DE-IDENTIFIED DEPOSITION OF A UROLOGIST IN A DEATH CASE INVOLVING A FAILURE TO TIMELY TREAT AND DIAGNOSE A PULMONARY EMBOLISM

1

2 SUPREME COURT OF THE STATE OF
COUNTY OF
3 ----------x
as Administratrix of the
4 Estate of

5 Plaintiff,

6 -against-

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8

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Defendants.
10
----------x
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12
13
February 11,
14 10:40 a.m.

15

16 EXAMINATION BEFORE TRIAL of the

17 Defendant,

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, 10016
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2 A P P E A R A N C E S:

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9 Attorneys for Defendants

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11 BY:

12

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

It is hereby stipulated and agreed by and between counsel for the respective parties hereto that all rights provided by

the C.P.L.R., including the right to object to all questions except as to form, or to move to strike any testimony at this examination, are reserved, and, in addition, the failure to object to any question or to move to strike any testimony at this examination shall not be a bar or a waiver to doing so at, and is reserved for, the trial of this action;

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It is further stipulated and agreed by and between counsel for the respective parties hereto that a copy of the within examination shall be furnished to counsel representing the witness testifying without charge.

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2 , a witness

3 herein, stated his office address as

4 , ,

5 , after having been first duly

6 sworn by a Notary Public of the State

7 of , testified as follows:

8 EXAMINATION BY MR. OGINSKI:

9 MR. OGINSKI: Please mark this

10 Plaintiff's 1. It is plaintiff's

11 inpatient medical records.

12 (Inpatient medical records for

January 16, admission was marked as Plaintiff's Exhibit 1 for identification, as of this date.)

MR. OGINSKI: This is the January 16th, admission.

Q Good morning, Doctor.

I would like you to look at records that have been put before you which have been marked Plaintiff's 1 for identification, which is, according to your counsel, the records from inpatient admission for the admission of January 16, .

, M.D.

On the first page is a Certificate of Death. To the bottom of the page under section 26 where it says

"cause of death", immediate cause is listed "bladder carcinoma".

Do you see that?

A Yes.

Q Is that an accurate description of this patient's cause of death, to your knowledge?

A No.

Q What was this patient's cause of death?

A Most likely pulmonary embolism.

Q What is a pulmonary embolism?

A It's a blood clot in the lungs.

Q Are you familiar with a medication known as fragmen?

A Yes.

Q What is fragmen?

A It's classified as a low molecular weight heparin.

Q How does that differ from Coumadin?

, M.D.

A The mechanism of anticoagulation is different. It affects different pathways.

Q Can you tell me why Mr. was on long term Coumadin therapy as of October of ?

A Subsequent to his bladder surgery he suffered a deep venous thrombosis of his right leg and was treated appropriately for that and then maintained on Coumadin, which is anticoagulation.

Q During the January 16, admission did you learn why Mr. 's Coumadin therapy was changed or substituted with fragmen?

MR. : I object to the form.

Q Did you learn at some point

during this hospital admission -- and again, all my questions are going to relate to the January 16th admission unless I indicate otherwise.

Did you learn at some point that Mr. was going to have a bronchoscopy or an endoscopy?

, M.D.

A Yes. He was going to have an endoscopy.

Q Did you also learn that prior to the endoscopy his Coumadin therapy would be changed?

A Yes.

Q From whom did you learn that information?

A From the Gastroenterology fellow.

Q What information were you told as

to why the Coumadin therapy would be changed prior to the endoscopy?

A They wished the patient's Coumadin withheld to avoid bleeding during the endoscopy.

Q As far as you knew, Doctor, were biopsies going to be obtained during the endoscopy?

A I don't believe so. There was a possibility that a small biopsy may have been done, but I don't believe it was planned.

Q In the event that biopsies were not planned to be done was there anything

, M.D.

associated with the endoscopy procedure that might make the patient more susceptible to

bleeding?

A Not in my opinion, no.

Q Before coming here this morning did you review this patient's medical record?

A Yes.

Q The medical records consist of the inpatient as well as the outpatient records?

A Yes.

Q Did you review any other documents as far as this patient's care and treatment prior to coming here today?

A No.

Q Did you review any textbooks or medical literature in preparation for today's deposition?

A I'm familiar with the literature.

Q Let me rephrase the question.

Solely for the purposes of this deposition did you go back to review any particular literature just for the sole

, M.D.

purposes of today's deposition?

A No.

Q Did you learn that prior to the endoscopy Mr. 's Coumadin was withheld?

A Yes.

Q And that at some point after that fragmen was ordered and given?

A Yes.

Q Did you also learn that after the endoscopy procedure had been completed Mr. received one dose of fragmen?

A Yes.

Q Can you tell me, Doctor, generally what are the clinical signs of a pulmonary embolism?

A Shortness of breath predominantly.

Q Are there any other clinical signs?

A The patient may have chest pain. He may feel faint.

Q How do you as a physician diagnose a pulmonary embolism?

, M.D.

A Other than clinical symptoms and signs?

Q In any fashion that you can tell me.

A Again, the patient presents the symptoms that I mentioned. Uh, the diagnosis is established based on a CT scan.

Q Is that the standard in which you can make the diagnosis?

A That's one of the standards, yes.

Q Are there any other diagnostic tests that you can use to confirm a diagnosis of a pulmonary embolism?

MR. : Beyond a CAT scan?

MR. OGINSKI: Beyond a CAT scan.

A Yes, but the CAT scan is generally preferred.

Q Can you just briefly tell me what are some of the other diagnostic tests that are available?

A Pulmonary angiogram.

Q Is the pulmonary angiogram an invasive procedure?

A Yes.

, M.D.

Q How do you treat a pulmonary

embolism?

A With anticoagulation.

Q In the year were you familiar with the types of anticoagulation that would be effective in treating a pulmonary embolism?

A Yes.

Q What were they?

A Unfractionated heparin or low molecular weight heparin.

Q How are the two heparins that you just mentioned distinct from each other?

A Again, mechanism of action.

Q Is one type of heparin preferred over the other in terms of treating a pulmonary embolism?

A No.

Q Is there any particular reason as to why you might use one particular type of heparin as opposed to the other?

A Yes.

Q What would that reason be?

25 A Low molecular weight heparin is

1 , M.D.

2 easier to give and requires less monitoring

3 than the unfractionated heparin.

4 Q Is there a particular method of

5 administration of this heparin, whether

6 injection, IV or some other route, that you

7 would use to give unfractionated heparin to

8 treat a pulmonary embolism?

9 A Well, heparin is given

10 intravenously. It can be given

11 subcutaneously.

12 Q Under what circumstances would it

13 be given subcutaneously?

14 A If it were given for prophylaxis.

15 Q Would you administer subcutaneous

16 heparin for an acute pulmonary embolism?

A No.

Q Why?

A It's generally felt that it's quicker, more effective given intravenously.

Q I want to direct your attention, going back to the October admission for a little bit and about why this patient came into the hospital in January of , specifically about his failure to thrive.

, M.D.

MR. : Are you talking the first admission in or the second?

MR. OGINSKI: The second.

MR. : The January 16th admission?

MR. OGINSKI: Correct.

Q Am I correct that from October until his admission in of January 16,

, that the patient lost a considerable

amount of weight over that period of time?

A Yes.

Q Did you make any determination during the time that you were caring for this patient as to why he was experiencing this weight loss?

MR. : Did he make efforts to determine or did he actually determine?

Q At any point while you were caring for this patient while he was alive did you come to any opinion or any impression as to why this patient was losing the weight that he was losing?

A No.

, M.D.

Q Was there any medical significance to you as a physician who was caring for the patient as to what his weight loss meant?

A No.

Q During the January admission, and I don't recall if it was the first hospital admission or the January 16th admission, did you become aware that the patient became hospitalized with hiccups?

A Yes.

Q And that he also had loss of appetite and generally was unable to keep any food down?

A Yes.

Q Initially when he presented did you make any determination as to the cause of that particular condition?

A No.

Q Did you obtain various consultations by other specialities to

23 evaluate those presenting complaints?

24 A Yes.

25 Q Would that include the GI

1 , M.D.

2 service?

3 A Yes.

4 Q As well as the Infectious Disease

5 service?

6 A Yes.

7 Q Prior to Mr. undergoing

8 the endoscopy to the end of his January

9 16th admission had you consulted with any of

10 the specialists who had seen and treated Mr.

11 as to the cause of his loss of

12 appetite and his hiccuping?

13 A That's a broad question.

14 Q I'll rephrase it, then.

15 Was there any type of consensus

between you and the other treating physicians as to what was causing this patient's hiccuping?

A No.

Q Was there any consensus among you and the other treating physicians as to the reason this patient was experiencing his loss of appetite?

A No.

Q In your practice do you use the

, M.D.

term failure to thrive?

A Yes.

Q Tell me what that means, Doctor.

A Some patients after surgery for reasons unclear simply don't rebound and improve and it's manifested by loss of

appetite, fatigue, sometimes depression. The normal recovery is delayed. The reasons are unclear.

Q Before January 16, had you formed any impression or any opinion as to any pathologic reason as to why this patient was experiencing his loss of appetite following his October surgery?

A Somewhat.

Q What was your opinion or impression?

A Again for reasons unclear, he had and suffered from intermittent chronic infection in his urinary diversion.

Q When you say "urinary diversion", can you be more specific?

A He had an orthotopic urinary diversion after his radical cystectomy.

, M.D.

Q Can you tell me what that means when you say an "orthotopic urinary diversion"?

A That's a neo bladder, as it were, made from his intestine and sutured on the inside so that he could urinate normally through the urethra without having a stoma or an external urinary collection device.

Q Generally after a procedure, a cystotomy that you mentioned, would you expect the patient to heal up and to have that diversion closed?

A It is closed.

Q What was it about this particular condition that you felt might be contributing to his inability to gain weight, or just the opposite, to continue to lose weight?

A Some of these become infected and the infection is generally easy to treat and

short lived, but his became chronic.

Q Following the procedure that Mr. had with you in October of did he continue to follow-up with you on a

, M.D.

regular basis?

A Yes.

Q Did you treat the condition that he had that you observed, the chronic infection that you mentioned?

A Yes.

Q Did you generally treat it with various types of antibiotics?

A Yes.

Q Did you see any type of improvement with the use of antibiotic therapy?

A Yes.

Q Do you have an independent memory of Mr. as to what he looks like and conversations you may have had with him?

A Very well.

Q Do you recall his wife, , as well?

A I do.

Q On each of the visits that Mr. came to your office for follow-up after the October surgery, did Mrs. accompany him on virtually each

, M.D.

visit, if you recall?

A I believe so, yes.

Q Did any other family member accompany him?

A To the outpatient visits I don't

know.

Q Now, the outpatient visits were in your private office within the hospital?

A No.

Q Where were they?

A They're in the computer.

Q Did you have another office that was outside of the hospital?

A No.

Q Where was your office, if you had one?

A Within the hospital.

Q When Mr. would come to see you, would it always be within the hospital?

A Yes.

Q Did you learn that after Mr. 's endoscopy that was done during the January 16th admission -- to be precise,

, M.D.

it was done on January 22nd -- that a diagnosis of candida was made and found in the esophagus?

A Yes.

Q From whom did you learn that information?

A From the attending.

Q That would be the GI attending?

A Yes.

Q Do you recall his name?

A Dr. .

Q Did you have a conversation with Dr. about what plan of treatment he intended to start Mr. on as a result of that candida finding?

A I don't recall, but I know how you treat it.

Q How do you treat it?

A With an antifungal agent.

Q The hiccuping that Mr.
initially presented with to the hospital was
treated with a medication. I believe it was
baclofen.
A That's correct.

, M.D.
Q Did the medication resolve the
hiccuping symptoms initially?
A Yes.
Q Did Dr. tell you
whether or not he had an opinion as to
whether the candida infection that Mr.
had was responsible for his loss
of appetite?
A No.
Q As of January 22, after the
endoscopy had been completed was there any
pathologic diagnosis made by any physician

that you're aware of as to the reason as to why Mr. was failing to thrive?

