DE-IDENTIFIED DEPOSITION OF A GYNECOLOGY RESIDENT IN A FAILURE TO TIMELY DIAGNOSE AND TREAT A BOWEL PERFORATION DURING GYN SURGERY CASE

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 3   SUPREME COURT OF THE STATE OF NEW YORK
     COUNTY OF
 4   ------------------------------------------x
 5   ,
                           Plaintiff,
 6
                -against-                Index No.
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10

11
                           Defendants.
12   -------------------------------------------x
13
                           10:35 a.m.
14
15
16         EXAMINATION BEFORE TRIAL of Defendant
17   , M.D., taken by Plaintiff,
18   pursuant to Order, at the offices of
19   , LLP, ,
20   , before
21  , a Registered Professional Reporter
22   and Notary Public within and for the State of
23   New York.
24
25
0002
 1
 2   A P P E A R A N C E S :
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 4
           THE LAW OFFICES OF
 5         GERALD M. OGINSKI, LLC
           Attorneys for Plaintiff
 6              25 Great Neck Road
                Suite 4
 7              Great Neck, New York 11021
 8         By:  GERALD M. OGINSKI, ESQ.,
                of Counsel
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Attorneys for Defendants
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21
22 By:

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0003
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2 IT IS HEREBY STIPULATED, by and between
3 counsel for the respective parties hereto,
4 that:
5 All rights provided by the C.P.L.R., and
6 Part 221 of the Uniform Rules for the Conduct
7 of Depositions, including the right to object
8 to any question, except as to form, or to move
9 to strike any testimony at this examination,
10 is reserved; and in addition, the failure to
11 object to any question, or to move to strike
12 any testimony at this examination shall not be
13 a bar or waiver to make such motion at, and is
14 reserved to, the trial of this action.
15 This deposition may be sworn to by the
16 witness being examined before any Notary
17 Public other than the Notary Public before
18 whom this examination was begun, but the
19 failure to do so, or to return the original of
20 this deposition to counsel, shall not be
21 deemed a waiver of the rights provided by Rule
22 3116 of the C.P.L.R., and shall be controlled
23 thereby.
24 The filing of the original of this
25 deposition is waived.
0004
1
2 , M.D.,
3 having been first duly sworn by the
4 Notary Public ( ), was
5 examined and testified as follows:
6 EXAMINATION
7 BY MR. OGINSKI:
8 Q. Doctor, can I get your name and
9 address, please?
10 A.
11
12 MR. OGINSKI: Off the record.
13 (Whereupon, a discussion was held
14 off the record.)

15 MR. OGINSKI: On the record.
16 Defense counsel has agreed to accept
17 service for the doctor, if and when she's
18 needed at trial.
19 Thank you.
20 EXAMINATION
21 BY MR. OGINSKI:
22 Q. What are the clinical signs of a
23 bowel perforation?
24 A. Well, there are many signs. Some of
25 them could be tachycardia, which is increased
0005
1 , M.D.
2 pulse rate, fever, abdominal tenderness,
3 decreased bowel sounds, abdominal guarding,
4 rigidity and the whole picture, a lot of other
5 signs.
6 This is what I can think of right
7 now.
8 Q. In the course of your medical
9 career, have you had occasion to diagnose a
10 patient with postoperative bowel perforation?
11 MS. : As an attending or as a
12 resident?
13 Q. During your residency, as an
14 attending, at any time.
15 MS. : Have you ever diagnosed
16 bowel perforation?
17 THE WITNESS: Not by myself but as a
18 whole team throughout maybe medical
19 school.
20 Q. In the course of your training and
21 residency, did you learn what the clinical
22 signs were of bowel perforation?
23 MS. : You mean the ones she
24 just mentioned?
25 MR. OGINSKI: Yes.
0006
1 , M.D.
2 Q. In other words, did you learn those
3 while you were in your residency?
4 A. Yes, and from academic teaching,
5 from textbooks and medical lectures.
6 Q. Now, in the event a patient does
7 have a bowel perforation, what symptoms would
8 you expect the patient to exhibit?
9 MS. : Other than what she's
10 just mentioned?
11 MR. OGINSKI: Well, those are
12 clinical signs.
13 I will rephrase the question.
14 Q. What is atelectasis?
15 A. Atelectasis is a collapse of the
16 basal lung.
17 Q. And have you had occasion to
18 diagnose atelectasis in your career?
19 A. I mean, it's not a clinical
20 diagnosis usually.

21   It's usually seen on x-rays or CAT
22   scan.
23   Q.   Have you had patients who have had
24   atelectasis?
25   A.   Yes. It's pretty common
0007
1   , M.D.
2   postoperatively.
3   Q.   Why is that?
4   A.   Because a combination of factors,
5   like general anesthesia, abdominal surgery.
6   Q.   What is peritonitis?
7   A.   When there is irritation of the
8   peritoneum due to any insult.
9   It could be blood. It could be
10   infection, any organism.
11   Q.   And did you learn about what
12   peritonitis is and how to diagnose it during
13   the course of your residency training?
14   A.   Yes.
15   Q.   And have you had occasion to treat
16   patients who have had peritonitis?
17   A.   Well, peritonitis is not very common
18   in OB-GYN, so, not really.
19   Q.   What is an ileus?
20   A.   Ileus is in the bowel. The function
21   is diminished because of multiple factors it
22   could be.
23   Q.   Do you see it often in postoperative
24   patients?
25   A.   Yes.
0008
1   , M.D.
2   Q.   Again, you learned about it and have
3   been exposed to patients who have had ileus
4   during the course of your training?
5   A.   Yes.
6   Q.   What is an intraabdominal abscess?
7   A.   When there is a collection of fluid
8   inside the abdominal cavity anywhere which is
9   possibly infected, but you are not sure if
10   it's infected or not.
11   Q.   And have you had occasion to treat
12   patients who have had intraabdominal abscesses
13   during the course of your training?
14   A.   Well, not treat by myself, but
15   occasion to see such patients, yes.
16   Q.   Were you taught by your seniors and
17   by the attendings about abscesses especially
18   intraabdominal abscesses?
19   A.   Yes, during the course of rounds and
20   lectures and seeing patients.
21   Q.   What is septic shock?
22   A.   Septic shock is due to infections
23   anywhere in the body. The blood pressure of
24   the patient drops and -- yes, pretty much
25   that's what it is.
0009

1 , M.D.
2 Q. Is is that synonymous with sepsis?
3 A. No.
4 Q. What is the difference?
5 I'm sorry. Let me rephrase it.
6 What is sepsis?
7 A. Sepsis is infection anywhere in the
8 body.
9 It could be widespread sepsis
10 affecting all the organs or only one organ of
11 the body, and when sepsis gets really bad it
12 can lead to septic shock. Septic shock is
13 usually the end stage.
14 Q. Have you had occasion to treat
15 patients who have had sepsis?
16 A. Again, OB-GYN, it's not very
17 common. So, not really. Maybe in medical
18 school I might have seen cases.
19 Q. Have you had occasion to treat
20 patients who have had septic shock during the
21 course of your training?
22 A. No.
23 Q. What is pleural effusion?
24 A. When there is a collection of fluid
25 in the pleural cavity.
0010
1 , M.D.
2 Q. What are some of the causes of
3 pleural effusion?
4 A. There are many causes.
5 It could be infected, like
6 tuberculosis or pneumonia or pleuritis, or it
7 can be from general condition which lead to
8 accumulation in the whole body, like
9 congestive heart failure.
10 Q. Can you tell me what is
11 pneumoperitoneum?
12 A. Air in the peritoneal cavity.
13 Q. And is that a common finding in a
14 post-operative patient?
15 A. Yes.
16 Q. Do you see that most often in a
17 patient who has had a laparoscopy compared to
18 a laparotomy?
19 A. Both cases we can see. I don't know
20 the exact numbers of patients.
21 Q. What is pneumomediastinum?
22 A. Air in the mediastinum cavity.
23 Q. How does that arise? How does that
24 happen?
25 A. Oh, it could be due to ruptured
0011
1 , M.D.
2 aneurism, ruptured esophagus.
3 Q. You are an obstetrician
4 gynecologist?
5 A. Yes.
6 Q. Are you an attending physician?

7 A. I just started, yes.
8 Q. Where?
9 A. Hospital.
10 Q. When did you finish your OB-GYN
11 training?
12 A. of .
13 Q. And where did you do your training,
14 your residency training?
15 A. Hospital.
16 Q. What are the most frequent
17 complications that are associated with an
18 intraoperative colon injury?
19 A. Would you repeat that, please?
20 Q. Sure.
21 I'm talking about the injury that
22 occurs during surgery to the colon.
23 Can you tell me what are the most
24 common complications that occur in the event
25 there is a, I should say, unrecognized colon

2 injury?
3 MS. : I am going to object to
4 that question.
5 MR. OGINSKI: I will rephrase it.
6 Q. Can you tell me what are the most
7 common complications of an intraoperative
8 colon injury?
9 A. Well, most common complications
10 could be infection in the peritoneum,
11 peritonitis, a fistula formation and
12 eventually colostomy formation for repair.
13 Q. Would abscesses be included within
14 that group of complications you just
15 mentioned?
16 A. Could be.
17 Q. Would ileus be one of the
18 complications that could arise from a colon
19 injury?
20 A. Well, we don't call ileus really a
21 complication. It could be a finding.
22 Q. Tell me how a bowel injury during
23 surgery could cause an infection.
24 A. Well, if there is spillage of fecal
25 matter into the peritoneal cavity that could

2 lead to infection and peritonitis.
3 Q. Can bowel injury cause any type of
4 fluid electrolyte imbalance?
5 A. Not initially. If it leads to
6 sepsis, septic shock then...
7 Q. How does bowel injury cause sepsis?
8 A. Again, if there is spillage of fecal
9 contents into the abdominal cavity it could
10 lead to infection and then it could lead to
11 blood -- infection of the bloodstream, and
12 that can lead to sepsis.

