****DE-IDENTIFIED DEPOSITION OF A GYN ONCOLOGIST IN A FAILURE TO DIAGNOSE PERFORATED BOWEL CASE DURING GYNECOLOGIC SURGERY****

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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS
- - - - - - - - - - - - - - - - - - - -x
,
Plaintiff,
-against-

,
Defendants.
- - - - - - - - - - - - - - - - - - - -x

August 13, 2008
10:20 a.m.

EXAMINATION BEFORE TRIAL of
, a Defendant in the above-entitled action, held at the above time and place, taken before Jennifer Brennan, a Notary Public of the State of New York, pursuant to Order.

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APPEARANCES:
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Attorneys for Defendants

BY:

Attorneys for Defendants

BY:

* * *

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STIPULATIONS

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

All rights provided by the C.P.L.R., and Part 221 of the Uniform Rules for the Conduct of Depositions, including the right to object to any question, except as to form, or to move to strike any testimony at this examination is reserved; and in addition, the failure to object to any question or to move to strike any testimony at this examination shall not be a bar or waiver to make such motion at, and is reserved to, the trial of this action.

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

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and shall be controlled thereby.

The filing of the original of this deposition is waived.

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

* * *

, the Witness herein, having first been duly sworn by the Notary Public, was examined and testified as follows:

EXAMINATION BY

MR. OGINSKI:

Q Please state your name for the record?

A

Q Please state your address for the record?

A

24
25 MR. OGINSKI: Let's mark the
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1 A.
2 doctor's office record as Plaintiff's
3 Exhibit 1 and Plaintiff's Exhibit 2
4 will be the original
5 record.
6 [The documents were hereby
7 marked as Plaintiff's Exhibits 1 and
8 2, for identification, as of this
9 date.]
10 Q Good morning, Doctor. Would
11 you agree that a perforated bowel during
12 laparoscopy is a risk of procedure?
13 A Please repeat the question.
14 Q Would you agree that a
15 perforated bowel during laparoscopy is a
16 risk of the procedure?
17 A Yes.
18 Q Would you also agree that a
19 perforated bowel during laparotomy is a
20 risk of the procedure?
21 A Yes.
22 Q Would you agree that the
23 failure to recognize, intraoperatively, a
24 bowel perforation, may be a departure
25 from good care?
0006
1
2 : I'll object to
3 the form of that question.
4 Q Would you agree that there are
5 times when a bowel perforation may occur
6 during surgery and that the failure to
7 recognize that perforation, may be a
8 departure from good and accepted medical
9 care?
10 A Yes.
11 Q Why?
12 A Because some perforations of
13 the bowel are detectable at surgery and
14 some perforations should be detectable by
15 reasonable effort during the surgery by
16 the surgeon.
17 Q And in those circumstances
18 where you mentioned that the surgeon
19 should recognize a bowel perforation,
20 would the failure to recognize, and again
21 I'm just talking generally, be considered
22 a departure from good and accepted
23 medical care?
24 A That would depend upon the
25 individual, that would depend upon the
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1 A.
2 individual circumstance and it's hard to
3 generalize.

Q If a bowel perforation occurs during a laparoscopy, what clinical signs would you expect to see postoperatively?
A I would expect to see increasing distension of the abdomen with increasing abdominal pain and tenderness. I would expect usually to see absent bowel sounds. I would expect to see spiking high fevers and elevated white count that usually would increase day-to-day.
Q What do you consider a high fever?
A A high fever -- well, the upper limits of normal is 38, but high would be let's say well over 39 and that's degrees Celsius.
Q Are there any other clinical signs that you would expect to see with a bowel perforation?
A These would be the cardinal signs. It may be that there is something

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A. that I'm not thinking of, but I can't think of anything offhand.
Q Why is the early diagnosis of a perforated bowel critical?
: Object to the form. You are assuming that it is.
Q Is the early diagnosis of a bowel perforation postoperatively important?
A Not necessarily.
Q Tell me what you mean?
A Well, the main -- what do I mean, you said?
Q Yes.
A The perforation of a bowel may lead to -- may lead to other things, such as septic shock. You want to diagnose it before it leads to that, but I think that there is usually a window during which if it exists, it can be diagnosed any time during the course of that window, without detriment to the patient, without further detriment to the patient I should say.
Q Generally would you agree that

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A. it's preferable to diagnose a perforated bowel earlier rather than later, I mean under the ideal circumstances, and again I'm talking generally?
A All other things being equal, yes.
Q Why?
A Because the sooner you know

about it, the sooner you treat it.
Q Why is it better for the patient to treat it sooner rather than later?
A Because the patient might develop these further infectious complications if not treated and really just because the patient is not -- you know, is ill under those circumstances and not being treated.
Q Would you agree that the prompt recognition and repair of a bowel perforation has certain advantages, including possibly minimizing or reducing the risk of a patient needing a second or maybe even a third surgery to correct the

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problem?
A No.
Q Tell me why?
A Because the patient is invariably going to need a second operation to correct the problem once it's perforated.
Q Why?
A Because there is a hole in the bowel and it needs to be repaired.
Q And is there any window of time within which the patient would avoid having a second corrective surgery in the event a bowel perforation occurs initially?
A I would think only if it were diagnosed actually at the time of surgery.
Q Can you reasonably say within 24 hours after surgery is done, that if a perforation was recognized, that the patient would not require a corrective surgery in order to fix the problem?
A No, I wouldn't say that at all.

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Q If there is prompt recognition and treatment of a bowel perforation, is the risk of abdominal sepsis less if it's treated earlier rather than later?
A I don't know what you mean by your question.
Q I'll rephrase it. One of the risks of bowel perforation -- withdrawn.
One of the risks of unrecognized bowel perforation is the patient can develop sepsis; correct?
A Yes.
Q What is sepsis?
A Sepsis, as I would understand

the term, would be a generalized infection through the body, possibly with shock.
Q And what is septic shock?
A Septic shock is dilatation of the blood vessels throughout the body and decrease in -- well, low blood pressure and failure to perfuse vital organs as a result of sepsis.
Q If a bowel perforation is

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promptly recognized and repaired, is the risk of sepsis to the patient less, if the recognition and repair of the condition is recognized earlier rather than in a later time?
A Probably -- yes, generally so.
Q Why?
A If a patient is not in sepsis at this very moment and you are repairing an injury to the bowel, then there isn't going to be further spillage of intestinal contents and any spilled intestinal contents would be evacuated and that would reduce the chance of sepsis. And that would be true any time before sepsis actually occurs.
Q If a patient is septic and the repair of a bowel perforation occurs at that point, is there a greater chance that the sepsis will progress to septic shock?
A I'm sorry, I'm not sure that I understand what you are asking.
Q I'll rephrase it. Does sepsis

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come before septic shock; are they in sequence -- withdrawn.
Can you have septic shock without sepsis?
A No.
Q What are the signs of sepsis?
A The signs of sepsis are a feeling of warmth and accompanied by fever, chills and sweats and generally a spiking and rising white count. And I would say and everything else is general. These would be the typical signs of sepsis, malaise, fatigue.
Q What are the signs of septic shock?
A Low blood pressure and -- yes, basically low blood pressure and then whatever signs of organ failure would go along with that, which are very variant and numerous.

Q If there is prompt recognition and repair of a bowel injury -- withdrawn.
Would you agree that the timely

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recognition of a bowel injury tends to result in lower morbidity for the patient?
A I'm not sure what you are asking me.
Q What is morbidity?
A Morbidity is a complication.
Q And if bowel perforation postoperatively is recognized, again sooner rather than later, is that generally favorable for the patient, in terms of their overall morbidity?
A The earlier -- if it's recognized earlier rather than later, then generally speaking, there is a lower chance of morbidity.
Q And would you agree, Doctor, to turn the prior question around, that the longer a diagnosis of an injury to the bowel is delayed postoperatively, that there is a greater risk of serious morbidity and associated mortality?
A This is a very general statement, but that would be the case.

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Q That would be true?
A It would be true to a large extent.
Q I would like you to define what adhesions are?
A Under normal circumstances, there is a cavity within the abdomen that occupies most of the abdomen called the peritoneal cavity, within which lie many organs and structures. And these structures are normally separate. Even if they lie against one another, they can be pulled apart; they don't stick together.
Adhesions -- this is true outside of the abdominal cavity as well in many parts of the body. Adhesions are fibrous tissue or scar tissue that cause structures near each other, which normally can be separated from one another, to adhere tightly to each other. It binds itself. It's sort of like an internal glue.
Q What is the procedure that you

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have available to you to break apart those adhesions, what is that called?
A The process of breaking apart adhesions can be called adhesiolysis.
Q Also known as lysis of adhesions, cutting the adhesions?
A Lysis is another word you can use.
Q What is a pneumoperitoneum?
A It's the presence of air or other gas within the peritoneal cavity.
Q Is that typically created when you perform laparoscopy?
A Yes, it is.
Q What is a pneumomediastinum?
A Pneumomediastinum is the presence of gas within the soft tissue of the chest that lies between the two lungs.
Q Is that commonly associated with the performance of laparoscopy?
A Yes, it is.
Q And tell me why that occurs?
A In performing laparoscopy, a

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surgeon infuses gas, and most typically carbon dioxide, into the peritoneal cavity through a port, through a sleeve that's placed through the abdominal wall into the peritoneal cavity. And there are several other such ports going through the abdominal wall through which the instruments are used.
The gas is under pressure. The pressure forces some of this gas into the tissues between the peritoneal cavity and the skin, which tend to be soft tissues, and the gas pushes its way up into the mediastinum.
Q Are you a member of the

; is that the right named the ?
A I've heard of such a society and I'm not a member of it.
Q A finding on X-ray of free air in the belly, what does that mean to you?
A It doesn't mean any one thing.
Q Are you familiar with the term,

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differential diagnosis?
A Yes.
Q What does that term mean to you?
A A differential diagnosis is a list of possible diagnoses to explain a

finding, a symptom, a physical finding, an X-ray finding, what have you.
Q And generally that list goes from most likely, all the way down to least likely; correct?
A It can. I mean, it's a list.
Q When you see the term free air in the belly on a radiology report, what is your differential diagnosis, and again I'm talking generally?
A I can't talk generally because it totally depends on the clinical circumstances.
Q Fair enough. Would you agree that the term, free air in the belly, can be a result of the air that's insufflated during laparoscopy?
A Yes.

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Q Would you also agree that free air can be a result of a perforated viscus?
A Yes.
Q Would you agree that free air in the belly can also be the result of a perforated bowel?
A Yes.
Q Are you familiar with the term atelectasis?
A Yes.
Q What is that?
A Atelectasis refers to a collapse of a portion of the lung without air or gas in the pleural cavity, but just that there are no -- there is no air in the air passages in a portion of the lung.
Q What does the term basal atelectasis mean?
A That there is collapse of some of the lower portions of the lung. By lower, I mean away from the head.
Q What is an abscess?

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A An abscess is a localized infection with a cavity and pus in the cavity.
Q And are you familiar with the term known as bandemia?
A Yes.
Q What is that?
A Bandemia refers to the presence of a certain kind of cell called bands, as a component of the white cells in the blood. There is always some bands, but an increase of the number of bands as

compared to the usual.
Q When do you typically see bandemia?
A Any time there is any kind of inflammation, whether it can be caused by surgery, by infection, by noxious agents, but it's basically a sign of inflammation, which can have many, many causes.
Q Is bandemia a precursor to infection?
A No, it can be a result -- no.

I don't mean that it is -- it can be a consequence of infection, but it's not a precursor to it.
Q Can you have infection without bandemia?
A Yes, you can, but generally mild ones.
Q What is septicemia?
A Septicemia refers to the presence of bacteria in the blood.
Q Is that analogous to sepsis?
A I don't know what you mean by analogous. Do you mean is it synonymous?
Q Yes, thank you.
A No.
Q We used the term a moment ago, viscus perforation, what is viscus?
A A hollow organ.
Q And the bowel is a hollow organ; correct?
A Yes.
Q Are you familiar with, and I'm asking about now percentages -- withdrawn.

All of my questions are going to relate to the time period of , unless I indicate otherwise.
What was your understanding of the risk of injury to bowel during the course of laparoscopy in ?
A The risk of injury to the bowel from laparoscopy depends markedly upon the kind of laparoscopic procedure performed.
Q Let's talk specifically about the type of procedure that was done in this particular case for , the BSO, bilateral salpingo-oophorectomy.
What is the percentage of the injury to bowel in this type of procedure?
A I can't give you a percentage

because each person is unique and had --
Q I'm sorry, I wasn't clear. I'm not talking about specifically this patient.
I would like to know the risk,

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in general, for performing a BSO in ?
A The risk of a bowel injury on entry into the abdominal capacity is about one in 300. The risk of bowel injury during the BSO is going to be somewhat more than that, but I couldn't quantitate it.
Q When you say "more than that," do you mean more than one out of 300?
A Yes.
Q Is that based upon your own personal practice or literature or something else?
A It's based upon my general knowledge of the field, whether that's literature, lectures, reading, whatever.
Q Are you familiar with the risks to the GI tract, in general, for this type of procedure?
A I don't understand your question.
Q I asked specifically about the risk to bowel.
My question now is a little

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more broad and asks about injury to the GI tract during the course of a BSO?
A Most of the risk would be to the GI tract. There might be a slight risk of injury to the stomach during laparoscopy. Such things have been reported, but are unusual. The rest of the GI tract would be the esophagus and hopefully we wouldn't have any risk of injury to the esophagus.
Q You mentioned you're currently aware of risk of injury during the BSO?
A I'm sorry, I didn't hear you.
Q You told me a moment ago that you did not have the specific percentages of the risk of injury to the bowel during a BSO?
A That's correct.
Q At some point before today, within up until today, did you know that percentage?
A As a number, I couldn't say. I've read it at some point in my readings or heard it in some point hearing

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lectures and at that point, I might have known it. But I can't tell you -- I have a general sense, but I couldn't give you a percentage, you know, 1.35 or something.

Q In addition to the risk to bowel, is there also a risk of injury to the major vessels during the course of laparoscopy?

A There is such a risk.

Q In , what was the risk of injury to major vessels during laparoscopy for a BSO?

A Again, the general risk of laparoscopy is probably something like one in 500 and the risk of major vascular injury during a BSO is slightly higher than that, but not as great of the risk to injury to the bowel.

Q Now, when a patient consults with you and you recommend a particular laparoscopic procedure, do you tell patients about the risk of laparoscopy?

