told me about, would you also expect to see respiratory difficulties?

A. You can.

Q. Would you expect to see cardiac abnormalities?

A. It's possible.

Q. Would you expect to see hypotension?

A. It's possible.

Q. What diagnostic tools do you use in order to assist you to determine whether or not a patient has a breakdown of

the anastomosis?

A. A lot is clinical judgment.

Q. Putting aside the -- I'm going to get to your clinical judgment, Doctor, but specifically what diagnostic tests are available to you to assist you in determining whether or not there may or may not be an anastomotic breakdown?

MR. : You are asking what's available, not what's required to be done?

MR. OGINSKI: Correct.

A. You can get some type of imaging study.

Q. Can you be more specific?

A. A contrast study where you take in dye and do some form of X ray or imaging, radiographic imaging.

Q. Is there a preferred test, whether you call it a gold standard test or some other test that is preferred, such as CT scan or MRI scan, to help you evaluate possible anastomosis breakdown?

MR. : Objection to

form.

MR. OGINSKI: I will rephrase it.

Q. If you suspect that a patient has some type of anastomotic breakdown, what diagnostic tests specifically; MRI, X ray, CAT scan or something else, is a preferred test to perform to assist you?

MR. : I have to object to the form when you say preferred, because preferred -- I'm not sure --

MR. OGINSKI: I will rephrase it.

Q. The contrast study you mentioned, is there a particular type of imaging study that is better to perform to help you see what's going on?

A. CAT scan or -- it also depends on where you suspect the leak.

Q. In 2007 the which you practiced, , they had CAT scans, correct?

A. That's correct.

Q. They had MRI equipment as well?

A. Yes.

Q. Now, the clinical examination that you mentioned a moment ago, that all goes to evaluating the patient's abdominal pain, distension and any other problems that may show up, correct?

A. Yes.

Q. At you had residents rotating through your department, correct?

A. Yes.

Q. You also had fellows?

A. Yes.

Q. Did you have any particular responsibility for overseeing or supervising fellows in the work that you did on a daily basis?

A. Could you be more specific?

Q. Sure. You were an attending in 2007, correct?

A. Yes.

Q. In the Department of

Gynecologic Oncology?

A. Department of Surgery.

Q. And the subdivision as well?

A. Subdivision, gynecologic service.

Q. Your specialty was gynecologic oncology?

A. Yes.

Q. You are board certified in GYN oncology?

A. Yes.

Q. As well as obstetrics and gynecology, correct?

A. Yes.

Q. You focus your practice primarily on GYN oncology, correct?

A. Yes.

Q. Is it fair to say you haven't delivered any babies since residency?

A. Yes.

Q. In addition to seeing patients in your office and operating on patients, do you also have a responsibility to teach residents and fellows at the ?

A. Yes.

Q. And you do that by teaching during surgery?

A. Yes.

Q. Do these residents or fellows also participate in your office hours?

A. Occasionally.

Q. Just talking about the teaching these residents and fellows during surgery, how do you actually teach them?

MR. : It is a broad question. It may depend on the situation.

MR. OGINSKI: I will rephrase it.

Q. When you perform surgery at -- again, my timeframe only refers to 2007 unless I indicate otherwise --

A. Okay.

Q. -- is it fair to say that you typically had a resident or a fellow participate in surgery with you?

A. Yes.

Q. Tell me what a resident or fellow would typically do during surgery.

MR. : Is there a way to quantify that or does that depend on the person or fellow or resident in the surgery?

A. It all depends. Typically residents do not do much at . It's mostly the attending and the fellow.

Q. With regard to Mrs. 's surgery on , 2007, you were scrubbed for the surgery, correct?

A. Yes.

Q. You had a resident also scrubbed for the surgery?

A. Yes.

Q. There was also a fellow, if I am not mistaken?

A. Yes.

Q. Do you recall -- we will go through a little bit later the op notes and things like that -- but do you recall who the resident was and who the fellow was?

A. The fellow was Dr. .

Q. And the resident?

A. Dr. .

Q. And as you sit here now, do you remember what year Dr. was at the time in of '07?

A. No.

Q. And the fellowship in GYN oncology, how many years is that?

A. Four.

Q. What year was Dr. in?

A. Dr. is a surgical oncology fellow.

Q. What year was he in at the time?

A. He was in his first year.

Q. As a fellow, correct?

A. As a fellow.

Q. Do you know how much training he had received prior to starting his first-year fellowship?

A. He completed a residency in general surgery.

Q. Do you know how many years that was?

A. I don't know specifically, but -- I can't --

Q. It's okay. I don't want you to guess.

The day after surgery, on 1st, 2007, I want you to assume for the purposes of my question that there was a delay in giving the patient her cardiac medication, specifically the Metoprolol.

A. Yes.

MR. : I have to object.

MR. OGINSKI: Let me just finish the question.

Q. I want you to assume that.

Do you have an opinion whether the delay in giving her her cardiac medication was a contributing factor to her cardiac symptoms?

MR. : I have to object to that.

MR. OGINSKI: Tell me why.

MR. : He is not going to assume any delay, alright? It may have been -- that's assuming already

an allegation is a fact. I object to that.

MR. OGINSKI: There's stuff in the records that I think bear me out, but I'm asking as a hypothetical.

You are not going to let him answer?

MR. : Not with an assumed delay, no. You can ask facts, but you can't assume delays.

MR. OGINSKI: I disagree.

Q. Did you learn from any doctor that there was an issue about when the patient was going to get her cardiac medications after her surgery of ?

A. Did I learn from any doctor?

MR. : That there was an issue?

MR. OGINSKI: Yes.

MR. : Objection to form.

Did you learn in that way?

THE WITNESS: No.

Q. Did you learn that Mrs. was taking cardiac medications to control her palpitations?

A. I don't understand the question. If you can --

Q. Prior to surgery, did you learn that the patient was on some type of cardiac medications?

A. I knew she was.

Q. What was your understanding as to why she was on a cardiac medication?

A. Because she had some palpitations.

Q. Do you remember as you sit here now what that medication was?

A. Metoprolol.

Q. Following the surgery, did you learn from any physician or nurse about the timing in which she received her Metoprolol following the surgery?

A. Following the surgery? I learned about it just before she was transferred to .

Q. What did you learn?

A. That she got her dose in the afternoon. Let me just -- I don't recall exactly what was said to me.

Q. Was this from a nurse, a physician or somebody else?

A. I don't recall who.

Q. The medication that she had received in the afternoon, was that extended release or instant release?

A. I don't recall what she actually took.

Q. Did you ever form an opinion as to whether the timing as to when she received her Metoprolol was a contributing factor to her cardiac situation right before her transfer to New York

?

MR. : Within a reasonable degree of medical certainty?

MR. OGINSKI: Yes.

A. No.

Q. No, you never formed an opinion?

A. Did I feel that it contributed to it?

Q. Yes.

A. I never formed an opinion, no.

Q. Did you learn from anyone whether this patient should have received that particular cardiac medication earlier in the day before she was transferred to the across the street?

A. No, I did not learn from anybody.

Q. Did you have a discussion with any consulting cardiologist before the patient was transferred to ?

A. Directly, no.

Q. Tell me about any indirect conversation where you learned about a conversation with a cardiologist.

A. There was a cardiac consultation called the evening that she was transferred, and it's my recollection that it was felt that she should be -- she would receive better cardiac care at .

Q. Is there a difference, to your knowledge, between extended release Metoprolol and instant release Metoprolol?

A. In general?

Q. Yes.

A. In general, extended release is probably longer-acting.

Q. Did you learn from either the patient or the patient's husband that Mrs. had in the past used the extended released Metoprolol and it simply had no real effect on her?

A. No.

Q. Did you learn from anybody that the patient's husband had specifically requested the immediate release form of the Metoprolol?

A. Nobody -- I did not learn from anybody that.

Q. In reviewing the notes for today's question and answer session, did you see any nursing notes about when this patient actually received her Metoprolol prior to the transfer to ?

A. In reviewing the notes, I believe it was in the afternoon.

Q. Did you see any notes -- by the way, was that a nurse's note?

A. Yes.

Q. Did you see any notation about the issue of timing of that particular medication and the conversations that ensued in order to get the patient that medication?

A. I don't recall the specifics of the note, I don't.

Q. During your preop consultation with the patient and her husband, did you tell them that they should do the -- withdrawn.

During your preop consultation with the patient, did you suggest to the patient that they should have -- let me rephrase it.

During your preop consultation did you tell the patient that she should have her hernia repair with you at ?

MR. : I have to object, but did you use those words?

THE WITNESS: No.

Q. Did you tell the patient that she should have the hernia repair with you instead of going to a general surgeon?

A. No.

Q. Did Mr. ask you whether they should go to a general surgeon to get the hernia repaired?

A. I don't recall that.

Q. Do you have privileges to perform general surgery at ?

A. Yes.

Q. In your practice, Doctor, do you perform hernia surgery?

A. Yes.

Q. Do you typically perform hernia surgery when it is related to surgery that you would perform regarding GYN oncology?

A. Yes.

Q. Now, I would like to go back

for a moment to what we were talking about regarding sepsis.

Would you agree, Doctor, that the earlier you intervene and treat a patient with sepsis the better likelihood that you can salvage the patient's situation?

MR. : Objection. That's vague as to time.

MR. OGINSKI: I'm sorry?

MR. : That's vague. Are you saying --

MR. OGINSKI: I will rephrase it.

Q. If you suspect that a patient has sepsis, would you agree that the earlier you treat or you diagnose and treat the condition the better chances of the outcome?

MR. : Objection to form. Over objection to form, I guess.

A. I think that would be a reasonable thing to assume.

Q. Tell me why.

A. As a condition gets worse, it typically in general gets more difficult to treat.

Q. What are the implications for the patient for not treating the patient earlier rather than later?

MR. : Objection.

Objection to that. I will tell you my basis.

MR. OGINSKI: It's okay.

Q. The surgery on , 2007 was an elective hernia repair, correct?

A. It was an exploratory laparotomy and hernia repair.

Q. The hernia repair, specifically, was elective?

A. Both surgeries were elective.

Q. I'm just focusing right now on the hernia repair. Correct?

A. Yes.

Q. I just want to make sure -- the exploratory laparotomy, as you

mentioned, was an elective procedure?

A. Yes.

Q. What were the indications for performing an elective laparoscopy?

A. Laparoscopy?

Q. I apologize.

What were the indications for performing an exploratory laparotomy on ?

A. The patient was having worsening abdominal pain in the setting of unexplained cause with a possibility of recurrence of ovarian cancer.

Q. In your review of the patient's records --

A. Yes.

Q. -- you recognize, I saw, that she had been treated for ovarian cancer by Dr. , correct?

A. Dr. was her surgeon before, yes.

Q. And that she had undergone surgery in 2004 and also in 2005, correct?

A. Yes.

Q. And that she continued to be seen and followed by various physicians following those two surgeries, correct?

A. Yes.

Q. And one of the purposes for her continuing follow-up was to check for any recurrence of cancer, correct?

A. Yes.

Q. On any of the notes that you reviewed did you observe any suggestion to indicate that there was a recurrence of cancer at any time up to , 2007?

MR. : I'm not sure what you mean by a suggestion. You mean concerns, suspicions?

MR. OGINSKI: I will rephrase it.

Q. Was there any documented notation by Dr. where she is indicating the possibility or the likelihood that this patient has a recurrence of cancer?

A. Dr. or any of the --

Q. I will start with

Dr. .

A. Not that I recall.

Q. Was there any discussion by Dr. , the patient's oncologist, that there was any type of recurrence of cancer up until , 2007?

MR. : Or suspicion or concern for?

MR. OGINSKI: Anything documented in the records.

A. In some of the records there was -- I recall that there was a note that cancer cannot be ruled out.

Q. Would it be fair to say, Doctor, that following surgical de-bulking that you can never completely rule out the recurrence of cancer, certainly on a microscopic level?

A. That's correct.

Q. From all the tests that this patient was receiving for follow-up to check for cancer recurrence, was there any evidence that any of those tests were positive for recurrence?

A. There was --

MR. : Answer the way you want to answer.

A. There was a PET scan that was concerning.

Q. And how far away was that PET scan performed in relation to the surgery that you performed?

A. I think it was a few months.

Q. Do you recall, was that a test you had ordered?

A. It was ordered by Dr. .

Q. And did you see the results of that test?

A. Yes.

Q. What, if anything, did that test result signify to you?

A. That she might be recurring.

Q. What tests do you typically have patients do to follow up for recurrence of cancer?

A. Well, physical exam, CA 125 is a blood test, some people order CAT scans.

Q. On any physical exam findings by Dr. or , was there any suggestion that there might be a recurrence of cancer?

A. Not that I recall on physical findings. Not that I recall.

Q. Was there anything about the patient's CA 125 levels that were concerning to any physician who had seen her in the past?

A. Not that I recall.

Q. She had had CAT scans, correct, for follow-up?

A. She had several CAT scans.

Q. Was there any suspicion or concern on any of the CAT scans that she had to suggest there was a recurrence of cancer?

A. There were some nonspecific nodules noted.

Q. Would you agree that those nonspecific nodules could be nothing or they might be recurrence?

A. They can be.

Q. But the fact they were nonspecific did not give you cause for concern?

MR. : Objection.

MR. OGINSKI: I will rephrase it.

Q. What was your opinion about these nonspecific findings?

A. These were findings that could be an early recurrence.

Q. What tests did you perform in order to evaluate the patient's abdominal pain prior to performing the exploratory laparotomy?

A. I believe she had a CAT scan and a small bowel series.

Q. What were the results of the CAT scan?

A. The CAT scan --

Q. We have the records. I am just asking your memory.

MR. : You want to ask him in what specific sense?

MR. OGINSKI: I will ask it a

different way.

Q. Do you have a memory as you sit here now whether the CAT scan results showed something that made you believe there was some recurrence?

MR. : In conjunction with -- just the findings?

MR. OGINSKI: Just the CT findings.

A. There was some increase in some adenopathy.

Q. Meaning what?

A. Enlargement of some lymph nodes.

Q. What does that suggest to you?

A. It could be a recurrence.

Q. What else could it be?

A. Inflammation, infection.

Q. You performed blood work on the patient as well?

A. I believe I ordered a CA 125.

Q. Was there anything abnormal about that result?

A. No.

Q. The small bowel series, was there anything to suggest that there was a problem with the bowel or any recurrence of cancer?

A. No.

Q. What else would account for the patient's abdominal pain? Withdrawn.

Did you form a differential diagnosis when trying to evaluate this patient's abdominal pain that was worsening?

A. It was unclear to me what the cause was, but I was concerned about cancer recurrence.

Q. What else could cause the patient's worsening abdominal pain?

A. Adhesions.

Q. Anything else?

A. Back then I thought it might -- there might be some component of her hernia, but I was not -- it was not clear to me what was the actual cause.

Q. What do you do to rule out or evaluate further the possible causes for the patient's worsening abdominal pain?

A. She had had a series of CAT scans, she had had a GI visit.

Q. Did you have any other tests that were available to you that would help you rule in or rule out the cause for this patient's continuing abdominal pain?

A. Radiologic tests?

Q. Anything else you had available to you.

A. I think she had had a series of CAT scans and the small bowel series.

Q. Did either of those two diagnostic tests explain what the pain was or the etiology was?

A. No.

Q. Why can adhesions cause abdominal pain?

A. If there's some component of tethering of the bowel.

Q. Explain what you mean by tethering.

A. If -- the bowel is a muscle and it squeezes the contents through. If there is some stricture or kinking, it

potentially could cause some cramping abdominal pain.

Q. There was nothing in the bowel series to suggest that there was any type of stricture; is that correct?

A. That's correct.

Q. How can a hernia cause abdominal pain?

A. If there is -- in a similar way; if there is stricture by the hernia causing some form of obstruction, that potentially could cause abdominal pain.

Q. Now, before you started to care for this patient had you learned from Dr. 's notes that the patient had already been diagnosed with a hernia?

A. No.

Q. Were you the first person to diagnose -- as far as you know -- to diagnose the patient's hernia?

A. No.

Q. Was this an incisional hernia?

A. It appeared to be.

Q. Was the hernia strangulating

any part of the bowel?

A. It did not appear to be.

Q. Do you base that upon your clinical examination?

A. That's correct.

Q. Did you also perform any X ray studies to confirm or rule out that possibility?

A. She had a series of CAT scans and small bowel series.

Q. How would you describe the nature of her hernia? Are you able to characterize it in any way?

MR. : I am not sure what you mean by the nature of it; how it was progressing, how it changed?

