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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS
- -x
,
Plaintiff,
-against-
, M.D.,
, P.C., UNIVERSITY
HOSPITAL, , M.D.,
, M.D., , M.D., P.C.,

Defendants.

Index No.: 7561/06
- -x
170 Old Country Road
Mineola, New York

December 15, 2006
10:24 p.m.

EXAMINATION BEFORE TRIAL of
, M.D., one of the Defendants in the above-entitled action, held at the above time and place, taken before Cynthia A. Laub, a Notary Public of the State of New York, pursuant to Court Order and stipulations between Counsel.

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STIPULATIONS

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

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

This deposition may be sworn to by the witness

being examined before a Notary Public other than the Notary Public before whom this examination was begun, but 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, 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.

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, M.D., the witness herein, having first been duly sworn by the Notary Public, was examined and testified as follows:

EXAMINATION BY

MR. OGINSKI:

Q. State your name for the record, please?

A. P .

Q. What is your address?

A. , , New York 11501.

Q. Good morning, Doctor.

A. Good morning.

Q. What is a septic hip?

A. A septic hip would be an infected hip.

Q. And what is septic arthritis?

A. It would be arthritis secondary to infection.

Q. Can you describe for me generally how one would get a septic hip.

A. Well, either from a penetrating injury or from hematogenous deposition into

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the hip joint.

Q. How do you diagnosis septic hip?

A. By history of physical and collaborative laboratory data.

Q. Can you describe for me generally what type of symptoms a patient would present with in a septic hip? And I'm talking generally about an elderly patient or someone in their early 70s.

A. They would have pain, restricted range of motion, possibly spasm, difficulty walking. I think those are the major features.

Q. In a septic hip, is the primary symptom generally accompanied by pain, or is pain one of the main factors associated with the --

A. The primary symptom is usually

pain.
Q. Is there also a component of a restriction of movement secondary to the pain?
A. There is almost always restriction of motion.

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Q. In addition, does the patient generally come in with complaints of either some type of limp or difficulty ambulating?
A. Yes.
Q. How do you treat septic hip?
A. There are a variety of ways you can treat a septic hip. Usually it's within intravenous antibiotics, I was going to say for six weeks, but it would be more correct to say until you've eradicated the infection. Sometimes it's not gone in six weeks. Sometimes it's necessary to operate on a hip and drain the material. That would be true in a newborn which is a common entity, but not in this elderly woman. And finally the most common infection in the hip we see today, where you've done a hip replacement and that becomes infected. In general that treatment involves removing the metallic components.
Q. How is treatment of septic arthritis different and distinct from treatment of septic hip?

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A. Well, septic arthritis would be different in the sense that if you knew that the infection was remote, long past, and corrected, and what you were dealing with was the residual from the septic hip, then the options would be the same as they would be with an arthritic hip. That is to say activity modification, pain medication, anti-inflammatory medication, physical therapy, and in such cases that was not sufficient, one could perform a joint arthroplasty, which is to replace the hip.
MR. : Could I trouble you to read back that last answer.
[The requested portion of the record was read by the reporter.]
Q. Doctor, is there some type of algorithm that you have used in the past? In order to treat a particular septic hip?
When I say "algorithm," I mean something that's written that you've consulted with to help you formulate treatment plans of this nature.

A. I have an algorithm. I don't

remember where I got it, but the answer is yes.

Q. In this particular case, treating , did you use that particular algorithm to treat her condition at any time?

A. I never established the fact that her hip was infected.

Q. I'll get to that.

A. Then I didn't apply the algorithm on the basis of not having established that the hip was infected.

Q. Fair enough.

How was it that you came to see in the middle of October of 2003?

A. I was called by another doctor, and this doctor had admitted her I think on the 8th of October.

Q. That's Dr. ?

A. Correct.

And he asked me would I see her and would I be willing to take over the case.

Q. And how was it that you knew Dr. at that time?

A. Well, he's on the staff at Hospital, and I -- I don't know how many years he's been there, but his father had been there too, and I knew them both.

Q. To your knowledge, was Dr. the physician that you had dealt with in October of 2003, an orthopedist on staff?

A. He was, yes. Yes.

Q. I would like you to turn, please, to the October 15, 2003 MRI result of the pelvis, without contrast.

A. Yes.

Q. Were you the physician who had requested that the patient have this particular MRI of the pelvis?

A. Yes.

Q. Before you had received the results of this MRI, can you tell me what was it that made you order or request this particular MRI of the pelvis on October 15, 2003.

And, Doctor, if you can, just point out to me what part of the medical

record you're looking at so we know.
A. I am looking at the medical record progress note of my own on 10/15.
Q. And is there a particular page number at the bottom that we can look at as well, so we're all on the same page.
THE WITNESS: (Indicating.)
MR. : I don't know if that's a page number.
MR. : I don't think ours were numbered.
MR. : Off the record.
[Discussion held off the record.]
Q. Let me go back for a moment, Doctor.
On October 15, 2003, after speaking to Dr. at some point, did you come and examine and talk to Anne ?
A. Yes.
Q. And at some point, either after

talking to , did you perform a physical examination on her?
A. Yes.
Q. And as part of your examination and your consultation, did you have conversations with her and maybe some of her family members?
MR. : Are we talking on 10/15 or 10/14. Because you're implying 10/15 was the first visit.
MR. OGINSKI: I'll rephrase it.
Q. Let me go back a moment, Doctor.
At any time after the MRI of the pelvis of October 15, 2003 was performed, did you personally review the MRI films?
A. Yes.
Q. Did you review them on your own or in consultation with a radiologist or an attending or someone else?
A. In the presence -- in the radiology suite with a radiologist.
Q. Was that done before or after the films were officially read as reported the next day on 10/16 by Dr. ?

A. It was done in and about that vicinity. I don't know if it was done before -- during the reading or after.
Q. Did you come to the same conclusions that the radiologist had come to concerning the evaluation of these particular films?

A. I did.
Q. At any time while you were treating , from October 15th, 2003 up until the time she was discharged I believe at the end of the month on October 25th, did you ever suspect that had a septic hip?
A. I considered it when we looked at the MRI.
Q. Did you ever consider that she had septic arthritis during that same period of time?
A. That would be part B of it, of the same previous answer.
Q. What was it about the MRI films or results that made you consider the possibility that she had a septic hip?

