SUPREME COURT OF THE STATE OF

COUNTY OF

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as Parents and Natural Guardians of , an infant under the age of fourteen years,

Plaintiffs,

-against-

, M.D., MEDICAL CENTER, , M.D., and , M.D.,

Defendants.

----------X

July 29,
10:09 a.m.

EXAMINATION BEFORE TRIAL of one of the Defendants, , M.D.

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MEDICAL CENTER,
, M.D.,
, M.D., , M.D.

BY: , ESQ.

ALSO PRESENT:

, M.D.

** ** **





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

It is hereby stipulated and agreed by and

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

It is further stipulated and agreed by and between counsel for the respective parties hereto that this examination 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 examination to counsel, shall not be deemed a waiver of the rights provided by Rules 3116 and 3117 of the C.P.L.R., and shall be controlled thereby.

It is further stipulated and agreed by and between counsel for the respective parties hereto that this examination may be utilized for all purposes as provided by the C.P.L.R.;

It is further stipulated and agreed by and between counsel for the respective parties hereto that the filing and certification of the original of this examination shall be and the same are hereby waived;

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

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2 , M. D.,

3 called as a witness, having been

4 first duly sworn, was examined and

5 testified as follows:

6 EXAMINATION BY MR. OGINSKI:

7 Q State your name for the record,

8 please.

9 A , M.D.

10 Q Your address, please?

11 A

.

MR. OGINSKI: Mark this as Plaintiffs' 1 and 2, the hospital record and the CV.

(Whereupon, the hospital record and the doctor's curriculum vitae was received and marked as Plaintiffs' Exhibits 1 and 2 for identification, as of this date.)

Q Good morning, Doctor.

A Morning.

Q Where do you currently work?

A At the Hospital of Health System.



, M.D.

Q What is your function or what is your position there?

A I'm the of the Pediatric Critical Care Services.

Q How long have you held that

position?

A That particular position it's been like two, three years after we merged with . Before that the exec title was of the Pediatric Critical Care Medicine at Hospital, and this overall it's like eleven years.

Q Are you familiar with the test called a cold agglutinin test?

A Yes.

Q What is that?

A I would not be able to give you the precise science of this, but it's when you have an infection with a specific bug, that infection may produce antigens which is a chemical material that tends to agglutinate, which basically means tend to aggregate or stick together when it is exposed to cold temperature.

Q Are there certain circumstances or

, M.D.

clinical situations that you as a physician will order a test such as a cold agglutinin test?

A A cold agglutinin test is a screening test. It is a very non-specific test that one may want to do if you suspect a specific infection. One would be a mycoplasma infection.

Q That was my next question. Can you tell me what is mycoplasma pneumonia?

A Generally speaking the micro organism that cause infection are divided into three. You have viruses, you have bacteria and you have some other parasites. There is something between a virus and a bacteria, and that would be the best definition of the mycoplasma. It's close to bacteria, but it doesn't have a wall and it's not really quite

as small as a virus. It's somewhere in between.

Q In the course of your medical career have you had occasion to treat patients who have had mycoplasma pneumonia?

A Yes.

Q How do you diagnose mycoplasma pneumonia?



, M.D.

A The way to diagnose it would be to, first of all, screen, do a general screening test called cold agglutinin, then you can send blood for titers of mycoplasma and this would be, you would be looking for the igM titers.

Q Is there also a different titer known as igG?

A There is igG too.

Q Does that have any effect on evaluating whether or not a patient has mycoplasma pneumonia?

A To the best of my knowledge igG would be something that would just say yes, the patient had in the past an infection, but igM would be more current.

Q In your hospital in August of , how long did it take to perform a cold agglutinin test, and I'm not asking for a specific --

A I'm not sure I understand that.

Q Do you perform a cold agglutinin test by a method of obtaining a blood specimen?

A Blood specimen.

Q Once the blood specimen is obtained



how long does it take to get the results back generally?

A I don't have a real knowledge about that. I can assume that this would take up to two days.

Q The same question with regard to the titers, that would be mycoplasma titers, how long does it generally take for those results to come back once a specimen is submitted?

A I would say days, but I'm not sure about it.

Q How do you treat mycoplasma pneumonia?

A mycoplasma pneumonia is a micro organism that would be treated with either erythromycin or some other antibiotics that belong to the same family. Would be others, you know, and I can mention a few.

Q Prior to coming here today did you review 's hospital chart?

A Yes, I did.

Q Separate and apart from the hospital record that your attorney has provided

, M.D.

here today, did you review any other records relating to this patient?

A No.

Q In preparation for today did you review any text books or medical literature on the issues involved in this case?

A No.

Q At some point during this child's hospitalization in August and September of at , did there come a time when you came and treated ?

A Based on the chart I would say yes.

Q Do you have an independent memory of this child separate and apart from any notes that are contained within the record?

A Not really.

Q Do you have any recollection of the patient's parents?

A Not really. I don't really recall

any specifics about this patient.

Q From your review of this chart did you learn that this child on admission to the hospital on August 19th, , had a complete white out as noted on the chest x-ray?





, M.D.

A What I recall is that she had a left-sided pneumonia. Whether this was a complete white out or not, that I cannot tell you, I don't remember.

Q On August 22nd, three days after admission, I'm going to show you a copy of an x-ray report taken while she was in the hospital. Does that indicate that there was a complete white out in the left lung?

A That's what it says. Under full

results it says, this is a little unusual. It says, "Full result history: Complete white out of left lung."

Q What, if anything -- I'm sorry?

A Can I just read it?

Q Go right ahead.

What, if anything, does that signify to you medically, Doctor?

A That particular these three words white out?

Q Yes, the white out.

A The white out means that there is a process in the left lung which takes the air space of the alveoli of the lung branchiomere





, M.D.

which indicates that either this is filled with fluid, pus, consolidated. So there is a

process there is a disease in that lung. The lung should be black, gray. It should not be white.

Q You're referring to observing it on a chest x-ray?

A Yes.

Q Is there any way for you to determine or to know based on the observation by the radiologist how long that white out had been present as of the time the x-ray had been taken?

MS. : Note my objection.

A No, there's no way to know how long this had been in place, that process.

Q Are you familiar with a Dr. ?

A Yes, I am.

Q How do you know Dr. ?

A Dr. is our pediatric pulmonologist. I don't really remember when he was hired.

MR. : He didn't ask you

, M.D.

that. Do you know?

THE WITNESS: Yeah, I know.

Q As you sit here now, do you recall having any conversations with Dr. about ?

A No, I don't recall.

Q Do you know Dr. ?

A I know Dr. .

Q What is his position at the hospital?

A At that time he was one of the pediatric surgeons on the voluntary staff.

Q Do you recall as you sit here now any conversations you had with Dr. about treating ?

A I do not recall.

Q From your review of the records did you see at various times of 's

hospitalization she underwent various surgical procedures in addition to placement of chest tubes as well as surgery to the lung?

A Yes.

Q At any time while you were treating her did you observe the scars or the incisions



, M.D.

that were made to her from the surgical procedures?

A Again, based on the chart, when I was on service she was already after the placement of chest tubes so I must have seen the scars.

Q After this child was discharged from the hospital, I believe it's September 6th, , did you ever see again?

A I don't recall that.

MR. : I think it was the

12th.

MR. OGINSKI: Maybe you're right. Yes, thank you. You are right.

Q In addition to seeing and treating patients in the critical care unit of Hospital, did you also maintain an office for private practice of medicine where you would see patients from time to time?

A No, but we do have occasionally patients that we would like to see in a follow-up, very specific patients.



, M.D.

Q Do you have any recollection or any notes which would suggest to you whether or not was one of those patients?

A I do not recall.

Q If a patient was asked to return

back for follow-up, where would they generally go? Would it be a clinic or is some other office within the hospital?

A Well, they would have to contact the physician that would follow them, and it would be in a clinic in one of the modules.

Q Is there anything that you recall, again, about the surgical incisions that you can tell me about, what they looked like or the size of those incisions as you sit here now?

A By recollection, no.

Q Again, from your review of this patient's chart, did you learn that during various surgical procedures she sustained iatrogenic injuries?

MR. : I'm not so sure through various, but I think there's mention of one in a procedure on the 6th I think.

, M.D.

MR. OGINSKI: I'll rephrase the question.

Q Did you learn during the course of the surgery to her lung she sustained an iatrogenic injury?

A I don't know what you mean by iatrogenic. I think that surgery is done by a surgeon. So every complication that's happened can be in a way defined as iatrogenic. She did have a complication during the surgery.

Q Let me just step back for a second. What's your understanding of an iatrogenic injury?

A Iatrogenic means that an injury was caused by something that a physician did or a care provider did to the patient.

Q What is your understanding that of

the complication that sustained during the course of her lung surgery?

MR. : Note my objection. He's not a surgeon, he didn't have anything to do with the surgery, but over my objection I'll let him answer in a general sense.



, M.D.

MR. OGINSKI: Generally.

A My understanding that that particular procedure was started out as a what we called a VATS, which is a video assisted procedure, and, again, my understanding is that inadvertently or during that procedure there was an injury in the way of a laceration or a tear on the left side of the diaphragm. I understand that the surgeon decided to turn the procedure into an open procedure and he fixed it.

