DE-IDENTIFIED DEPOSITION OF AN OPHTHALMOLOGIST IN AN IMPROPERLY PERFORMED CATARACT SURGERY CASE

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 2   SUPREME COURT OF THE STATE OF NEW YORK
     COUNTY OF KINGS
 3   Index No.
4   - - - - - - - - - - - - - - - - - - x

5
                        Plaintiffs,
 6
            - against -
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10
                        Defendants.
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12   - - - - - - - - - - - - - - - - - - x
13                      April 24,
                        1:17 p.m.
14
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16        DEPOSITION of DR.               , a Defendant
17   herein, taken by the Plaintiff, pursuant to Order, held
18   at               ,                ,    , before
19          , a Notary Public of the State of New York.
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0002
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     A P P E A R A N C E S :
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 4
     THE LAW OFFICE OF GERALD M. OGINSKI, LLC
 5   25 Great Neck Road
     Great Neck, NY 11021
 6   Attorney for Plaintiff
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 9
     Attorneys for Defendant,
10   DR.
     BY:
11
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14   Attorneys for Defendant,
, MD
15   BY:
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Attorneys for Defendant,
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BY:
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(Appearances continued on next page.)
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0003
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2   A P P E A R A N C E S : (continued)
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Attorneys for Defendant,
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BY:
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0004
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2   IT IS HEREBY STIPULATED, by and between the attorneys
3   for the respective parties hereto that:
4   All rights provided by the C.P.L.R., and Part 221 of
5   the Uniform Rules for the Conduct of Depositions,
6   including the right to object to any question,
7   except as to form, or to move to strike any
8   testimony at this examination is reserved;
9   and in addition, the failure to object to
10 any question or to move to strike any testimony

11 at this examination shall not be a bar or
12 waiver to make such motion at, and is reserved
13 to, the trial of this action.
14 This deposition may be sworn to by the witness
15 being examined before a Notary Public other
16 than the Notary Public before whom this
17 examination was begun; but failure to do so
18 or to return the original of this deposition
19 to counsel, shall not be deemed a waiver of
20 the rights provided by Rule 3116 of the C.P.L.R., and
21 shall be controlled thereby.
22 The filing of the original of this deposition is
23 waived.
24 IT IS FURTHER STIPULATED, that a copy of this
25 examination shall be furnished to the attorney for the
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1
2 witness being examined without charge.
3 D R. , after having
4 first been duly sworn by a Notary Public of the State of
5 New York, was examined and testified as follows:
6 EXAMINATION BY
7 MR. OGINSKI:
8 Q Please state your name for the
9 record.
10 A , MD.
11 Q What is your present address?
12 A.
13 .
14 Q. Hello, Doctor.
15 Can you tell me why
16 Ms. suffered vision loss after her
17 cataract surgery on ?
18 A. On November 5, she did
19 not suffer vision loss after cataract
20 surgery of November 5, .
21 Q. When was the first time that
22 she experienced vision loss that you are
23 aware of?
24 A. I first examined Ms.
25 on September 26, . She presented --
0006
1 DR.
2 Q. That wasn't my question. I'm
3 sorry. I will rephrase it, Doctor.
4 By the way, you were referring
5 to your chart which is marked as Plaintiff's
6 1 for identification, correct?
7 A. Correct.
8 Q. Let's go back for a moment.
9 You performed cataract surgery
10 on Ms. on November 5, ,
11 correct?
12 A. Correct.
13 Q. That was done at
14 ?
15 A. Yes.
16 Q. Now, tell me, what is a

17   cataract?
18   A.   A cataract is when the lens
19   inside the eye loses its clarity.
20   Q.   How does that happen?
21   A.   It happens most often due to
22   age-related reasons.
23   It can happen because of
24   metabolic disease, it could happen because
25   of an injury to the eye.

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1   DR.
2   There are lots of reasons for
3   cataract to occur, but pretty much everybody
4   if they live long enough at some point in
5   their life will get a cataract.
6   Q.   Does it form a cloud over the
7   lens?
8   A.   Sometimes. In fact, it comes
9   from the Latin word for cloud.
10   Q.   How do you diagnose a
11   cataract?
12   A.   By physical examination.
13   Q.   Can you be specific?
14   A.   You look at the lens inside
15   the eye and if the lens does not appear to
16   be clear, that's diagnosis.
17   Typically you also make sure
18   there are no other reasons for decreased
19   visual acuity.
20   Q.   Typically if a patient has a
21   cataract, would you also see decreased
22   visual acuity as well?
23   A.   Yes.
24   Q.   Are there instances where you
25   diagnose a cataract and the patient has no

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1   DR.
2   loss of visual acuity?
3   A.   Yes.
4   Q.   How common is that?
5   A.   Fairly common.
6   Q.   What specific instruments do
7   you use to assist you in diagnosing a
8   cataract?
9   A.   I use a slit lamp, I use a
10   retinascope and other instruments available
11   in the office.
12   Q.   Like what?
13   A.   Indirect opthalmoscope, direct
14   opthalmoscope.
15   Q.   What is an intraocular lens?
16   A.   Intraocular lens is the type
17   of lens that gets put in the eye after
18   removal of the cataract.
19   Q.   What are endothelial cells?
20   A.   Endothelial cells are cells in
21   the cornea which keep the cornea clear.
22   Q.   What is Lasik, L-A-S-I-K?

23 A. Laser assisted surgery to
24 remove refractive error.
25 Q. Have you ever performed Lasik
0009
1 DR.
2 procedures?
3 A. Yes.
4 Q. What is PRK?
5 A. PRK is also a form of laser
6 surgery to remove refractive error.
7 Q. Have you ever performed PRK?
8 A. Yes.
9 Q. Is Lasik surgery a treatment
10 for cataract?
11 A. No.
12 Q. Is PRK surgery a method of
13 treatment for cataract?
14 A. No.
15 Q. How do you treat a cataract?
16 A. There's only one way to treat
17 a cataract, and that's to have it extracted
18 surgically.
19 Q. Are there different gradations
20 of cataracts?
21 A. Yes.
22 Q. Can you explain?
23 A. Typically from -- well, you
24 could describe mild, severe, intermediate.
25 Some physicians use the grading
0010
1 DR.
2 scale from one to four.
3 Q. What do you use?
4 A. I may use either.
5 Q. In terms of a mild cataract,
6 what would you expect to see on examination
7 in comparison to, let's say, an
8 intermediate cataract?
9 In other words, how do you
10 distinguish between the two?
11 A. It's really based on physical
12 examination, the appearance of the lens
13 through the slit lamp, the discoloration of
14 the lens, the shape of the lens. That's
15 the main difference.
16 The visual acuity is not a good
17 test for the density or severity of a
18 cataract.
19 Q. Tell me why.
20 A. There are some people who have
21 a very mild cataract whose vision is
22 severely impaired. There are some people
23 who have a very dense cataract whose vision
24 is not as impaired.
25 Q. In a patient with a severe
0011
1 DR.
2 cataract as an example, what is it that you

3 visually see on examination that
4 distinguishes a severe cataract from, let's
5 say, a mild cataract?
6 A. A lot of times my view through
7 the lens will be impaired, so when I try to
8 look beyond it, I will have a lot of
9 difficulties with a severe lens, I'll have
10 a little bit of difficulty through a mild
11 lens.
12 Q. How would you describe perfect
13 vision?
14 A. How would I describe perfect
15 vision?
16 Q. Yes.
17 A. Perfect vision is when a
18 patient -- or a person is happy with their
19 vision. That's perfect vision.
20 Q. Is there some medical standard
21 by which you as an ophthalmologist would
22 define a patient with perfect vision from a
23 medical standpoint?
24 A. From a medical standpoint the
25 definition -- there is no such thing as

2 perfect.
3 There's normal, but there is no
4 such thing as perfect. What is perfect for
5 you is not perfect for somebody else.
6 Q. When somebody uses the term
7 20/20 vision, what does that mean to you as
8 a physician?
9 A. That means that they have good
10 visual acuity.
11 Q. Is there a visual acuity that
12 is better than 20/20?
13 A. 20/15, 20/13, 20/10. Just so
14 that you know, the average visual acuity of
15 a baseball player is 20/15.
16 Q. Are you familiar with a term
17 known as J-1?
18 A. Yes, I am.
19 Q. What does that mean to you?
20 A. J-1 stands for Jaeger-1. It
21 is typically used -- Jaeger connotation is
22 typically used to describe near vision.
23 Q. Can you be more specific as to
24 what you mean?
25 A. No.

2 Q. When you say used to describe
3 near vision, do you mean near perfect
4 vision or something else?
5 A. I don't understand your
6 question.
7 Q. Sure. Have you used this term
8 J-1 in your practice?

9 A. Yes.
10 Q. And what do you use it to
11 mean?
12 A. Just like 20/20 is a
13 measurement of distance vision, J stands
14 for Jaeger, it's a measurement of near
15 vision. There is J-1, J2, J-3, J-4.
16 Q. Which is the best, if you can
17 categorize it?
18 A. I would have to look at the
19 chart. I'm not sure. There's J-1, I'm not
20 sure if anything is better, but J-1 roughly
21 correlates to 20/20, I would think.
22 Q. A patient who has 20/25
23 vision, what does that mean to you?
24 A. There's a definition as to
25 what those numbers stand for, so it's not

2 what it means to me.
3 Q. Tell me what that definition
4 is.
5 A. The definition is that this
6 person at 20 feet sees what an average
7 person with good vision sees at 25 feet.
8 Q. Would the same be true for a
9 person with 20/30 vision?
10 A. Exactly.
11 Q. And just so I'm clear, Doctor,
12 is a person with 20/20 vision, do they have
13 better vision than, say, someone who has
14 20/30 vision?
15 A. By one measure, yes, but
16 "better" is a very subjective term.
17 Q. Tell me what you mean by that.
18 A. People can have complaints of
19 glare even with perfect vision.
20 As a plaintiff's attorney you
21 are probably aware there are a lot of
22 lawsuits after laser vision correction where
23 people see 20/20 but they still complain of
24 poor quality of vision, so 20/20 and 20/25
25 by one measure you can compare, but you

2 can't say one is better than the other.
3 Q. Let's talk just about visual
4 acuity.
5 Is a vision measurement of
6 20/20 quantitatively better than someone who
7 has 20/30 vision?
8 A. Yes.
9 Q. What is phacoemulsion?
10 A. Phacoemulsification, I think
11 you mean.
12 Q. Yes.
13 A. Phacoemulsification is a
14 method of removing cataract from the eye.

15 Q. How do you accomplish that?
16 A. Carefully.
17 Q. What method do you use? What
18 procedure? How do you actually accomplish
19 that?
20 A. I use a phacoemulsification
21 machine and a host of instruments under
22 microscope in the operating room.
23 Q. What is the purpose of that?
24 A. To remove the cataract from
25 the eye.

1 DR.
2 Q. What is corneal edema?
3 A. Swelling of the cornea.
4 Q. How do you diagnose corneal
5 edema?
6 A. By physical examination.
7 Q. Are there specific instruments
8 that you can use that will help you to
9 evaluate and determine whether there is
10 corneal edema?
11 A. The most important way is by
12 examination. There are other instruments
13 that measure the extent of corneal edema,
14 but really physical examination is the most
15 typical and common.
16 Q. When you say "physical
17 examination," Doctor, do you mean that
18 simply by looking at somebody's eye you can
19 tell or do you need a specific instrument?
20 A. I will usually look through
21 the slit lamp in the office.
22 Q. In the course of your career,
23 have you had occasion to see and treat
24 patients with corneal edema?
25 A. It's a very common condition,

1 DR.
2 it occurs in everybody after surgery, so
3 yes.
4 Q. What is ocular hypertension?
5 A. That's when the pressure
6 inside the eye is elevated.
7 Q. How do you recognize that?
8 A. By measuring the pressure in
9 the eye.
10 Q. How do you do that?
11 A. With an instrument called a
12 tonometer.
13 Q. Are you familiar with a term
14 known as cystoid macular edema?
15 A. Yes.
16 Q. What is that?
17 A. That's swelling in the back of
18 the eye in the retina.
19 Q. How do you recognize that
20 condition?

21 A. There are different ways of
22 recognizing it. One is by examining the
23 retina with an instrument, one is by
24 measuring the thickness of the retina with
25 the various instruments, you can also take
0018
1 DR.
2 a picture of the retina with a special
3 camera.
4 Q. And again, in the course of
5 your career have you had occasion to see
6 and treat that condition?
7 A. Yes.
8 Q. What is a condition known as
9 eyelid ptosis?
10 A. Droopiness of the eyelid.
11 Q. Can you tell me, Doctor, what
12 a subconjunctival hemorrhage is?
13 A. It is a hemorrhage under
14 conjunctiva.
15 Q. How do you recognize that?
16 A. By physical examination.
17 Q. Do you need any specific
18 instruments to see that?
19 A. Typically not, but we usually
20 use instruments available in the office
21 such as a slit lamp.
22 Q. When you hear the term
23 nearsighted, what does that mean?
24 A. That the person sees better at
25 near than in the distance.
0019
1 DR.
2 Q. And what is farsighted?
3 A. When they see better far away
4 than up close.
5 Q. Can you tell me what is
6 Descenets tear?
7 A. Tear in one of the layers of
8 the cornea.
9 Q. How do you recognize it?
10 A. By physical examination.
11 Q. Specifically what instruments
12 do you need to recognize that?
13 A. Slit lamp.
14 Q. Have you had occasion to see
15 and diagnose and treat that particular
16 condition?
17 A. Yes.
18 Q. What is the purpose of
19 cataract surgery?
20 A. To remove the cataract.
21 Q. What are the risks of
22 performing cataract surgery?
23 A. The risks of cataract surgery
24 are similar to risks of any type of
25 surgery.
0020

1 DR.
2 Q. I would like you to be
3 specific, please.
4 A. The list of possibilities is
5 very long. It's too long to list here.
6 Q. I will rephrase the question.
7 A. Death, blindness, things not
8 going the way people would like.
9 Q. Tell me what you mean.
10 A. Well, there are lots of things
11 that can happen during surgery.
12 You could have bleeding. You
13 could have infection after surgery. You
14 could have a problem removing the lens. You
15 could have a problem with the lens.
16 I have had the misfortune of
17 being in the operating room when the power
18 went out and the back-up generator didn't
19 kick in.
20 I have been in the operating
21 room doing cataract surgery when patients
22 have suffered an asthma attack.
23 I have had the misfortune of
24 being in the operating room where people
25 have an anxiety attack and start coughing or

1 DR.
2 get short of breath.
3 The list is extensive.
4 Q. What is the most likely risk
5 of cataract surgery or the greatest risk?
6 A. The greatest risk is death.
7 Q. When you talk to patients
8 about the risks of procedure, would you
9 agree it would be important for you to
10 discuss with them the most likely risks?
11 A. Yes.
12 Q. Why?
13 A. They have to make an informed
14 decision.
15 Q. And if a doctor does not
16 disclose to a patient the most likely risks
17 associated with a proposed procedure, would
18 you agree that that would be a departure
19 from good practice?
20 A. Yes. That's why I make sure I
21 always discuss the common things that could
22 go wrong.
23 MR. : Off the record.
24 (Discussion held off the record.)
25 Q. Doctor, I am going to reask my

1 DR.
2 question.
3 I would like you to tell me not
4 what the most significant risk is, such as
5 death, but what the most common risk or set
6 of risks that are seen with performance of