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MR. : I just object to the form.
Q. Was there anything specifically that you observed on the October 15, 2003 MRI of the pelvis that made you suspect or consider the fact that she had a septic hip or possibly septic arthritis?
A. The edema in the muscles that was reported.
Q. Tell me why that was significant or what that indicated to you, if anything?
A. Well, it suggested -- this was a very difficult case, and we had a long consultation on this.
It suggested -- I had been concerned -- if we could just go back, the reason the MRI was ordered also had to do with my consultation on the 14th.
Q. I will get to that, because I'll go through your notes.
But going back, Doctor, if you can, to the edema.
A. Edema, and it wasn't -- we discussed this with the radiologist,

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Dr. . This can be a sign of infection. He didn't feel that it was significant edema.
We also considered at that time aspirating the hip, and he felt because both the invasive radiology department and the orthopedic department can aspirate a hip, he felt that there was insufficient fluid there that we would get a positive fluid if I stuck a needle in the hip.
We had a conversation at that point. He felt that this intracortical

fracture was the more likely cause of the problem.
Q. Did you agree with that?
A. Yes.
Q. Now, you've had -- had you seen the prior results of the X-rays and other MRI films that were done from the time she was admitted on October 8th up until October 15th, describing the fact that there were no fractures or dislocations?
A. I had reviewed both the X-rays of the right hip, and the MRI of the lumbar

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spine prior to this.
Q. And was it your conclusion together with the radiologist who had evaluated those films you just mentioned that there was no evidence of fracture or dislocation in the right hip?
A. Yes.
Q. Now, at any time after you had this consultation with Dr. , after reviewing the MRI of the pelvis, did you write a note anywhere in the chart to indicate that you had, in fact, considered the possibility that had a septic hip?
A. No.
Q. Did you make any notes anywhere regarding the possibility that the edema represented some type of infection within the hip that could possibly necessitate some type of aspiration?
A. No.
Q. I would like you to turn, please, to your first note that you have in the chart concerning any discussion or

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consultation about this patient.
A. (Indicating.)
Q. That's what you're referring to. And that's a consultation note, Doctor?
A. Yes.
Q. And this was done on October 14, 2003?
A. Yes.
Q. If you can, please, Doctor, I would like you to read your note as written. If there are abbreviations, just tell me what the word represents. You don't have to tell me just the abbreviation.
A. 72-year-old female had the acute onset of low back pain last Wednesday.

Admitted to emergency room and had the diagnosis of spinal stenosis. Decadron four to five days did not help. Now physical exam suggests right hip osteoarthritis. Labs equal osteoarthritis of the right hip. Spinal stenosis at L3-L4.

Recommend, one, will accept patient. Two, MRI of the right hip. Three, do the epidural injection, and four, neuro consult.

Q. Do you have as you sit here now, Doctor, an independent memory of the conversation that you had with Dr. when the decision was made to switch the patient to your service?

A. Very vague recollection.

Q. Can you tell me what it is that you do remember and when it was that you had the conversation with Dr. ?

A. I think it was on the 13th or the 14th of the month. I think it was based on a telephone call to my office. And I think it was based on he was having difficulty with the patient, and the family somehow knew me, would I please take the patient.

Q. Had you ever treated before October of 2003?

A. No.

Q. Did Dr. ever suggest to

you that he considered the possibility that had some type of septic hip, or septic arthritis?

A. Not that I remember.

Q. The consultation note that you just read to me, that was done on October 14, 2003, correct?

A. Correct.

Q. You had performed the physical examination on Mrs. that day?

A. Yes.

Q. Had you observed any spasm in any part of her hip or leg at the time of your exam?

A. No.

Q. If you had noted a spasm, would you have expected to make a note of that within your consult note?

A. Yes.

Q. Tell me what type of physical exam you actually conducted to evaluate both her legs, her back, and her hip.

A. The first thing was a range of motion of the hip, and that's done in

various planes, flexion, extension, internal and external rotation, abduction and adduction.

Q. What were your findings on exam.

A. That she had limited rotation, particularly in internal rotation. She had pain in the groin. And then in regard to her neurologic situation, there was no neuro deprivation in the nerves that traversed the hip. This is with reference to the assumed diagnosis of spinal stenosis.

Q. Before you had examined her, had you reviewed any of her films up until that point?

A. Either just before or just after, I would review them. The orthopedic floor is near the X-ray department. It would be my usual and customary practice, you know, before I sat down and wrote this thing to do it, whether I did it before or right after the examination. I did have available to me whatever had been read already.

Q. The spinal stenosis that was reported previous to October 14th, that concerned primarily certain parts of her back, low back, including disc degeneration, disc bulges?

A. Correct.

Q. And certain areas that had spinal canal stenosis, correct?

A. That's correct.

Q. Had you formed any opinion on October 14th as to whether the patient's complaints that she was experiencing related solely to those issues concerning her back? In other words, the disc degeneration, the disc bulges and the spinal canal stenosis.

A. On the 14th, I was unclear as to that.

Q. What was it that made you believe that there was some additional pathology going on, other than the back problems that had been previously reported?

A. The pain in her hip.

Q. When you saw her on October

14th, did Mrs. specifically make

complaints to you about hip pain?
A. I think her complaints were generally the right lower extremity, which, you know, would be the whole gluteal area, the leg, the knee.
Q. But did she also make specific complaints relating to the hip itself?
A. I think she may have after the exam, because I -- my exam, whether it was the history or the physical, triggered me to order the MRI of the right hip.
Q. What is osteoarthritis?
A. Osteoarthritis is wearing away of the normal cartilage between the acetabulum and the femoral head. It's used to distinguish it from rheumatoid arthritis, which is an excessive wear of the articular cartilage, and it's used to specify arthritis that is secondary to wear, and it was the most prevalent type of arthritis from auto immune arthritis, which would be rheumatoid arthritis, or architectural irregularity secondary to

trauma, we would call this post-traumatic arthritis.
Q. Was it your understanding that Mrs. was atraumatic, she had nothing traumatic occur to her causing these problems or symptoms?
A. Yes.
Q. You had mentioned in your note that the patient had been on Decadron for four to five days which did not help. Is that a form of steroid?
A. Yes.
Q. And what is the significance of the fact that she had been on steroids for four to five days without relief?
A. Well, the significance was whatever the cause of her pain was, this didn't rectify it. And was not worth repeating. Sometimes these things are repeated.
Q. As part of your plan, you had recommended that you were going to do epidural injections. What was the significance or the purpose of that? Was

that primarily for pain relief?
A. It can be for both pain relief and it can resolve the problem. The point is that she was scheduled prior to my coming on the scene for these epidural injections, and this relates back to the

oral steroids were not helpful. So a member of the anesthesiology department who does pain control had suggested epidural injections into the epidural space, because in cases of spinal stenosis, this can be helpful. The help can range from pain relief to dispensing virtually all of the symptoms.

Q. Again, going back to the first time that you examined her, when you were manipulating or examining her hip in the right area, did she make complaints of pain during the manipulation?

A. Well, I think she did, because I ordered the test here.

Q. Was it your understanding that she had an inability to bear weight, to walk secondary to that pain?

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A. Yes.

Q. Was she able to passively move her hip?

A. To a limited extent.

Q. The joint effusion, going back to the MRI results, typically, is there any other condition that you would consider in a patient who has observed joint effusion on an MRI?