A Yes, I do.

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Q Why do you tell them?

A I tell them so that they can make an informed decision.

Q And would you agree, Doctor, that it's important to inform the patient about the risks that are associated with a particular procedure that you intend to perform?

A Please repeat the question.

MR. OGINSKI: Could you read it back?

[At this time, the requested portion of the record was read.]

A Significant risks.

Q And is bowel injury one of the significant risks that you would expect to tell a patient about when recommending a laparoscopic BSO?

A Yes.

Q Why?

A Because although not common, the incidents being certainly under five percent, it is something that can happen, that we know happens and that is clearly

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a serious -- a relatively serious thing when it happens.

Q Would you agree, Doctor, that if a doctor, such as yourself, when

consulting with a patient about a laparoscopic BSO, if the physician did not inform the patient about the significant risk of bowel injury during the procedure, that that would be a departure from good and accepted medical care?
A I think that a doctor should inform the patient that there is a risk of injury to the bowel with a laparoscopic procedure under ordinary circumstances.
Q If the physician did not tell the patient about that risk, would you agree that that would be a departure from good care?
A I'm not going to make a blanket statement about that, but under ordinary circumstances, the doctor should do that.
Q And they should do that so the

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patient could make an informed decision about whether they should go forward; correct?
A Yes.
Q If the patient does not have sufficient information because the doctor didn't fully inform them, would you agree that the patient would be at a disadvantage in making an intelligent decision about to proceed with the surgery?
MS. : I'll object.
Q Can a patient who is not informed of a significant risk of bowel injury during laparoscopic BSO, make a sufficiently informed decision about whether the procedure is right for them?
A I can't generalize, but under most circumstances, this is something that patients should be told and that would be a factor that most patients would want to have at their disposal.
Q What is your opinion, Doctor, if a physician does not provide that

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information to the patient prior to undergoing surgery?
A I don't understand what you are asking me.
Q What do you think about that?
MS. : You have to rephrase the question.
Q Do you have an opinion with a reasonable degree of medical probability as to whether a doctor who does not

provide the risk of bowel injury to a patient undergoing laparoscopic BSO, whether the failure to provide that information would be a departure from good and accepted medical practice?
A I think it would depend upon the circumstances and I couldn't make a blanket statement covering all cases.
Q I'm asking generally and you've already told me that it would be appropriate and in fact, the physician should tell the patient about the risk of bowel injury.
I'm simply reversing the

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question and asking whether the failure to tell the patient about the risk of bowel injury would be a departure from good and accepted medical care?
MS. : Asked and answered.
MR. OGINSKI: He didn't answer it.
MS. : Yes, he did.
Q Do you have an opinion, Doctor, as to whether -- in addition to telling the patient verbally about the risks of any laparoscopic surgery, do you provide them with written booklets or pamphlets about the procedure?
A I personally don't and I don't -- I personally don't. I'm not sure if my nurse did.
Q Do you typically draw any diagrams for the benefit of the patient, to explain what procedure you're going to perform?
A I typically point to a picture that I have in a book or on a model.

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Q Have you ever videotaped any of your discussions concerning informed consent with your patients?
A No.
Q Or audio recorded that conversation?
A No.
Q Now, would you agree, Doctor, that a patient who is not provided information about the risk of bowel injury, would not be presented with full information sufficient to make a decision about whether to go forward with the surgery?
MS. : That was asked and answered. You asked him that

question.
MS. : Note my objection.
Q Tell me why you cannot make a blanket statement about the failure to provide information concerning risk of bowel injury to a patient and whether that would be a departure from good care?
A In all medical activity, in all

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activity by a physician, including communications, you have to look at risk and benefit and you have to look at whether the information would be helpful to the patient, which would include such things as to how important -- the severity of the patient's condition, the urgency of the problem, the patient's state of mind, the patient's own desire, both expressed and apparent to hear information and other things. And you take all of these things into account when -- in discussing risks and benefits.
Q Doctor, you told me that you talk to the patient about all the significant risks associated with the procedure; correct?
A Uh-huh.
Q You have to answer verbally.
A Yes.
Q Death is obviously one of the most significant risks; correct?
A Not necessarily. Death is a risk, but it happens so infrequently

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that, you know, if it happens, it's obviously catastrophic, but it's not something that I necessarily discuss with patients.
Q Do you inform them that there is a risk of death with anesthesia?
A I typically do not.
Q Typically in a laparoscopic BSO, such as the one that was performed in this particular case, would you agree that major vessel injury and intestinal injuries are the most serious complications associated with this type of procedure?
A I would agree that they're very serious complications associated with this type of procedure. If we're talking about superlatives, I don't know, but they're certainly serious complications.
Q Are there ways to reduce risk of intestinal injury during laparoscopy?
A Yes.

Q How?
A One way is to give the

patient -- ask the patient to take a bowel prep prior to surgery. Another way is to perform open laparoscopy, meaning make the initial incision with a scalpel, as opposed to just a blind puncture.

And in terms of the actual performance of the laparoscopy, these are the two main things you can do in terms of technique, to reduce the risk of a bowel injury on performance of the laparoscopy.

Q With a bowel prep, the patient will evacuate the contents of the bowel?
A Yes.
Q And the reason why it reduces the risk is to eliminate any fecal spillage in the event there is a perforation?
A It does that too, in case there is a perforation. But it also tends to make the contents -- tends to make the bowel smaller. Once the air and fecal matter are evacuated, they occupy no space.

Q With an opened laparoscopy, am I correct you can visually see where you are inserting the instruments, at least initially?
A Yes, it doesn't entirely reduce the risk because you are still making that initial incision into the peritoneal cavity through a small incision, but in terms of -- but it gives you some greater measure of control, so that when you are making the initial incision, you can often see if there is something grossly wrong immediately below the peritoneum.
Q Would you agree, Doctor, that in a patient who had multiple surgeries, it's fair to assume that the patient has abdominal adhesions?
MS. : Note my objection to form.
MS. : You can answer if you can.
A It would be common for a patient to have adhesions.
Q And where there is severe

adhesions anticipated, would you agree in many cases, it would be preferable to

avoid laparoscopy all together and go straight to a laparotomy?
A In some cases.
Q Where significant adhesions have been documented from a patient's prior abdominal surgeries, would you agree that it is often preferable to go straight to a laparotomy, as opposed to attempting a laparoscopy?
A No.
Q Why?
A Because if you can achieve laparoscopic visualization, then you can see what the anatomy looks like, what the patient's insides look like, what the patient's structures look like. You can actually see the adhesions and then you can, if you're uncertain as to whether the laparoscopy is feasible, you can -- you do some preliminary dissection to determine if the dissection is feasible.
Q If a patient's prior surgeries

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have documented significant adhesions, is it your opinion that you can still attempt to perform laparoscopy?
A Again, I'm not going to say anything is 100 percent the case, but I think it's -- I think that in -- I think it's generally prudent to attempt laparoscopy.
Q If a patient has significant adhesions from prior surgeries, other than performing an open laparoscopy, can you attempt to place the primary trocar in an alternative location?
A You can.
Q What is blunt dissection and how does it compare to sharp dissection?
A Blunt dissection means that you're putting traction against tissue with either a -- let's start with sharp dissection.
Sharp dissection is cutting tissue with a scissor or a knife. Blunt dissection is putting pressure against tissue, either with a blunt instrument or

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with the finger.
Q Would you agree that in a patient with significant adhesions, that blunt dissection is not preferable?
A No.
Q Why?
A I think that the use of blunt versus sharp dissection is something that

needs to be decided by the surgeon at the time.

Now, when performing blunt dissection, it should always be performed, of course, with reasonable gentleness and so forth. But the thing is that when you cut something, on the one hand, you know where the instrument is. On the other hand, if there are adhesions, you can't necessarily tell where the adhesions end and a structure begins. On the other hand, when you don't have appropriate -- you don't have a sense for whether the tissue is yielding or not.

When you perform blunt

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dissection, you have a sense, whether with instruments or a finger, you have a sense of where the -- as to how dense the adhesions are. You have a sense as to how yielding things are, how yielding tissue is. And in many cases, adhesions will give way with blunt dissection and form a nice surgical plan in an area where cutting will be more likely to injure a vessel.

And blunt dissection, of course, is less likely to injure major vessels. So you have to, as a surgeon, at any given point, weigh the advantages and disadvantages of any particular dissection technique at that time, in that patient, with your own experience and what has worked for you as a surgeon. And you absolutely cannot make any generalization that this or that dissection technique should be carried out in any given circumstance.

Q Have you authored any peer review articles on the performance of

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laparoscopy?

A I don't recall. I know that there is at least one case report that I authored which was peer reviewed, which told the story of somebody's laparoscopic complication and I can't remember if I authored any other.

Q Other than a case report, have you authored any specific article about the performance of laparoscopic surgery?

A I don't believe so.

Q Would you agree, Doctor, that bipolar and ultrasonic devices can cause thermal injury by heat conduction, as

well as by direct contact?
A Please repeat the question.
Q Can bipolar and ultrasonic devices cause thermal injury to bowel or surrounding structures?
A Yes, they can.
Q And they do that by heat conduction and also by actually touching the instrument to a particular area?
A They can.

Q Would you typically avoid using monopolar electrosurgical devices during laparoscopy in a patient who has significant adhesions?
A Not necessarily.
Q Why would you -- are there some instances where you would?
A There are some areas in which I would use monopolar and there are some areas in which I would use bipolar.
Q What is the distinction?
A With a monopolar device there is an electrode usually on the leg, but on some distal distant part of the body, distant from where the current is being applied. And the current goes from the electrode to the tissue, where it disperses through the tissue and it's intense through the tissue and is carried to the electrode.
With a bipolar device, there are two electrodes and the current flows between the two electrodes rather than -- and then the electrode on the leg is just

a ground. This is my understanding of the difference between a monopolar and bipolar device.
Q Under what circumstances would you not use monopolar devices in a patient with significant adhesions?
A I would not use a monopolar electrical device if I felt I was operating in very -- near a significant blood vessel. And I would not use a monopolar device unless I were certain that the tissue that I was coagulating, was a distance from a structure, subject to injury by the monopolar device, such as bowel.
Q Now, in , you were the chairman of the Department of Obstetrics and Gynecology at Hospital?
A I was.
Q And are you still in that

position, that capacity?
A I am.
Q And you are a gynecologic oncologist by training; correct?

A An obstetrician and gynecologist and an gynecologic oncologist. It's a subspecialty. You have to do one before you do the other.
Q In , did Hospital have a separate division of gynecologic oncology?
A It had a service basically consisting of me and there is a private gynecologic oncologist that practices there as well.
Q Did the hospital have any GYN oncology fellows that rotated through your department?
A No.
Q There were OB/GYN residents that rotated through your department; correct?
A They didn't rotate through my department; they were intrinsic to the department. Medical Center had, at that time and still does, a fully approved residency in obstetrics and gynecology.

Q And there are no fellowships associated with the OB/GYN department then; correct?
A No.
MS. : Off the record.
[At this time, a discussion was held off the record.]
Q Doctor, at the conclusion of any laparoscopic procedure, especially after cutting adhesions, would you agree that it's important to inspect the intestines before removing your instruments?
A Yes.
Q Why?
A To -- let me back off and qualify that. It's important to inspect the intestines, in certainly the area where you operated, to look for injuries.
Q And would the failure to look for any injuries prior to completing your procedure and removing instruments, be considered a departure from good and

accepted medical care?
A One can't -- I'm not going to generalize about that.
Q I'm asking you as a physician who performs laparoscopy, would the failure to inspect the cavity where you have been operating prior to removing your instruments and completing the procedure, would that be considered a departure from good care?
A In some cases, yes, and some cases, no.
Q Tell me what cases you would consider it to be a departure?
A That would have to take into account why it was being done, why the procedure was being terminated, what had been done and many other factors.
Q You had told me a moment ago that it's important to check the area where you have operated, to check for any injuries?
A Generally so.
Q And would the failure to check

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for any injuries prior to concluding the procedure, be a departure from good and accepted medical care?
A Sometimes, yes; sometimes, no.
Q Are you saying, Doctor, that it would depend on each particular case individually?
A Yes.
Q Now, when you inspect the surgical area at the conclusion of laparoscopy, before removing your instruments, would you agree that it's good medical practice to when you write or dictate your operative report, to indicate the details of your inspection in your note?
A Not necessarily, no.
Q What is the purpose of creating an operative report?
A To document what you found and what you did.
Q And a year or two from the time of performing the surgery, would you agree that an operative report allows you

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to go back and refresh your memory about what you did and what you found and anything else that you observed?
A It does.
Q Now, if another physician were to look at your operative report and

certain things were missing from that report, how then, other than speaking to you, could that physician obtain that information about things that may have occurred during surgery, if it's not contained in the operative report?

MS. : Objection.

Q When you have -- withdrawn. If you inspect the patient's peritoneal cavity prior to completing your procedure, would you agree that it's good practice to record that in your operative note?

MS. : Objection.

You just asked him that.

Q When you dictate your notes, your operative note -- withdrawn.

You teach residents in your

0048

program; correct?

A Yes.

Q And as part of your teaching, do you teach them about the importance of keeping accurate records?

A Yes.

Q Why?

A Because it's important to keep accurate records.

Q Why?

A To document what you found and what you did.

Q Now, if a resident observed certain things during the course of surgery and did not record them, for whatever reason and I'm talking about significant findings, would you typically try and teach the resident and explain to them that they need to record significant findings that occurred during surgery?

MS. : Note my objection.

A I'm not sure what circumstances you're talking about.

Q I'm only talking about GYN

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surgery that's performed at Hospital in , that if a resident performed a procedure and dictated an operative note and the resident did not include significant findings, would that be something you would want to speak to that individual about and teach them what to put in their note?

A Okay, for my own cases, I almost always record -- I almost always dictate my own operative notes, so it doesn't come up.