Q. When you evaluated this patient's hernia -- by the way, that was a ventral hernia, correct?

A. Yes.

Q. Just describe what a ventral hernia is.

A. A hernia on the ventral abdominal wall.

Q. You told me that a possible cancer occurrence could also cause abdominal pain. Tell me how.

A. Sometimes with ovarian cancer you can get some nodularity or tethering of the bowel in similar ways that adhesions can cause the pain.

Q. Now, in a patient who has had prior GYN surgery, the type of laparotomies this patient had in 2004 and 2005, would it be correct to say that you would expect the patient would have some adhesions?

A. Expect.

Q. As far as your understanding, this patient's abdominal pain continued to worsen over time?

A. Yes.

Q. Did you learn how it limited her daily activities, if at all?

A. Prior to the surgery, she had come in and said that it was to the point where it was really impeding her activities.

Q. Did she also tell you about

her scheduling as to when she was going to have this done or whether she would have this done?

MR. : I object to form.

MR. OGINSKI: I will rephrase it.

Q. Are there any diagnostic tests that were available to you that would determine conclusively other than surgery whether or not the patient's adhesions were the cause for her worsening abdominal complaints?

A. Not with 100 percent certainty.

Q. Was there anything, again, any other diagnostic tools, that were available that would help you determine conclusively whether or not the hernia was the primary cause of her worsening of abdominal pain?

MR. : Objection to form.

When you say the primary cause, with 100 percent certainty it was the only cause?

MR. OGINSKI: No. I will rephrase it.

Q. Other than the CT scan where you told me there was some increase in adenopathy and the PET scan which you said was concerning for recurrence, was there anything else to suggest to you the possibility that there was a recurrence of cancer?

MR. : He also said the small bowel, right?

MR. OGINSKI: Yes.

A. Possibility of recurrence?

Q. Yes.

MR. : You mean on laboratory tests or -- not clinical?

MR. OGINSKI: Thank you. I will rephrase it.

Q. You have told me so far that the two things that suggest -- or were concerning to you for recurrence of cancer were the results of the PET scan and the CT scan; is that correct?

A. As far as testing?

Q. Yes. Just testing right now.
A. Testing.
Q. Were there any other tests that suggest to you the possibility of recurrence?
A. Not that I recall.
Q. From a clinical standpoint, what suggested to you the possibility of a recurrence?
A. Her worsening symptoms, abdominal pain in the setting of no explainable cause.
Q. Have there been cases where you have been called in to a general surgery case where you were on standby as a GYN oncology consult?
A. Occasionally.
Q. In other words, a patient is having general surgery and there is a finding during surgery and suspicions for cancer and you are now called down to evaluate or address it?
A. Not specifically at .
Q. In your training have you had

occasion to be called in as a consult from a GYN oncology standpoint?

A. To another service?

Q. Yes.

A. Once I recall some other surgeons wanted an opinion about a cyst of the ovary.

MR. : Let me get a menu to order lunch.

MR. OGINSKI: Sure.

(A short recess was taken.)

(Plaintiff's Exhibit 3 marked for identification.)

Q. Am I correct that the patient had no internal female organs that could account for any possible GYN pathology that would account for worsening abdominal pain?

A. Yes.

Q. During preop consultation with the patient and her husband, did she specifically ask any questions?

A. She was concerned if this could be cancer.

Q. Other than that concern, do

you recall any other specific questions that she raised?

A. Not specifically.

Q. Did Mr. ask you any questions specifically?

A. I don't recall the specific questions, but once again, there was concern about cancer.

Q. Did you ever recommend that they should go to a general surgeon to have the hernia repaired?

MR. : I thought that was asked and answered.

MR. OGINSKI: It's a little bit different.

A. I don't recall specifically saying that to them.

Q. Are there general surgeons within that you have on occasion referred patients to?

A. Yes.

Q. Did you at any time refer this patient to a general surgeon for

evaluation?

A. I don't recall doing so.

Q. Was there any evidence in any of your notes to suggest that you had referred the patient to a general surgeon?

A. No.

Q. Did you practice in the same group -- withdrawn.

A. Can I --

Q. Go ahead.

A. I did offer that she can go get another opinion.

Q. What was the response?

A. No. They specifically wanted me to do it.

Q. Were you aware as to why Dr. was no longer practicing or being able to see and treat Mrs. ?

A. She focused her practice on breast cancer surgery.

Q. Did you practice with her when she was practicing GYN oncology?

MR. : Again, objection to the form.

MR. OGINSKI: I will rephrase it.

Q. Did you participate in any type of faculty practice?

A. Yes.

Q. What was the name of that faculty practice?

A. It's the Department of Surgery, GYN Service Practice.

Q. Was Dr. part of that service?

A. Yes.

Q. How many other physicians in 2007 were part of that service? I don't need the exact number, Doctor.

A. Six or seven.

MR. : Is that an estimate?

THE WITNESS: Yes.

Q. How was it that you came to see Mrs. as opposed to any of one of those other physicians?

A. When Dr. decided to stop practicing GYN oncology, her patients

were assigned to new doctors.

Q. This was one of the new patients you were assigned to?

A. Yes.

Q. Now, once the patient was reassigned, did you request the patient come in for follow-up or did she come back on her own for routine follow-up care?

A. Yes. I did not request that they come in. I don't know the mechanism of how her appointment with me was scheduled.

Q. In your preop consultation note, did you indicate the possibility that this patient might have a recurrence of cancer?

A. Yes.

Q. Did you indicate that one of the reasons you were going to be performing an exploratory laparotomy was because of the unclear etiology of her worsening abdominal pain?

A. Yes.

Q. Doctor, let me show you a

photograph that's been marked as Plaintiff's 3 for identification and ask you if that photograph refreshes your memory about what the patient looked like.

MR. : Do I have this? Mr. Oginski, do I have copies of all of these?

MR. OGINSKI: I believe you do.

MR. : Do we know the date this was taken?

MR. OGINSKI: No, at least not off the top of my head.

I know the patient's husband talked about it.

MS. : At his deposition? I don't recall him testifying as to that picture. I don't recall ever seeing that picture.

MR. OGINSKI: I just marked it now. Regardless, you can have a copy of it.

MR. : We are going to need copies of it if you are asking

about anything that is marked today.

MR. OGINSKI: Yes.

MR. : By looking at the appearance, do you remember her or not?

THE WITNESS: I think her hair was different. I don't know if this is before her chemotherapy or not.

Q. Let's talk about the surgery you performed on .

A. Yes.

Q. Am I correct that you performed an anastomosis during that surgery?

A. Yes.

Q. An enterostomy was made during the surgery, correct?

A. Was noted, yes.

Q. What is an enterostomy?

A. It's a hole in the intestine.

Q. This particular enterostomy, was it intended to be made?

A. No.

Q. Do you have an opinion,

Doctor, with a reasonable degree of medical probability as to whether making an unintentional enterostomy during an exploratory laparotomy is departing from good and accepted medical care?

A. It is an occurrence that happens.

Q. In other words, it's a risk that you are aware that can occur, correct?

A. Yes.

Q. Am I also correct that during the course of your preop consultation this is one of the things that you will tell patients can occur during this type of surgery?

A. Yes.

Q. Just to be clear, the fact that an enterostomy occurs, in your opinion, is not a departure from good and accepted care, correct?

A. Yes.

MR. : I think he answered that.

Q. Would you agree, Doctor, that

if an unintended enterostomy is made and not recognized during the time of surgery that that would be a departure from good and accepted care?

MR. : Objection.

MR. OGINSKI: What is the objection?

MR. : Number one, that is not the facts in issue in the case.

MR. OGINSKI: I am just establishing --

MR. : Number two, there are enterostomies that can occur that are not observed until later.

MR. OGINSKI: That is why I am asking the question.

MR. : Those are not the facts in the case. I would like to keep it to the case.

MR. OGINSKI: There is no issue there. I will rephrase it, Doctor.

Q. Would it be correct to say that if an unintended enterostomy occurred

and you did not recognize it at the time it occurred, that that would be considered a departure from good and accepted medical care?

A. No.

Q. Tell me why.

A. It can happen. Some things are not clinically recognized.

Q. Now, in this patient's case you observed adhesions, correct?

A. Yes.

Q. Can you characterize the amount or type of adhesions that you encountered?

A. There were many adhesions. I can't specifically say all the details about it.

Q. Can you characterize the difficulty in taking down the adhesions during the surgery?

MR. : What do you mean characterize the difficulty?

Q. You performed a lysis of adhesions, correct?

A. Yes.

Q. Did you need to spend a lot of time taking down the adhesions, a short period of time or something else?

A. I don't recall the exact length of the lysis of adhesions part or segment of the operation.

Q. Was this, in your opinion, a difficult procedure?

MR. : Objection to form. What aspect of the procedure? The whole thing?

Q. The exploratory laparotomy.

MR. : When you say difficult, what does that mean? Difficult because you need a surgeon's skill to do it?

MR. OGINSKI: No.

Q. Did you find it, Doctor, to be a difficult procedure on this particular patient?

A. Not particularly difficult.

Q. Who performed the lysis of adhesions?

A. It was myself and Dr. .

Q. What was Dr. doing as far as lysing the adhesions?

A. He was either cutting some of the adhesions or I was cutting some of the adhesions. We work in tandem.

Q. What was Dr. doing?

A. Observing.

Q. Was she assisting in any regard?

A. Potentially with a retractor.

Q. The area where the enterostomy was made -- withdrawn.

Am I correct that the enterostomy was made in the bowel?

A. Yes.

Q. Is it your opinion that the enterostomy occurred during the course of taking down the adhesions?

A. Yes.

Q. Is that in an area where the bowel was adherent to the abdominal wall?

A. Yes.

Q. How did you recognize the

enterostomy?

A. After lysing adhesions you usually check the bowel to see if there has been any enterostomies.

Q. Do you surgeons use a term known as running the bowel?

A. Yes.

Q. What does that mean?

A. It means basically looking at the length of the bowel to inspect it.

Q. You mentioned a few moments ago that there are instances where you do not clinically recognize that there is an enterostomy, correct?

A. Possibly.

Q. In other words, the hole might be too small or it may --

MR. : Can we --

MR. OGINSKI: I will rephrase it.

MR. : I don't think it is an issue of fact. I don't think it is a claim in the case.

He is not going to give a

theoretical deposition.

Q. The area where the enterostomy occurred, what part of the small bowel was that?

A. I believe that was the ileum.

Q. What area is that?

A. That's the second part of the small bowel.

Q. If you could, Doctor, if you could turn to your operative note for a moment, please.

MR. : This would be in Exhibit 1.

Q. Again, the record that your attorney has provided has been marked as Plaintiff's 1 for identification.

If you can just look at that note, please.

A. The operative note?

Q. Yes, please.

MR. : That's it.

A. Okay.

Q. Now, did you dictate that operative note?

A. Yes.

Q. By the way, was it the custom and practice back at that you dictate your notes or did you type it into the computer or something else?

MR. : All of the notes?

MR. OGINSKI: The operative note.

A. Dictate.

Q. After you have dictated it, do you get a typed copy back for you to review?

A. Yeah.

Q. Do you then sign off on it?

A. Yeah.

Q. The copy that you are looking at now, is that a copy that you had signed?

A. Yes.

Q. You are talking about an electronic signature, correct?

A. Yes.

Q. Is there anything in your dictated operative note to indicate where the enterostomy was made?

MR. : Where it occurred?

MR. OGINSKI: Yes. Thank you.

A. Small bowel.

Q. Can you be anymore specific where within the small bowel the enterostomy occurred?

A. No.

Q. Now, in that area where the enterostomy occurred, was that area friable?

A. I seem to recall. I can't specifically say.

Q. Looking at your note, your operative note, Doctor, is there anything in your typed operative note to suggest that the area where the enterostomy occurred was friable?

A. I don't know if it was friable, but I was not happy with the appearance.

Q. I understand. I am going to get to that. I am just asking about the friability of the tissue.

A. No.
Q. When I use the term friable, what does that mean to you?
A. The tissue does not appear healthy, easily bleeds.
Q. Did you observe any evidence of a recurrence of cancer in the area where the enterostomy was found?
A. At the time of surgery?
Q. Correct. I'm talking about gross evidence of recurrence.
A. Gross evidence, no.
Q. On pathology, when you received the specimen back from pathology, was there any microscopic evidence of recurrence of cancer?
A. No.
Q. Did you observe any evidence of radiation-related bowel damage in the area of the enterostomy?
A. Radiation?
Q. Yes. Radiation-related bowel damage.
A. I did not.

Q. Are there instances, Doctor, where a patient will undergo a course of radiation and later on when you perform a laparotomy you will find evidence of bowel that has been damaged from radiation?

A. Yes.

Q. Am I correct that you did not see any type of evidence in this patient during --

MR. : He just said that.

Q. You are shaking your head yes?

A. Yes.

Q. The area where the enterostomy occurred, was that near the original bowel resection and anastomosis that was done by Dr. in 2005?

MR. : Just repeat that.

(Record read back.)

MR. : Characterize the word near.

Q. Was it in the vicinity? I will rephrase it.

Based on your review of

Dr. 's operative report and based upon your examination of the patient during surgery on , 2007, are you able to tell me whether the location where this enterostomy was found was near where Dr. had performed her anastomosis?

A. I can't recall.

Q. Is there anything in your operative note to indicate whether the enterostomy -- withdrawn.

Is there anything in your operative note to indicate where the patient's original anastomosis was and your observation of it?

A. No, I don't see anything.

Q. At any time during the course of your , 2007 operation, did you observe any evidence of gross recurrence of cancer anywhere within this patient's abdomen?

MR. : I think you asked and answered that.

MR. OGINSKI: I asked specifically in the area of where the

enterostomy was made.

MR. : That's fine.

A. Obvious?

MR. : Gross, obvious.

Right.

A. Not that I physically saw with my eyes.

Q. In the pathology reports, the tissue samples you submitted to pathology, was there any indication of recurrence of cancer in those notes?

A. Not in the samples I submitted.

Q. During the course of your surgery on , 2007, did you form an opinion with a reasonable degree of medical probability as to why this patient continued to have worsening abdominal symptoms?

MR. : Did you hear the question?

THE WITNESS: Can you repeat that?

(Record read back.)

A. No.

Q. Postoperatively, before the patient was transferred across the street to , did you form an opinion with a reasonable degree of medical probability as to why the patient had continued worsening of abdominal symptoms?

A. No.

Q. Now, tell me why you performed a bowel resection during this , 2007 surgery. I'm sorry. Let me stop you for a second.

I should have asked this: Can you describe the size of the enterostomy?

A. I can't specifically recall the actual size of it.

Q. Is there anything in your operative note that would tell you or refresh your memory about the size of the enterostomy?

A. It was not -- looking at my note, it was not a very, very small enterostomy.

Q. Which sentence or sentences

are you referring to that would give you that suggestion?

A. Given the size of the defect.

Q. Were you able to oversew that defect?

A. Given the size, I don't think I was.

Q. Was that one of the alternatives -- withdrawn.

When the enterostomy is recognized, am I correct that you have two options at that point; one is either oversewing the defect, correct?

A. Yes.

Q. And the other is performing a bowel resection?

A. Yes.

Q. Am I correct that the patient was bowel prepped prior to surgery?

A. I don't recall.

Q. At the time that you observed the enterostomy, was there a spillage or leakage of fecal contents?

A. There was. I don't think it

was -- I don't recall how much.

Q. But you noted in your operative note that there was, correct?

MR. : It says here.

A. Right, but I don't know how much was profuse. I don't recall it being profuse spillage.

Q. You also note in your operative report, We decided to resect a small portion of bowel.

Can you give me dimensions, if you know, as to what you refer to when you say small portion?

A. It was about 4, 5 centimeters.

Q. Who performed the bowel resection?

A. Myself and Dr. .

Q. Did you encounter any complications in performing the actual bowel resection?

A. No.

Q. Tell me what your thought process was as to why you chose to perform a bowel resection as opposed to oversewing

the defect?

MR. : To the extent he can recall what he was thinking.

MR. OGINSKI: Of course.

A. Just looking at my note, I believe that the area around where the enterostomy had occurred was not the healthiest appearing tissue.

Q. Tell me what you mean by that.

A. Many times if you have adhesions or a loop of bowel is adherent to, say, the abdominal wall, the whole surface of the bowel can look scarred or not clean.