Q Did you learn also as a general

matter during the course of the procedure that she sustained a diaphragmatic hernia?

A Through the chart, yes, that's what I understood. It is mentioned in the chart that through that tear in the diaphragm there was a creation of the diaphragmatic hernia.

Q And that she also sustained a collapsed lung during the procedure?

MR. : Off the top of my head, I mean, you're asking and I would prefer you look at the chart rather than answer. Maybe I'm wrong





, M.D.

but it seems to me she had a collapsed lung before the surgery, but I wasn't focussing on the

surgery.

MR. OGINSKI: I'll rephrase it.

Q Is there any question in your mind based on your review of the patient's records that she had pneumonia when she presented to the hospital on August 19th, ?

A No.

MR. : I think it was the 18th, but he wasn't there, but you mean from his review of the chart?

MR. OGINSKI: Yes.

Q In treating pneumonia especially in children is it important to know what type of organism is causing the pneumonia?

A It is.

Q Why?

A Well, when you know the organism, you can direct your treatment better, you can be more specific in your management.

Q By management do you mean treatment with antibiotics?

, M.D.

A Yes.

Q Are there certain medications that are more specific to certain types of organisms causing pneumonia as opposed to a broad spectrum antibiotics?

A Yes, but we generally use broad spectrum antibiotics, but I don't know if the broad spectrum antibiotics cover everything, the whole spectrum of micro organisms.

Q In your review of the record did you or do you recall what tests were actually done to identify this type of pneumonia this child was experiencing?

A What normally is done is that a blood culture is sent which would indicate whether or not the organisms causing the pneumonia are spread into the bloodstream. When a chest tube was placed a sample was sent for cultures and when bronchoscopy was done, the lavage fluid that was used was sent for

cultures.

Q How long did it take for the result of the cultures to come back, if you know, back in August of ?





, M.D.

A Generally speaking, cultures take about two, three days.

Q Did the cultures that were obtained reveal what organisms specifically was causing this child's pneumonia?

A No.

Q How do you know whether a patient, specifically a child, has a viral type of pneumonia as opposed to any other type?

A Normally speaking, a viral pneumonia does not give you an overwhelming picture as total white out of the lung with

fluid with such a significant pleural involvement. The patient may have fever, but he may not look clinically toxic and the white count, even though it's a nonspecific marker, may not be as elevated as you would see with a bacterial pneumonia.

Q Do you recall seeing that on admission had a normal CBC and there was no history of her having been on antibiotics prior to her admission?

A No.

Q Can you take a look at the record,



, M.D.

please, which has been marked as Plaintiff's 1?

MR. : I assume you're referring to the emergency room?

MR. OGINSKI: Yes.

MR. OGINSKI: Let me withdraw

the question and ask it a different way.

MR. : That's the problem of asking questions of somebody that wasn't there, but go ahead.

MR. OGINSKI: I'll try and speed it up.

Q In the emergency room record is a note that indicates bloods were drawn, cultures were done with CBC differential. You see that, right?

A Yes.

Q Do you see the results of those tests?

A Which date are we talking about?

Q 8/19/.

MR. : August 19th was when she came into the emergency room

, M.D.

and apparently blood was drawn.

Q You have that date, Doctor?

A I'm looking. Yes, I have it.

Q What do the results of the blood test tell you, if anything?

A There are many blood tests.

Q No, is there anything in those blood tests that were done on 8/19 that indicates to you -- well, first of all, was the CBC normal?

A It looks normal.

Q Was there anything that you saw in the patient's history that indicated that this child has been on antibiotics prior to arriving at the hospital?

A I didn't see that he had been on antibiotics.

MR. : She.

THE WITNESS: She, I'm sorry.

Q Are you familiar with the term differential diagnosis?

A Yes.

Q What is your understanding of that term?



, M.D.

A That there's more than one diagnosis for a disease and one would need to know a whole slew of diagnoses that would pertain to a certain symptom or certain symptoms.

Q Would you agree that any differential diagnosis of pneumonia should include a mycoplasma as being a cause of the condition?

A I would disagree with that because the mycoplasma pneumonia is to some extent age specific.

Q I'm sorry?

A Age specific. It's very, very uncommon up to the age of five years. It's somewhat seen between five and ten and it's common after ten years of age.

Q Would Legionella be included in a differential diagnosis of pneumonia or the types of organisms of pneumonia?

A It would.

Q How does the Legionella differ from mycoplasma?

A Well, Legionella is a very rare





disease and it tends to occur in patients who are immune compromised host first and foremost, and Legionella also should come in a context of a patient being exposed to some type of water vapors, some type of management through pipes and tubes with water.

Q In a patient specifically in an age group of four years old as this child was, would it be good practice in your opinion to consider mycoplasma as a differential diagnosis as a cause of pneumonia?

MR. : I'm going to object to would it be good practice. I mean, I don't know what that word means what. That phrase means, good practice. Has no legal significance to me.

Q There are various doctors who are in the residency in your department, correct?

A Correct.

Q During the course of training these physicians, do you teach them how to diagnose various conditions and diseases as well as advising them on what might be differential

, M.D.

diagnosis?

A Yes.

Q As part of a differential diagnosis when you're teaching these residents, do you advise them generally speaking to consider mycoplasma in an age group under the age of five as part of their routine in diagnosis and treatment of pneumonia?

A If the age group and the symptoms hint in that direction, yes.

Q What is it that would suggest to you that a child under the age of five would be experiencing mycoplasma pneumonia as opposed to any other type of pneumonia?

A I'm sorry, under the age of five?

Q Under, yes.

A Under the age of five I would say that common practice would be to consider the mycoplasma pneumonia only if regular common management for other types of pneumonia do not

yield the results that you expect.

Q With antibiotic treatment of pneumonia, at what point in time do you see resolution of the chest x-ray or a clearing or





, M.D.

improving of chest x-ray?

MR. : That question is somewhat confusing to me.

MR. OGINSKI: I'll rephrase the question.

Q In a patient who has been diagnosed with pneumonia and who has been treated with broad spectrum antibiotics and also has a chest x-ray indicating a white out, is there some point in time where you would expect to see a resolution of the chest x-ray in response to antibiotics?

A In a chest x-ray that shows white

out pneumonia with fluid with pleural effusion, the resolution takes, to see some degree of resolution, takes many days.

Q How do you know if the antibiotics are working and is attacking that particular pneumonia?

A Well, symptoms will improve, fever will not be as high, white count may decrease, some resolution of the pneumonic process in the lung will occur. All of these are markers of improvement.





, M.D.

Q Do you have an opinion with a reasonable degree of medical probability as to whether it would be a departure from good care to fail to consider mycoplasmas as part of an initial differential diagnosis in evaluating pneumonia?

MR. : I'm going to object to that. He is not here as an expert to testify what reasonable medical care is or isn't. In fact, he's already answered your questions about that particular organism.

MR. OGINSKI: Are you directing him not to answer?

MR. : Yes, I am.

MR. OGINSKI: Mark it for a ruling.

Q Did you learn from a review of this chart an Infectious Disease consult was not called until August 31st?

MR. : Object to the characterization was not called. You can ask him when it was called.

Q Did you learn that the first time

, M.D.
an Infectious Disease consult evaluated this child was on August 31st?

A Yes.

Q I'd like you to turn, please, to Page 8 of the hospital record?

MR. : Could you be a little more specific what it is because there doesn't seem to be a rhyme or reason to my copy.

MR. OGINSKI: For the record at least some of the pages are numbered on the bottom right. The date of the note is August 21, . The progress note August 21.

It's a PICU Fellow Admit Note.

MR. : Why don't we just use that?

MR. OGINSKI: I just have questions, I know it's in there.

Keep going.

MR. : The notes up here are in September.

MR. OGINSKI: There you go.

MR. : This one here?



, M.D.

MR. OGINSKI: That will be the next one. Go back two pages. There you go.

MR. : This PICU Fellow Admitting Note?

MR. OGINSKI: That's correct.

Q Doctor, can you tell just from the bottom of that page who wrote this note?

MR. : Well, I think the trouble with the page it ends over here on another page.

MR. OGINSKI: Correct.

MR. : It ends, for some reason this is stuck in the

middle and this note ends here, I believe.

MR. OGINSKI: Yes, I think you're right.

MR. : He wants to know can you identify the handwriting of that signature?

MR. OGINSKI: Which appears on Page 11.

Q Would that be a Dr. ?



, M.D.

A That was my first belief. I just want to make sure. I would say yes.

Q By the way, is that a man or a woman?

A It's a woman.

Q Is Dr. still employed at ?

A She's still there.

Q Do you know what her capacity or her position is?

A She's a third-year fellow.

Q In what field of medicine?

A Pediatric Critical Care Medicine.

Q What was the fellow's duties, if you can tell me, back in August of , in relation to treating patients?

A Well, the fellow is one level above residents, above the pediatric residents. He or she supervises residents. They provide care to the patients under the supervision of the attendings.

Q This particular admitting note, that was when the patient was transferred into the Pediatric Intensive Care Unit?

