SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF

- -x

, as Administrator of the , Deceased, and , individually,

Plaintiff,

-against-

Defendants.

- -x

10:45 a.m.

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

APPEARANCES:

LAW OFFICES OF GERALD M. OGINSKI, LLC
Attorneys for Plaintiff
25 Great Neck Road
Great Neck, New York 11021

BY: GERALD M. OGINSKI, ESQ.

Attorneys for all Defendants

BY:

Attorneys for Defendant

BY:

* * *

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.,

, M.D.

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 ,

.

Q Good morning, Doctor. What's

, M.D.

Toprol?

A To my understanding, Toprol is a beta blocker.

Q And what is a beta blocker?

A Beta blockers are a class of drugs used to treat hypertension and to control heart rate.

Q And what is Toprol XL?

A To my understanding, Toprol XL is a long acting form of Toprol.

Q Have you ever prescribed Toprol?

A I can't recall any specific instances, but I'm sure I have done so in the past.

Q And what is SVT?

A To my understanding, SVT is a supraventricular tachycardia.

Q If somebody is tachypneic, what does that mean?

A Tachypneic means breathing at a rapid rate.

Q What is, other than telling me what SVT is, supraventricular

, M.D.

tachycardia, what exactly is that condition? Can you define that?

A Supraventricular tachycardia?

Q Yes.

A Well, to my limited understanding, it's a form of tachycardia that originates in any part of the heart above the ventricles.

Q And tachycardia is what?

A I would define it as a heart rate greater than 100 beats per minute.

Q Are you familiar with the term known as premature complexes as seen on an EKG or interpreting an EKG?

A Yes.

Q What is that?

A A premature complex, to my understanding, appears earlier than expected on an EKG.

Q In , had you reviewed and evaluated patients' EKGs?

A At that time, yes.

Q What are palpitations?

A Palpitations, to my

, M.D.

understanding, is a sensation of heart racing fast or quickly.

Q And what is sinus tachycardia?

A Sinus tachycardia is a rhythm with a heart rate greater than 100 beats per minute.

Q Is that considered a normal finding, abnormal finding or something else?

A It's hard to pinpoint that because it's a very nonspecific finding.

Q What are troponins?

A To my understanding, troponins are enzymes that are markers of cardiac damage or heart damage.

Q And if you suspect a patient may have a myocardial infarction, is that one of the tests that you evaluate to determine whether or not there has been a myocardial infarction?

A Yes.

Q And do you do that by obtaining blood tests?

A Yes.

, M.D.

Q What are cytokines?

A I can't really be specific. It's a term I remember learning in medical school.

Q Where do you currently work, Doctor?

A I work currently at .

Q In what capacity?

A I'm a fellow there.

Q In what field?

A I am in the Department of there.

Q What year?

A I am in my year.

Q How many more years do you have to go to complete your ?

A Approximately one year and about three months or so.

Q And I'm sorry, what was the in?

A It's specifically in vascular medicine and it's primarily a clinical research training .

, M.D.

Q Are you a cardiologist?

A No.

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

A In .

Q When were you board certified?

A .

Q And when taking the board examinations -- withdrawn.

In order to obtain your board certification, did you need to take your board certification exam more than once?

A No.

Q Are you licensed to practice medicine in ?

A No, I am not.

Q Where are you currently licensed?

A .

Q By the way, Doctor, all of my questions are going to relate to November and December of , unless I indicate otherwise.

At that time, were you working

, M.D.

at ?

MR. : When you say "working at" --

MR. OGINSKI: I'll rephrase it.

Q Where were you working in November and December of ?

MR. : Physically?

MR. OGINSKI: Yes.

A I don't recall specifically. I know I was -- I did do a rotation at around that time.

Q Where did you do your residency?

A At .

Q In what area of medicine?

A .

Q At the end of , what year of your were you in?

MR. : At the end of , you mean December of ?

MR. OGINSKI: Yes.

A I was in my second year of .

Q And your

, M.D.

?

A Yes.

Q You started in ?

A Yes.

Q And you completed that in ?

A No, .

Q And for how long had you been through at the time, November, December ?

A I don't recall specifically, but I probably would guess four weeks.

MR. : Wait, that may create confusion. Are you giving him the total amount of time of your rotation or how long you had been rotating up to that time?

THE WITNESS: The total amount of time.

Q At ?

A Yes.

Q Describe for me your responsibilities during this time at ?

A I don't recall specifically,

, M.D.

but what I can tell you was that I was the on the in-patient services there.

Q And what does a in the in-patient services do?

A In general, we oversee . We take part in making sure that the day-to-day tasks are completed, as regards to patient care. And we also work with the on service and occasionally we work with .

Q Are there any who supervise the work that you do as a second-year ?

A I don't remember specifically.

Q Are there third-year who are present in the in-patient service, who supervise the work you do?

A I don't think so.

Q Describe for me -- withdrawn. Are there specific that were assigned to that particular service?

A Which service?

Q I'm only talking about the

, M.D.
in-patient service during this four-week
.
MR. : I think he said
in-patient services --
A I was on two services.
Q Describe for me both services,
please?
A I was on a lymphoma leukemia
service and I was also on a GI oncology
service.
Q And the occasion that you met
Mrs. , is that the one where you
were on the GI oncology service?
A I don't recall.
Q What service were you on on
December , ?
A I don't recall.
MR. : By the record,
would it help?
THE WITNESS: I'm not sure. I
don't think it would help from the
record.
MS. : Off the record.
[At this time, a discussion was

, M.D.

held off the record.]

MR. : You're asking him what?

Q Am I correct, Doctor, that in December , you saw and examined Mrs. ?

A I don't recall the specifics, but based on this note that I reviewed, I did.

Q Are you able to tell from the note, what service you were on at that time?

A No.

Q Just refer please, to what date the note you are referring to is?

A This is December , .

Q And at that time, I believe you said you were a second-year internal medicine ?

A Yes.

Q And you were doing a at ; correct?

A Yes.

Q Now, what was the procedure in

, M.D.

case you needed to talk with an physician about your examination and about your findings, explain the procedure to me?

A You mean in which regards or what situation?

Q You examine a patient and now you wish to --

MR. : They're different situations, that's the problem.

MR. OGINSKI: Okay, no problem.

MS. : Off the record.

[At this time, a discussion was held off the record.]

MR. : I think in terms of this patient, maybe it's easier to figure out why he would have been called to see this patient and maybe we can go from there.

Q Am I correct that you were called as a consult to see this patient?

A Based on what I see in the note, I was, yes.

Q Do you have any independent

memory of this patient, as you sit here now, separate and apart from anything you may have read in preparation for today?

A I vaguely recall meeting the patient and her husband.

Q Do you have any memory of the conversations that you had with either the patient or the husband?

A No.

Q Do you have any notes, outside of the record in front of you, other than that, about this particular patient?

A No.

Q Do you have any notes about any conversation you had with any other doctors, other than the ones that are described in your note?