13 Q. If a patient has a bowel prep prior
14 to any abdominal surgery and there is some
15 type of injury to the bowel intraoperatively,
16 is it still possible to have fecal contents
17 remaining within the bowel?
18 A. Yes.
19 Q. How does bowel injury cause an
20 intraabdominal abscess?
21 A. The same mechanism. Spillage of
22 fecal contents can get collected somewhere in
23 the abdominal cavity and cause abscess.
24 Q. Would the same be true for
25 peritonitis?
0014
1 , M.D.
2 A. (No response.)
3 Q. In other words, explain to me how
4 bowel injury causes peritonitis.
5 A. I think I just told you. It's the
6 same thing. Irritation in the peritoneum from
7 spillage.
8 Q. After the patient is closed and
9 brought back to recovery and they are back on
10 the floor, if you suspect that a patient has
11 an intraabdominal abscess, what diagnostic
12 tool in your opinion is the best tool to use
13 to evaluate that condition?
14 MS. : I am going to object to
15 that question.
16 I think it's too broad.
17 If you want to specifically ask
18 about that case.
19 MR. OGINSKI: No.
20 MS. : Because you didn't say
21 what kind of surgery you are talking
22 about she had. You just said after
23 surgery.
24 MR. OGINSKI: I will rephrase it.
25 Q. If the patient has some form of
0015
1 , M.D.
2 abdominal surgery and postoperatively you
3 suspect there is some type of intraabdominal
4 abscess, is there a particular diagnostic
5 tool that you have available to you back in,
6 and again --
7 MR. OGINSKI: I will rephrase it.
8 Q. All of my questions are relating to
9 the time period of unless I
10 indicate otherwise.
11 In of , what was the
12 best diagnostic tool to evaluate a possible
13 intraabdominal abscess?
14 MS. : I object, because she
15 was a resident at the time in and
16 she wasn't diagnosing patients.
17 MR. OGINSKI: She is a named
18 defendant in the case.

19 MS. : But she was a resident
20 and she wasn't diagnosing anything in
21 without the oversight of the
22 attending.
23 MR. OGINSKI: Then she can tell me
24 that, but I am still entitled to probe
25 her medical knowledge.
0016
1 , M.D.
2 MS. : She is not an expert
3 and it's starting to border on that.
4 MR. OGINSKI: She's a defendant.
5 She's a physician. I am entitled to
6 probe her medical knowledge and ask her
7 what she knows.
8 MS. : She was a resident in
9 . I just want to make that clear.
10 So you can answer the question.
11 MR. OGINSKI: There is no issue
12 about that.
13 MS. : There is an issue.
14 There is an issue.
15 Go ahead.
16 Q. What was the best diagnostic tool
17 that was available to you to evaluate a
18 possible intraabdominal abscess in of
19 ?
20 MS. : Over my objection, you
21 can answer.
22 A. Well, it's not a single tool. It's
23 a combination of a lot of things.
24 Q. Let me stop you.
25 Was there, for example, was a CAT
0017
1 , M.D.
2 scan the best thing to look at an abscess
3 intraabdominally?
4 Was it an MRI, a sonogram?
5 I just want to know if there is one
6 definitive diagnostic tool that would best
7 assist you in evaluating and diagnosing that
8 condition.
9 MS. : One film?
10 MR. OGINSKI: No.
11 Q. One particular tool that you would
12 consider the gold standard for evaluating
13 intraabdominal abscesses.
14 A. I am not an expert in intraabdominal
15 abscesses, and I don't know if there is a
16 single standard.
17 Q. If you suspected the patient had
18 peritonitis following abdominal surgery, what
19 would be the best diagnostic tool for you to
20 evaluate peritonitis?
21 MS. : Over my objection you
22 can answer.
23 A. Well, it's again a combination of
24 factors. It's not a single diagnostic tool.

25   Q.   I understand that, Doctor, and I
0018
 1   , M.D.
 2   understand you need to correlate things
 3   clinically together with diagnostic findings,
 4   but I'm just asking from a diagnostic
 5   perspective.
 6   For example, is a CAT scan
 7   preferable to an MRI to evaluate a patient's
 8   abdomen for determining whether or not the
 9   patient has peritonitis?
10   MS. : Objection. I think
11   it's broad but you can answer.
12   A.   I can't answer that. That would be
13   for the radiologist to determine, or an
14   expert.
15   We are OB-GYN.
16   Q.   If you want to evaluate a patient
17   who possibly has an intraabdominal abscess, is
18   a CAT scan a better diagnostic tool than an
19   MRI?
20   MS. : Over my objection you
21   can answer.
22   A.   I don't know.
23   Q.   Is a sonogram ever useful for you as
24   a physician to evaluate an intraabdominal
25   abscess?
0019
 1   , M.D.
 2   MS. : Over my objection, you
 3   can answer.
 4   A.   No.
 5   We're not experts in sonogram to
 6   diagnose abscesses.
 7   Q.   But if you suspect that a patient
 8   has an abscess, what diagnostic test would you
 9   recommend or order for the patient?
10   MS. : Over my objection, you
11   can answer.
12   As long as it's clear on what years
13   you are talking about.
14   A.   At that point I was a resident still
15   in training and I was doing what I was told to
16   do.
17   Q.   What were you taught was the best
18   diagnostic tool to use, to order, if you
19   suspected that a patient had an abscess, an
20   intraabdominal abscess?
21   A.   No. Again, there is no single
22   diagnostic tool. It's a whole combination of
23   factors, a clinical picture, along with the
24   radiologist.
25   Q.   Are there instances in gynecology
0020
 1   , M.D.
 2   where you will order an MRI?
 3   A.   Yes.
 4   MS. : For what?

5 MR. OGINSKI: Anything.
6 Q. As well as ordering a CAT scan?
7 MS. : For what?
8 MR. OGINSKI: In general.
9 Q. You have occasion to order those
10 tests, correct?
11 A. Yes.
12 MS. : Ever?
13 Q. It's important as a gynecologist to
14 know the differences between what a CAT scan
15 can do as opposed to what an MRI can do,
16 correct?
17 A. Yes, but for a gynecologist, that is
18 not for abscess. We are not taught that.
19 Q. Okay.
20 If you suspect that a patient has a
21 pleural effusion, what is the best diagnostic
22 tool to evaluate that condition?
23 MS. : Over objection.
24 A. I wouldn't know.
25 Q. Are you currently an employee of

0021

2 Hospital?
3 A. Yes.
4 Q. Do you work for a faculty practice
5 group or some other entity within
6 Hospital?
7 A. The faculty practice group.
8 Q. Does that have a name or
9 professional corporation name?
10 A.
11 Q. Are you a shareholder of that group?
12 A. No.
13 Q. In of , were you a
14 second year resident of Hospital?
15 A. Yes.
16 Q. And am I correct that your OB-GYN
17 training was years?
18 A. Yes.
19 Q. And before starting your residency
20 at Hospital, where did you go to
21 medical school?
22 A. In .
23 Q. Where?
24 A. Medical College,
25 .

0022

2 Q. When did you complete your studies
3 there?
4 A. In .
5 Q. And what did you do after completing
6 your medical school in ?
7 A. I did one year of emergency medicine
8 in the same college, and then I did two years
9 OB-GYN diploma in Medical
10 College.

11 Q. Also in ?
12 A. Yes, , .
13 Q. And after that, what did you do?
14 A. After that I worked in another
15 hospital, Hospital, for another
16 years, in , .
17 Q. In what field of medicine?
18 A. Same, OB-GYN.
19 Q. And then what did you do?
20 A. And then I came here. I took my
21 .
22 Q. Are you a U.S. resident?
23 I am sorry.
24 Are you a citizen?
25 A. No.

2 Q. Are you licensed to practice
3 medicine in the State of New York?
4 A. Yes.
5 Q. When were you licensed?
6 A. .
7 Q. You are not board certified yet,
8 correct?
9 A. No.
10 Q. Are you board eligible?
11 A. Yes.
12 Q. You have not taken your written
13 boards yet?
14 A. I took the written on . I
15 passed those, but orals are next year, oral
16 exams are next year.
17 Q. Today or sometime before today, did
18 you have a chance to review 's
19 hospital record?
20 A. Yes.
21 Q. Other than the record, did you
22 review any other documents relating to this
23 particular patient?
24 A. No.
25 Q. Did you review any deposition

2 testimony that has been given in this case?
3 A. No.
4 Q. Have you ever testified before?
5 MS. : Over my objection, you
6 can answer.
7 A. Testify meaning --
8 Q. Where an attorney is asking you
9 questions in a setting like this.
10 A. Yes.
11 Q. How many times have you done it in a
12 similar setting?
13 MS. : Over my objection, you
14 can answer.
15 A. Once.
16 Q. Have you ever testified at trial?