Q When you are teaching the residents, you told me you teach them to create accurate records, what do you do in an instance where a record is not accurate or there is missing information, in terms of teaching them what to do?
A I tell them that the information is missing and that they should record information of that character, to the extent that it's something that I think is something that should -- that should be there, to the

extent that it's something that I feel should be there.
Q Now, if a resident had performed a laparoscopic BSO and did not record that they inspected the surgical area prior to completing the procedure and is not contained within the operative note, is that something you feel would be appropriate or inappropriate?
MS. : Note my objection.
A You know, it's something that hasn't come up and I haven't reflected on at this point, but, you know.
Q Doctor, you have been the at Medical Center; correct?
A Yes, I have.
Q And that was for about years?
A Yes.
Q And during that time, you also taught OB/GYN residents; correct?
A Yes.
Q During the course of your work

at , if a resident performed a laparoscopic surgery and did not indicate in their note that they did not inspect the contents of the peritoneal cavity prior to completing the procedure, is that something you would address with a resident, in order to instruct them about what information should be in a note?
A Okay --
MS. : Note my objection.
A That particular scenario has never come up and I would be speculating.
Q After laparoscopic procedure, if a patient does not improve steadily, would you agree that one of the primary presumptive diagnoses to be excluded is injury secondary to either the procedure or the technique?

A It depends upon how the patient isn't improving.
Q Typically after surgery, you do expect them to recuperate over a period of time; correct?
A Yes.

Q And if you do not see that recuperation within that general model, do you, in your own mind, have some type of presumption and say, why is this patient not getting better?
A Your question is -- when you say recuperate, that's a very, very general question.
MS. : Can you rephrase it?
MR. OGINSKI: Sure.
Q At some point, if a patient is not getting better following laparoscopic surgery, do you form any type of presumptive diagnosis, that maybe one of the primary reasons why they're not getting better is because of the possibility of injury as a result of the procedure?
A If -- it depends upon the circumstances of their not getting better. Not getting better encompasses a wide range of signs and symptoms.
Q You had told me at the

beginning that one of the clinical signs of a bowel perforation is abdominal pain; correct?
A Yes.
Q And would you agree that in a patient who has a bowel perforation and has abdominal pain, that typically they require narcotic pain medication?
A I'm sorry, you kind of asked me a compound question and I don't understand it.
Q I'll rephrase it. Are you able to quantify the degree of pain that a patient with a bowel perforation experiences or characterize it?
A You can characterize it; I wouldn't say quantify it.
Q How would you characterize it?
A Mild, moderate, severe, more than yesterday, less than yesterday, the same as yesterday, that type of thing, dull, sharp, continuous, intermittent. There are many ways to characterize it.
Q Would you agree that after

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there is an intestinal perforation, the risk of sepsis is high?

MS. : Objection.

You already went over this.

Q When you have --

MR. OGINSKI: I'll withdraw it.

Q When performing a laparoscopy, an opened one, that you talked about earlier, would you agree that it's important to understand and know the anatomy, in order to avoid injury with placement of the trocar?

A To know anatomy, you're asking me?

Q Yes.

A The anatomy of the area where you are placing the trocar, yeah.

Q Why?

A So that you can be familiar with the sorts of things that can happen.

Q In this particular case on , with 's surgery, you performed an open laparoscopy; correct?

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A Correct.

Q Who made the decision to create the open --

A I did.

Q When you created the opening, did you also place a trocar as well?

A I placed, yes, I placed a trocar through the opened incision.

Q Who placed the trocar in this case?

A I did.

Q And there was a resident who was assisting you during this case; correct?

A Correct.

Q Customarily in a teaching hospital like Hospital, where you have residents, is it customary to allow the resident to make the initial incision and to place the trocar?

MS. : Note my objection.

A There is no hospital-wide custom or policy.

Q Now, one of the risks of injury

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during laparoscopy is the risk that occurs during the entry or the approach; correct?

A Yes.

Q As well as the possibility of injury during the actual procedure, whether it's manipulation of the scissor, forceps, probe or any energy device; correct?
A I wouldn't characterize the approach as not being part of the actual procedure.
Q Other than the risk of injury as a result of the approach, I'm talking now about risk of injury during the procedure?
A The procedure starts with the skin incision.
Q I'll rephrase it. Once you have entered into the peritoneal cavity, would you agree there is a risk of injury once you are performing the actual surgery, whether it's a BSO or whatever else you intend to do?

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A The -- I think I know what you are getting at, the dissection in the pelvis.
Q Thank you.
A Yes.
Q And you agree that is a risk?
A Certainly there is a risk, yes.
Q Now, does a patient with abdominal adhesions, place the patient into a higher risk category for trocar injury?
A If the adhesions are to the area where you are going to put in the trocar.
Q How do you know if the adhesions are in that location?
A You don't.
Q If you have documents, operative notes from prior surgeries, does that sometimes assist you in identifying where the adhesions are located?
A It doesn't tell you where the adhesions are. It lets you know that

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other people have found adhesions and lets you know there are adhesions.
Q But the fact that the patient is known to have adhesions from prior surgeries, does that, in and of itself, place the patient in a higher risk category of getting an injury as a result of placement of the trocar?
A Yes.
Q Why?

A Because there may be a higher risk of having adhesions in the area where -- well, in the anterior abdominal wall and you are going to be placing the trocar through the anterior abdominal wall.
Q Generally, would you agree that a patient who has adhesions is in a higher risk category for getting a bowel perforation, than someone who does not have adhesions?
MS. : You asked him that already. Asked and answered.
MR. OGINSKI: This is distinct.

This is a different question. I'm now making a distinction between someone who has adhesions and someone who doesn't.
MS. : You asked that already.
MR. OGINSKI: I didn't.
MS. : Yes, you did.
MR. OGINSKI: What was the answer?
MS. : Let her read it back.
Q Doctor, is a patient who has abdominal adhesions, at a higher risk for bowel injury from someone who does not have adhesions?
MS. : That's the same question. You asked him that already.
MR. OGINSKI: I didn't.
MS. : You did.
MR. OGINSKI: I didn't. I don't want to spend ten minutes --
MS. : It's annoying

if you keep repeating the same questions. You ask the same question five different ways, that's your style. You asked him this question already.
MR. OGINSKI: I disagree, but I don't want to spend 10, 15 minutes to have her search for it. You can tell me what you recall him saying. Do you want her to look for it?
MS. : Sure, he answered to the question already.
MR. OGINSKI: What was the answer, to your memory?
MS. : It doesn't matter. She'll read it back to you.

MR. OGINSKI: I didn't ask the question. I'll move on.
Q Doctor, if during the course of surgery, specifically laparoscopic surgery, where the patient has significant adhesions and you cannot readily identify the anatomy during the lysis of adhesions, do you then form an

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index of suspicion to the injury to the bowel or adjacent organs, as a result of being unable to identify the anatomy? I'll rephrase it.
In a patient who has significant adhesions, where you can't readily identify the anatomy, is a patient like that at higher risk for injury to the bowel?
MS. : That's the same question phrased another way, but go ahead, answer it.
A The patient is at higher risk for injury to the bowel if there are more -- going in prospectively, if there are more adhesions.
Q Now, before performing -- before making the entry, would you agree that you cannot predict with any accuracy, whether the intestine is adhered to the entry site?
A I'm not sure what you mean by, with any accuracy.
Q I'll rephrase it. You don't

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know with any degree of certainty, whether the intestine is right at the area where you intend to make your opening; correct?
A Know with any degree of certainty? I know that there is a possibility that the intestine may be adhered to the anticipated entry site.
Q Now, in an opened -- withdrawn. In a closed laparoscopy, once you are in, you've placed the trocar, you placed your instruments, what do you do to confirm there is no injury to the bowel or major vessels from the entry itself?
A In a closed laparoscopy?
Q Yes.
A I haven't done one in years, but there are a number of things you can do.
Q Such as?
A Such as inspect the entry site with another -- with a laparoscope placed

through another port, such as when you are pulling out the trocar at the end of

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the case, pull it out with the camera on, so that you'll see if you went through a loop of bowel or the lumen of the bowel.

Q Now, in an opened laparoscopy, what do you do to confirm there was no injury to the bowel or major vessels as a result of the entry?

A Okay, in an opened laparoscopy, you know that there is no injury to the major vessels because there are no major vessels anywhere near the umbilicus, assuming that's where you do it, so it's a non-issue.

As for the bowel, when you make the incision through the peritoneum, if the bowel is adherent there, you can readily see the lumen of the bowel, which has a characteristic appearance.

Q What if there are adhesions in that area, that prevent you from readily identifying that area?

A If there are adhesions, you would have cut through the adhesions into the bowel because you would have

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perforated it and you would see the lumen of the bowel on entry.

Q Now, you told me that when I asked you about reducing, things you can do to reduce the risk of intestinal injury, you said that open laparoscopy doesn't entirely remove the risk, tell me why?

A Because when you cut through the peritoneum, if the bowel is adherent right there, you can be cutting through a thin bowel or right into the lumen.

Q Would you agree, following dissection of dense adhesions, it's good to irrigate the neighboring intestine with sterile saline and perform a detailed inspection of the intestines to evaluate the integrity of the bowel?

A Generally speaking, that's a good idea after.

Q Why?

A To look for perforation or other injury.

Q How long does that actually

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take to do your inspection and to put in the sterile saline to inspect the

integrity of the bowel?
A Depending upon the circumstances, anywhere from a couple of minutes to ten minutes.
Q And if you do in fact perform a detailed inspection of the bowel and the intestines, would you agree that it's important to put that information in your operative report?
A Not necessarily, but -- not necessarily.
Q Would it be helpful to the person, the next physician who reads your operative report, to indicate that you did in fact perform an inspection of the bowel and this is what you found?
MS. : Note my objection.
A It might; it might not.
Q Now, I would like to direct your attention to this particular case.
Is there any doubt in your mind, Doctor, that

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experienced a bowel perforation, which was recognized on ?
A I believe it may have been recognized on a day or two earlier than that, on the . But there is no doubt in my mind that she experienced a bowel perforation.
Q And what makes you believe or makes you -- withdrawn.
What is your understanding as to when this bowel perforation was recognized; was it recognized intraoperatively or before the surgery was done -- withdrawn.
I'm not talking now about the suspicion of a bowel perforation, I want to know when it was actually diagnosed.
MS. : Let him look at the record.
MR. OGINSKI: Just so the record is clear, the doctor is looking at Plaintiff's Exhibit 2, which is the original hospital chart for this patient, for the hospital

0067

admission of .
Q Doctor, at any time or sometime before today, you had a chance to review the patient's chart that's currently in front of you?
A Yes.
MS. : A copy of it.
Q When before today did you

review it?
A I reviewed it yesterday, days ago.
Q And before that time, when did you last review it?
A I can't tell you. I don't have any recollection of reviewing it since she left the hospital.
Q In addition to the patient's copy of the chart from Hospital, did you also at some point before today, review your office records for this patient?
A Yes.
Q And when did you review that most recent to today?

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A A week ago yesterday.
Q And the same question, when had you reviewed it before that?
A A long time ago.
Q In preparation for today's deposition, did you review any medical literature?
A No.
Q Did you review any textbooks in preparation for today's deposition?
A No.
Q Did you review any deposition transcripts, specifically of , before coming today?
A I didn't.
Q Did you review any testimony at all by anyone given in this case, prior to today?
A No.
Q Do you have an independent memory as sit here now, as to when this particular bowel perforation was recognized and diagnosed? And I'll allow you plenty of time to go through the

0069

record, but just from your memory?
A I'm not sure what we mean by recognized or diagnosed.
Q I'll rephrase it. Am I correct that on , you performed surgery on ?
A Yes.
Q And during the course of the surgery, one of your findings was that you recognized there was a bowel perforation; correct?
A Yes.
Q And you identified that bowel perforation as being

millimeters in length; correct?
A I did.
Q And just to use the words you used in your operative report, it was an incision millimeters long; correct, and you are free to look at the operative report?
A That's the phrase that I use.
Q Now, would you agree, Doctor, that this patient did not suffer a

thermal burn; correct?
A There was nothing that I saw there at the time that was consistent with thermal burn.
Q Did you form an opinion on , as to whether the bowel injury happened during the surgery that had been performed eight days earlier on ?
A I don't recall.
Q Did you form an opinion when you recognized there was a bowel perforation on , whether this perforation was a result of something that occurred during her initial surgery on ?
A I don't recall what opinion, if any, I formed at that time.
Q Did you form any opinion as to the cause for this bowel perforation that you recognized on , as to how it came about?
A I thought there may be some possibilities probably.

Q And what were those possibilities?
A That one is that it was formed at the time of the initial surgery on the . Another is that it was formed while looking -- while inspecting the pelvic field on the .And the third is that it was formed at the time of the initial operation on the and enlarged during the dissection on the .
Q What made you believe that that was a possibility, that it was enlarged as a result of the surgery?
A Well, first of all, because the sigmoid colon had been stuck to other structures and it had to be peeled off. Second, because it did look as though it was fresh and if it had been as a result -- if it had been entirely as a

result of the prior operation, there might have been some areas of necrosis around the edges, but something that, you know, that you can't tell 100 percent

sure just by looking at it.

And finally, I did inspect the operative field and the colon before I closed on the and would have certainly noticed an incision that was millimeters long.

MR. OGINSKI: Can you read that back, please?

[At this time, the requested portion of the record was read.]

Q Doctor, can you turn to your first operative report dated ?

A Yes, I have it.

Q The bowel injury that you recognized on , did that happen during the laparoscopic portion of the surgery on ?

A No.

Q Did that happen during the laparotomy portion of the surgery on ?

A If it happened on the at all, it happened during the laparotomy

portion.

Q Would you agree that this bowel injury was not recognized at any time on , during the surgery that was performed?

A Yes.

Q Now, if this bowel injury, this millimeter long injury had been recognized during the surgery on , what would you have done in order to repair that?

A First, I don't know that there was a millimeter injury on the , but had I noted a millimeter injury on the or an injury of any size on the , I would have oversewed it.

Q Typically it would have been oversewn with one or two stitches of this size?

A Again, depending upon the size, I typically would have approximated it through and through silk and then pulled serosa -- correction. I would have

approximated it be through and through with chromic, then covered that with seromuscular silk sutures.

Q Would you agree, Doctor, for this size injury, assuming it was present on , that the oversewing of that defect would require very few sutures?

A I can't tell you exactly how many sutures it would require, but usually I would -- but it would been interrupted. Not interrupted, but running chromic and then several interrupted silk.

Q And based upon your experience, this would have been a simple matter to oversew it; correct?

A I don't know because I don't know what it looked like. But it would have been feasible had it been there.

Q This is not something you would have needed to call in a general surgeon to repair; correct?

A I'm a

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and I'm trained to repair this myself.

Q Is it fair to say during your career you have encountered bowel perforations during surgeries you have performed?

A Yes.

Q Is it also fair to say that you have repaired certain bowel injuries that occurred during surgery?