A That's correct.

Q Did Dr. have the duty of attending to this patient on a daily basis?

A If she was on service.

Q Getting to your involvement, were there times when you were designated to be on service in the Pediatric Intensive Care Unit?

A Yes.

Q On the occasions when you were not on service, did you have other partners or colleagues also in the same capacity as you who also attended to the patients in the PICU?

A Yes.

Q Turning to Dr. 's note, 8/21/ note, on the second page, which is Page 11, at the bottom, under her plan she writes on the second line: Start Nafcillin for possible staph infection. Do you see that?

A Yes.

Q That was relating to the pneumonia

as far as you know?

A Right.

Q She also writes: Consider

Vancomycin for possible drug resistant



, M.D.

pneumococca; is that right?

A Exactly.

Q What does that mean to you? What's

the medical significance of that statement?

A Well, what she was thinking.

MR. : Well, we don't know

what she was thinking, but your

interpretation of the note.

A My interpretation of that note was

first thought was this pneumonia was caused

either by a staph or by a strep. The strep is

strep pneumonia. Under very rare circumstances

the strep pneumonia may be not sensitive, may

not be sensitive to Ceftriaxone or Nafcillin and there is under certain circumstances where we decide to give Vancomycin.

Q She continues her note by saying: ID approval not obtained. What does that mean to you?

A It means that, what she meant here, what it looks like here is that if you want to start Vancomycin, at one point you would want to ID to approve that because Vancomycin is a drug that we would like to preserve for really





very specific patients that we feel are resistant to the regular antibiotics.

Q Is there anything to suggest that this statement, ID approval not obtained, related to anything else other than the Vancomycin?

A No.

Q Do you have an opinion as you sit here now after having reviewed this patient's record as to whether this child required an Infectious Disease consult as of August 21?

A No.

Q Did you learn from the record, again, why an Infectious Disease consult was obtained on August 31st?

A The consult was obtained for two reasons. The reason number one would be that we planned to treat the patient at home with antibiotics. Patients who go home on prolonged antibiotic treatments, IV, intravenous treatment, we refer them to ID for future follow-up.

The other reason was that we wanted their opinion since the patient had been treated for

, M.D.

a certain number of days and there was not a complete resolution of the pneumonic process.

Q A broviac, what is that?

A Broviac is a type of catheter. It's a long-term catheter made of silastic, silicone that has a cuff on it. So you put it in the vessel and you tunnel it under the skin and it can stay there for a long period of time. It's safe and you can send patients home with that.

Q Was that the intention for this patient to go home with a Broviac catheter for the insertion or the administration of IV antibiotics?

A That's my understanding, yeah.

Q Do you know who it was who called for the Infectious Disease consult?

A I was the attending on service during that period.

Q Did you call for the Infectious Disease consult?

A That I don't remember. It could have been me, it could have been the fellow, it could have been the resident. We all work as a



, M.D.

group. The plan was made and somebody must have called.

Q If you had been the one to make a determination to get an ID consult, would you customarily have advised the resident or the fellow to carry out that instruction and actually request it and have someone come and evaluate the child?

A Yes, that would be the common practice.

Q What was your practice back in August, September, , in terms of making notes and entries in the patient's chart on a daily basis?

A The attendings write notes. These notes are concise, straight to the point. We use a template that has certain entries that we fill. Obviously it's attending specific. Some attendings like to write a lot, some attendings write less. It's one note out of many notes that are written on a patient. Everything that's written on a patient is under the supervision of the attending.

Q Prior to writing your note on any



, M.D.

given day, was it customary for you to make rounds and actually see the patient?

A Yes.

Q As part of your seeing the patient, did you do that in the presence of either residents or fellows or other physicians?

A Yes.

Q On those occasions were there times when you would physically examine the child that you were treating?

A Yes.

Q As part of the notes when you finished examining the patient and rounds would you indicate what your findings were on examination separate and apart from any lab notes or test results that you observed or any plans?

A Not necessarily. The attending's note is an additional note to the other people's note. The fellow and the resident, you would find more about details of the physical examination in the resident's and the fellow's note than you would find in the attending's notes.

, M.D.

Q There are references throughout the chart. There are persons called RPN or someone making the note called RPN. Are you familiar with that? Would that be pediatric notes?

A It's a resident pediatric note, right.

Q In the Pediatric Intensive Care Unit did you generally have one fellow that was attending to patients or more than one at any given time?

A There is one fellow that takes the responsibility for patients who have multidisciplinary diseases. There is another fellow that has nothing to do with this that takes care of cardiac intensive care patients.

Q As you sit here now, do you have an opinion as to whether Infectious Disease consult should have been called in earlier than August 31, ?

A Based on what I read and based on

what I know, there was no real indication to call in an Infectious Disease consultation earlier.

Q In your opinion based upon your



, M.D.

treatment of this patient and reviewing patient's notes, did you get any sense or impression as to whether this child deteriorated from the time of admission during the course of her hospitalization or improved or something else if you can tell me generally?

MR. : Within what time frames are we talking about?

MR. OGINSKI: From the time of her initial admission on August 19th up to the time when you first began to treat her on August 29th.

A My impression from what I read in

the chart was that there was an initial improvement secondary to whatever had been done to this patient. There were "deteriorations" that were more due to specific procedures that were successful more or less, and a little later, but I don't think this is your question. Up until that time my impression is that there were ups and downs. There was an initial period of improvement and there was a period where things did not go as well, and I thought from what I read that this was secondary to





some problems with certain procedures.

Q Referring to the bronchoscopy?

A No, I'm referring to Dr. 's attempt to put a chest tube which was less than satisfactory in his view, and then the patient

was sent for interventional radiology to place a chest tube. This resulted in a response or a reaction by the airway where the patient needed to be intubated, and then there was a residual pneumothorax on the left that needed also to be treated.

Q I think there was also a note mentioned about a possible laryngospasm associated with that?

A Right.

Q Was the patient also placed in involuntary paralysis at that point or was it later on if you recall?

A Later on.

Q By the way since I bring that up now, the involuntary paralysis, for what benefit or what reason is that done?

A I don't know what you mean by involuntary paralysis. What does that mean?

, M.D.

Q Was there an instance where the child was placed in restraints?

A I don't recall that.

MR. : That would have anything to do with --

MR. OGINSKI: That was next question.

Q Was there an instance where after a surgical procedure was performed the child was sedated for whatever reason for a number of days?

A Yes.

MR. : Again, you're asking the doctor to interpret the chart. He really wasn't involved. I have no problem with that, but let's get it clear that this was from his review of the chart and his recollection of that. Let it also reflect that we're not specifically

22 referring to any page numbers and
23 you're asking him to sort of do this
24 off the top of his head, which I have
25 some reservation about, but I'll let



1 , M.D.
2 him answer it.
3 Q Was that when the patient was
4 placed on a respirator?
5 A Yes.
6 Q Why would the child be sedated
7 while on a respirator?
8 A Being on a ventilator.
9 Q On a ventilator, thank you.
10 A Being treated by mechanical
11 ventilation causes discomfort and pain to
12 patients so they need sedation.
13 Q Based on your review of the chart
14 and your knowledge of this patient, was there

any consideration by anyone at the hospital before August 31st that this child might be experiencing mycoplasma pneumonia?

A Based on what I read, we did not think about, nobody thought about mycoplasma pneumonia.

Q Am I correct that on August 31st as part of the ID consult that individual recommended that a cold agglutinin test be performed?

A Yes.



, M.D.

Q The cold agglutinin test revealed that the igM antibodies were present, correct?

A No, the cold agglutinin test was positive in addition to that there was an igM test.

Q The fact that the cold agglutinin

test was positive what information did that give you in terms of this child's condition? What did it mean to you?

A It tells that mycoplasma is an option, is a possibility.

Q Did you also learn that the igM antibody was positive?

A Yes.

Q What information did that tell you? What was the medical significance of that?

A That most likely the infection was caused by mycoplasma pneumonia.

Q Does a positive igM result indicate an acute infection?

A Yes.

Q Was there any indication that you could tell from a review of this patient's record that a cold agglutinin test would have

, M.D.
assisted you in diagnosing this child's condition earlier from when it was originally proposed on August 31st?

MR. : I'll object to that question. It's too convoluted?

MR. OGINSKI: I'll rephrase it.

Q Would a cold agglutinin test if performed early in the admission have assisted you in this diagnosing child?

MR. : I'm going to object. He also answered the question. He didn't feel it was called for up to that point. I don't know what would have assisted you. It's a little too speculative.

MR. OGINSKI: I asked a little bit of a different question earlier.

Q Was there anything to suggest in this child's chart prior to your involvement on August 29th that a cold agglutinin test should

have been performed from the time of her admission up until the time that you saw the patient?

A No.



, M.D.

Q Can you tell me whether it would be good medical practice to have performed a cold agglutinin test when evaluating and ruling out different types of pneumonia on admission?

MR. : Objection. Again, I object to that phrase, it's good practice, you know.

Q Would that test have assisted you in diagnosing and treating this child's condition?

MR. : Object to the question. It's not a question of

assisted or not. It's a question of in this view was it called for, and he's answered that in the negative.