17   A.   No.
18   Q.   And just for completeness, Doctor,
19   that other occasion when you testified, was
20   that as a fact witness or were you asked
21   questions about what had happened, or were you
22   one of the parties who were sued in a
23   lawsuit?
24   MS. : Over my objection you
25   can answer.
0025
 1   , M.D.
 2   Do you know if you were a party to
 3   that other suit or if you were just a
 4   nonparty witness.
 5   Do you know?
 6   THE WITNESS: I don't understand the
 7   meaning of party.
 8   MS. : She is not a legal
 9   expert. She may not know.
10   Q.   Were you sued in the case in which
11   you gave testimony?
12   MS. : Only if you know.
13   Only if you know.
14   MR. OGINSKI: The questions are
15   always if you know.
16   MS. : I just don't want her
17   to get confused with the legal...
18   A.   I was a resident.
19   MS. : He wants to know if you
20   were actually sued, served with a summons
21   and complaint, named in the caption in
22   that other case.
23   If you don't know, say you don't
24   know.
25   A.   I was dropped from the suit. So I
0026
 1   , M.D.
 2   don't know.
 3   Q.   Did you review any literature in
 4   preparation for today?
 5   A.   No.
 6   Q.   Did you review any textbooks?
 7   A.   No.
 8   Q.   Have you published anything in the
 9   field of OB-GYN?
10   A.   No.
11   Q.   Have you given any lectures to any
12   national bodies of OB-GYN, ACOG --
13   A.   No.
14   Q.   -- or any similar organization?
15   A.   No.
16   Q.   I would like you to turn please to
17   your   note.
18   A.   Um-hum.
19   Q.   What rotation were you on at that
20   time?
21   A.   I'm presuming GYN rotation.
22   Q.   And describe to me what your duties

23   were on the GYN rotation as a   year
24   OB-GYN resident.
25   A.   Well, we would come in at six

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1   , M.D.
2   o'clock in the morning and round on the
3   patients who were assigned to us by the chief
4   resident, and you write notes, you examine
5   them, and then we do sign-out time, which is
6   eight o'clock, seven to eight.
7   We discuss like morning records from
8   the night team to the day team, and then we go
9   to the operating room for cases that are
10   assigned to us by the chief resident.
11   In the evening around four or five
12   o'clock we round again with the chief, and go
13   home around 6:30.
14   Q.   If you were assigned to a particular
15   patient on any given day, would you tend to
16   see that patient regularly until they had left
17   the hospital, until you rotated out?
18   A.   No. The assignments would be
19   changed almost every day.
20   Q.   How many   year OB-GYN
21   residents were there at that time?
22   A.   We had   in the program.
23   Q.   in each year?
24   A.   Yes.
25   Q.   And there's a   year and also a

0028

1   , M.D.
2   year?
3   A.   Yes.
4   Q.   Now, the   years, what do you
5   call those?
6   Are those juniors?
7   A.   No,   year.
8   Q.   And the   years, are those the
9   chiefs?
10   A.   Yes.
11   Q.   And how many residents would be in
12   the GYN rotation at any one time?
13   A.   It really varies a lot, but it's
14   between   to   .
15   Q.   Do you have a memory of
16   separate and apart from this hospital
17   record?
18   A.   No.
19   Q.   Do you recall what she looked like?
20   A.   No.
21   Q.   Do you recall any conversations that
22   you had specifically with her during the time
23   that she was at   Hospital in
24   of   ?
25   A.   No.

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1   , M.D.
2   Q.   Do you have any memory of having any

3 conversation with any of 's
4 family while she remained at the hospital?
5 A. No.
6 Q. In the course of your review of this
7 patient's chart, did you see notes that you
8 had written and authored?
9 A. Yes.
10 Q. And was it customary, Doctor, that
11 after you rounded on a patient in the morning
12 or at any time during the day that you would
13 then enter a note in the chart reflecting
14 why you were there and what your findings
15 were?
16 A. Most of the time, unless we are very
17 busy or running somewhere.
18 Q. Now, I noticed there are notes in
19 two different formats.
20 One is in a form that you use, it
21 says postoperative progress note; correct?
22 A. Yes.
23 Q. And another is a progress note,
24 which is lined sheets.
25 A. Um-hum.

2 Q. Tell me the differences as to why
3 you would make an entry on the form
4 postoperative progress note, which is a
5 preprinted form, as opposed to a blank
6 progress sheet.
7 A. The morning round, the first note in
8 the morning would usually be on the preprinted
9 format, and after that, subsequently, if we
10 have to add anything in the chart would be in
11 these progress notes.
12 Q. If you had a discussion with your
13 chief residents or your senior residents above
14 you about a patient's course of treatment,
15 would you typically make an entry in the chart
16 about your conversation?
17 A. No.
18 Q. If you had a conversation with the
19 attending physician about an issue that needed
20 to be resolved concerning the patient's care
21 and treatment, what was your practice at that
22 time about recording that conversation in
23 summary in the chart?
24 MS. : Objection to form.
25 You can answer.

2 A. Sometimes we would write. Sometimes
3 not, because sometimes we were elsewhere and
4 you're talking on the phone or talking
5 somewhere else on the floor, not always you
6 can come in and make an entry.
7 Q. When you would write your notes,
8 would they be done at the time that you are

9 doing your examination or would they be at a
10 later time?
11 MR. OGINSKI: I am sorry.
12 Let me rephrase it.
13 Q. If you come and see the patient,
14 let's say at seven o'clock in the morning and
15 you examine them and it takes a few minutes
16 and now you leave, do you sit down and write
17 your note at that time or do you do it at a
18 later time, if you have some free time during
19 the day?
20 A. Most of the time we usually write it
21 right after the exam, unless we have been
22 called for an emergency. Then we come back
23 and finish up the note.
24 Q. What I would like you to do, Doctor,
25 I am going to ask you to read your note in its
0032
1 , M.D.
2 entirety and if there are abbreviations, just
3 tell me what they represent, and I will ask
4 you some questions about it later.
5 MS. : Read it slow for the
6 court reporter.
7 Q. Beginning with the date and time,
8 please.
9 A. ````. 12 p.m., note.
10 Called to the floor for T 38.9.
11 MS. : He wants you to tell
12 him what the abbreviations are.
13 Q. Temperature.
14 MS. : Temperature.
15 A. On examination, pulse is 112
16 permanent.
17 Respiratory rate 14 per minute.
18 Blood pressure 100 by 70.
19 Q. I am sorry. Is that 105 or 100?
20 A. No, 100.
21 Lungs clear to auscultation.
22 Abdomen soft.
23 Bowel sounds sluggish.
24 Dressing dry.
25 No calf tenderness.
0033
1 , M.D.
2 Assessment: Status post exploratory
3 laparotomy.
4 BSO, which is bilateral
5 salpingo-oophorectomy.
6 Lysis of adhesions with questionable
7 basal atelectasis.
8 Plan: Continue --
9 Q. You missed the line above that,
10 Doctor.
11 A. Oh. Watch for bowel perforation.
12 Plan: Continue vitals monitoring,
13 temperature monitoring. If continued spiking
14 consider x-ray FUA, which is flat and upright.

15 Physical therapy consult to
16 encourage ambulation and respiratory therapy.
17 Encourage incentive spirometer.
18 Encourage ambulation.
19 Q. You don't have to read the last,
20 Doctor.
21 A. Discussed with Dr. .
22 Q. Your signature appears at the
23 bottom?
24 A. Yes.
25 Q. Do you have a memory of discussing
0034

2 your findings with Dr. ?
3 A. No.
4 Q. Do you have any information in this
5 note about what Dr. ' response was to
6 your discussion?
7 A. No.
8 Q. Do you have anything to indicate
9 what his plan of treatment was, other than
10 what you have in your note here?
11 MR. OGINSKI: I am going to rephrase
12 that.
13 Q. Did Dr. recommend the
14 treatment plan that you have listed here?
15 MS. : Does she remember or
16 would it be the custom and practice to do
17 something?
18 Q. The plan that you have listed here,
19 was that your plan? Was it Dr. ' plan,
20 a combination or something else?
21 A. No. It's always the attending's
22 plan because we are really -- we really don't
23 write anything on our own.
24 Q. Did Dr. see the patient
25 around the same time that you did?
0035

2 A. I don't know.
3 Q. Was Dr. with you when you saw
4 the patient?
5 A. I'm not sure. I don't remember.
6 Q. You mentioned in the note that bowel
7 sounds were sluggish.
8 Tell me what that means.
9 A. Sluggish means slower.
10 Q. And did you have any reason or
11 explanation for why they were sluggish?
12 A. I mean, my thinking from my
13 knowledge right now is that it could be
14 because of normal postoperative findings.
15 Q. Now, in the assessment you indicated
16 questionable basal atelectasis.
17 Tell me what you meant.
18 A. Because it's a normal postoperative
19 finding. So I guess that's why I'm writing it
20 here.

21   Q.   What finding did you observe that
22   suggested that this patient possibly had basal
23   atelectasis?
24   A.   I presume it must be the fever,
25   that's why, because the first cause of fever
0036
1   , M.D.
2   here we think about basal atelectasis.
3   Q.   This particular fever that was
4   noted at 38.9, is that outside the range of
5   normal?
6   MR. OGINSKI: Withdrawn.
7   Q.   Is that febrile?
8   A.   I mean, clinically significant fever
9   is more than 39.
10   Q.   You wrote down, watch for bowel
11   perforation.
12   Tell me why you wrote that.
13   A.   I don't remember why I wrote that
14   but it's a normal -- I mean, this is what we
15   are taught in the training, to look for all
16   these things postoperatively.
17   Q.   What was it about the patient's
18   findings that suggested to you that someone
19   should watch for bowel perforation?
20   MS. : Objection.
21   A.   (No response.)
22   Q.   Was there anything in this patient's
23   examination that suggested she had a bowel
24   perforation?
25   A.   I don't remember the patient at that
0037
1   , M.D.
2   time, but it's a normal statement.
3   Q.   Doctor, I am only asking based upon
4   your note.
5   Is there anything in here, any of
6   your findings, to suggest that this person had
7   a bowel perforation at that time?
8   MS. : Based on your note,
9   he's asking.
10   A.   Not really, because it says abdomen
11   soft.
12   Maybe it was tachycardia, a
13   temperature of 38.9, but nothing really
14   significant.
15   Q.   At that time, did you suspect that
16   the patient might have a bowel perforation?
17   A.   According to my note, no. I don't
18   remember anything.
19   Q.   And what was the reason for writing
20   to watch for bowel perforation?
21   MS. : I think she just told
22   you that.
23   Asked and answered.
24   Q.   Now, what was it that you would be
25   looking for, for bowel perforation?
0038