A Yes, I have.

Q Have there been instances where you had to call in a general surgeon to come in and repair a defect that occurred during GYN surgery?

A Without using the word have to, there are times when I have, for a variety of reasons, then if it involved something like the stomach, if it involved the stomach.

Q I'm only sticking to bowel.

A There have been times. There certainly have been times for a variety of reasons, but I feel like I'm capable of repairing bowel injuries.

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Q Now, if you recognize a bowel perforation intraoperatively, is it correct to say that the patient would not require colostomy at that point?

A That's correct.

Q Is it also fair to say that the

patient would unlikely become septic as a result of that oversewing the bowel defect, in general?
A The patient might well develop an infection postoperatively if there is a perforation, but, but the chances of a serious infection are much less.
Q Now, in a patient whose bowel perforation is not recognized at the time of surgery, would you agree that one of the risks of bowel perforation, as you mentioned, is infection?
A Yes.
Q Can the patient also get a fluid electrolyte imbalance?
A Not as a direct result of the perforation.
Q Can there be intestinal fluid

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and feces containing bacteria that will empty out into the abdominal cavity?
A Yes.
Q Does that produce any toxins or follow the bacteria into the blood stream?
A It can.
Q Can an unrecognized bowel perforation lead to intraabdominal abscesses?
A Yes.
Q How?
A Any infection from -- any bacteria from any cause, it can happen with or without bowel injury, but if there is a bacterial contamination of the abdominal cavity, then this can result in formation of an abscess.
Q How do you diagnose an abscess?
A There are a number of ways, but -- there are a number of ways. It depends on where the abscess is too.
Q If you think the patient has some type of intraabdominal abscess, what

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are the diagnostic tests you have available to you, in , that would assist you in making the diagnosis?
A Those are basically radiologic tests, ultrasound and CAT scan.
Q And at Hospital in , did you have available to you ultrasound?
A Yes.
Q As well as CAT scan?
A Yes.
Q Now, if the abdominal cavity

becomes contaminated from a bowel perforation, can that lead to inflammation of the peritoneum?
A Yes, it can.
Q And what signs or symptoms would you expect the patient to exhibit if that occurred?
A Severe pain, marked distension, rigidity of the abdomen, absence of bowel sounds, vomiting, absence of flatus, absence of stool.
MS. : Off the
0079
record.
[At this time, a discussion was held off the record.]
Q Where there is inflammation of the peritoneal cavity from an unrecognized bowel perforation, can you get the subperitoneal blood vessels where they become porous, causing the interstitial fluid to leak into the third space?
A That happens after any laparotomy.
Q What is an ileus?
A Ileus is a condition where without obstruction, the intestine is not undergoing peristalsis or the peristalsis is markedly diminished.
Q Is that also known as paralytic ileus?
A Yes.
Q Is that similar to gastroparesis?
A I'm not sure that the term gastroparesis is a very precise term.
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Q What is your understanding of gastroparesis?
A I don't have one. I don't use it.
Q In a patient who has an unrecognized bowel perforation, can you see an ileus or do you sometimes -- withdrawn.
In a patient who has an unrecognized bowel perforation, is ileus one of the findings that you may see?
A It's a finding after most large operations, so you can see it. So you can see it, but it's not clear it's due to the bowel perforation.
Q Would you expect the ileus to resolve within a short period of time after the surgery has been complete,

whether a day or two or some other time period?
A I've seen ileus last up to a week and a half. And in somebody with a laparotomy, with extensive dissections, I wouldn't be at all surprised to see an

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ileus last for up to a week, in the absence of any complication.
Q Can a patient who has ileus, have positive bowel sounds?
A Yes.
Q Can a patient who is experiencing flatus, have an ileus?
A Ileus is generally -- ileus is generally thought of as being incompatible with flatus, except for very mild ileus.
Q In a patient who -- can a patient who has a bowel movement, have an ileus?
A Ileus is generally thought to be incompatible with a bowel movement, unless it's very, very mild.
Q In a patient with unrecognized bowel injury following surgery, can accumulative fluid in the peritoneal cavity cause the lungs to get pushed or to expand and contribute to partial lung collapse?
A Virtually everyone who's had a

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laparotomy, has some partial lung collapse, atelectasis especially.
Q Can the inflammation of the peritoneal cavity, can that accumulate in the chest as pleural cavity effusion?
A Pleural effusion is a fairly nonspecific sign and a lot of things -- it's not common to see that postoperative.
Q What is peritonitis?
A I didn't hear your question.
Q What is peritonitis?
A Peritonitis is an infection of the peritoneal cavity. It's an inflammation of the peritoneal cavity. It doesn't need to be infectious.
Q And is peritonitis a frequent complication associated with a colonic injury?
A Yes.
Q Is ileus also a complication associated with a colonic injury?
A As I just said, it's very nonspecific and you will see that to some

0083

extent in almost every major laparotomy.
Q Is intraabdominal abscesses frequently associated with a colonic injury?
A Yes.
Q I know you said pleural effusion is nonspecific, but do you often see it with a colonic injury?
A You can. I can't say if you see it often. I don't know that you do.
Q Now, getting back to , would you agree, Doctor, that on , when you initially performed your surgery, that there is no question that she had dense adhesions?
A I agree with that.
Q In fact, the adhesions were so dense and thick, that you had to cancel the laparoscopy and convert it to an open procedure; correct?
A I didn't cancel it, I converted it.
Q I'll rephrase that. You had to convert the laparoscopy to a laparotomy?

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A That's correct.
Q Would it also be correct to say that you had difficulty finding the surgical planes between the ovary and the sigmoid mesentery because she had a belly full of adhesions?
A That's correct.
Q And did you spend a great deal of time lysing the adhesions, trying to find and identify the anatomy?
A I don't remember offhand how much time I spent, but that was a substantial portion of the case, yes.
Q And in a patient such as , where there are such dense and thick adhesions, is it more difficult to identify the anatomy than in someone who doesn't have all those adhesions?
A Yes.
Q And after you lysed or cut through the adhesions in order to accomplish the procedure on , am I correct that you inspected the cavity, the area where you were

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operating?
A That's correct.
Q And based upon your examination, you did not find any injury

to either major vessels or to any injury to the bowel?
A That's correct.
Q Now, what role did the resident play in participating in her surgery on ?
A The resident basically was first assisting me. The resident who was participating in this operation on would have tied knots, held clamps, held retractors, probably placed clamps across the ovaries when the vessels had been dissected. The resident --
Q I'm sorry to interrupt, Doctor, I assume you are telling me based upon what a first assistant typically does?
A I am telling you what a second-year resident operating with me on a pound patient, with dense

0086

adhesions, would have done.
Q Now, I'll ask you, do you have a specific memory as you sit here now, as to what this resident did during the course of this procedure, separate and apart from what you expect and customarily have the resident do?
A No.
Q And am I correct that the patient's weight is a factor, in terms of difficulty in performing the surgery?
A Yes.
Q Why?
A Because first of all because that means that the abdominal wall is thicker, so that the hole is deeper, so to speak, the incision is deeper and more difficult to use instruments. It's more difficult to -- and then some of the tissues will be infiltrated by fat, which just means that there is generally a little less room in which to operate. And then in terms of retraction, which is holding tissues away

0087

from other tissues to create exposure and visibility, it's physically more difficult because it weighs more.
Q This resident, whose name is , ?
A Yes.
Q Is it a man or woman?
A She's a woman.
Q Is Dr. still a resident at Hospital?

A No.
Q When did finish residency?
A finished residency at the end of .
Q Of what year?
A This .
Q Where does Dr. practice?
MS. : Note my objection.
MS. : You can answer.
A She told me she was going to practice in .
Q Have you spoken to Dr.

about this particular case after the lawsuit was started?
A No.
Q Have you spoken to Dr. for any reason at all, after completed residency up until today?
A Yes.
Q When did you last speak to ?
A About two weeks ago.
Q Was that in regard to a patient?
A No.
Q Was that in regard to this particular case?
A No, called me to tell me passed boards, that was all that was said.
Q Are you aware of what hospital is affiliated with in ?
A told me what hospital would be affiliated with. I don't know with -- I don't know definitively. Obviously if applied and got privileges.

Q What hospital?
A in .
Q Did Dr. lyse any adhesions during the surgery?
A No.
Q You were the only one who broke apart and cut the adhesions?
A Yes.
Q Now, if you suspect that there is a bowel injury intraoperatively, what are some of the things that you can do to definitively identify whether there is in fact a defect in the bowel?
A Well, usually you'll know just by looking at it and one thing you can do is pour saline in and then in the course

of manipulating the bowel, you will see bubbles.
Q Are there any other ways that you can identify if there is a bowel injury intraoperatively?
A Yes.
Q What other ways?
A You can instill fluid into the

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rectum and see if it comes out the colon.
Q And what type of fluid do you use?
A Saline tinged with a blue dye.
Q Have you ever used a Betadine liquid in order to evaluate the integrity of the bowel?
A I have not.
Q If you suspect intraoperative bladder injury, what do you do to definitively identify a bladder injury?
A Instill water or saline tinged with a blue dye into the bladder.
Q Is that methylene blue?
A Usually I use methylene blue.
Q When you pour saline on the bowel and you say you look for bubbles, do you instill air into the bowel with a syringe?
A No, there is generally air in the bowel that has -- as you manipulate the bowel, you are squeezing it.
Q How long does it take, you told me earlier the length of time it can take

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to pour saline on and look for bubbles?
A Uh-huh.
Q If you were to instill fluid into the rectum, the blue dye, how long does that part of the process take?
A The whole thing would take about 15 minutes.
Q Now, if you suspect bowel injury during the course of the laparotomy, am I correct that you can visually inspect with your hands and run the length of the bowel to see if there is any injury?
A Yes.
Q And is there any distinction to -- withdrawn. Am I correct that on , you had no suspicion -- withdrawn.
On , did you have any suspicion that the patient might have any type of injury to the bowel intraoperatively?

A No.
Q And would it be fair to say
0092
that you did not perform any of those procedures that we just talked about, including pouring saline, looking for bubbles to the colon?
A When I irrigate, I am always looking for bubbles, that's pretty routine.
Q You did not instill any blue dye into the colon?
A I don't believe so.
Q And did you not that do that for the bladder as well?
A Correct.
Q When you performed this procedure, did you install bladder catheters?
A Yes.
Q And is that something that you put in or you had a urologist do that?
A A bladder catheter?
Q Yes.
A The resident does that. It's just done through the urethra.
Q What is the purpose of putting
0093
in bladder catheters prior to doing either laparoscopy or laparotomy?
A To drain the urine, so you know how much urine is put in.
Q I apologize, ureteral catheters, were they inserted in this patient?
A No.
Q And am I correct that you did not call in any general surgeon to come in to assist you or evaluate the patient during the surgery?
A That's correct.
Q What is a walled off abscess?
A It's basically synonymous to an abscess.
Q What does the term loculated mean?
A Loculated means that there are several different fluid cavities in cyst and abscess, whatever you are talking about, several different cavities filled with fluid.
Q In a patient who has no bowel
0094
injury, is it common to see intraabdominal abscesses following

laparoscopic or laparotomy surgery?
A It's not uncommon.
Q To what, if anything, do you attribute intraabdominal abscesses following laparoscopic surgery or laparotomy surgery?
A Okay, following -- let me correct following. Laparoscopic surgery done by itself, you rarely see an abscess following a laparotomy. Despite using sterile technique, there is no way that an operation can be completely sterile. There is dust in the air. The sterile prep of the skin is never 100 percent effective in cleaning the bacteria off the skin and there is always some bacteria in the blood.
In addition, so now after an operation and especially a difficult one, there is always a small amount of or a large amount of fluid that's just exuded into the peritoneal cavity, sometimes

0095

minimal bleeding and whatever contamination there might be or even the bacteria that are just ordinarily floating around in the blood will colonize, will sometimes colonize the fluid that you invariably -- that you invariably get in the pelvis and when that happens, you can get -- develop an abscess.
Q How do you distinguish whether that abscess is from just normal contaminants in the air or surrounding area or as opposed to as a result of an injury to the bowel?
A What you do is you treat it with antibiotics and if it gets better, then you know it's an ordinary, run of the mill abscess from, you know, skin contaminants or whatever. If it doesn't get better or if it gets worse, then you are going to look for other causes.
Q If you suspect the patient has intraabdominal abscess following surgery, what diagnostic tests were available to

0096

you -- withdrawn.
If you suspect a patient has peritonitis, what diagnostic tests would you use to definitively confirm that finding?
A You generally don't. It's a clinical diagnosis.
Q And if you suspect a patient

has an ileus, are there diagnostic tests you can use to assist you in confirming the diagnosis?
A CT, X-ray. They're not definitive. You take any kind of radiographic tests into consideration with the entire clinical picture. And an ileus is not thought to be a radiologic diagnosis, but is thought to be a clinical diagnosis that is made by overall consideration of physical and radiologic considerations.
Q As part of your training to become an , am I correct that training is distinctly different from radiologists, who do their

0097

training and become board certified in that field?
A It's different, yes.
Q And am I also correct that you are not a specialist in radiology?
A That's correct.
Q And when you order a CAT scan or an ultrasound, you rely typically on the radiologist to formally interpret those imaging studies?
A They interpret it and we go over it with them.
Q And in the course of --
A As needed.
Q In the course of your career, Doctor, have you had occasion to read and interpret CAT scan films and images?
A To read them, yes. To do formal interpretation, no.
Q If you suspect the patient has pleural effusion, what are the best diagnostic tools to use to help you evaluate that condition?
A I'm sorry?