Q If mycoplasma pneumonia had been initially diagnosed upon her admission or shortly after her admission, what is the accepted method of treatment of the mycoplasma?

MR. : I'm going to object to the question. You can ask him what the effective treatment of mycoplasma pneumonia is. I think



, M.D.

he's already told you that.

Q In this instance how was the mycoplasma pneumonia treated?

A This particular instance?

Q Yes.

A The patient was started on Azithromycin for antibiotics for this.

Q In addition to the Azithromycin was the patient also continued on the other two antibiotics that she had been receiving as well?

A I'm going to have to look.

Q Specifically the Nafcillin and also the Ceftriaxone?

A Yes, the patient was on Nafcillin and Ceftriaxone as well.

Q Can you tell me why the patient was continued on those two medications in addition to the Azithromycin that was prescribed for her?

A I believe that one of the thoughts was that perhaps this was not just a pure mycoplasma pneumonia. Maybe it was a pneumonia that may have started with

, M.D.

mycoplasma and it was a superimposed infection later or visa versa. It started from a different micro organism and mycoplasma came in a little later.

Q Are you familiar with a medication known as Macrolide?

A No.

Q Is Amoxicillin effective in treating mycoplasma pneumonia?

A As far as I know, no.

Q Can you determine from the record whether the Azithromycin was successful in attacking or treating this particular type of pneumonia?

A I don't think you can say from the record whether or not this was the Azithromycin in and of itself because, again, it was given with other antibiotics as well, but the patient did well, did better as time went by.

Q Do you have an opinion, Doctor, with a reasonable degree of medical probability that if this child's mycoplasma pneumonia had been diagnosed in or around the time that she was admitted to the hospital whether she still





, M.D.
would have required the lung surgery that she underwent?

MR. : That's highly speculative.

MR. OGINSKI: I'm only asking his opinion if he has one.

A That's really impossible to know.

Q Do you have an opinion, again, with a reasonable degree of medical probability if this child had been treated for mycoplasma pneumonia on admission or shortly afterwards whether she would have required the

bronchoscopy that she had?

A Again, impossible to know.

Q Is there any way to know with a reasonable degree of medical probability whether she would have needed to have a portion of her lung removed during the course of the lung surgery?

A I don't have a way of knowing that.

Q Can you turn, please, to the Infectious Disease Consultation Note, which is dated August 31, ?

Doctor, this is a two-page note.



, M.D.

Can you tell from the bottom of the second page the name of the individual who evaluated this child on August 31.

A I would say, but not with, I wouldn't be a hundred percent sure about it,

but it looks like it's Dr. .

Q What was Dr. 's capacity or his title at the hospital at that time?

A He's of Pediatric Infectious Diseases.

Q Did you ever have a conversation with Dr. about this patient in or around August 31?

A I don't recall.

Q I'd like you to turn to the second page of his note, the bottom third of it where he discusses the assessment and plan. Could you read as best you can, Doctor, that note?

A From four-year-old female?

Q Yes, please.

A Four-year-old female with, I think, pneumonia left. Left pleural effusion. Current treatment Ceftriaxone. There's something in parenthesis there that I can't --

, M.D.

Q Is that Nafcillin?

A Nafcillin, yeah, sorry. Adequate for strep pneumonia and streptococcus areas.

Q Infections?

A Infections, right. Secondary -- no, I'm sorry. Yeah, infections secondary to low WBC count. What is that, can't?

Q Would it be continue?

MR. : Don't guess or speculate. If you can't read his handwriting, just say I can't read it. Go to the next word.

A Low grade temps. Unresponsiveness to current prescription and failure to find empyema on, I think it's thoracocentesis. Would consider alternate etiologies.

Q Let me stop you for a moment, Doctor. What is empyema?

A Empyema is a fluid, it's an exudate

in the pleural space that has a high content of protein and white blood cells. In its extreme form it would be pus.

Q The failure to find empyema on thoracocentesis, what is the medical





significance of that to you?

A I would have to say that we all believed and continue to believe that the patient had empyema. I have no idea why he said failure to find empyema.

Q Underneath where he writes, alternate etiologies, he lists various things. Do you see that?

A Yes.

Q Can you read what those are please?

A EG mycoplasma, chlamydia and Legionella.

Q He recommended various tests?

A He recommends cold agglutinin is number one, number two is mycoplasma titers, number three is would continue IV.

Q Would that be antibiotics, ABX?

A Continue IV antibiotics, right, until discharge.

Q Then he writes, is possible or if possible?

A Would then suggest.

Q Oral?

MR. : Doctor. He's



, M.D.

asking you. I'm not here to guess or speculate. If you can't read the guy's handwriting, and I have to admit I have a hard time, don't guess

or speculate.

Q Doctor, does it look like oral antibiotics?

A Oral, right, antibiotics.

Q And the doctor adds high does of Amoxicillin or Macrolide antibiotics?

A That's what it says.

Q Depending upon cold agglutinin?

A Right.

Q At the bottom he continues by stating and I'm going to read if you don't mind: No definite empyema with an arrow, effusion. Only modest white blood cell count. Do you see that?

A Yes.

Q What is the significance of that statement to you?

A Well, the significance of this the way I interpret it is that he wasn't sure or he felt it wasn't a full blown picture of empyema.

, M.D.

So he says no definite empyema. He wasn't definite about it. The effusion does has WBC, which is what you would want to see, which is part of the definition of empyema, but in his opinion it was only a modest WBC count.

Q Prior to the child receiving Azithromycin, can you tell with a reasonable degree of medical probability whether the antibiotics she had been receiving prior to that time were effective in treating the mycoplasma pneumonia?

A I would say not effective, but could have done something to it.

Q Can you say with a reasonable degree of medical probability that since the cold agglutinin test was positive as of August 31 that it also would have been positive on her admission of August 19?

MR. : I'm going to object

to the question. How is somebody going to know that?

MR. OGINSKI: I don't know, that's why I'm asking the question.

A There's no way of knowing.



, M.D.

Q In a four-year-old child who has undiagnosed and untreated pneumonia, what clinical symptoms would you expect to see in such a patient?

MS. : Objection.

MR. : I'm going to object. First of all, I don't quite understand the question. A child came in and pneumonia was diagnosed. So, you're asking him some speculation about before the child

13 came in or something?
14 MR. OGINSKI: I'll rephrase the
15 question.
16 MR. : His involvement
17 was even ten days after she came in
18 with the pneumonia.
19 Q As a general question, not specific
20 to this case, in a child under the age of five
21 who does have pneumonia that goes undiagnosed
22 and untreated, as a physician what clinical
23 symptoms would you expect the child to have as
24 the disease progresses?
25 MS. : Objection.



1 , M.D.
2 MR. : I don't see the
3 relevancy to the issues of this case
4 vis-a-vis
5 Hospital. You're attempting to use

the doctor as an expert against the co-defendant and private attending. I would object. I'm not even sure that's what you're doing. I'm just confused by the question.

Q Is there any way for you to tell me what symptoms an untreated pneumonia produces as a general question?

MS. : Just note my objection.

MR. : In children? I mean, I don't think, you know, this is like trying to practice medicine by Merck's Manual. I don't think it works that way.

Q From the time that was admitted to the hospital on August 19th, , am I correct that she remained in the general pediatrics unit for about two days before being transferred to PICU?

, M.D.

A Yes.

Q From the time she was transferred to the Pediatric Intensive Care Unit until the time of her discharge, am I correct that she remained in the Pediatric Intensive Care Unit through the length of her hospitalization?

A To my recollection from reviewing the chart she stayed in the ICU until she was discharged.

Q Are you aware of the total cost for her hospitalization at in August and September?

A No.

Q If I were to tell you that we have received a bill or a printout from the hospital evidencing charges in the amount in excess of a hundred and two thousand dollars for that hospitalization, would you be able to express

an opinion as to whether those charges were reasonable and customary in August of ?

MR. : I'm going to object. Whatever the bill is, the bill is. I mean, he has nothing to do with the billing. If you have a



, M.D.

bill, I assume that's what it is. I'm not going to argue with you. I don't even have a bill. I don't think it's fair to ask him what's reasonable and unreasonable.

Q Is mycoplasma pneumonia considered a bacterial infection?

MR. : I think he's answered that already.

A It's not a real bacterial infection. The only thing that resembles a

bacterial infection is the fact that there is antibiotics that this organism would be, there is antibiotics that would eradicate mycoplasma infection.

Q Would you agree that the sooner the patient is treated for this particular condition, the better it would be for the patient?

MR. : I'm going to object to the question.

Q Would you agree with the general principal that the sooner the patient is diagnosed with whatever condition they're



, M.D.

experiencing, the greater likelihood the patient's problems with resolve in an earlier time?

MR. : I don't think

that's a fair question in the general sense. I'll let him -- I figure you're getting to the near of your tender. I don't want to be obstreperous. I'll reserve my objection to the time of trial.

A As a general principal an early diagnosis is better.

Q Do you have any knowledge as you sit here as to whether this child received antibiotics for any condition at all in the week or two prior to her admission to Hospital?

MS. : Note my objection.

MR. : You can answer the question if you know.