1 , M.D.
2 MS. : We already went through
3 this at the beginning of the deposition.
4 MR. OGINSKI: But I asked generally
5 before. I am asking specific to this
6 patient now.
7 MS. : Are there any
8 differences?
9 MR. OGINSKI: I don't know.
10 MS. : She already went
11 through the signs and symptoms that you
12 would look for a bowel perforation
13 post abdominal surgery.
14 Why don't ask you her whether there
15 are any differences between what she said
16 before and with this patient?
17 Q. Doctor, what is it you intended to
18 look for, to watch for if this patient did in
19 fact have a bowel perforation?
20 MS. : Over my objection, you
21 can answer.
22 A. It's not me alone particularly who
23 would be watching for bowel perforation. Just
24 the writing, watch for bowel perforation,
25 means general statement for everybody, like
0039
1 , M.D.
2 vital signs monitoring, looking for how she
3 tolerates food, abdominal signs, all the signs
4 I told you before.
5 Q. Wouldn't that be true of any
6 postoperative patient who has had surgery?
7 A. Exactly.
8 Q. Why specifically did you write this
9 particular note, this particular liner note to
10 watch for bowel perforations?
11 MS. : She just told you it
12 was a general statement, as for any other
13 thing she wrote.
14 Q. Were you taught that postoperatively
15 you should always watch for signs of bowel
16 perforation?
17 A. Yes.
18 Q. Okay. And it's a standard and
19 routine thing you do as a physician, correct?
20 A. Yes.
21 Q. And if there are certain signs of
22 bowel perforation then you will take it one
23 step further and evaluate; correct?
24 A. Right.
25 Q. Did you write in every postoperative
0040
1 , M.D.
2 patient to watch for bowel perforation?
3 MS. : Objection. Objection.
4 Q. Were you taught to write in your
5 notes watch for bowel perforation in every
6 postoperative patient?

7 MS. : Objection.
8 You can answer.
9 A. Well, we were not taught clearly as
10 to write or not to write but always think
11 about it.
12 Q. Is there any difference --
13 MR. OGINSKI: Withdrawn.
14 Q. When you examined the patient, she
15 had tachycardia; correct?
16 A. Yes.
17 Q. And she had a fever, right, even
18 though -- how would you characterize this
19 fever?
20 Low grade or something else?
21 A. Low grade.
22 Q. Was there any abdominal tenderness?
23 A. Well, according to my note it
24 doesn't mention. So I don't know.
25 Q. Did you evaluate for abdominal
0041
1 , M.D.
2 tenderness?
3 A. Yes.
4 Q. And if the patient had tenderness,
5 would you have expected to make note of that?
6 A. Yes. But it's also a normal
7 postoperative finding. She's only post-op day
8 one, so she would be having tenderness at the
9 incision post-op.
10 Q. Did you ever see or examine this
11 patient before ?
12 A. No.
13 Q. The sluggish bowel sounds that you
14 observed, that you attributed to the patient's
15 recent surgery; correct?
16 A. I did not attribute to anything. I
17 am presuming now that it could be a normal
18 postoperative finding.
19 Q. What other causes --
20 MR. OGINSKI: Withdrawn.
21 Q. If you have sluggish bowel sounds
22 postoperatively, what else could it signify?
23 A. Any irritation of the bowel can lead
24 to ileus. So it could be recent surgery or
25 infection, electrolyte imbalance.
0042
1 , M.D.
2 Q. How often would you typically round
3 on a patient? Would it be twice a day?
4 A. Yes, but not always on the same
5 patient.
6 Q. Now, did you learn, in reviewing
7 this patient's chart and in the notes that you
8 had written that she maintained a fever
9 throughout most of her postoperative period,
10 certainly through post-op days one through
11 five?
12 MS. : You have to check.

13   A.   I will have to check.
14   Q.   All right. I will come back to
15   that, then.
16   Now, did you see, Doctor, that on
17   a chest x-ray was taken?
18   A.   I didn't, no.
19   Well, here there is a note from the
20   x-ray people.
21   Q.   You are referring to a 7:30 p.m.
22   note on ?
23   A.   Yes.
24   Q.   And in the note that appears at
25   11:30 p.m., it says GYN note; do you see that?
0043
 1   , M.D.
 2   A.   Yes.
 3   Q.   Are you able to tell who wrote that
 4   note?
 5   A.   It was one of my chief residents at
 6   that time.
 7   Q.   Do you know who?
 8   A.   Dr. .
 9   Q.   Do you know Dr.   ' first name?
10   A.   .
11   Q.   Does Dr. still work at
12   Hospital?
13   A.   Yes.
14   Q.   Is she an attending?
15   A.   Yes.
16   Q.   In Dr.   ' note at 11:30 p.m.,
17   on the first page of it, do you see toward the
18   bottom it says, preliminary report of chest
19   x-ray, free air under the diaphragm, likely
20   due to abdominal surgery?
21   A.   Yes.
22   Q.   Did you ever learn the results of
23   that chest x-ray on ?
24   MS. : Did she ever?
25   MR. OGINSKI: Yes.
0044
 1   , M.D.
 2   A.   I was not even in the hospital.
 3   We go home at 6:30, 7:00, and we are
 4   not supposed to be there.
 5   Q.   You are not on the night shift at
 6   that time?
 7   A.   I presume not, because I'm writing a
 8   note in the daytime. I can hardly be a night
 9   person.
10   Q.   The following day on
11   you have a note; correct?
12   A.   Yes.
13   Q.   And that's the postoperative
14   progress notes?
15   A.   Yes.
16   Q.   Is that timed at 6:50 a.m.?
17   A.   Yes.
18   Q.   In your note, Doctor, do you refer

19   to the chest x-ray that was done the day
20   before?
21   A.   It says chest x-ray pending.
22   Q.   Did you ever learn as of the time
23   you wrote this note on , that there
24   was free air observed on chest x-ray? I
25   should say free air under the diaphragm.

2   A.   No, because usually if the chest
3   x-ray is done in the evening, we don't have a
4   radiologist to report it, and I would not
5   know what had happened the night before,
6   before I round on the morning, because we
7   get the morning report after I round between
8   7 to 8.
9   Q.   If a patient had diagnostic tests
10   such as an MRI, CAT scan, or an x-ray, was
11   part of your duties to actually go and view
12   and look at those diagnostic studies?
13   MS. : As a   year
14   resident?
15   MR. OGINSKI: Yes.
16   A.   Probably not.
17   Q.   Did you look at the patient's chest
18   x-ray at some time on in the
19   morning?
20   A.   I have no idea.
21   Q.   Is there anything in your note to
22   suggest that you, personally, looked at the
23   patient's chest x-ray?
24   A.   Nothing in the note suggests that.
25   Q.   Free air under diaphragm, what does

2   that represent in a postoperative patient?
3   A.   From my knowledge right now I would
4   say it could be normal postoperative finding.
5   Q.   What else could it represent?
6   A.   Bowel perforation, abscess.
7   Q.   Did you have any conversation with
8   any of your senior residents about the chest
9   x-ray that the patient had the day before?
10   MS. : According to her note?
11   MR. OGINSKI: On ,
12   yes.
13   A.   Like I said, when we come in we just
14   quickly see the patient and then we discuss
15   the patient after seeing the patient between
16   7 to 8 in the morning report.
17   So I am not sure if I had this
18   conversation.
19   Q.   Did you see the patient again for
20   which you have a written note on
21   ?
22   A.   I don't know.
23   MS. : He wants to know if you
24   have another written note for

1 , M.D.
2 A. I don't think so, unless it's in the
3 chart.
4 MS. : No. Just based on this
5 chart, do you have another note for
6 ?
7 THE WITNESS: No.
8 Q. Doctor, I would like you to read
9 your note of , 6:50 a.m.
10 A. Postoperative day number 2.
11 Procedure: Status post laparoscopy,
12 exploratory laparotomy, BSO bilateral
13 salpingo-oophorectomy, lysis of adhesions.
14 Primary gynecologist diagnosis:
15 Bilateral ovarian cyst.
16 Walking, yes.
17 Voiding, no.
18 Flatus, yes.
19 Defecation, no.
20 Tolerates liquids, yes.
21 Tolerates regular diet, no.
22 Q. You don't have to read the vital
23 signs, doctor, just your notes underneath
24 that.
25 Actually, I'm sorry.

1 , M.D.
2 The vital signs here, the patient
3 had a temperature of 39.4?
4 A. Yes.
5 Q. Is that febrile?
6 A. Yes.
7 Q. You noted maximum temperature also
8 of 39.4; correct?
9 A. Yes.
10 Q. Do you know whether she was
11 tackycardic at the time?
12 A. My notes say pulse rate of 96.
13 Q. And how would you describe that?
14 A. It could be normal.
15 Q. For this patient?
16 A. For anybody.
17 Q. Go ahead, please.
18 A. The examination?
19 Q. Yes.
20 A. Chest, clear.
21 Decreased air entry in the basal
22 region.
23 CVS, which is cardio vascular
24 system, within normal limits.
25 Abdomen soft.

1 , M.D.
2 Bowel sounds, plus.
3 Q. What does that mean?
4 A. Present.
5 Dressing, dry.

6 No calf tenderness.
7 Bowel sounds plus normal. I think
8 normal is with the bowel sounds.
9 Q. Continue.
10 A. The last --
11 Q. You can skip the letters.
12 A. Problems.
13 Q. Recent imaging?
14 A. Yes, chest x-ray pending.
15 Problems, postoperative day number 2
16 of laparotomy,.
17 Fever no, regular diet or bowel
18 movement. No voiding.
19 Plan: Follow blood and urine
20 cultures.
21 Follow chest x-ray.
22 Incentive barometer, physical
23 therapy, ambulate, pain management.
24 **Close watch for any signs of bowel**
25 perforation.

2 Discharge today, no, because of
3 fever and awaiting bladder and bowel
4 functions.
5 Signature.
6 Q. On the bottom right of your plan,
7 again you write, close watch for any signs of
8 bowel perforation.
9 Based upon your examination, did
10 this patient have any signs of bowel
11 perforation?
12 A. I'm looking at my note. I don't
13 think so because the bowel sounds are normal
14 and abdomen is soft.
15 Q. When you write, follow chest x-ray,
16 for whose benefit was that information?
17 Was that a note for you to follow or
18 another resident or someone else?
19 A. For the whole team.
20 Q. And whose obligation was it to check
21 on the x-ray results, the official report?
22 A. Well, it's not a single person's
23 obligation. It's the whole team. Anybody,
24 whoever gets time checks the x-ray first and
25 looks at it.