0098

Q If you suspect the patient has pleural effusion, what are the best diagnostic tools available to you to help you evaluate that condition?
A Generally speaking, generally speaking in a postoperative state, there is no need to evaluate it. It's a minor -- if there is a small pleural effusion, it's an expected finding and you don't evaluate it, but you make the diagnosis on the basis of X-ray and CAT scan.
And if for some reason or other you need to evaluate it, then you can get

somebody to aspirate pleural fluid with a needle, somebody in pulmonary medicine or something.
Q If a patient has intraabdominal abscess, what clinical symptoms would you expect to see with that condition?
A You can have a wide range of clinical symptoms, ranging from nothing, to severe pain, nausea, vomiting, high fever. It's a very -- and many things

0099

that I could talk about as far as symptoms are considered. It's a very, very broad range of spectrum of findings.
Q If a patient has an ileus, what clinical symptoms would you expect to see?
A With ileus, you expect to see distension -- symptoms, did you say?
Q Yes.
A Distension isn't a symptom. You expect -- basically you would expect to see nausea, absence of flatus, absence of stool, feeling of fullness, generally absence of pain.
Q In an ileus, what diagnostic findings would you expect to see?
A On physical exam, distension, decreased or absent bowel sounds. On an X-ray, dilated loops of bowel, usually with air in the colon.
Q Before performing the second surgery on , did you come to either a working diagnosis or some conclusion that this patient had an

0100

intraabdominal abscess?
A Yes.
Q And do you recall when it was, and just by memory now, do you recall when it was that you came to that conclusion that she had an intraabdominal abscess?
A No.
Q Do you have a note contained within this chart that would refresh your memory as to when you first concluded or believed that she had an intraabdominal abscess?
A Yes.
Q Take a look, please?
A Will you read the question back?
Q Do you have a note of your own that indicates when you first recognized or had a working diagnosis that the

patient had an intraabdominal abscess?
And again, I'm not referring to anyone else's notes, I'm only talking about your own notes.

A I would have to compare this note with the CT findings.
Q For the record, what note are you referring to?
A The note I wrote at on . Yes, the answer, this note on the .
Q You're talking about your note at ?
A Referring to the report of the CT scan on the .
Q Can you turn please back to your note?
A Yes.
Q What I would like you to do please, is read your entire note in its entirety and if there are abbreviations, tell me what they represent?
A "Gram" --
Q Beginning with the date and time?
A . Gram negative rods in blood culture, sensitivity pending. CBC done at ."

Q You don't have to read the results, continue on.
A The results are part of --
Q Go ahead, Doctor.
A We have a white blood count of 8,200; a hemoglobin of 12.4; hematocrit of 36.1; platelet count of 245. "Lungs clear; defecated last night; abdomen soft; non-tender, no abdominal pain. Temperature curve improving."
Q What does that mean?
A It meant that she had been febrile and that the tendency was to come down to normal.
Q Do you know whether that was as a result of medication, like Tylenol or anything else she was getting, as opposed to anything else -- withdrawn.
Do you know why her temperature curve was improving?
A Very likely she had fever due to atelectasis which was resolving.
Q Go ahead.
A "CT report as noted,

interpretation not consistent with more benign physical findings. Nevertheless, will treat with Amp, Gent, Flagyl for septicemia. Continue regular diet. Assess results of treatment."

Q And your signature appears there; correct?

A My signature.

Q Tell me what you meant when you wrote the interpretation of the CAT scan was not consistent with the more benign physical finding?

A Her physical findings were those of somebody with a normal postoperative course. She had a postoperative fever, which was a little high for atelectasis, but I've seen it with atelectasis and it was improving. Her abdomen was soft. I didn't write about it, but we knew that she had bowel sounds. We knew that she was defecating. We knew that she wasn't having nausea or vomiting, that she was tolerating a diet. She was -- I wrote "no

0104

abdominal pain," which means, of course, that she was having the incisional pain and discomfort consistent with surgery, but no abnormal abdominal pain. That's not precisely what it says, but that's the sum and substance of what that means. And so her physical examination was that of somebody who is recovering from surgery.

Her white count, which isn't precisely examination, but it's something I look at with regard to examination, was normal and was not really what you would expect. You would expect to have an elevated white count and rising in somebody with an abscess untreated with antibiotics.

Q Now, did you learn from the patient directly that she had defecated the night before?

A No.

Q Who did you learn that from?

A One of the residents and I can't tell you which one.

0105

Q Can you look please at the postoperative progress note by a GYN resident?

A I'm looking at it.

Q And this note is written by Dr. ?

A It is.
Q And Dr. was what year resident in ?
A Second.
Q And is Dr. still affiliated with Hospital?
A Yes.
Q In what capacity?
A just joined the staff as an attending physician.
Q In other words, completed residency and is now working full-time at the hospital?
MS. : Note my objection to the form.
A has completed her residency and is employed by the organization which operates our hospital, with duties

being to practice OB/GYN at our hospital.
Q 's an attending physician?
A 's an attending physician.
Q Now, if you look at Dr. 's note, on the left side -- withdrawn.
At the top this is dated and time is ;
correct?
A Yes.
Q "Patient's post-op day number three," and at the bottom left there is a list of problems. In the middle of it, it says "no bowel movement."
Do you see that?
A I do.
Q Can you explain the distinction, if any, between the note that Dr. wrote about no bowel movement as of the time of this note, compared to the information you obtained a little later in the afternoon on the , indicating that the patient had a bowel movement?
A No, I can't.

Q I would like you to turn please to Dr. 's note of timed at p.m. This is actually a regular progress note at p.m.
A I have it.
Q Now, Dr. 's note indicates that was called to see the patient because of an elevated temperature?
A That's correct.
Q Temperature of 38.9 is elevated; correct?
A Yes, it is.

Q Under the abdominal finding she wrote, "soft and bowel sounds sluggish"; correct?
A Yes.
Q Under assessment it says, "status post exploratory laparotomy/BSO/lysis of adhesions, with a question mark, basal atelectasis"; correct?
A Yes.
Q And as far as you recall, all this information is correct?

A Yes.
Q And then Dr. continues on the next line, it says "watch for bowel perforation"?
A Yes.
Q Do you know why Dr. made that entry?
MS. : Note my objection.
A No.
Q Did you have any discussion with Dr. after was called to examine the patient at around p.m. on ?
A I'm certain that I did, but I don't remember the tenor of the conversation.
Q Do you know what clinical symptoms Dr. was concerned about, that might have suggested that this patient could have a bowel perforation?
A No, I don't.
Q Do you know what diagnostic findings she was referring to when she indicated that she wanted to watch for

bowel perforation?
MS. : Note my objection.
A No, I don't.
Q Is there anything unusual or out of the ordinary as of , according to the note contained by Dr. , that would suggest to you that this patient might have bowel perforation?
A No.
Q Did you have any discussion with Dr. within the next day or two, the or the , to suggest that this patient had a bowel perforation and I'm talking about your memory as you sit here now, about a specific conversation you may have had with her?
A I clearly don't have any memory

of a conversation I had with Dr.
several years ago.
Q Am I correct that Dr. is
a woman?
A Yes.
Q At the conclusion of your
0110
surgery on , did you have
any discussion with Dr. about the
concern or possibility that this patient
might have a bowel perforation?
A I don't remember the tenor of
any conversation I had with Dr. .
Q Is there anything in your
operative note or note that you recorded
on , to suggest or imply
that the patient might have a bowel
perforation as a result of the surgery
that was performed?
A Not that I'm aware of.
Q Can you turn please to your
note on , please, timed at
?
A Yes.
Q I would like you to read that?
A " . Temperature
as documented. Abdomen soft, non-tender;
extremities soft, probably atelectasis."
Q What was your plan of treatment
at that time?
A Routine postoperative
0111
management.
Q Did the patient make any
complaints to you when you examined her
at that time?
A If so, I'm not aware of it. If
there would have been anything out of the
ordinary, I would have written it down.
Q Am I correct the patient was
placed on a PCA pump, a pain control pump
postoperatively?
A I don't recall, but we can --
Q I'll withdraw it and go back to
it later.
A That would have been what I
would have done ordinarily as routine in
somebody who had a laparotomy.
Q At the bottom of that page, the
anesthesia note, acute pain service,
, timed at , it says
"on PCA with Morphine"; correct?
A Yes.
Q Does that mean the patient was
getting an administration of pain
medication with a pump?

0112

A Yes.
Q The patient activates it?
A Yes.
Q In , if a patient had complained to you about pain postoperatively, would you typically make a note of it in the chart?
A No, everybody has pain postoperatively.
Q And you are referring to commonly incisional pain?
A Usually incisional pain and which is exacerbated on breathing, but that would be excisional pain.
Q Can you turn please to the note dated , timed at ?
A Yes.
Q It's on two different pages. Are you able to tell who wrote that note?
MS. : Can you identify the note?
MS. : at 11:30 p.m.

0113

A No.
Q Do you know Dr. ?
A We didn't have a Dr. . We still don't.
Q Are you able to identify the signature that appears at the end of that note?
MS. : He just told you he couldn't.
Q Is it customary to obtain a postoperative X-ray following laparotomy?
A We frequently do.
Q Why? I should be more clear. A postoperative chest X-ray, is what I should have asked?
A We might. I mean, we sometimes do.
Q Why was a chest X-ray ordered for this patient on ?
A To make sure that -- the best I can do is to piece it together by taking all of these notes taken together. It was to look for pneumonia.
Q What was the suspicion that the

0114

patient might have pneumonia?
A Just that the temperature was -- that had a temperature, that it was 39, which you certainly see for

atelectasis, but it's a little bit high, that 's obese and prone to both pneumonia, per se and prone to aspiration. And I tend to be very proactive in ordering studies because -- in ordering studies.

Q Now, the group that you practice under was known as ?

A Yes.

Q Did you have any other people working in that group, any other physicians besides yourself?

A About or . is basically the group -- the medical practice that encompasses the full-time staff of , and and probably a few freestanding physicians as well.

Q Now, were there times where you

0115

were on call for your patients and other times when you would have covering service?

A Covering?

Q Covering doctors, when you were not available?

A Yes.

Q What was the arrangement if you were away and you needed someone to cover for you?

A I would make arrangements.

Q Would that be with a private attending; would it be with a group, a faculty practice?

A It would generally be with a private attending.

Q And back in , customarily how many days or nights a week would you be on call?

A Generally I would be on call for my patients weekdays, Monday through Thursday and alternating weekends, at that time, usually with , .

0116

Q Was it your custom to round on your patients each day?

A Yes.

Q And in addition to your administrative duties as the of the department, did you also have a private practice where you saw and treated patients?

A Yes, I did.

Q Were you also responsible for

service patients?
A Yes, I was.
Q And I should have been more specific, were you responsible for seeing and treating service patients?
A I did.
Q Now, did you typically see and treat -- withdrawn.
Did you typically go on rounds with your patients in the morning, afternoon, some other time?
A It varied.
Q When you made your rounds, did you usually do it with the team that was

assigned to your patients or on your own?
A I invariably did it with a resident who was assigned to . Sometimes it wasn't invariably, but I regularly did that. But sometimes if they were all scrubbed when I was making rounds, I would go on rounds with somebody who was assigned to .
But it's a reasonably small program. They made turnover rounds together and communication between the team and the team was good.
Q How many residents were there per year?
MS. : Note my objection.
A There were three residents per year, with four in the first year.
Q Where did you go to school, Doctor?
A .
Q When did you graduate?
A In .
Q You just took the exam?
A Yes.

Q Going back to the note on at , there is a preliminary report of a chest X-ray which indicates that there is free air under the diaphragm?
A Yes.
Q And this doctor writes "likely due to abdominal surgery"?
A Yes.
Q Do you agree with that statement?
A Yes. Well, the day after surgery, there would invariably be free air under the diaphragm from that cause.
Q Is there any cause to see free air in a postoperative patient, other

than from the abdominal surgery?
A Anything else that there might be, would be in addition to the free air that one would normally have. So that then there is no way of telling air from one source or another source.
Q Why do you encourage patients to ambulate after surgery?

A Because it's supposed to -- first of all, it's supposed to help them resolve atelectasis. It's supposed to help them regain their bowel function, have their ileus resolve and it's good prophylaxis against deep venous thrombosis.
Q Can you turn please to --
A May I use the bathroom again?
MR. OGINSKI: Sure.
[At this time, a short recess was taken.]
Q Doctor, after the chest X-ray came back, was there any evidence of pneumonia on the chest X-ray?
MS. : You're talking about the ?
MR. OGINSKI: Yes.
A No.
Q In the absence of pneumonia, which is the reason why you told me it was ordered, what did you do to further evaluate the elevated temperature that the patient was experiencing?

A I'm sorry?
Q You told me that the reason why you ordered the chest X-ray or a chest X-ray was ordered, was an attempt to evaluate possible pneumonia.
Having seen that the X-ray was negative for pneumonia, what did you then do to further evaluate the patient's elevated temperature?
A This was the . At that point, we worked with the presumptive diagnosis of atelectasis and observed her.
Q Now, on at , there is a nurse's note indicating the patient's temperature was 39.4?
A Yes.
Q And that is elevated; correct, abnormally elevated?
A Yes.
Q Did you form any opinion as of

, as to any other cause for the findings on the chest X-ray, which

was taken on , in other words, the free air under the diaphragm?
A The presumptive diagnosis was that this was due to recent surgery.
Q Now, on , there is a note indicating that a venous duplex was performed?
A Yes.
Q Is there a note in the chart to indicate why a venous duplex was ordered and performed?
A No, there is not.
Q As you sit here now, do you have any knowledge as to why a venous duplex was done?
A Yes.
Q Why was it done?
A Again, as part of the fever workup.
Q And why is a venous duplex done to evaluate a fever workup?
A To look for thrombophlebitis.
Q Are there any other causes, other than thrombophlebitis, that would

be associated with an elevated temperature such as this patient had now for a day postoperatively?
A The most likely, as I indicated, was atelectasis. There are others.
Q Was it your custom and practice in not to administer prophylactic antibiotics for a laparoscopy?
A I don't remember what my custom and practice was in for laparoscopy.
Q Was it your custom and practice in not to give prophylactic antibiotics for a laparotomy?
A My custom and practice was to give prophylactic antibiotics for laparotomy if -- yes, for laparotomy.
Q Was this patient given any prophylactic antibiotic prior to surgery?
A My recollection is was given Mefoxin.
Q Now, as a , you perform surgery; correct?
A Among other things.

Q Sure, you do exenterations?
A Yes, I can.

Q And debulking?
A Yes.
Q And you do hysterectomies?
A Yes.
Q And you do other surgeries commonly associated with treating cancer, GYN cancer; correct?
A Yes.
Q Am I correct this surgery for this patient did not involve any type of cancer issues?
A That's not correct.
Q I'll rephrase it then. Before going in to perform surgery on , did you suspect that this patient had any form of GYN cancer?
A I thought there was a small possibility that she might.
Q What part of her anatomy did you suspect that she had some type of GYN cancer?
A I didn't say I suspected that

0124

she had. I said she might.
Q Was there a particular part of her anatomy?
A If she had, I would have suspected her right ovary.
Q Did you confirm that suspicion in any note that you have in this hospital chart?
A She didn't have cancer.
Q My question was, Doctor, at any note that you entered in this hospital chart for this patient, did you ever indicate your suspicion about the possibility that she could have cancer, at any time preoperatively or postoperatively?
A Not explicitly, no.
Q In your office chart that you brought with you here today, that's marked as Plaintiff's Exhibit 1, do you have any note specifically confirming your suspicion that she had possibly had some type of cancer?
MS. : He didn't say

0125

suspicion. He said a small possibility.
MR. OGINSKI: Thank you.
MS. : Can you read the question back?
[At this time, the requested portion of the record was read.]
A No.