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 7   cataract surgery.
 8        A.      Before I answer that question,
 9   I have to qualify it and say that cataract
10   surgery is a very safe type of surgery.
11   99 percent of cataract surgery is performed
12   without any complication.
13                Depending on the patient in
14   front of me, the risks vary.  Somebody who
15   has diabetes has one set of risks, somebody
16   with advanced age has a different set of
17   risks, somebody who had prior Lasik surgery
18   has a third set of risks.
19                The range of people who undergo
20   cataract surgery goes from little kids who
21   are born with cataracts to the elderly.
22                It is very hard to say globally
23   what is the greatest risk for that diverse
24   group of people.
25        Q.      I am going to narrow it down.
0023
 1                DR.
 2                Solely from a technical
 3   standpoint of performing the actual cataract
 4   surgery by you as an ophthalmologist,
 5   putting aside any co-morbid situations the
 6   patient may have that may change the risks,
 7   I would like to know, the performance of
 8   cataract surgery, what are the risks
 9   associated with that in and of itself?
10                MR. :  Objection.  You can
11        answer.
12        A.      The greatest risk that
13   typically happens that causes, let's say,
14   longterm problems for the patient is
15   difficulty with removing the cataract from
16   the eye.  That is the greatest sort of
17   thing.
18        Q.      And what would you consider to
19   be the next likely risk?
20        A.      Again, it depends on who we
21   are talking about.
22                If you would like to ask me
23   about a specific person, I will tell you
24   what it would be.
25                Or if you would like me to give
0024
 1                DR.
 2   you a typical conversation I have with a
 3   patient of a certain age, I will be happy to
 4   do it for you.
 5        Q.      I am only talking about adults
 6   without any co-morbid conditions.
 7        A.      What age?
 8        Q.      58 years old.
 9        A.      Prior surgery or not?
10        Q.      Yes.
11        A.      If you would like to know what
12   I told Ms.  --
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13 Q. Not yet. I will. Not yet.
14 I am just asking now in general
15 tell me the most likely risks associated
16 with performing cataract surgery.
17 A. The most likely risks of
18 performing cataract surgery are difficulty
19 removing the lens from the eye.
20 We might have postoperative
21 infection that could lead to blindness.
22 We can have an intraoperative
23 event that would require reoperation.
24 Lastly, I tell everybody that
25 when we pick a lens there is a margin of

2 error with our calculations, because the
3 calculations are mathematical formulas.
4 Q. What is that margin of error?
5 A. I typically tell patients who
6 have not had any prior surgery that
7 99 percent of the time it is plus or minus
8 0.75 diopters.
9 It's different for people who
10 have had prior surgery.
11 Q. What is it for people who have
12 had prior surgery?
13 A. There's no good way to
14 calculate intraocular lens for people who
15 have had prior surgery.
16 Q. I'm sorry. My question was
17 incorrect. You told me you tell patients
18 there is a margin of error when picking a
19 lens based upon whether the patient had
20 surgery in the past or did not.
21 You told me what the margin of
22 error was for a patient who did not have
23 surgery.
24 My question now only is what is
25 the margin of error for picking a lens with

2 a patient who has had surgery?
3 A. It's greater.
4 Q. How much greater?
5 A. I can't answer that. The
6 methods are not as precise because of prior
7 intraocular surgery.
8 Q. When you say that when picking
9 a lens there is a margin of error, do you
10 mean that in some instances the lens that
11 you pick may not be accurate for their
12 particular eye?
13 A. What I mean is that we have a
14 calculation that predicts a result, and
15 based on that calculation I pick a lens,
16 and sometimes it happens that the result is
17 not what we expected.
18 Q. Why is that?

19 A. There are any number of
20 reasons, including that the lens may be
21 mislabeled, the calculations were
22 incorrect, there's some sort of systemic or
23 one-time error during the measurements.
24 The list could go on and on,
25 but often we never find out why exactly, why
0027
1 DR.
2 there is an error.
3 Q. Now, when you are going to be
4 performing cataract surgery on a patient,
5 is that lens waiting for you at the
6 surgical center when the patient is going
7 to have the procedure or is it brought to
8 you or you take it with you? How does that
9 work?
10 A. I fill out a sheet, a lens
11 order form based on my review of the chart.
12 It's faxed to the surgical center.
13 When the patient is in the room
14 there is a time-out situation before surgery
15 is started. The nurse, I guess the
16 circulating nurse --
17 Q. I'm sorry to interrupt. I
18 will go through that with you, but do you
19 bring the lens with you?
20 A. No. It is procured by the
21 surgical center.
22 Q. Going back to the risks of the
23 cataract surgery and your discussion with
24 the patient about the risks, you have told
25 me if you don't discuss the risks with a
0028
1 DR.
2 patient, they can't make an informed
3 decision about whether to go forward with
4 the procedure, correct?
5 A. Yes.
6 Q. Do you have a specific memory
7 of talking to Ms. on the first
8 visit about this particular case?
9 A. Yes.
10 Q. Do you have a specific memory
11 about the specific risks that you told her
12 about in her particular case?
13 A. I specifically remember.
14 Q. I am not going to ask you yet.
15 I just want to know if you do.
16 A. Yes.
17 Q. Do you have in your notes
18 recorded anywhere specific risks that you
19 discussed with her?
20 I am not asking whether you
21 have a notation saying risks discussed. I
22 am now asking whether you have specific
23 risks that you recorded as having discussed
24 with the patient.

25 A. I do not have recorded -- I
0029
1 DR.
2 don't have a record of specific risks that
3 were discussed with the patient.
4 Q. Just so the record is clear,
5 Doctor, you are now looking at your note
6 for September 26, , correct?
7 A. Yes.
8 Q. Have you recommended cataract
9 surgery for patients who have had
10 20/20 vision?
11 A. Not that I recall.
12 Q. Have you recommended cataract
13 surgery for patients who have had 20/30
14 vision?
15 A. I may have.
16 Q. I missed one. Have you
17 recommended cataract surgery for patients
18 who have had 20/25 vision?
19 A. I may have also.
20 Q. Just to be complete, Doctor,
21 have you recommended cataract procedures
22 for patients who have 20/40 vision?
23 A. Yes.
24 Q. How do you determine if a
25 patient is a candidate for cataract surgery
0030
1 DR.
2 from an ophthalmological standpoint?
3 A. I would say the most important
4 thing to me is the patient's level of
5 satisfaction or dissatisfaction with their
6 visual acuity, their complaints.
7 If they are not complaining
8 with 20/40, I will typically not recommend
9 surgery.
10 However, if somebody is active
11 and does have complaints about their visual
12 acuity and the visual acuity interferes with
13 their lifestyle, I would -- I am more
14 comfortable offering early cataract surgery.
15 Q. If a patient has a complaint
16 of diminished vision as well as a
17 cataract -- I am going to withdraw the
18 question.
19 If the patient has no
20 complaints yet has some diminished visual
21 acuity, would you recommend cataract
22 surgery?
23 A. I would discuss the diagnosis
24 of the cataract with a patient based on
25 what you just said.
0031
1 DR.
2 Most people without a complaint
3 would not choose to have surgery.
4 Q. Now, let's go back to the

5 choosing the lens. You were talking about
6 margin of error.
7 How do you actually determine
8 and evaluate the strength of the intraocular
9 lens?
10 A. We have a few different
11 instruments that we use in the office.
12 Q. What are they?
13 A. We use the most advanced
14 instrument available called an IOL Master,
15 the latest software, version five, I
16 believe.
17 Q. What does that do?
18 A. It measures the eye for the
19 intraocular lens.
20 Q. And is this something the
21 patient looks into and then there is some
22 way for the machine to calibrate and
23 calculate what lens is necessary?
24 A. Absolutely.
25 Q. And how reliable is this

0032

1 DR.
2 device?
3 A. It is the most reliable device
4 on the market available today.
5 Q. I'm only talking now, Doctor,
6 about the treatment that this patient
7 received from you in September up to
8 January .
9 Is your statement the same for
10 that particular time period, putting aside
11 currently?
12 A. Yes.
13 Q. The margin of error you
14 described, is that from this particular
15 machine?
16 In other words, the calculation
17 that comes out of this machine, is there
18 some margin of error from that?
19 A. No matter what method is used
20 in calculating the intraocular lens, there
21 is a margin of error like in any
22 scientific, I guess, procedure or
23 experiment.
24 Q. When you are using this device
25 to evaluate the intraocular lens, the power

0033

1 DR.
2 that you are going to be putting in, are
3 there any other ways for you to measure the
4 strength of the intraocular lens without
5 using this device?
6 A. Yes. We have an ultrasound
7 machine called an A-scan.
8 Q. Anything else?
9 A. We use to supplement -- well,
10 are you asking me about how it was done in

11   Ms. 's case or --
12   Q.   In general in September of
13   .
14   A.   In September of a patient
15   that I would have seen would have had IOL
16   Master measurements and some duplicate
17   measurements just as a confirmation.
18   Q.   Those duplicate measurements,
19   what would you use?
20   A.   I typically remeasure the
21   corneal curvature.
22   Q.   With what?
23   A.   A machine called a
24   keratometer.
25   Q.   Why do you use these

2   additional devices to either compliment or
3   supplement the IOL Master?
4   A.   In this case or --
5   Q.   In general, Doctor.
6   A.   Generally in our office we
7   have a very rigorous program to keep track
8   of our outcomes, and the program has shown
9   that and occasionally the IOL master makes
10   a pair in the keratometry readings, and
11   that's why all patients get a number of
12   readings, just as an overabundance of
13   caution.
14   Q.   What happens if your
15   measurements are different from the IOL
16   master? What do you do in that instance?
17   A.   I use my experience to make a
18   decision.
19   Q.   If a patient presents to you
20   with a mild cataract, what is the risk to
21   the patient of not having any surgery?
22   A.   The risk? I don't understand
23   that phrase.
24   Q.   What will happen to a patient
25   if they have a mild cataract that is not

2   treated surgically?
3   A.   There is no risk. The
4   cataract will progress over time and at
5   some point down the line the patient will
6   require surgery, but there is no risk.
7   There is no immediate risk.
8   Q.   Are you able to predict over
9   what time period that cataract will get
10   worse?
11   A.   I have no way of predicting,
12   nor do I ever make predictions like that.
13   I do know that it is unlikely,
14   if ever, that the cataract will get better.
15   In fact, I could say a typical cataract does
16   not get better.

17 Q. Are you familiar with any
18 medical literature that describes the
19 length of time over which a cataract will
20 deteriorate and get worse?
21 A. Not off the top of my head.
22 There have been some epidemiologic studies
23 where visual acuity is measured over time.
24 I don't recall the result.
25 Q. I am only asking if you know

2 of anything specifically as we are here
3 now.
4 A. No.
5 Q. Would you agree, Doctor, that
6 when discussing with the patient any
7 recommendations of whether to proceed
8 forward with cataract surgery, that one of
9 the -- or at least part of the discussion
10 would include not doing the surgery at all,
11 what would happen?
12 A. I always -- that's part of my
13 discussion always. I always offer patients
14 a choice of not doing anything and waiting
15 six months to a year or longer for the
16 cataract to evolve.
17 In fact, what I always say is
18 cataract surgery is never an emergency like
19 cardiac surgery. It's elective, outpatient
20 surgery.
21 Q. Would you agree, Doctor, that
22 if an ophthalmologist fails to tell a
23 patient that one of the options is not to
24 go ahead with the surgery in light of a
25 cataract that that would be a departure

2 from good care?
3 MR. : Objection. You can
4 answer.
5 A. I don't know any doctor who
6 fails to tell the patient that the option
7 is not to have surgery.
8 Q. Let me rephrase it.
9 If a physician is recommending
10 the patient have cataract surgery, and
11 during that discussion they do not discuss
12 with them the fact that they could choose
13 not to do anything, would you agree if a
14 doctor does not tell the patient that they
15 can choose not to do anything that that
16 would be improper medical care?
17 MR. : Objection. You can
18 answer.
19 A. It's typically discussed, but
20 I am not an ethicist. I can't speak for
21 other doctors. I know that I always
22 discuss it.

23 Q. Why do you discuss it?
24 A. Because cataract surgery is
25 always elective, outpatient surgery.
0038
1 DR.
2 Q. Is the reason why you discuss
3 it with the patient because you want the
4 patient to know what their options are?
5 A. I always discuss it because I
6 want the options -- I want the patient to
7 know what their options are and I want to
8 impress on the patient that even safe
9 surgery carries certain risks with it.
10 Q. And if for whatever reason a
11 physician does not tell the patient all of
12 those options, the failure to tell the
13 patient about the available options, would
14 you agree it is a departure from good care?
15 MR. : Objection. You can
16 answer.
17 A. I think it's important to
18 discuss all the available options with the
19 patient, and I think not discussing all
20 available options is not the best care.
21 Q. What was your affiliation with
22 TLC in September of ?
23 A. I performed my Lasik surgery
24 at the in ,
25 .
0039
1 DR.
2 Q. How long have you had that
3 affiliation?
4 A. Probably for ten years, close
5 to ten years.
6 Q. Did you have any other
7 affiliation with them besides being able to
8 perform Lasik surgery at their
9 ?
10 A. Not that immediately comes to
11 mind.
12 Q. Are you familiar with a
13 program that has known as the lifetime
14 enhancement program?
15 A. Yes.
16 Q. What is that?
17 A. It's where the patient, if
18 they do their surgery at gets a
19 lifetime enhancement for free, at no cost
20 or something like that.
21 Q. Have there been instances
22 where patients have shown up for treatment
23 at and they have been referred to you?
24 A. As far as I know, including
25 Mrs. , no patients have ever been
0040
1 DR.
2 referred to me by .

3 Q. Do you know how it was that
4 Mrs. came to you?
5 A. I'm not sure how she came to
6 me, but she did mention that she was seen
7 at in in .
8 Q. Do you have any notation as to
9 who actually referred her to you?
10 A. She was referred by her
11 primary care physician, Dr. ,
12 .
13 Q. The note that you were looking
14 at, Doctor, to tell me who referred her,
15 where were you looking, Doctor?
16 A. I'm looking at the upper
17 right-hand corner of my progress note.
18 Q. I want you to assume that
19 Mrs. has given testimony in this
20 case that after being seen at --
21 A. Can I refer to a different
22 part of my chart --
23 Q. Sure.
24 A. -- and augment my answer?
25 Q. Yes.

0041

2 A. Just reviewing, I see that in
3 her new patient information form
4 Mrs. filled out she was referred
5 by the .
6 Q. And do you know how it was
7 that would have referred her to
8 you?
9 MR. : Objection.
10 A. I didn't ask her why --
11 MR. OGINSKI: I'm sorry. I
12 am going to rephrase the question.
13 Withdrawn.
14 Q. Did you have an arrangement
15 with that they would send you patients?
16 MR. : Objection.
17 A. Absolutely not.
18 Q. Did you receive any financial
19 compensation from for any patients that
20 they referred to you?
21 MR. : Objection.
22 A. No.
23 Q. Did you pay any financial
24 compensation or any type of financial
25 incentive to to have patients referred

0042

2 to you?
3 MR. : Objection.
4 A. No. I would guess --
5 Q. I don't want you to guess,
6 Doctor.
7 A. Do you want my opinion?
8 MR. : There is no

 9   question, so don't guess at anything.
10   MR. : I don't have a copy
11   of that.
12   MR. : Remind me, I will
13   make a copy before everybody leaves.
14   Just make yourself a note and I will
15   give it to you.
16   Q.   Doctor, let's talk about the
17   .
18   Do you practice together with
19   Dr. ?
20   A.   We are partners.
21   Q.   How long have you been
22   partners?
23   A.   Since year .
24   Q.   Can you explain to me your
25   partnership relationship?
0043
 1   DR.
 2   MR. : Objection.
 3   MR. OGINSKI: I will rephrase
 4   the question.
 5   Q.   Are you a shareholder of the
 6   ?
 7   A.   Yes.
 8   Q.   When did you become a
 9   shareholder?
10   A.   I started, I think in the year
11   , maybe . I don't recall exactly.
12   Q.   And in addition to being a
13   shareholder, are you also an officer of the
14   ? Do you have some title?
15   A.   I'm not sure. It's a two
16   partner group, so I'm not sure. I may be
17   the vice president. It was a joke.
18   Q.   Where is the office located?
19   A.   , ,
20   .
21   Q.   Do you have any other offices?
22   A.   We have a satellite office in
23   .
24   Q.   Was that office in existence
25   in September of ?
0044
 1   DR.
 2   A.   Yes.
 3   Q.   And am I correct that you
 4   treated Ms. solely at the
 5   office?
 6   A.   Yes.
 7   Q.   Now, when did you first start
 8   to work with Dr. ?
 9   A.   . August, July.
10   August .
11   Q.   And did you join him, did he
12   join you?
13   A.   I was an employee and then I
14   became a partner.