A. Any other diagnosis than what?

Q. Then septic hip.

A. Yes.

Q. What else would it possibly be?

A. A severely arthritic hip will have a joint effusion. A fractured hip with some bleeding into the hip will have a joint effusion.

One of the common reasons that I see that now are that people are on Coumadin, and they have injury insufficient to fracture of the hip, but sufficient to cause bleeding, which is very painful.

Q. Is there a difference, Doctor, between joint effusion and edema in and

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around the hip?

A. It's a fine distinction, because with a joint effusion, you will get edema about the hip.

Q. Can you turn, please, to the actual MRI report of 10/15.

A. I'm --

Q. Just to be clear, it's the MRI of the pelvis without contrast.

A. I have it.

Q. In the third full paragraph,

Doctor, it says, quote, there is significant edema around the right hip, especially in the abductor muscle region, period. There is a small right hip joint effusion, close quote.

Tell me what those two sentences mean, Doctor.

A. Could you ask that in a more specific manner.

Q. Sure.

What do those two sentences mean to you after reading them.

A. Well, they mean that something

is going on in the hip.

Q. Do those two sentences represent the same area of the hip and do they represent the same thing?

A. They are close to each other. And to some extent, they do represent the same thing.

Q. In addition to evaluating a patient as you told me earlier, with history, examination and lab work, was it your understanding that Mrs. ' lab work had been somewhat normal up until the point that you had examined her?

A. No.

Q. Tell me what was abnormal or out of the ordinary as of the time that you first saw her on October 14th?

A. Well, the radiograph of the hip dated 10/20 -- well, that was after I saw her. I think there was one before that. But the MRI of the back --

Q. I'm sorry, Doctor. I was not clear. Let me go back.

When I refer to lab work, I'm

referring to blood work, and things of that nature.

I wanted to ask you as part of your evaluation whether you felt that Mrs. ' lab work or blood work had been in any way abnormal to suggest to you that there might be some type of infectious process going on.

A. Yes.

Q. And if you can, please, tell me what it was that suggested to you that she had some type of abnormality or infectious process going on.

A. On 10/15/2003, she had a positive urine culture.

Q. Other than the positive urine

culture which was ultimately treated, and I know a urologist was consulted as well, were there any other abnormalities that you observed in the lab work --

A. Prior to --

MR. : Just note my objection to the form.

MR. OGINSKI: I'll rephrase the question.

Q. Other than the positive urine culture, were there any other significant abnormalities that you observed either on the 14th or the 15th, when you saw her?

MR. : Are you talking about labs now or something else.

MR. OGINSKI: Just labs. Labs, blood work.

A. Yes.

Q. Tell me what you see.

A. She had an elevated white blood cell count.

Q. And what was that count, and when?

A. On admission, it was 14.4.

Q. From the time of admission up until a week later, were you able to tell whether that reverted to normal --

A. It did not.

Q. It stayed abnormal?

A. It did.

Q. As of October 15th, can you tell me what the white blood count was.

A. My record doesn't have October 15th.

Q. Do you have the 14th, or the 16th, Doctor?

A. I have 10/8, 10/9, 10/23 and 10/25.

Q. So it's going up at that point.

A. Yes.

Q. To your knowledge, Doctor, during the time that you were caring for Mrs. , did she ever have a history of fever?

A. No.

Q. Did she have an abnormal sedimentation rate?

A. I don't have a sed rate.

Q. What is the significance of a sed rate?

A. Any inflammation will raise the sed rate.

Q. The fact that she had an

elevated white count at some point throughout her hospitalization, was that consistent with the urinary tract infection

that was diagnosed, or was it possibly a component of some other infectious process that was going on as well, if you can tell me?

A. I could answer both to both of them.

Q. Can you tell me what synovitis is.

A. Yes.

Q. Please.

A. Synovium is a thin layer of cells that lines all the joints, all the major joints. It's a velvet-like structure. It's the common denominator to any irritation of the joint. That is to say if you were to bang your knee and it blew up or was sore, you would have some synovitis. If you fractured your knee adjacent to the joint, you would have some synovitis. If you tore your meniscus, you would have some synovitis. Anything that causes the joint to be inflamed will cause some synovitis.

Q. Are you familiar with a term

known as transient synovitis?

A. Yes.

Q. What is that?

A. This is a condition in children, and usually young children, and it's common, and the hip becomes -- the joint becomes inflamed. Clinical significance is to distinguish it from an infected hip. And it can be very difficult.

Q. In your opinion, Doctor, at any time that you were caring for Mrs. , did she have synovitis of the hip?

A. It was my opinion that she did have some synovitis of the hip.

Q. Had you formed any opinion as to the cause of the synovitis?

A. Yes.

Q. What was that opinion?

A. That she had a stress fracture.

Q. Are there other diagnostic tools that were available to you in October of 2003 that would assist you in confirming whether or not the patient had a non-displaced stress fracture?

A. More accurate than the MRI?
Q. Yes.
A. I think not.
Q. Generally, Doctor, the X-rays, are they the first diagnostic tool that you use to evaluate a potential fracture?
A. Yes.
Q. Are they best used to evaluate hard surfaces such as bone?
A. Yes.
Q. And in what circumstance would you then go to a CAT scan to evaluate a patient's boney structure?
A. The clinical problem to which you refer is where a patient, and this happens with great frequency, comes in with pain in the hip, with what appears to be a negative X-ray. What test you do next, you're correct, you could do a CT scan. It is the policy of the hospital that a rapid-sequence MRI is more accurate, and therefore that is what we do.
Q. And in your opinion, is that a better tool, diagnostic tool to evaluate

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the hard structure, the boney structures, as opposed to the surrounding soft tissue structures?
A. The difference in accuracy between the two tests is probably rated between one and two percent, for a sensitivity and specificity.
Q. Other than the CT scan and other than this rapid-sequence MRI, were there any other diagnostic tools available to you that would give you similar information or more accurate information about whether or not -- or give you confirmation that a patient had a non-displaced stress fracture?
A. Yes.
Q. What were they?
A. The only test I can think of would be a bone scan, and -- but it might not have been, because a bone scan can have a false negative too.
Q. Would it be accurate to say that on any of the diagnostic tools that you had available, there was always a possibility

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of false positives or false negatives?
A. Yes.
Q. In October of 2003, did University Hospital have a bone scan machine?