A No.

Q In a patient who is losing weight such as Mr. for unknown pathologic reasons are there other means and methods that are available to you as a physician to provide nutrition to the patient other than orally?

A Yes.

Q What are those means?

A Intravenous nutrition,

, M.D.

supplements.

Q Are there other types of means in which to provide nutrition to the patient other than by IV?

A There was high caloric oral intake medication, supplements.

Q Is there also something known as parenteral nutrition?

A That's what I meant by intravenous.

Q Is a gastrostomy also a method by which patients can receive additional nutrition?

A If they can't eat, yes.

Q Would the IV nutrition, the parenteral nutrition, allow a patient such as Mr. to gain back a lot of the weight that he had lost over a period of months?

A It's unlikely.

Q Why is that?

A You can't really provide accurate caloric intake long-term for a patient.

Q Is it simply a maintenance

, M.D.

caloric intake or something else, the parenteral nutrition?

A It's a supplemental oral intake.

Q The surgery that you performed in October of , the cystoprostatectomy, at the completion of that procedure clinically and pathologically were Mr. 's margins free of any remaining cancer, to the best of your knowledge?

A Yes.

Q What were the statistics for this patient's survival?

MR. : I object to the form.

MR. OGINSKI: I didn't finish the question.

Q Is there something known as a five year survival rate that you're familiar with?

A Well, we don't use that term.

Q What term do you use to discuss or evaluate a patient's survivability after undergoing cancer surgery?

A I guess we re-evaluate that every year.

, M.D.

Q But are there some generally known statistics in the literature for patients that undergo the type of procedure that Mr. had in October of as to whether or not he can or he may expect to continue living without a recurrence?

A No.

Q Is there any literature that you're aware of that discusses survival rate of patients who had the type of cancer that

Mr. had?

A Yes.

Q Does any of that literature discuss the rate of recurrence?

A Yes.

Q Can you tell me what those rates generally are?

MR. : I object to the form.

You can answer, if you can.

A That's too broad of a question.

Q Did you have any expectation for Mr. after his cancer surgery was completed in October as to whether he would have survived for a five year period

, M.D.

without having a recurrence of this type of cancer?

A We hoped he would.

Q Were there any statistics or medical literature to support your expectation that this patient once he's had the surgery and was free and clear of any margins would likely survive past a five year survival period without a recurrence?

MR. : Based upon the cancer status alone? Not if anything else that might happen to him?

MR. OGINSKI: Correct.

A We hoped he would.

Q I am asking specifically: Is there anything within the literature as to the percentage of patients with this type of cancer who will go on beyond a five year period of time who will go on without having a recurrence?

A You can't predict what's going to happen in an individual patient.

Q But generally, in the worldwide medical literature that you may be familiar

, M.D.

with are there any general statistics that you were aware of as of as to his expectancy, as to what he could expect to happen to him over the next few years?

A Again, we hoped he would survive.

Q I understand that, but are there any medical literature to support any information about the statistics?

A His pathology had a favorable prognosis.

Q What type of cancer was Mr. diagnosed with in October?

A Bladder cancer.

Q Was there a specific subset of bladder cancer that he was diagnosed with?

A He had transitional cell carcinoma.

Q By the way, is that a treatable type of cancer?

A In most cases, yes.

Q Does surgery typically, assuming you've obtained all the cancer, typically cure the patient of this type of cancer?

A It often does, yes.

, M.D.

Q Jumping for now to January of .

Was there anything to suggest during Mr. 's last hospital admission to that there was any recurrence of the type of bladder cancer that he was treated for back in October?

A No.

Q Let me return for a moment to the

endoscopy that we talked a little bit about.

Did any of the GI physicians who were taking care of Mr. suggest to you why they were requesting an endoscopy?

A I requested it.

Q Why did you request an endoscopy?

A To investigate the patient's hiccups and why he was having trouble swallowing and eating.

Q Had you formed any opinion prior to the endoscopy as to what was going on with him, as to what was causing those particular complaints?

A No.

Q In preparation for the endoscopy

, M.D.

you had mentioned to me the Coumadin was to be withheld, correct?

A Correct.

Q Once you take a patient off the anticoagulation therapy such as Coumadin does the patient become or is the patient at risk for a pulmonary embolism?

MR. : I object to form. I think that's a little broad.

Q Once a patient is taken off of Coumadin therapy is there a period of time by which the Coumadin still will have some effectiveness?

A Yes.

Q What is that period of time?

A At least four to five days.

Q After that period of time what happens to the patient in terms of the risk to him or her about having a pulmonary embolism, assuming that he or she does not get any additional anticoagulation medicine?

MR. : I object to the form.

You can answer, if you can.

A I don't know.

, M.D.

Q Does the patient's risk for a pulmonary embolism increase if the patient is not re-started on any other type of similar anticoagulation therapy?

MR. : You mean in this case, in this patient?

MR. OGINSKI: Generally.

MR. : Then you're taking into account millions of different patients with millions of different circumstances. I don't know that he can answer that.

MR. OGINSKI: Let me rephrase the question.

MR. : It's a lot easier if you talk about this patient.

Q Once Mr. 's Coumadin was stopped, assuming only for the purposes of this question that he did not receive any anticoagulation medicine after four or five days, would he then be at higher risk for developing pulmonary embolism?

A Not likely in four or five days.

Q After that period of time. In other words, after those four or five days have completed and you're on day six, seven and eight and so on. In that instance.

A I can't answer that.

Q By the way, are you aware that this patient's endoscopy took place on a Tuesday, on January 22nd?

A Yes.

Q And Mr. 's Coumadin was withheld as of Friday, the weekend before? Are you aware of that?

A Yes.

Q And on Saturday and on Sunday, the days preceding the endoscopy, he did not receive any Coumadin during those days, correct?

A Yes.

Q Did Mr. receive any fragmen, the low molecular weight heparin, on Saturday or Sunday?

A No.

Q Who made the decision as to when Mr. would receive fragmen?

MR. : At what point in time?

, M.D.

Q From the time that the Coumadin

is stopped as of Friday the weekend before his procedure, at that point do you know who made a decision as to whether or not he would be receiving fragmen over the weekend on Saturday and Sunday?

A No.

Q Did you have any input into determining when this patient should receive fragmen?

A Yes.

Q What was your opinion and what was your input at that time?

A Well, it was appropriate to withhold the Coumadin in preparation for his endoscopy. We then had to determine when to start the low molecular weight heparin pending the timing of the endoscopy. The endoscopy was scheduled for Monday morning. It was cancelled because of emergency. The patient was then covered with low molecular weight heparin in preparation for the

24 endoscopy rescheduled Tuesday morning. The
25 decision when to do that juggled the timing

1 , M.D.
2 of the endoscopy and was made by myself and
3 a fellow.
4 Q Which fellow was that?
5 A Dr. .
6 Q What service was he on back in
7 ?
8 A Urology.
9 Q You had mentioned that the
10 endoscopy did not go for on Monday
11 because of an emergency.
12 That was an emergency related to
13 other patients, correct?
14 A That was a decision of the
15 Gastroenterology service.
16 Q It had nothing to do with Mr.

's condition as to why he did not have the procedure on Monday; is that correct?

A That's right.

Q As far as you know, on Monday when he received the fragmen that was a subcutaneous injection?

A Yes.

Q That was 5,000 units?

, M.D.

A Yes.

Q If you had learned that the GI physicians did not plan on obtaining any biopsies during the procedure, would it still have been your opinion to replace the Coumadin with the fragmen?

A Yes.

Q By the end of the weekend, by the end of Sunday night had the Coumadin's effect worn off?

A No.

Q Did Mr. 's risk for developing a pulmonary embolism increase by the end of the weekend as a result of his not being on any type of anticoagulation therapy as of Sunday night?

A No.

Q Do you have an opinion as to whether Mr. should have received any fragmen over the weekend, on Saturday or Sunday?

MR. : I object to the form.

You can answer.

MR. OGINSKI: I'll withdraw the

, M.D.

question.

Q Would it have been appropriate for Mr. to receive some type of fragmen over the weekend prior to his anticipated endoscopy?

A Not necessarily, no.

Q When you say "not necessarily", can you be any more specific?

A No.

Q Was the one dose of fragmen that was given to this patient on Monday, the 5,000 units of the fragmen, sufficient to anticoagulate?

A Yes.

Q How do you know that?

A Well, he had been on Coumadin for a number of months previous to his admission and the Coumadin was withdrawn only for a few days. So to supplement that with a standard dose of fragmen at that point, it seems reasonable that he would maintain his

23 anticoagulation.

24 Q When changing anticoagulation

25 therapies on a patient and withholding it

1 , M.D.

2 and then re-starting a substitute therapy,

3 is it often times appropriate to obtain

4 patient's PT and PTT levels?

5 A Yes.

6 Q What information do those

7 particular tests tell you?

8 A In a patient on Coumadin, uh,

9 they tell you the level of anticoagulation.

10 Q As far as you know, were those

11 levels obtained at some point after the

12 Coumadin was stopped but before the fragmen

13 was administered?

14 A Yes.

Q Were those levels normal?

A No.

Q What were the results of those levels?

MR. : You can look at the chart if you want.

Counsel, you have no problem with him looking at the chart?

MR. OGINSKI: Not at all.

Off the record.

(Discussion was held off the

, M.D.

record.)

A You're talking about the 18th and 19th?

Q Yes.

A Maybe it's the 19th and 20th.

MR. : I think it's on this

one actually (indicating).

Q Saturday and Sunday, the 19th and the 20th.

A On 1/19 the INR was 1.88 and on 1/20 the INR was 1.60.

Q What did those results signify to you, Doctor?

A They were above normal.

Q What do you do to address those particular results?

MR. : I object to the form of the question. That was the intent of the results.

Q Were additional PT/PTT tests obtained on Monday the 21st?

A Yes.

Q What were the results of that?

A 1.47.

, M.D.

MR. : He is talking about PT/PTT. You're talking about INR.

MR. OGINSKI: I'll go through it again.

Q The INR on January 21 was 1.47, correct?

A Yes.

Q What does INR tell you?

A The INR is the ratio of the PT and the standard in the laboratory and that's the value we use to monitor anticoagulation.

Q The 1.47 value on January 21, that was within normal limits?

A No. That's elevated.

Q Was that the result that you intended?

A That's acceptable, yes.

Q Was another INR obtained on January 22nd before the endoscopy was

22 performed?

23 A I don't recall.

24 Q Is there another INR result noted

25 for January 22nd?

1 , M.D.

2 A Yes.

3 Q What time is listed under the

4 result?

5 MR. : Is there a time?

6 Q Is that the 1710, Doctor?

7 A 1710.

8 Q That would represent 5:10 p.m.?

9 A Yes.

10 Q That would be after the endoscopy

11 had been performed, correct?

12 A Yes, but he's receiving fragmen.

13 Q Are you aware that Mr.

did not receive another dose of fragmen on Tuesday, which was January 22nd, prior to his undergoing the endoscopy?

MR. : Let's just make it clear. Are you asking him how many doses he received on Tuesday?

MR. OGINSKI: No. I'll rephrase the question.

Q You've already indicated that on Monday the 21st of January he received one dose of fragmen, correct?

A Yes.

, M.D.

Q Did Mr. receive another dose of fragmen on Tuesday, January 22nd before his endoscopy?

A No.

Q Would it have been acceptable for Mr. to have received another dose of fragmen on Tuesday, January 22nd prior to his endoscopy?

MR. : I object to form.

You can answer.

A I don't know that.

Q Would there have been any reason not to administer another dose of fragmen to Mr. prior to his endoscopy on Tuesday, January 22nd?

A I don't know that.

Q Are there certain patients who are or have certain risk factors for developing pulmonary embolism?

A Yes.

Q Does a patient's age affect whether or not they may be at risk for a pulmonary embolism?

A I am unaware of that.

, M.D.

Q Does a patient's past medical or surgical history have any affect on their risk factor for developing a pulmonary embolism?