Q. Did the tissue have a dusky appearance?

A. I don't recall.

Q. Was the tissue necrotic?

A. The tissue at the enterostomy site, I don't recall.

Q. Is there anything in your note to suggest that the tissue at the enterostomy site was dusky in appearance?

A. No.

Q. Or that it was necrotic?
A. No.
Q. Now, when you perform an anastomosis, Doctor, you are cutting out a section of the bowel, now you have to connect the two open pieces together, correct, in a lay term?
A. Yes.
Q. The two areas that you were connecting together, is that the ileum, that particular loop?
A. I believe it was, yes.
Q. I just want to be clear. Does your note indicate it was the ileum?
A. No, it does not.
Q. Was there anything suspicious to you about the two ends of the anastomosis that you were now joining together?
A. Not that I recall.
Q. Is there anything in your note to suggest that there was any problem or concern you had with that part of the anastomosis?

A. I didn't have any concern. I inspected that area.

Q. Did you find any evidence of friable tissue at the anastomosis ends, the two ends that you were joining together?

A. Not that I recall.

Q. Am I correct that there was -- you found no evidence of any radiation-related bowel damage to those two ends that you were joining together?

A. No.

Q. Did you have any difficulty performing the anastomosis?

A. No.

Q. Did the resident participate in the anastomosis?

A. No.

Q. Did Dr. participate in the anastomosis?

A. We both did it together, yes.

Q. How do you connect the two open pieces together to form the closed anastomosis?

MR. : In a generalized

way?

MR. OGINSKI: Yes.

A. We use staplers, surgical staplers.

Q. How does that accomplish what you need to do to close off the two open ends?

A. Could you --

MR. : I'm not sure what you mean by that.

Q. Tell me what a surgical stapler is.

A. Surgical stapler is a devise which staples similar to a paper stapler. It staples rows of -- it inserts rows of staples into the bowel wall.

Q. The length of the staple itself, how long is that?

MR. : An individual staple?

MR. OGINSKI: Yes.

MR. : Do you know the length of an individual staple?

THE WITNESS: The actual

length, no.

Q. Do you know the part that goes into the tissue to hold it together, not the width, but the actual length, the points that go in?

MR. : Are you talking about the stapler gun or the actual staple?

MR. OGINSKI: The actual staple.

MR. : Do you know the size of an actual staple?

A. There are different types of staples. Some have thicker staples than others.

Q. The ones used in this anastomosis, what was used?

A. I would have to -- I mean -- I don't know what exactly was used. Typically I will use one that puts 3.5 millimeter and a 4.8 millimeter stapler.

Q. That measurement is what? Is that the width or the depth of the staple?

A. It is the depth of the staple.

Q. Now, on a paper stapler you have a bottom piece that folds over the staple to hold whatever the paper it's holding. Is that similar in a surgical stapler?

A. Yes.

Q. Who applied the staples in this anastomosis?

A. Who fired the stapler?

Q. Yes.

A. I believe it was Dr. .

Q. Were you directing Dr. as to where those staples should be placed?

A. Yes.

Q. Are you able to tell how many staples were placed?

A. How many actual little staples?

Q. Correct.

A. No.

Q. Do you have a memory as you sit here now as to how many were placed during this anastomosis?

MR. : How many staples?

A. How many individual?
Q. Yes.
MR. : Don't guess.
A. I can't count the little -- they are very small each one.
Q. In order to achieve closure for each side, can you approximate how many staples are necessary?
A. Well, can you clarify that? I mean, how many applications of the stapler or how many individual little staples? Because each application of the stapler puts several rows of staples.
Q. Thank you.
MR. : I think that's what you were trying --
MR. OGINSKI: Correct.
Q. When you fired the staple gun, how many staples come out at one time?
A. Multiple.
Q. Can you give me an estimate?
A. It depends what staple gun you use. Usually anywhere from two to four rows of staples.

There are multiple staples in each row.

Q. Did you use any type of suture material to close either side of the anastomosis in this case?

A. To close?

Q. I am specifically talking about the bowel anastomosis.

MR. : Just explain what sutures you used.

A. I used some silk as part of the anastomosis to reinforce it.

Q. Why is that done?

A. One of the areas where there might be tension is what we call the crotch, or the area where the two loops of -- two limbs of intestine might have some tension, to potentially decrease that on the staple line, I personally like to put a stitch there.

Q. Who put the sutures or the stitches that were used here?

A. I don't recall.

Q. You mentioned in your note

that 4-0 silk sutures were used for the crotch sutures.

A. Right.

Q. Do you have a memory as to whether you performed that or Dr. performed it?

A. I don't recall who actually placed that suture.

Q. Was there sufficient skin to hold those sutures?

A. Yes.

MR. : Skin? You mean tissue?

MR. OGINSKI: Thank you. Bowel tissue.

Q. How long did the bowel resection and anastomosis take?

A. I don't know the exact time.

Q. Can you approximate for me?

MR. : There is an operative note.

MR. OGINSKI: I understand. I am asking this particular part of the surgery.

MR. : Does it give you --

A. It doesn't give you an exact time.

MR. : There is a start and end there.

Q. I am asking specifically within the operation how long it took to perform the actual bowel resection and the anastomosis.

MR. : That part of it?

MR. OGINSKI: Yes.

MR. : Do you know without guessing?

A. I can't specifically say in this case how long it actually took.

Q. Are you able to tell me if it took longer than an hour?

A. I don't think so.

Q. Can you give me a range; half hour to an hour? I don't want you to guess.

A. I would say somewhere between 10 minutes and 30 minutes.

Q. Now, after you completed the anastomosis and you placed the staples, what do you do to check the integrity of that anastomosis?

A. You look at the edges of the bowel to make sure that it looks pink, you look at the staple lines to make sure that they are -- the rows of staples are there, and you also -- I typically like to check the lumen or palpate it to see if there's adequate lumen.

Q. Did you do that?

A. Yes.

Q. What did you find when you did that?

A. Everything seemed fine.

Q. As far as you were concerned, the staples had been placed properly?

A. Yes.

Q. And the sutures that were placed, the 4-0 silk sutures were also placed properly?

A. Yes.

Q. They had been tied off

correctly?

A. Yes.

Q. The silk sutures used, in your opinion, was appropriate for this particular area of bowel?

A. Yes.

Q. Were these absorbable or nonabsorbable sutures?

A. Nonabsorbable sutures.

Q. Other than touching and looking to see the integrity of the bowel, is there anything else that you did to evaluate the integrity of the anastomosis?

MR. : He told you what he did.

MR. OGINSKI: Other than that.

MR. : More than just what you said?

THE WITNESS: No.

Q. Are there ever instances where you will instill liquid into the bowel after performing an anastomosis to evaluate the integrity of the anastomosis?

A. Not the small bowel.

Q. Did you encounter any complications during this anastomosis?

A. No.

Q. Did you observe any breakdown of skin at the anastomotic site on either side of where the resection occurred?

A. No.

Q. How did you clean out whatever contents came from that enterostomy?

MR. : Any spillage, you mean?

MR. OGINSKI: Yes.

A. We irrigate.

Q. Why do you do that?

A. To potentially decrease any bacteria or contents that might be left behind.

Q. Was it your policy preoperatively that the patient receive antibiotics?

A. Yes.

Q. Did you administer or order antibiotics intraoperatively?

A. They usually give the

antibiotics just before surgery and it lasts several hours.

Q. Once you observed the enterostomy and spillage of the fecal contents, did you then request or order additional antibiotics at that point?

A. Not specifically.

Q. Did you have any suspicion at the time that you completed this patient's surgery on th that there was any leakage of this anastomosis?

A. No.

Q. As far as you were concerned the anastomosis was closed and secure, correct?

A. Yes.

Q. Am I correct that after completing the anastomosis you again checked to make sure everything was okay?

A. Yes.

Q. Now, if I can, Doctor, point you to your operative note. About six lines from the bottom of the first page you wrote -- actually seven:

The remaining intestines were also inspected and there were two areas that were de-serosalized which were oversewn with 4-0 silk.

Tell me what you meant by that.

A. The serosa is the top, outer layer of the intestine. Sometimes, whether that be from taking down adhesions or just separating bowel from each other, that top layer can get peeled off and you can basically re-approximate the two edges of that top layer in the suture.

Q. What is the purpose of doing that?

A. Just to potentially reinforce that area.

Q. What happens if you observe the de-serosalized area and you leave it alone, nothing happens?

A. Potentially nothing.

Q. Where was this area that you observed the de-serosalized area?

MR. : You mean can he be more specific than what's on the op

note?

MR. OGINSKI: Yes.

A. I don't specifically recall the exact spot.

Q. Now, on rd, 2007 --

MR. : .

MR. OGINSKI: I said that, rd.

Q. On rd, 2007, the patient was reoperated on at , correct?

A. Yes.

Q. That was done by Dr. ?

A. Yes.

Q. Were you present in the operating room at the time that he took the patient back to the operating room?

A. Yes.

Q. And during the course of Dr. 's -- withdrawn.

Did you participate, actively participate in this patient's surgery?

A. No.

Q. Am I correct that the surgery

was done at across the street from
?
A. Yes.
Q. Did you have privileges to see
and treat patients at ?
A. No.
Q. Did you have courtesy
privileges to be in the operating room
specially for a patient of yours now being
reoperated on?
MR. : What is courtesy
privileges?
MR. OGINSKI: I will rephrase
it.
Q. Tell me how it was that you
came to be in the operating room at
.
Did you have privileges to
perform surgery at in 2007?
A. No.
Q. How was it that you came to be
present in the operating room when
Dr. took this patient to the
operating room on rd?

A. I asked him if -- I don't recall if he asked me if I would want to go or if I asked him if I could watch.

Q. During the course of surgery, did you observe leakage of fecal contents into the patient's belly?

A. Yes.

Q. Am I correct that you also saw the anastomotic perforation?

A. I saw the specimen, yes.

Q. Tell me what you mean by the specimen.

A. He removed a segment. He removed the anastomosis and there was -- it had opened.

Q. Which loop of bowel was this?

A. It was the segment of small bowel that had been anastomosed.

Q. Are you able to identify or tell me from your memory what it was that you observed on rd? In other, words the location where the breakdown occurred.

MR. : The location?

MR. OGINSKI: Yes.

A. The location of the breakdown?

Q. Let me rephrase it.

Which loop of bowel was this where you observed the leakage of the fecal contents?

MR. : You mean like the ileum or --

MR. OGINSKI: Correct.

MR. : What portion of the small intestine was it?

A. Looking at my note, I did not specifically say which portion of small bowel it was, but that was the area that had opened.

Q. Doctor, what are the different ways an anastomosis can perforate or break down?

A. Well, you can have leakage from a segment of the staple line or the entire staple line.

Q. How does that occur?

MR. : Wait a second. Are you asking now all the mechanical

ways that patients can end up with leakage?

MR. OGINSKI: Yes.

MR. : That's a different question.

THE WITNESS: I don't understand.

MR. OGINSKI: I will rephrase it.

Q. An anastomosis can break down when the skin is friable at the area where the anastomosis occurred, right?

A. The intestine, right.

Q. I'm sorry. In other words, where the skin can no longer hold the staples or sutures?

A. It is a possibility.

Q. But that didn't occur in this case, correct?

A. I was not that close to the specimen to tell you.

Q. Based upon your performing the original surgery and performing the original anastomosis, you told me a few

moment ago that the tissue at the anastomosis site was not friable, correct?

A. At the time of my surgery, yes.

Q. Did you review Dr. 's operative report?

A. No.

Q. In the course of discussing the patient with Dr. during the course of surgery, did you have any discussion with him or were you present to overhear a discussion about whether the anastomotic site, whether the tissue was friable?

A. I don't specifically recall.

Q. Another way that the anastomosis could break down or fail would be if the staples were not placed correctly, correct?

A. That is a possibility.

Q. Is it fair to say that based upon what you told me earlier that is not the case here?

A. That's correct.

Q. Another reason anastomosis could break down is if the sutures used are not placed properly?

MR. : What sutures? The crotch suture?

MR. OGINSKI: Any sutures.

A. This was a stapled anastomosis, so the sutures wouldn't have been an issue.

Q. Are there any other ways that an anastomosis can break down?

MR. : Now you are talking about a different series of issues.

Now you are talking about patient-dependent issues, not the surgery-dependent issues, right?

MR. OGINSKI: I just want to know generally what ways an anastomosis can break down.

MR. : What can lead to the failure anatomically or in a given patient other than these?

MR. OGINSKI: Correct.

MR. : Do you understand what he's saying?

THE WITNESS: What can lead to it breaking down, sure.

MR. : I am not the questioner, but I think there are two issues here; one is what happens when you do the surgery itself, right?

MR. OGINSKI: Yes.

MR. : And the other is the patient itself, what can go wrong with the patient that can lead to failure.

MR. OGINSKI: Correct. I will rephrase it.

Q. From a technical standpoint, what can cause anastomotic breakdown?

MR. : That's what he was telling you before.

MR. OGINSKI: Yes.

A. Either there is a staple failure or the staples don't actually hold the tissue together.

It's possible that the area

where the staples were fails or is weakened and it leaks. It's possible that -- is this what you're asking?

Q. Yes.

A. It's possible that it's a combination of both.

Q. When you say a combination of both, what are you referring to?

A. The tissue or the actual staples. So I think you can either have a failure of the actual staple, you can have a failure of the tissue around where the staples are placed, potentially a combination of both.

Q. Anything else?

MR. : This is from the technical point?

MR. OGINSKI: Yes.

A. If there's too much pressure behind -- on the staple line, it could disrupt too.

Q. How would you know if there was too much pressure on the staple line?

A. You might not.

Q. At the time that you performed the anastomosis and you placed the staples, if there is pressure there? Do you see some type of tension?

A. I am actually not talking about that type of pressure. I was meaning if there was back-pressure pushing on your anastomosis, it could blow it open.

Q. What would cause that back-pressure?

A. Potentially distal obstruction.

Q. Are you talking about --

A. Bowel obstruction.

Q. Thank you. This patient had no evidence of any distal bowel obstruction, correct?

MR. : When?

Q. From the time when you closed her up.

A. No.

Q. And during the time you were treating her before she was transferred to , you did not believe she had any

type of evidence of bowel obstruction, correct?

A. That's correct.

Q. Now, we know from Dr. 's operative report that there was a perforation along the staple line, along the anastomotic staple line.

Do you have an explanation as to how that occurred?

MR. : Now -- okay. So now this is more than just technical issues, it's whatever his thinking was with this patient?

MR. OGINSKI: Correct.

A. I don't have a specific answer as to why it occurred.

Q. Did Dr. give you an opinion as to why this occurred?

MS. : Objection.

Q. You can answer, Doctor.

A. I don't recall.

Q. Is there anything in any note that you have written for this patient that would suggest what Dr. thought at

the time that he may have discussed with you about the reason why this anastomosis broke down?

MS. : Objection.

MR. : I'm losing myself here. Are we now asking about theoretical issues and possibilities --

MR. OGINSKI: No.

MR. : -- as opposed to specific, this is what it is?

MR. OGINSKI: I will go back. I will rephrase.

Q. Did Dr. voice an opinion during the course of this patient's surgery as to why this anastomosis failed?

A. I don't recall.

Q. Is there anything in any note that you wrote to suggest that he voiced such an opinion about why this anastomosis failed?

A. No, I don't recall.

Q. Was Dr. with you at the time that this patient was operated on at

on rd?

A. No.

Q. Was Dr. present?

A. No.

Q. Did you have a conversation with Dr. during this patient's surgery about what you had done a few days earlier as far as the anastomosis and the resection?

A. I told him what happened in my surgery.

Q. What, if anything, did he say?

A. During the operation?

Q. During the surgery.

A. I just know that he said that the area where the leakage was from, the anastomosis, the staple line.

Q. Did you form an opinion at that time as to why this anastomosis failed?

A. No.

MR. : Like, this could be?

MR. OGINSKI: For any reason.

MR. : Now he is asking you what possibilities there were.

MR. OGINSKI: Yes.

MR. : What were the potential possibilities that you considered? Is that what is going on here?

MR. OGINSKI: No. I will rephrase it.

Q. When you observed that there was a leakage of bowel contents into the patient's abdomen and that there was a perforation along the anastomotic staple line, did you form an opinion at that time as to what caused this or how this could have occurred?

A. No.

Q. Since that time up until today, have you formed an opinion as to how this occurred?

A. Now?

Q. From rd, 2007 up until today, did you form any opinion as to why this patient's anastomosis broke down?

A. I think I've mentioned the reasons why it potentially could have.

Q. I am just asking specifically in this patient's case, after the surgery of rd, did you ever form an opinion as to why this particular anastomosis broke down?