Q You told me you just recently took the bar exam, was that the bar exam?
A And .
Q And if you are successful in passing the bar, do you intend on practicing law?
MS. : Objection, don't answer.
Q Do you intend on stopping practicing medicine in the near future?
MS. : For any reason?
MR. OGINSKI: Yes.
A I don't have any intention in the near future for stopping the practice

of medicine.
Q Did you learn about the venous duplex results at sometime on ?
A I don't recall.
Q Is there anything in your note on , that would reflect whether you learned of the venous duplex results?
A No.
Q At the bottom, two lines from the bottom of your note, Doctor, it says, "Results of lower extremity Doppler pending"?
A Correct.
Q At some point after that, on the , did you learn the results of the venous duplex?
A I would be fairly certain that I had, but it's not documented.
Q What is your recollection of the results of the venous duplex?
A Had they been positive, we would have instituted treatment of deep

venous thrombosis. The fact that we did not institute treatment of deep venous thrombosis, suggests that they were negative and I knew they were negative.
Q What treatment would you normally use for deep venous thrombosis?
A At that time, intravenous Heparin.
Q And did you call -- withdrawn. If I.V. Heparin was to be used, would you need to call in any type of consultation to determine the dosages and the length of time that Heparin is to be used?
A No.

Q That's something that's within your realm of expertise?
A Yes.
Q Now, turn please to the progress note, the form?
A Okay.
Q On the bottom right of the plan, at the bottom, Dr. 's note, it says "continue Heparin," do you see that?

A Yes, "b.i.d."
Q Why would the patient be given Heparin in the absence of a diagnosis of deep venous thrombosis?
A She was getting subcutaneous Heparin as prophylaxis against deep venous thrombosis.
Q In the middle of Dr. note on the right side it says, "DVT study negative," do you see that?
A Yes.
Q Is it still appropriate to continue a patient on Heparin, in light of a negative DVT study?
A Absolutely.
Q Why?
A Because this was for prophylaxis of deep vein thrombosis. She was obese. It was not clear at that point that she was ambulating well and she was at high risk for development of deep vein thrombosis, given that she had a long operation and was obese. So that it was appropriate to give her this

prophylaxis, which would have continued had she -- which was independent of the Doppler scan which was to determine whether she had it not, whether she was at risk for it.
Q She had no prior history of a DVT or thrombus in the past; correct?
A Correct.
Q Now, on at Dr. progress note timed at , at the bottom --
A We're talking about the one on the template?
Q Yes, correct. And by the way, this is a template that residents write each day when they see the patient; correct?
A Yes.
Q At the bottom of Dr. 's note under plan, it says "Close watch for

any signs of bowel perforation"?
A Uh-huh.
Q Do you have any knowledge as you sit here now, as to why Dr. was

concerned about the possibility this patient had a bowel perforation?
MS. : Note my objection.
A Please repeat the question.
MR. OGINSKI: Would you?
[At this time, the requested portion of the record was read.]
MS. : No speculation, just conversation or note or something of that nature.
A As to why she thought she had a bowel perforation?
Q Based upon Dr. 's note, do you have any reason to believe or know why she suspected there might be a bowel perforation?
MS. : Note my objection.
A I don't know that she did on the basis of this note. That's not what the note says.
Q Tell me your interpretation of that note.
MS. : Note my objection again.

A My interpretation of that note is that I teach patients -- I teach residents to always have a high suspicion for the possibility of bowel perforation. And they are inclined to write that when they're following my patients, to keep me happy.
Q Other than just writing it to keep you happy, do you think that it also encompasses the possibility that they at least have it in the forethought of their mind?
MS. : Objection, state of mind.
MS. : Note my objection.
Q Did you have a conversation with Dr. about any thoughts may have had about any possibility of a bowel perforation on ?
A I can't recall that.
Q Is there anything, as far as her findings contained within this note, which would suggest to you that this patient possibly had a bowel perforation?

A No.
Q Her abdomen, according to the note, was soft and she had positive bowel sounds; correct?
A Correct. Her white count was normal and there was nothing here that suggested that she had free air under the diaphragm, that everybody does who has an X-ray the day after surgery.
Q Did you form -- withdrawn. Did you come to any other conclusion on as to the reason or any other reason for the patient's elevated temperature, other than what you already told me?
A No.
Q Now, can you turn please to the nurse's note, ?
Do you see the note after that is dated and that would be ?
A That's what it says.
Q And after that is a nurse's note?

A Yes.
Q And the note after that is also a nurse's note, now with a date of ; correct?
A Yes.
Q What's the time on that note?
A It looks like
Q Do you have any knowledge as to why there would be a note from the day prior, in between a note that had a day later?
In other words, why are they out of sequence?
MS. : Note my objection.
MS. : No speculation.
Q I don't want you to guess, Doctor.
A I have no -- the answer to that is no.
Q At the bottom of the page there is a sticker that says, "CT scan completed"; correct?
A Yes.

Q We know that the patient was sent for a CT scan on -- well, according to this stamp, on ; correct?
A Yes.
Q And we also have a dictated report from the radiologist indicating a

date of .
Are you able to determine which date this patient had her CT scan?
A She had a CT scan, I believe, on the .
Q Can you explain then on the --
A No, wait, stop. The answer to that is -- I change that. Probably on the . I can't say 100 percent sure.
Q Do you have any knowledge as to why the date of , with that sticker saying "CT scan completed," appears under the , note?
MS. : Note my objection.
A Do I have any knowledge?
Q Yes.
A No, I have no knowledge.

Q Is there any note in the chart on -- is there any note in the chart on ,that would suggest or indicate the reason as to why this patient required a CT scan?
A No.
Q Is there any note in the chart on , to indicate why this patient would need a CT scan?
A No.
Q Who ordered the CT scan? Just so we're clear, you're looking at the physician order sheet; correct?
A I'm looking at the physician order sheet and I can't read the signature.
Q And what date and time is noted for the order for the CAT scan?
A
Q If you wanted to find out whose signature that was, how could you do that?
MS. : Note my objection.
A I don't know.

MS. : And he's not going to.
Q Is there anybody in the that you could turn to and ask to identify a particular signature?
MS. : He's not going to.
MR. OGINSKI: I'm not asking him to. I'm asking if he knows if there is someone there.
MS. : Note my objection.

Off the record.
[At this time, a discussion was held off the record.]
Q Why was a CT scan ordered on the ?
Again, I don't want you to guess or speculate.
A I have to guess. I think I know why because of my practice of managing these patients, but I would have to guess.
Q I don't want you to guess.

0137

Under what circumstances would you order a CAT scan for a postoperative patient?
A Many circumstances.
Q If you suspected that there was some type of injury that occurred during surgery, would that be one reason why you would order a postoperative CAT scan?
A It would.
Q If you suspected that there was an infectious process going on, would that be another reason why you would order a CAT scan?
A Yes, and fever.
Q As part of the fever workup?
A As part of the fever workup. Over 39 you think about pelvic phlebitis, abscess, any intraabdominal process.
Q Were you informed by a resident of the CT findings?
A Yes.
Q And who informed you about the CT findings?
A I don't know.
Q And what is it that you are

0138

referring to in the chart or in your note, that indicates you were advised about the CT finding?
A Where I write "CT report is noted."
Q That report, was that a written report or verbal report?
A I can't tell you that as I speak to you.
Q Did you have a conversation with the radiologist who interpreted that CAT scan?
A Yes, I did.
Q And who was the doctor who interpreted that?
A Dr.
Q Spell it as best you can?
A

Q And do you have a specific memory of talking to her about this CAT scan report?
A I don't have a clear recollection of the conversation. I have a specific recollection of talking to

0139

her.
Q And is this radiologist, is she an attending?
A Yes.
Q Did you let her know your feelings or belief that the report was inconsistent with your physical findings?
A What I would invariably do --
Q No, I'm sorry, Doctor, I'm not asking generally.
A I do not have a specific recollection of verbiage that took place.
Q In the report, if you can turn to that report, please?
A Yes.
Q indicates within the report that bowel injury cannot be excluded, do you see that?
A Yes.
Q Can you read for me please the exact words she used?
MS. : It's typewritten it speaks for itself.
MR. OGINSKI: I would like him

0140

to read it.
MS. : It's typed.
MR. OGINSKI: I would like him to read it.
MS. : Just this once. We are not reading typed written notes into this record.
A "Injury involving portion of the intestinal tract, with perforation, cannot be excluded."
Q What does that mean to you?
A It speaks for itself.
Q I would like to know what your understanding is of what you just read?
A That cannot say that there is no perforation of the bowel.
Q What do you do in light of that information, as far as further evaluating the patient for injury to the bowel?
A It depends upon the overall clinical picture.
Q And does this interpretation suggest that there is still a possibility that there is an injury to the bowel?

0141

A That there is a possibility, yes.
Q And what options are available to you in order to further evaluate the bowel at that point?
A At this point I could do a lower GI study, if the radiology service is willing to do it, which a lot of times they're not or I could follow the patient clinically.
Q What do you mean, if the GI service is willing doing it?
A If they're willing to do it.
Q Why wouldn't they?
A You have to ask them, but sometimes you'll ask them for procedures and they'll say the CT -- it won't show you anything that the CT doesn't.
Q Is another way to evaluate whether there is injury to the intestinal tract, by going in surgically and visually observing it?
A Yes.
Q And would it be correct to say

0142

that you would need a higher index of suspicion of bowel injury to go in and operate, in light of your clinical findings on the ?
A That's correct.
Q Now, turning to your note again, Doctor, --
A Okay, I have it here.
Q -- you said that nevertheless, you will treat with triple antibiotics; correct?
A Yes.
Q Now, the nevertheless refers to what, to the finding that there might possibly be an injury to the bowel or something else?
A No, it refers to the benign physical findings.
Q And why did you feel it prudent to give the patient antibiotics at this point?
A Because there was a collection consistent with an abscess and there was fever. And even though I would

0143

ordinarily expect X-ray findings of this magnitude to be associated with a much worse clinical picture, I was saying, well, if the radiologist says there is an

abscess there, I'll treat her for an abscess.
Q Can you have a bowel perforation in the absence of bowel sounds? I'm sorry, let me rephrase that.
If a patient has bowel sounds, can they still have a perforated bowel?
A Probably, yes.
Q If the patient has a soft abdomen, is that consistent with a bowel perforation?
MS. : Can you read that back?
[At this time, the requested portion of the record was read.]
A It would be very unusual to have a bowel perforation of any duration and have a soft abdomen.
Q Would it also be inconsistent for a patient to have a non-tender belly

0144

if they have a perforation?
A It would be very unusual.
Q Now, can you turn please to the PGY-4 note of , timed at ?
A I have it in front of me.
Q Who wrote that note?
A This is Dr.
Q What year resident was Dr. at this time?
A Fourth year.
Q Do you have any knowledge as to where Dr. currently works?
A No.
Q Or what hospital 's currently affiliated with?
A , but I have no idea.
Q Dr. writes, "The patient complains of mild pain in the lower abdomen."
Did you make a similar observation when you saw the patient about less than an hour earlier?
A I wrote "no pain," which as I

0145

explained much earlier, meant that she had pain consistent with her postoperative state, but no pain in excess of that.
Q This note by Dr. , would you consider that to be a new finding or something that's consistent with what you were observing in the last two days?
MS. : Note my objection.
A I would consider it to be

consistent with my findings.
Q And she writes under the abdomen, that abdomen was soft; she had positive bowel sounds and is that, "no rebound"?
A Yes, "no rebound, no guarding."
Q Now, under the CAT scan findings writes, "Multiple fluid collections, can't rule out bowel injury"; correct?
A Yes.
Q Other than administering the antibiotics to address the abscess, were any further steps taken to attempt to

0146

rule out bowel injury on ?
A No.
Q Would it be prudent, Doctor, in your opinion with a reasonable degree of medical probability, to take steps to attempt to rule out the possibility of bowel injury, at the same time that you are trying to treat the abscesses?
A Not at this point.
Q Is that because of the clinical picture as of the time that you examined her on the ?
A In part.
Q What's the other part?
A Well, she either has an abscess or a bowel injury. If she has a bowel injury, she's going to need a colostomy. If the abscess responds, that's fine.
We watch her closely in the meantime and if she doesn't respond, then little or nothing is lost by watching her and seeing how the clinical picture evolves.
Q Is she septic as of

0147

A As I define septic, having a systemic infection, I thought she was not.
Q Did she have evidence of septicemia as of this date?
A Defining it as blood in the -- as bacteria in the blood, she had bacteria in the blood, which is a common finding with an abscess.
Q And if as of she did -- withdrawn.
If you had confirmed as of she had a bowel perforation and required surgery to repair that, would you be the one who would be

performing the colon repair and colostomy --
A Yes.
Q -- or would you call in a general surgeon to do that?
A I would have done that.
Q And is it preferable -- withdrawn.

Can you turn please to the note, , timed , ?
A Yes.
Q Can you tell who wrote that note, please?
A Dr. .
Q Do you have any knowledge as to where Dr. currently works?
A Yes.
Q Where?
A At
Q As an attending?
A Yes.
Q And Dr. ' plan was to continue close observation; correct?
A Yes, among other things.
Q Was there any other discussion about -- withdrawn.
The CAT scan addressed the multiple fluid collections and the abscesses. Did you come to any presumptive or working diagnosis that the fluid collection that you observed or was

visible on CAT scan, was from any other cause?
MS. : Could you rephrase that, please?
Q Did you form an opinion on as to any other possible cause for the abscess or fluid collection?
MS. : Other than what?
Q Other than what you already told me?
MS. : I don't get the question. Please rephrase it.
Q Did you form an opinion as to the cause for the patient's abscess on ?
A As to the cause for the patient's abscess?
Q Yes.
A No, I did not.
Q Did you form an opinion as to

the cause for the fluid collection on ?