A I don't believe so.

Q If a patient is immobile for a period of time, does that increase their risk factor for developing a pulmonary embolism?

A Yes.

Q Why?

A Immobility applies sluggish circulation and that can precipitate clots, venous clots.

Q If a patient has a history of a DVT, would that place them at an increased risk for developing a pulmonary embolism?

A I'm not sure of that.

Q Did you learn from Dr.
that during the endoscopy procedure there
were no biopsies obtained?
A I'm not sure if I learned from
him or subsequently, but I realized no
biopsies were done.

, M.D.
Q Is there anything associated with
the endobronchial brushings that were done
during the endoscopy that would cause
bleeding?
A I am not a gastroenterologist,
but --
Q Just to your knowledge, Doctor.
A No.
Q Since no biopsies were done
during the endoscopy on January 22nd is

there any reason that you are aware of medically as to why this patient could not get an additional dose of fragmen on the morning of January 22nd before his endoscopy?

MR. : Objection. You're now going back and saying why didn't they give him a dose. They didn't know that a biopsy wasn't going to be done. So that's not a fair question.

MR. OGINSKI: I'll rephrase the question.

Q You had mentioned earlier that you and the fellow were deciding when to

, M.D.

give this patient fragmen based on when he would have the endoscopy, correct?

A Yes.

Q And that he was originally scheduled for the procedure on Monday and he did receive a dose on Monday, correct?

A Yes.

Q Knowing that his procedure was pushed off until Tuesday, was there any discussion that you had with any physician as to whether the patient should receive another dose of fragmen on Tuesday before his endoscopy?

A Not that I recall.

Q Did you learn from any source, a review of the records or any doctor, that during the endoscopy procedure the patient's blood pressure dropped to the end of his procedure?

A I don't believe it did.

Q Were there any discussions that you learned of or participated in with any of the physicians that performed the endoscopy that Mr. might have had

, M.D.

a pulmonary embolism at the conclusion of his endoscopy?

A No.

Q Did you learn that Mr. had passed out on January 22nd at about five p.m., about five hours after his endoscopy procedure?

A Yes.

Q How did you learn that?

A I believe I became aware of it the following day.

Q Do you know who or do you recall who informed you of that information?

A I don't know.

Q During the hours when you are not physically within the hospital are there

18 various fellows or residents that are on
19 your service who will care for your patients
20 in the evening hours and the early morning
21 hours?
22 A Yes.
23 Q You were an attending in urology;
24 am I correct?
25 A Yes.

1 , M.D.
2 Q And you still are?
3 A Yes.
4 Q Were there urology residents who
5 rotated through your service?
6 A Yes.
7 Q Were there also fellows who were
8 training, doing additional training, in the
9 field of urology that also rotated through
10 your field of service?

A Yes.

Q Were there occasions back in the year where the resident or fellow who was caring for a patient would from time to time call you after you had left the hospital to advise you about what was going on with one or more of your patients?

A Yes.

Q Did you ever receive a call from any doctor at the hospital about Mr. 's diagnosis of a pulmonary embolism on CT scan on January 22nd?

A I don't recall.

Q Did you have a custom and practice back in January of whereby if

, M.D.

a doctor, whether it be a resident, a fellow

or an attending, called you when you were out of the hospital, whether you were at home or elsewhere, that you make notes of conversations about a particular patient and then at some later time put that information into the patient's chart?

A No.

Q Is there anything in your review of this patient's medical records to indicate whether or not you were called on January 22nd in the evening to let you know about the patient's condition in the evening hours?

A No.

Q The following day, January 23rd, when you learned that Mr. had passed out at about five p.m. the day before, what other information were you provided at that time about this patient's condition?

A The events and results of the CT scan.

25 Q Can you tell me more specifically

1 , M.D.

2 what it was?

3 A I don't recall the exact details.

4 Q Did you have any conversation

5 with Mr. 's daughter on January

6 23rd at whatever time it was that you

7 learned of the events of the day before?

8 A I don't recall.

9 Q Did you learn that it was Mr.

10 's daughter who was on the

11 phone with him at about five p.m. when he

12 was no longer responsive and that she had

13 hung up and then contacted the nurse's

14 station to alert them to a problem?

15 A Yes.

16 Q If a patient experiences an acute

pulmonary embolism, are there instances where the effects of that pulmonary embolism will not appear for a period of time?

A I am not aware of that.

Q The shortness of breath that you mentioned initially when we started as being a sign of pulmonary embolism, does that appear immediately with an acute pulmonary embolism?

, M.D.

A Usually, yes.

Q Are there occasions when it will take a period of time, minutes, hours, or some other period, where you would expect to see or you would see shortness of breath?

A I am not sure how to answer that question.

Q I would like you to turn, please,

to the note for January 22nd, I think it's a nurse's note, timed at approximately five p.m.

Doctor, can you read that note, please? I understand it's not your note, but if you can read it as best you can, that would be helpful.

MR. : If there is anything you can't read, just say can't read or illegible.

A "1/22/ five p.m. Called to room by patient's daughter. Patient passed out in bed. Found patient clammy. BP 98/60. HR 173. 02 Sat 83-percent."

Q Let me stop you for a moment, Doctor.

, M.D.

What is the medical significance of an oxygen saturation of 83-percent, if any?

A He is getting less than sufficient.

Illegible. "Temperature 36. Patient complaining of SOB", shortness of breath, "O2 3-4 liters applied."

Q Does that indicate whether it was nasal cannula or face mask or some other method?

A No.

Q Go ahead, please.

A " , PA in to see patient. EKG done. Bloods drawn. Patient to go for CT scan."

Q In your review of this patient's records is there any note by this PA about what this person observed and did?

A No.

Q Were there PAs that were

affiliated with the Urology service in January of ?

, M.D.

A Yes.

Q Was this one of the PA's on the Urology service?

A Yes.

Q Was it customary that when a medical provider saw a particular patient, made observations and rendered treatment, that they make notes in the patient's chart about what they did and what they saw?

A No.

Q Can you explain to me why that was?

Let me ask it this way. Was there a hospital policy that you were aware

of that any time a health care provider, whether it be a nurse, a physician, resident, fellow, attending, PA, any time they saw and examined a patient, that they make a note of their findings and observations in the patient's chart?

A I am unaware of that.

Q Was there any commonly accepted practice that if a health care provider saw and treated a patient, that they make an

, M.D.

entry in the patient's chart for the benefit of the entire medical team that was caring for the patient?

A Not in each case, no.

Q Is there any reason that you know of now why this particular PA did not make an entry in this particular chart about what

she did or observed at that time?

A No.

Q Have you spoken with this physician's assistant about what she did on January 22, in relation to this patient?

A No.

Q Is there any note from any physician between the five p.m. nurse's note on January 22nd and until the CAT scan was done at around seven or 7:30 p.m.?

A No.

Q If a physician had come in to examine the patient and did in fact examine the patient, would you expect to see a note in the chart by that particular physician?

A I may or may not.

, M.D.

Q Under what circumstances would you not expect to see a note by a physician who examined a patient?

A It would depend on the circumstances.

Q Were there any unusual circumstances that you learned of or were aware of on January 22, that would have prevented any of the health care providers from making any entries in this patient's chart, assuming they saw and examined him?

A No.

Q Can you make an assumption as you sit here now that since there is no physician's note between five p.m. and eight p.m. for January 22nd that no physician examined this patient during that time frame?

A No.

Q Is there anything within this entire hospital record which would suggest

to you that any physician, whether it be a resident, a fellow or an attending, saw and examined Mr. between five p.m. and

, M.D.

eight p.m. on January 22nd?

MR. : Solely within the chart you mean?

MR. OGINSKI: Solely within the chart.

A No.

Q Have you had any discussions with any doctors who cared for Mr. that they saw and examined Mr. between five p.m. and eight p.m. on January 22nd?

A Rephrase that, please.

Q We know that Mr. was noted to have passed out, according to his

daughter, at around five p.m. and we know that the nurse came in to evaluate him at that time according to this note.

Let me rephrase the question.

This five p.m. note, was that a nurse's note?

A Yes.

Q Based upon this note we know that a physician's assistant, , saw the patient.

Do we know what time based upon

, M.D.

this note?

A Well, somewhere around five p.m. or shortly thereafter.

Q Is there anything in the record to suggest that any doctor saw this patient between five p.m., when this condition was

observed, until the CAT scan was reported and the results were reported at approximately eight p.m.?

A Not in the record, no.

Q Is there any information that you have about any doctor who saw and examined Mr. at any time between five p.m. and eight p.m. on January 22nd?

A Well, I believe Dr. saw the patient.

Q What information do you base that upon?

A He was, I believe, notified of this event and generally would make rounds in the evening and see the patients.

Q What do you base that conclusion on, Doctor, that he saw the patient?

A He told me.

, M.D.

Q When did he give you that information?

A I believe that was the following day.

Q Dr. is the Urology fellow?

A Yes.

Q Are you familiar with a Dr. ?

A No.

Q What is Dr. 's first name?

A .

Q Can you spell that?

MR. : It's on the Stipulation.

Q Where does Dr. work currently, if you know?

A Hospital.

Q What is his position there currently?

A It is a fellow in Urology.

Q Is the fellowship a two year

program or three?

A Three.

Q Do you know what year he is in now?

, M.D.

A His second.

Q When did he normally make rounds?

A They would make rounds early in the morning and at some point in the afternoon or early evening.

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

A The fellows.

Q Was there more than one Urology fellow at any given time?

MR. : On his service?

Q On your service.

MR. : Covering his patients?

That's a very broad question.

Q When Dr. spoke to you the following day on January 23rd, did he tell you who accompanied him to Mr. 's room?

A I don't recall that.

Q What specifically did Dr. tell you?

A I don't recall that.

Q Did Dr. tell you that he had examined the patient at some point in

, M.D.

the evening January 22nd?

A At some point I was made aware of that, yes.

Q At any point after that

conversation did you ever look in the chart to see what Dr. 's findings were with regard to any examination that he may have performed the evening before on January 22nd?

A I don't recall.

Q Is there anything in this hospital chart to indicate that Dr. made a note or an entry in this patient's chart for any examination he may have done on January 22nd in the early evening?

A Not in the record, no.

Q Have you spoken with Dr. since this patient died on January 23rd up until today about any examination he may have performed on January 22nd?

A No.

Q When the fellow would make rounds in the morning, would you usually accompany him?

, M.D.

A On some occasions, yes.

Q On those occasions when you would accompany the fellow would there also be a resident that would be with you, as well, in the morning?

A There may or may not be.

Q If you saw and examined a patient together with a fellow in the morning rounds, did you have a custom and practice as to whether you would make a note in the chart about your findings and your examination?

A No.

Q Would you expect a resident to make a note in the chart about the examination and the findings?

A Yes.

Q If the fellow did not make an

entry in the patient's chart after you and he examined the patient together, would you inquire of that particular fellow as to why they didn't make an entry in the chart about that particular examination?

A No.

, M.D.

Q Is there a particular reason that you're aware of as to why physicians make notes in the patient's chart when they see and examine the patient?

MR. : I object to the form.

You can answer.

In a general way?

MR. OGINSKI: In a general way.

MR. : Under any possible circumstance?

MR. OGINSKI: Yes.

A Why we make notes?

Q Yes.

A Well, it's a general recording of what happens at that particular time regarding the events of a patient.

Q In the event that other health care members who are caring for a patient need information about what was done for the patient hours before or days before and they cannot contact the physician who is caring for the patient, does the hospital record provide that information so that the next health care provider can look at it and see

, M.D.

what was done for the patient at any given time?

MR. : I object to the form.

You can answer.

A Well, in general, yes.

Q Did Dr. tell you on January 23rd what his findings were about any examination he may have done on Mr. on January 22nd?

A I don't recall specifics.

Q Did Dr. tell you what time he saw Mr. ?

A No, not that I recall.

Q Did he tell you why he went to see Mr. ? Whether it was routine or for a specific reason or anything else?