A. No.

MR. OGINSKI: Let's take a break.

(A lunch recess was taken.)

CONTINUED EXAMINATION BY
MR. OGINSKI:

Q. Doctor, you told me earlier you had performed bowel resection and anastomosis throughout your career.

Can you estimate for me how many times you performed bowel resection with anastomosis?

A. I had a question about your last question that you asked me. I don't think I specifically got the full gist of what you were trying to ask me.

Q. If you hang on I will go back

to that, but if you can tell me the number of bowel resections with anastomosis you have done.

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

Q. What was it that you wanted to add to the last question, Doctor?

A. I wasn't too clear on -- you're asking me exactly what I think happened or what actually happened?

Q. I want to know why this bowel anastomosis failed. Why was there a perforation?

A. I gave you some reasons why it potentially could.

Do I have an absolute answer? I suspect one of the things that happened is that she built up some pressure in her intestine, possibly from a postop obstruction, and it blew out the anastomotic line, the staple line.

Q. And did you form that suspicion at the time of the surgery?

A. At time of Dr. 's

surgery?

Q. Yes.

A. I don't know if it was right at that time. It was something that I might have thought about that day, thinking about what could have happened, but it was when looking at it, I took a look at the specimen and it was a big opening, so I suspected that there was a big blowout, which for me, thought that there was some back-pressure, like an explosion of a can top.

Q. Did you record that suspicion or make a note of that anywhere?

A. No. I mean, I can't be absolutely sure.

Q. I am just asking if you did. The possible bowel obstruction that you mentioned that may have caused the built up pressure in the intestine -- withdrawn.

If a patient has bowel obstruction, they typically experience some type of clinical symptoms, correct?

A. You can, yes.

Q. Some of the symptoms include nausea, correct?

A. Yes.

Q. Other symptoms include vomiting?

A. Yes.

Q. Symptoms include abdominal pain?

A. It can, yes.

Q. And if there was a suspicion of a bowel obstruction, there are various tests you can perform to rule in or rule out bowel obstruction, correct?

A. Yes.

Q. One of those tests is a CT scan?

A. Yes.

Q. Another test is a GI series?

A. Yes.

Q. I mean, you also have the ability, although I don't know you would want to, to perform a colonoscopy?

A. Not for this type of obstruction, no.

Q. At any time from , 2007 up until the time that this patient was reoperated on on rd, 2007, did you form any suspicion at all that this patient had any type of bowel obstruction?

A. Well, there was a question when I -- I think either right after surgery or going into surgery, apparently she had had some emesis during the day before surgery.

Q. She had one episode of vomiting, correct?

A. I don't recall how many because I wasn't at the bedside, but she had vomited during that day.

Q. The emesis means vomiting, correct?

A. Yes.

MR. : What are we talking about? We are in New York ?

MR. OGINSKI: He just mentioned preop before th.

MR. : Preoperative?

MR. OGINSKI: Yes.

MR. : Are we talking about preoperative before ?

THE WITNESS: I'm sorry. Before the second surgery, Dr. 's surgery.

Q. From the time that you performed surgery on th up until the time that she went back for the second surgery, was there any evidence that this patient had a bowel obstruction?

A. She had some vomiting.

Q. Vomiting can be for many different reasons, correct?

A. That's true.

Q. Did you make any notation in any note to suggest that the vomiting that the patient experienced on the day that she was going to have -- that she ultimately had the second surgery was in any way related to a possible bowel obstruction?

A. I don't recall I did.

Q. While the patient was at , did she exhibit

any clinical signs or symptoms to suggest to you that she had evidence of a bowel obstruction?

A. No.

Q. When she was transferred to , did you see her on a daily basis?

A. I had stopped in on that Sunday right before -- the day she was there.

Q. That's ?

A. Yes.

Q. Did you stop in as a social visit or as her physician who examined her and then talked to her?

A. I went as a social visit to see how she was doing.

Q. During that visit, did you physically examine her?

A. I recall that I did examine her that evening when I went back to see her. I don't recall --

Q. We will get to that. When you went to visit her, you told me as a social visit to see how she was doing, did you

examine her at that time?

A. I don't recall.

Q. If you had examined her at , would it be customary for you to make a note in the patient's chart to reflect the fact that you were present and did an examination?

MR. : In 's chart?

MR. OGINSKI: Correct.

A. Not necessarily.

Q. If you had examined the patient while she was at , would you have expected to make a note in the patient's chart from ?

A. It's unclear if that's the custom.

Q. You tell me, Doctor, because there are some notes that you have written that appear in the patient's chart that involve conversations with physicians who are at as well as your being present at .

A. Yes.

Q. In your review of this patient's chart and your office notes, is there any notation to suggest that you examined this patient on rd?

A. rd?

Q. I apologize. On .

A. Yes.

Q. And that examination was done at ?

A. Yes.

Q. And that was more than just a social visit, correct?

A. Yes. I did examine her.

Q. And you then dictated a note or you put in the computer a note?

A. I wrote a note.

Q. And that note appears where in your office chart; in the chart or in the chart?

A. I wrote one earlier in the day and the chart and then that evening I actually wrote one in the chart.

Q. In any of those notes do you indicate the possibility that this patient had a bowel obstruction?

A. There were some findings that could suggest it.

MR. : I think he is asking -- are you asking something different?

Q. Other than observing the fact that she had vomited on the day prior to surgery, the day of surgery, what other findings did you observe that might suggest a bowel obstruction?

A. Her abdomen was a bit more distended.

Q. Was or was not?

A. It was.

Q. Anything else?

A. No.

Q. What are the possible reasons to account for the patient's distended abdomen?

MR. : What are we talking about now, that he considered

at the time?

MR. OGINSKI: Yes. At the time.

MR. : This is at what point in time? When he examined her, right?

MR. OGINSKI: Yes.

THE WITNESS: That was in the evening.

MR. : Okay. So now we are in a place. Now let's do a question.

THE WITNESS: In the evening.

MR. : What is the question? What are the considerations of what the distension could be?

MR. OGINSKI: Yes.

A. It could be from obstruction, it could be from ileus.

Q. Anything else?

A. Could be from a potential leak.

Q. What is an ileus?

A. Ileus is where the bowel

doesn't contract and move gas and contents and is basically paralyzed.

Q. Are there instances where postoperative patients will be allowed food solids and maybe it be too early for them and they will throw up some of that?

A. That's possible.

Q. That doesn't necessarily mean they had a bowel obstruction, correct?

A. Correct.

Q. Did you have a discussion with Dr. about the possibility that this patient might have any type of bowel obstruction prior to the rd surgery?

A. I don't recall.

Q. Is there anything in your note, regardless of wherever it's contained, to suggest that the bowel obstruction was something that you were considering as a possibility to explain this patient's condition?

A. I don't recall specifically writing down that I thought that she had a

bowel obstruction.

Q. Separate from your memory, is there any note that you have reviewed that reflects that? Withdrawn.

Is there any note you have authored to suggest that they were thinking along the lines that there was a bowel obstruction that would explain the following symptoms or conditions?

MR. : I have to object to the form.

Now you are asking him not necessarily what the words say but the words may signify?

MR. OGINSKI: Yes.

MR. : I thought he answered that before when he said the possible causes of distension.

MR. OGINSKI: I will go back.

Q. You mentioned to me that one of the possibilities for the breakdown of the anastomosis was the build-up of pressure in the intestine from a bowel obstruction.

A. That's one cause.
Q. At the time that Dr. 's surgery was being performed, did you have that opinion?
A. I thought that could be a possibility.
Q. Did you tell Dr. that you thought that might be a reason?
A. I don't recall saying that.
Q. Tell me about the conversation you had with Dr. during surgery.
MR. : That you remember.
A. That I remember?
Q. Of course.
A. Just really what he found.
Q. Other than telling you what he found, did he say anything else about his findings?
MR. : Not sure what that means.
Q. Tell me what he said to you as best you can remember.
A. The whole staple line was

open.

Q. Did you offer any suggestions or recommendations as to how to repair this condition?

A. No.

Q. Did Dr. tell you how he was going to repair this problem?

A. No, he didn't discuss it specifically.

Q. Did you observe what he was doing?

A. I observed that he resected the portion of the bowel where my anastomosis was.

Q. Did he perform an anastomosis?

A. No.

Q. Did he tell you why he was not performing an anastomosis?

A. I seem to recall the anesthesiologist said there was some issues with the patient's stability and asked him to finish the surgery.

Q. Meaning her blood pressure was dropping?

A. I don't specifically know what they were having. I just recall him having a conversation with Dr. saying to expedite the surgery.

Q. Am I correct that if there is no anastomosis done after a bowel resection that there is no continuity of the bowel?

A. Right.

Q. What happens to the fecal contents if there is no continuity?

MR. : You mean if he just let two ends alone in the middle of the bowel?

MR. OGINSKI: Yes.

A. You can either put a tube down to try and minimize that, and I believe his plan was to come take bring her back to the OR at a later date.

Q. You mentioned to me -- going back for a moment -- that the patient had vomited the day before she ultimately had her second surgery.

A. Yes.

Q. Had you cleared her for solid

foods?

MR. : What do you mean?

The day before?

MR. OGINSKI: Dr. told me that there was an episode of vomiting the day before she had gone back to the OR.

MR. : She went to surgery like midnight, right?

THE WITNESS: The change from at midnight on Sunday morning -- I'm sorry -- so Monday morning, I guess, whatever time the surgery was. I think it was actually just past midnight, so technically on the 3rd.

Q. Had she been cleared to eat solids at the time that she was still at ?

A. I don't think so. I don't recall.

Q. When Dr. showed you and told you that there was a perforation along the anastomotic staple line, what was going through your mind at that time?

MR. : I object to the form.

Do you remember specifically other than what he just said?

MR. OGINSKI: Yes. Correct.

MR. : Is there anything else you can recall thinking when he said that?

THE WITNESS: No.

Q. When you performed the surgery on this patient on th, was the stapler that was being used to perform the anastomosis, was it working properly?

A. Yes.

Q. Did you have any problem using the stapler?

A. Not that I recall.

Q. Your operative note indicates there were two staplers used.

A. Yes.

Q. Did both of them work correctly?

A. Yes.

Q. If any one of them did not

work correctly did you have the ability to then request or get another stapler?

A. Sure.

Q. Did you have to do that in this patient's case?

A. No.

Q. Was there any instance where any piece of equipment that you were using during this patient's surgery on th did not work as it was supposed to?

A. Not that I recall.

Q. Do you have an opinion as to whether any piece of equipment failed you during the course of your surgery on th?

MR. : You mean at the time he did it?

MR. OGINSKI: Correct.

A. At the time I did it, not that I -- everything seemed to work fine.

Q. On rd, during Dr. 's surgery, did you form an opinion as to whether there was any defect

in the staples that were used to hold the anastomosis together?

A. That was one of the possibilities that might have occurred.

Q. In your viewing what was there, the perforation, did you observe anything to suggest that the staples had failed, that there was some defect in the staples?

MR. : He might not have had the ability to do that. Did you?

A. I didn't pick up the specimen or touch it. I just looked.

Q. Did Dr. or anybody assisting him comment on the staples?

MR. : That you overheard.

A. Not that I overheard. All I recall is he said the whole staple line was wide open.

Q. Did you ever review the pathology report of the specimen submitted as a result of Dr. 's surgery?

A. No.

Q. What is peritonitis?

A. Peritonitis is an inflammation in the peritoneal cavity.

Q. From your view in the operating room at on rd, were you able -- did this patient have peritonitis?

A. I can't say from my view. I was actually standing in the corner of the OR.

Q. Before the patient was taken to the operating room at , did you have an opinion as to whether she had peritonitis?

A. I don't specifically recall if she had.

Q. During your examination of the patient on , did you form an opinion as to whether the patient had peritonitis?

A. ?

MR. : In the evening.

A. No. I don't specifically recall saying she definitely has

peritonitis.

Q. What are the symptoms that a patient would experience if they have peritonitis?

A. Usually intense abdominal pain, you can have fever.

Q. Can you have hypotension?

A. It's possible.

Q. Can you have decreased renal function?

A. These are all possibilities --

Q. Can you have --

A. -- if it's infectious.

Q. Isn't peritonitis by its very nature infectious?

A. No. You can have a reactive peritonitis.

Q. If there is bile in the abdominal cavity, will that cause peritonitis?

A. If it's -- it can.

Q. If there are fecal contents within the abdominal cavity, will it cause peritonitis?

MR. : Will it or can it?

A. It can. It doesn't necessarily have to.

Q. Other than clinical examination, how do you diagnose peritonitis?

A. You base a lot on clinical. It's a clinical condition.

Q. Are there any tests that you use to help you determine definitively whether a patient has peritonitis?

A. No. Peritonitis is a clinical finding.

Q. Postoperatively after your surgery on th, did you have a discussion with the patient's husband?

A. About --

Q. The original surgery?

A. Just a discussion?

Q. Yes. Did you come out after and told him how the surgery went?

A. Yes, I spoke to the patient's husband after my surgery.

Q. Tell me what you told Mr. .

A. I told him that we had encountered an incidental enterostomy and I resected a portion of the bowel, I did not see any obvious cancer but I did do biopsies and we repaired the hernia.

Q. You specifically told him that a hole was made in the bowel?

A. Yes.

Q. What, if anything, did he say or question about that?

A. He wasn't -- he didn't have much to say.

Q. Was anyone present with him at the time you spoke to him after the surgery?

A. I believe there was another gentleman who was there. I can't -- I specifically can't give you his name.

Q. Did that other gentleman ask you any questions?

A. I don't recall.

Q. Did Mr. ask you any

questions?

A. Not -- I can't recall what questions he asked me.

Q. Did --

MR. : If any.

A. If any.

Q. Did you tell Mr. what an intentional enterostomy was?

A. Yes.

Q. What did you tell him?

A. I told him that there was a -- we had encountered a hole in the intestine.

Q. Did you explain to him how that occurred, either how you recognized it or why it occurred?

A. I don't know if I went into the specific details of when or how it occurred, but I did mention that we had found it.

I do specifically go into these things preop.

Q. I understand. I am not asking generally. I am asking specifically what you told him on this occasion.

Was the anastomotic perforation diagnosed while the patient was still at ?

A. No. She had no signs of it.

Q. The patient developed cardiac symptoms postop, one day postoperatively, correct?

A. Yes.

Q. To what, if anything, did you attribute those cardiac conditions?

A. The patient had a history of this in the past. I suspected it was another instance of this.

Q. You are aware that her palpitations were pretty much controlled by the medication that she was taking, correct?

MR. : I object to the form of that.

Q. Did you learn from the patient that the palpitations for which she was taking the cardiac medication was pretty much under control?

MR. : You're saying

what the patient told Dr. ?

MR. OGINSKI: Yes.

MR. : Did she say that to you in sum and substance at any time?

THE WITNESS: I don't recall specifically.

Q. Was it your understanding that the patient's palpitations were under control with the use of her cardiac medication?

A. Yes.

Q. What specifically was it that might have aggravated or precipitated a further episode of her palpitations if her medications were controlling?

A. The stress of surgery, stress of anesthesia.

Q. We know, Doctor, that this patient's anastomotic perforation was diagnosed during surgery on rd.

Do you have an opinion with a reasonable degree of medical probability whether this condition had been diagnosed 24

hours earlier whether this patient's outcome would be any different?

MR. : I have to object to the form.

That makes an assumption that it was present 24 hours earlier.

MR. OGINSKI: Correct.

MR. : Do you know if the outcome would have been different assuming it was existent 24 hours earlier?

MR. OGINSKI: Correct.

MR. : With all of those provisos.

A. If it existed 24 hours earlier, which I don't think it did, obviously knowing about it earlier would potentially change the prognosis.

Q. Why?

A. If she needed any intervention to handle it, it potentially could have been earlier.

Q. What makes you believe that this anastomotic perforation was not

present more than 24 hours earlier?

A. She had no signs of it; no abdominal distension, she did not have any fever, she did not have a white count.

I physically examined her myself. She was awake, alert, she was not -- there was no mental status changes, she was not complaining of abdominal pain.

She did not -- clinically, in my judgment, she did not have any signs. Her bowels were functioning.

Q. You knew that because of what? How do you know that?

A. My exam.

Q. This is the exam on which day or dates?

A. When I came in that evening.

Q. If you can be specific, Doctor.

MR. : Postop day one?