A No, I don't.

Q After December , , did you ever see or examine this patient again?

A I don't recall.

Q Is there anything in the hospital record that you reviewed, that indicates you did?

, M.D.

A Not in what I've reviewed, no.

Q What is a myocardial infarction?

A My understanding at the time of when this occurred or this note was written, is that a myocardial infarction would have been damage or insult or damage to the heart muscle.

Q What are the symptoms of myocardial infarction?

A Symptoms can vary quite a bit.

Q What are the most common ones that you expect to see?

MR. : Object to form.

Q What symptoms would you expect a patient to have when suffering myocardial infarction?

A I can't really say I expect any symptoms in particular. Although, at my level --

Q Hang on, Doctor, I'll rephrase it.

When you learned about myocardial infarctions, either in medical

, M.D.

school or in your residency training, what did they teach you about the symptoms of a myocardial infarction?

MR. : Objection.

Q I'll rephrase it. What are the symptoms of myocardial infarction?

A There are many symptoms. Patient can have no symptoms at all. You can have chest pain, shortness of breath, palpitations, nausea, dizziness, stomach pain even. And that's not inclusive of, I mean, it's a large list, I would say.

Q Most common ones are the ones you identified?

A I would say so, at my level of training at the time.

Q The chest pain, do you typically see radiating chest pain?

MR. : Typically, objection to form.

Q Is radiating chest pain a symptom of a myocardial infarction?

A It may be.

Q As of December of , had you

, M.D.

ever diagnosed anyone as having a myocardial infarction?

A I don't specifically recall any instances, but I do believe I would have seen and diagnosed patients with myocardial infarction up until then.

Q And as a , did you have experience reviewing or interpreting EKGs or ECGs?

A Yes.

Q If you had a question about the interpretation of a particular electrocardiogram, who, if anyone, would be available to you to discuss that with, back at ?

A I don't recall back then, no.

Q Were there that were available to you, should you need to discuss these EKGs?

A I don't recall in this scenario, but in general, there will be someone available.

Q When you were called to evaluate Mrs. , did you perform an

, M.D.

EKG or ECG on her?

A I don't recall doing so.

Q In your note, Doctor, I'm going to ask you to take a look at that, is there an indication that you did, either you or somebody else, performed an EKG on December , ?

MR. : Objection to form.

It may just reflect an interpretation of an EKG, as opposed to performing it. Are you making the distinction?

MR. OGINSKI: I'll do that.

Q Looking at the bottom of your note, it says "ECG," and there are two different dates on there; correct?

A Yes.

Q On the date of , was that an ECG that you had performed?

A I don't recall doing so, so I'm not sure.

Q Was this your interpretation of the patient's ECG?

A So what I've written here would have been my interpretation, yes.

, M.D.

Q At the time that you interpreted this -- I'm sorry, do you call it an EKG or ECG?

A It's interchangeable in my mind.

Q At the time you interpreted this patient's ECG, had any other physician interpreted that same ECG?

A I don't know.

Q Is there anything in your note to reflect that there was another doctor before you, who had reviewed it and interpreted that ECG?

A It's unclear to me.

Q Do you know Dr. ?

A Based on this note, there is a Dr. who is a .

Q A GYN ?

A Yes.

Q Do you have a memory of a conversation with him about this patient?

A No, I don't recall any conversation.

Q Is there anything in your note

, M.D.

reflecting a conversation with Dr. ?

A It says here --

Q Don't read it yet. I'll ask you to read it later.

Is there anything in your note that indicates you had a conversation with Dr. ?

MR. : That's a yes or no.

A Yes.

Q Had you ever spoken to Dr. before that date, for any reason?

A I have no recollection of doing so.

Q Did you ever speak to Dr. after ?

A I don't recall doing so.

Q What is a differential diagnosis?

A To my understanding back in , differential diagnosis is essentially a list of diagnoses that are likely to be contributing to a patient's acute medical issue.

, M.D.

Q What is the purpose of formulating some sort of differential diagnosis when evaluating a patient?

A My understanding at that time, the purpose would be to essentially again, think of the most likely causes or underlying diagnosis for what the acute medical issue would be.

Q After evaluating Mrs. on December , , was it your impression that she was suffering from a myocardial infarction?

A I don't recall the specifics, but based on the note, that was a concern.

Q Can you be more specific?

A Can I quote in here what I say or wrote?

MR. : Yes, sure.

A So I have written down here that she had an EKG with diffuse ST-T segment changes and T-wave inversions in the anterolateral leads --

Q I'm sorry, Doctor, I'll have

, M.D.

you read the entire note in a minute, but my question is, had you come to the conclusion or did you reach a diagnosis after examining her, that she had a myocardial infarction?

MR. : Objection to the word conclusion or diagnosis versus impression, suspicion. I don't know which -- you're trying to make it sound definitive versus potential. Do you follow my concern?

MR. OGINSKI: Yes.

Q Did you determine following your examination, that this patient was suffering from an acute myocardial infarction?

A Do you mean definitively?

MR. : I think that's what he's asking.

A No, I have written down based on the note, that there was a concern for that, an ACS.

Q Tell me what you mean by that?

A A concern for an acute coronary

syndrome.

Q Which means what?

A Essentially anything that could be causing ischemia of the heart muscle.

Q In other words, that was on your list of possibilities that the patient could be suffering from; correct?

A It appears so, based on the note, yes.

Q According to your note, is that what you felt to be the most likely thing going on with her at that time?

A Based on the note, yes.

Q Did you formulate an opinion at that time, as to the cause of the patient's chest pain?

A I don't recall specifically, but based on the note, it seems like the concern was that she may be having ischemia of the heart muscle, which probably would be causing her chest pain.

Q What is ischemia?

A Ischemia is a lack of oxygen to the heart muscle.

, M.D.

Q In her case, what would be causing that?

A It's difficult to say.

Q Did you form an opinion on , , as to the etiology for why she might be experiencing the ischemia leading to chest pain?

A So in , based on my training at that time and given that she had recent surgery, there would have been a concern that she would be having an ACS in the setting of the postoperative period.

Q Explain that to me, please.

A To my understanding at that time, postoperative myocardial infarction is a seen complication.

Q Is a what?

A Is a seen complication. It can be seen. I can't say with what frequency, but it can be seen.

Q And are you aware under what circumstances it can be seen?

MR. : Objection to form.

, M.D.

That seems very broad.

Q Under what circumstances would you expect to see this type of complication?

MR. : Objection to form.

Again, that's really broad.

MS. : Objection.

MR. : He said it could be seen in a postoperative setting.

Q Can you be anymore specific, other than what you told me, as to when you would see it?

A All I can say is, it can be seen in patients after operations.

Q Do you know the etiology as to why?

A I can't really say.

Q As of , , had you personally seen patients who had had postoperative MIs?

A I don't recall any specific instances. Although, I would say that it's safe to say that I would have.