A He told me what happened.

Q What was it specifically that he told you?

A We reviewed this event.

Q The event, you're referring to the five p.m. note --

A Yes.

Q -- or the episode where he passed

, M.D.

out?

A Yes. The subsequent CT scan, the results of the CT scan and then we were just gonna talk about what to do.

Q What did he tell you were the results of the CT scan?

A Well, I went and looked at the CT scan.

Q Before we get to your actual observation, what did Dr. tell you the CT scan showed? Was that a bilateral pulmonary embolism?

A Yes.

Q Did he categorize the size of that bilateral pulmonary embolism?

A I don't know.

Q Did Dr. tell you he had

reviewed the films with a radiologist?

A I don't remember that.

Q Did Dr. tell you what

treatment was renderede patient upon

the results of the CAT scan coming back

showing that there was a pulmonary embolism?

A Yes.

, M.D.

Q What did he tell you was done at

the time that the CAT scan confirmed the PE?

A He was given fragmen.

Q Did he order the fragmen?

A I believe so, yes.

Q What method was the fragmen

administered?

A Subcutaneously.

Q Did you ask Dr. whether or

why the patient did not receive IV heparin

to treat the PE?

A I don't recall that.

Q Did you ask Dr. whether the patient was given oxygen once the PE was confirmed by CAT scan?

A I don't recall asking him, but it was.

Q The record indicates that he was given oxygen by nasal cannula, correct?

A Yes.

Q That was two liters per minute?

A Yes.

Q Did you ask Dr. why or how it was that only two liters per minute nasal

, M.D.

cannula was administered as opposed to any other route of administration of oxygen?

A I don't remember that.

Q Did you ask Dr. whether he made a note after seeing this patient in the early evening of January 22nd?

A I don't recall.

Q Did you learn from Dr. whether any other doctor saw Mr. at any time from five p.m. on January 22nd until the CAT scan results came back at approximately eight p.m.?

A I don't remember.

Q Is there anything within the hospital record to indicate that any physician saw this patient from eight p.m. on January 22nd until the early morning hours of the next day, January 23rd, before six o'clock in the morning?

A Not in the records.

Q Do you have any knowledge, independent knowledge, as to whether any doctor did in fact see this patient at any time between eight p.m. on January 22nd and

, M.D.

six a.m. on January 23rd?

A I can't recall specifically.

Q Does the record indicate what time the fragmen was administered to the patient on January 22nd?

A Well, at some time between --

MR. : Look at the actual administration record.

Q Doctor, I am going to withdraw the question.

I am going to ask you to look at the physicians order sheet from January 21 through January 23rd (handing).

On January 21st do you see that there is a verbal order by Dr. to an , nurse, for fragmen 5,000 units

subcutaneously, one dose?

A Yes.

Q That's timed at nine a.m. on January 21st, correct?

A Yes.

Q If I remember correctly, you indicated that was the Monday in anticipation of the endoscopy?

, M.D.

A Yes. No. This is Monday.

Q January 21st.

A Endoscopy was cancelled. Therefore, the fragmen was started.

Q Okay. By nine a.m. you already knew that the endoscopy was not going for?

A I believe so, yes.

Q In the middle of the page there is a note to the bottom, an order, saying "withhold fragmen tonight and in a.m."; is that correct?

A Yes.

Q Can you tell who wrote that order?

A I don't know for sure.

Q Regardless, there appears to be some note or some signature timed at three a.m. on January 22nd.

Would this appear to be a nurse's note that's co-signing the order?

MR. : Don't guess. If you know.

A I don't know that, to be honest

, M.D. with you.

Q Okay. Can you turn the page, please?

Looking at January 22, physicians order sheet, there is an order number three in the middle of the page which says "fragmen 5,000 units subcutaneous, one dose"; is that correct?

A Yes.

Q Can you tell as to when that medication was carried out or ordered?

MR. : When was it administered?

MR. OGINSKI: Yes.

MR. : Turn to the other records. Not the orders sheet, but the actual administration records. I know it appears on two pages. Do you have it in front of you?

I can go get my annotated copy and find it on my copy.

MR. OGINSKI: Let's do that.

(A brief recess was taken.)

Q Doctor, your attorney has

, M.D.

provided you with various documents from the chart regarding the medication dose.

What is the name of that sheet that you're looking at, if it has a name?

A This is the medication administration record.

Q Is there a note on there that indicates what time the patient received fragmen on January 22nd?

A Yes, but I can't read it.

Q Doctor, let's go back for a moment to the physicians order sheet.

The order on January 22nd, number two, prescribes Diflucan.

Am I correct that that was

ordered for the candida infection in the esophagus?

MR. : If you know.

A Yes.

Q And also, the note presumably as to when this order was carried out, there is a signature and a time there of three p.m., correct?

A "3 P".

, M.D.

Q Can we assume that this order was written after the endoscopy done on January 22nd?

MR. : Do you know? I don't know if you can assume anything.

Q Was Diflucan ordered before the endoscopy?

A I don't know.

Q Can you tell from this physicians order sheet on January 22nd whether this order was written after the endoscopy?

A I don't know exactly.

Q Looking at another page of the physicians order sheet dated January 23, , there is an order for fragmen 5,000 units.

Is that twice a day?

A Bid. Yes.

Q Can you tell from this note as to when this order was carried out?

A No.

Q Does this signature that appears next to the note indicate a counter signature by a nurse that the order was then

, M.D.

addressed?

A This is when the order was taken off. It doesn't mean when it was given.

Q When you say "taken off", what do you mean?

A Order recorded.

Q At some point after that you would expect the medication to be administered, correct?

A Yes.

Q The time listed here is what?

A Ten something a.m. when this was noted.

Q Is there anything in the record that you mentioned earlier as to whether Mr. received fragmen on January 23rd prior to his death?

MR. : Can I hear the question back?

(The requested portion was read back by this reporter.)

23 A Well, it's listed.

24 Q Does that listing in the

25 administration record tell you what time you

1 , M.D.

2 received the fragmen?

3 A I'm not sure.

4 Q How many times did he receive

5 fragmen on January 23rd?

6 A I'm not sure. I believe once.

7 Q How much weight had Mr.

8 lost from October until January ,

9 approximately?

10 A Forty, fifty pounds.

11 Q When Mr. was in the

12 hospital during the last admission January

13 16th to the 23rd, was he bedridden during

14 that admission?

15 A No.

Q Did he have bathroom privileges?

A Yes.

Q Was he able to walk the hall or walk as needed?

A Yes.

Q Was he receiving an IV?

A I believe so, yes.

Q Do you recall any discussions that you had with on January 22nd before the endoscopy procedure?

, M.D.

A No, not on the 22nd.

Q Did you have any discussions with him the day before on January 21st?

A No.

Q Did you have any conversations with him over the weekend on the 20th or the

19th of January?

A No.

Q Did you have any conversations with him on the 18th, the Friday?

A Yes.

Q Tell me what it was you said to him and what he said to you.

A I don't recall specifically.

Q In substance what was it that you said to him and what did he say to you?

A Can I refer to my note?

Q Sure.

MR. : You can always refer to the notes.

A This is on the 18th?

Q Yes.

A It's Friday afternoon. I just reviewed the clinical course.

, M.D.

Q Doctor, can you read your note in its entirety and if there are abbreviations, just tell me what they represent.

A "As above".

Q Starting with the date and time, if there is one.

A "1/18/ . As above." Referring to events previously. "Condition stable. Workup continues with support of care. Discussed plans with patient."

Q Is that your signature that appears after that?

A It is.

Q Do you have any other notes for that day?

A No.

Q Did you examine Mr. on that day?

A Yes.

Q What were your findings?

22 A I don't recall, except that he
23 was stable.
24 Q What type of examination did you
25 conduct on that day?

1 , M.D.
2 A I would generally examine his
3 abdomen.
4 Q I am sorry, let me ask it a
5 different way.
6 Do you have a specific memory as
7 you sit here now as to the precise
8 examination that you conducted of him on
9 January 18th?
10 A No.
11 Q Continue with your explanation as
12 to what you would do.
13 A What I did?
14 Q You mentioned you would have

examined his abdomen.

Anything else?

A Well, he still had tubes in

place. We would have examined that, his

abdomen, his general condition.

Q Did Mr. make any

complaints to you on the 18th?

A No.

Q If he had made any complaints,

would you have recorded them?

A I may or may not.

, M.D.

Q Is there any way for you to know

if he made any complaints if it's not

recorded in your note of January 18th?

A Not specifically.

Q Did any resident or fellow

accompany you on the 18th during your examination?

A I don't recall.

Q If a resident or a fellow had been present with you, would you have expected them to make their own note of the examination and the findings?

A No.

Q Is there a note by anyone on the Urology service for the 19th of January, Saturday?

A Yes.

Q Who saw him on that Saturday?

A I believe it was Dr. .

Q Did Dr. examine Mr. on the 19th?

A Yes.

Q What were his findings according to the note that appears in the chart?

, M.D.

A Well, his abdomen was benign. There was no tenderness of his ankles.

Q Are there any complaints noted in this note?

A No. It seems the patient is doing better.

Q The hiccups had resolved as the of the 19th?

A That's what it says.

Q And his appetite had improved?

A Yes.

Q He was afebrile?

A Yes.

Q And the plan was what? Is that "Renal service recommendations"?

A Yes.

Q Do you know what that refers to?

A I think just continued support of care, hydration.

Q Did anyone from the Urology service see Mr. on the 20th, Sunday?

A Yes.

Q Who saw him on Sunday?

, M.D.

A Dr. .

Q Who is Dr. ?

A She's a resident.

Q Do you know what year?

A I don't recall.

Q A urology resident?

A Yes.

Q Is she still at the hospital?

A No.

Q She completed her training?

A No.

Q Do you know where she is working now?

A Yes.

Q Where?

A Hospital.

Q Do you know why she left ?

A She completed her rotation.

Q Can you read Dr. 's note, please? To the bottom half of her note where it says "patient".

A "Patient without complaints. Continues to hiccup, but improved.

, M.D.

Persistent low grade temperature. Continue present management. Chest x-ray today."

Q Did you have any conversations with either Dr. or Dr.

over that weekend about this patient?

A I don't remember that.

Q Did you have conversations with any physician at about Mr. 's care during the weekend of January 19th and 20th?

A I don't recall.

Q Can you turn, please, to the January 20th/21st note?

Tos the bottom half of the page is that Dr. 's note?

A Yes.

Q He's on the GU service?

A Yes.

Q Besides the patient's vital signs and -- what does the U/O represent? Is that urinary output?

A Yes.

Q Underneath that is written "abdomen" -- is that "soft"?

, M.D.

A Yes.

Q Does that indicate to you that he did some sort of examination?

A Yes.

Q What was his plan?

A "Upper GI series", but that refers to a gastroscopy, and then "continue regular diet".

Q Is Dr. 's note dated or timed?

A I don't see that.

Q Was there any rule that you knew of at the hospital that required notes to be dated and timed?

A No.

Q Was it good medical practice to date and time your notes?

A It's generally done.

Q Did anyone from the Urology service see the patient on January 21st?

A Well, I believe that Dr. 's note refers to the 21st.

Q What makes you believe that?

A Because he assumed the service.

, M.D.

Q He what?

A He assumed my service Monday morning.

Q Is there anything other than that assumption to indicate that someone else from the service saw them that day?

A Not from the record, no.

Q Let me ask you to take a look at the January 21st note timed at 7:45 by the GI physician.

Do you recognize the signature that appears after this first note?

A No.

Q I am going to read the first two lines, which says "stable through weekend. Hiccups ceased with baclofen. Improved oral intake. Did not receive low molecular weight heparin over weekend."

Did I read that correctly?

A Yes.

Q Did you have any conversations with this GI physician as to why or whether this patient should have received low molecular weight heparin over the weekend?

, M.D.

A No.

Q Underneath the "plans" in the same note it says "for EGD today depending

upon add-on case load" and then following "EGD" with an arrow "re-start anticoagulation".

Do you see that?