15 Q. At any time before you
16 performed cataract surgery on
17 Mrs. , did Dr. see or examine
18 this patient?
19 A. No.
20 Q. Did you have any conversations
21 with Dr. about this particular
22 patient before November 5, ?
23 A. No.
24 Q. In preparation for performing
25 this patient's cataract procedure, did you
0045
1 DR.
2 review any textbooks to refamiliarize
3 yourself with any aspect of the surgery you
4 intended to perform?
5 A. Can you repeat the question?
6 Q. In preparation for this
7 patient's cataract surgery, did you review
8 any textbooks prior to performing her
9 procedure?
10 A. I reviewed some articles.
11 Q. Which articles did you review?
12 A. I reviewed some articles on
13 calculating intraocular lenses on patients
14 after Lasik.
15 Q. Do you recall the names of
16 those articles?
17 A. No, I don't recall.
18 Q. Do you have those articles?
19 A. I could get you copies.
20 Q. How many different articles
21 were there?
22 A. I reviewed two or three
23 articles, and I have to make a note that
24 about, I would say, a few times a year I
25 perform cataract surgery on somebody who
0046
1 DR.
2 has had prior refractive surgery, so this
3 is not a one-time event.
4 Q. I am only asking about any
5 literature or textbooks that you reviewed
6 prior to her surgery in anticipation of her
7 surgery.
8 Do you recall the names of the
9 journals in which those articles appeared?
10 A. I would say
11
12 Q. By the way, Doctor, have you
13 published anything in any peer review
14 journal in the course of your career?
15 A. No. I have had a few
16 , but not articles.
17 Q. Have you contributed to any
18 textbooks in the field of ophthalmology?
19 A. No.
20 Q. Other than the articles you

21   mentioned, did you review any other medical
22   literature in preparation for this
23   patient's surgery?
24   A.   I would have to say yes, but
25   not specifically for this surgery. For
0047
 1   DR.
 2   this type of surgery.
 3   This is a -- this type of
 4   surgery is always complicated and uncertain,
 5   and so I keep current with the latest
 6   thinking on this subject matter, which is
 7   picking intraocular lenses for people with
 8   laser vision correction.
 9   MR. : Before you ask the
10   question next question, I have to use
11   the men's room.
12   (A short recess was taken.)
13   (Record read back.)
14   Q.   After reviewing the articles
15   that you described for me, did you
16   formulate or come to any conclusion as to
17   whether the calculations that you were
18   going to use for this patient's intraocular
19   lens were accurate?
20   A.   Can you repeat the question
21   again?
22   Q.   Sure. At the time that you
23   were reviewing these articles, had you
24   already calculated the intraocular lens you
25   were going to use for Mrs. ?
0048
 1   DR.
 2   A.   I believe I said I reviewed
 3   articles for cases like this, not for this
 4   specific case.
 5   Q.   Have you ever recommended
 6   cataract surgery for patients who have J-1
 7   vision?
 8   A.   Yes.
 9   Q.   And same question for J-2
10   vision.
11   A.   Yes.
12   Q.   And 3 and 4 as well?
13   A.   Yes. And J-1 minus.
14   Q.   Is that even better than J-1?
15   A.   No.
16   Q.   The J-1 plus, is that better?
17   A.   Yes.
18   Q.   Have you recommended cataract
19   surgery for patients with J-1 plus?
20   A.   I do not recall.
21   Q.   Out of the cases that you do
22   recall having performed or recommended,
23   have you ever recommended a cataract
24   surgery for patients with J-1 plus?
25   A.   I do not recall.
0049

1 DR.
2 Q. Did you use any type of
3 algorithm to assist you in performing this
4 patient's surgery?
5 A. Can you define algorithm or
6 explain it?
7 Q. Any type of document, like a
8 flow chart or decision-making tree, to use
9 that to assist you in performing this
10 particular procedure.
11 A. I used measurements that were
12 calculated, two sets of measurements.
13 Q. That's not what I'm talking
14 about, Doctor.
15 A. Nothing that's written.
16 Q. There came a time when
17 treating Mrs. that you performed
18 an intraocular lens exchange, correct?
19 A. Yes.
20 Q. What was the reason you
21 performed an intraocular lens exchange?
22 A. Mrs. was not happy
23 with the outcome of her cataract surgery.
24 Q. Under what circumstance would
25 you perform an intraocular exchange?

1 DR.
2 A. When the lens needsto be
3 exchanged.
4 Q. And is that solely based upon
5 a subjective complaint by the patient or
6 are there objective findings that you as a
7 physician can find using your equipment?
8 A. Both.
9 Q. Before actually performing the
10 corrective procedure on November 19, ,
11 did you use any instruments to determine
12 whether or not the patient's intraocular
13 lens which was put in on November 5 was in
14 fact the correct power?
15 A. There is no instrument
16 available that would calculate that without
17 removing the lens.
18 Q. What did you do in order to
19 objectively evaluate the patient's
20 intraocular lens from the time that the
21 patient had the procedure on
22 November 5th up until the time you did the
23 corrective procedure on the 19th?
24 A. We performed what's called
25 refraction.

1 DR.
2 Q. What is that?
3 A. When we measure the patient --
4 we measure the refractive state of the eye.
5 Q. How do you do that?
6 A. By refracting them.

7 Q. How?
8 A. Putting lenses in front of the
9 eye, what's better one or two, etcetera.
10 Q. Did you ever recommend to this
11 patient on September 26 that one way to
12 correct her visual acuity was with
13 eyeglasses?
14 A. Yes.
15 Q. What is contained within your
16 office record that confirms that?
17 A. There is a measurement,
18 there's a refraction of both eyes and the
19 visual acuity with those lenses.
20 Q. What lenses?
21 A. The refraction, the findings.
22 Q. The corrective lenses?
23 A. Right.
24 Q. What were the measurements for
25 those corrective lenses?
0052
1 DR.
2 A. Minus one, plus one, access
3 100 in the right eye. Minus one-half, plus
4 one-half, access 75, left eye.
5 MR. : This was before the
6 first surgery we are talking?
7 THE WITNESS: September 26.
8 MR. : Before the cataract
9 surgery.
10 MR. : Before anything.
11 Okay.
12 Q. That would tell you that you
13 measured the patient to see how --
14 withdrawn.
15 Tell me the purpose for doing
16 that.
17 A. This gives me what's called
18 best corrected visual acuity.
19 Q. What did the patient say to
20 you, if anything, when you performed that?
21 A. I'm completely not happy with
22 my right eye, I want to get rid of the
23 cloudiness right away.
24 Q. Did she make a complaint to
25 you of cloudiness?
0053
1 DR.
2 A. Yes.
3 Q. Do you have anything in your
4 notes for September 26th which would
5 confirm the patient's complaint of
6 cloudiness?
7 A. Give me a second to review my
8 notes.
9 Q. I'm specifically only asking
10 about September 26.
11 A. The chief complaint states
12 that the patient came for cataract

13 evaluation.
14 Q. My question, Doctor, was is
15 there anything contained within your notes
16 to confirm the patient's complaint of
17 cloudiness.
18 A. Not directly.
19 Q. Now, when the patient first
20 comes to your office, am I correct that
21 they fill out a form, general information
22 about any past medical history, correct?
23 A. Yes.
24 Q. And reason why they are there,
25 correct?
0054
1 DR.
2 A. They don't always fill out the
3 reason why they are there.
4 Q. But that's part of the form,
5 correct?
6 A. It lists past medical history
7 and allergies and stuff like that.
8 Q. Is there a part on your form
9 for patients to fill out to explain the
10 reason why they are there, what complaint
11 do you have, what problem brings you to
12 this office today?
13 A. I'm reviewing the form because
14 I don't think so.
15 Q. Doctor, I'm going to show you
16 a document dated September 26, and ask
17 if that's a copy of the document contained
18 in your record.
19 A. Yes.
20 Q. You have the original?
21 A. Yes.
22 Q. Have you brought all your
23 original records for this patient?
24 A. Yes.
25 Q. Are there any other records
0055
1 DR.
2 you have regarding this patient that you
3 have not brought with you today?
4 A. No.
5 Q. I understand you have not
6 brought with you your billing records,
7 correct?
8 A. Right.
9 Q. Where are those kept for this
10 patient?
11 A. On the computer system.
12 Q. I ask that after today you
13 obtain those records and provide them to
14 your attorney, please.
15 MR. : We will take it
16 under advisement.
17 You can ask me for anything
18 you want after the deposition, just

19   send me a letter and we will respond
20   accordingly.
21   Q.   On the patient's form she
22   filled out on September 26, Doctor, there
23   is a checklist of items for them to provide
24   as well as any details, correct?
25   A.   Yes.
0056
1   DR.
2   Q.   And under the first listing in
3   this checklist it has under the eyes, there
4   is a circle of poor vision, it's circled,
5   correct?
6   A.   Yes.
7   Q.   Is there anything on this page
8   that the patient completed that indicates
9   that her reason for coming to you was for
10   cloudy, anything cloudy in her eyes?
11   A.   Poor vision could be
12   interpreted as cloudiness.
13   Q.   It could be interpreted as
14   simply decreased vision because of a change
15   for many different reasons, correct?
16   MR. : Objection. You can
17   answer.
18   A.   I suppose.
19   Q.   How soon after Mrs. 's
20   November 5, procedure did she express
21   her displeasure with her outcome?
22   A.   The next day.
23   Q.   November 5?
24   A.   That would be November 6.
25   Q.   Right. I'm sorry. That was
0057
1   DR.
2   on follow-up to your office, correct?
3   A.   Yes.
4   Q.   Did you test her visual acuity
5   in her right eye at that time?
6   A.   Yes.
7   Q.   And what did you note her
8   visual acuity to be on November 6?
9   A.   20/100 uncorrected.
10   Q.   And before her surgery on
11   September 26, , what was her visual
12   acuity in her right eye uncorrected?
13   A.   20/40.
14   Q.   How would you describe the
15   change between the 20/40 to the 20/100?
16   A.   20/100 is typical for postop
17   day one.
18   Q.   Why?
19   A.   Because the eye just underwent
20   surgery. That's just the typical visual
21   acuity.
22   Q.   What is it about the surgery
23   that would cause a patient to have this
24   type of visual acuity following surgery?

25 A. There's some swelling of the
0058
1 DR.
2 cornea which is noted. Just general eye
3 inflammation.
4 Q. Did you consider this to be a
5 problem at that point?
6 A. No.
7 Q. Did you consider this to be a
8 surgical complication at this point?
9 A. No.
10 Q. Did you form any opinion as to
11 whether there was a problem with the
12 intraocular lens that had been inserted the
13 day before?
14 A. Based on Mrs. 's vocal
15 reaction, I decided to pursue the matter
16 further --
17 Q. My question was --
18 A. -- and get to the source of
19 her displeasure.
20 MR. OGINSKI: Can you read
21 the question back, please?
22 (Record read back.)
23 Q. I am not asking what you did
24 yet. I'm just asking on the day you saw
25 and examined her on November 26, did you
0059
1 DR.
2 form an opinion that there might have been
3 a problem with the lens?
4 MR. : I object.
5 I think that he answered that
6 question already. I think that he
7 said that he did not think it was a
8 problem.
9 Q. During the course of your
10 examination of the patient's right eye, did
11 you come to any conclusion that there was
12 a -- withdrawn.
13 Separate and apart from any
14 complaints the patient made, during your
15 examination did you come to any conclusion
16 that there might be a problem with the
17 patient's lens?
18 A. I do not recall.
19 Q. Is there anything in your
20 office record to indicate that there was a
21 problem or you formed an opinion that there
22 might be a problem with the patient's lens
23 as of November 6?
24 A. No.
25 Q. Going back to the November 26
0060
1 DR.
2 visit, Doctor, when you told me you
3 examined --
4 A. September 26 or November 26?

5 Q. Thank you. Let me withdraw
6 that.
7 Going back to September 26, the
8 first visit to your office when you
9 evaluated the patient with corrective
10 lenses, did you recommend to the patient
11 that one option or alternative is to have
12 contact lenses to correct her visual acuity?
13 A. I do not recall if contact
14 lenses were discussed.
15 Q. Is there anything in your
16 office note to indicate whether you
17 discussed contact lenses?
18 A. No.
19 Q. Was the use of contact lenses
20 an option for this patient on
21 September 26th?
22 A. Option for what?
23 Q. For treating her visual
24 acuity.
25 A. No.

1 DR.
2 Q. Why?
3 A. Her diagnosis is cataract and
4 treatment for cataract is not contact
5 lenses.
6 Q. Now, how did you characterize
7 this patient's cataract on September 26th;
8 mild, intermediate, severe or something
9 else?
10 A. Nuclear sclerotic.
11 Q. What does that mean?
12 A. It means that the center of
13 the lens is cloudy, the nucleus.
14 Q. Are you able to characterize
15 that particular cataract in terms of
16 severity, whether it's mild --
17 A. It's mild.
18 Q. In terms of the other grading
19 one through four, are you able to
20 characterize it in that fashion as well?
21 A. I did not grade it in my note.
22 Q. Are you able to put a grade on
23 it as we sit here now as to what you would
24 compare it to?
25 A. No.

1 DR.
2 Q. Is there a particular reason
3 why you could not do that?
4 MR. : Objection.
5 Q. Is there any particular reason
6 as you sit here now as to why you could not
7 comparatively relate your observation of
8 mild cataract to the grading system you
9 told me about earlier, one through four?
10 MR. : Objection. You can

11 answer.
12 A. The grading scale is not
13 helpful in my planning of the surgery.
14 That's why it's not used.
15 Q. Was performing another Lasik
16 procedure an option for this patient on
17 September 26?
18 A. No.
19 Q. Would another Lasik procedure
20 correct the patient's visual acuity?
21 A. No.
22 Q. Did you form an opinion on
23 September 26 as to whether this patient's
24 visual acuity change was a result of her
25 cataract?

2 A. Yes.
3 Q. What was your opinion?
4 A. That the patient's visual
5 acuity change was the result of her
6 cataract.
7 Q. Did you record in your notes
8 how long the patient had experienced a
9 change of visual acuity in her right eye?
10 A. No.
11 Q. Do you have an independent
12 memory as you sit here now as to how long
13 the patient had a change in visual acuity
14 prior to coming to you?
15 A. I remember her saying a few
16 months.
17 Q. Did Mrs. wear contact
18 lenses at the time she came to see you?
19 A. At the time of the visit, she
20 was not wearing contact lenses.
21 Q. Did she routinely wear contact
22 lenses?
23 A. No.
24 Q. Did she wear eyeglasses,
25 corrective eyeglasses?

2 A. Not that I am aware of.
3 Q. Is there anything in your
4 notes to indicate whether the patient did
5 have corrective lenses?
6 A. Actually, I apologize. Can I
7 change an answer to that?
8 Q. Yes.
9 A. She was wearing reading
10 glasses.
11 Q. Can you now tell me what it
12 was you just lifted up?
13 A. I looked at the record of the
14 eyewear, eyeglass measurements she was
15 wearing.
16 Q. Doctor, that little piece of

17 paper that looks like a receipt, tell me
18 what that is.
19 A. The two of them here, one is a
20 measurement from a machine that's called an
21 auto-refractor, the other one is from a
22 machine called a lensometer.
23 A lensometer measures the
24 prescription of the glasses that the patient
25 has.