2 Q. And on , again when
3 you wrote, close watch for any signs of bowel
4 perforation, what specifically did you mean?
5 MS. : This is .
6 MR. OGINSKI: I apologize. What did
7 I say?
8 MS. : .
9 **Q. When you wrote, on ,**
10 close watch for any signs of bowel
11 perforation, what specifically did you mean?

12 **MS. : Over my objection you**
13 **can answer.**
14 **A. I didn't mean anything specific.**
15 **Again, it's like a normal**
16 **postoperative course.**
17 Q. When you checked the patient for
18 calf tenderness, what was that purpose? Why
19 did you do that?
20 A. It's not -- it's a normal thing for
21 every postoperative patient, we always check
22 for calf tenderness.
23 Q. Why?
24 A. Because they have a risk of having
25 deep venous thrombosis.

2 Q. And if there is tenderness, what
3 would it suggest to you?
4 A. Deep venous thrombosis.
5 Q. Can a patient who is in the
6 postoperative period have a bowel perforation
7 and have a soft abdomen?
8 MS. : Can it ever happen?
9 MR. OGINSKI: Yes.
10 A. I don't know.
11 Q. Did you participate in this
12 patient's surgery on with
13 Dr. ?
14 A. No.
15 Q. Did you participate in the patient's
16 corrective surgery on ?
17 A. No.
18 Q. Were you present for any
19 conversation between Dr. and the
20 residents regarding a decision to take the
21 patient to the operating room on
22 ?
23 MS. : Objection.
24 MS. : Over my objection, if
25 you remember.

2 MR. OGINSKI: What is the
3 objection?
4 MS. : She already said she
5 has no recollection of any conversation.
6 So I am objecting because it's already
7 been asked and answered.
8 But go ahead.
9 A. I don't remember.
10 Q. Did you have any specific concern on
11 that this patient might have a
12 bowel perforation?
13 A. As per my note, whatever I thought
14 must be in the note. I mean, I don't
15 remember.
16 Q. I am only asking you, Doctor, based
17 upon your note.

18 Was there anything in here to
19 suggest that you had a concern that this
20 patient had a bowel perforation?
21 A. Nothing very specific.
22 Q. Was there anything in general that
23 you thought this patient might have that would
24 lead you to conclude that she might have a
25 bowel perforation?

2 A. No.
3 Q. Were you taught what the standard of
4 care was in the event that a bowel perforation
5 was recognized postoperatively; in other
6 words, what do you do for a patient who has a
7 bowel perforation?
8 Were you taught that?
9 A. Yes, over the course of years.
10 Q. And what were you taught?
11 A. Well, if it's a recognized bowel
12 perforation, then she needs to be reoperated
13 and then you do a colostomy or bowel
14 anastamosis.
15 Q. Have you participated in those types
16 of corrective surgeries?
17 A. No.
18 Q. Am I correct that typically a
19 gynecologist does not tend to do that type of
20 bowel repair?
21 MS. : Over my objection.
22 Ever in any hospital or in the whole
23 world?
24 Q. At Hospital, Doctor, in the
25 event there is a recognized bowel perforation

2 postoperatively, who gets called in to do the
3 repair?
4 A. It's usually the oncologist or the
5 surgeon, either/or.
6 Q. Now, you again saw the patient on
7 ; correct?
8 A. Yes.
9 Q. And you have a note timed at 6:40
10 a.m., right?
11 A. Yes.
12 Q. At that time, did you learn that a
13 CAT scan was ordered and completed the night
14 before?
15 A. As per my note, I don't think so.
16 I mean, I don't think I knew.
17 Q. Is there anything in your note to
18 suggest why this patient might have been sent
19 for a CAT scan on ?
20 A. No.
21 Q. Do you indicate in your note what
22 the official radiology finding was from the
23 chest x-ray that was taken on ?

24 A. No.
25 Q. Did you have any conversation with
0056
1 , M.D.
2 Dr. on in the morning
3 about this patient?
4 A. I don't remember.
5 Q. Did you have a conversation with
6 your other residents, either before or after
7 you examined the patient on , about
8 the plan of treatment and her management?
9 A. Well, I must have discussed in the
10 sign-out report, and it's usually the senior
11 chief residents who talked to the attending
12 and they decide the final plan of action.
13 Q. Now, can you turn back one page,
14 please.
15 MR. OGINSKI: Off the record.
16 (Whereupon, a discussion was held
17 off the record.)
18 Q. Doctor, can you read your note,
19 please?
20 MS. : From?
21 MR. OGINSKI: .
22 A. 6:40 a.m., postoperative day 3.
23 Procedure status post laparoscopy,
24 explore, an exploratory laparotomy, bilateral
25 salpingo-oophorectomy, lysis of adhesions,
0057
1 , M.D.
2 bilateral ovarian cyst.
3 Walking, yes.
4 Voiding, yes.
5 Flatus, yes.
6 Defecation, no.
7 Tolerates liquids, yes.
8 Tolerates regular diet, yes.
9 Temperature 39 degrees centigrade,
10 T max, maximum temperature, 39.4.
11 6 a.m., 140 over 70, blood pressure.
12 Pulse 88 per minute.
13 Respiration 14.
14 Pain score, 2 out of 10.
15 IV --
16 Q. You don't have to read that. What
17 is your physical exam?
18 A. Chest clear, cardiovascular system
19 within normal limits.
20 Abdomen soft.
21 Bowel sounds plus, present.
22 Sero sanguinous, discharge from the
23 stitch line, dressing changed.
24 Q. Doctor, you said there was discharge
25 from the suture line?
0058
1 , M.D.
2 A. Yes.
3 Q. Continue.

4 A. Labs.
5 Q. You can go past that.
6 A. Pathology diagnosis pending.
7 Problem: Postoperative day 3,
8 fever, no bowel movement and sero sanguinous
9 discharge from the wound.
10 Plan: Encourage ambulation,
11 incentive barometer. Follow white blood cell
12 count today.
13 Wound dressing daily or b.i.d.
14 Continue Heparin.
15 Discharge today, no.
16 Postoperative fever and rule out
17 wound infection.
18 Q. Is that rule out or work up?
19 A. Rule out, R/O.
20 Q. Again, your signature appears at the
21 bottom?
22 A. Yes.
23 Q. Why was the patient receiving
24 Heparin?
25 A. I don't know, but I guess because --

2 MS. : Don't guess.
3 A. I don't know.
4 Q. The fact that the patient was now in
5 post-op day 3, with no bowel movement, is that
6 a normal observation?
7 A. Could be, yes.
8 Q. Over what period of time would you
9 suspect the patient not to have bowel movement
10 following surgery?
11 A. Sometimes it can go up to a week or
12 more.
13 Q. The fact that the patient again
14 had a fever, a continuous fever since her
15 surgery, what, if anything, did that signify
16 to you?
17 A. I don't know if this is continuous
18 fever throughout the day or not, but this is
19 the morning note that I write.
20 Q. Well, you told me on the 13th she
21 had a fever of 38.9.
22 On the 14th she had a fever of 39.4.
23 And at the time you are examining
24 her now on the 15th at the time she had a
25 temperature of 39 with a max of 39.4.

2 What, if anything, was the
3 significance of those findings to you?
4 A. It could be a lot of things.
5 Q. Such as what?
6 A. Such as lung atelectasis, deep
7 venous thrombosis, pneumonia, wound
8 infection.
9 Q. Had you come to any conclusion as of

10 the 15th of as to the cause or
11 etiology for this patient's fever?
12 A. It's not up to me to reach the
13 conclusion.
14 Q. I'm just asking if you did, Doctor.
15 A. I don't think so. I would just
16 write whatever the findings are and the
17 attendings decide.
18 Q. Why would blood cultures and urine
19 cultures be obtained?
20 A. It's the normal thing to do if the
21 patient has fever.
22 Q. And what would those cultures tell
23 you?
24 A. If the patient has sepsis or urinary
25 infection.

0061

1 , M.D.
2 Q. Was the patient receiving any
3 postoperative antibiotics, prophylactics?
4 A. I'm not sure.
5 Q. Is there anything in your note to
6 indicate whether she was getting any type of
7 prophylactic antibiotics?
8 MS. : Just in this note.
9 A. No.
10 Q. Was there anything in your finding
11 here to suggest on 15th that this
12 patient had a bowel perforation?
13 A. No.
14 Q. Is there any particular reason why
15 you did not write the words, or in substance,
16 watch for bowel perforation, as you had done
17 in the two prior notes of the 13th and the
18 14th?
19 A. I don't remember.
20 Maybe because she -- I don't know.
21 Q. What made you believe that this
22 patient likely had a wound infection?
23 MS. : Where does it say she
24 likely has a would infection?
25 Q. You wrote, rule out wound

0062

1 , M.D.
2 infection.
3 MS. : That doesn't mean the
4 same thing. Please rephrase your
5 question.
6 Q. What made you believe that the
7 patient had a wound infection?
8 MS. : Again, objection.
9 That's not what it says.
10 Q. Doctor, you are familiar with the
11 term differential diagnosis; right?
12 A. Yes.
13 Q. What does it mean?
14 A. Well, you have a series of diagnoses
15 and then you have a differential, like many

16   other diagnoses that could be the patient's
17   real diagnosis.
18   Q.   And in order to rule out different
19   possibilities you will conduct different tests
20   to rule out a particular condition; correct?
21   A.   Yes.
22   Q.   Now, if you suspect that a patient
23   has a condition you will try and rule that
24   out; correct?
25   MR. OGINSKI: Withdrawn.
0063
1   , M.D.
2   A.   Yes.
3   Q.   And in this instance you wanted to
4   rule out that the patient had had a wound
5   infection based on the findings you observed
6   regarding discharge from the suture line?
7   A.   I wouldn't rule it out myself. I
8   would just read the findings to my chief or
9   the attending, and they will tell me to do
10   whatever tests to do and we will go from
11   there.
12   Q.   How do you rule out a wound
13   infection?
14   A.   It's clinical, wound discharge, or
15   cultures from the wound.
16   Q.   And were cultures from the wound
17   obtained?
18   MS. : According to your
19   note.
20   A.   I don't know.
21   Q.   Did you obtained wound cultures?
22   A.   Well, if I had obtained, it's not in
23   the notes.
24   I don't remember.
25   Q.   Is there anything -- I may have
0064
1   , M.D.
2   asked this. I am sorry if I did.
3   Is there anything in this note to
4   reflect the chest x-ray findings from
5   13th?
6   MS.: You already asked that
7   in the last note, about the last note.
8   Q.   I'm asking on the 15th
9   note, is there anything to suggest that you
10   had obtained the information regarding the
11   13th official chest x-ray read?
12   MS. : You are asking if it's
13   written in her note?
14   MR. OGINSKI: Yes.
15   MS. : Is it there in your
16   note, he wants to know.
17   That's a different thing of her
18   being aware of the results.
19   MR. OGINSKI: Correct.
20   : But he wants to know if
21   it was written in your note.