A. Yes.
Q. Was that one of the tools that was available to you, if you felt necessary, to have the patient undergo such a test?
A. Yes.
Q. At any time while was at , did you recommend or order a bone scan for her?
A. No.
Q. Is there any particular reason as to why a bone scan was not recommended or ordered?
A. I think we discussed that with the radiologist, and they didn't feel it would be helpful. Again, that's a recollection from the past.
Q. Do you recall whether that concerned the same conversation when

evaluating the MRI of the pelvis on October 15th?
A. I think it would have been at the same time, yes.
Q. How much fluid is necessary in order to perform an aspiration of a hip?
A. Well, I can't answer that -- I can give you a couple of sentences, but the answer is the probability of achieving a successful aspiration is proportional to the amount of fluid. The more fluid the more likely you'll get it, the less, the less likely you'll get it, and the range is from zero to a hundred. I've done a number of aspirations in my career of the hip, and it could be -- unless there's a significant amount of fluid, the word for it I think is -- I'm trying to think of it, they have the same thing in pathology, where the specimen doesn't contain the cells that represent the condition.
Q. Going back for a moment to the actual report of the MRI of the pelvis where it says that -- where Dr.

reports that there is significant edema around the right hip. What was it specifically that indicated or suggested to you that there was insufficient fluid there to withdraw as part of an aspiration?
A. That was his answer to me. I asked him do you think there's enough fluid in there that I can get it out with a needle, because they do that in the department of radiology. We could either

do it up in the operating room as the orthopedic surgeons or alternatively they have a relatively aggressive intervention radiologist.

Q. If you can, Doctor, I'm not talking about now, I'm only talking about the time period back in October of 2003.

A. This is applicable to October of '03. Dr. does this kind of work or did that kind of work, and it was his feeling that he could not -- we would not get fluid, and the way he would do it, he would do it with a CT guided needle, and I would do it with an image intensifier

needle, and I suspect that he's aspirated more hips than I have.

Q. Do you recall having a conversation with Mrs. or her family about this possibility, that she might have some type of infection in the hip, and there was some consideration about aspirating the hip?

A. No.

Q. No, there was no such conversation, or no, you don't recall any?

A. No, I don't recall any.

Q. Would you agree, Doctor, that in patients who do have a septic hip, that they don't always have fever or abnormal lab work?

A. Yes. Yes. I would agree.

Q. And is that because that infection might be localized to a specific area within the hip?

A. Part A of your question is true. Part B, I don't know why.

Q. Other than aspirating or attempting to aspirate that fluid in the

hip, which is suspected to be infected, is there any other way to evaluate that fluid, other than aspiration?

MR. : I object to the form.

MR. OGINSKI: I'll rephrase the question.

Q. The fluid that was observed as evidenced on the MRI report, and as seen on the films, is there any other way to evaluate that fluid, other than by aspirating it?

A. We talked about the bone scan. Sometimes a gadolinium-enhanced scan can show it better. And you can certainly

do -- open the hip surgically and culture it.
Q. When you remove fluid in some fashion from a possibly suspected hip, what is it that you're looking for? What are you looking at when you see that fluid?
A. You may see in that fluid, you may see that it's thick, opaque, white to green, or you may see that it simply

appears to be normal. In both cases, what you do is look at it under the microscope and do a gram stain and cultural part of it.
Q. If it turns out that the fluid is discolored or thick or -- as you described before, different colors, what does that suggest to you?
A. That would suggest infection.
Q. From grossly looking at it and seeing those discolorations and the thickness, what type of treatment do you give to the patient, once you make that diagnosis and recognize that there's some type of infection there?
A. Intravenous antibiotics is the most common treatment.
Q. In addition to removing that fluid, do you also send that for culture?
A. Yes.
Q. Once it's determined that there is some type of infectious process within that fluid, is it customary for you to call an infectious disease consult in

determining what's the best antibiotic to treat that particular infection?
A. Yes.
Q. In this particular case, at any time after October 14, 2003, did you ever consult with or ask for an infectious disease consult for Mrs. ?
A. No.
Q. If a patient has a septic hip that is unrecognized, can you tell me what type of injury or damage that infection can cause to that particular hip?
MR. : I'm going to object to the form of that question.
MR. OGINSKI: The reason I'm asking is because there are -- I'm going to the issue of damages and injuries with an unrecognized or undiagnosed condition, which I think applies here. So my question relates

to his knowledge of possible problems that can arise with an untreated infection in the hip.

MR. : It's awfully vague

though when you say unrecognized infection or --

MR. OGINSKI: I'll try and rephrase it.

MR. : If you can be a little more specific.

Q. Doctor, if a patient has a septic hip that is untreated, what type of injuries would you expect the patient to have as a result of that untreated septic hip?

MR. : When you say "untreated," are you having any time period in mind? That's where I have the problem. I mean this patient was seen fairly soon, as I understand it, after she got out of the hospital. When you say "untreated," it sounds like it's untreated for a long time.

MR. OGINSKI: Fair enough. No problem.

Q. In a septic hip that is not treated for that particular condition, can the patient suffer cartilage damage?

MR. : I'll let him answer over objection.

I still object to the form, but I'll let him move on.

A. Yes.

Q. How does that occur? In other words, why does that take place? Why or how?

MR. : Objection to the form.

MR. : I object to this whole line of questioning.

If you can answer it, go ahead.

A. The bacteria, if they are there, can produce toxic products to the cartilaginous surface.

Q. Can osteomyelitis result from an undiagnosed or untreated septic hip?

MR. : Objection to form.

MR. : Same objection.

He can answer.

MS. : Join.

A. This is a chicken-and-the-egg question. In a sense was it osteomyelitis

first or septic arthritis first.
Q. Can you just define for me osteomyelitis.
A. Osteomyelitis is infection in bone.
Q. What is osteonecrosis?
A. Osteonecrosis refers to bone death mostly around the hip which is not related to a bacterial cause.
Q. Can a septic hip ultimately result in destruction of the hip bone, need for hip replacement?
A. Yes.
Q. And how does that occur?
A. Well, by the mechanism that I mentioned.
Q. Going back to your first exam on October 14th, did Mrs. have any risk factors for poor outcome, to your knowledge, before she ever came into Hospital based on your examination and discussion with her?
A. No.
Q. Was it your understanding that

she had no prior hip pathology before she came into --
A. No. No.
Q. Can you turn, please, to the next note that you have --
By the way, let's go to your actual typewritten note that you have that came from I believe it's your own office.
A. My office.
Q. Doctor, if you can read your note dated October 14, 2003, the typewritten note.
A. This 72-year-old female is seen in the hospital in consultation and then transferred to our service.
Fundamentally, her problem is that she was admitted in what appeared to be a week's history of low back pain and pain down the right leg. She has had DepoMedrol IV without substantive improvement, and testing has included an X-ray which showed some degenerative changes and X-rays of the back which showed spinal stenosis.

My physical examination suggested arthritis of the hip.
I have spoken to the patient's family, and they would like to transfer her

to our service, period. I explained to them that we want to get a neurology consult and an MRI of the hip, because I think that this is the primary pathology.

Q. Can you explain to me how it is that you have a dictated note in your office record together with your handwritten note for this same date in the hospital?