A. Postop day one.

Q. You are talking about the patient had bowel sounds?

A. 1st.

Q. What was it during your exam that told you that the patient's bowels were functioning?

A. She wasn't vomiting, her abdomen was soft.

Q. Did you listen to her bowels?

A. I don't specifically recall listening to her bowels.

Q. When there is no vomiting and the abdomen is soft, that suggests to you that there is good bowel function?

A. Yes.

Q. Did this patient have sepsis?

MR. : When?

MR. OGINSKI: At any time.

A. I think after the surgery she was either -- septic.

I think that's what ultimately -- I can't say for sure because I wasn't specifically taking care of her, but I think that's what ultimately took her life.

MR. : What surgery?

MR. OGINSKI: I will rephrase

it.

Q. On , 2007, was the patient septic?

A. There was a concern that there may be a concern of sepsis.

Q. What was the concern?

In other words, what problems did the patient have or exhibit to suggest that she was septic?

A. I believe she needed to be intubated, her blood pressure had dropped.

Q. She looked septic?

A. Clinical picture, yes.

Q. On 1st, did she have that same type of clinical picture?

A. No.

Q. Do you have an opinion as to whether this patient's sepsis was timely and properly diagnosed?

MR. : Objection.

MS. : Objection.

MR. : I object to the form.

I think what you are asking is

related to the co-defendant. It is not appropriate.

MR. OGINSKI: They are working in tandem as a team to treat the patient, so there is some communication between the two and I'm asking whether he has an opinion.

MR. : I don't know that he has the ability and the capacity having not reviewed all the charts and being aware of everything to know those things.

MR. OGINSKI: I will rephrase it.

Q. Doctor, during the course of caring for this patient, at any time up until rd did you form an opinion in your own mind that there was a delay in diagnosing this patient's sepsis?

A. A delay? Diagnosis?

Q. Yes.

A. No.

Q. Did you have an opinion in or 2007 that this

patient's condition --

A. '07?

Q. Let me rephrase it.

The sepsis that you told me about that was observable in different fashions on -- withdrawn.

Would you agree that a breakdown of the anastomotic site, that it's unusual to have such a breakdown within 24 to 48 hours following surgery?

A. Yes.

Q. Are you aware of any medical literature that discusses the timing of anastomotic breakdown or the mechanism of an anastomotic breakdown?

MR. : That is an improper question. He doesn't have to answer that. That's fishing.

He is not here to espouse on any medical literature. You know that.

MR. OGINSKI: I am asking if he is aware of any.

MR. : It doesn't

matter. That is inappropriate. I have been around the block a few times on that question.

MR. OGINSKI: Mark it for a ruling.

(Marked for a ruling.)

Q. At any time while this patient was at did you suspect that she had any type of infectious process?

A. She did not have any clinical signs of infection.

Q. Did she have any laboratory signs to suggest that she had an infection?

A. No.

Q. You are aware that preoperatively she had -- withdrawn.

In a patient who has normal preoperative white blood count and now postoperatively their white blood count drops significantly and their hemoglobin increases what, if anything, does that suggest to you in and of itself?

MR. : In this patient?

MR. OGINSKI: Yes.

A. It is a common finding after someone has had chemotherapy, after they undergo surgery for them to have a drop in their white blood cell count.

Q. You are aware that this patient's chemotherapy occurred many years prior to the , 2007 surgery?

A. Yes.

Q. And that her prior lab work was otherwise normal in terms of white blood count and hemoglobin?

A. Yes.

Q. You are saying following surgery you would expect to see a drop in white blood count?

A. Chemotherapy affects bone marrow. If they can't produce white blood cells at a -- what happens after surgery is your white blood cell count goes up from the stress of surgery.

If you don't have good reserve in your bone marrow, probably because of all the chemotherapy she received, it can't replace it, so you will drop below it.

Your white blood cell count will be low, and it will take longer than someone who hasn't had chemotherapy to rebound.

Q. Did she have this type of problem in her second surgery in 2005 with Dr. ?

A. I believe so.

Q. Where her white blood cell count dropped and her hemoglobin increased?

A. I would have to look through the charts.

Q. Is there anything you recall seeing in her prior surgical history as to whether that condition occurred; in other words, following her 2005 surgery her white blood cell count was preoperatively normal then dropped significantly together with a rise in hemoglobin?

A. I can't recall specifically, I would have to go through the chart, but I do operate on patients who have had multiple agents of chemotherapy.

Q. I am asking specifically, not

generally.

Is there any other reason that would account for a drop in a patient's white blood count postoperatively and a similar rise in hemoglobin other than the past chemotherapy?

A. That's probably the most common thing.

Q. Would infection cause a precipitous drop in white blood count?

A. It is a possibility.

Q. Now, do you recall seeing this patient's preoperative white blood count to be in the vicinity of about 8,000?

MR. : Do you want him to look it up or do you want to know if he recalls that?

Q. If you recall.

A. I don't recall specifically. I can certainly look.

Q. Do you remember whether the patient's blood work or white blood count postoperatively was in the range of 2,000?

A. I don't know the specific

numbers. I would have to --

Q. If you can, let's take a look at those post and preop labs. It's 6.8?

A. Yes.

Q. That's within normal limits, right?

A. Yes.

Q. Just for the record, that's dated 27, 2007, correct?

A. Yes.

MR. : Now let's find the other one.

A. This is , then .

Q. What is the value of the white blood count on ? This is preop, I assume, correct?

A. is the day of surgery, so immediately postop.

Q. That shows 11.3?

A. Right.

Q. And is that within normal limits?

A. It's just above the normal values.

Q. What does that signify to you, if anything?

MR. : Is it significant?

THE WITNESS: After surgery it's not significant.

Q. The day after there are two white blood cell counts, the first one timed at 11:48?

A. Right.

Q. And that's reported as 2.6?

A. Yes.

Q. What does that mean to you, if anything?

A. As I mentioned, it's common to see this after surgery.

It dropped below normal because she used all her white blood cell counts immediately after surgery, then afterwards her bone marrow just can't produce it as fast as someone who hadn't had chemotherapy.

Q. Knowing this beforehand, is there anything that you can do to help a patient protect themselves against

infection knowing that this could possibly occur?

A. You typically don't do anything because it does rebound as it was here, just a little bit slower.

Q. And the white blood count later in the day timed at 20:09 is reported at 3.6, correct?

A. Right.

Q. That's still abnormal?

A. It's starting to come back up.

Q. Did you suspect this patient had any infection on this date on 1st?

A. No.

Q. Now, if you look at the patient's hemoglobin from the preop.

MR. : Preop is 12.6 on ?

THE WITNESS: It's 12.6, 12.9.

Q. Does that have any significance in relation to the white blood count?

A. No. As I mentioned, the white

blood cell count production will increase slower.

Q. Can you have a raging infection without signs of infection?

MR. : I object.

It's very hypothetical, don't you think?

Q. What is a subacute infection?

A. Subacute?

Q. Yes.

MR. : Is that defined? Is that an actual defined term?

Q. Are you familiar --

MR. : Is that a term you use?

THE WITNESS: I typically don't use that term.

Q. Or subclinical infection?

A. Subclinical is something where you don't show signs, as like fever.

Q. Can a patient have a subclinical infection yet their labs show that there is evidence of infection?

A. It's possible.

MR. : Are you talking in a theoretical range?

THE WITNESS: Theoretical, anything is possible.

Q. I am asking in general, Doctor, can you have a patient that has an infection that doesn't show symptoms of infection but if you look at their labs you can see evidence of it?

A. Typically I would say you would see some symptoms, other symptoms.

Q. Now, the cardiac issues that this patient was presenting with on postop day number one, was there any impression that this was from a result of any type of peritonitis?

A. She did not have any signs of peritonitis.

Q. Was there any suggestion or belief that her cardiac problems were aggravated because of some underlying infection?

A. She did not have any signs of it.

Q. The medication that she was given, the Metoprolol that we talked about earlier, did that stop her palpitations?

A. On the day of postop --

Q. Postop day one.

A. I don't know the sequence of medications that were given. I wasn't present for that portion of care.

Q. Why was the patient transferred to ?

A. It was felt that she needed -- potentially needed some services that we don't have at .

Q. What specifically?

A. Specifically cardiac -- intensive cardiac services.

Q. Now, at you have an ICU, correct?

A. Yes.

Q. If a patient needs intensive monitoring, certainly immediately after surgery, they will go into the ICU?

A. Yes.

Q. Was there any particular

reason why this patient was not brought to the intensive care unit at as opposed to transferring her to ?

MR. : I think he just answered that.

A. There are some services that we don't have at our ICU, specifically cardiac services.

Q. If you need a cardiac consult are you able to obtain one at ?

A. Yes.

Q. Whose recommendation was it to transfer the patient?

A. The cardiologist had felt she would be better served at .

Q. Were there specific tests or equipment that they had at that were not available at ?

A. Well, they had the capability of doing cardiac catheterization which we don't have, so they have a higher level of cardiac care at .

Q. Was there anything specific

that the cardiac consultation told you that this patient needed that they can only get across the street at ?

A. I don't recall.

Q. Is there anything in the notes that you saw to suggest what specific testing equipment this patient needed that was not available at ?

A. I would have to look back.

Q. In addition to her cardiac issues on postop day number one, did she also have shortness of breath?

A. Not when I was -- not that I witnessed.

Q. Did you learn from any physician that she had shortness of breath on postop day one from any physician?

MR. : At any time during the day?

MR. OGINSKI: Yes.

A. I would have to look back. I don't specifically recall that.

Q. Did you learn from either the patient or the patient's husband that she

was having difficulty breathing?

A. Is it okay if I look at my notes?

Q. We are going to go through the notes in a little bit. I am asking from your memory what you reviewed and what you recall.

A. I specifically don't recall shortness of breath that she complained to me.

I recall when I came in to see her late Saturday night she was feeling well.

Q. Now, on postop day number one -- I just want to be clear -- she had some cardiac issues, correct? She had evidence of palpitations?

A. That's correct.

Q. Did she also have SVTs?

A. Looking back at the notes, I believe she did. I would have to look back. Specifically, I did not diagnose.

Q. We saw postoperatively she had a drop in her white blood count?

A. Yes.

Q. Do you have a memory as to whether she was lethargic?

A. No. She was conversing with me as here I am conversing with you.

Q. Did you examine her abdomen on postop day one?

A. Yes.

Q. What were your findings on your exam of her belly?

MR. : I think he answered that before. He did.

You're starting to go around and back again.

MR. OGINSKI: I didn't ask specifically what the abdomen findings were.

MR. : I'm pretty sure you did, but let's roll through it. If you remember. Do you remember?

A. Her abdomen was soft, non-tender.

Q. Did the patient have chest pain?

A. When I saw her she did not.

Q. Did you learn from anybody on postop day number one that she had chest pain?

A. I would have to specifically look at the note.

Q. Did you form an opinion on 1st as to why she was -- withdrawn.

Other than the stress of the surgery, did you form any other opinion or form a differential diagnosis as to why she experienced a recurrence of her cardiac palpitations?

A. Well, I think that this is a recurring thing that she had done in the past with her prior surgeries.

It was also a question whether she could have had some type of infarct, I believe that was one of the concerns and one of the reasons they wanted to transfer her to the cardiac unit at .

Q. On rd when you were in the operating room with Dr. and

you saw that she had this perforation, looking back at that time, did you form any opinion as to why she developed cardiac problems and whether they were at all related to this perforation of the anastomotic lining?

A. I don't think they are related.

Q. Tell me why.

A. Because she did not have any signs of perforation when I examined her.

I specifically came in -- so I wouldn't rely on anyone else's exam -- to examine her the evening on postop day one.

Q. You told me earlier that -- we went through the mechanics of how perforation of anastomosis can break down.

A. Sure.

Q. In a situation where there is not what you describe as a blowout, but rather a leakage that then leads to a full breakdown, when you have a leakage can that account for an exacerbation of a cardiac condition?

A. I think it would have to be a major, major leakage, which by then you would have some other clinical findings.

Q. Is there any way to prevent the type of anastomotic breakdown that you observed on rd?

MR. : You mean in the surgery that he did on th?

MR. OGINSKI: No. I am going to ask it a different way.

Q. We know she had the anastomotic breakdown that you saw on rd during Dr. 's surgery.

Is there any way to prevent that from happening?

MR. : I object to form. That's speculative.

I don't understand what you're saying. He already testified to no complications --

MR. OGINSKI: Okay, I will rephrase it.

Q. Is there any way to prevent anastomotic breakdown similar to one that

you observed on rd?

MR. : Other than what he did in surgery?

MR. OGINSKI: Correct.

A. No.

Q. Did you ever discuss your suspicions about the built up pressure being a possible cause for this anastomotic breakdown with Dr. ?

A. No.

Q. Did you ever have any discussions with him after rd, 2007 at any time up until today about those suspicions or thoughts as to why this occurred?

A. I don't recall speaking to him specifically about that.

Q. Did you have any conversations with Dr. following the rd surgery about what you observed?

MR. : After the surgery on ?

A. That evening?

Q. At any time.

MR. : After the surgery, at any time -- after Dr. 's surgery, at any time did you speak to Dr. about what you observed in the surgery?

MR. OGINSKI: Correct.

MR. : Do you follow the question?

THE WITNESS: Yes.

A. I don't recall specifically if we talked about it. I did mention what had happened to Dr. .

Q. Did he say anything in response?

A. I don't recall.

Q. Did you have any conversations with Dr. about what had occurred?

A. No.

Q. Did you have any conversation with any other physician about what you observed on rd?

MR. : At what point in time?

MR. OGINSKI: After

rd.

A. After rd, yes.

Q. With who?

A. I let the surgical QA team know.

Q. Why do you do that?

A. Because it was an unexpected outcome after surgery. It's part of quality assurance.

Q. What do you do in that instance? Do you give a presentation as to what occurred? What happens at that point?

A. They do their own internal review.

Q. As part of their own review, did they talk to you about what had occurred?

A. Yes.

Q. Did you prepare any written notes or reports about what had occurred?

A. No.

Q. Did you prepare any written notes about that conversation with the people on the QA team?

A. No.

Q. Did they provide you, after doing their own internal investigation, with any type of report?

A. No.

Q. Were you present for any mortality or morbidity conference at which this patient's care was discussed?

A. Yes.

Q. Tell me about that.

A. I went to the conference.

Q. Tell me when that was.

A. I don't recall the specific date it was.

Q. How soon after the patient had died; a week, a month, a year, something else?

A. I would say within a few weeks.

Q. Who was present during that meeting?

A. Dr. was present.

Q. Anybody else?

A. Their whole department of surgery.

Q. Who presented the patient's case?

A. It was one of the residents.

Q. Do you recall who?

A. No.

Q. Was it a resident or a resident?

A. .

Q. Had that particular resident participated in this patient's care while she was at ?

A. I specifically don't know.

Q. What was discussed?

MS. : Objection.

MR. : That is an objection by counsel for . It's their M and M conference.

MR. OGINSKI: Let me explore a little further.

Q. This particular conference, were you asked to be present?

A. Not specifically.

Q. Tell me how you happened to be at the conference.

A. Dr. said they were going to present the case, and I went.

MS. : Objection to this line of questioning.

I think the only proper questions would be if he made any statements.

MR. OGINSKI: I am still exploring.

Q. Were you asked to give any explanations during the course of this conference or describe what occurred and what treatment you rendered?

A. I was asked why I selected Aloe Derm.

Q. Other than that question, were you asked to talk about anything else from your standpoint?

A. No.

Q. Did Dr. give any information to the people at this conference?

MS. : Objection.

A. I don't recall.

Q. Was there any discussion amongst the people that were present about the treatment rendered and the outcome?

MS. : Objection. This is privileged.

MR. OGINSKI: I am not asking yet what was actually said. I am just asking did they talk about something like this.

MS. : Did they talk about something like what?

MR. OGINSKI: Did they discuss the patient's care, treatment.

MS. : This is all Q and A. It's all privileged. You can ask if he made a statement.

MR. OGINSKI: I don't know that yet.

MS. : You're not allowed to fish for it though.

MR. OGINSKI: I am entitled to know what was said.

MS. : You are only entitled to know what was said by Dr. .

MR. OGINSKI: That's not true because he is an outsider who is participating in a conference, so this is a little bit different than if he is in his own at a Q and A conference.

We have a difference of opinion.

MS. : I object to all of this. If we can mark it for a ruling.

(Marked for a ruling.)