Q Did the patient's ECG

, M.D.

interpretation, suggest to you that she was having a myocardial infarction?

A Yes, based on the note.

Q Was there anything specific about the postoperative phase, that might lead to this patient to be suffering a myocardial infarction or cardiac event?

MR. : Objection to form.

MS. : Objection.

Q What clinical symptoms did this patient have, to suggest that she was having a cardiac event?

A Based on the note, she had palpitations and chest pain.

Q At the time that you saw and examined her, did you learn that she was postoperative from abdominal hernia surgery?

A Based on the notes, I wrote down that on , she had elective ventral hernia repair.

Q Had you spoken with her surgeon, either at the time you examined her or shortly after?

, M.D.

MR. : The actual surgeon who performed the procedure?

MR. OGINSKI: Yes.

A I can't really say because I don't know if Dr. was in the surgery or not. I don't know. Who do you mean specifically?

Q Did you ever speak with Dr. about this patient on , ?

A I don't recall doing so. I don't see any mention of that in the note.

Q Do you know Dr. , ?

A No.

Q Do you know Dr. , ?

A No.

Q Do you know Dr. ?

A I recall speaking with her, yes.

Q And she's an cardiologist?

A I believe so, yes.

, M.D.

Q At some point, either before or during your examination of Mrs. , did you learn that during her hernia repair surgery, that there was an incidental enterotomy made?

A I don't see any mention of that in my note and I'm not really sure what enterotomy is.

Q Did you learn from any doctor, that during Mrs. 's surgery for the hernia repair, that a hole had been made in her intestine intraoperatively and that in order to repair it, she needed an anastomosis?

A I don't see any mention of that in the note here.

Q At the time that you came to see Mrs. -- withdrawn.

When you were called on a consult, was it customary for you to read the patient's chart, to see what had gone on before?

A You mean in general?

Q In general.

, M.D.

A Yes, I would review whatever information would be available to me at the time.

Q And why is that helpful for you?

A It's helpful to understand why the patient is there and understand the context in which I would be seeing the patient.

Q At the time that you saw Mrs. on , , had you reviewed the patient's operative report?

A I don't recall.

Q Is there anything in your note to indicate you reviewed any type of operative report?

A I don't see any mention of any review of an operative note.

Q Is there anything in your note to indicate that you were aware the patient had a portion of her intestine removed during that surgery?

A I'm sorry, can you repeat that?

Q Sure. Is there anything that

, M.D.

you recorded in your note, that reflects your awareness of the patient -- part of the patient's intestines being removed during the course of her surgery on ?

A I don't see anything regarding that in the note.

Q If you had learned of that information, is that something that you would have expected to make a note of in the patient's chart?

MR. : Objection to form. It depends on when he learns it, under what circumstances.

MR. OGINSKI: I'll rephrase it.

Q If, during the course of your consultation, you learned the patient had a hole made in her intestine and had part of her intestine removed, would you have expected to make a note of that finding in your note?

MR. : Objection to form.

MS. : Objection to form.

, M.D.

MR. : Again, the word expected to make, it depends on when he learns it and what point in time. Maybe he learns it after he writes the note.

I'm just objecting, that is the extent of it. If you can answer the question otherwise, but other than that, that's my objection.

A I can't really say. I don't know -- I can't recall what I read. Again, like I mentioned, based on this note, I don't see any mention of that, so --

Q At any time while you were examining and evaluating Mrs. , did you ever consider the possibility that her chest pain could be related to anything other than ischemia?

MR. : Objection to form.

Q Were there any other possible causes for this patient's chest pain, other than ischemia?

MR. : Again, objection

, M.D.

to form, any possible causes. He came up with a differential diagnosis. Did he conclude that --

Q Did you consider any other reasons for the patient's chest pain, other than ischemia?

A Based on my notes, I was concerned for ischemia and ACS. It seems like ACS and ischemia, secondary to rebound tachycardia.

Q Did you consider any other possibilities for this patient's chest pain, other than what you just described?

MR. : After he did his evaluation?

MR. OGINSKI: Yes.

MR. : I'll object to the word consider. The word consider versus conclude is different.

MR. OGINSKI: I understand.

MR. : Okay.

A Honestly, I can't really say what my thought process was back then because I don't have full recollection of

, M.D.

the entire scenario.

Q Is there anything recorded in your note, to indicate you were considering any other alternatives for the onset of the patient's cardiac problems, other than what you have noted in the note?

A I don't see any indication.

Q Did you ever consider the possibility that her abdominal or -- withdrawn.

Did you consider the possibility during your examination and evaluation of her, that a surgical or abdominal process may have caused or triggered this cardiac event?

MR. : Again, my objection is to, he may have considered and may not have believed it true.

MR. OGINSKI: Whatever it is.

A I don't recall my thought process, what I considered back then.

Q And is there anything in your

, M.D.

note to indicate any other possibilities that you were considering, other than what you've recorded?

A I don't see anything else written in the note.

Q What led you to the belief that this patient was having an acute coronary syndrome?

A So based on the note, there were EKG changes that would be concerning for an acute coronary syndrome.

Q And these were new changes; correct?

A Based on the note, there were changes that were not seen on an EKG done prior.

Q Now, that prior one, was prior to her hospital admission, prior to surgery; correct?

A I don't know.

Q I want you to assume, Doctor, that her surgery was, as you mentioned, . I also want you to assume that she, as part of her

, M.D.
preadmission testing, had an EKG done on
.
Based upon that information, is it your interpretation that these findings on st, represented new findings, when compared to the EKG?
A Yes.
Q Do those EKG -- withdrawn. Tell me what those EKG finding actually represent to you?
A Which EKG findings?
Q The , .
A In regards to any particular findings or --
MR. : I think he's asking for globally.
MR. OGINSKI: Yes.
A So to me, it means that she had an accelerated heart rate. And she has changes, so T-wave changes, that would be concerning for ACS, in my understanding at that time.
Q Now, you use the term ACS, how is that different from defining it as a

, M.D.

myocardial infarction? How is the terminology different?

A I don't know if I can really go beyond the specifics of that. I would say that an ACS causes infarction. Infarction, in my understanding, is dead tissue of the heart.

Q Am I correct that you spoke with attending cardiologist about this patient?

A I don't recall the specifics, but according to the note, I discussed the case with her.

Q You had this discussion with her by telephone; correct?

A Yes.

Q Did Dr. come in to see and examine the patient in your presence?

A I don't recall.

Q Is there anything in your note to indicate that she came to examine the patient while you were there?

A I see nothing in the note to indicate that.

, M.D.

Q Were you able to transmit or send to Dr. , the EKG or ECG that you had interpreted, the one you were looking at on , ?

A I don't know.

Q Was there a means for you to transmit the patient's EKG to an attending who you were now consulting with?

A I don't know.

Q Did Dr. indicate to you that she was able to visualize or view the patient's EKG through some technology and that she was able to review it while you were on the phone?

A I don't recall any such indication being made.