A. Yes.

Q. Tell me, please.

A. It's our custom and practice to dictate notes of people we don't admit into the hospital.

For instance, if you go in because you're going to get your hip or your knee replaced, and we have no record, I make an office record, so that if people should call the office, speak to one of my partners, or my physician's assistant, we

have an -- some ongoing record of what we're doing and why they're there, and what hospital they're in.

Q. Let's turn back to the hospital record itself. And I would like you to go to the next note that you have after October 14th.

Is that the October 15th handwritten note, Doctor?

A. Yes, it is.

Q. Can you read that, please.

A. Neuro note appreciated. The patient got no help from the epidural, period. The MRI of the hip will be done and will be -- and would help to get an MRI of the pelvis.

Q. I just want to make sure I have that correct. The MRI of the hip will be done --

A. Will be done and will be -- and -- this single word I can't read, but to get an MRI of the pelvis.

Q. Had you formed an opinion as of October 15th as to whether an MRI of the

pelvis should have been done at any time earlier, before you came on to the scene?

MR. : Objection.

MR. : Objection.

MS. : Objection.

Q. The neuro note that you referred to, which neuro note are you referring to?

A. The consultation of 10/15.

Q. Was that by Dr. Chao?

A. Yes.
Q. Reading Dr. Chao's consult note, what was his impression -- overall impression?
A. Severe hip and right groin pain with movement. Normal deep tendon reflexes in knee and ankle and normal sensation suggests no significant sciatic nerve lesion, but the patient will need EMG studies to assess plexus injury, or consider pelvis MRI, agreed with MRI of hip.
Q. Had you spoken with Dr. Chao at any time after he had performed his consultation?

In other words, other than reading the note, had you actually spoken to him?
A. I don't recall.
Q. Do you have any memory as you sit here now of talking to Dr. Chao at any time while Mrs. was within the hospital under your care?
A. While she was in the hospital, I spoke to him. I don't remember the date of the conversation or the thrust of the conversation.
Q. Now, on the 15th, when you wrote your note, had you conducted an examination of Mrs. ?
A. Yes.
Q. First of all, what complaints, if any, had she made to you at the time of your examination on the 15th?
A. The complaints were the same as they were on the 14th.
Q. Is that something that you remember as you sit here now, or is that something that's recorded within your note?

A. Had they changed, I would have amplified the note.
Q. Your findings on examination, can you specify for me what they are, as they obviously are not recorded within your note.
A. They were pain in the groin and loss of motion of the hip.
Q. Were they any different than what you had observed the day before?
A. No.
Q. Is there any particular reason as to why you did not record your findings, your clinical findings on examination in

your 10/15 note?
A. Well, in a 24-hour period, nothing had changed, so I didn't -- I think most doctors, it's their customary practice to note changes, rather than clinically the same. Sometimes we write that.
Q. Again, Doctor, there's nothing in your note to indicate that things were the same or different at all, separate and apart from what you've already wrote?

MR. : Note my objection.
A. I don't understand that question.
Q. Sorry. I apologize.
Turn, please, to the next note that you have.
A. My next note?
Q. Yes.
A. 10/17.
Q. To your knowledge, did University Hospital employ orthopedic physician's assistants that were on staff at the hospital?
A. Yes.
Q. On those occasions when it was maybe a vacation or you were not seeing a patient physically within the hospital, what was your understanding as to how often those physicians' assistants would see an orthopedic patient?
MR. : Objection to the form.
MR. : Note my objection to the form as well.

I'll let him answer over objection.
A. At least every day.
Q. Did you typically talk to the physicians' assistants who had seen and treated your patient?
A. I did.
Q. In this particular case, there is a note on October 16, timed at 9:30, ortho PA note. Do you recognize the individual who wrote that particular note either by signature or handwriting?
A. It would have been only one of two people.
Q. Who would they be?
A. DD, who is not there anymore, and Glenn, who is not there anymore.
Q. And do you know DD's last name?
A. (phonetic) or

(phonetic).
Q. Do you know where DD works currently?
A. I don't know if she works currently.

Q. And the other individual was ?
A. Yeah.
Q. Do you know the last name?
A. .
Q. Doctor, when you returned back to the hospital on October 17th, was it customary for you to review the patient's medical records to see what changes if any may have occurred since you last saw the patient?
A. Yes.
Q. Do you recall reading over the ortho PA's note to see if there were any changes?
A. I don't recall reading that note.
Q. But was that your custom and practice back then, as it is now?
A. Yes.
Q. Going to your October 17 note, please, did you perform a physical examination?
A. Yes.

Q. On that date.
A. Yes.
Q. Could you read your note.
A. 10/17/03, the patient's range of motion is better.
The MRI equals stress fracture of hip, period.
Plan, traction and gradual mobilization next week.
Q. What was the purpose of the planned traction and mobilization?
A. The planned traction was to relieve her pain, because that's just well known in any rotating condition of the hip.
The gradual mobilization was because the fracture was very small, and I felt that the healing period would be sufficiently short. Rather than being six or 10 weeks, more in the range of three to four weeks, and that the risk of fracturing through it was not so high that we could afford to do that.
Q. In your career, Doctor, have you seen an atraumatic stress fracture similar

to the one that you were discussing here in this case?
A. I have.
Q. Other than traction and mobilization, is there any other type of treatment that is useful to treat this type --
A. Of stress fracture?
Q. Yes.
A. You can perform an internal fixation of the fracture.
Q. Was that ever considered?
A. It was.
Q. And tell me when it was considered.
A. When I first compared the MRI with the X-rays.
Q. Tell me what you saw or interpreted when you did that.
A. The cortex was not broken, and I thought protecting the hip would be sufficient to allow it to heal.
MS. : Do you mind if we take a quick break.

[A recess was taken.]
Q. Doctor, in the early stages of the septic hip, if X-rays are taken, would you agree that X-rays in the early stages would not usually show evidence of problem except maybe some soft tissue swelling?
A. They may not, correct.
Q. Within say a week of an ongoing septic hip process, would you possibly see some type of joint narrowing?
MR. : Just note my objection.
I'll let him answer, but it's vague.
Q. Again, on X-rays.
A. In a week, I don't think so.
Q. Would you see any type of evidence of osteoporosis or other boney changes within a week of septic hip?
MR. : Same objection.
I'll let him answer.
Q. On X-ray.
A. No, I don't think so.
Q. At what point in time would you

expect to see articular cartilage loss in a septic hip on X-ray?
A. I can't answer that in the form

asked.
Q. Is there a particular reason as to why you don't see evidence of bone loss in a septic hip soon after the process has started?
A. The statement is true, I'm not so sure I know why.
Q. Let's go back, please, to your October 17 note.
Had Mrs. ' complaints changed at all as of the 17th?
A. No.
Q. On your examination, did you conduct the same type of physical examination that you had done on each of the prior days?
A. Yes.
Q. And you actually apply your hands to her legs, to her back and to other parts of her body?
A. Yes.