A That was the abscess.
Q At any time after , did you formulate a cause or determine an etiology for the abscess?
A We have a presumptive cause of perforation that was part of our differential all along, but that became the presumptive cause when we operated.
Q Do you record that presumptive cause of perforation anywhere, before ?
A Again, by implication when I said that I had read the CAT scan results, which certainly came up in my discussion with Dr. and I wrote it on the , I mean, this is certainly something we were thinking about on the and very seriously.
Q And the note that you are referring to now is a note that you wrote on ; correct?
A note.
Q Does that reflect that you had been thinking about that particular

condition a day or two before?
A It doesn't reflect it, no.
Q Can you turn please to the nurse's note? There is a stamp at the bottom of that note that says, "CT scan completed."
What is the date of that?
A .
Q Do you know why there appears to be two CAT scan completion stamps or --
A No.
Q -- stickers, one with the , one with the ?
A No.
Q Now, by post-op day number four on the , the patient still had a fever and maximum temperature of 39 degrees Celsius?
A Yes.
Q Is it normal for a patient to have post-op fever four days after surgery?
A It's not common, no.

Q Did the CAT scan findings indicating the patient had an abscess --

withdrawn.
Is it a single abscess or is it multiple abscesses?
A It looks like it may be multiple abscesses.
Q Did that account for your belief -- withdrawn.
Was it your belief that the reason the patient was experiencing the elevated temperatures as of post-op day number four, was because of the abscesses?
A Yes.
Q Did you attribute the elevated temperature to any other cause, other than the abscesses?
A No.
Q Now, there is a note and I don't know the date, there doesn't appear to be a date --
MS. : It's on the back of a page.

0153

Q On the back of , there appears a note and it starts with "O"?
A Yes.
Q Are you able to identify who wrote that note?
A I'm not 100 percent sure. I think I know who it may be.
MS. : Don't guess.
Q Is that a physician's note?
A Yes.
Q Do you know what specialty, whether this person is an attending, a resident, GYN or something else?
A May I consult with my lawyer?
MS. : You can't guess. You either know or you don't know, that's the answer.
A If it's who I think it is on the basis of handwriting, then I know who it is. Otherwise, I don't know.
Q Is there a date associated with this note, other than it's on the back of the page of the ?

0154

A That's it.
Q Did you have any conversation with the individual who wrote this note?
A I don't know.
Q What are blood cultures?
A Blood cultures are a test. A blood culture is a test where blood is taken from the vein and examined in the

lab for the presence of bacteria in the blood.
Q And blood cultures were done in this case; correct?
A Yes.
Q Were they normal, abnormal or something else? I'm going to withdraw the question and come back to it.
On Doctor, did you suspect that the patient had a bowel perforation?
A I knew that it was a possibility, but my working diagnosis at this point -- I suspected that she might. I thought she might or she might not and was treating her presumptively for an

0155

abscess.
Q Am I correct that the administration of antibiotics to treat the abscess would not definitively treat any bowel perforation?
A That's correct.
Q In fact, the only way to definitively treat a bowel perforation is to surgically correct it?
A That is correct.
Q And is there anything on the note that you wrote, to confirm your suspicion or possibility that these findings that you are observing might be bowel perforation?
MS. : I don't think he has a note.
A I didn't have a note and I suspect this may have been on a weekend.
Q And the individual whose note you aren't clear about, may have been the one covering for you?
A Yes.
Q On the , do you have

0156

anything written which would suggest or confirm your belief that she might have a bowel perforation?
A I'm going to say the same thing, that there is a note on the back by somebody who I think may have been covering for me. And my suspicion is that the and were Saturday or Sunday. I suppose we could look on a calendar.
MS. : You don't have a note; right?
THE WITNESS: I don't have a note.

MS. : That's the answer.
Q And the notes for the individual who wrote these notes that are undated and untimed, say nothing about the possibility the patient may have a bowel perforation; is that correct?
A That's correct.
Q Is there a policy in the department of that every note

that's written, has to be dated and timed?
MS. : Note my objection.
A There is a policy that -- I don't know if it's an policy or hospital policy. Certainly every note has to be dated and I'm certain every note has to be timed.
Q Were you aware that the patient -- withdrawn.
Can you turn please to Dr. 's progress note, the template again, for ?
A Here it is.
Q And at the bottom right, Dr. writes "Patient complains of pain, wants to go home"; right?
A That's not Dr. 's note.
Q Whose note is it?
A The same person who wrote the note the other day, that I'm not 100 percent sure who wrote it.
Q In any event, she complains of pain.

Is there anything in this note that indicates what part of the body she had the pain in?
A No.
Q If you turn one page back, there is a nurse's note, also , at the bottom, the very last line says "pain level four"?
A Uh-huh.
Q To your knowledge, was the pain she was still experiencing related to incisional pain and normal postoperative pain?
A I don't -- as I say, I think this was a day I wasn't in there, so I have no personal knowledge.
Q Can you turn please to the nurse's note, also , timed at ?
A Yes.

Q And in the first line at the end it says, "Patient complains of pain, gave two tabs Percocet as per p.r.n. order"?

0159

A Yes.
Q Again, are you able to determine from the note where she was experiencing the pain?
A No.
Q Do you have any memory as you sit here now, as to where she was experiencing the pain?
MS. : I think he just said he wasn't there on the .
Q Can you turn please to the template note, postoperative progress note dated ?
A I have it. It was out of order.
Q A further CAT scan was ordered on ; correct, if you look in the middle of page, it talks about CAT scan findings?
A Yes.
Q Do you have knowledge as to why a repeat CAT scan was done on ?

0160

A She had been on antibiotics for a couple of days, to see how she was doing.
Q And what was the consensus as to whether the antibiotics were improving her condition?
A I'm sorry?
Q What was the belief or consensus as to whether the antibiotics were improving her condition?
A I don't know what you mean by belief or consensus.
Q Did the antibiotics improve her condition?
A Clinically she seemed better, but we wanted -- but the CT was done to determine objectively how the abscess looked.
Q And the finding, at least according to this physician -- can you determine who the individual is?
A It says Dr. , .
Q What year was Dr. ?

0161

A At that time, a .
Q Where does Dr. currently work?
A Dr. is in private practice in , admitting patients to several hospitals, including ours.
Q What were the CAT scan results -- withdrawn.
It indicates pneumoperitoneum; right?
A Yes.
Q Was that a normal finding or abnormal finding?
A It's something that often, perhaps usually, but not always, is resolved by this time, five, six days later.
Q And the fact that it has not resolved as of post-op day six, what did that suggest to you, if anything?
A It suggested either that this was residual pneumoperitoneum from her surgery or that this was from a bowel

0162

perforation.
Q What is done at that point, in order to rule out that possibility?
A Apparently I was informed of the results close to midnight on the and at that point what I decided on was CT drainage of the abscess.
Q And the note that you are referring to, Doctor, that's a note that you wrote the next day on the ; correct?
A Yes, it is.
Q Now, CT drainage would simply drain whatever fluid the abscess was creating; correct?
A That's correct.
Q And would not address the issue of the possibility the patient had a bowel perforation; correct?
A It would in a sense because if she had a perforation, you might be draining fecal material and would make a presumptive diagnosis.
Q Is there any reason you did not

0163

take the patient to the operating room on , once you learned of the CAT scan findings?
A Yes, because I learned about it at 11:00 at night. And if you are going to do a big operation and if somebody

isn't in an emergency condition, you want to do it at a time when you have the best possible access to facilities, you want to do it during the day, on a weekday, when you have your regular OR team and when everybody is fresh.

Q And what is different about doing surgery in the early morning hours, as opposed to doing it the following day?

A By early morning hours --

Q Midnight, 1 o'clock, the earliest you can get your patient to the operating room schedule?

A First of all, you are dealing with nurses who may not be familiar with your instrumentation. Second, you are dealing with -- second, everyone is fatigued and isn't going to be doing

0164

their best work. And again, if you have to, if there is -- if somebody is critical, if somebody is unstable, you're going to do it.

But if somebody is stable, you want to do it when -- if you need immediate consultation for some reason or other, then people are around; you don't have to call people in. If you are doing it at night, there are two nurses who may not be people who work with you. There is one anesthesiologist. If the patient is unstable and you need another anesthesiologist, you have to call him in from home. You're operating basically with whatever residents you have there. If you need some kind of consultation from another surgical specialty, a general surgeon, a chest surgeon, whatever, you have to call them in from home. If they're unstable afterwards and you have to bring them to the ICU, you don't have the people around.

I mean, you always want to

0165

do -- you always want to do surgery during the day, when you have maximal resources and people are at their best.

Q I just want to be clear, Doctor, did you have a specific knowledge on the evening of , after learning about the CAT scan results, that the nurses that were on staff at the hospital that evening in the operating room, were not familiar with the instrumentations that you used in order to perform surgery?

MS. : Note my objection.
A Generally speaking --
Q I don't want general. I just want to know specifically in this case.
A Then let me finish and you can tell me if you don't like my answer.
MS. : No.
A I did not know that there were nurses at the hospital. They have to call them in. And I had no knowledge of what -- I had no knowledge of who the nurses were.

Q Did you have any knowledge, again at that time, , in the late evening, as to whether any of the particular people that you would need to perform surgery, were in fact fatigued?
A Yes.
Q Who?
A Me. It was midnight.
Q Other than yourself, were there any other or surgeons that you could have called, who may have been on call and affiliated with the hospital, that you could have called in as well?
A Dr. , who also would have been operating at midnight.
Q By the way, do you still perform ?
A No.
Q When did you give up ?
A When I left the in . Occasionally I was call. Occasionally I took night call in various situations

that I had, but I never, except in the , I never had primary care for patients.
Q Did you have attending or admitting privileges at any other hospital besides in ?
A Yes.
Q Which ones?
A , , .
Q Has your license to practice medicine ever been revoked?
A No.
Q Has it ever been suspended?
A No.
Q You are board certified; correct?
A Yes.

Q You're board certified in obstetrics and gynecology?
A Yes.
Q And you are board certified in gynecologic oncology?
A Yes.

0168

Q As far as the boards, did you ever have to take the written or oral boards more than once?
A Yes.
Q Which one?
A The oral.
Q How many times did you need to take that?
A Twice.
Q And as far as the boards?
A The same.
Q You had to take the oral twice?
A Yes.
Q When did you attain your first certification for your boards?
A .
Q Have you had to have that renewed after a number of years?
A I did not, but I did voluntarily in .
Q Since that time, have you renewed it?

0169

A No.
Q Is there any requirement that you're aware of, to renew it?
A No.
Q Same question with regard to your boards?
A I voluntarily renewed it in and there was requirement -- and is no requirement to renew that.
Q Do you participate in continuing medical education courses?
A Yes, I do.
Q Have you personally ever lectured to any national body of within the last ?
A National?
Q Yes.
A No.
Q Any national meetings or yearly meetings?
A No, I have not done that. I have only given grand rounds.
Q Am I correct you do have some

0170

publications to your name?
A Yes.
Q And that includes both peer review and --
A Non-peer review.
MR. OGINSKI: Do you have a copy of his CV?
MS. : Yes.
MR. OGINSKI: May I have it, please?
MS. : You could have had it hours ago.
Q Have you written anything on the topic of diagnosis and prevention of bowel injury?
A Not specifically. I wrote a chapter on routine postoperative care, that I don't know if it has anything about that or not.
Q Was Ms. 's case ever presented at grand rounds?
A No.
Q Did you ever have any conversations after she was discharged

0171

from the hospital, about her care and treatment?
A Yes.
Q Tell me about that.
A I spoke with , who ultimately repaired the colostomy.
Q Did you learn that it was in fact his partner who did the repair, , , who did the repair?
A No, I didn't.
Q Did you ever see a copy of the colostomy reversal, the operative report?
A No, I did not.
Q Tell me what you remember about your conversation with Dr. ?
A Dr. told me that she had -- that she had a reversal of her colostomy and that it went smoothly, that's about all I can remember. I can't remember anything else.
Q Did you ever have any discussion with Dr. about the timing and when the bowel perforation was

0172

recognized?
A Not that I recall.
Q Did you have any conversation with any of the residents after

, about when the bowel perforation was recognized?
A Not that I recall.
Q Do you have an opinion with a reasonable degree of medical probability, as to whether this bowel perforation should have been recognized on ?
A I do.
Q What is your opinion?
A I don't think that it should have been recognized on the .
Q Why?
A Because I think that I took appropriate steps to look for a bowel perforation and I didn't find one.
Q And can you account for the reasons why you did not find one at that point?
A No, I cannot.

0173

Q Now, on -- if in fact you had made the decision to take the patient to the operating room in the early morning hours of , if I understand you correctly, you're saying that this patient still would have required a colostomy; correct?
A Yes.
Q Was Ms. septic on ?
A I don't think so and if she was, it was mild.
Q Was she septic on the ?
A Same thing.
Q She still had an elevated temperature; correct?
A She again had an elevated temperature.
Q And in your opinion, were the antibiotics she was receiving working?
A They seemed to work transiently. They seemed to work for a while and at this point, they had stopped working.

0174

Q Now, I would like you to turn please to the note, it's p.m. or p.m., I can't tell, in the middle of page, can you make out what time that note is written?
A It looks to me to be
Q Are you able to determine who wrote that note?
A No.
Q In that note it says

"Preliminary radiology report, extensive free air is noted throughout the abdomen and pelvis, highly suggestive for hollow viscus perforation. No bowel obstruction is identified."

What is your understanding of this note?

MS. : Note my objection.

A That it's likely that she has a bowel perforation.

Q And in light of that information, is there a particular reason why this patient was not taken to the operating room shortly afterwards?

0175

A The reason, as I said, was that I wasn't going to take her to the operating room in the middle of the night if she was stable.

Q What was the reason for not taking her to the operating room the next day, on the , in light of the findings shown here on the p.m. note that says, "highly suggestive for hollow viscus perforation"?

A I don't recall why I elected to obtain -- I don't recall why I -- well, I know there were a few things. First of all, she had an albumin of 1.7 and she's severely malnourished.

Q You are referring to your note on the ?

A Yes, and it will be in the lab reports.

Q The time of your note is when?

A 10:40 a.m. I'm sorry, 14:45.

Q That's 2:45 p.m.?

A Yes.

Q So a good number of hours have

0176

transpired by the time you see her.

My question is, did anyone advise you on the evening -- withdrawn.

Did you learn that the patient's albumin was low on ?

A I'm sure I did not.

Q Low albumin is indicative of what?