A Yes.

Q What was the reason for re-starting --

A That was the plan all along, to maintain him on some sort of anticoagulation medicine.

Q Was there any plan for or preference for re-starting him on the Coumadin after the endoscopy surgery?

A No.

Q Why was he going to be continued or re-started on the low molecular weight heparin as opposed to any other type of therapy?

A Well, surrounding the endoscopy he would be on the low molecular weight heparin, but would be re-started on the

, M.D.

Coumadin after he were discharged.

Q Turn, please, to the January 22nd procedure note.

The attending during the endoscopy was Dr. , correct?

A Yes.

Q And his assistant was Dr. ?

A I believe so, yes.

Q According to the note?

A Yes.

Q To the bottom of the page, the fourth line from the bottom, it says "re-start anticoagulation. Watch warfarin.".

Did I read that right?

A Yes.

Q What is warfarin?

A Coumadin.

Q Do you know why warfarin was going to be started as opposed to the low molecular weight heparin?

MR. : I object to the form of the question.

Q What does this note mean to you,

, M.D.

Doctor, the sentence that I just read to you?

A I don't know.

Q Did you have any conversations with Dr. or Dr. after the endoscopy was done as to what type of anticoagulation therapy the patient should receive?

A No.

Q Did you see the patient on January 22nd?

A Yes, at some point.

Q Do you have a note that reflects any examination you made on that date?

A I don't believe so, no.

Q What is it that you recall that suggests to you that you saw the patient on January 22nd?

A Only that I was in town and it was a Tuesday.

Q Did you examine the patient on the 22nd?

A I am sure I did.

Q Is there anything contained

, M.D.

within the records to reveal what your

examination consisted of and what your findings were?

A I didn't write a note.

Q Is there any resident or fellow note about any examination or findings for January 22nd?

A Again, I believe this note from Dr. is on the 22nd and there is a note on the 22nd by Dr. . I'm sorry, I got the dates mixed up. The 22nd is a Tuesday.

Q Where do you see Dr. 's note?

A On 1/22/ 6:40 a.m.

MR. : It's this (indicating).

Q Is there any note by any Urology physician who saw the patient after the endoscopy was done but before five p.m.?

A Yes.

Q Who was that?

A It says "GU". I don't exactly

25 know who wrote it.

1 , M.D.

2 Q Is there a signature that appears

3 next to that particular note?

4 A There is an abbreviated

5 signature.

6 Q Do you recognize that abbreviated

7 signature?

8 A It looks like Dr. , but I'm

9 not exactly sure.

10 Q There is a number that appears

11 next to that, correct?

12 A Yes.

13 Q Are you familiar with that

14 particular number?

15 A It looks like a beeper number.

16 Q Were each of the fellows or

17 residents supplied with a number that they
18 can be contacted by?
19 A Yes, but it varied.
20 Q What time was this note written
21 on January 22nd by the GU physician?
22 A Uh, I don't know.
23 Q After reading the note does it
24 suggest to you that it was written at some
25 point after the endoscopy had been

1 , M.D.
2 performed?
3 A Yes.
4 Q Is there anything in that note to
5 indicate that that physician performed a
6 physical examination of Mr. after
7 the endoscopy?
8 A It's not mentioned here.
9 Q The note refers only to a

conversation with Infectious Disease, correct?

A That's correct.

Q When you learned on January 23rd that Mr. had suffered a bilateral pulmonary embolism, did you ask any of the physicians caring for him why he was not taken to the Intensive Care Unit?

A I don't recall that.

Q Is it good medical practice to put a patient into the ICU when they are suspected or confirmed as having a bilateral pulmonary embolism?

A Not in every case, no.

Q In this patient's case would it have been preferable to have him in the ICU

once the diagnosis of a bilateral PE was made?

A No.

Q Why?

A He was stable. He was monitored. He was anticoagulated. He was given the proper care for what he had at the time.

Q Do you have an opinion as to whether the failure to take him to ICU once the diagnosis of a PE was made represented a departure from good medical care?

MR. : Objection to form.

You can answer it.

A Do I have an opinion? Yes.

Q What was that opinion?

A That it did not represent a departure from good medical care.

Q You had mentioned earlier when we first started the deposition that once a diagnosis of a pulmonary embolism was made the preferred method of administration of

23 anticoagulation would be IV heparin,
24 correct?
25 A No. That's not what I said.

1 , M.D.
2 Q When I had asked you earlier how
3 you treat a pulmonary embolism, you advised
4 me or I recall you mentioning that you would
5 administer heparin by intravenous and
6 another method would be subcutaneous for
7 prophylaxis; is that correct?
8 A No.
9 Q How do you treat a pulmonary
10 embolism, Doctor?
11 MR. : Asked and answered.
12 He gave a prior answer. You're
13 disagreeing with what he said before.
14 MR. OGINSKI: No. My notes
15 indicate that those were the answers

to that question. Since that's not what the doctor indicated, I would like to know what the proper treatment is for pulmonary embolism.

Q In terms of anticoagulation therapy.

MR. : I object to form.

You can answer.

A There are two alternatives. One is IV heparin. The other is low molecular

, M.D.

weight heparin.

Q How is low molecular weight heparin given?

MR. : We've been through this. Asked and answered. The whole beginning of your exam was about this

topic. We're not going to go over it all again.

Q Is there any way for you to ascertain from the administration sheet of medications as to what time or approximately what time this patient was given fragmen on January 22nd?

MR. : Didn't we go through this?

MR. OGINSKI: I had asked him specifically what time is indicated that he received it. I am asking him now, since he couldn't tell or read that time, whether he can ascertain or estimate from the notes that are above and below the fragmen note as to when this patient received the medication.

MR. : Can you infer it by

, M.D.

anything else in the chart?

A I can't read the exact time.

Q Is there any other source that you could go to that would tell you precisely when this patient received fragmen on January 22nd?

A Yes, the nurse's note.

Q Do you have that nurse's note?

MR. : On the 22nd?

MR. OGINSKI: Yes.

A Yes, I have it.

Q What note are you referring to, Doctor?

A The nurse's note from seven p.m. to seven a.m. 1/22 to 1/23/ .

Q Can I see what the page looks like?

A We talked about this before (indicating).

Q What is it within this note that tells you when this patient received fragmen?

A Well, the sequence of how it's written.

, M.D.

Q Specifically what is contained within that nurse's note that tells you when this patient received fragmen?

A Well, the nurse reports "patient went for spiral CT scan and received fragmen sub q as per order.".

Q Does it tell you whether the patient received fragmen after the CT confirmed pulmonary embolism or before the CT was done?

A Not specifically, no.

Q Is there any other source that you can turn to that would give you that precise information as to when this patient received fragmen?

A You're asking me to interpret the medications sheet and I can't read it.

Q As best you can tell me, other than the medication administration sheet and the nurse's note, is there any other information in these records that would tell you when the patient received fragmen on January 22nd?

A I can't answer that.

, M.D.

Q Why can't you answer it?

A I can't infer from the records.

Q Do you know where the original recorded notes are for this particular page,

referring to the administration of medication sheet for January 22?

A No.

Q Do you personally know what happens to the original handwritten sheet?

A No.

Q Just to clarify, Doctor. Before Mr. had his endoscopy he was to receive one dose of fragmen, correct?

MR. : Which day are we talking about?

MR. OGINSKI: That's what I want to clear up.

Q On Monday, the 21st.

A The fragmen was given after the endoscopy was cancelled Monday morning.

Q Would you expect to have an administration note reflecting that the patient got fragmen at that time or that day?

, M.D.

MR. : You mean a doctor's note? What do you mean?

Q If the patient had been given fragmen on Monday, January 21st, would you expect to see a written entry in the administration record sheet?

A I don't know.

Q What is the purpose of the administration record sheet?

MR. : Give it to him and let him look at it.

MR. OGINSKI: I will be happy to, but I will follow-up at some point.

A At some point, at somewhere you would expect to see that medication had been given.

Q Is there anything in this administration record sheet to reflect that

the patient received fragmen on January 21?

A There is this sheet. There is other sheets.

MR. : That's not the only sheet.

MR. OGINSKI: I know that.

, M.D.

Q I am just asking this sheet alone.

A This isn't the whole record.

Q I am going to ask you about the others.

Is there anything on this page that you've been referring to for the last few questions to indicate that this patient received any fragmen on January 21?

A Not on this specific sheet.

Q I am going to get to any other notes in a moment about January 21.

Again, looking at the medication dosage administration sheet, on the left side that says "initials" and then there appears to be dates, these lines or notations that appear on various dates, can you assume that these are initials?

A Yes.

Q Then there is a space for the medication and the dosage; am I correct?

A Yes.

Q And then there is a column that says "HR".

, M.D.

To your knowledge, what does that represent?

A Hours.

Q Does that indicate to you the hour upon which the patient was administered various medication?

A I don't know that.

MR. : This is really a nursing document, not a physician document.

MR. OGINSKI: I know. I just want to clarify this. I am going to move from this in a moment or two.

Q The bottom of the page where it relates to fragmen dosage for January -- what is that, 22nd, Doctor?

A 23rd.

Q Under the HR heading column is the number ten written in there?

A Yes.

Q Can you infer from that whether that represents a ten o'clock administration of the medication or not? Is there any way for you to determine whether that represents

, M.D.

ten o'clock? Again, I don't want you to guess.

A I know what this means. This means to give it twice a day twelve hours apart.

Q That would be the one zero?

A Well, it's ten o'clock in the morning and ten o'clock at night.

Q Can you tell from this note whether the patient actually received any of those doses of fragmen on the 23rd?

A I don't know that.

Q Let me go --

MR. : The initial on that date (indicating).

Q Does that suggest anything to you, Doctor, that there is an initial at the

end of that row?

A Yes. We know he received one dose on that day.

Q Now let me go back a few steps and ask if there are any other notes in the chart that indicate to you that the patient received fragmen on January 21st.

, M.D.

A You're talking about the hospital record or this sheet?

Q I am going to withdraw the question.

MR. : We've been through the fact that he got three doses, one dose each day, 21, 22 and 23. What is it you're after now?

MR. OGINSKI: I want to see where

there is confirmation of the January 23rd fragmen dose, that it was administered. We know that there was an order. Is there confirmation anywhere to indicate the patient received the dose on that date?

MR. : It's about six pages further back.

A "1/21 fragmen sub q ten a.m."

Q Is there anything to confirm that the patient received fragmen on January 22nd?

A Yes.

Q What time is that noted?

A That's what I can't read.

, M.D.

MR. : We've been over this in some detail.

Q How long does it take for low molecular weight to work from the time it's injected?

MR. : I object to the form.

You can answer, if you can.

A I don't know that.

Q How long does it take for the patient to achieve optimal efficacy of the low molecular weight heparin after an injection?

A It's pretty quick.

Q Can you give me a time frame, please?

A No, because it's not monitored. It doesn't require monitoring, so we don't have a biochemical record of that.

Q When you mentioned that "it's pretty quick", can you give me some idea in terms of time, whether minutes, hours or some other time frame, that you can tell me as to when you would expect the patient to

receive the optimum results from an

, M.D.

injection, subcutaneous injection, of low molecular weight heparin?

A Not really.

Q Is there any range of time that you can tell me that you're aware of?

A Well, the doses are given once or twice a day. So it's relatively rapid and lasts for that period of time.

MR. : You're kind of out of his field of expertise here. He is not a hematologist.

Q Once the diagnosis of a bilateral pulmonary embolism was made in Mr. , was there any reason as to why he did not receive intravenous heparin at that

time?

MR. : I object to form.

You can answer.

A Well, he is receiving fragmen.

Q Am I correct that IV heparin is a quicker, faster route than subcutaneous injection?

A The patient is being anticoagulated.

, M.D.

Q To achieve optimal treatment for a patient with a diagnosed pulmonary embolism would you agree that the accepted treatment of choice would be the administration of IV heparin?

A No.

Q Is it your opinion that since the patient was already receiving a single dose

of fragmen, that that was sufficient to anticoagulate him?