Q Did you discuss with her the patient's EKG from , during your discussion?

A I don't recall the specifics of the discussion, but in general, I would have, yes.

Q And why would it be important

, M.D.

for you to do that?

A It would be important to present that there are new findings, that were not seen prior.

Q Did have a telemetry floor?

A I don't know.

Q The floor that the patient was on, did they have telemetry?

A I don't remember.

Q Did have an ICU?

A I don't remember.

Q Why did you consult with Dr. ?

MR. : Explain that.

A Based on the note, she was the on call attending cardiologist.

Q And why would it then be necessary to discuss this patient with her?

A So I don't remember the specifics of how things worked there, but my assumption would be that she would be

, M.D.

supervising me, as the resident for this particular consultation.

Q When you called her, describe for me what information you provided to her?

A I don't recall the specifics.

MR. : What type of information, given a --

A In general, what I would provide to any supervising physician is the background, the context of information as to why the patient is there, from what I understand, my physical exam findings, any study findings and give my initial impression. And then discuss with the attending thereafter, what plan should be formulated and carried through.

Q Do you also make recommendations as to what you believe should be done and compare it with the attending?

MR. : Objection to form.

Q As part of your practice, would

, M.D.
you make recommendations to the attending?
MR. : What his suggested plan would be?
MR. OGINSKI: Correct.
MR. : Okay.
A Back then, I would make an initial impression and again, discuss what I thought should be done, in terms of management and formulate an overall final plan with the attending then.
Q Do you know Dr. (phonetic)?
A No.
Q Did you ever speak with Dr. ?
A I don't recall.
Q Were you involved in the process with transferring this patient to , ?
A I don't recall specifically being involved in the transfer.
Q Once the patient was -- withdrawn.

, M.D.

Are you aware from reading the note, that the patient did actually get transferred to ?

MR. : From reading his note?

MR. OGINSKI: I'm sorry.

Q Did you learn from reading any notes in the chart, that the patient was transferred to ?

MR. : But I don't think -- just make an assumption that that occurred.

Q Did you ever speak to any doctor who treated her at ?

A I don't recall doing so.

Q Did you ever learn that this patient died shortly after her transfer to ?

MR. : Ever learned?

MS. : Objection.

Q Other than any conversation with your attorney?

MR. : Up to the time of the lawsuit?

, M.D.

MR. OGINSKI: Correct.

A No, I did not learn that.

Q If bowel contents leak into an abdominal cavity, can that cause irritation?

MR. : Objection to form.

MS. : Objection.

MR. : Irritation of --

MR. OGINSKI: I'll rephrase.

Q Postoperatively, if bowel contents, for whatever reason, leak into the abdominal cavity, where it should not be, what type of problems might you see in such a patient?

MR. : Again, hypothetically can occur?

MR. OGINSKI: Yes.

A I'm not a surgeon at all, so I have very limited experience with bowel surgery.

But my assumption at that time, that level of training, would be that patient would have signs of peritoneal irritation.

, M.D.

Q And how does peritoneal irritation manifest itself?

A My understanding of that level of training, would be it can include high fever, a tense and rigid, very tender abdomen. Those would be the most significant findings I would think of at that time.

Q Can leakage of bowel contents into the abdomen, trigger a cardiac event?

MR. : Objection to the term, cardiac event. I don't know what that means.

MS. : Objection.

MR. OGINSKI: I'll rephrase it.

Q Can leakage of bowel contents into the abdomen, trigger an acute coronary syndrome?

A At that level of training, I can't really say.

Q Are you able to say currently, with your current knowledge of medicine?

MR. : Objection.

, M.D.

MS. : Objection.

Q Do you have any opinion as you sit here now, as to whether bowel contents that leak into an abdominal cavity, can cause acute coronary syndrome?

A No, I don't believe so.

Q Tell me why.

MS. : The question was, do you have an opinion.

MR. : He said "no, I don't believe so."

Q Just to be clear, Doctor, you do not have an opinion or you're answering the actual question? I'll rephrase it. I'll clean it up.

First, do you have an opinion as to whether abdominal contents that leak into an abdomen, can cause acute coronary syndrome?

MR. : You're asking based on what he knew and understood at the time?

MR. OGINSKI: Yes.

, M.D.

A I would not have had an opinion on that.

Q Now, you indicated in your note that the patient's beta blocker had been held postoperatively, do you see that?

A Yes.

Q What did that mean to you?

MR. : Objection to form. It's just a fact. I'm not sure what you are asking.

MR. OGINSKI: Withdrawn.

Q Did you learn that the patient had been on a beta blocker prior to surgery?

A I don't recall specifically, but my note says that she has been on Toprol XL, 50 daily.

Q Did you learn why she was on Toprol XL?

A I don't remember specifically. But based on the note, it seems there was a questionable history of SVT.

Q Is that consistent with palpitations?

, M.D.

MR. : Is what?

MR. OGINSKI: The SVT.

MR. : Is SVT palpitations?

MS. : Is that a question?

MR. OGINSKI: I'll rephrase it.

Q Did you learn for how long she had been taking that beta blocker?

A I don't recall.

Q I understand you don't recall, Doctor, I'm asking, does your note indicate --

MR. : That's a different question.

MR. OGINSKI: You're absolutely right, I'm sorry.

Q Does your note indicate for how long she had been on beta blocker?

A There is no mention of duration on here.

Q Does your note indicate why she was removed from the beta blocker during the course of her surgery?

, M.D.

A There is no indication why that was done.

Q Do you have any knowledge as to why she was removed from the beta blocker during surgery?

A No, I don't.

Q Does your note indicate for how long the patient had not received her beta blocker, after having her surgery?

A I'm sorry, can you repeat?

Q Sure. Do you indicate in your note, how long the patient had not had her beta blocker following surgery?

A I see no indication here.

Q If a patient does not receive their beta blocker or restart it in a timely fashion, what can occur?

MR. : Objection to the form, beta blocker can be started in a timely fashion.

MS. : Objection.

Q Are you aware from anything in the hospital chart to indicate that it was the intention of the doctors treating

, M.D.
her, to restart her on the Toprol postoperatively?

MR. : Objection to form.

MS. : Objection.

MR. : When?

MR. OGINSKI: At any time postoperatively.

MR. : We know she did get it postoperatively, so there is an order there at some point. So I'm not sure what you are asking.

MR. OGINSKI: I'll rephrase it.

Q Did you learn during your examination, that it was the intention of the doctors caring for her, to restart her on her beta blocker at some point postoperatively?

MS. : At the time of his consult?

MR. OGINSKI: Yes.

MR. : Again, I have to object to the form.

MR. OGINSKI: Give me some idea where your objection is so I can

, M.D.

rephrase it.

MR. : The word is intention, I intend to restart it or I did restart it or there is an order to restart it, rather than getting into someone's brain.

Q When you learned that the patient was not on her beta blocker, did you ask why?

A I don't recall having discussions or asking anyone anything, so I can't really say. I don't recall.