A From what I read it appears like the patient had not been getting antibiotics before coming to .

Q Do you have an opinion as you sit

, M.D.
here now and having the benefit of treated the child and also having reviewed this patient's chart as to whether this child had been given antibiotics a week or two prior to her admission whether her outcome and progress at would have been any different?

MS. : Note my objection.

MR. : It's very speculative. I'll let him answer over my objection.

MS. : Just note my objection.

A I wouldn't know because --

MR. : You don't have to because. If you wouldn't know, you wouldn't know.

Q Can you tell me why you wouldn't know?

A Because I wouldn't know what type of antibiotics the care provider elects to give to this patient.

Q If the child had received broad spectrum antibiotics within a week or two





, M.D.

before being admitted to the hospital, would you then have an opinion as to whether her outcome or her progress would be any different at ?

MS. : Note my objection.

MR. : This is speculative. Again, I don't want to have to drag the doctor back here. I'll let him answer over my objection.

A A broad spectrum antibiotic

doesn't say much. It doesn't necessarily say that it covers the organism that may have caused that infection.

Q Do you know Dr. who's sitting here at the table today?

A No.

Q Have you ever had a conversation with Dr. about this patient?

A Not that I recall.

Q When you came on service on August 29th, in the Pediatric Intensive Care Unit, do you have any memory of 's parents being at her bedside?



, M.D.

A I don't have that recollection.

Q Based upon your treatment of this child and, again, your review of the notes, was there any consideration by you or any other physician at that this child

was experiencing a viral pneumonia?

A It doesn't appear from the chart that we were considering a viral pneumonia.

Q Did you ever learn from any of the doctors or nurses or 's parents that the child had been treated by her pediatrician specifically Dr. in the week or two prior to her arrival at ?

A I don't have that recollection.

Q Is there anything to indicate to you that 's pediatrician prior to her admission to had been treating her as if she had some type of viral infection?

MS. : Just note my objection.

MR. OGINSKI: You may answer.

MR. : I control you.

THE WITNESS: I have no ability to

, M.D.

interpret what she's saying so I'm not going to listen anymore.

Q Did you ever learn from anyone at the hospital that prior to 's admission to on August 19th that her pediatrician had considered her to have some type of viral infection?

MS. : Objection.

MR. : I think he answered that already.

MR. OGINSKI: I don't think I got an answer.

MR. : I think he said he didn't know about the doctor.

MR. OGINSKI: I know they didn't have any conversations.

MR. : How would he ever know what anybody said about him?

MR. OGINSKI: Not specifically Dr. , but a pediatrician that was caring for the child prior to her admission.

MR. : You can answer.





, M.D.

A What one can learn from the chart was that the patient had had a period of fever of a febrile illness prior to coming to , and it appears that the child had received only Motrin, I guess, against a fever or for pain or something. So, one could indirectly assume that that febrile illness was considered to be viral and not bacterial.

Q Is periumbilical pain a clinical symptom of pneumonia?

A Yes.

Q How does that present itself in

terms of the diagnosis?

A A child who has a low burn pneumonia or has a one-sided pneumonia, the referred pain can go to the abdomen. So, it's quite common to see pediatric patients with pneumonia who complain of abdominal pain.

Q Before we get to your specific notes, Doctor, before you came on service am I correct that Dr. was the physician on service?

A That is correct.

Q Dr. is an attending at



, M.D.

?

A Exactly.

Q He still works there, correct?

A Yes.

Q Have you had any conversations with

Dr. from the time that this lawsuit started until today about ?

A No.

Q Have you reviewed Mr. or Mrs. 's deposition transcript prior to coming here today?

A No.

Q Can you turn, please, to Page 19 of the chart?

MR. : Could you be more specific?

MR. OGINSKI: Well, the page that would be --

MR. : What date?

MR. OGINSKI: -- August 22nd, .

MR. : We were there already, right?

MR. OGINSKI: No.

, M.D.

MR. : The resident's note?

MR. OGINSKI: The PICU Fellow Procedure Note.

Q Doctor, this note indicates that Dr. performed the insertion of the left chest tube, correct?

MR. : Assuming that's Dr. and he says he thinks it is.

Q In the top or in the middle where it says Operator, it says: , do you see that?

A Yes.

Q Does that indicate to you that Dr. placed the chest tube?

A She placed the chest tube and supervised.

Q Was this done in the Pediatric Intensive Care Unit or at another place within

the hospital?

MR. : Again, he wasn't there, but is he able to interpret from the note?





, M.D.

Q From the note can you tell where the procedure was done?

A I would say within the Pediatric Intensive Care, yes.

Q At the second to last line of Dr. 's note there is a question mark and then it says: Laryngeal spasm without intubation. Do you see that?

A Yes.

Q What does that mean to you?

A It means that during sedation, this is deep sedation, we're talking about some of the patients may respond with laryngeal spasm.

Q Can you turn please to the next page, Page 20, dated August 23rd, , where it says RPN at the top?

A Yes.

MR. : That's 8/23.

MR. OGINSKI: Yes. 8/23 timed at ten o'clock.

A I see that.

Q In the middle of the page under the chest x-ray this physician writes: Still with "white out" of left lobe CT in place, correct?



, M.D.

A Correct.

Q This person is referring to the chest x-ray and the chest tube still being in place, correct?

A Correct.

Q Doctor, as of August 22nd according to the order sheet this patient was receiving morphine sulfate. Can you tell me what morphine sulfate is, what type of medication it is?

A It's a pain killer.

Q How would you describe this type of pain killer. Is this a narcotic, is this an over-the-counter type of medication or something else?

A It's a narcotic.

Q There's also a note in the order sheet of August 22nd, , requesting that pleural fluid be evaluated for cell count gram stain, culture, glucose, protein, albumin, LDH and AFB?

MR. : We don't have the order sheet in front of us, but if you say it, you're reading from a

, M.D.

copy, I assume you're doing it accurately.

Q Assuming that to be the case, for what purpose would you generally order those types of lab tests?

A We would want to know what type of fluid this was exudate, transudate.

Q Did you learn, again, from your treatment of this patient that at various times she received a morphine drip?

A I don't recall that.

Q What is a fentanyl drip?

A Fentanyl drip is a, fentanyl belongs to the same family as morphine is, which is opiate narcotics, and fentanyl drip, drip is drugs we give to patients who receive mechanical ventilation, again, to alleviate discomfort and pain.

Q Do you recall as you sit here now

at various times did receive a fentanyl drip?

A Yes.

Q Are you familiar with a medication known as Norcuron?





, M.D.

A Norcuron, yes.

Q What is that?

A This is a neuromuscular blocking agent it causes paralysis, it paralyzes the patient.

Q Are you familiar with a medication known as Propofol?

A Yes.

Q What is that?

A It's a sedative/anesthetic.

Q What is Ativan?

A Ativan is a valium-like medication,

a sedative.

Q Are you aware from time to time did receive those various medications either by bolus or IV or other methods during her hospitalization?

A Yes.

Q What is Dopamine?

A Dopamine is a drug that belongs to the vasoactive drugs. It causes an increase in the cardiovascular performance. It improves cardiovascular performance. If a patient has a low blood pressure, that would be one drug they



, M.D.

would give in order to stabilize the blood pressure.

Q Did have arterial blood gases done on a frequent basis?

A How did you start the question

again, I'm sorry?

Q Let me rephrase it. Arterial blood gas testing, that's done by taking a needle and inserting it somewhere in the arterial system, correct?

A That would be one way of doing it.

Q Are there other ways?

A A patient who is in the ICU on mechanical ventilation we tend to put a catheter in the artery and have it stay there so we don't need to stick the patient periodically we just have a catheter there and we can always go and draw blood.

Q As far as you recall based upon your review of the chart and treating this patient, did receive arterial blood gas tests from time to time?

A Yes.

Q What is the purpose of the arterial

, M.D.

blood gas?

A The purpose is to make sure that there is adequate gas exchange for the patient during mechanical ventilation.

Q I'd like you to turn, please, to your first note, which is on Page 71 dated August 29th.

Is this the template that you discussed earlier?

A That's the template.

Q Within the template you check off or mark on the computer various items that you feel is necessary, correct?

A Right.

Q At the time that you came on service and saw on August 29th, she was on a ventilator, correct?

A Correct.

Q You note the various settings

there, correct?

A Right.

Q Towards the meddle of the page under ID, you note that she is afebrile with a maximum temperature of 100.7?



, M.D.

A Right.

Q How do you define febrile?

A Again, there's, I would say there is the black and white range and then there is the grayish range. 100.7 could be defined as afebrile or could be defined as a very low grade temperature.

Q Is there a specific black and white range that you define to be febrile or from a particular number upward?

A I would say that under these circumstances we would say that anything above

one hundred and one we would mark as febrile.

Q Why is that different as opposed to a text book definition of what you would consider to be febrile?

A Because a patient on mechanical ventilation gets heated gases through the tube of the ventilator. There is a cascading humidifier that attaches to the ventilators and we heat it because we don't want the patient to become hypothermic. It's a matter of titration. It depends on how much you dilate up and how much you dilate as necessary.



, M.D.