2 Q. What was the significance, if
3 any, of the fact that the patient already
4 had reading lenses?
5 A. What is the significance?
6 It's typical to have reading glasses at the
7 age of 58.
8 Q. Did the fact that the patient
9 had reading glasses affect your decision as
10 to whether or not to recommend cataract
11 surgery?
12 A. No.
13 Q. Was anyone else present with
14 Mrs. on this first visit on
15 September 26, ?
16 A. As far as I can recall, no.
17 Q. Was anyone else in the office
18 with you at the time of your consultation
19 with the patient after your exam?
20 A. I do not recall exactly. I
21 would imagine there were secretaries
22 present at the front desk.
23 Q. On the day after the cataract
24 surgery on November 6th, when you mentioned
25 that the patient was not happy with the

2 outcome, am I correct that you told the
3 patient she needed to wait and give it
4 time?
5 A. Yes.
6 Q. And you wanted to wait to see
7 if the swelling decreased, correct?
8 A. Yes.
9 Q. How much time did you intend
10 to wait before taking any type of
11 corrective action?
12 A. I waited a week.
13 Q. And at that point what did you
14 do?
15 A. Mrs. was very vocal
16 in her disappointment and unhappiness.
17 On November 8th she came in for
18 an unscheduled visit. I examined her. I
19 performed a refraction on the right eye. I
20 found that the best corrective visual
21 acuity --
22 Q. You don't have to go through

23   your notes. I will go through them a
24   little bit later. I just want to know
25   specifically --
0067
 1   DR.
 2   A.   How long?
 3   Q.   Let's go back for a second.
 4   You mentioned that she came for
 5   an unscheduled visit on November 8.
 6   Is there anything in your note
 7   which indicates why the patient was there on
 8   November 8th?
 9   A.   There's nothing in my note,
10   but I distinctly remember that upon arrival
11   to the office she was very vocal. By
12   "vocal," I mean loud, some people might say
13   hysterical.
14   Q.   How would you say it? How
15   would you describe it?
16   A.   Very loud. Inconsolable. Not
17   proportional to the finding on physical
18   exam. Inconsolable. Unreasonable.
19   Q.   What was her problem that she
20   told you?
21   A.   I am blind.
22   Q.   She wasn't able to see out of
23   her right eye?
24   A.   She specifically told
25   everyone, I am blind.
0068
 1   DR.
 2   Q.   What did she tell you?
 3   A.   I am blind, crying.
 4   Q.   When you examined her were you
 5   able to confirm whether or not what she was
 6   saying was correct, in the layman's sense
 7   of not being able to see out of her eye
 8   correlating with her being blind?
 9   A.   I was able to confirm that she
10   had good visual acuity and a normal healing
11   process and that there was nothing
12   particularly wrong with her situation.
13   Q.   Were you able to confirm
14   whether she was able to see out of that
15   eye?
16   A.   Yes.
17   Q.   Was she able to see?
18   A.   Yes.
19   Q.   How do you correlate that with
20   her complaint that she was blind and unable
21   to see?
22   A.   I do not.
23   Q.   Did you check her visual
24   acuity on the 8th?
25   A.   Yes.
0069
 1   DR.
 2   Q.   What was it in her right eye?

3 A. Best corrected visual acuity,
4 20/25.
5 Q. And that means you are using
6 lenses to correct the vision?
7 A. Yes.
8 Q. What is her uncorrected visual
9 acuity?
10 A. I did not check it that day.
11 Q. Is there a reason why you did
12 not check her uncorrected visual acuity?
13 A. One of the most important
14 measurements is the best corrected visual
15 acuity. I wanted to make sure that her
16 best corrected visual acuity is good.
17 20/25 is almost perfect.
18 Q. In fact, it was better than
19 what she first started out with on
20 September 26, correct?
21 A. Yes.
22 Q. Did you form an opinion on
23 November 8 as to why this patient was
24 having these complaints that she expressed
25 to you in your office that day?

2 A. No.
3 Q. Now, going back to the
4 September 26th initial visit, Doctor, the
5 patient's best corrected visual acuity was
6 20/40, correct?
7 A. Yes, in the right eye.
8 Q. And you also noted that she
9 had J-1 for the right eye?
10 A. J-1 minus.
11 Q. And just so I remember it
12 correctly, that is a little bit less than
13 the J-1?
14 A. Yes.
15 Q. But better than J-2?
16 A. Yes.
17 Q. And in performing a cataract
18 surgery, Doctor, how much better did you
19 expect this patient's visual acuity to be
20 as a result of the cataract procedure?
21 A. I expected her to be
22 significantly better and not to have a
23 subjective complaint of cloudiness.
24 Q. Can you quantify, when you say
25 you expected her to be significantly

2 better, how much better?
3 A. I did not see a reason why she
4 could not achieve 20/20 with glasses or
5 without best corrected visual acuity of
6 20/20.
7 Q. Did you discuss with the
8 patient the risk of performing cataract

 9   surgery in order to accomplish the
10   difference between 20/40 visual acuity
11   compared to trying to get to 20/20 visual
12   acuity?
13   A.   Can you repeat the question?
14   Q.   Sure. You told me your goal
15   of performing this patient's cataract
16   surgery was hopefully to try and achieve a
17   best corrected vision of 20/20.
18   Did you discuss with her the
19   risks of performing the cataract surgery in
20   order to try and get to that goal?
21   A.   Yes.
22   Q.   And did you discuss with her
23   the benefits of doing this procedure?
24   A.   Yes.
25   Q.   And the benefits were that the
0072
 1   DR.
 2   cataract would be gone and she would have
 3   improved vision, correct?
 4   A.   Yes.
 5   Q.   And the risks --
 6   A.   One of the benefits.
 7   Q.   By the way, do cataracts
 8   recur?
 9   A.   No.
10   Q.   If a patient has a cataract
11   surgery where an intraocular lens is put
12   in, can the patient later on develop a new
13   cataract in that eye?
14   A.   No.
15   Q.   Was it your opinion that this
16   patient's recommendation for cataract
17   surgery -- withdrawn.
18   Was it your opinion, Doctor, on
19   September 26 that the benefits of performing
20   this cataract surgery outweighed the risks?
21   A.   I discussed the risks and
22   benefits with the patient. We both made
23   the decision together. I did not make the
24   decision for the patient to proceed with
25   the surgery.
0073
 1   DR.
 2   Q.   Would you also agree that
 3   there are instances where you as a
 4   physician will make a recommendation to the
 5   patient and your recommendation, if phrased
 6   properly, will certainly induce or entice a
 7   patient to do one thing instead of another?
 8   MR. : Objection.
 9   MR. OGINSKI: I will rephrase
10   it.
11   Q.   Putting aside any comment made
12   by Mrs. , was it your opinion that
13   the benefits of performing cataract surgery
14   on this patient in her right eye outweighed

15   the risks?
16   A.   I recommended the surgery if
17   the patient was bothered by vision, by her
18   current situation.
19   I explained to the patient the
20   only way to get rid of her cataract and to
21   improve her visual acuity is to have it
22   removed.
23   I also explained to the patient
24   that her other eye is 20/20, which has good
25   vision, and many people in her situation

2   choose not to proceed with surgery.
3   I also impressed on her that
4   this is elective, outpatient surgery and
5   there is no rush to do it.
6   Q.   What was her reply to you?
7   A.   I want to get rid of it as
8   soon as possible.
9   Q.   And is that something that you
10   recall?
11   A.   It's something that I recall
12   and it's something I recall -- I recall her
13   sentiments. It's not written down.
14   Q.   And from a medical standpoint,
15   was it your opinion that the patient would
16   far benefit from having the cataract
17   surgery in comparison to any risks that
18   were associated with it?
19   A.   My medical opinion is that she
20   would benefit from cataract surgery.
21   Q.   Going back to , Doctor,
22   were you aware of any list maintained by
23   by them so that if a patient came from
24   a particular area; , ,
25   , they would then direct a patient to

2   a doctor who was located in any one of
3   those geographic areas?
4   MR. : Objection.
5   You are asking him to know the
6   procedures, what is doing?
7   MR. OGINSKI: If he knows.
8   A.   I am unaware of any
9   arrangement. Never benefited from.
10   Q.   When you were calculating this
11   patient's intraocular lens, at the time of
12   doing this calculation did you use the IOL
13   master?
14   A.   Yes.
15   Q.   Did you use the keratometer?
16   A.   Yes.
17   Q.   Did you also use the A-scan?
18   A.   I did not use the A-scan.
19   Q.   Were the findings with the
20   keratometer consistent with the IOL master?

21   A.   Yes.
22   Q.   Did you have any reason to
23   disagree with the calculations that you
24   arrived at with the keratometer?
25   A.   I did. Did I have -- well --
0076
 1   DR.
 2   Q.   I'm only talking about before
 3   you did the surgery.
 4   A.   Can you read back the
 5   question?
 6   Q.   I will rephrase it.
 7   When you perform the
 8   measurements using the keratometer to
 9   calculate the intraocular lens power, after
10   coming up with those measurements did you
11   feel that those were accurate?
12   A.   I wasn't sure.
13   Q.   What did you do next to either
14   confirm that or to rule it out?
15   A.   I did another set of
16   measurements.
17   Q.   Using what?
18   A.   Historical numbers which had
19   come from .
20   Q.   And how did you do that?
21   A.   I called , I spoke to a
22   patient consultant. I asked them for these
23   measurements. They gave them to me over
24   the phone.
25   I plugged the numbers into the
0077
 1   DR.
 2   spreadsheet and I pushed the calculate
 3   button.
 4   Q.   The numbers that were given to
 5   you by , what timeframe did those
 6   numbers come from?
 7   Were they from when the
 8   patient had her surgery?
 9   A.   Yes. They are preoperative
10   measurements.
11   Q.   How was that going to assist
12   you in calculating the intraocular lens
13   measurement?
14   A.   One of the techniques to
15   measure the intraocular lens in a patient
16   who has had refractive surgery is to use
17   historical data.
18   Q.   And when you plugged in that
19   information into the program, did you get
20   different numbers from the way you
21   calculated it using the keratometer?
22   A.   I don't believe so. In fact,
23   I remember getting exactly the same
24   numbers, but I will tell you in just a
25   second.
0078

1 DR.
2 (Pause.)
3 A. I got just about the same
4 numbers.
5 Q. At what point in time did you
6 begin to question the intraocular lens
7 measurements after the original procedure
8 was done?
9 A. I never questioned them.
10 Q. Did you ever feel that the
11 measurements for the intraocular lens were
12 incorrect?
13 A. There are two ways to answer
14 it.
15 Do I think that there's -- I
16 think the best tools available to me at the
17 time produced an unexpected outcome.
18 Q. Tell me what you mean.
19 A. What I mean is based on my
20 experience using a number of techniques,
21 sometimes even in one patient will get one
22 eye that's perfect using these techniques
23 historical and actual, and we get the other
24 eye which uses the same measurements, but
25 we get a situation where the result is not

1 DR.
2 what we expected because of prior
3 refractive surgery.
4 Q. You told me that it can
5 produce unexpected outcome, an unexpected
6 outcome.
7 Prior to surgery, knowing that
8 the patient had -- you were aware the
9 patient had prior corrective surgery, what
10 steps are you able to take in order to
11 prevent such an unexpected occurrence from
12 occurring?
13 A. We analyze our outcome data to
14 make sure there is no systematic or
15 reproducible error.
16 Q. I want to be clear, Doctor.
17 The unexpected outcome you described, what
18 exactly are you talking about?
19 A. Both sets of calculations
20 predicted that if I implant the 19-diocter
21 lens, I should get a result outcome that's
22 very close to plano.
23 Q. "Plano" is what?
24 A. Zero refractive error. Very
25 close. I have two different ways of

1 DR.
2 calculating, and both of them produced very
3 similar outcome.
4 Q. And now the unexpected outcome
5 you told me about, what exactly were you
6 talking about?

7 A. The unexpected outcome is that
8 when we measured Mrs. 's refraction
9 after surgery, we got a significant -- or
10 we got a refractive error.
11 Q. Tell me what that means.
12 A. It means she needed glasses to
13 get the best corrected visual acuity.
14 MR. : Can I just ask,
15 what would be an acceptable result?
16 THE WITNESS: Well, acceptable
17 to the patient. If the patient is
18 happy, that is acceptable.
19 MR. : 20/20 would be
20 acceptable, 20/25, 20/30 acceptable?
21 THE WITNESS: Depends on the
22 personality. You need 20/40 to drive,
23 let's say, so many people are
24 comfortable with 20/40 or better, but
25 not everybody.

2 20/40 after Lasik correction,
3 let's say, is not typically acceptable
4 to the patient.
5 20/40 after cataract surgery,
6 to an older person it might be more
7 acceptable. It's not like a set --
8 MR. : I see. Okay.
9 Q. How do you account for this
10 unexpected outcome?
11 A. I don't understand your
12 question.
13 Q. How did it happen where she
14 now needed glasses to correct the
15 refraction error in light of the
16 intraocular measurements that were done
17 preoperatively?
18 A. It's one of the -- there's no
19 good explanation per se, but there's a --
20 you know, to answer correctly I would have
21 to do a surgery on the other eye to do a
22 scientific study.
23 I don't have a scientific
24 accounting for you, but I would imagine --
25 well, that's all I am going to say.

2 Q. Would technical error during
3 the surgery account for one reason why the
4 patient might have a problem with what you
5 described as an unexpected outcome?
6 A. No.
7 Q. Would a defect or problem with
8 the calculations or the machine that's used
9 to calculate the intraocular lens power
10 account for the need for this patient to
11 have glasses to correct the refraction
12 error?

13 THE WITNESS: Can you read
14 that back?
15 (Record read back.)
16 A. You are asking me to
17 speculate. You didn't say did. You said
18 would. I can't speculate. That is your
19 job.
20 Q. Did you ever tell
21 Mrs. why she had this outcome?
22 A. We discussed with
23 Mrs. before surgery that picking a
24 lens for patients that have had prior
25 refractive surgery is more difficult.

0083

1 DR.
2 Q. And what can you do as a
3 physician in planning this type of
4 procedure that you are recommending to
5 minimize the risk of this type of outcome?
6 A. I did everything I could.
7 Q. Is there anything else that
8 could have been done that was not done in
9 order to minimize the risk that this
10 patient would have the outcome that you
11 described as an unexpected outcome?
12 A. Nothing that works based on my
13 experience.
14 Q. Did any of the literature you
15 reviewed discuss this particular outcome?
16 A. I do not recall.
17 Q. Now, the fact that the patient
18 needed glasses to correct the refractive
19 error, does that mean, that her visual
20 acuity was worse than when she started?
21 A. No. It's better.
22 Q. From a practical standpoint,
23 from the patient's view what is the effect
24 of her needing glasses to correct the
25 refractive error?

0084

1 DR.
2 MR. : Objection.
3 MR. OGINSKI: I will
4 rephrase.
5 Q. This refractive error you told
6 me about, what is the practical effect of
7 that to the patient?
8 MR. : Objection.
9 You are asking him to answer
10 about how it would affect, what her
11 state of mind is? I don't understand
12 what you are asking.
13 Q. You told me about the
14 unexpected outcome, the patient now would
15 need glasses to correct this refractive
16 error. Why would she need glasses?
17 A. To get the best quality of
18 vision.

19 Q. If she does not use
20 eyeglasses, what type of vision will she
21 have?
22 A. Blurry.
23 Q. Are you familiar with
24 something known as finger counting?
25 A. Yes.

2 Q. What does that mean?
3 A. As a figure of speech or as a
4 measurement of visual acuity?
5 Q. As a measurement of visual
6 acuity.
7 A. The patient can count fingers
8 usually if you mark the distance how close
9 to the face.
10 Q. I would like you to turn,
11 please, to the September 26 notes, please.
12 I would like you to read, I am
13 going to have you read your notes, Doctor.
14 You don't have to read the
15 computerized measurements. I just want to
16 know about your handwritten notes, beginning
17 at the top.
18 If there is an abbreviation,
19 please tell me what it represents. Don't
20 read the abbreviation, just tell me what it
21 is.
22 A. September 26, . There is
23 a circled E which means eligibility or
24 validity of insurance was checked by EB.
25 There is the patient's name, ,

2 there's consult, and then there is
3 Dr. on the right-hand side.
4 It says 58-year-old woman,
5 complaining of and referred by Dr.
6 for cataract evaluation, OD.
7 Past ocular history, it says
8 PRK OU .
9 Q. That means both eyes?
10 A. Yes.
11 There's manifest, big letter
12 MODOS which is where we document her
13 refractive error and the visual acuity, and
14 it says 20/40 plus 3 in the right eye, 20/20
15 in the left eye, with the proper reading
16 glasses, she was able to see J-1 minus in
17 the right eye and J-1 in the left.
18 Go on to the physical exam,
19 there is visual acuity, OD 20/40, OS 20/20,
20 there is the measurement of the near vision
21 J with her current glasses which is J-1
22 minus and J-2, there's the pressure, TA,
23 which is tonometry applanation at 18 in the
24 right eye, 15 in the left eye.