MR. : He wasn't receiving a single dose. It was twice a day. That was the order.

Q On January 22nd he had received only one dose, correct?

A Correct, but the diagnosis of pulmonary embolism was not made until later on the 22nd.

Q As of now we cannot tell when this patient actually received the fragmen, whether it was after the diagnosis or before, correct?

A He is still anticoagulated.

Q As of January 22nd in the evening

, M.D.

is he still receiving the benefits of the Coumadin that had been discontinued as of Friday, January 18th?

A I am sure he is.

Q Is it your opinion that this patient did not need to have IV heparin because he was receiving some form of a low molecular weight heparin?

MR. : Objection. Asked and answered. He gave his reasons.

Q Is there any situation under which a patient with a pulmonary embolism you would recommend receiving IV heparin as opposed to fragmen?

A No.

Q From the time that the nurse came in to evaluate the patient at approximately, or at least the note is timed at five p.m., is there any other pulse oximetry taken at any time after five p.m. to tell you whether the patient is responding to oxygen therapy?

A A pulse oximeter is continuous.

Q Is there any recorded note

anywhere in the chart to tell us what the

, M.D.

patient's oxygen saturation level was at any

time after five p.m.?

A On what date?

Q January 22nd.

A Well, there is the note that the

patient is receiving three to four liters of

oxygen.

Q Again, the note doesn't reflect

whether that was by nasal cannula or face

mask.

Is there a difference, Doctor?

A I don't believe so, no.

Q Other than that note, is there

any other indication as to whether the

patient's saturation level improved as a result of that oxygen therapy?

A No, but this is adequate oxygen.

Q How do you know that?

A It's three to four liters.

Q How do you know that the patient is perfusing the oxygen that they're receiving by whatever route it's being given?

A Well, this patient passed out and

, M.D.

then quickly came to.

Q Let me rephrase the question.

Without an oxygen saturation level by pulse ox or by drawing blood, is there any way for you to know how well the patient is perfusing oxygen?

MR. : He said the pulse oximeter was continuous. There is just not a note of it. That's a big difference.

Q Without a recording of what the patient's oxygen saturation level was, is there any way for you to determine how well the patient is perfusing the oxygen?

A Yeah.

Q How well?

A I'm talking to you right now. I am perfusing very well.

Q Is there any such indication or suggestion of something similar that the patient was conversing with the nurse at some point after the oxygen was given?

A We can infer that he in fact went for his CT scan, in fact came to the floor

, M.D.

stable. He is not an extremist now, so I assume he is oxygenated. You don't have to have a note to say that.

Q Would you agree that there are different levels in which a patient can have different oxygenation levels?

A Yes.

Q Even though a patient may be able to converse with you, they still may not be saturating as well as they should be; is that fair?

A No, that's not fair.

Q Other than making the various inferences that you did, is there anything recorded in any of the notes in the chart to confirm what the patient's oxygen levels were from five p.m. until the time the CAT scan was done?

A No.

Q What time did the patient have

the CAT scan?

A I don't recall.

Q Is there anything to suggest that

there was a delay associated with obtaining

, M.D.

the CAT scan?

A I don't know that.

Q Who ordered the CAT scan?

A I believe it was the fellow.

Q Which fellow?

A Dr. .

Q Did Dr. review the films

himself?

A I don't know that.

Q You had mentioned that on January

23rd you learned of the events that had

happened before you personally looked at the

films yourself, right?

A Yes.

Q What did you interpret those films to show?

A Well, I am not a radiologist, but it appeared to be a bilateral pulmonary embolus.

Q Knowing that you're not a radiologist, from time to time are you called up to review CAT scans and interpret them?

A Yes.

, M.D.

Q If you have questions about what you see, you will speak with a radiologist, correct?

A Yes.

Q Did you speak to any radiologist

about what you observed?

A No.

Q At any time after you looked at the films did you ever learn that a radiologist confirmed those findings?

A Oh, yes.

Q Is a pulmonary embolus preventable?

MR. : Objection. That's extremely broad. I object to the form of the question.

Q Why wasn't an echocardiogram ordered for this patient at some point after five p.m. on January 22nd?

A Well, since his surgery he had suffered these chronic urinary tract infections and there was a consideration of bacterid endocarditis and in fact, echocardiograms have been done before with a

, M.D.

suspicion of valve abnormalities and there was some concern that this may have caused an arrhythmia or somehow been involved in his episode of passing out.

Q When you mention irregularity of the valve, are you referring to some type of vegetation?

A Yes.

Q Was that ever confirmed or ruled out as a result of any echocardiogram done?

A The echocardiograms were always indeterminate.

Q Was an echocardiogram performed on January 22nd or January 23rd?

A I don't believe so, no.

Q Are you familiar with something known as a Greenfield filter?

A Yes.

Q What is a Greenfield filter?

A That's a filter that's placed in the inferior vena cava to prevent migration of blood clots.

Q Was there any discussion amongst the physicians caring for Mr. as

, M.D.

to whether he should be receiving a Greenfield filter in light of the diagnosis of a bilateral pulmonary embolism?

A Yes.

Q What was the consensus, if there was one, about that topic?

A Well, we had considered that previously when he was hospitalized for his infection and the antibiotic induced renal failure and the fact that he suffered a DVT, that in the face of requiring tube drainage for his kidneys that a filter would be

placed so that we could stop the oral anticoagulation and that was not done. In a similar fashion, he is being anticoagulated, so we felt a filter offered no significant advantage over what he was receiving at the current time.

Q The anticoagulation you mentioned is the fragmen?

A Yes. He had been on Coumadin. He was hospitalized. The only reason the Coumadin was stopped, withheld, it was a temporary order, covered with fragmen. The

, M.D.

plan was then to re-start the Coumadin after the endoscopy. So the plan all along was to continue his anticoagulation upon discharge.

Q Was there any discussion after he

had been diagnosed with a pulmonary embolism of placing a Greenfield filter?

MR. : Asked and answered.

He just answered that question.

MR. OGINSKI: Not specific to the timing. We talked about admissions previous.

MR. : He answered your question.

MR. OGINSKI: I am just trying to find out whether there was any specific discussion after he had been diagnosed with the PE, whether there was any discussion about putting in a Greenfield filter at that time.

A We considered it, yes, and we elected to continue his anticoagulation.

Q Was there any discussion as to whether IV heparin should be administered rather than fragmen?

, M.D.

A No.

Q Is it your opinion, Doctor, with a reasonable degree of medical probability that once the pulmonary embolism was suspected and ultimately confirmed that the standard of care did not require IV heparin to be administered?

MR. : He's answered that a couple of times now.

MR. OGINSKI: It's a different form. I have one more follow-up question on that and then I am going to move on.

MR. : He's answered it already. You've been around this in every way conceivable.

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

MR. : He's given you all of his reasons for that in the past in some detail. You've really covered it.

Q Doctor, would you agree that IV heparin is a better and faster agent than a

, M.D.

subcutaneous fragmen injection for treating an acute pulmonary embolism?

A No.

Q Did Mr. continue to receive the oxygen therapy at three to four liters per minute from the time that that's recorded at five p.m. on January 22nd?

A I believe he did, but I can't say for sure.

Q On January 23rd was Mr. receiving oxygen therapy?

A I do not recall.

Q Is there anything in any of the notes that would suggest to you that he was receiving oxygen therapy on January 23rd?

A Yes.

Q Which note are you referring to, Doctor?

A Dr. 's note on 1/23 at 6:40 a.m.

Q Can you read that note, please?

A "Patient without complaints. Negative sign shortness of breath. Heart rate 118 over 98. Blood pressure is 115

, M.D.

over 90. Expiratory rate 20. Saturation 98-percent. Two liters." That refers to oxygen.

Q Underneath where it says "chest CT scan, pulmonary bilateral PE", underneath that, can you read that, please?

A "Patient without respiratory problems today. Fragmen started. ID and GI input."

Q Does it say "started yesterday"?

A Yes. Well, I believe so. I'm not sure.

Q Okay. Go ahead.

A "ID and GI input appreciated. Cardiology consult. Echo for pericardial, fusion. Diflucan for thrush. Duplex Doppler."

Q Do you know why a duplex Doppler was requested?

A We were still uncertain as to the source of his pulmonary embolus.

Q At any time did you determine the source of his pulmonary embolus?

A I did not.

, M.D.

Q Did you review the patient's autopsy report?

A Yes.

Q Is there anything indicated in the patient's autopsy report to indicate the source of the patient's pulmonary embolism?

A No.

Q At the time of Mr. 's death was he free of any bladder cancer?

A There was no bladder cancer found.

Q When Dr. refers to "fragmen started yesterday", is there any indication as to what time the patient received fragmen?

A It's not mentioned, no.

Q Did you have any discussion with

Dr. on January 23rd?

A I don't recall.

Q Did you have any conversation

with Mr. on January 23rd?

A I did.

Q When did you speak to him?

A I saw and examined him about

, M.D.

11:30.

Q A.m.?

A Yes.

Q Who was with you at the time of

your examination?

A Myself.

Q Was anyone with Mr. at

that time?

A He was alone.

Q Mr. , was he able to converse with you?

A Yes. He appeared fine. In fact, I remember that day very specifically, that he felt the best he'd felt in days.

Q What did your examination consist of?

A It was more of a general assessment and discussion with the patient. He appeared fine.

Q Other than his general appearance, did you conduct a physical examination of him?

A Just a cursory exam of his tubes. He appeared stable. I did not see any

significant change.

Q Did you put your hands on his

belly to assess his abdomen?

A Yes.

Q Did you listen to his chest?

A No.

Q Was he in an ICU setting at the time that you saw him on January 23rd?

A He was on the eighth floor in Hospital.

Q Which is what?

A It's a surgical floor.

Q How does that differ from an Intensive Care Unit facility?

A Well, --

Q Is there a difference between a patient being in an ICU and being on the eighth surgical floor?

A Yes.

Q What is the difference?

A Well, patients in the ICU are sicker. They're often intubated. They require active support. They're not

25 ambulatory.

1 , M.D.

2 Q How many nurses are assigned to

3 patients on the eighth floor?

4 A Per patient?

5 Q Yes.

6 A I'm not sure.

7 Q How many patients are assigned to

8 nurses in the ICU?

9 A I am not sure of that.

10 Q Is there a closer ratio of nurse

11 to patient ratio in the ICU than on the

12 eighth floor?

13 A I am not sure of that.

14 Q The surgical floor, the eighth

15 floor that you mentioned, is that similar

16 to, for lack of a better word, a regular

floor?

A It's a hospital floor.

Q In January of how many patients were assigned to each individual nurse on any given shift?

A I don't know that.

Q When you saw Mr. at 11:30 a.m., other than telling you that he felt the best he felt in days, did he say

, M.D.

anything else to you?

A I don't recall.

Q What did you tell him? What did you say to him?

A Basically, I reviewed with him what had happened the day before.

Q If you can be specific, it would be helpful.

A I can't be very specific.

Q Did you tell him that he had a pulmonary embolism?

A He knew that already.

Q Did he ask any questions about it when you saw him?

A I don't recall.

Q Did he ask what treatment he would be receiving for the pulmonary embolism?

A I don't recall that.

Q Did he ask you when he could expect to leave the hospital?

A I don't recall.

Q Was Mr. receiving any form of oxygen when you saw him at 11:30

, M.D.

a.m. on January 23rd?

A I don't remember.

Q Did Mr. have any shortness of breath when you saw him at 11:30 in the morning?

A No, he did not appear to have it.

Q You used the word cachectic in your notes.

Do you recall that?

A (Witness nods.)

Q Are you familiar with the term cachectic?

A Yes.

Q What does that mean, Doctor?

A It's a general sign of weight loss.

Q How did Mr. appear to you physically when you saw him on January 23rd at 11:30 a.m.?

A He appeared as he always had appeared in the past few months, and that was chronically ill.

Q What specifically was it about him that appeared chronically ill?

, M.D.

A He showed signs of weight loss, pale skin. He didn't have a lot of energy.