So sometimes 100.7 could indicate that the patient is afebrile, but because the humidifier was a little too hot the temperature went a little higher.

Q As of the August 29th date she's

receiving Nafcillin and Ceftriaxone?

A That's correct.

Q How would you those characterize

those two antibiotics, if you can?

MR. : This is somewhat repetitive, but I'll let him answer it again.

A Ceftriaxone is broad spectrum, Nafcillin is more of a narrow spectrum.

Q Separate and apart from this commuter template do you have any handwritten notes throughout the chart that you have seen during your review of the chart?

A I don't recall seeing any.

Q Can you turn to the next page, please. It's Page 72, same date, August 2, it's the PICU Fellow Progress Note. Toward the bottom third of the page the doctor writes Decadron 425 milligrams for extubation.

, M.D.

What does that refer to?

A This is a steroid that we sometimes give to patients before extubation. The purpose of this is to reduce the edema in the windpipe, in the trachea.

Q Can you turn, please, to Page 76, your note dated August 30th.

Is the patient still on the ventilator as of this date?

A No.

Q Is there any change that you note in your examination of this patient on August 30th in comparison to your note the day before other than the fact she's no longer on the ventilator?

A Patient is stable from a cardiovascular standpoint. No, there's not

much, and, you know, there's a finding there was found on cat scan which I made a note of it there that the patient had a residual pneumothorax.

Q How, if at all, was that residual pneumothorax being addressed?

A What was that again, I'm sorry?



, M.D.

MR. : How was it being addressed.

Q Let me ask it this way, is there anything to suggest or to indicate in your own note how the residual pneumothorax was being addressed?

A From the note, no. I don't see it.

Q Can you turn, please, to the following page, Page 77, the PICU Progress

Note, dated August 30th. Specifically toward the bottom of the page where the doctor writes about the cat scan. It says: Pneumothorax left small post collection of, does that say, abscess?

MR. : What? Where are we?

A Where are you reading?

Q The lower third of the page where it's written gas there's a note that says: Cat scan, CT scan?

A Okay.

Q It says pneumothorax left small post collection. Can you read the next two words?



, M.D.

A Small posterior collection.

Q Thank you.

A Of or, either of or or abscess.

Q Then it indicates the arrow going up would be increase aeration?

A Increased aeration in the apical portion still with consolidation of lower base.

Q The fact that there's a consolidation of the lower base, what does that refer to and what does that mean to you?

A That could mean that the patient still has the pneumonic process in place to some extent. The other option is that because the patient has the pneumothorax there is air that occupies space in the hemithorax that the lung trunk and the medical term would be became atelectasic. Patient developed atelectasis.

Q Can you turn, please, to the August 31 RPN note timed at 9 A.M., and at the bottom under the assessment and plan, under number 4 it lists ID and has Nafcillin with a dosage Ceftriaxone, and then it has next line, I want to know if you can read that, Doctor?

A Yes, trache culture positive for



, M.D.

streptococcus viridans group.

Q Underneath that can you read what it says?

A ID consult I think it's pneumonia X.

Q What does that indicate to you, if anything?

A I don't know.

Q Can you read the name of the physician or the name of the individual who wrote that note, which just for the record is at Page 80?

A I cannot.

Q Can you into your next note please on August 31, which is noted as Page 81. You note that in the respiratory column that she is

extubated on a face mask, correct?

A Right.

Q She is receiving oxygen at that time?

A Yes.

Q In the ID portion of your note you comment that she receives antibiotics at home via Broviac?



, M.D.

A Right.

Q Was there some impression or some plan at that point that you intended to discharge the patient in the very near future?

A Based on that I would say that was the intent.

Q Is there something about the child's condition that changed that caused you to change your plan to allow her to remain

further in the hospital?

A I can't see it from this note.

Q Is there anything in your review of the other notes in the chart which would suggest to you why the patient remained in the hospital after the plan was formulated that she would be discharged shortly thereafter?

A From the notes that come later and from the re-evaluation by surgery, it appeared that the patient in that side of the chest, in the left pleural space, had what we call loculated pneumothorax, loculated collection of fluid, and it appeared that in order to get rid of that, in order to remove those loculations the patient would need a surgical intervention.



, M.D.

Q How does the loculated pneumothorax

occur?

A Well, if you have pus, if you have debris in the pleural space, it tends to organize, it tends to create a peel around certain areas. Even though we were born with one space, the pleural space, because of the infectious process one can have loculated areas with processes.

Q How do you treat these loculations that you described?

A One way to treat it would be to be conservative and just give antibiotics for a long period of time in which case symptoms may linger a little, but eventually, in most of the these patients not all of them, recover and it just resolves. If one wants to facilitate recovery, one would resort to surgery which would be a removal of those peels that the patient developed in the pleural space.

Q Does mycoplasma pneumonia resolve on its own without treatment?

A I would say it might resolve on its

25 own. Again, based on my knowledge mycoplasma



1 , M.D.

2 pneumonia under certain circumstances could be

3 a self-limiting disease.

4 Q Can you turn, please, to your

5 September 1 note -- before we get to that,

6 Doctor, let me just ask you to go back one or

7 two pages to Page 85?

8 MR. OGINSKI: That's it right

9 there.

10 MR. : The back is

11 social service note.

12 MR. OGINSKI: Correct, social

13 service note.

14 Q At the top of the page it says

15 underneath the first line it says: Family

16 remains constant at bedside. Do you see that?

17 A Yes.

Q The second line of the note, okay. That's the social work note, correct, at the top right?

MR. : Department of Social Services.

A Yes.

Q Can you turn, please, to your note dated September 1. Is there anything different





, M.D.

about what you observed that's contained within your note in comparison with the prior day's note, Doctor?

MR. : I'm confused.

Q Based upon your note are you able to determine whether the child's condition has changed, improved, gotten worse or anything else just based on your own note?

A What it says here is that the patient requires a little less oxygen. So, I would believe that overall he's doing better. There's a statement here that he required asemic epinephrine. So I guess he had some degree of strider which was treated with epinephrine.

Q Strider, can you define that, Doctor?

A Strider in this instance may reflect the fact is that he.

MR. : She.

A She had an endotracheal tube and once you remove the tube there's some degree of edema that could cause some degree of airway obstruction that manifests itself by noisy



breathing.

Q Is nasal flaring a clinical sign to you of difficulty breathing?

A Could be, yes.

Q Is grunting a clinical sign to you of a patient experiencing difficulty breathing?

A Could be.

Q Could you turn back one page, please, to Page 88, PICU Fellow Note, dated 8/29/. In the middle of the note where this physician discusses ID, he or she discusses the results of the mycoplasma titers, correct?

A Yeah.

Q Here it's described as 1:256?

A Yes.

Q What is the significance of that to you?

A It's positive.

Q The value in and of itself does it have any significance other than the fact that it's positive, whether it's high, low?

A I have to look at reference values.

I wouldn't know offhand.



, M.D.

Q The doctor also towards the bottom of the note in the assessment and plan writes: Four-year-old female pneumonia/empyema status post acute respiratory failure.

Do you know at what point in time the physician who wrote this note was referring to with acute respiratory failure?

A He was referring to the time this the patient was placed on mechanical ventilation and was intubated. This was the time of the procedure of interventional radiology.

Q Can you turn, please, to Page 92 with the date of September 2nd. It's an RPN note.

MR. : 12 P.M. note?

MR. OGINSKI: 12:40 P.M., correct.

Q Do you know the name of the physician who wrote this note, Doctor?

A No.

Q According to this note in the middle of the page under ID, this individual writes mycoplasma igG/M pending; is that



, M.D. correct?

A Yes.

Q As of that time those results had not come back, correct?

MR. : That's what pending means.

A I don't know how true this is, but that's what he meant, he or she.

Q At the top of the note the doctor

writes the patient required stat Albuterol. Do you see that?

A Yes.

Q I'm sorry, stat Albuterol Nebulizer?

A Right.

Q For labored breathing and strider?

A Right.

Q What is the purpose of giving Albuterol Nebulizer for this patient for this condition?

A What it say stat Albuterol Neb and vesemic epinephrine so the Albuterol --

MR. : Overnight for labored breathing. It's better to



read the note in its entirety than take it out of context.

A If the labored breathing was secondary to strider, which means something that the airway obstruction, the Albuterol would do nothing. If the resident, it was unclear to the resident it was strider only or a combination of strider and some wheezing over the lung field, then a combination of the two would make sense. Based on my note it looks like the patient required vesemic epinephrine for some airway obstruction as described.

Q During the course of 's hospitalization did she receive x-rays on a somewhat frequent basis?

A Yes.

Q In addition to x-rays did she also receive cat scans or have cat scans performed?

A Yes.

Q Were there occasions when you would personally review the chest x-rays that were obtained for her?

A Yes.

Q Were there also times from time to



, M.D.

time that you reviewed the actual CT films that were obtained for her?

A Yes.

Q For what length of time did you remain the service attending in the PICU from the time that you began your service on August 29th?

A Well, the modus operandi for the ICU, and it's been like that for a few years already, is that each attending comes on service for a few weeks. Normally we start on a Monday and we sign out by the next Monday morning. From what I read in the chart it appears that I started for that particular week I started on a Tuesday.