25 Q. That is within normal limits?
0087
1 DR.
2 A. Yes.
3 On the left-hand side, there
4 are some markings that certain measurements
5 were TOMY, and also IOL master performed to
6 determine lens.
7 For IOL calculations, there are
8 a whole bunch of check boxes, which means
9 everything was normal, except for when we
10 get to the lens it says cataract on the
11 right-hand side and NS on the left-hand
12 side.
13 Q. Doctor, where do you have
14 cataract written?
15 A. On the right-hand side.
16 Q. If you could just point it to
17 me.
18 A. Right here.
19 There's also underneath a
20 notation that the patient was dilated and a
21 retinal examination was performed,
22 everything appeared normal.
23 There is assessment, it says
24 visually significant cataract OD, underneath
25 it says risks and benefits discussed.
0088
1 DR.
2 Q. Let me stop you for a second.
3 You wrote visual significant cataract?
4 A. Yes.
5 Q. And how do you distinguish
6 those terms with what you told me earlier
7 as describing this patient as having a mild
8 cataract? Are they the same, different?
9 A. Visually significant cataract
10 means that the vision is impaired by
11 cataract --
12 Q. Go ahead, please.
13 A. -- as opposed to not visually
14 significant cataract, where the patient has
15 no complaints, I would just write cataract.
16 Q. Go ahead.
17 A. Risks and benefits discussed.
18 Get records from .
19 There are other notations that
20 were made by other people, not me.
21 It says booked 11/5/07,
22 cataract extraction OD with IOL. There's a
23 signature and authorization number from the
24 insurance company.
25 Q. How is it that the patient saw
0089
1 DR.
2 you that day instead of Dr.
3 A. I'm not sure how she came to
4 see me. I have no idea.

5 Q. Do you recall the patient
6 asking you any questions during the
7 consultation?
8 A. Yes.
9 Q. What did she ask?
10 A. What happens if I don't do
11 surgery.
12 Q. And your reply?
13 A. I said the vision will stay
14 the way it is for now and will gradually
15 get worse.
16 Q. What, if anything, did she say
17 in response to that?
18 A. I want to get rid of the
19 cataract right away. I don't want to walk
20 around with it. Something to that effect.
21 Q. Did she ask any other
22 questions that you recall as you sit here
23 now?
24 A. We discussed the procedure for
25 cataract.
009
1 DR.
2 Q. I just want to know if you
3 remember any questions that she asked.
4 A. She asked typical questions
5 people ask during discussion, like --
6 Q. I'm sorry, Doctor. I don't
7 want to know generally. I want to know
8 specific if you recall as you sit here now.
9 A. She asked about the recovery
10 period.
11 Q. Your answer?
12 A. Usually from a few days to a
13 few weeks.
14 Q. Any other questions that she
15 asked?
16 A. No, not besides the typical
17 general questions that people ask.
18 Q. Are there any other specific
19 questions that you recall her asking?
20 A. No.
21 Q. Now, once you determined what
22 intraocular lens you were going to use, you
23 sent that information over to the
24 ambulatory surgery center in anticipation
25 of this patient's surgery?
0091
1 DR.
2 A. At some point before surgery,
3 I typically forward the request for the
4 lens.
5 Q. And immediately prior to
6 performing the surgery on the day of
7 surgery when you are at the surgical
8 center, do you personally make sure that
9 the lens that you have is the same one that
10 you requested originally?

11 A. Yes.
12 Q. Did you do that in this case?
13 A. Yes.
14 Q. Was there anything you found
15 to be unusual or abnormal about either the
16 packaging, about the lens itself, about the
17 contents of it compared to the requirement
18 that you had as to what power lens this
19 patient was going to have?
20 A. No. The lens comes in a
21 sealed box, and the sealed box appeared
22 normal.
23 Q. Lets go to the first
24 postoperative visit on November 6th.
25 Again, I am going to ask you to

2 read your note. First, before that, I want
3 to read the November 5th note you have,
4 please.
5 A. It says cataract extraction OD
6 with IOL at Brook Plaza ASC. There's a
7 sticker for the lens implant. It says very
8 hazy, and it says rhexis.
9 Q. What do you mean by "very
10 hazy?"
11 A. It's more of a note to me that
12 the view during surgery was a little bit
13 hazy or very hazy.
14 Q. Tell me what the significance
15 or implication is of that.
16 A. There's no significance to
17 anyone other than me really, a note what to
18 expect on the first day perhaps. I don't
19 recall what the significance is, but --
20 Q. Was this --
21 A. -- it is a typical
22 intraoperative notation.
23 Q. Is this a finding that you
24 would typically expect to have when doing
25 cataract surgery?

2 A. Sure.
3 Q. Is there anything unusual
4 about this particular observation?
5 A. No.
6 Q. The term rhexis, what does
7 that mean?
8 A. Rhexis is part of the
9 procedure that we do. We do a capsular
10 rhexis, but it just means -- it doesn't
11 mean anything. It just means that --
12 there's no connotation to this note.
13 Q. When you say you do a capsular
14 rhexis, tell me what that means.
15 A. The cataract is like a grape.
16 It has a skin. It's called the capsule.

17 In order to get to the inside,
18 we do what's called a capsular rhexis. We
19 peel the skin off in sort of a continuous
20 fashion.
21 Q. Did you speak to the patient
22 after surgery on November 5?
23 A. Yes.
24 Q. Did you provide her with any
25 written documents as to what she could
0094
1 DR.
2 expect to experience postoperatively?
3 A. I think there is a discharge
4 note, a standard discharge note that the
5 patient gets.
6 Q. That is from the ambulatory
7 surgery center?
8 A. Yes.
9 Q. On your first visit with the
10 patient on September 26, did you provide
11 her with any brochures or pamphlets about
12 how this procedure is performed?
13 A. After the fact?
14 Q. No. On the first visit
15 when --
16 A. I don't recall if she was
17 provided.
18 Q. Did you have booklets or
19 pamphlets for patients to learn about how
20 cataract surgeries are done?
21 A. I typically go over it myself.
22 Q. I am asking whether you had
23 any materials.
24 A. Not typically.
25 Q. Did you have a website back in
0095
1 DR.
2 September of ?
3 A. I may have.
4 Q. On your website, if you had
5 it, did you offer any information about how
6 you cataract procedures are done?
7 MR. : Objection.
8 You are asking him about
9 something he said he may have had.
10 Q. Doctor, to your best
11 recollection, did you have information
12 online that would assist patients in
13 understanding how cataract procedures are
14 done that you could direct them to?
15 A. If patients ask me, I direct
16 them to a website which is not my own
17 website.
18 Q. I am only asking about yours.
19 A. I don't recall if in if I
20 had any cataract videos. There is some
21 text. There was some text.
22 Q. Lets go, please, to the next

23   visit, November 6.
24   Do you recall any comments the
25   patient made on this particular visit?
0096
 1   DR.
 2   A.   The patient was distraught.
 3   Q.   Hang on. I just want to know
 4   if you recall them.
 5   A.   Yes.
 6   Q.   Did you record any of the
 7   comments the patient made in any of your
 8   notes on November 6?
 9   A.   No.
10   Q.   Tell me what you remember the
11   patient telling you.
12   A.   That she was blind and could
13   not see.
14   Q.   Did she say anything else?
15   A.   She said a lot of things.
16   Q.   Tell me what you remember her
17   saying.
18   A.   Her overall ethic was very --
19   she was crying and loud. Loud crying and
20   saying she cannot see and what did you do.
21   Things to that effect.
22   Q.   Did you tell her
23   preoperatively that the first couple of
24   days she might have difficulty seeing?
25   A.   Yes.
0097
 1   DR.
 2   Q.   And did you tell her for how
 3   long that would continue before it got
 4   better?
 5   A.   Yes. I gave her general
 6   guidelines.
 7   Q.   Over what period of time did
 8   you tell her that her vision would
 9   initially be worse, then improve?
10   A.   From a few days to a few
11   weeks.
12   Q.   Let's go to your note, please.
13   Her visual acuity was 20/100 in the right
14   eye?
15   A.   Yes.
16   Q.   That was best corrected?
17   A.   It is uncorrected.
18   Q.   What is TA?
19   A.   Pressure. Tonometry.
20   Q.   The 11, is that normal?
21   A.   11 is the time. 18 is normal.
22   Q.   Did you do any examination of
23   her left eye at that time?
24   A.   No.
25   Q.   Continue with your handwritten
0098
 1   DR.
 2   part of the notes.

3 A. It says Zymar 4/0, Pred Forte
4 4/0, follow up one week, there is an arrow
5 to the word that says refract.
6 Q. When you wrote in the middle
7 of the page, it says positive injection,
8 what does that mean?
9 A. 11/5 -- 11/6?
10 Q. Here.
11 A. Plus injection. That means
12 the eye is a little bit red.
13 Q. Is that normal?
14 A. Yes.
15 Q. Underneath that you wrote bit
16 hazy. What does that mean?
17 A. That means there is corneal
18 edema.
19 Q. This you said was normal and
20 expected following the surgery?
21 A. Yes.
22 Q. Are there patients in whom you
23 perform cataract surgery who you don't have
24 this condition show up postoperatively?
25 A. Some.
0099
1 DR.
2 Q. Are there patients who you
3 perform cataract surgery on who are able to
4 see well the day after surgery?
5 A. A few.
6 Q. Let's go, please, to the next
7 note that you have. What is the next
8 time -- I'm sorry, withdrawn.
9 You prescribed medication for
10 the patient, correct?
11 A. Yes.
12 Q. That was for the right eye, am
13 I right?
14 A. Yes.
15 Q. And is Vigamox the same as
16 Pred Forte?
17 A. No. Vigamox is similar to
18 Zymar. It is an antibiotic.
19 Q. Why did you prescribe that?
20 A. To prevent postoperative
21 infection.
22 Q. At the time of the surgery do
23 you routinely recommend or prescribe
24 antibiotics?
25 A. Yes.
0100
1 DR.
2 Q. Did you do that in this case?
3 A. Yes.
4 Q. On November 5, you gave her a
5 prescription for an antibiotic?
6 A. I would imagine, but she may
7 have gotten samples.
8 Q. Let me rephrase. Is there

9   anything in your note for November 5 or
10 anywhere else --
11   A.   November? Repeat.
12   Q.   Sure. On the day of surgery,
13 do you have anything in your note to
14 confirm that you gave the patient a
15 prescription to obtain an antibiotic from
16 the pharmacy?
17   A.   No.
18   Q.   You mentioned that sometimes
19 you will give a patient --
20   THE WITNESS: Can you read
21   back the question two questions ago?
22   (Record read back.)
23   THE WITNESS: I want to
24   just --
25   MR. OGINSKI: Go ahead.
0101
1   DR.
2   THE WITNESS: I don't always
3   give the prescription at the time of
4   the surgery. It's either done at the
5   time of surgery or the next day.
6   Q.   I want to show you a copy of a
7   patient prescription for Vigamox.
8   The prescription that's on the
9   container, it indicates it is for the left
10 eye.
11   Am I correct that you did not
12 intend and not write a prescription for the
13 patient's left eye?
14   A.   It does say left eye.
15   Q.   Am I correct that your
16 prescription is solely for the patient's
17 right eye?
18   A.   Yes.
19   Q.   Do you have any information as
20 to why that particular prescription refers
21 to the patient's left eye?
22   A.   No.
23   Q.   There was no reason for this
24 medication in the patient's left eye on
25 November 6, correct?
0102
1   DR.
2   A.   Right.
3   Q.   Let's turn, please, to the
4   next visit, November 8.
5   MS. : Before we do that,
6   could we take a five-minute break?
7   MR. OGINSKI: Sure.
8   (A short recess was taken.)
9   Q.   Doctor, let's turn, please, to
10 the November 8th visit.
11   A.   Yes.
12   Q.   The notations that appear on
13 the right side towards the top, the
14 positive 0.75, what is that?

15 A. It says plus 0.75, plus 1
16 and-a-half, access 107. There is an arrow
17 that says 20/25, that is the refraction.
18 Q. That means in layman's terms,
19 if you can tell me, please.
20 A. That means with that
21 particular set of lenses the patient saw
22 20/25.
23 Q. Continue, please, with your
24 other handwritten portion of the notes.
25 A. It says clear on the
0103
1 DR.
2 right-hand side. It says under assessment
3 doing well, follow up two weeks.
4 Q. Now, this was the unscheduled
5 visit you told me about earlier?
6 A. Yes.
7 Q. Do you have any other memory
8 of what Mrs. said to you on this
9 visit other than what you already told me?
10 THE WITNESS: Can you read
11 back what I already told him?
12 Q. Let me do it this way,
13 Doctor --
14 A. Are you trying to trick me?
15 Q. Absolutely not. I want to
16 know what you remember.
17 A. Let's see what I told you.
18 Q. Let me do it this way: Tell
19 me what you remember the patient saying to
20 you on November 8th.
21 A. November 8th, I remember her
22 walking into the office and being very
23 vocal about the fact that she's blind and
24 she cannot see. That's all.
25 Q. After doing your examination
0104
1 DR.
2 and checking her visual acuity, what did
3 you tell her?
4 A. I reassured her that she in
5 fact is not blind, and I explained to her
6 that the visual acuity is changing and
7 evolving, and we have to be patient and
8 give nature a chance to do its work.
9 Q. Did you think that the corneal
10 edema was causing her inability to see
11 well?
12 A. It's not noted in my note that
13 there was in fact any corneal edema.
14 Q. To what, if anything, did you
15 attribute her comment of her not being able
16 to see well in light of her visual acuity
17 of 20/25?
18 A. At this point, I'm beginning
19 to think probably that there is indeed some
20 refractive error that's causing her poor

21 visual acuity.
22 Q. Did you comment to her about
23 that?
24 A. I explained that -- yes, I did
25 comment.
0105
1 DR.
2 Q. What, if anything, did she say
3 in response?
4 A. She was distraught and she
5 said, I'm never wearing glasses again.
6 Q. How would the corrective
7 lenses, wearing glasses, have helped her
8 condition at that point?
9 A. At that point I did not
10 recommend corrective lenses.
11 Q. Now, from the time that the
12 patient had the procedure on November 5th
13 up until the time she arrived in your
14 office on November 8, did she call your
15 office to speak to you about any complaint
16 she had?
17 A. I don't recall.
18 Q. If she had called you and you
19 were in the office at the time, would you
20 typically make a note in your chart about
21 any phone conversation you had with the
22 patient?
23 A. Not necessarily.
24 Q. Under what circumstances would
25 you make a note?
0106
1 DR.
2 A. If there was some exceptional
3 circumstances, such as -- well, if there
4 were some exceptional circumstances.
5 Q. If the patient called you
6 afterhours when you were no longer in the
7 office and you spoke with her, would you at
8 some later point make a note in your chart
9 indicating you had spoken with the patient
10 at some previous time?
11 A. Not unless it was material to
12 the treatment of the patient.
13 Q. If a patient called
14 afterhours, were there days when you would
15 be on call and be receiving phone calls
16 from patients who had concerns and other
17 days when Dr. would take call?
18 A. Yes.
19 Q. Do you have any memory of the
20 patient ever speaking to you any day you
21 are on call in November of ?
22 A. No. Not afterhours.
23 Q. Let's go, please, to the next
24 visit, November 12. The patient's visual
25 acuity on that day was 20/100?
0107

1 DR.
2 A. Yes.
3 Q. Still the same from the 8th,
4 correct -- I'm sorry. It was different
5 than the 8th, am I correct?
6 A. Well, one is uncorrected, one
7 is corrected.
8 Q. Is there any particular reason
9 why you did not perform a corrected visual
10 acuity on November 12?
11 A. Because only four days have
12 elapsed and I did not deem it necessary.
13 Q. Was it your opinion that you
14 felt the patient's visual acuity would not
15 have changed during those four days?
16 A. I did not see how that would
17 alter my treatment plan.
18 Q. The pressure in the patient's
19 eye, that's 16?
20 A. Yes.
21 Q. Is that, again, within normal
22 limits?
23 A. Yes.
24 Q. What specific complaint, if
25 any, did the patient make on this visit?
0108
1 DR.
2 A. This, again, was an
3 unscheduled visit, and it was a complaint
4 of -- a very vocal complaint about poor
5 visual acuity.
6 Q. Do you have anything recorded
7 in your note which confirms that?
8 A. No. The fact that it's not
9 recorded typically means -- in this case
10 means that it was difficult to record these
11 things because of extraneous factors.
12 Q. Be more specific. Tell me
13 what you mean.
14 A. It typically means that the
15 patient does not necessarily want to answer
16 questions or is inconsolable.
17 Q. Typically when you see a
18 patient postoperatively, are you making
19 notes at the time they are in your office
20 or do you make notes after the patient has
21 left the office at some later point during
22 the day?
23 A. I typically do it at the time
24 of the visit.
25 Q. Once the patient has left the
0109
1 DR.
2 office, is there anything that would
3 prevent you from making notations in the
4 patient's chart about those things you were
5 unable to write down at the time the
6 patient was in front of you?