Q. And were your findings recorded in your October 17th note?
A. No.
Q. Based upon your custom and practice, Doctor, can you tell me whether there were any significant changes between the prior two examinations and what you observed on October 17th?
A. What I observed on the 17th was that her range of motion was better than it had been the day before.
Q. And had you come to any conclusion as to why it was better?
In other words, was it because of the medication -- pain medication she was receiving or something else that you concluded --
A. I thought based on our working diagnosis, that she had a stress fracture of the hip, that putting her at rest had reduced the symptoms.
Q. Again, let me ask you to turn back, please, to the MRI of the pelvis without contrast. It's the October 15th.

The same one we've been discussing all along.
A. Yes.
Q. In the middle of the third paragraph, can you point out to me, Doctor, where specifically within this evaluation you felt or concurred with Dr. ' opinion about the possibility that there

was a non-displaced stress fracture.
MR. : Note my objection to the form.
MR. : You can answer.
A. The sentence that says there's a limited abnormality within the right femoral neck just superior to the intertrochanteric region which is low in signal on T1 and high in signal on T2 weighted images. This may represent a short fracture line. Less likely, this could represent a prominent vascular structure within the medullary cavity.
Yes. That's the part.
Q. And that was it?
A. Yes.

Q. And based upon your evaluation and viewing the actual films itself, was it your concurrence that Mrs. had or -- if you can tell me, possibly had a fracture?
A. Yes.
Q. Was it your opinion that the films that you were viewing were sufficient enough for you to make this diagnosis?
A. Well, they were the best we could get.
Q. Did you ever consider obtaining another set of films after October 15th to reconfirm whether or not there was, in fact, this type of fracture for which you were treating her?
A. Yes.
Q. At what point in time did you consider getting another set of films to reevaluate this condition?
A. 10/20/03.
Q. What films did you obtain on 10/20/03?
A. X-rays of the right hip.

Q. And for what purpose did you obtain X-rays on 10/20/03?
A. For the purpose to see whether or not this stress fracture had increased, decreased, remained the same, or other changes had occurred.
Q. Was there any particular reason as to why a repeat MRI was not re-obtained instead of X-rays at that time?
A. I didn't think that the time was sufficient in five days to justify the MRI.
Q. Based upon the X-rays that were on record on October 20th, they concluded

degenerative changes but no definite fracture or dislocation; is that correct?
A. That's correct.
Q. Based upon the fact that there was no definite fracture or dislocation, did your treatment plan change at all?
A. No.
Q. Did you consider aspirating Mrs. ' hip on October 20th once it was recognized that there was no fracture or dislocation --

0062

MR. : Objection --
Q. -- based upon the X-rays?
MR. : Objection to form.
A. The original X-ray, as you said, did not show the fracture.
The point of the X-ray was not to see if it was negative, but to see if it had become positive.
Q. Once the X-rays of October 20th reported that there was no definite fracture or dislocation, did you consider obtaining a repeat MRI to either reconfirm that there was, in fact, this non-displaced stress fracture, or to rule out that possibility?
A. I don't recollect -- the game plan through the entire process was at a reasonable interval of time, if we didn't satisfy that we were making it better, to repeat it, but I thought that the range would be more like two weeks, and this was based on the fact that the known problem with infection in a joint or in a bone is that the proportionate radiographic changes

0063

are slow to develop. And the more of these tests you do, the less likely you'll have to do them again. So allowing sufficient time to transpire for the thing to become positive so that it's easy to read was always an issue.
Now with specific regard to Mrs. , on having gotten that X-ray on 10/20, and I don't know what time of day that was done, this was reinforced by the finding on 10/21 that she was clinically getting better.
Q. Again, Doctor, we know that she had been on multiple pain medications. As of October 21st, had you formed my opinion as to whether the condition that you observed, that she was getting better as you described, was related to the use of

the pain medication?
A. Well, I thought it wasn't.
Q. To what, if any, did you attribute her getting better at that point in time?
A. Well, we had her at bed rest, in

traction, and if the diagnosis of a stress fracture was right, 90 percent of the time these things are going to heal themselves if you don't stress them. And I thought this was -- looking at our working diagnosis, that this was the way the thing was going.
Q. Were there any other discussions that you had with any radiologist after October 15th about the possibility of aspirating her hip from October 15th up until the time she was discharged on October 25th?
A. Not that I remember.
Q. Let's turn, please, to the next note you have in the record.
Do you have another note after October 17th, Doctor?
A. I do.
Q. By the way, on dates that you were not present in the hospital seeing and examining Mrs. , did you have a partner or somebody else in your office that would come to see and examine her?

A. Yes.
Q. Who would that be, if it was the same person?
A. Well, during her hospitalization, both Dr. and Dr. had --
Q. What was the last name, Dr. and --
A. .
Q. In your review of Mrs. ' records, did you see any notes written by either Dr. or Dr. ?
A. I did.
Q. Let's first go to your next note, and then I'll go back for a little bit to your partners' notes.
Is the next note you have on October 20th?
A. Yes.
Q. Can you read your note, please.
A. Feeling much better, will discontinue Duragesics and discontinue traction in a couple of days.

25 Q. The Duragesic is the pain patch
0066

2 or the pain relief?
3 A. Yes.
4 Q. And what was the purpose of
5 discontinuing the Duragesic?
6 A. I didn't think she needed it.
7 Q. Were you aware that Mrs.
8 was experiencing some type of mental status
9 change as a result of the medication she
10 was receiving?
11 A. I was aware that there was a
12 period of confusion. I didn't know whether
13 it was attributable to the medicine, the
14 prolonged hospitalization, the bed rest.
15 Q. At some point, once she was
16 taken off or tapered off some of her
17 medications, did the confusion issue
18 disappear?
19 A. It did.
20 Q. Now, if you can go back one or
21 two pages, Doctor, to another orthopedic
22 note that is written, it appears to be by a
23 Dr. , M.D., October 19th, timed
24 at 2010.
25 A. Right. I think I have it here.
0067

2 Q. Do you know who Dr. Floyd is?
3 A. I do.
4 Q. Who is he?
5 A. He was an orthopedic resident at
6 the time.
7 Q. I'm sorry to jump back to your
8 October 20th, note, Doctor. Did you
9 conduct another examination --
10 A. Yes. Yes.
11 Q. Was Mrs. -- did she make
12 any complaints to you on the 20th at all?
13 A. Well, she was still not feeling
14 well, but she was feeling significantly
15 better than she had before.
16 Q. As part of your examination,
17 again, Doctor, did you do the same type of
18 physical that you had done days earlier?
19 A. I did.
20 Q. Did you record any of your
21 findings in your note?
22 A. Well, in the fact that I was --
23 implicitly the fact that I was going to
24 discontinue the traction and she was
25 feeling better, I think that she allowed
0068

2 easier motion with less resistance and less
3 complaints.