Q Does your note reflect why the patient had not been on the beta blocker as of the time you saw her?

A All I can say is the note says it was held post-op and the reason is unclear.

Q Did you ever formulate an opinion on , , that the reason for this patient's acute coronary syndrome and her symptoms, was because her beta blocker had not been given to her?

, M.D.

MR. : The lack of the beta blocker caused an ACS?

MR. OGINSKI: Yes, that is the question.

A I'm sorry, so the question --

MR. : He's trying to ask you, did the lack of the beta blocker, did you believe cause the actual ACS?

A Aside from the note, I can't really say what I thought back then.

Q Can the lack of beta blocker on a patient who had been receiving beta blocker in the past, cause or contribute to a patient developing ACS?

MR. : Objection.

MS. : Objection.

Pre-op, post?

MR. : It's vague in time.

Q Based upon your note, Doctor, are you able to determine whether holding the beta blocker, the Toprol XL, caused or contributed to her ACS?

, M.D.

A Am I able to determine that?

Q Yes.

MS. : Today or back then?

A That's difficult for me to say.

Q Tell me why.

A I guess holding -- you know, it's difficult to really know why someone is really having an ACS. They can be due to many reasons.

Q If a patient who is on beta blocker, is removed from the beta blocker, such as Toprol, can that trigger SVT?

MS. : Objection. It's too broad.

MR. : Again, this is a hypothetical that may not be related to her time and circumstances.

Q I'm asking your general medical knowledge.

MR. : Do you know?

A In my general medical knowledge, what's the rest of the

, M.D.

question?

Q Can a patient who is on beta blocker, who is then removed for a period of time, then develop SVT, as a result of withholding that beta blocker?

MR. : Objection, vague, period of time.

MS. : Objection.

MR. OGINSKI: General question.

A I can't really say. I'm not a cardiologist.

Q Did you order that this patient receive her beta blocker?

A Did I order?

Q Yes.

A I don't recall ordering a beta blocker for her.

Q Would you have ordered the beta blocker?

MR. : Objection. I don't know what that means.

MS. : Objection.

Q When you learned that the patient's beta blocker had been withheld

, M.D.

postoperatively -- withdrawn.

MR. : She got beta blocker before this is done.

Q Do you have an opinion, Doctor, with a reasonable degree of medical probability, as to whether a patient whose beta blocker is held postoperatively, combined with a leakage of bowel contents into the abdominal cavity, can cause or trigger a cardiac event?

MR. : Objection.

MS. : Objection.

MR. : Based on his understanding at that time?

MR. OGINSKI: Yes.

A Based on my understanding at that time, I can't make any such conclusion.

Q Tell me why you can't?

A At the time, I'm a trainee. I'm still learning and I can't really go beyond that. I mean, it's not something that I learned specifically, so --

, M.D.

Q Did you ever -- withdrawn. During your discussion with Dr. , did you ever communicate to her the fact that the patient had, during her hernia repair surgery, that a hole was made in the bowel and that there was an anastomosis?

A I don't recall the specifics.

Q Is there anything in your note to indicate that you relayed that specific information to her?

MR. : I think it's kind of asked and answered through other information, questions you asked before.

MR. OGINSKI: I would like him to answer that one.

A So did I -- is there anything in the note to say that I told her that?

Q Correct.

A I see nothing in the note saying that I told her that specifically.

Q Now, you had requested that the patient have troponins done; is that

, M.D.
right?
A I had made a recommendation based on the note, to check a stat troponin.
Q And as part of your duties as a consult, do you actually order those tests?
MR. : Objection. You can see who ordered the test in the chart.
Q The recommendation was made to who?
MR. : It says, "check stat troponin."
MR. OGINSKI: Right.
MR. : It doesn't say order the troponin.
Q Did you check the troponins?
A Meaning, did I -- what do you mean by did I check?
Q Did you see what the results were?
A Oh, did I see what the results were, I don't recall.

, M.D.

Q Do you have the results in your note?

A I have in my note that it was pending.

Q Did you ever learn that the troponin levels were normal or within normal limits?

A At that time, I don't remember what I learned about the lab results.

Q At any time, within days after , , did you learn the results of the troponin?

A I don't recall doing so.

Q Did you ever learn that this patient had exploratory surgery when she was at , other than conversations with your attorney?

A At that time, I don't recall the specifics of her history.

MR. : No, this is not her history before she came to you. After you saw her.

A Oh, after, no. At that time, I don't recall learning such a thing.

, M.D.

Q Did you ever review this patient's autopsy results?

A I don't recall doing so.

Q Did you ever have a conversation with any physician, that the an anastomotic suture line had deteriorated and fallen apart?

A I don't recall doing so.

Q When you conducted your examination of Mrs. on st, did you examine her belly?

A I don't recall specifics of the exam, but based on the note, there was an abdominal exam.

Q You mention that there is a surgical dressing there and you wrote "NT to light palpation," that's nontender?

A Yes, nontender.

Q What is written underneath that?

A "JP drain with serosanguinous fluid."

Q Did you ever come to the conclusion or form an impression that

, M.D.

Mrs. was septic at the time that you examined her?

A I see no indication of that in the notes.

Q What is sepsis?

A To my understanding at that time, sepsis would mean infection of the blood stream.

Q How do you diagnose sepsis?

A At that time, I would say the diagnosis would be based on positive blood cultures, fever, high white count -- sorry, high white blood cell count.

Q Other than the diagnostic tests you just mentioned, are there any clinical tests or findings you might see in a patient with sepsis?

MR. : Can you be more specific? That's very vague.

MS. : Objection.

Q Other than the tests you just told me about, what clinical findings would you typically see in a patient with

, M.D.

sepsis?

MR. : Objection. Now you're asking the whole gamut of anything that a patient can have.

MS. : Objection, it's beyond --

MR. : It's very, very far.

Q Whose decision was it to transfer this patient?

MR. : To where?

MS. : He didn't know about it. I'm sorry.

MR. OGINSKI: Just make an objection then.

MS. : Objection.

MR. : Why don't you ask if it was his decision.

MR. OGINSKI: I want to know whose decision --

MR. : He can tell you whose it wasn't.

MS. : His.

MR. : Why don't you

, M.D.

start with that.

Q In your conversation with Dr. , was there a decision made during that conversation to transfer this patient to ?

MR. : In that conversation?

MR. OGINSKI: Yes.

A I don't remember.

Q Is there anything in your note to indicate that there was a discussion about transferring the patient?

A All I can say specifically is that rapid response and ICU teams were consulted and will see patient. So I don't -- I can't really make much conclusion based off of this, whether she was going to be transferred or not.

Q What was the purpose of consulting with rapid response and the ICU team?

A I don't know. I'm assuming this was all based off of my discussion with Dr. and her final

, M.D.

conclusions.

Q And who consulted with them, was it you or somebody else?

A I don't recall.

Q Did you request those consults?

A I don't recall.