A Malnutrition.

Q And how does a patient like this develop malnutrition, while she was receiving I.V. fluids during her hospitalization?

A First, she was malnourished in the hospital, but not severely. She had

an albumin earlier in her hospitalization that was two point something. So she came into the hospital somewhat malnourished.

Second, I.V. hydration is not nutrition. It doesn't give you protein.

Q Was the fact that she had a low albumin, a reason not to take her to the

0177

operating room?

A It was another reason to take her to the operating room at a time when I could maximize the resources and the team.

Q What do you do if a patient has low albumin?

A What you do is you operate with people with whom you can work very efficiently and get her -- do an operation as quickly as you can do it safely, with as little blood loss as you can get by and get her off the table and bring her to the intensive care unit, if necessary, during the day.

Q What does her low albumin have to do with whether or not you are going to take her to the operating room?

A Having a low albumin is one of the highest risk factors for surgical complications.

Q Like what?

A Like any surgical compensation you can think of, infection, pneumonia,

0178

if there is a repair, failure of the repair.

Q Then why did you take her to the operating room on ?

A Because she clearly had a perforated viscus and it had to be done regardless. And at that point, I had the ability to do it with another attending, during the day.

Q You told me a little earlier that you elected to do an interventional radiology procedure to drain the abscess on the ?

A Yes.

Q When you had a conversation with someone around 11 at night on the , did you learn about this preliminary radiology report, indicating that this was highly suggestive for hollow viscus perforation?

A Yes, I did.

Q And with whom did you have a

conversation that evening?
A With the resident on call.

Q Who was that?
A I don't know.
Q Did the resident on call make any recommendations to you, telling you that he or she believed that the patient should go to the operating room that night?
A I don't recall.
Q Did the resident make any recommendations that the patient should go to the operating room to explore the abdomen the next day?
A I don't recall.
Q Did you tell the resident that you wanted to take the patient to the operating room the next day?
A I don't recall.
Q Are there any other tests that you can perform to definitively confirm a hollow viscus perforation, other than the CAT scan?
A As I say, a lower GI study, injecting -- giving somebody an enema of contrast and seeing if it exits the

rectum.
Q Did you have any reason to disagree with the radiologist's interpretation of this particular CAT scan done on the ?
A This was an off site interpretation.
Q Called Night Hawk?
A This was Night Hawk and I frequently seen over read films.
Q I'm not talking about frequently. I'm talking in this case?
A In this case, I had no reason.
Q The individual who interpreted this particular study, was it an attending, a fellow, a resident or something else?
A It was Mr. or Dr. . I don't know who interpreted it. It's somebody -- I don't know who they are. Excuse me, may I take a break?
MR. OGINSKI: Sure.
[At this time, a short recess was taken.]

Q Doctor, there is a nurse's note on , 10:30, p.m., which says

"Radiology called stating that patient is positive for left pleural effusion."
Was that consistent with your knowledge she had a pleural effusion throughout her postoperative course up until then or was this a new finding?
A I don't recall whether I was aware of it.
Q Can you turn to the note timed 11:50 p.m. and is that by Dr. ?
A I can't say for sure.
Q In any event, this note indicates that right after CT scan, tried to eat and vomited times one?
A Yes.
Q Is that significant at all in light of her findings?
A I don't know.
Q Is vomiting an indication of some bowel injury?
A It can be.

0182

Q Had the patient attempted to eat any type of food before ?
A She had been on a regular diet and tolerating it, so this is new.
Q When you say "regular diet," you mean more than clears?
A Yes.
Q And under the CAT scan findings it indicates "Extensive free air throughout the abdomen and pelvis." And under assessment it says, "questionable possible bowel injury"; correct?
A Yes.
Q What is written under plan and your name?
A "Patient discussed with Dr. . Continue antibiotic treatment. Close observation. Follow-up CT scan official report by Hospital radiologist. Tylenol for fever."
Q Does that refresh your recollection as to whom you might have spoken to?

0183

A No.
Q Turn please to your note. I would like you to read your note, starting with the date and time?
A Are we talking about , 14:45
Q Yes.
A "Patient continues febrile. CT

shows large left flank abscess with free air, but patient and, I meant patience, abdomen flat, soft, non-tender abdomen. Will attempt CT drainage. If unsuccessful, open drainage and TPM."

Q Did you consider performing surgery at that point, in order to address the possible perforated viscus?

A Open drainage would have addressed the viscus. Open drainage does mean a laparotomy.

Q And the labs that appear above your note timed at 10:40 a.m., other than the albumin being abnormal, is there anything else significant?

A Yes, the white count is on its

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way up; it's elevated.

Q And that's indicative of infection, sepsis or something else?

A Infection. This is high, but not sky high.

Q Can you turn please to the note, , timed at 12:30 p.m.?

A Yes.

Q The first line, "Patient complains of mild pain in the lower abdomen"?

A Yes.

Q Is that the same type of pain she had exhibited on days prior or is this different?

A I don't think she has any different pain, but I can't say for sure.

Q Can you turn please to a note that you have timed at 13:15?

Just so we're clear, Doctor, this note preceded your 14:45 note; correct?

A That's -- so it would seem

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either that or the 13:15 is an error.

Q Read your note, please?

A "Erythema of left flank noted. No tenderness, no edema. Impression, rubor, meaning redness, secondary to abscess. Doubt necrotizing fasciitis."

Q Why would an abscess cause this condition, the erythema?

A Because if it's underneath -- but it can cause redness. There was no edema.

MS. : Erythema, he said.

A Meaning redness. Any abscess

anywhere can cause redness in the skin most adjacent to the abscess.
Q Did you speak to the interventional radiologist who performed the procedure, the drainage?
A After -- I'm not sure. I know I spoke to him at some point.
Q Were you present for the procedure?
A No, I wasn't. I think Dr.

, she was.
Q Did you learn what the findings were?
A Yes.
Q What were the findings?
A The findings was that there was feculent material draining out of the abscess.
Q What is feculent?
A Resembling feces.
Q What is that indicative of?
A It's highly suspicious for a perforation.
Q Once you learned that information, what was your plan of treatment?
A My plan of treatment was to perform a laparotomy.
Q When did you learn that information?
A Late in the afternoon of the .
Q And can you tell me why the patient was not taken to the operating

room on the ?
A Because I would have been doing it after hours and with the same consideration, that she was stable and that I decided to do it at the next opportunity that I could, during regular operating room hours.
Q Did you have a conversation with the patient about your findings?
A Yes, I did.
Q Was the patient conscious and awake during the conversation?
A Yes.
Q Were any family members present?
A I can't say for sure. I spoke at various times during this with her and her father and with her and her father together.
Q Before doing this surgery of

, I assume you had a discussion with the patient about the risks of this particular procedure and I'm again referring to the

surgery now?
A Okay, yes.
Q And was anyone with her at the time you had a conversation about the risks of the surgery?
A I don't remember.
Q Was there ever any discussion with her referring physician, as to whether he would also be present with you at the time that you performed the surgery?
A Yes, there was.
Q Tell me about that.
A He said that he wanted to -- this was Dr. . He said he wanted to and then later on we had a conversation where he said, just do it yourself.
Q Now, after your discussion with the patient about the risks of the procedure, did she agree to go forward with it?
A Yes.
Q Did she sign any consent form

in your office to have the procedure done?
A I don't believe so.
Q The consent form was signed at the hospital; correct?
A Yes.
Q Now, typically the resident will take care of having the patient sign the consent?
MS. : Note my objection.
A What generally -- I generally confirm with the patient what they're having, then the resident obtains the consent.
Q And in the consent for the surgery, was there anything specifically written in there to suggest that bowel injury or injury to any adjacent organs to where you were operating, was a possibility?
A No.
Q Now, on at 5:30 p.m., there is a note by Dr. . It says, "The patient need bowel

prep with an exploratory laparotomy, possible bowel resection, possible colostomy and OR called"?
A Yes.
Q That's in anticipation of having the patient go for surgery; correct?
A Yes.
Q Am I correct you can also take the patient to the operating room without a bowel prep?
A Yes.
Q Is it fair to say it's preferable to have the patient bowel prepped before this type of surgery?
A It's preferable.
Q Did that factor play a part in when the surgery would be performed?
A I didn't do it the next day because of the -- exclusively because of the bowel prep. But I mean, everything you do plays a factor in everything else.
But as I said, it's highly desirable to do things during hours and

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it's also highly desirable to do a bowel prep.
Q What do you consider to be normal operating hours?
A Starting an operation anywhere between 7:30 or 8, to early afternoon.
Q And can you give me a time frame or range of time frame that early afternoon would encompass?
A No, I couldn't. It -- you know, I would talk to the operating room and see basically -- I don't know, 1 o'clock, 2 o'clock probably. I can't nail it down. I can't say 2:47 or something like that.
Q Was there any issue at all about the operating room being -- withdrawn.
How many operating rooms are there at Hospital?
A There are about nine.
Q Was there any issue about not having availability of a room?
A If the case is urgent enough,

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then you can generally get the room.
Q And did you determine, did you feel that this particular case on the , was urgent enough to require surgery?
A On the , yes. It wasn't an

emergency, but it was something that I wanted to get done the next day.
Q Would it have been preferable to perform the surgery on the , if the operating room and their staff and everybody that you needed was present and available?
A I don't think the results would have differed, except she would have had the colostomy a day earlier.
Q And after the procedure, you're aware the patient remained in the hospital an additional or days to recuperate?
A Yes.
Q And she saw you in follow-up in your office?
A Yes.

Q And what was your impression as to how she was recuperating after the eight days she was in the hospital and after discharge?
A Her recuperation basically was slow and steady and pretty much what we would have expected. She was somebody who had had two operations, was both obese and malnourished and she really did as well as I would have expected. And then subsequently, she appeared to do well as well.
The colostomy was a difficult colostomy because her abdominal wall was so thick, that the bowel just didn't reach the skin without putting it on tension and as -- nevertheless, we didn't have any necrosis of colostomy or any abscess. The bag didn't fit especially well, but that was to be expected. And my impression was that her recovery had been proceeded pretty well.
Q Do you learn she had a difficulty with the colostomy bag would

leak on a regular basis?
A As I just said, I knew that and this was something that I anticipated as I -- again, as I just said because it was a very difficult colostomy. Usually to do a colostomy -- always when you do a colostomy, you want to bring a significant amount of bowel out, so that it protrudes beyond the skin. And this just was not possible with her and that creates a stoma that pulls down on the skin and causes leakage.

Q Did you learn from anyone, other than your attorney, that she recently underwent hernia repair, an incisional hernia repair?
A I am learning that for the first time from you, as I speak to you now.
Q Do you have any independent memory of conversations that you had with the patient's mother and father before her perforation was diagnosed on the ?

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A I have some recollection of conversations with her father; none with her mother.
Q Tell me about the ones you recall with her father?
A I think that I had extensive discussions with him all along, telling him what I thought might be the case. Initially that there appeared to be an abscess and that perforation, I thought was an outside chance. And later on telling him what I thought, what I was doing and why.
Q Did you ever have any further discussions with the radiologist who performed the CAT scan of the , Dr. , about the finding of the
A I don't recall.
Q Did the doctor who interpreted the CAT scan on the , have access to the CAT scan that was done on the ?
A You'll do best to ask them.
Q I'm only asking if you're aware?

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A All I would know is --
MS. : It's yes or no.
A The answer is no.
Q The CV that your attorney provided, is that an updated CV?
A This is a CV that is approximately seven or eight months old.
Q And the last article that you have written, whether peer review or non-peer review, appears to be ; is that correct?
A I haven't written anything in the last few years. That's probably right, as far as medical literature.
Q Were you ever asked to discuss Ms. 's care at any mortality or morbidity conference?

A No.
Q Have you ever testified before?
A Yes.
Q As an expert, how many times have you testified?
A In court, around or

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times.
Q Is that for plaintiff or defendant?
A In court, I've testified for defendants.
Q And how many times have you given deposition testimony, where you are the one being sued as a defendant?
A Perhaps or times.
Q And how many times have you testified in court as a defendant?
A times; of them malpractice suits.
Q Are you licensed to practice medicine in any other state?
A Yes.
Q Which ones?
A .
Q Do you have an active practice in ?
A No.
Q Did you ever discuss with the patient's father, as to why you were not taking Ms. to the operating room

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earlier than ?
A I discussed with Ms. 's father what I was doing and why and to the extent that I wasn't taking her to the operating room, I think that was implicit, but --
Q Is it your opinion, Doctor, that it was not a departure -- withdrawn.
Was it a departure from good practice not to take the patient to the operating room on , after learning about the CAT scan findings?
A It was not a departure.
Q Was it a departure from good practice not to take the patient to the operating room on the , in light of the CAT scan findings of the 18th?
A It was not a departure.
Q And again, is the reason why you feel it was not a departure, because you felt the patient was still clinically stable at that time?
A I would I have discussed

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extensively why I did what I did and I would say that it would be an oversimplification to sum it up in ten words.

MR. OGINSKI: Thank you.

EXAMINATION BY

MS. :

Q Doctor, my name is . I'm from . I represent Dr. and Hospital. I just have a couple of quick questions.

You were asked today earlier about two notes which appear, the first one appears on the back of a postoperative progress note and the other one appears on the back of a progress note, both of which appear to be undated.

Can I just ask you, on the bottom of the progress note, does it appear that there is writing in blue pen with an arrow?

A Yes.

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Q The back of that progress note has the same writing in blue pen; is that correct?

A Yes.

Q From your understanding of the way the notes are written in Hospital Medical Center, would the arrow indicate the note was written on the same day?

A Yes, it was one note and what was on the back, was a continuation of what was on the front.

Q Would the same apply for progress note, meaning the arrow on the bottom of the page and the blue pen would indicate what's on the back is a continuation?

(Continued on the next page.)

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A Yes.

MS. : Thank you.

(Time noted: 3:25 p.m.)

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Subscribed and sworn to before me
this day of ,

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E X H I B I T S

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

I, , a Shorthand
Reporter and a Notary Public, do hereby
certify that the foregoing witness, was
duly sworn on the date indicated, and
that the foregoing is a true and accurate
transcription of my stenographic notes.

I further certify that I am not employed by nor related to any party to this action.

____

ERRATA SHEET
VERITEXT/NEW YORK REPORTING, LLC

CASE NAME:
DATE OF DEPOSITION:
WITNESS' NAME:

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BEFORE ME THIS______DAY

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