22 A. It's not in the notes.
23 Q. When you would round on a patient in
24 the morning, would you review the patient's
25 record to see what notes, if any, were made
0065
1 , M.D.
2 the night before?
3 A. Sometimes yes, sometimes no.
4 Q. And why would you sometimes review
5 the patient's chart from the night before?
6 A. Depends on how much time you have in
7 the morning, because any time in the morning
8 report we will get to know from the night
9 shift residents what was done.
10 Q. And what was your practice at that
11 time when you were given information by the
12 people who were leaving -- who had done
13 the night shift and now you were coming on
14 duty?
15 Would you make notes about different
16 things going on with different patients?
17 A. We do have a sign-out list which is
18 prepared by the night shift and given to the
19 day shift, and we write things to do.
20 Whatever our chief residents tell us to do,
21 we just do it.
22 Q. What do you do with that list?
23 A. We have it.
24 Q. Where?
25 A. We carry it the whole day with us.
0066
1 , M.D.
2 Q. What do you do after the day is
3 over?
4 A. Garbage.
5 Q. Do you give that list to the next
6 group of residents who are coming on for the
7 night shift?
8 A. Then you make up a new list.
9 Q. On 15th there is a note
10 timed at 17:00, which says, gram negative rods
11 in blood culture.
12 Do you see that?
13 A. Yes.
14 Q. What does that mean?
15 A. That means there is some sort of a
16 growth coming from the blood culture results.
17 Q. Are you able to identify where
18 within the patient that those gram negative
19 rods are or is that system-wide throughout the
20 blood?
21 A. Very hard to say.
22 Q. Are you able to tell me who wrote
23 this particular note?
24 A. Dr. .
25 Q. Turn please to the note timed at
0067
1 , M.D.

2   7:40 p.m., the note. Who wrote that
3   note?
4   A.   Another chief resident of mine.
5   Q.   Who was that?
6   A.   Dr. .
7   Q.   What is Dr. 's first name?
8   A.   .
9   Q.   Does Dr. work at
10   Hospital?
11   A.   No.
12   Q.   Where does Dr. work?
13   MS. : Objection.
14   You can answer if you know.
15   Q.   Do you have any knowledge as to
16   whether Dr. works in ?
17   MS. : Objection.
18   A.   I have no idea.
19   Q.   Did you learn --
20   MR. OGINSKI: Withdrawn.
21   Q.   Were you still on duty at 17:40?
22   A.   I have no recollection.
23   Q.   Do you have another note for this
24   patient on 15th?
25   A.   No.

2   Q.   Doctor, I want you to go back one or
3   two pages, please.
4   There is a notation or at least a
5   CAT scan sticker that appears in the bottom
6   left of that page.
7   Do you see that?
8   A.   Yes.
9   Q.   It says, "CAT scan completed," and
10   then it has a date of   .
11   Do you see that?
12   A.   Yes.
13   Q.   Is there an indication on that note
14   that appears right above it to indicate the
15   reason for the CAT scan?
16   A.   None of them is my notes.
17   Q.   I understand.
18   I'm just asking is there anything in
19   that nurse's note that indicates to you why
20   this patient was sent for a CAT scan?
21   MS. : I object.
22   She cannot interpret other people's
23   notes and the notes speak for
24   themselves. You can read them as well as
25   she. She wasn't there and she didn't

2   order the CAT scan. She didn't have a
3   CAT scan done.
4   Q.   Well, when you came in on the
5   15th, was there any discussion or anything to
6   suggest to you that a CAT scan was done the
7   day before?

8 A. I don't remember at all.
9 Q. We know that the patient did go for
10 a CAT scan on 15th.
11 Did you ever review the patient's
12 CAT scan?
13 A. I don't remember, because I'm not
14 the only person following the patient. It's
15 the whole team of residents.
16 Q. I'm just asking whether you did,
17 Doctor.
18 A. I don't remember.
19 Q. Now, going back to Dr. 's note,
20 please, timed at 17:40.
21 A. Um-hum.
22 Q. In the middle of the note, are you
23 able to read what -- it's a he, right?
24 A. She.
25 Q. -- what she writes about the CAT

2 scan?
3 MS. : Only if you can read
4 it.
5 A. No.
6 Q. Do you see where I am referring to?
7 MS. : Right here?
8 MR. OGINSKI: Yes, right there
9 (indicating).
10 MS. : Only if you can read
11 it. It's not your note.
12 A. Multiple fluid collection.
13 Q. Does that say can't rule out bowel
14 injury?
15 A. Could be, yes.
16 Q. Did you ever have any discussion
17 with Dr. about this observation on
18 15th?
19 A. I have no idea.
20 She's the chief resident.
21 Q. I am just asking whether you had a
22 conversation.
23 A. I don't remember at all.
24 Q. Did you ever have a conversation
25 with Dr. --

2 MR. OGINSKI: Withdrawn.
3 Q. Were you ever present for a
4 conversation that Dr. had with
5 Dr. on 15th?
6 MS. : Objection.
7 You are asking her to comment on a
8 conversation?
9 MR. OGINSKI: She's sitting in the
10 room.
11 MS. : Note my objection.
12 MR. OGINSKI: What is the basis?
13 MS. : She's can't comment on

14 a conversation she wasn't part of.
15 MS. : She is allowed to
16 comment on a conversation she heard about
17 the care, but I object.
18 She has already said numerous times
19 she has no recollection of any
20 conversations, which is beating a dead
21 horse here.
22 MR. OGINSKI: I still don't
23 understand your objection.
24 MS. : You can ask the
25 question.
0072
1 , M.D.
2 You have my objection.
3 MR. OGINSKI: Okay.
4 EXAMINATION
5 BY MR. OGINSKI:
6 Q. Doctor, were you present for any
7 conversation between Dr. and Dr.
8 on 15th?
9 A. I don't remember.
10 Q. When you came into the hospital --
11 turn to the next page, please, to a note by
12 Dr. at 11:00 p.m. on 15.
13 A. Yes.
14 Q. Going down to the bottom of this
15 note on the first page --
16 MS. : On the first page?
17 MR. OGINSKI: Yes.
18 Q. -- it says CAT scan of the abdomen.
19 Multiple fluid collections. Possible
20 abscesses.
21 Do you see that?
22 A. Yes.
23 Q. Were you ever made aware of that
24 finding when you came into the hospital the
25 next day on the 16th?
0073
1 , M.D.
2 MS. : According to her note?
3 MR. OGINSKI: Yes.
4 MS. : According to your note,
5 do you know if you were aware of that?
6 A. No.
7 Q. No, you were not aware; or, no, you
8 were not told?
9 A. I don't think so.
10 Q. Why?
11 Why do you say that?
12 A. Because I was day shift, and I must
13 have just come in and rounded.
14 Like I said, we don't talk before
15 seven. We talk after.
16 Q. Is there anything in your note on
17 16th to reflect what the chest x-ray
18 on 13th was, what the official
19 radiology read was?

20 MS. : As a result of what is
21 listed there, is what you are asking
22 her?
23 MR. OGINSKI: Yes.
24 A. The results are not listed.
25 MS. : In your notes.

2 THE WITNESS: In my notes, yes.
3 Q. When you go to check on a patient,
4 if you are the one to be writing the note, is
5 it also your obligation to check on the
6 patient's labs?
7 A. Well, the previous labs, we do, yes.
8 Q. And as part of checking the
9 patient's labs, do you do that by checking the
10 computer?
11 A. Not always.
12 Sometimes we just go by the list
13 that we have.
14 Q. And if the patient had had, let's
15 say, an x-ray or a CAT scan the day before or
16 the night before, how would you learn that
17 information just from looking at either the
18 chart or the computer?
19 A. It's not always in the computer
20 because the investigations are done at night.
21 They don't even come up in the computer unless
22 they have been read officially the next day by
23 the radiologist, which may happen in the
24 afternoon.
25 MS. : He just wants to know

2 how you would learn about the result of
3 any imaging studies.
4 MR. OGINSKI: Thank you.
5 MS. : How would you learn
6 about it?
7 A. In the morning at 6 o'clock?
8 Q. Yes.
9 A. If they have already been reported
10 officially by the radiologist, until then they
11 would be in the computer. Otherwise, I would
12 not find out.
13 Q. Can you read your note, Doctor, for
14 16th.
15 A. 6:40 a.m., postoperative day 4:
16 Status post laparoscopy, exploratory
17 laparotomy, bilateral salpingo-oophorectomy,
18 extensive lysis of adhesions.
19 Bilateral ovarian cyst.
20 Walking, yes.
21 Voiding, yes.
22 Flatus, yes.
23 Defecation, yes.
24 Tolerates liquids, yes.
25 Tolerates regular diet, yes.