MR. : Objection to form.

Did you request, you mean after Dr. ?

Q Based upon your note, it says "Rapid response and ICU teams consulted," does that mean you consulted with them or something else?

A It doesn't say, based on the note, who did.

Q Do you have a memory as to who that was?

A No, I don't recall.

Q What I would like you to do please, is I would like to you read your note. And if there is an abbreviation, tell me what it is, starting with the date?

A " , , medicine

, M.D.

consult/cardiology. Reason for consult, chest pain. ID, identification, -year old female with acute onset of palpitations and chest pain in setting of sinus tachycardia."

Q Let me stop you, Doctor. Can sinus tachycardia cause chest pain?

A I think it's fair to assume that it can.

Q Go ahead, please.

A "History of present illness, 59 year old female, history of ovarian cancer, status post resection with total abdominal hysterectomy salpingo-oophorectomy."

Q Let me stop you for a second. Did you learn when that had occurred, when the patient had had -- when she was status post resection?

MR. : As opposed to learn --

MR. OGINSKI: I'll rephrase it.

Q At the time of your obtaining this history, did you learn when she had

, M.D.
had that condition?
A While obtaining the history, I don't recall.
Q In other words, was it a year earlier, five years, ten years or some other point in time?
A I don't recall.
Q Go ahead, please.
A "Questionable history of SVT, supraventricular tachycardia, post-op."
Q That's referring to the , surgery, ?
A I don't know actually.
MR. : No, this is a history and he's talking about , meaning the day before, questionable SVT, post-op.
When you say "post-op," do you mean following the surgery she had the day before or following her prior history?
THE WITNESS: Yeah, I don't know. Based off the note, I don't remember.

, M.D.

Q Continue, please.

A "For which she has been on Toprol XL, 50 daily, well controlled. On November 30th had elective ventral hernia repair, without complications."

Q Let me stop you for a second, Doctor.

Who did you obtain that information from?

MR. : Which information?

Q About the elective ventral hernia repair without complications?

A I don't remember specifically. But in general, the history would have been obtained from whoever requested the consultation and from the charts, whatever is available there.

Q Go ahead, please.

A "Toprol XL held post-op, reason unclear. Called for consult at 7 p.m. Reportedly at approximately 4 p.m. developed sensation of palpitations with heart rate in 110s. Unclear from patient's verbal history as to whether

, M.D.

she has chest pain or shortness of breath."

Q Now, Doctor, a heart rate in the 110s, what does that represent to you, if anything?

A That's a tachycardia.

Q Go ahead, please.

A "Current in-patient medications, Fentanyl PCA."

Q That is the pain pump?

A Yes.

Q Go ahead.

A "Reglan."

Q If you can, tell me what that is and what it's for?

A Reglan is used to treat nausea. "Simethicone," I can't really recall what it's used for. I think for just heartburn. "Tinzaparin, 4,500 units subcutaneous daily." I don't recall specifically why she was on that, but I believe that's a blood thinner.

MR. : I don't think he asked you question.

, M.D.

MR. OGINSKI: I just asked him if he could identify what the medication is for.

MR. : Okay.

A "Percocet, p.r.n." is a pain medication. "Ambien," it's a sleep medication. "Colace," is a stool softener for constipation. "Toradol, p.r.n.," also a pain medication. And "Benadryl, p.r.n.," can be used for lots of different things, for allergies, for sleep or for even for nausea.

"On physical exam, general exam, she was pale, anxious, mildly confused, tachypneic. Vital signs, 37.2 degrees Celsius; heart rate in the 95 to 110s; blood pressure, 88 over 57; and oxygen saturation, 95 percent on room air."

Q Is that a normal finding, the oxygen saturation?

A Based on this, it could be considered borderline low, but it's often times not very reliable, in my experience

, M.D.

in the hospitals.

Q Are there other diagnostic tests that you can use, that give a better reliable indicator of the patient's oxygen saturation?

MR. : For what circumstance?

MR. OGINSKI: Just to evaluate their vital signs.

MS. : Objection.

A There are.

Q Like what?

A You can do an arterial blood gas, but that's not routinely done.

Q Go ahead, please.

A "The neck exam, there was no jugular venous distension. Cardiovascular, there was an S-1, S-2, frequent premature beats, no murmurs, rubs or gallops."

Q And that's based upon your examination with a stethoscope; right?

A This would have been, yes.

Q Go ahead.

, M.D.

A "On respiratory exam, very poor inspiratory efforts. Therefore, it was a suboptimal exam. No rales, rhonchi or wheezing."

Q I'm sorry, Doctor, when you learned that information or observed that, did you form any opinion in your mind, as to why she was having that poor inspiratory effort?

MR. : What was your impression as to that?

A I don't remember what my impression was for that at that time.

Q Go ahead.

A "Abdominal exam, hypogastric, surgical dressing intact. Nontender to light palpation. JP drain with serosanguinous fluid. Extremities exam, warm and dry, one plus pedal edema, no cyanosis. Labs, troponin is pending; CBC or complete blood count is pending; CMP or comprehensive metabolic panel is pending."

Q Did the patient exhibit or tell

, M.D.

you that she was nauseas?

A I see no mention of that in the notes.

Q Did you learn that she -- withdrawn.

Had she been vomiting?

A I see no mention of that in the note.

Q Is that the type of information that you would typically ask her?

A I don't remember if I asked her, but typically I would.

Q And if the information was negative -- withdrawn.

If it was positive, would you have written it down, in light of her symptoms and why you were being called?

MS. : Objection.

MR. : If she had positive nausea and vomiting, would you have documented that, if she gave you that history?

A If she gave me that history, I would have written it down.

, M.D.

Q Go ahead, please.

A "Studies, a portable chest X-ray is pending. She had a TTE or transthoracic echocardiogram from and the findings were EF, ejection fraction of 73 percent, normal wall motion, normal chambers, trace mitral regurgitation. EKG or electrocardiogram" --

Q Let me stop you. That ejection fraction information, where did you obtain that information?

A I don't recall specifically.

Q Did the patient relay that information to you?

A I don't recall specifically.

Q Go ahead, please, with the ECG findings.

A " , , heart rate 56, sinus rhythm, normal axis, T-wave inversion in lead three and lead V1, intervals within normal limits."

Q Can you characterize those findings? In other words, is this a

, M.D.

normal ECG, is it abnormal or something else?

A At my level of training back then, I would interpret this as probably a normal --

Q Continue, please.

A " , , at 19:41, 118 beats per minute, sinus rhythm with premature complexes, normal axis, down sloping ST segment in lead one, flat T-wave in AVL. T-wave inversions in V2 through V5, with a flat T-wave in V6, and I wrote down that these are new."

Q Are you able to tell from this ECG interpretation, what part of the heart this is occurring in?

A So at that level of training, I can't say specifically. But the understanding would be that there is -- these changes correspond with the anterior and lateral portions of the heart.

Q Continue, please, on the next page.