Q Did he still have bathroom privileges as of January 23rd?

A I don't remember.

Q Had you observed him walking around his room when you saw him that morning?

A No. He was in bed.

Q Did Mr. ask you any questions when you saw him on the 23rd?

A I am sure he did, but I don't recall specifically.

Q Do you have a note in the chart

that reflects your seeing the patient on January 23rd?

A No. I did not write a note.

Q If a doctor who was caring for Mr. wanted to know who had seen the patient that day, how would they learn other than speaking to you directly that you had been there and examined him at that time?

A They would ask me.

, M.D.

Q How would they know that you had examined him if there is nothing to indicate that you did so in the chart? How would they know to ask you?

A Because I'm the attending of record, my name is on the chart, nurses often refer to physician's visits without a

physician writing them.

Q Is there anything that you've seen in this chart in the nurse's notes that reflects confirmation that you were present at a given time on January 23rd?

A No, I didn't see any.

Q Did you have any conversation with any of Mr. 's family after 11:30 a.m. but before he coded?

A I don't recall.

Q Did you learn at some point after 11:30 a.m. that there was a problem?

A Yes.

Q When did you learn it and how did you learn it?

A I went back to the operating room to speak with Dr. to formulate a plan

, M.D.

about what to do with Mr. 's recent diagnosis of pulmonary embolus and we heard the page of a code on the eighth floor and, um, called the floor, was told it was Mr. . We went immediately to the bedside.

Q What did you observe when you got there?

A There was a code in progress.

Q Do you know who was running the code or in charge of the code?

A I don't.

Q Did you participate in the code?

A No.

Q Did you remain present for the duration of the code?

A Yes.

Q At some point was Mr. pronounced dead?

A Yes.

Q Did you have any conversations with any of the doctors who were participating in the code after he was pronounced?

, M.D.

A I don't recall.

Q Did you write any note about any conversations you had with any of the doctors after the code? I am not talking about a discharge note. I am talking about any handwritten note.

A No. I don't think so, no.

Q Did you participate in any conversation with the doctors participating in the code as to whether or not the patient should be anticoagulated during the code?

A I don't recall.

Q Did you see that there was a note

by at least one physician debating whether or not anticoagulation therapies should be administered during a code?

A Yes.

Q And ultimately a decision was made not to give additional anticoagulation medicine?

A No. He is talking about plasminogen activators. That's not the same thing.

Q Why did that doctor choose not to

, M.D.

give plasminogen activators during the code?

A Because of the risk of stroke.

Q Was there also a suggestion that by doing chest compressions if there were fractures associated with a compression,

that the patient could experience significant bleeding?

A It's possible.

Q Did you have any conversation with anyone from Mr. 's family after he was pronounced dead?

A Yes.

Q Was that on January 23rd?

A Yes.

Q Who did you speak with?

A The patient's wife and, um, his daughter.

Q Do you recall how long the code lasted?

A I have a rough idea. I don't know specifically.

Q Roughly what is your understanding?

A I think twenty, thirty minutes,

, M.D.

something like that.

Q Did Mr. 's pulmonary embolism cause his cardiopulmonary arrest?

A Yes.

Q What was the mechanism in which it caused it?

A The clots travel to the heart and block the pulmonary artery, so there is no blood flow to the lungs, leading to respiratory, followed by cardiac arrest.

MR. OGINSKI: Could I get the answer read back?

(The requested portion was read back by this reporter.)

Q How does one prevent the migration of a clot from traveling to the heart in someone who has been confirmed as having a pulmonary embolism?

A Well, a pulmonary embolism by

definition has already occurred.

Q How does one prevent the migration of those clots from traveling elsewhere in the body?

A You can't.

, M.D.

Q Would a Greenfield filter help in preventing further clots from disbursing in the body?

A No.

Q Would additional types of anticoagulation therapy help in preventing formation of additional clots?

A No.

Q Does heparin have any effect upon a clot that is already present within the body?

A Yes.

Q What is the effect?

A It helps dissolve it.

Q Are you familiar with something known as a VQ scan?

A Yes.

Q Is that also known as a ventilation-perfusion scan?

A Yes.

Q Under what circumstances would you as a physician request such a scan in a patient with a suspected pulmonary embolism?

A Well, it's -- it's, um, one of

, M.D.

the methods for diagnosis of pulmonary embolism, along with a CT scan.

Q Is a CT scan a better or more reliable diagnosis test for diagnosing a PE

than a VQ scan?

A I'm not sure of that.

Q Can you state with any reasonable degree of medical probability whether this patient's bilateral pulmonary embolisms were preventable?

A No.

Q Do you have an opinion with a reasonable degree of medical probability whether if Mr. had received IV heparin after the embolisms had been diagnosed, whether that would have altered or affected the outcome?

A Yes.

Q What is your opinion?

A It would have unlikely affected the outcome.

Q What do you base that conclusion on?

A The fact that he's currently

, M.D.

undergoing anticoagulation.

Q In your opinion was that anticoagulation sufficient enough to address the reason as to why he was receiving the anticoagulation?

A Yes.

Q Do you have an opinion, again with a reasonable degree of medical probability, whether if he had received a Greenfield filter shortly after being diagnosed with the bilateral pulmonary embolisms, whether that in and of itself would have affected his outcome?

A Yes.

Q What is your opinion?

A It's unlikely to have affected the outcome.

Q Again, what do you base that

conclusion on?

A Well, we know that Greenfield filters don't prevent pulmonary emboli.

Q Does it have any affect or assistance on an embolism that is already present from migrating to other parts of the

, M.D.

body?

A No.

Q Where is the Greenfield filter usually placed?

A In the inferior vena cava.

Q From the time that the CAT scan confirmed his bilateral pulmonary embolisms at around 7:30 or eight p.m. on January 22nd until he coded at around twelve p.m. on January 23rd are there any notes by any

doctor to indicate that they were aware that he had a confirmed pulmonary embolism?

A We know that they were aware.

Q I am asking: Are there any notes recording that fact in the chart?

A Not specifically, no.

Q Did you ever ask Dr. why he did not make a note about his observations and examination of the patient on January 22nd?

A No, I haven't.

Q Tell me about the conversation that occurred between you and Mr. 's daughter and his wife after the

, M.D.

patient died.

A Well, I don't recall the details.

It was simply informing them of the death and consoling them.

Q Did they ask any questions?

A Um, I don't recall specifically.

Q Was there some discussion about an autopsy being requested?

A Yes. I discussed an autopsy with Mrs. .

Q Am I correct that initially it was refused and then --

A Initially she did not want an autopsy.

Q And then at some point afters they agreed to it, correct?

A Yes.

Q Did anyone, to your knowledge, notify any family member that Mr. had been diagnosed with pulmonary embolism at any time before he coded on January 23rd?

A I don't recall.

Q Did Dr. tell you whether he saw the patient at any time from midnight on

, M.D.

January 23rd up until the time that Dr. saw the patient and has a note timed at 6:40 a.m.?

A I don't recall the specifics.

Q Is there anything in the notes to indicate that any physician saw this patient from the time after Dr. may have seen him on January 22nd until the morning of January 23rd?

MR. : Asked and answered.

You went through this before.

MR. OGINSKI: His answer was no, correct?

MR. : Correct.

Q I am going to return back to the failure to thrive, Doctor.

At any time before January 22nd, in other words, from January 16th to January 22, , had you formed any opinion with a reasonable degree of medical probability about Mr. 's life expectancy?

MR. : Can I hear that question back, please?

(The requested portion was read

, M.D.

back by this reporter.)

A Well, we were concerned about his chronic illness and the fact that he had not rebounded from his surgery and we were grappling with that problem and I was very distinct about that. I don't remember specifically whether we addressed longevity. His chronic illness was certainly of considerable concern.

Q Other than the concern that you mentioned, had you formulated any type of opinion as to, you mentioned longevity, how much longer he could be expected to live, assuming his condition does not improve?

A I cannot recall specifically.

Q Did you form any opinion during this same time frame, January 16th up until January 22nd, as to the patient's, you used the term longevity, or his life expectancy assuming his condition improved?

A No.

Q Would you agree, Doctor, that a failure to thrive without a pathologic diagnosis does not mean that his life

expectancy would be less than it ordinarily

will be? Would you agree with that?

A No.

Q Why not?

A Well, it's unusual to have a failure to thrive in someone who presumably undergoes, a, quote, successful operation, and I have certainly seen those patients not do well and have, I believe, shortened life expectancies for reasons that are unclear. I can't explain it.

Q Is there any literature that you're aware of that addresses this particular issue regarding patients who fail to thrive after cancer surgery?

A I am not aware of specific literature. Every cancer surgeon has seen it.

Q Did you have any discussions with either the patient or the patient's family members about the concern involving his chronic illness and what it might mean for

him in the long-term?

A We had discussions about his

, M.D.

failure to thrive. I don't believe we addressed the issue of survival.

Q Any survival issue, would that relate not only to his inability to thrive, but would that also relate to chances of recurrence of bladder cancer?

A Well, there is a whole host of variables.

Q Such as what? Give me an idea.

A His failure to thrive, his urinary infections, his urinary diversion, which is not a normal bladder, his prior history of DVTs, his diabetes, his general -- general condition, all of which collectively would impact his life

expectancy.

Q Since Mr. 's death on January 23, up until the present time have you formulated an opinion as to whether his life expectancy would have been decreased had he continued to fail to thrive, assuming that he did not die of the pulmonary embolism?

A Yeah.

, M.D.

Q What is that current opinion?

A He would have suffered a premature death had he continued to fail to thrive.

Q What do you base that conclusion on, Doctor?

A My experience.

Q Assuming the pulmonary embolism did not cause his death, what is it about the failure to thrive that you feel would have caused premature death?

A Again, it's one of these diagnoses that you can't explain, but his chronic infection, his inability to eat, his weight loss. The whole syndrome. I've seen it before.

Q How many times?

A Fortunately it's uncommon.

Q The infection, as of the last hospital admission was that being treated adequately in your opinion?

A Yes.

Q Addressing the inability to eat issue. When we talked about the methods in

which to provide the patient with nutrition, assuming the other methods were employed to give the patient nutrition, would your answer be the same, that he would still have continued to fail to thrive?

A Yes. He could eat.

Q What else about urinary diversion would have contributed in your opinion to his premature death, assuming he went on his way without any effect of the pulmonary embolism?

A He had an insult to his kidneys previously. He had these chronic infections in his urinary pouch. There was no sign that these would not recur. He had never properly learned to urinate and use his urinary diversion well, like most patients. Things were not going well.

Q Were there alternative treatments that would have been available to him assuming he had progressed along the route

you just mentioned to address those things, whether it be a kidney transplant or other methods, to take care of those things?

, M.D.

A Yes, but that's speculation.

Q Would it be fair to say, Doctor, that the conclusion you reached --

A He would have never received a kidney transplant.

Q Since you bring it up, tell me why.

A He has a history of cancer. He has a urinary diversion that would make it difficult. He has a history of infection. His general condition. It's very unlikely he would be accepted on a transplant list.

Q What was the cause for the chronic infections?

A I don't know.

Q All the cultures came back negative, right?

A That's not true.

Q I'm sorry. I shouldn't say that. I'll rephrase the question.

The antibiotic therapy he was receiving to address the urinary infections, am I correct that that did not prevent the infections from recurring?

, M.D.

A Correct.

Q Did you at any time determine why he was getting these recurrent infections?

A No.

Q Was there any suggestion by any of the other doctors who cared for him as to

why he was getting these recurrent infections?

A No.

Q How would the recurrent infections have affected his overall general health, assuming everything else to be the same?

A Well, a chronic infection makes one ill, it causes one to lose weight, it causes one not to have a good appetite, it diminishes one's energy, it makes one depressed.

Q If we assume that for each urinary infection that he had, that he was treated appropriately for that, can you also then assume that the infection would go away for a period of time?

A I did not see the infection go

, M.D.

away for any significant length of time since the man's operation.