MS. : You can obviously explore this with Dr. , but I don't think it's appropriate to explore it with Dr. .

MR. OGINSKI: I disagree.

MR. : The only thing we will permit to be answered at this point is whether or not there were discussions, yes or no, and then conclusions and actual statements.

He has already told you the only thing he was asked about was Aloe Derm, I believe, so that's the parameters we are going to work by hopefully.

Q. During this conference was anybody there, like a stenographer, taking down what was said?

A. I don't know.

Q. Was this done as part of grand rounds or rounds of the residents?

A. I specifically don't know. I attended it, they asked me one question, I left.

Q. Do you know if this was specifically part of their mortality and morbidity evaluation of patients who have bad outcomes?

A. I believe it was their M and M conference.

Q. What makes you believe that?

A. That's why they presented the case. They presented their cases.

Q. Was there any type of similar

presentation done at ?

A. We reviewed our case, yes.

Q. Tell me about that.

MR. : What do you mean, Tell me about that?

Same objection applies.

Did you give a written statement?

Q. When you say we reviewed what occurred, can you be more specific?

MR. : I don't want him to go into details.

MR. OGINSKI: I will rephrase it.

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

A. The GYN service.

Q. Can you be anymore specific?

MR. : I'm not sure what you are asking. Could you be more specific?

Q. The GYN service, what do you mean? The chairman, the associate chairman?

A. Chairman, all the attendings, fellows, residents, nurses.

Q. What was the purpose of reviewing this particular patient's case with the GYN service?

A. Part of our M and M structure at .

Q. Is that different than giving rounds to the residents?

A. Yes.

Q. How is it different?

A. Giving rounds? I don't understand what you are saying.

MR. : You mean like the teaching element?

Q. Is it different than teaching rounds?

A. Yes.

Q. As part of your discussion with the GYN -- by the way, when did that occur?

A. I can't put a finger on the exact date.

Q. How soon after the patient

died did this occur?

A. It was probably a few months, I would say.

Q. Were you asked to provide any written statement to this group of physicians?

A. No.

Q. Were you asked to present the patient's treatment that you rendered?

A. Yes.

Q. Can you tell me how many people were present when you presented this information?

MR. : How many in number?

MR. OGINSKI: Yes.

MR. : Don't guess.

A. I can't guess.

Q. Are residents present or just attendings?

A. No. If residents are rotating with us, they attend.

Q. Was Dr. present?

A. I don't recall him being

present.

Q. Was Dr. present?

A. No.

Q. Was there any other GYN attending who participated in this patient's care present?

A. I don't recall if Dr. was there.

Q. As a result of that meeting was any written report generated for which you received a copy?

A. No.

Q. Did this group of physicians render any opinions to you or to the group of physicians about the course of treatment that was rendered to this patient?

MR. : Objection to form.

Are you just asking a yes or no?

MR. OGINSKI: Yes.

MR. : In a verbal form?

MR. OGINSKI: Correct.

MR. : That is a yes or

no.

A. Opinion?

Q. Yes.

MR. : On any issue?

MR. OGINSKI: Yes.

A. No one had an issue.

Q. Did anyone criticize or critique the care that was rendered to this patient?

MR. : Objection. That's improper.

MR. OGINSKI: Off the record.

(Discussion held off the record.)

(A short recess was taken.)

Q. Doctor, you told me on 1st you did not feel the patient was septic; is that correct?

A. That's correct.

Q. On there is a note in the chart that you wrote that said septic picture.

A. That's correct.

Q. What clinical findings suggested to you that she was septic on

?

MR. : That was the evening when you wrote the note?

THE WITNESS: Yes.

MR. : Do you remember?

A. Can I look at my note?

Q. Sure. You are welcome to.

MR. : I don't have the chart.

MR. OGINSKI: I have it.

MR. : Whatever you recall as well.

A. Just thinking back, I seem to recall that they had to give her some ventilatory support and they were having issues with her blood pressure being too low.

Q. I'm showing you a copy of what's in my chart, record.

While we have that out, Doctor, please just tell me the date and time, and if you can read your note in its entirety.

If there are abbreviations, you

don't have to tell me the abbreviations, just what it represents.

A. , 8:20 p.m. GYN attending. Patient with decreased blood pressure, septic picture, etiology unclear, temperature today.

MR. : Does that say positive?

A. Positive temperature today and positive emesis.

Physical exam; pulse 80s to 90s, abdomen softly distended.

Assessment plan; septic picture, will await CT scan. As for general surgical consult in the event she needs exploration.

Q. Exploration you said, right?

A. Yes.

MR. : Exploration.

Q. What was your differential diagnosis as to why she was septic?

MR. : Did he tell you that earlier?

MR. OGINSKI: No.

MR. : I think he did. I wrote that down.

Do you see what's happening? Because we are going back over what we have done before. He already told you.

I wrote possibilities, obstructions, ileus leak. I think I wrote that.

A. Leak.

MR. OGINSKI: That was a general question.

MR. : That was before he said I examined her at night, I recall you asked what his differential was at that point, and then you asked him about what all those terms meant.

That's what he was saying, within the differential, I believe.

Q. Did the patient have evidence of abdominal pain -- withdrawn.

Did you perform a physical exam?

A. I did press on her abdomen.

Q. You did or didn't?
A. Did.
Q. Do you note that in your note?
A. Yes.
Q. What do you say?
A. Abdominal; abdomen soft and distended.
Q. Do you typically find that on postop day one or two following this type of surgery?
A. You can.
Q. That finding in and of itself, was that an abnormal finding to you?
A. Not this finding in and of itself.
Q. Was she febrile?
A. She had a temp that day. I don't recall when.
Q. Was she intubated at the time that you saw her?
A. I believe -- I can't recall specifically if she was or not.
Q. Does your note reflect whether she was intubated at that time?

A. It doesn't reflect that.

Q. You wrote, etiology unclear. Are you referring to the etiology of her septic picture?

A. Of this picture, yes.

Q. As part of your differential for this picture, did you consider the possibility of a leakage or perforation of the anastomosis?

A. That was in the differential.

Q. Did you record or write the differential down anywhere?

A. No.

Q. Did you discuss your thoughts about your differential diagnosis with any physician?

A. I think I spoke with the people caring for her and suggested they get a general surgery consult.

Q. Specifically did you tell any of the doctors caring for her? And this was in the cardiology department?

A. CCU, cardiac care unit.

Q. Did you suggest to them your

thought process about the differential as to why she might be septic?

A. I don't recall specifically talking about that.

Q. Did you have any discussion with anyone at the CCU about the possibility she might have a leak or perforation?

A. Specifically, I don't recall if I mentioned that to -- those actual words.

I think I did mention that there could be an intraabdominal process as the etiology.

Q. Did you recommend getting a CT or did another physician recommend that?

A. I don't recall specifically if they had already ordered it.

Q. Other than getting a CT scan was anything else done to address her septic picture?

MR. : I don't know what you are asking. By Dr. or by the doctors there?

MR. OGINSKI: I will rephrase it.

Q. Other than the cardiac issues that were being dealt with in the cardiac care unit and now your observations of her septic picture, other than obtaining a CT scan to evaluate further what was happening, was she treated for the septic picture prior to the CT results?

A. I can't say all the specific treatments that were going on at in the sense I don't know what was ordered or the specific medications she was on.

Q. The note you just read to me on , does that indicate that you had ordered the CT?

A. No.

Q. Just said will await CT results, correct?

A. Correct.

Q. Did you ever learn why a CT was ordered?

MR. : Why was it ordered? Did you ever learn that?

A. No.

Q. Was the patient hypotensive at the time you examined her on ?

A. At this time?

Q. Yes.

A. I believe she was, because I mentioned she had a decreased blood pressure.

Q. Was she tachycardic?

A. It doesn't appear that way.

Q. I'm sorry. I should have asked it a different way.

Does your note reflect that the patient was tachycardic at the time of your exam?

A. No.

Q. Did she have any symptoms consistent with a pulmonary embolus as of as of the time you examined her?

A. She had a decreased blood pressure.

Q. Was she receiving oxygen?

A. I don't know.

MR. : He said he didn't recall if she was intubated or not.

Q. You told me previously there was a thought that she might also have had an infarct or a myocardial infarction, correct?

A. At .

Q. Was that ever ruled in or ruled out while she was at ?

A. I don't know.

Q. Did the patient's condition deteriorate once she arrived at ?

A. From the time she arrived?

Q. Yes, to the time she underwent surgery.

A. Yes.

Q. Did you speak to any surgeon who consulted on the patient before she was taken back to the operating room?

A. Dr. and the resident who -- the surgical resident.

Q. Was that done by telephone or in person?

A. In person.

Q. Was that done at or at ?

A. At .

Q. Tell me about that conversation or conversations.

A. I just told them what I had done at my surgery.

Q. Tell me as best you can, Doctor, specifically what you would have told Dr. .

MR. : Now you are asking him specifics that he may not recall.

Q. Whatever you recall is what I'm asking.

A. Specifically that she had a bowel enterostomy with anastomosis -- resection and anastomosis and a ventral hernia repair.

Q. Did you tell him or suggest to him why you were asking for a consultation?

A. I did. I mean, he came and I said I want a surgeon to evaluate her in the event that she needs to go to the

operating room.

Q. Why might she need to go to the operating room?

A. If the etiology for her condition was potentially a leak, she might have to go back to the operating room.

Q. What, if anything, did Dr. say to you in response?

A. I don't recall. He came and he evaluated her.

Q. Were you present at the time that he examined the patient?

A. I was present with him. I don't recall if I was there with every exam he did.

Q. No. At the time that you did speak to him, did he examine the patient in your presence?

A. Yes.

Q. Tell me what examination he performed.

A. I recall he pushed -- examined her abdomen.

Q. Anything else?

A. I believe prior to going back to the -- taking her to the operating room, he took out some of her surgical staples in the skin.

Q. You were present for that?

A. I don't know if I was actually present or looked afterwards, but I think he had explored her incision.

Q. After he had examined her in your presence, did he have another conversation with you about what he intended to do or what he was going to do?

A. Prior to going back to the operating room, he said yeah, I think she has to go back to the operating room.

His intention was to take her back to the operating room.

Q. Did he say why?

A. I think that there was suspicion that there was a leak.

Q. Did he tell you why he suspected it?

A. No.

Q. Did he tell you what clinical

findings he observed to suggest that?

A. Before?

MR. : Before he goes back to the operating room.

A. I think there was some drainage out of the incision that was concerning that there might be a leak.

Q. The drainage was discolored, correct?

A. I believe so.

Q. Yellow-ish or green-ish fluid?

A. I don't recall the specific color.

Q. What does the drainage suggest?

A. That it could be bowel contents.

Q. Does that also suggest some type of infectious process?

A. Separate from a leak?

Q. Yes, or together with a leak.

A. Well, it could potentially be an infection. An infection can result from a leak, if that's your question.

Q. Did the patient ever have the CT scan before going back to the operating room?

A. No.

Q. Are you able to tell me why she did not have the CT scan before going back to the operating room?

A. I don't know the specific reason. I believe that she was intubated.

Q. Did you ever review the preop consult by Dr. ?

A. No.

Q. Did you ever speak to Dr. after the patient died?

A. I spoke to him after the death.

MR. : The M and M, he said.

MR. OGINSKI: Thank you.

Q. Separate and apart from any conference you told me about, did you ever have any further conversation with him about this patient after she died?

A. Not that I recall.

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

A. No.

Q. Who is Dr. ?

A. is one of the GYN oncology fellows.

Q. Did Dr. participate in this patient's care in any regard?

A. He was the fellow on call on postop day one.

Q. Do you have a memory of talking to Dr. about this patient?

A. I recall him calling me the evening on postop day one to let me know the events that had occurred that day, including the issue with the palpitations and the transfer.

Q. Did you consult with any general surgeons while the patient was still at on postop day number one?

A. No.

Q. Do you know Dr.

?

A. She's one of the cardiologists.

Q. At ?

A. At .

Q. Did you speak to her about this patient?

MR. : I think you asked that before. He said he never spoke to her.

Q. Did Dr. care for this patient in the CCU at ?

A. No.

Q. Do you know a Dr. , ?

A. No.

Q. Did you speak with any resident or fellow at about Mrs. before her second surgery?

MR. : I'm sorry, what did you say?

MR. OGINSKI: Did he speak to any resident or fellow at before she had her second surgery.

MR. : He said he spoke to the surgical resident.

Q. Are you aware, Doctor, that this patient died from overwhelming sepsis?

MR. : Objection to form.

A. Am I aware?

Q. Yes.

A. I don't know what the final cause of death was declared, but that was something I assumed.

Q. Did you ever review the autopsy report?

A. No.

Q. Did you ever see the death certificate?

A. No.

Q. Do you have an opinion with a reasonable degree of medical possibility whether this patient had been reexplored on , whether she would be alive today?

MR. : Objection to form.

A. ?

MR. : When the patient was at New York ?

MR. OGINSKI: Yes.

MS. : Objection.

MR. : I have to object to that.

MR. OGINSKI: I am asking if you have an opinion.

MR. : Do you know with a reasonable medical certainty whether she would be alive today?

THE WITNESS: No.

MR. OGINSKI: My question is a little bit different, but I will accept that for now.

A. I can't say.

Q. Why can't you say?

A. Because she was explored, I think as the clock changed from to rd.

I think she was explored at a timely point and the clinical findings suggested that there was something she

needed to be explored for.

Q. My question -- I am going to rephrase it -- was if she had been explored a day earlier, do you have an opinion with a reasonable degree of medical possibility as to whether her outcome -- whether she would still be alive today?

MR. : Again, I have to object on multiple grounds.

There's care of a whole other provider here. He is not accessing all the treatment related to that point in time. He only has limited knowledge and access to it.

I don't think it's a fair question because he only has limited ability to answer that.

Q. Based upon what you observed on rd, do you have an opinion as to whether if this patient had been operated on a day earlier whether her outcome would be any different?

MR. : I will object as improper cross-examination.

MR. OGINSKI: Mark it for a ruling. I disagree.

(Marked for a ruling.)

Q. Did you have any conversation with Dr. about whether or not this patient's outcome would be any different if she was operated on earlier?

A. No.

Q. Let's talk, Doctor, about your -- going back to your preop consultation with the patient and her husband, talking about the surgery you were proposing to do.

A. Sure.

Q. You discussed various risks with them, correct?

A. Yes.

Q. And you document in your note that you discussed certain risks with them, correct?

A. Yes.

Q. You discussed the possibility of a bowel perforation?

MR. : Do you want to

have the note in front of him?

MR. OGINSKI: General. Just in general from your memory.

A. I discussed these things.

Q. One of the things was possible bowel injury, correct?

A. Bowel injury.

Q. You discussed the possibility of infection?

A. Yes.

Q. Did you discuss the possibility of death?

A. Yes.

Q. Did you discuss the possibility of an enterostomy made during surgery?

A. Yes.

Q. Did you discuss the possibility that they might -- the patient might need anastomosis?

A. Yes.

Q. Or bowel resection?

A. Yes.

Q. Does a patient who has had

chemotherapy in the past, does that increase their risk for poor outcome for a hernia repair?

A. It can.

Q. How?

A. I think chemotherapy has an effect on dividing cells. That's why we give it. It potentially has an effect on wound healing.

Q. How could that affect a patient who undergoes a hernia repair in terms of outcome or expected outcome?

MR. : He just answered that.

Q. Other than telling me about the outcome it has on healing, how else might it affect them?

MR. : If at all.

A. If at all, maybe potentially have poor wound healing.

Q. Meaning what that there would be delay in wound healing?

A. Longer delay.

Q. What about the possibility of

infection?

A. It's a possibility.

Q. What else would there be, if anything?

A. More difficult surgery.

Q. How?

A. She had intraperitoneal chemotherapy.

Q. Why would that affect her surgery?

A. In the sense that instilling chemotherapy into the abdomen could lead to more adhesions, sometimes quite extensive.

Q. So other than the adhesions and the effect on wound healing, is there any other effect that history of chemotherapy would have?

MR. : I think he has been through more than that, potentially increased risk of infection --

MR. OGINSKI: Yes.

Q. Anything else?

A. I think if they have

toxicities from chemotherapy it could contribute to their postop recovery.

Q. There was no evidence of that in this patient's case, correct?

A. Not that I can recall.

Q. Did the patient's history of chemotherapy affect how her postoperative course presented itself?

MR. : Can he know for certain?

MR. OGINSKI: Yes.

MR. : I have to object. It's a very broad question.