0076
1 , M.D.
2 Temperature 38, T max 39, 12/15, 6
3 a.m., blood pressure 110 by 70, pulse 92,
4 respiration 16, pain score 2 out of 10.
5 MS. : Do you need all this?
6 MR. OGINSKI: No.
7 Q. Go to the physical exam.
8 A. Chest and cardiovascular system
9 within normal limits.
10 Abdomen soft.
11 Bowel sounds present.
12 Stitch line healthy.
13 No discharge.
14 And then labs.
15 Q. You can go down.
16 A. Problems: Fever.
17 Plan: Follow complete blood cell
18 count today. Continue triple antibiotics.
19 Ambulate, continue physical therapy,
20 and close observation, and postoperative
21 fever.
22 Signature.
23 Q. And you wrote she was not going to
24 be discharged today?
25 A. No.
0077
1 , M.D.
2 Q. And what do you have written on the
3 bottom, please?
4 A. Postoperative fever.
5 Q. What information is contained on the
6 very bottom of that note?
7 A. That's not my note.
8 Q. Whose note is that?
9 A. Dr. , it looks like.
10 Q. Are you able to read that note?
11 MS. : Only if you can.
12 A. It says one -- I don't know what
13 this is -- day of IV antibiotics, and then I
14 don't know what this is, and discharged
15 tomorrow.
16 Q. Doctor, what do you do if another
17 physician who is caring for the patient writes
18 a note in the chart and you cannot read their
19 handwriting?
20 MS. : That's very, very
21 vague.
22 Do you mean writes it -- are you
23 talking about a note that she has to
24 review for some purpose?
25 I really don't understand the
0078
1 , M.D.
2 question.
3 Q. Another doctor writes a note for a
4 patient that you were caring for. As part of
5 your review, and you cannot read the doctor's

6   note and you need to know what the information
7   is in that note, what do you do?
8   MS. : You mean as a second
9   year resident?
10   MR. OGINSKI: Yes.
11   MS. : Like would she go up to
12   the attending and ask what it says?
13   MR. OGINSKI: Whatever.
14   A.   I don't know.
15   I wrote this in the morning and I
16 don't know what time he came in later in the
17 day and wrote it. I would not even know if he
18 wrote on my note.
19   Q.   My question was, if you couldn't
20 read another doctor's note, what do you do in
21 that instance?
22   MS. : That she needs certain
23   information from that note?
24   MR. OGINSKI: Yes.
25   A.   I would probably ask another
0079
1   , M.D.
2   resident or my chief resident, who would know
3   the plan, and ask them what do you think he
4   wrote or she wrote.
5   Q.   The patient's temperature was 38
6   degrees.
7   How would you characterize that?
8   A.   Now or at that time?
9   Q.   At the time.
10   A.   Just a temperature of 38.
11   Q.   Is it normal? Is it febrile? Is it
12 low? You tell me what it represents.
13   A.   Well, it's not febrile by
14 definition.
15   Q.   Does the patient still have some
16 type of low grade fever?
17   A.   No.
18   Q.   The maximum temperature was 39,
19 which you have already told me represents
20 fever, correct?
21   A.   Yes.
22   Q.   Do you know --
23   MR. OGINSKI: Withdrawn.
24   Q.   Did you record the patient's
25 etiology for her continued fever?
0080
1   , M.D.
2   A.   It's not in the notes.
3   Q.   In your review of the patient's
4   record in preparation for today, did you see
5   any notations which would indicate the reason
6   or the cause for this patient's continued
7   fever?
8   MS. : Up to this point?
9   MR. OGINSKI: Yes.
10   A.   But I'm not the only person who is
11 involved in this care. So it's not up to me

12   to decide the etiology.
13   MS. : He just wants to know
14   if you see any indication in the chart up
15   to this point as to what the etiology of
16   the fever was.
17   THE WITNESS: From everybody else's
18   notes?
19   MS. : Yes. You don't have to
20   read them all but just generally from
21   what we have learned.
22   THE WITNESS: Dr. ' note --
23   MS. : Go ahead. Answer the
24   question.
25   A.   The only note I see is from

2   Dr.   from at 5 p.m., which says
3   treat with Ampi, Genta, and Flagyl, for
4   septicemia.
5   Q.   Doctor, based upon your note of
6   16th, were there any clinical signs
7   to suggest that this patient had a bowel
8   perforation?
9   A.   As per my note, no.
10   Q.   Is there any specific reason that
11   you know of as you sit here now as to why you
12   did not record the phrase, watch for bowel
13   perforation?
14   A.   It might have been that she must
15   have been improving clinically. That's why.
16   Q.   Is there any other reason that you
17   can think of?
18   A.   No.
19   Q.   Who is Dr.   ?
20   A.   He was my resident at
21   that time.
22   Q.   And where does he work now?
23   MS. : Objection.
24   A.   I don't know.
25   Q.   Would you turn to the note

2 . It's a postoperative progress
3   note.
4   MS. : ?
5   MR. OGINSKI: Yes.
6   Q.   Can you tell me who wrote that note?
7   A.   Dr. .
8   Q.   Who is Dr.   ?
9   A.   She was also my resident.
10   Q.   Where does Dr.   work?
11   MS. : Objection?
12   A.   Hospital and another
13   hospital.
14   Q.   Which one?
15   A.   I don't know.
16   Q.   Is she an   ?
17   A.   Yes.

18 Q. An OB-GYN?
19 A. Yes.
20 Q. On the left side of the problem
21 sheet, number 3, says pelvic abscess.
22 Do you see that?
23 A. Yes.
24 Q. Under recent imaging, in the middle
25 of the page under CAT scan, it says -- can you
0083
1 , M.D.
2 read that?
3 MS. : Only if you can. It's
4 not your note.
5 MR. OGINSKI: We know it's not her
6 note.
7 MS. : I want to make it clear
8 for the record.
9 MR. OGINSKI: Okay.
10 A. It looks like pneumoperitoneum,
11 multiple fluids collection, possible abscess.
12 Q. Did you learn that information from
13 anyone on ?
14 A. I have no idea.
15 I don't even know if I was there at
16 that time. She's senior to me. She wouldn't
17 relate to me.
18 Q. Did you ever learn up until
19 why this patient was receiving Heparin?
20 MS. : Based on her notes?
21 MR. OGINSKI: Yes.
22 MS. : Based on your notes.
23 A. No.
24 Q. Was there any suspicion that the
25 patient had a DVT?
0084
1 , M.D.
2 MS. : Objection.
3 Based on her notes?
4 Because I am not going have her go
5 through everything.
6 Q. Based on your notes.
7 A. No.
8 Q. Was there any suspicion that the
9 patient had a pulmonary embolus?
10 MS. : Based on your notes.
11 A. Based on my notes, no.
12 Q. Did you have an understanding as to
13 whether the patient had some venous condition
14 that required her to be Heparinized prior to
15 her arrival at Hospital on
16 ?
17 A. I don't know. I did not know the
18 patient before surgery.
19 Q. Can you turn please to the
20 , 5 p.m. note. I'm sorry. 10:20 p.m.
21 note.
22 Right there (indicating).
23 A. Okay.

24   Q.   It says, patient's CAT scan of
25   abdominal pelvis report came back.
0085
 1   , M.D.
 2   Are you able to tell who wrote that
 3   note?
 4   A.   No, no.
 5   Q.   Did you ever learn the information
 6   contained within this note?
 7   It says, extensive free air is noted
 8   throughout the abdomen and pelvis. Highly
 9   suggestive for hollow viscus perforation.
10   A.   This is at 10:20 p.m. So I don't
11   know.
12   Q.   What does hollow viscus perforation
13   mean to you?
14   A.   I mean any viscus which is hollow,
15   hollow structure, meaning bowel.
16   Q.   And when it's written, extensive
17   free air observed, what does that mean to you?
18   A.   Extensive free air means extensive
19   free air.
20   Q.   Why would there be extensive free
21   air in a finding like this?
22   MS. : Objection.
23   MR. OGINSKI: Withdrawn.
24   Q.   If there is a bowel perforation,
25   explain to me why radiographically you would
0086
 1   , M.D.
 2   see free air?
 3   A.   Because bowel is in connection with
 4   exterior through the bowel and through the
 5   rectum. So you can have free air inside the
 6   abdominal cavity.
 7   Q.   Would you turn, please, to
 8   Dr. 's note at 11:50 p.m. on
 9   .
10   Under his assessment he writes --
11   she writes, questionable possible bowel
12   injury.
13   Do you see that?
14   A.   Yes.
15   Q.   And under plan, what does it say
16   under the first line under the plan?
17   MS. : Only if you can.
18   A.   I don't know. Something discussed
19   with Dr. .
20   Q.   When you came in the next morning,
21   did you see in the chart that there were these
22   notes by your fellow GYN residents regarding
23   the CAT scan findings?
24   A.   I don't remember.
25   Q.   Is there anything in your
0087
 1   , M.D.
 2   note timed at 6:40 a.m. to suggest that
 3   you were aware that the patient, number one,

4 had a CAT scan and, number two, what the
5 findings were?
6 A. Well, my note says follow official
7 CT scan. So I guess I knew that she had
8 it, but it was probably not officially
9 reported.
10 Q. Is there anything in your note to
11 suggest that you were aware of what the
12 unofficial read of the CAT scan was?
13 A. It's not in my notes.
14 Q. Did the patient have a fever when
15 you examined her?
16 MS. : On ?
17 MR. OGINSKI: Yes.
18 A. As per my notes, no.
19 Q. Her abdomen was soft and she had
20 positive bowel sounds?
21 A. Yes, according to my notes.
22 Q. Under pathologic diagnosis, what is
23 a mucinous cystadenoma?
24 A. It's a benign cyst of the ovary.
25 Q. Read please from problems and plan.