Q. Is that something you have a specific memory of as you sit here now?
A. No. But it would be consistent with my practice.
Q. What is the next note that you have?
Doctor, is the next note you have for October 21st?
A. It is.
The patient continues to improve. Better range of motion and she can take axial pressure on her leg.
Plan, gradual increase in physical therapy, and reexamination.
Q. When you examined her, was she able to get up and walk?
A. Could she -- did I get her up and walk or could she.
Q. Did you, did you get her up --
A. I did not.
Q. You were aware that she was having physical therapy each day as per

your instructions?
A. Correct.
Q. Was it your understanding that the physical therapy was at some point helping you in making her feel better?
A. Yes.
Q. Let's go to the next note you have, please.
A. 10/22.
Q. Go ahead.
A. Okay. Doing well. Plan, discharge on Friday.
Q. Had you done any physical examination on the 22nd?
A. That would have been my standard practice.
Q. Is there anything to confirm as to what your physical findings were on that date?
A. My note that she's doing well would be inclusive with the range of motion, and the pain over the groin was better.
Q. Do you have another note after

October 22nd?
A. On the 24th.
Q. Can you read that, please.
A. I can.
Up out of bed in a chair. On intravenous for antibiotics for urine. To get renal ultrasound and renal profile,

period. Urology feels that the urine retention is not due to a neurogenic bladder.
Q. Did they tell you what they felt it was due to?
A. No.
Q. Did you form any opinion as to why she was experiencing the problem that she was?
A. For retaining her urine?
Q. Yes.
A. I thought it was due to the infection that they were treating her for, or to the long time she was recumbent in bed.
Q. Did you perform a physical examination on the 24th?

0071

A. Yes.
Q. What were your findings on the 24th?
A. That the leg was moving better, and she was continuing to improve.
Q. Do you have another note after the 24th?
A. I do not.
Q. Let's go -- there is a note on the 25th by an ortho, and timed at 1530. Do you recognize that individual's signature or the note?
A. I do.
Q. Who is that?
A. .
Q. Who is ?
A. He is the chief of orthopedics at Hospital, and we -- our group cross covers with them for the weekends.
Q. Can you, as best you can, read Dr. note.
A. Discuss with patient regarding discharge. Patient wish to leave today and would like to sign out AMA, if not

0072

discharged. Patient has urinary tract infection, currently being treated. Foley removed. Patient voided five cc's on her own. Patient understood risks and benefits of staying in versus leaving. Patient wished to leave at this time. Will discontinue with Cipro recommendation as above.
Q. Did you have a conversation with Dr. after the patient was discharged?
A. Yes.

Q. Tell me about that conversation.
A. This was I think on a Saturday afternoon, it might have been on a Sunday afternoon. But on Monday, he called me up and told me that she had been adamant with leaving, the family was prepared to leave, and if they didn't leave against medical advice -- he thought rather than inflaming the situation, he just told them what his advice was and gave them a prescription, and let them go.
Q. Did he indicate to you why they

0073

were so concerned about leaving at that point in time? Was there something specific?
A. I don't think -- other than wanting to leave, they made it clear to him.
Q. Had they expressed any dissatisfaction either about the care they were receiving at or by someone else necessitating the need to leave the hospital at that point?
MR. : Objection to form.
MR. : You're asking him what was said.
I'll let him answer.
Just note my objection.
Q. Was there anything more specific than what you've told me already that was creating a problem that they felt needed to be addressed elsewhere?
MR. : Note my objection to the form.
If you're asking him was there any further conversation on this point,

0074

I have no problem with that. But you're putting more into the question, I think.
MR. OGINSKI: Fine.
Q. Other than what you've told me, was there anything more specific that you remember being discussed?
A. No.
Q. Going back to the two partners that you mentioned and their notes, if you can, please, I would like to go through those notes.
A. Okay.
Q. If you can tell me what dates your partners' notes appear in the record, please do that.
A. 10/16.

MR. : Why don't you start on October 8th.
A. My partners.
Q. Your partners.
MR. : Go back from the beginning and -- the 16th could be the first, but just go through and be sure.

A. I believe 10/16 is the first.
MR. : Off the record.
[Discussion held off the record.]
Q. And whose note appears on 10/16 that you recognize?
A. Dr. .
Q. Can you read his note, please.
A. Yes. Reassessed right groin pain. Without -- and I can't read that word. Something range of motion right hip. With back pain or sciatica. Awaiting MRI results, right hip.
Q. What is the next note for?
A. For one of my partners?
Q. Yes.
A. 10/18.
Q. Can you read that, please.
A. 10/18/03 --
Q. That appears under the 12:15 note that's at the top?
A. Correct.
Q. Go ahead.
The orthopedic note that you're

referring to, Doctor, appears on the bottom half of the page?
A. Yes.
The first -- ortho is the first line. The second line is -- I think stable. Third line is in bed. The fourth line is NVF.
Q. Which stands for what?
A. I don't know.
MR. : Neurovascular intact?
THE WITNESS: It might be there.
A. It looks like negative groin pain. Negative GR. And then the last line, stable.
Q. You indicated on the second line it said what, stable twice? Does that say above?
A. Afebrile. It's afebrile.
MR. : Off the record.
[Discussion held off the record.]

Q. And which of your partners wrote this note?

A. .

Q. Let's go to the next one, please.

A. 10/19, ortho.

Q. And who wrote this note?

A. .

So the first line is feeling better. Still pain with right hip movement. NVF, probably neurovascular functioning. And then I think the last line is stable.

Q. After Mrs. was discharged from University Hospital, did you ever learn that she was admitted to St. Francis Hospital?

A. I did.

Q. How did you learn that information?

A. From my attorney.

Q. Separate and --

MR. : Just note my objection to that.

Q. After Mrs. was discharged on October 25, 2003, within the next few

weeks or months after that fact, did you learn from either Mrs. or anyone in her family that she had been admitted to St. Francis Hospital for further care and treatment regarding her hip?

A. I did not.

Q. Separate and apart from what you have learned from your attorney, did you review any of Mrs. ' medical records from St. Francis Hospital or anything that occurred to her after her discharge from ?

A. No.

Q. Have you reviewed Mrs. ' deposition transcript?

A. No.

Q. Doctor, are you Board certified?

A. Yes.

Q. In orthopedics?

A. Yes.

Q. Are you Board certified in anything else?

A. No.

Q. When were you Board certified?

A. 1979 or '80.

Q. Have you been recertified over time?
A. It's not necessary.
Q. Has your Board certification ever been revoked or suspended?
A. No.
Q. Has your license to practice medicine in the State of New York ever been suspended or revoked?
A. No.
Q. Are you licensed to practice in New York?
A. Yes.
Q. Are you licensed to practice in any other state?
A. Yes.
Q. Which other states?
A. .
Q. Is that an active license that you currently have?
A. No. I have inactive licenses in .
Wherever else I've lived. I forget.