MR. OGINSKI: I will rephrase it.

Q. Did any of the patients findings -- clinical, diagnostic findings -- have anything to do with her prior -- I'm sorry.

We talked about the lab work.

A. Yes.

Q. And your thoughts about --

MR. : You don't have to rephrase it. We know we talked about

that.

MR. OGINSKI: Alright.

Q. Is there anything else that this patient experienced as a result of her prior chemotherapy?

MR. : In terms of how she presented clinically?

MR. OGINSKI: Yes.

A. Can you rephrase it?

Q. Sure. From the time that her surgery -- this patient's surgery was finished on th -- until she's transferred to the next day, did this patient's history of having chemotherapy affect anything regarding her condition?

MR. : Other than what he talked about earlier?

MR. OGINSKI: Correct.

A. I don't believe so.

Q. From the time she arrived at until the time she passed away did her history of chemotherapy usage have anything to do with her condition at

?

MR. : I have to object to that. How can he know everything?

Q. I am asking if you know.

A. I can't say with certainty.

Q. I am not asking with absolute certainly. I am asking -- I should have said with a reasonable degree of medical possibility, do you have an opinion as to whether the patient's prior chemotherapy usage affected this patient's condition from the time she arrived at until the time that she passed?

MR. : If you know.

A. With certainty or --

MR. : Don't speculate.

A. I can't speculate.

Q. Now, Doctor, let's talk about the hernia.

Did you have any difficulty performing the hernia repair?

A. No.

Q. Any technical difficulty?

MR. : Other than the

enterostomy?

MR. OGINSKI: Yes.

Q. The actual reduction of the hernia, was there any difficulty with that?

A. It was difficult in that there was the adhesions, in that sense, but that's it.

Q. As a result of this patient's hernia, was there any bowel obstruction?

A. From the hernia?

Q. Yes.

A. Not clinically that I could see.

Q. Was there any strangulation of bowel that you observed?

A. No.

Q. Was there any gangrenous bowel you observed?

A. No.

Q. Do you have a memory as you sit here now about your preop consultation with the patient and her husband?

A. Yes.

Q. What are the risks did you

tell them were associated with the procedure that you were contemplating?

MR. : You don't have to guess.

Q. Is there anything you remember?

MR. : I don't follow what you're saying.

Q. We went through some of the risks --

MR. : I understand what you did, but I am saying he could have the form in front of him when he goes through it with the patient.

Are you asking him to memorize what's on the form?

MR. OGINSKI: No.

Q. Are there any other risks you discussed with the patient that you haven't told me about?

MR. : Do you want to go through the form? Would that assist you?

THE WITNESS: Yes.

A. I use the form. I put the form in front of the patient and I literally go through every risk that's on there.

Q. Did you tell the patient that there was no guarantee that performing these surgical procedures would resolve her abdominal pain?

A. Yes.

Q. What did she say to that, if anything?

A. They understood, acknowledged it. They wanted something done.

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

A. University.

Q. When did you graduate?

A. .

Q. Did you go right into residency after that?

A. I did an internship.

Q. Where?

A. At , Queens.

Q. In what?

A. OBGYN.
Q. One-year position?
A. Yes.
Q. Then what did you do?
A. I did a year of research.
Q. Where?
A. University of
.
Q. In what field?
A. GYN oncology.
Q. Was that at ?
A. No. Medical school.
Q. Which one?
A. University of
.
Q. What did you do after that?
A. I did my residency at
University of .
Q. In OBGYN?
A. Yes.
Q. That was four years?
A. Yes.
Q. After that?
A. I did my fellowship OBGYN at

.

Q. How many years was that?

A. Three years.

Q. Was there any additional --

you went to ?

A. .

Q. How long did you spend there?

A. One year.

Q. What was the name of it? What

was the name of the place in ?

A. .

Q. What was that --

A. That was the main place I was

at.

Q. That was a year doing what?

Was that a fellowship?

A. Radical vaginal surgery,

laparoscopic surgery, general surgery, GYN

oncology or surgical oncology.

Q. After that you returned back

to ?

A. Yes.

Q. As a full-time attending?

A. Yes.

Q. Had you been a full-time attending ever since?

A. Yes.

Q. What year was that?

A. I returned in , summer.

Q. Have your attending privileges ever been suspended from ?

A. No.

Q. Have they ever been revoked?

A. No.

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

A. Yes.

Q. When were you licensed?

A. I would have to look.

Q. Approximately.

MR. : Approximately.

A. .

Q. Are you licensed in any other state?

A. .

Q. Anywhere else?

A. No.

Q. Is the license

active?

A. Yes.

Q. Has that ever been suspended or revoked?

A. No.

Q. Have you ever testified before?

A. Yes.

Q. How many times?

A. Once.

Q. As an expert or as a participant, as a party being sued in a lawsuit or something else?

A. Party in a lawsuit.

Q. Where you were being sued?

A. One of the people.

Q. How long ago was that?

A. It was a case from residency.

Q. More than ten years ago?

A. Probably.

Q. The case that you were involved in, do you know where that was located; Manhattan, Brooklyn?

A. .

Q. Did you also testify at trial?
A. Yes.
Q. That was the same case?
A. Same case.
Q. Have you testified any other time other than today?
A. No.
Q. Have you ever testified as an expert?
A. No.
Q. Ever reviewed cases as an expert?
A. I was asked to review a case once I think, once or twice.
Q. When was the last time?
A. Probably a year ago. This was just where the lawyers asked me to review charts. Is that basically what you're asking?
Q. Yes. Do you know a Dr. , ?
A. No.
Q. Is Dr. still affiliated with ?

A. No.

Q. Do you have any knowledge as to where Dr. practices?

A. University of .

Q. Do you know where Dr. practices?

A. I think she's still in .

Q. Do you know where Dr. practices?

A. is still affiliated with .

Q. Do you socialize with Dr. ?

A. No.

Q. I should have asked this earlier: Do you have a copy of your CV?

MR. : I have it.

(Plaintiff's Exhibit 4 marked for identification.)

Q. Doctor, your attorney has provided me with a three-page copy of your CV.

When was the last time you updated this?

A. A week ago.

Q. And is it correct and accurate, to the best of your knowledge?

A. Yes.

Q. You were board certified in OBGYN in ?

A. Yes.

Q. And GYN oncology in , correct?

A. Yes.

Q. Have you needed to become recertified yet?

A. Not yet.

Q. Do you have an opinion, Doctor, with a reasonable degree of medical probability as to whether there was a delay in diagnosis of this patient's sepsis?

MS. : Objection. We went over this.

MR. : We have been there and back. It's too broad.

MS. : And it's not what

he --

MR. : I am objecting for the record.

Q. Do you have an opinion with a reasonable degree of medical probability as to whether, if anything, you had done differently during your surgery on th, would have changed or altered this patient's outcome?

MR. : I object to the degree it calls for speculation, but you may answer.

A. I don't think anything that I did would have been different.

Q. Do you have an opinion as to whether there was a delay in diagnosis of this patient's bowel perforation while she was still at ?

A. In my judgment, she didn't have a bowel perforation at .

Q. Have you authored any medical articles that have appeared in any peer review journals?

MR. : Yes or no.

A. Yes.

Q. Do you list them in your CV?

MR. : It's not in this document.

A. I keep it on a separate document.

MR. OGINSKI: Provide a copy of that to your attorney, please, and we call for that.

(Request.)

MR. : I will take that under advisement, because publications are a matter of public record.

MR. OGINSKI: It's part of his record.

MR. : It's a matter of public record.

MR. OGINSKI: I don't know that.

MR. : You can research his name and find it.

Q. Can you tell me approximately how many publications you have authored?

A. Just peer reviewed?

Q. Yes.

A. Somewhere between and .

MR. OGINSKI: So, again, I would ask that you provide a copy of whatever you have to your attorney and we would ask for a copy of that.

MR. : I understand, but our position is it's a matter of public domain.

MR. OGINSKI: I am still entitled to it.

Q. Now, Doctor, what is your current title -- administrative title -- at ?

MR. : Don't use the word "administrative." I don't know what that means.

Q. What is your title?

MR. : As an attending?

MR. OGINSKI: Yes.

A. Associate attending surgeon.

Q. Do you hold any academic position?

A. At .

Q. What is that position?
A. Associate professor.
Q. Are you an officer of any of the medical societies that you list on your CV on page three?
A. No.
Q. Let's turn, please, to your first note that you have for this patient, your office note.
MR. : That would be in this section. I tabbed them for you.
These are typed notes so do you need him to read these notes into the record?
MR. OGINSKI: No.
A. The first one I wrote?
Q. Yes.
MR. : Can you give him the date?
Q. What is the date you have?
A. .
Q. Tell me what was the purpose for the patient appearing in your office at that time.

A. The patient had a follow-up scheduled with me.

As I mentioned previously, she was a former patient of Dr. 's and her patients were allocated to the different attendings when she decided to stop her GYN oncology practice.

Q. Did the patient have any specific complaints on that visit?

A. I suspect --

Q. I'm sorry, Doctor. I should have said this earlier: I don't want you to guess.

Is there anything contained in your note for that date that tells you what specific complaints the patient had?

A. No.

MR. : What do you mean; no, there's nothing that tells you or no, there's no specific complaints or -- I'm not sure what the question and answer reads as, although that is your job, not mine.

MR. OGINSKI: Thank you. I

will rephrase it.

Q. Is there anything in your note to suggest what the patient's complaints were, if any?

A. It was suggested she had some abdominal symptoms, but it doesn't appear that she had complained of them to me on that day.

Q. Specifically what in your note are you referring to?

A. She had a GI work-up done.

Q. But at the time that she saw you on did you record any patient complaints?

A. I didn't record any specific complaints.

Q. What treatment, if any, did you render to the patient?

A. I drew some labs or ordered some labs and examined her.

Q. What conclusions did you reach after your exam?

A. Based on my exam, she did not have any evidence of cancer.

Q. When did you advise her to return for follow-up?

A. .

Q. When is the next note you have for this patient?

A. From me or just --

Q. Just you.

By the way, did she see any other GYN physicians in your group between and the next visit?

A. Not that I recall.

Q. Okay. Go ahead.

A. I mean, my nurse spoke to her but you don't want that.

Q. No.

A. You are not talking about GYN chemotherapists?

Q. No.

A. .

Q. Do you have a date, please?

A. .

Q. Did you record any complaints the patient -- withdrawn.

Did the patient make any

complaint on that day as reflected in your note?

A. No.

Q. What treatment did you render to the patient?

A. I examined her, I ordered a C-125, looks like I ordered a CT scan.

Q. For what reason?

A. As a follow-up, evaluate for disease.

Q. The results of those two tests, I believe you told me earlier they were both negative, correct?

MR. : I think he said the C-125 was negative.

A. C-125 was 6.

Q. Is that normal or abnormal?

A. That's normal.

Q. And the CT results?

A. CT scan from , she had some borderline-sized chest nodes.

Q. Those are the nonspecific adenopathy you told me about earlier?

A. Increased nonspecific

adenopathy, yes.

Q. What did you tell the patient about the results of that test?

A. Let me just read the rest of it here.

She had a non-obstructing ventral hernia, she had some mildly-distended small bowel.

Q. Based upon the results of both the CA 125 and the CT scan did you recommend any additional treatment?

A. I think she needed to be further followed up with a repeat CT scan.

Q. When did she next return to your office?

MR. : It should be clipped.

A. .

Q. What complaints, if any, did you record in your note on ?

A. She had intermittent abdominal pain.

Q. Anything else?

A. At this exam I noted her

hernia.

MR. : I think he is asking if there's any other complaints at that point.

MR. OGINSKI: Correct.

MR. : Just take a look.

A. I think the abdominal pain was the main issue.

Q. What treatment did you render?

A. I examined her, I discussed the hernia and I mentioned that it may or may not be the cause of her abdominal pain. It didn't appear that it obviously was a cause.

I did give her precautions about emergency settings, such as obstruction. I ordered a CA 125.

Q. Did you order a repeat CT scan?

A. I don't think I ordered one at that time. It doesn't seem that way. Let me just check.

MR. : You have the small bowel after that, right? I

think that was the last one.

A. I didn't order any other tests aside from the CA 125.

Q. What were the results of the CA 125?

A. 6, normal. That was on .

Q. When did she next reappear in your office for follow-up?

A. Next in the office?

Q. Yes. Is that in the visit?

A. Yes.

Q. Let me just ask you, Doctor, in a patient who has a history of ovarian cancer, specifically the type she had, and I think it was either stage 3B or 3C --

A. 3C.

Q. What is the statistical recurrence rate for patients who have now been successfully treated?

MR. : I object to the form, "successfully treated," but what is the recurrence rate?

MR. OGINSKI: Correct.

A. 70 to 80 percent of these patients recur.

Q. Is that over a period of five years?

A. Yes.

Q. Without going back and revisiting your thoughts as to why this patient's anastomotic breakdown occurred -- you told me your thought process -- do you have any medical literature to support that mechanism that you described?

MR. : You don't have to answer that question. That is an improper question.

Q. Is there any medical literature that you have seen or reviewed that supports your theory as to why this patient's anastomotic breakdown occurred?

MR. : Again, counsel, that is an improper question.

Objection.

MR. OGINSKI: I disagree.

MR. : You can't come to

a deposition and fish around for any literature.

MR. OGINSKI: I am entitled to ask him if he reviewed any medical literature that supports his claim or his defense that he knows about.

MR. : No. You asked him if he reviewed any literature in preparation for today, and I think he answered that. The answer was no.

Q. Are you aware of any medical literature, Doctor, that supports what you told me is the reason why this patient might have experienced the breakdown of her anastomosis?

MR. : I object to that.

MR. OGINSKI: Are you directing him not to answer?

MR. : Yes. It is an improper question.

MR. OGINSKI: I disagree. Mark it for a ruling.

(Marked for a ruling.)

MR. : It is not

admissible even at trial to say that.

MR. OGINSKI: Mark it for a ruling.

Q. Let's turn to the visit, please.

The patient had some changes in her complaints, correct?

A. Yes.

Q. Her condition -- her abdominal condition was getting worse?

A. That's correct.

Q. And she also said it was more frequent?

A. That's correct.

Q. Had you had a discussion with the patient before about the possibility of her needing surgery?

A. I had mentioned it to her. That's why they came in on the th.

Q. Did you explain to them what would occur, if anything, if she did nothing as an alternative?

A. Specifically, you know, I can't specifically recall the actual

conversation.

Q. Was this the time that you had the discussion with the patient about what the risks were?

A. Yes.

Q. And you also discussed with them what procedure you were going to perform?

A. Yes.

Q. Is it fair to say that if this patient had not agreed to have the surgery of th she would still be alive today?

MR. : Objection.

I don't think that's a fair statement and it's speculative, so I am not going to allow the answer today.

Q. During the first surgery on th, when you observed the enterostomy, was there any other part of the patient's bowel that you felt was of significance, anything else that you observed?

MR. : I am going to object, because he reviewed some things with you before and he talked about the de-serosalized tissue.

Q. Is it fair to say those observations that you made that you felt were significant, that you addressed them and recorded them in your operative note?

A. Yes.

Q. Other than the patient's abdominal complaints, did she have any other symptoms that she complained of?

MR. : On ?

MR. OGINSKI: Yes.

A. I think the main complaint was her abdomen, if I can recall. That's it.

Q. You mentioned on the second page of your office note toward the bottom under plan, you say:

The risks and benefits of ventral hernia repair as well as the failure rates and recurrence of hernia were discussed with the patient and her husband in detail.

What were the failure rates?

A. Typically I'll use 10 to 20 percent. I don't specifically recall if that was the number that I gave to the patient.

Q. Is that a failure rate of the hernia, being able to reduce the hernia, or does that refer to something else?

A. The hernia.

Q. In that statistical number that you gave me, does that mean that in those instances you were unable to reduce it to relieve the patient's symptoms?

MR. : What does that number represent is all he is asking.

MR. OGINSKI: Thank you.

A. The recurrence that the repair did not work.

Q. Why in your opinion did this patient require a mesh?

A. It's something that I talk to patients about and I consented for in the event that I use it.

Q. That's a decision that you

make during surgery as to whether or not they need it?

A. Typically.

Q. In this case you used a mesh, correct?

A. In this case I did.

Q. Let's turn, please, to the nursing addendum dated . It looks like this.

MR. OGINSKI: Off the record.

(Discussion held off the record.)

(A short recess was taken.)

MR. : Okay. We're on that note.