7 A. No.
8 Q. Is there anything in this
9 particular note that would confirm any of
10 those things you have told me that you
11 remember as you sit here today?
12 A. Just my memory.
13 Q. Continue, please, with your
14 impression and diagnosis.
15 A. Continue medications, follow
16 up Friday for refraction, right eye.
17 Q. What did you tell the patient
18 on this visit?
19 A. I asked her to be patient and
20 return on Friday for refraction.
21 Q. What did she say in response?
22 A. Okay, but I'm not wearing
23 glasses.
24 Q. Why do you believe she was
25 fixated on the fact that she was not going

2 to wear glasses? What did she tell you
3 about that? I am going to rephrase the
4 question.
5 Did you ask her what she meant
6 as to why she kept repeating that she did
7 not want to wear glasses?
8 A. The phrase, I do not want to
9 wear glasses is pretty clear to me and to
10 you probably.
11 Q. Put it in context for me,
12 Doctor. She is complaining she can't see
13 well, you tell her to give it more time,
14 she said she doesn't want to wear glasses.
15 How does that fit into what you
16 are saying?
17 MR. : Objection.
18 I don't understand. What do
19 you mean how does it fit in?
20 MR. OGINSKI: Withdrawn.
21 Q. Did you say anything to her
22 that would lead her to believe that she
23 would need glasses?
24 A. I asked her on November 12 to
25 return on Friday for refraction.

2 Q. And that would be to evaluate
3 her for eyeglasses?
4 A. That would be to see where we
5 stand, where we are after surgery, how the
6 eye is doing, how she is doing.
7 Q. Now, the measurements that
8 appear on that little piece of paper on the
9 right side, what do those represent?
10 A. A measurement by a machine
11 called an autorefractor.
12 Q. Are those measurements normal

13   or abnormal?
14   A.   They are normal.
15   Q.   Let's go, please, to the next
16   visit. What date is that?
17   A.   November 16th, .
18   Q.   What complaints did you record
19   on this visit?
20   A.   There is no complaint. It
21   says -- well, there is no complaint.
22   Q.   Did the patient make any
23   complaint to you?
24   A.   She complained of blurry
25   vision.

0112

1   DR.
2   Q.   And do you have that recorded
3   anywhere?
4   A.   No.
5   Q.   Any particular reason as to
6   why you did not record that?
7   A.   No.
8   Q.   Continue, please, from the
9   top.
10   A.   Status, post facial/PCIOLOD.
11   Q.   In English, please.
12   A.   After facial emulsification
13   surgery, intraocular lens implantation
14   right eye.
15   It says PF20, that means she is
16   using the Pred Forte drops twice a day in
17   the right eye.
18   There is a refraction
19   underneath with the best corrected visual
20   acuity of 20/20 in the right eye, 20/20 in
21   the left eye.
22   Q.   And the measurements that
23   appear, it says J-1 and J-1, do those refer
24   to the right eye, left eye or both?
25   A.   The top one is the right

0113

1   DR.
2   eye -- the top is the right, the bottom is
3   the left.
4   Q.   And the uncorrected visual
5   acuity is 20/150?
6   A.   Yes. And 20/20 minus in the
7   left. The physical examination is
8   normal --
9   Q.   Hang on one second, Doctor.
10   How do you explain the
11   difference in the uncorrected visual acuity
12   of 21/50 on November 16 in comparison to
13   four days earlier on November 12 of 20/100?
14   A.   I don't think the change is
15   significant.
16   Q.   Was there any significant
17   change with the uncorrected visual acuity
18   of November 16th compared to any other

19   visual acuity you took after the cataract
20   surgery was performed?
21   A.   No.
22   Q.   Go ahead, please, with your
23   note.
24   A.   The physical examination is
25   normal. There is a notation next to the
0114
1   DR.
2   lens in the right eye that says PCIOL.
3   It says, discussed risks and
4   benefits of IOL exchange, including possible
5   complications. Lens exchange OD as per
6   patient.
7   Q.   Tell me what you meant by
8   that.
9   A.   Which part?
10   Q.   That lens exchange OD as per
11   patient.
12   A.   That means the patient insists
13   on having a lens exchange.
14   Q.   Was it your recommendation to
15   perform the lens exchange?
16   A.   It was one of the options
17   given to the patient.
18   Q.   Let's go through the options
19   you gave the patient.
20   A.   Wearing glasses and having
21   perfect vision, waiting a longer period of
22   time and considering an enhancement laser
23   vision correction or having a lens
24   exchange.
25   Q.   How would wearing glasses
0115
1   DR.
2   create perfect vision for her at that
3   point?
4   A.   She would have 20/20 vision.
5   Q.   And am I correct that her only
6   problem at this point was that she had
7   blurry vision?
8   A.   No.
9   Q.   What else was creating a
10   problem for her vision on November 16th?
11   A.   I don't think she had a
12   problem with her vision.
13   Q.   What was the problem as far as
14   you understood it?
15   A.   She did not want to wear
16   glasses.
17   Q.   How much more time did you
18   recommend or suggest to the patient as far
19   as waiting a longer period of time? Did
20   you tell her a week, a month, a year?
21   What timeframe did you suggest
22   to her?
23   A.   Mrs. wanted --
24   Q.   I am asking what you told her

25   as far as how much time she should wait.
0116
 1   DR.
 2   A.   Up to three months.
 3   Q.   And the enhancement you
 4   mentioned, that would be another Lasik
 5   procedure?
 6   A.   PRK.
 7   Q.   Did you recommend that she
 8   have that?
 9   A.   It was one option given to
10   her.
11   Q.   Did you recommend having PRK
12   procedure over a lens exchange?
13   A.   We discussed the risks and
14   benefits of everything. I do not recall
15   recommending one over the other.
16   I think the discussion was
17   driven by Mrs. .
18   Q.   Wearing glasses has little
19   risk, there is no risk associated with it,
20   correct?
21   A.   No.
22   Q.   Waiting longer also has no
23   risk associated?
24   A.   No.
25   Q.   The enhancement, the PRK,
0117
 1   DR.
 2   certainly has risks associated, correct?
 3   A.   Yes.
 4   Q.   And performing a lens exchange
 5   also has certain risks?
 6   A.   Yes.
 7   Q.   Are the risks associated with
 8   PRK surgery, are they greater than risks
 9   associated with cataract surgery?
10   A.   Both surgeries are very safe.
11   Q.   My question though is if you
12   have a choice and the patient is not the
13   one going to determine, just from a medical
14   risk standpoint, which has greater risk;
15   the PRK procedure or cataract procedure,
16   all other things being equal?
17   A.   I think both are very safe.
18   You are asking me which is safer, Boeing or
19   airbus.
20   Q.   Would you agree, Doctor, that
21   technical proficiency is one factor that
22   can -- withdrawn.
23   When you talked to the patient
24   about undergoing a PRK procedure, what was
25   her comment in response to that?
0118
 1   DR.
 2   A.   She did not want to do it.
 3   Q.   Did she explain to you why?
 4   A.   Yes.

 5   Q.   What did she say?
 6   A.   It required waiting a few
 7   months.
 8   Q.   Why would she have to wait a
 9   few months?
10   A.   For her vision to stabilize
11   and her cornea to heal, and generally that
12   type of...
13   Q.   Did you expect that if the
14   patient waited and did nothing as of
15   November 16th that at some point in the
16   near future she would get improved vision
17   or her vision would improve?
18   A.   She was 20/20 on
19   November 16th.
20   MR. : Do you mean her
21   uncorrected vision?
22   MR. OGINSKI: Yes.
23   MR. : Uncorrected.
24   THE WITNESS: He has to say
25   it.
0119
 1   DR.
 2   MR. : You're right.
 3   Q.   Was it your opinion on
 4   November 16 that if she did nothing and
 5   continued to wait that her uncorrected
 6   vision would improve?
 7   A.   I did not think that it would
 8   materially improve.
 9   Q.   Why?
10   A.   Based on the measurement of
11   her refractive error on that day and the
12   trend before.
13   Q.   Did you tell Mrs.
14   that if she waited that she could still
15   have a lens exchange at some later time?
16   A.   Yes.
17   Q.   And what was her response, if
18   any?
19   A.   She wants to have it done as
20   soon as possible.
21   Q.   Now, Doctor, if you for
22   whatever medical reason felt that
23   performing a procedure was not appropriate,
24   am I correct that you would have no
25   hesitation to speak up and tell the patient
0120
 1   DR.
 2   that fact?
 3   A.   Yes.
 4   Q.   In this instance, when the
 5   patient voiced her concern, voiced her
 6   desire to have a lens exchange as soon as
 7   possible, what was your response to that?
 8   A.   I explained the risks and
 9   benefits of the procedure to her, and after
10   I was sure that she understood the risks

11   and benefits of the procedure, we agreed to
12   proceed.
13   Q.   Were the risks of the lens
14   exchange any different than performing the
15   original cataract surgery?
16   A.   The risks of the lens exchange
17   are greater than cataract surgery.
18   Q.   Why?
19   A.   It's trickier.
20   Q.   How?
21   A.   The lens that is exchanged has
22   to be removed from the eye. It's a fairly
23   bulky object.
24   Q.   Have you performed lens
25   exchanges before this?
0121
 1   DR.
 2   A.   Yes.
 3   Q.   Give me an idea of how many
 4   you have done in your career.
 5   A.   I do about five to ten a year.
 6   I have been practicing for the last ten
 7   years.
 8   Q.   That's just specifically the
 9   lens exchange?
10   A.   Yes.
11   Q.   Did you tell Mrs.
12   specifically that the risks of doing this
13   lens exchange were greater than the
14   original cataract surgery?
15   A.   I explained to her that this
16   surgery is trickier and in some ways more
17   difficult, but overall lens exchange is a
18   very safe operation.
19   Q.   Would you agree, Doctor, that
20   if a physician in general does not inform
21   the patient about the risks associated with
22   a lens exchange that that would be a
23   departure from good medical care?
24   MR. : Objection. You can
25   answer.
0122
 1   DR.
 2   A.   Yes.
 3   Q.   Again, the reason would be
 4   that the patient would not be able to make
 5   an informed decision about what procedure
 6   to go ahead with?
 7   A.   Yes.
 8   Q.   You performed the lens
 9   exchange on November 19th, correct?
10   A.   Yes.
11   Q.   Before going ahead with the
12   lens exchange, what did you do to evaluate
13   what type of lens or the power of the lens
14   that you were going to implant?
15   A.   I used my preoperative
16   measurements and postoperative measurements

17   to calculate the power of the lens.
18   Q.   Was there anything in those
19   measurements that were different than the
20   measurements that you had used
21   preoperatively?
22   A.   No.
23   Q.   How is it then that you were
24   able to get a different power intraocular
25   lens to use for the lens exchange?
0123
1   DR.
2   A.   I had my postoperative
3   results. I took my preoperative
4   measurements, I looked at what the
5   predicted outcome was versus the actual
6   outcome and I made a simple adjustment.
7   Q.   And how did you know to make
8   that adjustment by increasing the power to
9   22 as opposed to any other number?
10   A.   Based on my training and
11   experience.
12   Q.   Did you consult with anyone in
13   calculating and evaluating the power lens
14   you were going to be implanting on the
15   19th?
16   A.   I do not recall if I consulted
17   specifically for this case, but calculating
18   powers of a lens exchange is something that
19   I frequently do, and thus I feel
20   comfortable and competent doing it.
21   Q.   I'm just asking if you did.
22   A.   I don't recall if I
23   specifically discussed this case.
24   Q.   Were there occasions when you
25   would discuss a particular case with your
0124
1   DR.
2   partner, Dr. ?
3   A.   We sometimes discuss
4   interesting cases informally.
5   Q.   Do you have any memory of
6   discussing this patient's care and
7   treatment before November 19th specifically
8   with respect to the decision of what power
9   lens to use to replace?
10   A.   I don't think I discussed
11   specifically the specifics of the case with
12   Dr. .
13   Q.   Is there anybody else that you
14   would consult with on a regular basis in
15   deciding what power lens to use to perform
16   an exchange?
17   A.   The lens companies, for
18   example, offer a service that you could
19   contact, you could call and they will
20   assist you with making those calculations,
21   but it is an informal type of arrangement.
22   Q.   Did you do that in this

23   patient's case?
24   A.   I don't recall.
25   Q.   If you had, would you have
0125
 1   DR.
 2   made a note anywhere?
 3   A.   No, I would not have.
 4   Q.   Do you have any memory as you
 5   sit here now of contacting any company as
 6   you mentioned to discuss --
 7   A.   I don't recall contacting any
 8   company for this particular case.
 9   Q.   Did you review any specific
10   literature in preparation for this
11   patient's lens exchange on November 19?
12   A.   Not for this particular case.
13   Q.   Let's go to your November 19
14   note.
15   A.   Yes.
16   Q.   Am I correct that you did the
17   lens exchange at the same center, the
18 ?
19   A.   Yes.
20   Q.   They had that lens ready
21   waiting and available for you?
22   A.   Yes.
23   Q.   Is there anything that you can
24   tell me about that particular lens or how
25   it came packaged or anything about it that
0126
 1   DR.
 2   you believe was abnormal or out of the
 3   ordinary?
 4   A.   No.
 5   Q.   Let's go through your notes,
 6   please.
 7   A.   11/19/, --
 8   this page four. Lens exchange. Lens out
 9   of the bag easily. Then there is a plus,
10   posterior vitreous pressure, difficulty
11   cutting the lens.
12   PC tear, posterior capsular
13   tear. Anterior vitrectomy. Lens in
14   ocellus.
15   Then there is a diagram of
16   sutures, suture placement. Then there is a
17   sticker to the lens -- of the lens that was
18   implanted.
19   Q.   This note is made
20   intraoperatively?
21   A.   I do not recall the timing,
22   exact timing of the note.
23   It was made -- it was probably
24   made after the surgery, not
25   intraoperatively. After the surgery.
0127
 1   DR.
 2   Q.   Under the visual acuity

3 measurement for the right eye, what does
4 that say?
5 A. Hand motion.
6 Q. That's all she could see
7 before the lens exchange or after?
8 A. After.
9 Q. Is that normal, abnormal or
10 something else?
11 A. Well, it's poor.
12 Q. Did you form any opinion as to
13 why she only had that visual acuity in the
14 right eye at that time?
15 A. Did I? Yes.
16 Q. What was your opinion?
17 A. It's the typical course or
18 frequent course after surgery, after
19 complex surgery.
20 Q. Could I just see your note,
21 Doctor.
22 A. Sure.
23 (Pause.)
24 Q. On the bottom of the note can
25 you just read what's recorded there?
0128
1 DR.
2 A. It's dated 11/20/. It says,
3 patient has copy of her chart.
4 Q. Whose signature is that?
5 A. I think it's Mrs. 's.
6 Q. I am going to show you a
7 photocopy of the same record and just ask
8 you to take a look at it.
9 At the top, Mrs. 's
10 name does not appear as it is in the
11 original chart, and the notation about the
12 11/20/ does not appear there either.
13 Do you have any knowledge as to
14 why those notations don't appear on this
15 particular page?
16 A. Where do you not see notation
17 of 11/20/?
18 Q. First patient name does not
19 appear at the top of the photocopy.
20 A. Okay.
21 Q. At the bottom on your original
22 note, you have notations about the patient
23 having a copy of her chart, and there is
24 nothing here.
25 Do you have any knowledge as to
0129
1 DR.
2 how this particular photocopy does not have
3 that information as you have in your
4 original chart?
5 A. I would imagine the chart was
6 first photocopied then the patient signed
7 it.
8 My part of it seems to be