Q You continued for the one week to

the next Tuesday?

A Right. Not Tuesday, probably until Monday.

Q Is there anything in the record to suggest that you saw, treated or examined at any time after you left the PICU service?

A I don't remember seeing that.



, M.D.

Q Can you turn, please, to Page 94, with a date of September 2nd, .

This note, am I correct that this is not in your handwriting?

A Exactly.

Q Would that be Dr. 's handwriting?

A Yes.

Q Explain to me, Doctor, how is it

that you came to sign Dr. 's note?

A I think what happened is that because I'm the chief of the division, I have other duties. So, a lot of times I would ask somebody else to take over the service for me and I would come a little later, a little later of the day and would stay on call for the night. I must have reviewed the note and I don't see that I added anything, but most of the time what I do is I review the note and I add my signature so that I agree with what you wrote and I take over from that spot.

Q Is there anything to indicate that your signature to this particular note occurred at any time after the patient was discharged in



, M.D.

terms of a post discharge review of the chart?

A I wouldn't know that.

Q Are there times when a patient will be discharged and you'll be asked to either prepare discharge summaries or review certain records where you will counter sign certain notes in a chart after the patient has left the hospital?

A There would be cases where I will be called to the medical records to sign certain pages that for some reason I forgot to sign or something of that nature.

Q Is there any way for you to determine as you sit here today as to whether that was the case in this instance or whether this is simply --

MR. : As he told you that it more likely was.

MR. OGINSKI: Correct.

Q Is there any way to tell?

A No, but in this instance it would be the same day I would add my signature as one who took over for either that afternoon or at one point.

, M.D.

Q Dr. writes in the general comment in the bottom of her notes that surgery was reconsulted. Do you know what surgery was asked to re-evaluate the patient?

A Yeah, I think I answered that. Based on the CT scan, based on the chest x-ray and based on some of the clinical findings that the patient may have had we felt that it was loculated that pneumothorax, loculated fluid that we felt would not resolve on its own within an acceptable period of time. It would take very, very long, and we wanted their opinion about a surgical procedure to remove that loculation.

Q Did you have any conversation that you noted in the patient's record to indicate

that you spoke to any surgeon or anyone on the surgery service about the surgical option?

A I don't have recollection of that. I may have done it, but I don't have recollection of that.

Q Is there anything that you have had seen in the notes other than the surgeon's own notes that suggests to you that any of your





, M.D.

colleagues in the ICU had any conversation about the potential surgery with anyone in the surgical team?

A I didn't see anything in the notes although we do talk to the surgeons about our patients. That would be a general statement for everybody.

Q Can you turn, please, to Page 99, which is dated 9/3 at 11 A.M.?

MR. : Surgical attending note?

MR. OGINSKI: No, above that.

MR. : Infectious, ID note?

MR. OGINSKI: Yes, ID.

Q By the way, Doctor, do you know the name of the individual who wrote this note?

A I can't interpret the signature.

Q On the third line down from the note it says on IV what appears to be Ceftriaxone, PO Azithromycin. Do you see that?

A Yes.

Q As far as you know this patient was receiving Azithromycin by IV, correct, and not



, M.D.

PO?

A It says PO here.

Q I understand that, but from your knowledge of this patient and what she was receiving from the Azithromycin, was it your understanding that she would be receiving it from intravenous methods?

A I have to go back to my note.

Q Go ahead.

A According to my note the antibiotics were given IV.

Q Is there anything in the record to suggest that this patient, , received oral Azithromycin?

MR. : Other than this apparent typo?

MR. OGINSKI: Well, it's a handwritten note, but other than that note.

A I don't recall.

Q Would, in your opinion, oral Azithromycin have you been as effective as IV administration of the Azithromycin?

A Generally speaking we believe that





, M.D.

IV antibiotics is more effective than PO.

Q Can you turn, please, to Page 99, same page, the surgical attending note. In the middle -- by the way, do you know the name of the individual who wrote this note?

A Looks like it's .

Q In the middle of the note he writes CT from yesterday showed total left and upper lobe collapse with loculated pneumothorax, correct?

A Yes.

Q How does the left and lower lobe collapse in this instance, what causes it to collapse?

A As I said before, when you have air trapped in the pleural space, something else

has to give so the lung collapses and the air is taking its place.

Q In that instance where you have a collapsed lung, do you also see any type of shift of the trachea or the adjoining structures within the chest?

A You could see.

Q The surgeon also mentions the



, M.D.

possibility of a thoracotomy decortication. Do you see that?

A Yes.

Q Describe for me, Doctor, or explain to me what is a decortication is?

A A cortex is a peel. Decortication is actually taking off that peel and letting the lung re-expand.

Q The VATS, that would be the video

assisted?

A Right.

Q Are you familiar with the method in which that is performed in terms of the incisions necessary to accomplish that procedure?

MR. : The doctor's not a surgeon. To some extent I'm familiar with it, but I don't think I'm qualified to testify about it and I don't think a critical care physician would be expected to testify about it either.

MR. OGINSKI: I only have one or two questions about it.



, M.D.

MR. : You can answer.

A I'm familiar to the extent that

I need to be familiar with it.

Q Do you know what type of incisions are made to accomplish the VATS procedure?

A It's a small incision to allow the insertion of a scope.

Q Can you estimate the size of such an incision allowing variances from patient to patient?

MR. : It would depend on the size of the person. These questions are best answered to a surgeon not to this doctor.

THE WITNESS: Can I answer?

MR. : If you can.

A I would say if you know the caliber of the scope, the diameter of the scope it would be a centimeter or maybe two centimeters larger than the diameter of the scope.

Q Did you learn at some point during the procedure which underwent that she needed to have an open thoracotomy or the procedure converted to an open thoracotomy?

, M.D.

MR. : He didn't learn during the scope procedure. At some later point it had to be converted to a full thoracotomy.

Q Can you turn, please, to Page 108 with the date of September 4, ? At the top it says: Pediatric Critical Care. Do you know whether this was a physician nurse or some other?

A This was a fellow.

Q What was name of the fellow?

A .

Q Is Dr. still at ?

A Yes.

Q What is her capacity there?

A At the moment she is an

Q At the Department of Pediatrics?

A In the Pediatric Critical Care that's within the Department of Pediatrics.

Q At the bottom of her note she writes: Supervised by Dr. ?

A That's me.



, M.D.

Q What is it that you were supervising in relation to her note if you can tell?

A The common practice is that everything that's done by the fellows and by the residents is supervised by the attending. The fellows are requested to write it not every time they do it, but they are requested to write who was their attending for that particular day or for that particular week, but

since it's a daily note, for that particular day who supervised them. So that's all she did. The whole care is supervised by Dr. . I was the attending on service.

Q This phrase does that necessarily mean that you were present at the time she conducted her examination or any procedures that was done?

A It means that everything that was done to the patient was discussed with me that either I was there to give instruction or was there in any way, shape or form that she needed me to be.

Q Turn to Page 113 with the date of



, M.D.

September 5 timed at 8:30 A.M. It's an Attending Progress Note. Am I correct again that this is Dr. 's note?

A Right, she wrote the note.

Q And you countersigned it at some point later that day?

A Right, for the record I believe this was the way it was done. I really don't recall why at that particular day or the two notes that we saw she wrote it. I'm sure she was involved, but I don't know if this was later today, later that same morning, in the evening I came back on service and countersigned it.

Q Have you had any conversations with Dr. from the time this child was discharged up until today about the care and treatment she received at ?

A Not that I recall.

Q Is Dr. currently working at the hospital?

A Yes.

Q What is her position?

A She's an attending.

, M.D.

Q After underwent surgery on September 6, did she return back to the Pediatric Intensive Care Unit?

A From what I recall she did.

Q Did you see any other notes after September 6th to suggest to you that you had seen and evaluated at any time afterward?

A No.

Q Doctor, can you turn, please, to Page 129, with a date of September 7th. Dr. again writes the note and in it she indicates that the patient was going to be receiving a transfusion, correct?

A Yes.

Q Do you know the reason for the transfusion?

A Well, she indicates that the hematocrit dropped to 20.4.

Q This was during the course of surgery?

MR. : This is post surgery after one day.

Q The rest of the note indicates that



, M.D.

she was intubated at that time?

A Yes.

Q She writes when intubated better air entry in left than yesterday but still decreased, correct?

A Correct.

Q You, again, countersigned that note?

A Yes.

Q She writes: Will speak with Dr.

. Is she referring to herself, to you or to anybody else that was part of your team?

A Either or.

Q Can you turn, please, to Page 139, the attending note, dated 9/8, and, again, this is Dr. 's note?

A Right.

Q In the middle of the page under ID she writes: Following up mycoplasma pneumonia titers (very high) -- can you read the next part of the line, Doctor -- oh, as per ?

A Right.

Q What does that mean?



, M.D.

A Well, that, you know, that type of test is sent out to that Laboratory and they give you reference values.

Q The fact that the titers were very high according to the note, what does that signify to you medically?

A It means that it's not equivocal. It's more likely to be the infection.