Q When you say significant period of time, what period or range of time are you referring to?

A When we cure an infection, we would like it not to come back at all. Certainly a number of months. That was never achieved.

Q What was the longest period of time for which Mr. was free of any type of recurrent infection?

A I don't recall specifically.

Q Can you approximate?

A Well, it's a little bit more than a month.

Q If each of his infections were treated appropriately, assuming again embolisms did not cause his death, would you agree that your conclusion that he would

suffer premature death, would you agree that that would be different or that it would not apply? Assuming he were appropriately treated for each of the infections.

, M.D.

A No.

Q Can you give me a time frame or a time estimate as to how premature you would expect to see his death assuming the fact that he would fail to thrive?

MR. : I object to form.

MR. OGINSKI: I'll rephrase it.

Q You told me a few moments ago that assuming Mr. continued to fail to thrive and assuming he did not die of his pulmonary embolism, that you expected that he would suffer premature death.

Can you give me any type of time frame in which you would expect to see that premature death?

A No.

Q Would you agree that giving such a time frame would be speculation?

A Yes.

Q Did you speak with Dr. after this patient died?

A No.

Q Did you speak with Dr. after the patient died to discuss the course of

, M.D.

events leading to his death?

A I never spoke to Dr. that I recall.

Q Did you speak to Dr. after the patient died about the events leading to

his death?

A No.

Q Was Dr. present for the code?

A Yes.

Q Did you ever speak to him about the cause of this patient's death after the code was performed?

A I don't recall.

Q Did you ever speak to the pathologist who performed the autopsy on this patient?

A I did not.

Q Are you familiar with a procedure known as an embolectomy?

A Yes.

Q What is an embolectomy?

A It's a surgical procedure to remove blood clots from the pulmonary

, M.D.

artery.

Q Was there any discussion by any of the doctors caring for Mr. after he had been diagnosed with a pulmonary embolism that he undergo an embolectomy?

A I don't recall.

Q Is there anything in the hospital record to confirm or indicate or suggest that an embolectomy was considered after the diagnosis of bilateral pulmonary embolisms were made?

A I don't believe so.

Q Do you have an opinion as you sit here now as to whether an embolectomy would have helped this patient in terms of treating and addressing the pulmonary embolism he was diagnosed with?

A Yes.

Q What is that opinion?

A It would have been of no help at all.

Q Why is that?

A It rarely is.

Q What is that information based

, M.D.

upon?

A Experience.

Q Did any doctor to your knowledge have any conversations with Mr. 's family members to discuss the treatment options for his pulmonary embolism once it had been diagnosed on January 22nd?

A I don't recall specifically.

Q Did any doctor to your knowledge have any conversation with Mr. about the treatment options to treat the

pulmonary embolism?

A I don't recall that specifically.

Q Is there anything in the hospital record that would tell you that a doctor did in fact have a conversation with the patient and discuss the various options available to treat the pulmonary embolism?

A No, but that's what we were planning when he coded.

Q I am only asking about anything recorded in the record from the time that he was diagnosed with the pulmonary embolism until he died.

, M.D.

A No.

Q Based upon your knowledge of Dr. 's experience, was it your

understanding that Dr. was familiar with the various treatment options of treating a patient with a pulmonary embolism?

A Yes.

Q The diabetes that you mentioned, am I correct that this patient was a non-insuline dependent diabetic?

A That's correct.

Q His diabetes was controlled by medication and/or food?

A It was controlled by medication.

Q Doctor, I am going to show you a final page of the autopsy report, which is the heading "final comment".

I ask you to look at the last paragraph, please (handing).

A (Witness perusing document.)

Q Can you read the last paragraph?

MR. : Out loud?

MR. OGINSKI: Yes.

, M.D.

MR. : There is no reason for him to read it out loud. It's typed.

Q Does the note in the last paragraph indicate that "there was no evidence of residual carcinoma"?

A Yes.

Q It also makes mention that "the lungs were congested and heart showed biventricular dilatation".

What does that mean to you?

A That means the heart acutely failed.

Q And there is also a description of the pulmonary embolus. It's described as "a large saddle-shaped pulmonary embolus".

What is the significance of that?

A That it blocked both branches of the pulmonary artery.

Q Can you turn, please, to your discharge summary, which is typed?

Specifically, Doctor, this is a three page typed report, correct?

A Yes.

Q Did you dictate this report?

, M.D.

A I did not.

Q Who dictated this report?

A Generally it's a clerk.

Q A clerk dictates the report?

A Well, I am not sure of that.

Q Looking at this three page note, Doctor, the last page has your name listed there.

A Yes.

Q What does that tell you? It gives you a date of February 1, , time four p.m.

What does that tell you?

A It doesn't tell me anything.

Q How would this note get into this patient's record?

A It's dictated.

Q Who dictates it?

A A clerk.

Q How does a clerk obtain the information that's contained within this note that has your name on it?

A From the medical chart.

Q Did you dictate this note?

, M.D.

A I did not.

Q If you had dictated it, how would you know that you had dictated it?

A Well, for instance, operative reports, you will see who dictates it. It will say dictated by.

Q Let me ask the question differently.

From time to time do you dictate discharge notes on patients that you discharge from the hospital?

A No.

Q Do the fellows or residents dictate discharge notes?

A Usually not.

MR. : Off the record.

(Discussion was held off the record.)

Q The individual or clerk that generates this discharge note, do they speak with the doctor who has treated the patient during this admission?

A I doubt it.

Q At any time before this lawsuit

, M.D.

was started did you ever receive a copy of this patient's discharge report?

A Well, I read it when he was discharged, after the event. I had to sign it.

Q The copy that you sign, where does that go?

A It's done on computer.

Q You sign it on the computer or indicate by some method that you read it and agreed with it?

A I signed it.

Q Does your electronic signature appear on this discharge note?

A I'm not sure of what an

electronic signature is.

Q When you click sign --

A Let me.

Q Go ahead, Doctor.

A It can't get into the chart unless I sign it.

Q Turn, please, to the second page of the discharge note.

The paragraph titled

, M.D.

"course/other treatment", on the third line down it says "on 1/22 patient had passed out in bed and was found to be clammy, with blood pressure 98 over 60.".

Do you know where this individual obtained the information that the patient was clammy at that time?

A That's recorded in the nurse's note.

Q Which nurse's note are you referring to? The five p.m. note?

A Yes.

MR. : That word specifically is in there.

Q Can you turn, please, to that January 22, five p.m. nurse's note?

Just leave that page aside because I am going to address that after.

A All right.

Q Four lines down, the first word, do you see that?

A Yes.

Q Going back to the discharge note, Doctor, the second paragraph again, where it

continues "he recovered rapidly, however, and remained alert and without dyspnea, chest pain, cough or tachycardia until his subsequent fatal acute episode the following day.".

Do you know where this individual obtained that information?

A I can't say specifically.

Q Do you know whether this clerk who prepared this discharge note consulted with any doctor who had been caring for Mr. during the last few days before his death?

A I don't know.

Q A few sentences further on in the same paragraph it states "CT scan identified bilateral pulmonary emboli. Patient's condition suddenly deteriorated early afternoon of 1/23. He became unconscious, with full cardiopulmonary arrest. Attempts at resuscitation were unsuccessful and the

patient expired on 1/12/ at 1:13 p.m.
Consent for autopsy was obtained personally
by me.".

, M.D.

Do you see that?

A Uh-huh.

Q That last sentence, Doctor, does that indicate that someone other than a clerk was putting this information in this note?

A I -- I don't know.

Q When the note reflects that "the consent for autopsy was obtained personally by me", does that refer to the clerk having obtained the autopsy consent or something else?

A It -- it -- it refers to the fact that I requested an autopsy.

Q But the grammar would not be correct for the clerk?

A Correct.

Q I am going to show you, Doctor, the CAT scan result dated January 22, which concluded that the patient had bilateral pulmonary embolism had (handing).

Is there a time on that report as to when that's reported?

A Do you have the next page?

, M.D.

Q Not in my copy I don't have. You might have it in your chart.

MR. : Just for the use of finding it, use my copy.

MR. OGINSKI: That's the second page?

MR. : Yes.

A I don't see a time. It's dictated on the 23rd, so I know it's done after the scan.

Q Page 2 of the CAT scan report, there is also a note here indicating that there is a phone call with Dr. on January 22nd, correct?

A Yes.

Q Does that note indicate what time the phone call was made to Dr. ?

A Not specifically, no.

MR. OGINSKI: Off the record.

(Discussion was held off the record.)

Q To your knowledge, Doctor, had Mr. had an inferior vena cava filter previously inserted during a prior

, M.D.

hospital admission?

A He did not.

Q I am going to show you a discharge summary for Mr. 's discharge from the hospital during his admission from November 16, to December 4, . It's a three page note.

If you look at the second page of that report, on my copy it's actually highlighted, there is an indication in that note that states that "the patient did undergo placement of an inferior vena cava filter.".

Do you see that?

A Yes.

Q Is that an inaccurate statement?

A Yes. That's incorrect. He went to have the procedure done and it was cancelled by the radiologist (handing).

Q At any time after January 23,

did you have any additional conversations with Mrs. at any time up until the present day?

A You know, I believe so, but I

, M.D.

can't recall specifically. I believe we discussed the autopsy findings.

Q Was that by telephone or she came to the office or something else?

A I don't recall.

Q Do you have any independent memory as to what it was you told her and what she said to you during this conversation?

A No.

Q Do you recall when that conversation took place?

A No, not specifically.

Q Was there any discussion with Dr. prior to performing the endoscopy as to whether he would obtain biopsies during the procedure?

A No, I don't recall that.

Q I am going to show you a note which appears to be a three page note by a physician on the GI service dated January 17th and ask you to look at that (handing).

I am going to specifically ask you questions about the last paragraph on

, M.D.

the third page.

A (Witness perusing document.)

Q Have you had a chance to look at that?

A Yes.

Q Is that a Dr. who wrote that note, if you can tell?

A It appears to be, yes.

Q Does Dr. indicate in the last part of the note that the patient was going to be removed from the Coumadin specifically because biopsies were anticipated being done during the endoscopy?

A That's what he writes.

Q Thank you.

A (Handing.)

Q To your knowledge, Doctor, any time a medication is ordered for the patient does that get charged against their hospital bill or to their hospital bill?

MR. : If you know.

MR. OGINSKI: I am going to rephrase the question.

Q Any time a medication is

, M.D.

administered to the patient does that medication then get charged to the patient?

A Not in every case, no.

Q Under what circumstances would medication not be charged to the patient?

A Well, I believe there are some global fees. For instance, in the operating room. So there is an operating room fee that will incorporate all of the medications. The individual requirements in the hospital I don't know.

Q Assuming there is no such global fee for particular sets of medications, in other words, unrelated to any surgery, would you expect the hospital to bill or charge for various medications?

A I don't know that.

Q Have you had on occasion opportunities to review bills for patients

for their hospital admissions?

A I never have.

MR. OGINSKI: Off the record.

(Discussion was held off the record.)

, M.D.

Q Doctor, I had asked you before what would have happened to Mr. had he continued to fail to thrive. I am going to ask a slightly different question now.

Had his failure to thrive improved would you agree or can you determine or render an opinion whether or not he still would have had a premature death?

A I don't know.

Q Thank you, Doctor.

(Time noted: 2:00 p.m.)

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

STATE OF)

: SS

COUNTY OF)

I, , hereby certify that I have read the transcript of my testimony taken under oath in my deposition of February 11, ; that the transcript is a true, complete and correct record of my testimony, and that the answers on the record as given by me are true and correct.

_____

Signed and Subscribed to before me, this ____ day of _____, .

_____
Notary Public, State of

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WITNESS

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

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4 STATE OF)

5 : SS

6 COUNTY OF)

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8 I, , a Shorthand

9 Reporter and Notary Public within and for

10 the State of do hereby certify:

11 That , the witness

whose examination is hereinbefore set forth, was duly sworn by me and that this transcript of such examination is a true record of the testimony given by such 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 14th day of February, .

_____

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