, M.D.

A "Continued, and then , , continued cardiology/medical consult. Assessment and plan, 59 year old woman with history of SVT or supraventricular tachycardia, on chronic rate control with beta blocker, with acute onset of palpitations and generalized malaise, in setting of sinus tachycardia in post-op period. History significant for beta blocker, Toprol XL, being held in immediate post-op period. Exam significant for relative hypotension, systolic blood pressures in 80s."

Q I'm sorry, is that a normal finding or abnormal finding?

MR. : What?

Q The relative hypotension?

A It depends on the situation.

Q What was your opinion as of that time, as to whether this was a normal or abnormal finding?

A Based on the note, the concern would be, it would be related to an ACS.

, M.D.

Q Is that normal or abnormal?

A ACS?

Q No, the fact that she had systolic blood pressures in the 80s?

A So that would be concerning, yes, based on the notes.

Q Go ahead, please.

A "ECG or electrocardiogram with diffuse ST-T segment changes" --

Q I'm sorry, Doctor, I don't know if you mentioned the sinus tac.

A "With sinus tachycardia."

Q Start from the beginning of the sentence.

A "Exam significant for relative hypotension. Systolic blood pressures in 80s with sinus tachycardia. Electrocardiogram with diffuse ST-T segment changes and T-wave inversions in anterolateral leads. Recommendations and plan, concern for ACS in immediate post-op period versus rebound tachycardia in setting of held beta blockers and secondary ischemia rate related."

, M.D.

Q Can you explain that, please?

MR. : Explain what?

Q The rebound tachycardia in setting of held beta blockers, secondary ischemia rate related?

A You mean, explain --

MR. : In what way?

Q Tell me what that means.

MR. : I have to object to form.

Q What is rebound tachycardia?

A It's a phenomenon I remember learning in that time, where if a beta blocker is held, you have a rebound accelerated heart rate.

Q And how did you know -- withdrawn.

What made you believe that she had secondary ischemia?

A Based on the note, it says, "secondary ischemia rate related," so related to her rates possibly.

Q Explain that to me.

MR. : Objection to form.

, M.D.

Q Tell me what you were thinking as to how you came to that thought process?

MR. : I still don't get what you are asking him, tell you what he's thinking.

Q Secondary ischemia is what?

MR. : He's been around and around this issue.

Q What is secondary ischemia?

A To my understanding at that time, secondary ischemia is ischemia related to an underlying cause. So it's a phrase basically, the way it's used here.

MS. : Off the record.

[At this time, a discussion was held off the record.]

MR. OGINSKI: What was the last question and answer?

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

Q Did you determine what was the underlying cause in this patient's case,

, M.D.
as to why she was experiencing the ischemia?

MR. : I think he asked and answered that. He said ACS in a postoperative setting, or something like that.

Q Is that right?

A Yes.

Q Go ahead, Doctor, continue.

A "Check stat portable chest X-ray. Check stat troponin. Transfer to telemetry. Maintain systolic blood pressure greater than 100 with I.V. fluid boluses. Attempt rate control with I.V. or intravenous Lopressor, starting at 2.5 milligram I.V. push. Discussed with consult requesting GYN fellow, , regarding contraindications to antiplatelets and anticoagulation. Agreed to give 325 milligrams by mouth, aspirin times one and initiate Heparin drip as per ACS protocol."

Q And what is that?

A What is --

, M.D.

Q The ACS protocol?

A My understanding at that time, is ACS protocol is a number of steps a clinician would undertake to diagnose and treat an ACS.

Q And what was the purpose of administering Heparin?

A Heparin is one of the agents given in ACS.

Q Why?

A That's just what I learned. It's a blood thinner.

Q Why is it necessary to give a blood thinner in that context?

A At that level of training, I can't really say why. It's part of what we were taught to do. And if it's written here, it was after discussion with Dr. , so --

Q You mentioned contraindications to, what is that, antiplatelets?

A Yes.

Q What is that?

A Antiplatelets would be the

, M.D.

aspirin here.

Q Go ahead, continue, please.

A "Would discontinue Tinzaparin and Ketorolac, NSAID or nonsteroidal antiinflammatory drug. Rapid response and ICU teams consulted" --

Q Let me stop you, Doctor. Right above that, the note that's crossed out, read that please, if you would?

A "Rapid response team consulted, will continue care overnight."

Q And you have a line through that and you wrote "error"?

A Yes.

Q Go ahead.

A "Rapid response and ICU teams consulted, will see patient. Above assessment and plan discussed with on call attending cardiologist, , as well as patient's primary team. I will continue to follow in immediate acute period."

Q Is that your signature?

A Yes, that's my signature.

, M.D.

Q And at that time, you were a PGY-2; correct?

A Yes.

Q Who was the patient's primary team that you refer to?

A I don't recall. Based on the note here, it was some gynecologic service probably.

Q Do you have any other note similar to the note that you just read in this chart?

A I don't recall writing any other notes, so I don't know.

Q I would like you to turn please to the rapid response team note dated , timed at 7:50 p.m.

A Okay.

Q I understand this is not your note, Doctor, but I would like you to read it --

MR. : He's not going to do that.

MR. OGINSKI: Why?

MR. : That's not

, M.D.

appropriate.

MR. OGINSKI: I have questions for him.

MR. : Objection. You have a question, ask him a question, but he's not going to read the note.

Q What time was your note written?

A I don't remember what time.

Q Was it before or after the rapid response team note?

MR. : The rapid response team note starts at a time and continues for several times.

MR. OGINSKI: I know.

Q Are you able to tell whether it was before or after?

A I don't recall what order anything occurred, in terms of charting.

MR. : The only thing he can say is it says, "Rapid response and ICU team consulted, will see patient." So that's from note.

, M.D.

Q Did you speak to anyone in the rapid response team?

A I don't recall.

MR. : Asked and answered.

Q Let's turn please to the order sheet dated

A Okay.

Q Doctor, looking at the computerized order sheet, under primary diagnosis, it's listed, "Ovary, malignant neoplasm," do you see that?

A Yes.

Q Where did you obtain the information about malignant neoplasm?

MR. : According to Dr. 's order?

MR. OGINSKI: Yes.

MR. : That's Dr. .

MR. OGINSKI: I'm sorry.

Q Going down to the bottom of that page, the order is , , timed at 7:10 p.m.

MR. : Got it.

, M.D.

A Okay.

Q Under primary diagnosis, you list, "Adrenal cancer"; correct?

A Yes, I see that.

Q Are you aware, Doctor, that this patient at no time had adrenal cancer?

A Based on my note, I don't see any history written there, adrenal cancer.

MR. : So you clicked the wrong cancer?

MR. OGINSKI: That's not right.

Q Let's look at the enzyme results, Doctor.

The enzyme results are shown as dated , ; correct?

MR. : Wait, there are two.

Q The troponin --

A Yes.

Q Those show that they're both normal or within normal limits?

A Yes.

, M.D.