Q Referring to what, the mycoplasma?

A The mycoplasma.

Q On this date the lower chest tube was going to be discontinued and she was to be extubated?

A Yes.

Q Am I correct that she was still on sedation as of that time, but was going to be weaned from the sedation?

A Right.

Q Turn, please, to the next note Page 145.

MR. : Under 9/9?

MR. OGINSKI: Yes.

Q Again, this is Dr. 's note?

A Right.

, M.D.

Q As of 9/9 she had been extubated, correct?

A It says successfully extubated, right.

Q Is there anything to suggest the condition of the child in comparison to how she was after the surgery for the three days prior to that time?

MR. : I'm a little confused about that.

Q Does Dr. 's September 9 note compare the child's condition for the prior day, two or three?

MR. : The note speaks for itself, but I'll let him, over my objection, interpret it.

A I was going to say the note speaks on itself. The fact that the patient was

successfully extubated that's one thing. She can breathe on her own, the gas looks good, it looks like the Azithromycin was discontinued because it says stat post Azithromycin and the only thing the patient is getting at the moment is the Nafcillin and the Ceftriaxone.





, M.D.

Q Is there any reason you can think of as you sit here now as to why the Azithromycin would be discontinued in light of the high mycoplasma titers that were observed?

A I think the Infectious Disease people suggested a certain period of treatment of the Azithromycin. I don't recall how long they wanted, but it could have been five days or so, but we continued the other drugs with their approval, with their blessing for a little longer.

Q Can you turn, please, to Page 151 with a date of September 10th. This would be a note that you wrote, correct?

A Right.

Q What is the child's overall condition as of that date?

A I would say pretty good.

Q According to the chest x-ray, her left lung is re-expanded?

A Re-expanded.

Q I take it that's a good thing?

A A good thing.

Q How would you describe her white



blood count and her hematocrit on that date?

A Hematocrit is adequate, but it would be post transfusion obviously and the white count is normal.

Q On a daily basis when you examine the patient and then later make your notes, as part of your examination did you elicit from the patient any complaints he or she may have on daily basis if they're able to communicate?

A Right, I mean, it all depends. It depends on the patient, depends on, you know, how I want to examine the patient, what I need to know from the patient.

Q In the event that you elicit information from the patient specifically from a child, would you customarily make a note in that your template chart about what your findings were on the examination?

A As I said the purpose of the pediatric care attending progress note is not to elaborate every little detail of the examination and every little details of the test that we send off. That belongs to the residents and the fellows. They do their job

, M.D.

under our supervision. We just point out certain important issues that we feel are important from the attending standpoint.

Q Can you turn, please, to Page 156, dated September 11th, ?

A Right.

Q Dr. wrote this note, correct?

A Exactly.

Q He is also one of the members of your team?

A Yes.

Q He is also still currently at your hospital?

A Yes.

Q Is there any change in Dr. 's evaluation of this patient in comparison to yours from the day before, any significant

change?

A Not a significant change.

Q Based upon your review of this patient's record did you see any other note with your name or entry on it after September 10th?





, M.D.

A No.

Q Can you tell me why needed a nasogastric tube feeding?

A Do you want to refer to a certain period of time?

MR. : Can you direct his attention to something, you know, it's a big chart and you're asking him there's a lot of times that he wasn't directly involved.

MR. OGINSKI: Yes, I'll clarify it.

Q On August 29th, there's a Pediatric Nutritional Screening Form. At the top of the note it indicates that the patient was at a poor appetite and was receiving nasogastric feedings?

A I want to see if this comes under the context of this patient being ventilated or not.

Q Other than possibly needing the nasogastric feedings when she was ventilated, is there anything else that you recall that suggested or required her to have nasogastric





feedings after being taken off the ventilator?

A I don't recall.

Q That's fine. Do you have an

opinion, Doctor, as you sit here today with a reasonable degree of medical probability as to those types of activities that this child might be unable to perform today, again, realizing that you have not seen and examined her today, but based upon your treatment of her in August and September of ?

MS. : Note my objection.

MR. : How could he have an opinion? I mean, you know he hasn't seen her.

MR. OGINSKI: Let me rephrase it.

Q As of the time that you last saw , have you formed any opinion as to those types of activities that you would expect that she either could not do as a result of her medical condition at that time or would be limited from doing as of the time that you last saw her?

MS. : Again, note my

, M.D.

objection.

MR. : If you can answer it, go ahead, but over my objection.

A I would say once the lungs re-expand the patient should have a full recovery.

Q Would that be true regardless of whether she had surgery to re-expand the lungs?

A That would be true regardless.

Q The fact that had a portion of her lung removed during the open thoracotomy, does that in and of itself limit or inhibit her activities as of the time that you last saw her or would you expect it to?

MS. : Objection.

MR. : I think he's answered the question. Now you're

nitpicking through individual things and asking him I don't think that's fair, but, again, I'll let him answer over my objection.

MR. OGINSKI: I disagree with your assessment.





, M.D.

MR. : That's what happens during litigation.

MR. OGINSKI: Let me rephrase the question.

Q Is there anything to indicate to you as a physician who was treating that the removal of part of her lung during the open thoracotomy would in any way impact her ability to do any type of activity after resolving or leaving the hospital?

MS. : Not my objection.

A If there was a removal of the lobe or partial of the lobe of a lung under the age of eight years, this shouldn't effect the performance of a child because at that age they continue to grow new lung tissue. Obviously every patient should have a period of convalescence after surgery in any disease, but she should be fully recovered.

Q Does the regrowth of lung tissue occur so that the lung is now as it was before as the lobe had been removed or a portion of lobe? To what extent should the lung tissue regrow?



, M.D.

A She should have the same amount of lung tissues as she had before.

Q Would that same be true of the air

5 capacity within that lung?

6 A The same would be true.

7 Q Doctor, your attorney has provided

8 me with a copy of your curriculum vitae; is

9 that correct?

10 A Yes.

11 Q Have you seen this?

12 A Yes.

13 Q As far as you know is it up-to-date

14 and accurate to the best of your knowledge?

15 A Yes.

16 Q Just to move things along quickly,

17 you are licensed to practice medicine in the

18 State of 0?

19 A Yes.

20 Q Are you board certified in any

21 field of medicine?

22 A Pediatrics and Pediatric Critical

23 Care Medicine.

24 Q When was the last time you were

25 recertified in any of those fields?

, M.D.

A It should say here. It says that in I was board re-certified in Pediatric Critical Care and board re-certified in Pediatrics, .

Q Has there ever been a time through the course of your career that your license to practice medicine in the State of New York has been revoked or suspended?

A No.

Q Are you board certified in any other specialties of medicine other than the ones you have here?

A No.

Q Do you have any other licenses in any other states to practice medicine?

A Not at the moment.

Q In August of were you licensed

in any other states?

A No.

Q Are you affiliated with any other hospital other that the one you currently work for?

A In ?

Q Yes.





, M.D.

MR. : No, now.

MR. OGINSKI: I'm sorry.

Q Currently are you affiliated with any other hospital other than the 0?

A It's hard to answer this question, and I'll tell you why it's hard.

Q Tell you what, let me ask you this way, do you have attending privileges with other hospitals that are not directly

affiliated with ?

A They're in a dormant phase. We used to have some affiliations with Hospital. I may still have privileges there and in the past a little before that we had some affiliation with Hospital.

Q I notice you have various publications to your name. To your knowledge, Doctor, is this a complete listing of publications as best you can tell?

A Yes.

Q Do you have any publications dealing with the diagnosis and treatment of pneumonia or specifically -- let me just stick



with pneumonia first?

A Not directly pneumonia.

Q Have you published anything

involving the diagnosis and treatment of mycoplasma pneumonia?

A No.

Q Can you turn, please, to the operative report of 9/6?

MR. : You mean the dictated operative report?

MR. OGINSKI: Correct.

Q Doctor, we had discussed previously about, well, you mentioned were complications that arose during the course of the procedure. Dr. in his note in his preoperative diagnosis uses the term iatrogenic creation of diaphragmatic hernia, correct?

A Yes.

Q Is there any difference in your mind whether this is one and the same in terms of what you had mentioned was complications?

A It's the same.

MR. OGINSKI: Thank you, Doctor.

(Time noted: 12:32 P.M.)

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

STATE OF NEW YORK )

) ss.:

COUNTY OF )

I, , M.D., hereby certify that I have read the transcript of my testimony taken under oath in my deposition of the 29th day of July, . That the transcript is a true, complete and correct record of what was asked, answered and said during this deposition, and that the answers on the record as given by me are true and correct.

, M.D.

Signed and subscribed to
before me this day
of , .

Notary Public





I N D E X



E X H I B I T S



QUESTION MARKED FOR RULING

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1
2 C E R T I F I C A T E
3
4 I, , hereby certify
5 that the Examination of , M.D., was

held before me on July 29, ;

That said witness was duly sworn before the commencement of the testimony;

That the within testimony was stenographically recorded by myself, and is an accurate record of the Examination of said witness;

That the parties herein were represented by counsel as stated herein;

That I am not related to any of the parties, in the employ of any of the counsel, nor interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 29th day of July, .

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