Q. Doctor, in this nurse's note, do you see there is a notation saying:

Patient's husband upset because wife was promised pill earlier and immediately release rather than extended release, in the middle of the page?

A. Yes.

Q. Do you have an opinion as to whether there was a delay in getting this patient the proper form of her cardiac

medication?

A. I can't say.

Q. Did you ever speak with Dr. about the timing of her getting her cardiac medications?

A. No.

Q. Did Dr. ever offer you any opinion or thoughts as to what was causing her cardiac condition?

MR. : I think said he never spoke to her directly.

Q. Did anybody, any doctor, relay any information to you about the cause for this patient's cardiac condition?

A. No.

MR. : Other than what he said?

MR. OGINSKI: Yes.

Q. Did this patient have a fever postoperatively at ?

A. No. Not that I recall.

Q. When the patient was at , did you review any of the notes written by the physicians at ?

Did you review the patient's chart?

A. No.

Q. On the patient is noted to have chest pain, palpitations and decrease in blood pressure.

I'm looking at the procedure critical event note dated You can take mine. I just had a quick question.

Based upon the observation of decreased blood pressure, do you have any reason to know why the patient was experiencing a decreased blood pressure?

A. I suspect it was due to her arrhythmia.

Q. Why would arrhythmia cause decreased blood pressure?

A. If the heart is not pumping well. It was also a question of whether she had a heart attack. Those are things that might cause it.

Q. That information, how did you learn that information about arrhythmia and

possible heart attack?

A. Discussed with my fellow.

Q. Was that discussion -- did that take place before or after Dr. consulted on the patient?

A. I believe it was after.

Q. Now, this diagram, is that a diagram that you generated?

A. Yes.

Q. Was that during the preop consultation?

A. Yes.

Q. Just tell me, Doctor, what the diagram is and what it represents.

A. So this is the patient, this is her prior incision.

Q. That is a vertical incision?

A. Yes. This is the area of the hernia, this is some intestine, this is a mesh.

Q. What are the notations, the writings that you have on left and right side of that diagram?

A. This is looking at hernia

repair where sometimes I place the mesh.

Q. What are the words you have written there?

A. Peritoneum in fascia.

Q. And on the other side?

A. Infection.

Q. Now, there's a note also in the chart, I will show it to you. I believe it is a resident's note. It says:

Patient was accepted for transfer to ICU. However, patient primary service in cardiology are transferring patient to .

MR. : Do you see that note?

THE WITNESS: Yes.

Q. Did you have any conversations with anybody about transferring the patient to ICU?

A. I spoke to my fellow, Dr. , and after his discussion with the ICU staff and the cardiology staff it was felt that her issue would have been better addressed at .

Q. Did any doctor suggest that the patient's cardiac problems were secondary to something else that was going on with her?

A. I did come in to examine her and I did not feel that was the case.

Q. Other than yourself, did any other physician make any comment either to you or indirectly that her cardiac condition or her symptoms were secondary to some other process?

MR. : We are talking about the patient at ?

MR. OGINSKI: Yes.

A. When I spoke to Dr. , initially he told me he didn't think it was anything except for cardiac as well.

Q. Can you turn, please, to your note dated 1st timed at 11:15 p.m. This one, Doctor.

A. Okay.

Q. Can you read that note, please, in its entirety.

A. , GYN attending,

11:15 p.m. Events from today noted; patient feeling fine --

Q. I'm sorry, it says, Patient was feeling fine?

A. Patient was feeling fine, but this evening complained of chest pain.

Noted to have heart rate approximately 120s. EKG with new changes. Rule out MI work-up initiated. Patient awaiting transfer to New York for cardiac management.

Physical exam is noted by the house staff. Assessment plan; afib.

Q. Does that say afebrile or afib?

A. Afib.

Q. Go ahead.

A. Plan for transfer to New York , discussed with patient's husband and patient will follow at .

Q. Did you read Dr. 's note, the consult note?

MR. : Dr. ? I

don't think she wrote a note.

MR. OGINSKI: I'm sorry.

Cardiology consult note.

Q. Did you read it before the patient was transferred?

A. Yes.

Q. Did you have a conversation with Dr. ?

A. No.

Q. , the doctor who apparently performed the consult?

A. No.

Q. Can you turn, please, to a note timed at 7:50 p.m. on 1st. It looks like this.

Can you tell me who or what specialty wrote that note?

A. This is what's called a rapid response team. I can't read the signature.

Q. That's the team that appeared following the patient's presentation of her cardiac symptoms?

A. Yes.

Q. Based upon the Troponin levels

that were done on 1st and also and the labs, there was no evidence of a myocardial infarction, correct?

A. That is correct.

Q. Did you ever speak to the medical examiner who performed the autopsy on this patient?

A. No.

Q. Are you aware whether Dr. ever spoke to the medical examiner?

A. No.

Q. You have a written note which says attending summary dated ?

MR. : You mean like a discharge summary note?

MR. OGINSKI: No. This is in the record. It says attending summary. It says:

I saw the patient at New York , CCU today.

MR. : Okay. That's here.

Q. Now, this is timed at 3:02 p.m.

A. Right.

Q. Does that reflect the time approximately that you saw the patient or is that done at sometime later in the day?

A. It was probably in the -- in that area. Probably late morning or early afternoon. I usually go to church in the morning, so...

Q. This was a Sunday, you said?

A. Yes.

Q. By the way, did Mrs. have any difficulty conversing with you in English?

A. No.

Q. You were able to understand her?

A. Yes.

Q. She spoke with a accent, correct?

A. Yes.

Q. You mentioned in your note of that her heart rate is

controlled but she did have a fever.

Did you form any opinion as to why she had a fever at that time?

A. A fever is a common finding postop. Sometimes if patients are in bed you can have fevers. It's a very common thing to see in the first two days after surgery.

Q. Would you read that fever is also sign of infection?

A. It can be.

Q. When she was at postop day one, was she on antibiotics?

A. No.

Q. Tell me why you wanted her started on IV antibiotics on .

MR. : It didn't say he wanted her --

Q. You wrote:

I have spoken to the CCU team regarding the patient. She will be started on IV antibiotics and kept NPO for an ileus.

Tell me why a decision was made, if you know, to put the patient on IV

antibiotics.

A. I can't speculate. I mean, why they decided to --

Q. I don't want you to guess, Doctor.

A. I can't speculate.

Q. Did you learn from any physician at why they were giving her -- they wanted to give her IV antibiotics?

MR. : You mean a specific reason rather than prophylactic?

MR. OGINSKI: Correct.

A. I can't say.

Q. Did you discuss with anybody at the possibility that she might have an ileus?

MR. : Wait. At what point now? At the time of this note?

MR. OGINSKI: Yes.

A. I can't recall.

Q. Who was it who first had the idea or suspicion that the patient had an

ileus?

A. I can't recall if when I saw her or if they suspected it. I really can't recall where that diagnosis came up.

Q. You told me that you saw the patient or you had two different notes for this date, .

A. Yes.

Q. I think once in the morning, one was later in the evening?

MR. : Yes. You saw the other one.

MR. OGINSKI: Right.

Q. In the other note that you told me about, the one in the evening, did you make any notation about your thoughts that the patient might have an ileus?

MR. : No. We wouldn't do that.

A. I think I had noted that she vomited, but I didn't specifically say an ileus.

Q. There's also a note on 4th that you wrote about a

telephone conversation with Dr.
that also appears in the
record.
A. Yes.
MR. : We have it.
Q. Tell me about that
conversation.
A. Dr. had paged me
because her condition had rapidly
deteriorated, and I think his feeling was
she wasn't going to survive. He was
notifying me.
Q. At the time of your
conversation had she already coded a number
of times?
A. Yes.
Q. When you say you spoke with
the husband, was that in person or was that
by phone?
A. By phone.
Q. The conversation with the
husband I assume took place before she
died?
A. I think it was right before

she passed away.

Q. Did Mr. ask you why she was in such a condition, why she had deteriorated so significantly?

A. No.

Q. Did you offer any opinion as to why she was in such a poor condition?

A. No.

Q. Did you ever have any conversation with Mr. after his wife died?

A. I had a brief --

MR. : Did we mark that?

MR. OGINSKI: No. Let's mark that.

(Plaintiff's Exhibit 5 marked for identification.)

Q. Doctor, your attorney gave me earlier a note that you had written that appears in the chart, chart, two dates; 5 and 10, handwritten notes. You wrote these?

A. Yes.

Q. Do you know where the original is?

A. I think it's in my -- a folder I keep in my office for thank you cards and stuff like that.

Q. Why did you write a note that appears in the patient's chart telling them that you sent a condolence card to the patient's husband?

MR. : I don't know if that appears in the patient's chart.

I think that is from his own folder. He brought it, so we produced it.

Q. During your conversation of , did you offer the patient any thoughts as to why his wife had passed away?

A. No.

MR. : What is the date of that conversation?

MR. OGINSKI: 10.

A. No.

Q. After that date, did you have

any further conversation with the patient's husband, Mr. ?

A. No.

Q. When you called Mr. , you actually spoke with him?

A. Yes.

MR. : On the th?

MR. OGINSKI: Yes, on the th.

A. Yes.

Q. Did he say anything in response to your words, to what you were telling him?

A. I don't recall the specifics of what he said to me.

Q. When was the first time you felt that the patient might have an intraabdominal process going on?

MR. : I think he answered that.

MR. OGINSKI: He told me at one point he thought she might have an intraabdominal process.

MR. : Then he came back

at night. Didn't he say that? Answer the question.

A. At the time of my second note on .

Q. When it was learned that the patient was septic, did that account for why the patient was hypotensive?

A. That was one of the concerns, that possibility.

Q. Did anyone connect the patient's septic picture with her cardiac manifestations?

MR. : I have to object to form, because you asked him his opinion on that.

MR. OGINSKI: I will rephrase it.

Q. Did anyone discuss with you the possibility that the septic picture she was experiencing was a direct cause or contributing factor to her cardiac issues?

A. At ?

Q. Yes.

A. The cardiac as far as her

blood pressure issues?

Q. Blood pressure, hypotension, palpitations.

MR. : Now you are expanding it. You mean the cardiac picture that presented at or the cardiac picture she was presenting at that time?

MR. OGINSKI: At that time at .

A. If there was concern about the abdomen?

Q. No. I will rephrase it.

Once there was a suspicion or belief that she was septic, did anyone connect her sepsis with her cardiac issues that she was having?

A. There was a concern, yes. That's why they called the general surgery team.

Q. When you say there was a concern, tell me what you mean by that.

A. That's one thing that's on the differential; could this have an

intraabdominal process causing the symptoms.

Q. During Dr. 's surgery, was there any evidence of ischemic bowel observed?

A. I can't say.

Q. Was there any ischemic bowel that you observed during that surgery?

A. At Dr. surgery?

Q. Yes.

A. I wasn't close enough to really look into the surgery.

Q. Was there anything that any of the doctors participating in that second surgery told you about that they had observed any ischemic bowel?

A. Not that I recall.

Q. Did you observe bile within the patient's abdominal cavity?

A. As I mentioned, I was in the corner of the room so I didn't have a real direct into the abdomen view.

Q. Were you scrubbed?

A. No.

Q. Are you familiar with the term known as fat necrosis?

A. Yes.

Q. What is that?

A. It's when fat dies; necrosis.

Q. Did you see any fat necrosis during the surgery?

A. As I mentioned, I was in the corner of the room. So the details of the surgery, I can't answer them.

Q. Did you overhear anybody participating in the surgery say that they had observed and seen fat necrosis?

A. I don't recall hearing anybody say that.

Q. Am I correct that Dr. left the patient's wound open -- surgical wound?

A. Yes.

Q. Why was that done?

A. She was becoming unstable, and I don't know the exact reason why he did it, but I know she was becoming unstable at that time.

Q. Do you have an opinion, Doctor, with a reasonable degree of medical probability whether anything you did for the care of this patient caused or contributed to her death?

MR. : You can answer that over objection.

That is a yes or no.

Do you have an opinion whether anything you did caused or contributed?

THE WITNESS: No.

Q. Do you have an opinion whether anything that anyone at did or did not do caused or contributed to this patient's death?

MR. : I object to that.

MR. OGINSKI: Are you directing him not to answer?

MR. : I don't think it is a proper question. Yes.

Q. Following Dr. 's surgery, did the patient remain intubated?

MR. : I don't think he

saw -- what you know.

A. The patient was transferred to their ICU and that's -- then I -- that's all I know.

Q. Did you ever see the patient after she left the operating room?

A. After she left the operating room, I stopped by later that day and didn't examine the patient but just spoke with Dr. .

Q. That's on rd?

A. rd.

Q. Tell me about that conversation.

A. They were addressing some wound problems, wound issues.

Q. What information did Dr. tell you about the patient?

A. I don't recall the specifics.

Q. Did you have any additional conversation with Dr. on that day?

A. Not that I recall.

Q. When the patient was in ICU, was she conscious?

A. I don't know.

Q. Did you see Mrs. before -- withdrawn.

From the time that you examined the patient on , the evening, up until the time she was taken to the operating room, did you see her before she went into the OR?

A. Before she went into the OR?

Q. Yes.

A. From the time I saw her to the time Dr. decided to take her to the OR, I did see her either with him or right after him.

Q. Where was she at the time that you saw her?

A. In the CCU.

Q. Was she awake at that time?

A. She was --

MR. : Don't guess. Do you know?

A. I can't say.

Q. Was she conscious?

A. I can't say.

Q. Was she talking?

A. I don't think she was talking.

Q. When was it that somebody alerted you or told you about this wound fluid coming from the wound?

A. I recall that that was the factor where Dr. -- that was the deciding factor to take her back to the operating room.

Q. From the time that the decision was made to take the patient to the operating room, how long did it take to actually get the patient into the OR?

A. I don't know. I can't say, but it wasn't a long, long time.

Q. How soon after you saw the patient in the evening of was it before the decision was made to take the patient back to the OR?

A. I don't recall the specific time when the decision was made where she went -- where they decided to take her back to the operating room.

Q. How were you alerted to the

fact that the patient was going back to the operating room?

A. I was still in that area around the CCU or in the waiting room.

Q. Did you have any other patients that you were caring for or any of your patients who were also at other than Mrs. ?

A. No.

Q. Now, did you know Dr. before he started to care for Mrs. ?

A. No.

Q. Is it your understanding that he is an attending surgeon?

A. Yes.

Q. When you spoke to Mr. on th, tell me what you said to him and what he said to you.

MR. : As best you can recall.

A. I just asked him how he was doing and he told me he went to to visit his daughter because he needed to get away, and I just offered my condolences

and offered if there was anything I could do to call me.

Q. Now, I want you to assume that Mr. has testified in this case; he was asked questions by different attorneys.

A. Okay.

Q. And specifically testified -- withdrawn.

While the patient was at postop day one, was there any indication that would warrant a CT scan?

A. No.

Q. Mr. , I want you to assume he has testified that following surgery when you spoke to him he said that he was not told that there was a hole or an enterostomy made.

Assuming that fact to be true, do you have any reason to disagree with Mr. 's recollection of that conversation?

MR. : I object to that. That's argumentative.

Objection. You don't have to

answer that. You have given your recollection.

The jury will decide who they believe and don't believe.

MR. OGINSKI: Thank you, Doctor.

MR. : Thank you very much, counsel, for accommodating me today.

(Time noted: 4:36 p.m.)

DR.

Subscribed and sworn to before me on this _____day of _____, 2010.

_____
NOTARY PUBLIC

I N D E X

WITNESS
DR.

E X H I B I T S

PLAINTIFF'S		PAGE	LINE
Exhibit 1 -	inpatient chart	(premarked)	
Exhibit 2 -	outpatient chart	(premarked)	
Exhibit 3 -	photograph	52	13
Exhibit 4 -	CV	202	21
Exhibit 5 -	document	235	17

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

I, Kim Auslander, a Court Reporter and a Notary Public within and for the State of New York, do hereby certify:

That the foregoing witness, DR. , was duly sworn by me on the date indicated, and that the foregoing 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 January, 2010.

_____

KIM AUSLANDER

ERRATA SHEET

VERITEXT/NEW YORK REPORTING, LLC

CASE NAME: v

DATE OF DEPOSITION: January 19, 2010

WITNESS' NAME: DR.

PAGE/LINE(S)/ CHANGE REASON

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DR.

SUBSCRIBED AND SWORN TO
BEFORE ME THIS______DAY
OF_______________, 2010.

____

NOTARY PUBLIC

MY COMMISSION EXPIRES________________