Q. Doctor, have you published in the course of your career?
A. Yes.
Q. Can you tell me approximately how many publications you have?
A. About 20.
Q. Within the last five years, have you published?
A. Yes.
Q. Do you have a recent CV that you can provide your attorney with?
MR. : Yes. We'll provide it to you.
MR. OGINSKI: Thank you.
Q. Have you ever testified?
A. Yes.
Q. Approximately how many times as a defendant?
MR. : Just note my objection.
But I'll let him answer.
A. I think in the range of five. Or six.
Q. Have you ever testified as an

expert being called upon by either plaintiff or defendant to come into court and give expert testimony?
A. Yes.
Q. Approximately how many times?
A. Over the 30 years, early in my

career, I might have gone five or 10 times a year, and more recently, I don't think last year I went at all. So it's been a declining involvement.

Q. I should have clarified.

Have you ever been called as an expert in a medical malpractice matter?

A. I have.

Q. Can you just give me an estimate as to how many times you have testified as an expert in malpractice cases.

A. I think in the range of five to 10 times.

Q. Per year, over the --

A. Oh, no. My whole career. That's my whole career.

Q. Out of those five to 10 times, can you tell me how many for plaintiff, how

many for defendant?

A. I think they were all for defendant.

Q. What hospitals are you currently affiliated with?

A. here in , and in .

Q. In October of 2003, did you have the same privileges --

A. Yes.

Q. -- at and ?

A. I did. I did.

Q. Were your privileges at ever suspended in October of 2003 for any reason?

A. No.

Q. Same question as to Hospital.

A. No.

Q. To your knowledge, was Mrs. ' medical care and treatment discussed at any type of grand rounds given after she had been discharged to which you were present and participated in?

A. Not in the orthopedic department, no.

Q. Did you ever have any further conversations with Dr. who had originally -- who you had spoken to about the MRI of October 15th, at any time after Mrs. was discharged from Hospital on October 25, 2003?

A. I may have spoken to him again. I don't have a recollection of that.

Q. Can you turn, please, to your

dictated discharge summary.
There are notations -- now, Doctor, I see you looking at a copy of what I presume you had dictated on the hospital chart.
Is it customary that after you dictate the discharge summary, that you get a copy of that to go into your office chart?
A. It is.
Q. If you make changes and sign the discharge summary that appears in the hospital record, do you customarily make a

copy of that and put that copy somewhere else, either in a chart or elsewhere?
A. No. No.
Q. Can you turn, please, to that -- when I say "that," the discharge summary to which your counsel is referring to, that appears in the hospital record.
There are certain handwritten notations made on this page. Did you make those changes?
A. Yes.
Q. Am I correct, Doctor, that the copy that you have in your own record does not contain those handwritten changes?
A. Yes.
Q. If you can, please, just referring to the one that appears in the hospital record. I know we're using a copy. Can you read the sentence beginning with her initial assessment, where the first change appears.
MR. : I'm not sure what you're referring to.
Q. In the third line, it says her

initial --
MR. : Objection.
Q. Her initial assessment was probably disc herniation, however, it became clear with several days in the hospital that it was not low back with disc herniation.
Did I read that correctly?
A. Yes.
Q. But it became more suspect that this was a hip problem.
A. Correct.
Q. And we discussed that based upon your examination, that you felt it was hip pathology.
A. Correct.

Q. Going down to the bottom, under final diagnosis, tell me what you wrote, Doctor.
A. Edema right hip, question disc herniation.
Q. What did you mean by that?
A. I meant that the edema in the hip was significant, and I still remained

unclear that the stress fracture was the ultimate diagnosis.
Q. Contained within this discharge summary, did you indicate anywhere your thoughts that possibly Mrs. would benefit from an aspiration to evaluate that edema in the right hip?
MR. : I'm going to object to the form.
I don't think that's what he said.
Q. Did you have any opinion as of the time that you dictated the note on November 24, 2003, as to whether Mrs. had a component of a septic hip as of the time of her discharge on October 25th?
MR. : Can I hear that question back. That's a little bit complex.
[The requested portion of the record was read by the reporter.]
MR. : I understand where you're getting the 10/24 date from, but I don't know that he's testified to

that yet.
In other words, you're reading it correctly on the chart, but I don't think that's been established yet. That's one reason for the objection.
Q. Doctor, at the time of discharge, had you formed any opinion with a reasonable degree of medical probability as to Mrs. having some components of a septic hip at the time of discharge?
A. The best way I can answer that is to say I still had questions when I filled in this edema, right hip, disc herniation, and the chart is complete with stress fracture. When I filled these in, when I handwrote them in, compared to 11/24, I can't account for that date, what date that happened.
Q. If you -- I know that you were planning to see her in follow-up in the office, as you had originally intended.

What tests or treatment did you plan on providing to Mrs. had she returned to you to further evaluate whether

or not this was a stress fracture, or edema played some role in her ongoing problem?

A. Well, she should have been feeling a lot better if it were a stress fracture. I would x-ray it, and if she was feeling better, that would take care of the thing.

Alternatively, if she continues to be having problems, then I think repeating the MRI, the blood test and all that would be what I had in mind.

Q. Did you ever speak to Mrs. again after October 25th, when she was discharged from ?

A. I did not.

Q. Did you ever tell Mrs. or any of her family members after the October 20th X-rays of her right hip that you had seen some swelling or redness inside the hip or some type of infection around the hip?

A. I don't remember any conversations subsequent to that.

Q. Do you recall having any

conversations with Mrs. ' daughter or son-in-law at any time?

A. I do not.

Q. Do you recall either Mrs. or any of her family members asking what type of potential infection she might have, separate and apart from a urinary tract infection, that might be causing or attributing to her ongoing problems?

A. I do not.

MR. OGINSKI: Thank you, Doctor. I have nothing further.

MR. : No questions.

MR. : No questions.

MS. : I just have one question.

EXAMINATION BY MS. :

Q. My name is , and I represent Dr. .

Just turning to your conversation you had with Dr. , you said that he mentioned that there was difficulty with the patient.

Do you remember specifically what difficulty he was having with the patient.

A. I do not.

MS. : No further questions.

[Time noted: 12:21 p.m.]

_____

P , M.D.

Subscribed and sworn to before me this_____day of_____, 2006.

_____

Notary Public

I N D E X

REQUESTS

Page	Line	Description
80	11	Recent CV

CERTIFICATION

I, Cynthia A. Laub, a Notary Public for and within the State of New York, do hereby certify:

That the witness(es) whose testimony as herein set forth, was duly sworn by me; and that the within transcript is a true record of the testimony given by said witness(es).

I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 27th day of December, 2006.

_____

Cynthia A. Laub

* * *

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