9 intact, and the photocopies are made by the
10 secretaries at the front desk.
11 Q. Let's go, please, to the next
12 visit, November 20th. Did Mrs.
13 make any complaint on that day?
14 A. Yes.
15 Q. What did she say to you that
16 is recorded in your note?
17 A. What's recorded in my note, I
18 did not record her complaint, but what she
19 said is that she was crying and said that
20 she is blind and I ruined her eye.
21 Q. Did you agree with that?
22 A. No.
23 Q. What was it about your
24 examination that suggested that what she
25 was saying was inaccurate?
0130
1 DR.
2 A. Her eye was not ruined and she
3 is not blind, and I did not agree with her.
4 Q. What objectively based upon
5 your examination suggested to you that she
6 was not blind and her eye was not ruined?
7 A. Her eye was structurally
8 intact.
9 Q. What was her visual acuity on
10 November 20th?
11 A. It's not recorded. I would
12 imagine it's hand motion.
13 Q. What accounted for the fact
14 that the patient --
15 A. Or maybe we weren't able to --
16 well, it wasn't recorded.
17 Q. Did you attempt to obtain her
18 visual acuity?
19 A. I would imagine I did.
20 Q. Do you have anything in your
21 notes that you attempted but were unable to
22 obtain it?
23 A. No.
24 Q. Read, please, your handwritten
25 note.
0131
1 DR.
2 A. Subconjunctival hemorrhage.
3 Next to cornea it says three plus edema,
4 two plus stria.
5 Next to anterior chamber, it
6 says deep and formed. Next to the pupil, it
7 says postsurgical.
8 Next to the lens, it says
9 posterior chamber intraocular lens in place.
10 There is a notation that says B scan and it
11 says no RD, no retinal detachment.
12 Q. Anything else in your
13 handwriting?
14 A. There's a notation of the left

15   eye which is normal.
16   Q.   Now, you mentioned in your
17   note on November 19th that you had
18   difficulty cutting the lens. Tell me what
19   you meant by that.
20   A.   I had difficulty cutting the
21   lens with an instrument.
22   Q.   Did that difficulty cause or
23   create any further damage to the patient's
24   eye?
25   A.   I'm not sure how to answer
0132
 1   DR.
 2   that.
 3   Q.   Did you encounter any
 4   complications during the second surgery?
 5   A.   The second surgery was --
 6   Q.   November 19.
 7   A.   November 19 was complex and
 8   difficult.
 9   Q.   You mentioned in your
10   typewritten operative report that there was
11   a significant amount of posterior vitreous
12   pressure.
13   A.   Yes.
14   Q.   Tell me what that means.
15   A.   What that means is that --
16   well, the back half of the eye or the space
17   behind the lens is filled with gel called
18   the vitreous.
19   For any number of reasons that
20   gel could be pushing forward. When that
21   occurs, the physical structure of the eye
22   changes. It collapses instead of being
23   inflated. It collapsed sort of like a
24   balloon.
25   Q.   Is this something you can
0133
 1   DR.
 2   recognize preoperatively?
 3   A.   No.
 4   Q.   How do you recognize it
 5   intraoperatively?
 6   A.   When you see the eye is
 7   collapsing.
 8   Q.   To what, if anything, did you
 9   attribute that to when you observed it?
10   A.   It's part of -- well, there
11   are, I suppose, reasons for that which you
12   think about during surgery.
13   Q.   What are they?
14   A.   You could have bleeding, you
15   could have something pushing on the eye
16   physically like a finger or instrument, you
17   could have a patient who is squeezing the
18   lids trying to shut her eye, you could have
19   fluid that's not going in the right place
20   in the eye from a surgical instrument.

21   The list is extensive. All
22   those were considered as things were
23   happening.
24   Q.   Did you observe bleeding?
25   A.   Luckily, no.
0134
 1   DR.
 2   Q.   Did you observe anything or
 3   anybody pushing something against her eye?
 4   A.   No.
 5   Q.   Did you observe the patient
 6   squeezing her lid as if she wanted to shut
 7   her eye?
 8   A.   I do not recall exactly what
 9   the cause of posterior vitreous pressure
10   was at that time, but it is -- it becomes
11   an urgency to complete the surgery at that
12   point.
13   Q.   Why?
14   A.   Well, because let's say there
15   is bleeding that causes this, and that
16   could lead to blindness, irreversible
17   complete blindness.
18   Q.   Is there anything that you
19   recall that the patient did that may have
20   contributed while on the table to an
21   increased posterior vitreous pressure?
22   A.   No.
23   Q.   Did you form any opinion or
24   come to any conclusion during the surgery
25   as to why she had this significant
0135
 1   DR.
 2   posterior vitreous pressure?
 3   A.   I do not recall what I thought
 4   at the time of surgery other than it's very
 5   important to complete this operation in the
 6   most successful way possible.
 7   Q.   You wrote, and I'm quoting:
 8   "It was noted that there was a
 9   significant amount of posterior vitreous
10   pressure. At the time the lens was
11   manipulated. One of the haptic was brought
12   out."
13   When you wrote "at the time the
14   lens was manipulated" --
15   A.   I need to see the operative
16   report.
17   Q.   Sure. In the middle of the
18   page.
19   A.   Yes.
20   Q.   Did you mean that you observed
21   the posterior vitreous pressure when you
22   were manipulating the lens?
23   A.   What it means is that halfway
24   through the procedure when the lens was out
25   of -- halfway through the procedure this
0136

1 DR.
2 developed, you could say at the point of no
3 return, past the point of no return.
4 Q. So what do you do in order to
5 stop further damage or injury from
6 occurring at that point?
7 A. You do the best you can.
8 Q. Meaning what?
9 A. Well, there are techniques.
10 You try to reinflate the eye, you try to
11 look and see why it's occurring, you try to
12 asses and see what the cause is and take
13 care of the cause. Sometimes you don't
14 find the reason.
15 Q. And during surgery did you
16 find a reason for why this was happening?
17 A. I do not recall a specific
18 reason.
19 Q. Is there anything in your
20 operative report which would indicate
21 specifically what reason you believed it
22 was occurring?
23 A. No.
24 Q. Continuing, you wrote that
25 there was a small posterior capsular tear

0137

1 DR.
2 centered. What was that tear from?
3 A. From the manipulation of
4 material, manipulation of the eye.
5 Q. Am I correct that before doing
6 the lens exchange on November 19 she did
7 not have a capsular tear?
8 A. Yes.
9 Q. You continued the sentence by
10 saying, and there was vitreous to the
11 wound, most likely from excessive posterior
12 vitreous pressure. Tell me what you meant.
13 A. The vitreous was being -- the
14 vitreous was coming from the back of the
15 eye to the front of the eye to the wound to
16 the opening in the cornea.
17 Q. Was that an abnormal finding?
18 Is that something that shouldn't happen?
19 A. It's something that often
20 happens.
21 Q. The fact that it was
22 happening, what did that mean to you?
23 A. It means that we have to take
24 care of the vitreous coming to the wound.
25 Q. And how do you do that?

0138

1 DR.
2 A. You remove it using an
3 instrument called a vitrector or performing
4 a procedure called anterior vitrectomy.
5 Q. When you saw the patient in
6 the office later that day on November 19,

7 did you discuss with her the problems that
8 you encountered during the procedure?
9 A. I'm sure I did.
10 Q. Do you have a memory
11 specifically as to telling her about the
12 issues that you discussed and have recorded
13 in your operative report?
14 A. I have a memory of discussing
15 it with her. I do not have a written
16 record.
17 Q. What, if any, response did
18 Mrs. make in response to your
19 comments?
20 A. She was very upset.
21 Q. Was anyone else with her at
22 that time?
23 A. I believe somebody came with
24 her, but I do not recall the relationship.
25 Q. When you had this discussion

0139

1
2 with Mrs. about the event of the
3 November 19th surgery, was anyone else in
4 the room with you at the time you spoke to
5 her?
6 A. There may have been people
7 coming in and out. I don't have a record.
8 Q. You saw her the next day on
9 November 21?
10 A. Yes.
11 Q. And she still only had hand
12 motion at that time?
13 A. Yes.
14 Q. Did you attempt to obtain her
15 visual acuity, best corrected visual
16 acuity?
17 A. No.
18 Q. How do you know that you did
19 not attempt to take those measurements?
20 A. There's no notation.
21 Q. You mentioned on the 20th, the
22 day before that, there was no notation
23 about visual acuity that's corrected, and
24 you said you might have tried to take it
25 but could not?

0140

1
2 A. Yes.
3 Q. How do you differentiate
4 between the 20th and the 21st in terms of
5 whether or not you could or could not take
6 the visual acuity?
7 A. I don't understand your
8 question.
9 Q. Sure. Were you able to take
10 the patient's best corrected visual acuity
11 on November 21st?
12 A. It's noted what it is.

13 Q. My question --
14 A. Yes. Best corrected
15 visual acuity, no. We did uncorrected
16 visual acuity.
17 Q. Is there any reason as to why
18 you did not do best corrected?
19 A. Based on the physical exam, I
20 did not think it would be helpful.
21 Q. Can you read your notes,
22 please.
23 A. Postop day number two,
24 Pred Forte, 4-0, Zymar, 4-0. Uncorrected
25 visual acuity, hand motion. Pressure is

2 12. It says three plus edema next to the
3 cornea. Subconjunctival hemorrhage. PCIOL
4 in place.
5 Under assessment and plan it
6 says, Pred Forte every two hours for two
7 days, then four times a day in the right
8 eye, and it says Zymar four times a day in
9 the right eye.
10 Q. The hemorrhage you observed,
11 is that a normal finding following surgery?
12 A. Yes.
13 Q. When did you tell the patient
14 that that would resolve?
15 A. A few weeks.
16 Q. Did you also observe any
17 ptosis to the patient's eyelid at that
18 time?
19 A. It's not noted, but that would
20 not be unexpected.
21 Q. And what causes lid ptosis?
22 A. A lot of reasons.
23 Q. Tell me.
24 A. In this case or generally?
25 Q. In this case.

2 A. It could be the swelling from
3 the injection, the swelling of the eye.
4 The speculum is a spring-loaded metal
5 instrument that sometimes stretches the
6 skin and the muscles in the lid.
7 The eye could be in pain and
8 the patient could be closing the eye
9 involuntarily. So the list is extensive.
10 Q. I am going to show you,
11 Doctor, six photographs that were
12 previously marked at Plaintiff's deposition
13 on November 16, . This is taken
14 approximately one week after her lens
15 exchange.
16 I would just like you to look
17 at those, please.
18 (Pause.)

19 Q. I want you to assume that the
20 person in those photographs is
21 . Do you recognize her from those
22 photographs?
23 A. Yes.
24 Q. Do those photographs refresh
25 your memory as to how the patient's eye

2 from a gross standpoint looked
3 approximately one week after the lens
4 exchange?
5 A. Yes.
6 Q. Specifically, Doctor, looking
7 at these photographs, tell me in general
8 what you see.
9 A. Well, I see what you see.
10 Q. And from your standpoint, can
11 you identify what you see?
12 MR. OGINSKI: Withdrawn.
13 Q. Do you see a hemorrhage?
14 A. Yes.
15 Q. There appears to be cloudiness
16 of the patient's lens, correct?
17 A. Of the cornea.
18 Q. What would account for the
19 cloudiness of the patient's cornea?
20 A. It's a postoperative state.
21 Q. And the medications you gave
22 her, the Pred Forte, is that designed to
23 minimize and decrease swelling?
24 A. That is an antiinflammatory.
25 Q. That would decrease swelling?

2 A. Yes.
3 Q. Does that have any affect on
4 the cloudiness of the cornea?
5 A. It's not designed to treat --
6 yes. Yes, it will.
7 Q. Do you also observe ptosis in
8 the patient's right eye in some of these
9 photographs?
10 A. Yes.
11 Q. And is there anything unusual
12 about the patient's ptosis that --
13 withdrawn.
14 Did you tell the patient that
15 her cornea is going to improve over time as
16 far as the cloudiness?
17 A. On the 21st or in general?
18 Q. Again, I want you to assume
19 these photographs were taken approximately
20 seven days after the 19th, which is about
21 the 26th of November.
22 Assuming that date or in and
23 around that date, what did you tell the
24 patient as to whether or not she would have

25   the cornea clear up at any point in the
0145
 1   DR.
 2   future?
 3   A.   I told the patient that
 4   hopefully her cornea will clear up, but it
 5   will take time.
 6   Q.   Did you give her an estimate
 7   of how much time it would take?
 8   A.   I do not recall giving her a
 9   specific timeframe.
10   Q.   Did you form any opinion as of
11   the 20th of November as to whether the lens
12   that you implanted was causing any
13   difficulty with her ability to see clearly?
14   A.   I did not think the lens was
15   causing her difficulty seeing on
16   November 20.
17   Q.   What was your opinion as to
18   why she was having difficulty seeing at
19   that time?
20   A.   Corneal edema.
21   MR. OGINSKI: There are seven
22   photographs for the record, not six.
23   Q.   Going now to the 21st of
24   November, she still only had hand motion at
25   that time, visual acuity of hand motion?
0146
 1   DR.
 2   A.   Yes.
 3   Q.   When is the next time that the
 4   patient returned to your office?
 5   A.   December 6th.
 6   Q.   From November 19th up until
 7   December 6, did you have any conversations
 8   with Dr. about this patient and her
 9   progress?
10   A.   Not formally. I may have
11   informally.
12   Q.   Tell me what it was that you
13   may have informally discussed with that
14   doctor prior.
15   MR. : Objection to the
16   form of the question.
17   Q.   What did you talk about?
18   A.   We talked about how -- let me
19   try to formulate it.
20   We talked about what it's like
21   to have Mrs. in the office when she
22   comes. We discussed the clinical situation.
23   I would imagine that's what we
24   would have discussed, and we may have
25   discussed the plan, but this is all informal
0147
 1   DR.
 2   sort of watercooler chatter.
 3   Q.   When you take call or when
 4   Dr. is taking call from you, am I

5 correct that you give him information about
6 any patients you may have just operated on?
7 A. No.
8 Q. Do you sign out to Dr.
9 or anybody else?
10 A. No. Not unless I am going on
11 vacation.
12 Q. If a patient has a
13 complication and Dr. is on call and
14 takes call, how is he going to have
15 information about what happened with a
16 particular patient if you did not give him
17 that information?
18 A. I am on call 99 percent of the
19 time.
20 Q. So if a patient has a problem,
21 they are going to reach you practically
22 each time?
23 A. Typically, yes.
24 Q. And tell me what you meant
25 when you discussed with him what it's like
0148
1 DR.
2 having Mrs. as a patient.
3 A. Mrs. would come to
4 the office, would walk in and proceed in a
5 very loud voice, start saying, I'm blind,
6 he made me blind, he ruined my life. Words
7 to such effect.
8 She would be inconsolable by
9 our staff. They would not know how to
10 accommodate her. Things would come to a
11 halt.
12 I would take her into the room,
13 and instead of -- I would try to perform the
14 exam and she would be crying the whole time,
15 not always cooperative, sort of like that.
16 Very upset. What I just said.
17 Q. When you mentioned she would
18 say that she's blind, would she do this in
19 your waiting room, to your staff in your
20 office?
21 A. I think everywhere.
22 Q. Were you typically in the
23 waiting room to observe and hear her say
24 these things?
25 A. I could hear her.
0149
1 DR.
2 Q. From where?
3 A. From my examination room.
4 Q. And these are the things that
5 you heard or things that other people told
6 you about?
7 A. These are the things that I
8 heard.
9 Q. And did this happen on each of
10 the follow-up visits to your office?