Q And in light of your observation and examination of the patient, if her enzyme levels are normal, as indicated in this result, what other condition would account for this patient's symptoms?

MR. : Objection.

MR. OGINSKI: Withdrawn.

Q Does this rule out the fact that she did not have a myocardial infarction?

A No, it does not.

Q Tell me why.

A I would say the definitive test would be a cardiac cath.

Q Did Dr. ever recommend a cardiac catheterization for this patient?

A I don't recall.

Q Is there anything in your note that reflects that she recommended a cardiac catheterization?

A That she recommended one?

Q Yes.

, M.D.

A I don't see that written in the note. Let me just -- not specifically a cardiac catheterization. I don't see anything that suggests that.

Q Now, why are series of troponins done over time; what is the purpose of that?

A To my understanding at that level, that they should be checked serially because they can take time to become elevated.

Q Is there any reason that you can think of as you sit here now, as to what would account for the patient's symptoms that you observed on st, assuming she did not have evidence of a myocardial infarction?

MR. : Objection. That's not a proper question.

Q Based upon the fact that there is --

MR. : He can only testify based on the evidence he had at the time.

, M.D.

MR. OGINSKI: I'll rephrase it.

Q On , , the results of the troponins, did you ever see these results?

A I don't recall. I saw them just during preparation.

Q Other than -- I'm talking about at the time this patient was being seen and treated in December of ?

A It's possible. I don't recall though.

Q Assume that you saw the first result showing troponin, did you reach any different conclusion as to the cause for this patient's chest pain and ongoing symptoms?

A I can't really assume because I don't recall.

MR. : Assume you did see it and it was negative?

MR. OGINSKI: Yes.

MR. : Would that change your impression that you had.

THE WITNESS: I'm sorry, I

, M.D.

didn't understand the question, so can you repeat the question?

MR. : Assume you saw it and it was negative, would that have changed your impression that you had?

THE WITNESS: No, it would not have, no.

Q Tell me why.

A Because the definitive test would have been to do a cardiac cath. So if the troponin was negative and you have EKG changes that are concerning for ACS, then the patient would need a cardiac cath to really definitively rule in or rule out.

Q Did have the facilities to perform a cardiac catheterization?

A I have no idea.

MR. : You have no recollection?

THE WITNESS: Yeah, no recollection.

Q Do you know Dr. ?

, M.D.

A No, I don't.

Q Doctor, did you have a discussion with Dr. about restarting the patient on the beta blocker?

A I don't remember the specifics of what I discussed. But anything that I wrote here under recommendations and plan, would have been what the final recommendations were that she gave me.

Q Has your license ever been suspended?

A My medical license, no.

Q Has your license ever been revoked?

A No.

Q Where did you go to college?

A .

Q When did you graduate?

A .

Q And where did you go to med school?

A University.

, M.D.

Q ?

A Yes.

Q From when to when?

A

Q And that's when you started your residency in ?

A Yes.

Q Have you ever testified before?

A Testified?

Q Either in this setting or a courtroom?

A No.

Q Have you ever been sued before as a defendant, as a doctor?

A No.

Q Do you have any publications to your name?

A Yes.

Q How many?

A One manuscript and one abstract.

Q Published or unpublished?

A Published.

Q What is the manuscript about?

, M.D.

A It's from college, it's basic science research.

Q And the abstract, what's that about?

A That's peripheral arterial disease.

Q What is that published in?

A In Circulation, I believe, the journal, Circulation.

Q Are you the primary author?

A Yes.

Q Have you presented at any national medical societies?

A Yes.

Q How many?

A How many societies or how many --

Q How many presentations?

A I would say around -- I know two of, at least, I can remember.

Q What were the topics?

A The two that I remember were peripheral arterial disease.

Q Is that an area of your

, M.D.

research?

A Currently, yes.

Q Do you have an opinion as you sit here now, as to whether this patient's diagnosis of sepsis was timely made?

MS. : Objection.

MR. : Objection.

MS. : He didn't diagnose sepsis.

MR. OGINSKI: I want to know if he has an opinion.

A I have no opinion.

Q Do you have an opinion with a reasonable degree of medical probability, as to whether this patient received appropriate cardiac care while at on , ?

MR. : Objection to form. You want to know if he thinks his care was good or cardiac -- I don't know what you mean by cardiac care.

Q Do you have an opinion with a reasonable degree of medical probability,

, M.D.
as to whether the treatment Mrs.
received on , , at
, was within good and accepted
medical standards?

MR. : I'll object to that on multiple grounds. You are asking him to comment on everybody's care and that's inappropriate.

Q Do you have an opinion, Doctor, whether the treatment you provided to Mrs. , was in accordance with good and accepted standards of care on , ?

MR. : As a PGY-2.

A I do have an opinion, yes.

Q And what is your opinion?

A My opinion is that I did what I should have at that level of training. And I took information from all available sources, the patient, the chart, I'm assuming, as well as the team, I'm assuming, disseminated the information to my and relayed her final recommendations.

, M.D.

MR. : And followed through on the plan, her plan, whatever?

THE WITNESS: Yes.

Q The Toprol that we talked about previously, is that typically given in pill form?

MR. : Which one?

MR. OGINSKI: The extended release.

MR. : XL, do you know?

A I believe so.

MR. : How else would you do it? It would have to be a pill form. If it's I.V., it's in there.

Q Were you involved in the decision to administer Metoprolol by I.V.?

MR. : Objection to the form, involved in the decision.

Q Did you order I.V. Metoprolol?

MR. : Did you order it?

A I don't remember.

MR. : Let's see if you

, M.D.

have an order for it.

A It says here, "Ordered by ."

Q Looking at the bottom of that order, it indicates that the patient was given I.V. push Metoprolol; correct, at 6:27 p.m.?

MR. : That's the order time?

MR. OGINSKI: Yes.

A You mean --

MR. : What is the question?

Q The order to give the patient Metoprolol -- by the way, Metoprolol is the same as Toprol, it's a beta blocker; correct?

A It's a beta blocker, yes.

Q Do you know why this patient was given that medication, Metoprolol, by I.V. push?

A That I don't know why specifically. My assumption is that these were the recommendations that were

, M.D.

given to me, relayed through the attending.

Q Was the administration of Metoprolol by I.V. done because the patient's beta blocker had been held postoperatively?

MR. : Objection.

Q Are you aware of that?

MS. : Objection.

MR. : Do you know, yes or no?

A I don't know.

MR. OGINSKI: Thank you, Doctor.

MS. : No questions.

MR. : Thank you.

(Time noted: 12:25 p.m.)

_____

, M.D.

Subscribed and sworn to before me this day of , _.

.

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: VS.
DATE OF DEPOSITION:
WITNESS' NAME: , M.D.

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, M.D.

SUBSCRIBED AND SWORN TO
BEFORE ME THIS______DAY
OF_______________, _.
____
NOTARY PUBLIC
MY COMMISSION EXPIRES__________________