11   A.   It happened on most of the
12   visits, especially early on in the
13   treatment.
14   Q.   Did you ever discuss with
15   Mrs. the reasons why she was so
16   tearful or upset?
17   A.   I tried to be supportive and
18   say I understand what you're going through
19   that you don't see well, but I also tried
20   to explain to her that things will get
21   better and that this requires time and
22   patience and things will get better.
23   Q.   Now, am I correct that you
24   sent the patient to a Dr. ?
25   A.   I sent her on the 20th, yes.
0150
 1   DR
 2   Q.   Of November?
 3   A.   Yes.
 4   Q.   Why did you send the patient
 5   to Dr. ?
 6   A.   Mostly to reassure
 7   Mrs. that her eye is not ruined.
 8   She was skeptical and
 9   inconsolable, and to offer her a chance to
10   get a second opinion.
11   Q.   Dr. is a retinal
12   specialist?
13   A.   Yes.
14   Q.   Had you sent patient of yours
15   to him in the past?
16   A.   Yes.
17   Q.   And did you speak with him
18   before the patient got there to be
19   examined?
20   A.   Yes.
21   Q.   And do you remember what you
22   said to him and what he said to you during
23   this conversation?
24   A.   I typically --
25   Q.   Not typically, Doctor. I want
0151
 1   DR.
 2   to know specifically.
 3   A.   Specifically, I gave him the
 4   medical history of what transpired, I gave
 5   him a summary of the medical history --
 6   Q.   I'm sorry to interrupt. I am
 7   going to let you finish.
 8   Without telling me about the
 9   conversation, if you could just tell me what
10   you actually discussed.
11   A.   I said, this is a patient -- I
12   said, , I have this patient, this is
13   her story, she had cataract surgery on the
14   5th, she had a refractive surprise, I did a
15   lens exchange yesterday, encountered some
16   difficulties, there is a lot of corneal

17   edema and she cannot see well, I think the
18   eye is fine, I want to make sure that it's
19   fine and the patient wants to make sure.
20   I want you to take a look and
21   see if anything needs to be done from your
22   end.
23   Q.   Did you suspect that the
24   patient had any type of retinal damage at
25   that time?
0152
1   DR.
2   A.   I had minimal suspicion.
3   Q.   Did you suspect that there was
4   any type of corneal damage at that time?
5   A.   Yes.
6   Q.   What was your opinion?
7   A.   Corneal edema.
8   Q.   Corneal edema you said would
9   resolve over time?
10   A.   Yes.
11   Q.   Separate and apart from that,
12   did you form any opinion as to whether she
13   had any other type of corneal damage?
14   A.   Permanent?
15   Q.   Yes.
16   A.   No. Not on the 20th.
17   Q.   After the patient was seen and
18   examined on the 20th, did Dr. call
19   you and tell you what his findings were?
20   A.   He called me and then sent me
21   a letter.
22   Q.   Did he call you on the same
23   day?
24   A.   Yes.
25   Q.   Tell me about what he told
0153
1   DR.
2   you.
3   A.   He said her eye is basically
4   fine.
5   Q.   Then he sent you a follow-up
6   letter about his exam, correct?
7   A.   Yes.
8   Q.   Do you have that in your
9   chart?
10   A.   Yes.
11   MR. OGINSKI: I just ask for
12   a copy of that from counsel.
13   (Request.)
14   MR. : Of what?
15   MR. OGINSKI: That letter
16   from Dr. .
17   MR. : You don't have it?
18   MR. OGINSKI: I don't have
19   it.
20   Q.   Now, there were certain
21   recommendations about medication that she
22   should continue. Did you agree with his

23   assessment and plan?
24   A.   Yes.
25   Q.   Did you again speak to
0154
 1
 2   that day after she had been
 3   to Dr. ?
 4   A.   I don't recall.
 5   Q.   Did Dr. give you an
 6   impression as to whether Mrs.
 7   verbally stated that she understood what he
 8   was saying? Did he say anything to that
 9   effect?
10   A.   I don't recall.
11   Q.   Did Dr. say anything to
12   the effect that the patient was emotional,
13   crying, hysterical or anything like that?
14   A.   We typically don't discuss
15   those things.
16   Q.   I'm only asking if you did,
17   Doctor.
18   A.   I don't recall.
19   Q.   Did you ask Dr. to come
20   and see this patient at any time up until
21   December 6, ?
22   A.   No.
23   Q.   Let's go to your
24   December 6th note. Can you read that,
25   please?
0155
 1   DR.
 2   A.   Status post-cataract
 3   extraction, lens exchange, neuro 128,
 4   pressure 14. All the other things are
 5   checked off. Pred Forte 4-0, Muro PRN.
 6   Q.   Did you test her visual acuity
 7   that day?
 8   A.   It does not appear that I did.
 9   Q.   And for what reason did you
10   not check her visual acuity on that visit?
11   A.   I do not recall.
12   Q.   What complaints, if any, did
13   Mrs. make that you recorded in
14   your note?
15   A.   This is part of her regular
16   postoperative examination.
17   Q.   Did she make any complaint?
18   A.   She complained as always of
19   poor vision.
20   Q.   I'm sorry. I'm going to
21   rephrase that.
22   Did you record any of the
23   patient's complaints she may have made on
24   this visit?
25   A.   No.
0156
 1   DR.
 2   Q.   Would you agree if a patient

3   makes a complaint of poor vision that would
4   be a significant complaint?
5   MR. : Objection. You can
6   answer.
7   A.   Sometimes when the complaint
8   does not change it's not recorded or it is
9   understood to be a constant complaint.
10   Q.   As you sit here now, is it
11 your understanding that the patient still
12 had a continued complaint of difficulty
13 seeing?
14   A.   Yes.
15   Q.   This is the right eye?
16   A.   Yes.
17   Q.   Did she still have hand
18 motion, she was only able to see hand
19 motion at that time?
20   A.   It is not recorded.
21   Q.   Had her vision improved at all
22 as of December 6 in any fashion at all,
23 subjectively or objectively?
24   A.   It is not recorded.
25   Q.   Have you ever testified

2   before?
3   A.   I have testified, yes.
4   Q.   How many times?
5   A.   Well, I have testified at
6   numerous trials, including traffic
7   violation trials.
8   Q.   Let's focus solely on medical
9   malpractice trials.
10   A.   No, I have never testified.
11   Q.   Have you ever testified like
12 we're here today in a deposition format?
13   A.   I have never been deposed
14 before.
15   Q.   The numerous trials you talked
16 about, other than traffic tickets, what
17 were they for generally?
18   A.   I testified once in a product
19 liability case.
20   Q.   Was that as a treating
21 physician or as an expert?
22   A.   As an expert.
23   Q.   On behalf of an injured
24 person?
25   A.   Injured person, and once in

2   the World Trade Center bombing.
3   Q.   And that was on behalf of
4   whom?
5   A.   Injured person, as a treating
6   physician.
7   Q.   Let's go to your next note,
8   December 18.

9 A. Yes.
10 Q. By the way, how much did you
11 charge the patient for the original
12 cataract surgery?
13 A. She got charged nothing. Her
14 insurance paid. I don't know what the fee
15 is. Not that much.
16 Q. My question was how much was
17 she charged for the surgery itself?
18 MR. : Objection.
19 Q. How much did you charge her or
20 her insurance company for the cataract
21 surgery done on November 5?
22 MR. : Objection to form.
23 You can answer if you know.
24 A. There is a bill that goes
25 out --
0159
1 DR.
2 Q. I just want to know the
3 amount, Doctor.
4 A. The patient wasn't charged
5 anything.
6 Q. How much is the bill for your
7 services?
8 A. The patient was not charged
9 anything.
10 Q. That wasn't the question. You
11 didn't perform this surgery for free,
12 correct?
13 A. Right.
14 Q. How much did you charge?
15 A. I don't send out the bills.
16 Q. In your experience working as
17 an ophthalmologist for ten years, what do
18 you charge for a cataract procedure?
19 A. In my experience, what I
20 charge and will get paid are two different
21 things.
22 Q. I am just asking what you
23 charge.
24 A. Typically I charge somebody
25 who doesn't have insurance $1,500.
0160
1 DR.
2 Q. And somebody who does have
3 insurance how much?
4 A. There is a schedule that
5 insurance companies pay. It doesn't matter
6 what I charge them.
7 It has no bearing on -- what I
8 charge them and what I get paid has no
9 bearing.
10 Q. My only question is what did
11 you charge her insurance company.
12 A. I don't recall.
13 Q. How much did you receive as
14 compensation from the patient's insurance

15   company?
16   A.   I have no idea.
17   Q.   Would that information be
18   contained in the billing records?
19   A.   Yes.
20   MR. OGINSKI: I would ask for
21   copies of those.
22   (Request.)
23   MR.: As I said before,
24   make the request in writing. I will
25   take it under advisement.
0161
 1   DR.
 2   MR. OGINSKI: Okay.
 3   Q.   Let's go, please, to the
 4   December 18th visit.
 5   Did you take the patient's
 6   visual acuity on that date?
 7   A.   Yes.
 8   Q.   What was it?
 9   A.   Best corrected visual acuity,
10   21/50.
11   Q.   Is that normal or abnormal for
12   this patient?
13   A.   Well, it is what it is.
14   Q.   In comparison to what she had
15   prior to her cataract surgery, is it better
16   or worse?
17   A.   It's worse.
18   Q.   In comparison to her vision,
19   her visual acuity after the cataract
20   surgery but before the lens exchange, was
21   this visual acuity better or worse?
22   A.   Worse.
23   Q.   And to what, if anything, did
24   you attribute this worsening visual acuity
25   on December 18th?
0162
 1   DR.
 2   A.   To corneal edema or
 3   postoperative state.
 4   Q.   Did you observe the patient's
 5   corneal edema to improve at all since the
 6   lens exchange on November 19th?
 7   A.   I'm not sure. It's not in my
 8   note.
 9   Q.   Do you have a memory of the
10   patient's corneal edema improving, not
11   improving?
12   A.   I have a memory of it
13   improving slightly.
14   Q.   Is there any reason why that
15   information doesn't appear in any of your
16   notes?
17   A.   No, there is no good reason.
18   Q.   Did the patient make a
19   complaint to you about anything on
20   December 18th?

21 A. The patient was not happy with
22 her visual acuity.
23 Q. Is there anything that you
24 have recorded in your notes about the
25 patient's complaint?
0163
1 DR.
2 A. No.
3 Q. Again, that comment you
4 mentioned was based on your memory?
5 A. Yes.
6 Q. Did you discuss with her why
7 she had difficulty or -- withdrawn.
8 Did you discuss with the
9 patient why her visual acuity was worse now
10 than at any time in the past?
11 A. Yes.
12 Q. What did you tell her?
13 A. Because of the corneal edema.
14 Q. By the way, Doctor, the
15 medications that you had prescribed for
16 her, did you have any reason to believe
17 that the patient was not compliant with
18 taking the medications that you had
19 prescribed?
20 A. No.
21 Q. Continue, please, with the
22 rest of the note.
23 A. Best corrected visual acuity
24 21/50, the pressure is 17. There is a
25 diagram of the sutures.
0164
1 DR.
2 Q. The pressure of 17, is that
3 normal?
4 A. Normal.
5 There is a diagram of sutures
6 in the cornea, and a note, sutures removed.
7 There is a drawing of the retina, and it
8 says looks good, no edema.
9 It says, Pred Forte once in the
10 right eye, Nevanac twice in the right eye,
11 Muro as needed.
12 Q. What is Nevanac?
13 A. Nonsteroidal antiinflammatory
14 drug.
15 Q. What is Muro?
16 A. Saline solution.
17 Q. On the bottom left it says,
18 counseled patient. What does that mean?
19 A. This is a note written by
20 somebody who was in the room. Just that we
21 discussed issues with the patient.
22 We had a discussion about
23 prognosis and situation.
24 Q. Who was this additional
25 person?
0165

1 DR.
2 A. This is somebody called a
3 scribe.
4 Q. Who is that?
5 A. Physician's assistant, let's
6 say.
7 Q. And specifically who is that?
8 A. I'm not sure who this was.
9 Q. How many different scribes did
10 you have working in your office?
11 A. About three.
12 Q. What was their function?
13 A. To assist us in things around
14 the office.
15 Q. And specifically what was the
16 patient's prognosis as of December 18?
17 A. Guarded.
18 Q. And did you have an opinion as
19 to how much more time the patient required
20 in order for the corneal edema to improve
21 her visual acuity?
22 A. On December 18, less than a
23 month had passed from surgery. I thought
24 it is prudent to wait longer.
25 Q. How much longer?
0166
1 DR.
2 A. I thought it was important to
3 see the trend.
4 Q. Did you ever discuss
5 Mrs. 's care again with Dr.
6 at any time after that one time on
7 November 20th?
8 A. I do not recall.
9 Q. Did you ever refer the patient
10 to Dr. again after November 20th?
11 A. No, not that I recall.
12 Q. Do you know Dr. .
13 A. Yes.
14 Q. Who is Dr. ?
15 A. Dr. is a corneal
16 specialist.
17 Q. Did you ever refer the patient
18 to Dr. ?
19 A. Dr. did.
20 Q. Did you ever do it?
21 A. No.
22 Q. Why did Dr. refer the
23 patient to Dr. and when?
24 THE WITNESS: Can I answer for
25 Dr. ?
0167
1
2 MR. : If you know. Only
3 if you know.
4 A. At that point we had discussed
5 the case --
6 Q. I'm sorry. Just to be clear,

7 when is that?
8 A. January 2nd, .
9 Q. Hold off. I will come back to
10 that.
11 MR. : If you are going to
12 go until 5:00 -- I have something I
13 have to do before 5:00. It depends
14 how much longer you have.
15 MR. OGINSKI: I have more.
16 MR. : Okay. So what we
17 are going to do is break now and then
18 we are going to have to figure out a
19 date that's convenient for everybody
20 again in the near future to finish it.
21 MR. OGINSKI: Okay.
22 MR. : Is that good for
23 everybody?
24 MR. OGINSKI: That's fine.
25 Off the record.
0168
1 DR.
2 (Discussion held off the record.)
3 MR. OGINSKI: Back on the
4 record. We are going to stop with
5 Dr. 's deposition now and
6 reconvene on a date that is convenient
7 for everybody, and the deposition is
8 still open.
9
10 (Time noted: 4:35 p.m.)
11
12
13 ------------------------------
14 DR.
15
Subscribed and sworn to
16
before me on this _______day
17
of _______________________, .
18
19
20
____
21 NOTARY PUBLIC
22
23
24
25
0169
1
2 I N D E X
3
4 WITNESS
5 DR.
6

7 EXAMINATION BY PAGE
8 MR. OGINSKI 4

9
10 COUNSEL REQUESTS PAGE LINE
11 153 13
12 160 22
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0170
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2
3 E X H I B I T S
4
5 PLAINTIFF'S PAGE LINE
6
7 Exhibit 1 - chart (premarked)
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0171
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2
3 C E R T I F I C A T I O N
4
5 I, , a Court Reporter
6 and a Notary Public within and for the State
7 of New York, do hereby certify:
8 That the foregoing witness, DR. ,
9 was duly sworn by me on the date indicated, and that the
10 foregoing is a true record of the testimony given by
11 said witness.
12 I further certify that I am not
13 related to any of the parties to this action
14 by blood or marriage, and that I am in no way

15   interested in the outcome of this matter.
16   IN WITNESS WHEREOF, I have hereunto
17   set my hand this 24th day of April, .
18
19
20
21   ______________________
22
23
24
25
0172
 1
 2   ERRATA SHEET
               VERITEXT/NEW YORK REPORTING, LLC
 3   CASE NAME:
     DATE OF DEPOSITION: April 24,
 4   WITNESS' NAME: DR.
 5   PAGE/LINE(S)/   CHANGE   REASON
                  ____/________/____________________/___________
 6   ____/________/____________________/___________
                  ____/________/____________________/___________
 7   ____/________/____________________/___________
                  ____/________/____________________/___________
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17   ____/________/____________________/___________
                  ____/________/____________________/___________
18   ____/________/____________________/___________
                  ____/________/____________________/___________
19
                                            ----
20   DR.
                   SUBSCRIBED AND SWORN TO
21   BEFORE ME THIS______DAY
                   OF_______________, .
22
                   ____
23   NOTARY PUBLIC
24   MY COMMISSION EXPIRES________________
25