2 A. Fever, positive blood culture,
3 malnutrition.
4 Plan: Follow complete blood cell
5 count today. Continue physical therapy.
6 Possible nutrition consult.
7 Follow blood cultures sensitivity.
8 Get pre albumin.
9 Continue IV antibiotics.
10 Follow official CT scan.
11 And discharged today, no.
12 Evaluate the cause of fever and
13 continue IV antibiotics.
14 Q. Is there any mention about the
15 patient's Heparin?
16 MS. : In that note?
17 MR. OGINSKI: Yes.
18 A. Not in the note.
19 Q. Why did the patient have
20 malnutrition?
21 A. I don't know.
22 Q. Did you have any conversation with
23 Dr. regarding the patient's
24 malnutrition?
25 A. I don't remember.

2 Q. Did you have any discussion with the
3 residents as to why this patient was not going
4 to the operating room to address the findings
5 that were observed on the CAT scan?
6 MS. : Can you read the
7 question back, please?
8 I didn't get it.
9 (Whereupon, the requested portion

10 was read back by the reporter.)
11 A. I don't remember.
12 Q. Is there anything in your note to
13 suggest the patient might be going to the
14 operating room?
15 A. Not in the notes.
16 Q. Was there anything in this note that
17 would suggest to you that you suspected or
18 that the patient --
19 MR. OGINSKI: Withdrawn.
20 Q. Is there anything in your
21 note to suggest that you were thinking
22 this patient might have a bowel perforation?
23 MS. : What in your note, he
24 wants to know. Is there anything in your
25 note to suggest that.

2 A. No. It just lists the findings that
3 I have. It's not my thinking.
4 Q. Were you present for any
5 conversation that any of your residents had
6 with Dr. regarding any decision being
7 made whether the patient should go to the
8 operating room?
9 MS. : Over objection, you can
10 answer.
11 A. I don't remember.
12 Q. Would you agree, Doctor, it is
13 important to recognize a bowel perforation
14 early?
15 MS. : Generally?
16 MR. OGINSKI: Yes, generally.
17 MS. : Over objection, you can
18 answer.
19 A. Yes.
20 Q. Why?
21 A. Because if you diagnose early you
22 can treat it early.
23 Q. And what is the implication for the
24 patient if it is not recognized early?
25 MS. : What are all the

2 implications of any random patient? I
3 think that's really broad.
4 MR. OGINSKI: I'll rephrase it.
5 Q. Would you agree, Doctor, that the
6 longer a bowel perforation goes unrecognized
7 in the postoperative period, that there's a
8 greater risk of mortality and associated
9 morbidity?
10 MS. : Over objection, you can
11 answer.
12 A. Are you talking about my knowledge
13 right now or from the time I was a second
14 year?
15 Q. Your general knowledge of medicine.

16 A. Yes.
17 Q. Why?
18 A. Well, if it's longer it could lead
19 to fistula formation or sepsis.
20 Q. Did you learn on 19th that
21 the patient was going to have drainage of her
22 pelvic abscess by interventional radiology?
23 MS. : Based on her note did
24 she know that?
25 Q. Is there anything in the office that

2 suggests to you that you know that?
3 MR. OGINSKI: I will rephrase it.
4 MS. : The reason is your
5 questions are vague.
6 MR. OGINSKI: I'll rephrase it.
7 Q. In your review of the chart, did any
8 of the notes refresh your memory about this
9 patient going for interventional radiology to
10 drain her abscesses?
11 MS. : Refresh your memory, he
12 wants to know.
13 A. No.
14 Q. Is there anything in your note to
15 suggest --
16 MR. OGINSKI: Withdrawn.
17 Q. Did you ever learn at any time on
18 19th that the patient went to have
19 her abscesses drained by interventional
20 radiology?
21 A. I don't remember at all.
22 Q. Did you ever learn on 19th
23 what the findings were by the interventional
24 radiologist?
25 A. I don't remember.

2 Q. Can you turn, please, to a 5:30 p.m.
3 note by Dr. on 19th.
4 A. Um-hum, yes.
5 Q. It says, case discussed with
6 Dr. -- what is that name there?
7 A. .
8 Q. Who is Dr. ?
9 A. I think she was a cover
10 . She must have been at that time,
11 if her name is there.
12 Q. The note continues and says, patient
13 needs bowel prep and exploratory laparotomy,
14 possible bowel resections, possible colostomy.
15 Did you ever learn that information
16 from Dr. on 19th?
17 MS. : On 19th.
18 A. I don't remember. It's 5:30.
19 Q. The note continues and says, patient
20 explained.
21 Did I read that right?

22   A.   Yes.
23   Q.   It says OR called. Consent to be
24   obtained.
25   When it says OR called, what does it
0094
 1   , M.D.
 2   mean to you?
 3   A.   They usually call the operating room
 4   to schedule the surgery.
 5   Q.   Did you ever learn on 19th
 6   that the patient was going to have surgery on
 7   the 19th?
 8   A.   I would never learn. She's my chief
 9   resident. She wouldn't inform me.
10   Q.   I am just asking if you know,
11   Doctor.
12   A.   I don't remember.
13   Q.   Did you learn on 20th the
14   following day that the patient was taken to
15   the operating room on the 20th?
16   A.   Well, as per my note in the morning,
17   it says OR today. So I guess the plan was to
18   take her to the OR.
19   Q.   Did you ever determine --
20   MR. OGINSKI: Withdrawn.
21   Q.   Were you present for any
22   conversation with any resident as to why the
23   patient was not taken to the operating room
24   on 19th as opposed to the 20th?
25   A.   I don't remember being present.
0095
 1   , M.D.
 2   Q.   On   20th, when you saw the
 3   patient before she went to the operating room,
 4   did you learn from anyone why she was not
 5   taken to the operating room the night or the
 6   evening before the 19th?
 7   A.   As per my note, no.
 8   Q.   When you saw the patient at 6:40
 9   a.m., it is now post-op day 8, did she have
10   fever?
11   A.   According to my note, no.
12   Q.   What was your physical exam, Doctor?
13   A.   Chest, cardiovascular system within
14   normal limits. Abdomen, soft. Stitch line
15   healthy.
16   Bowel sounds present.
17   Q.   You can go down to the problems.
18   A.   Postoperative day 8, bowel
19   perforation, malnutrition, fever.
20   Plan: OR today. Possible bowel
21   resection, possible colostomy.
22   Total parenteral nutrition after
23   surgery. Nutrition consent.
24   Discharge today, no.
25   Patient for OR today.
0096
 1   , M.D.

2 Bowel perforation, malnutrition.
3 Q. What findings suggested that this
4 patient had a bowel perforation?
5 MS. : Based on her note?
6 MR. OGINSKI: Yes.
7 MS. : I mean that question
8 doesn't make sense. We had scans and
9 everything else that diagnosed it.
10 I don't understand your question.
11 Q. Is there anything in your note which
12 would indicate or suggest that this patient
13 had a bowel perforation?
14 MS. : Other than she wrote
15 bowel perforation?
16 MR. OGINSKI: I want to know why she
17 wrote it.
18 A. Maybe it's general knowledge from
19 discussion from the prior day. I'm not sure
20 why.
21 Q. Did you ever record what the CAT
22 scan results were?
23 A. It's not recorded in my notes.
24 Q. Did you ever learn of the CAT scan
25 results from either 15th or

2 ?
3 A. I don't remember. It's not in my
4 notes.
5 Q. Did you ever have any conversation
6 with the patient about these findings?
7 A. I don't remember.
8 Q. Did you have any conversation with
9 any resident or attending about whether this
10 patient should have been taken to the
11 operating room before 20th, , to
12 explore for possible bowel perforation?
13 A. I don't remember.
14 Q. Did you continue to see the patient
15 after her 20th surgery?
16 A. I don't remember. I will have to
17 look through the notes.
18 MS. : Off the record.
19 (Whereupon, a discussion was held
20 off the record.)
21 A. 27th of .
22 Q. What time is your note?
23 A. 12:27. Must be an error. I don't
24 know.
25 Q. Why do you say that?

2 A. Because it's the same date.
3 Q. What do you mean?
4 A. , . It's probably an
5 error. I'm not sure.
6 Q. You mean the date and time are the
7 same?

8 A. Yes.
9 Q. Can you go down to the problems and
10 the plan, please?
11 A. Problem, postoperative day 7.
12 Colostomy, drains in situ, obesity.
13 Plan, physical therapy.
14 Ambulate, CT scan if vomiting
15 again. Follow labs today.
16 Q. Did you ever have any conversation
17 with Dr. , after this patient had her
18 surgery on 20th, regarding the events
19 that preceded the 20th surgery?
20 A. I have no idea.
21 Q. Was Ms. 's case ever
22 presented at rounds after 20th?
23 A. Rounds meaning?
24 Q. Where the residents or attendings
25 discuss patients and problems that may occur.

2 MR. OGINSKI: I'll withdraw it.
3 Q. From time to time are various
4 patients, during the course of their
5 hospitalizations, discussed either at
6 grand round or educational rounds with
7 attendings?
8 A. Are these bedside rounds?
9 Q. No.
10 In an educational setting where you
11 talk about the patients and what's going on
12 and how to prevent or watch for certain
13 things.
14 A. I don't remember.
15 Q. Were you ever asked to prepare any
16 written report or notes about your involvement
17 with this particular patient?
18 A. No.
19 MS. : Objection.
20 Q. Were you present for any
21 conversation between --
22 MR. OGINSKI: Withdrawn.
23 Q. Were you ever present at any
24 mortality or morbidity conference concerning
25 this patient?

2 MS. : Objection.
3 You can answer.
4 MR. OGINSKI: I'm entitled to know
5 if she was present. I didn't ask her
6 what was said.
7 MS. : You can answer.
8 A. I don't remember.
9 Q. Did you ever learn --
10 (Cell phone interruption.)
11 A. Sorry.
12 Q. On 20th before the patient
13 was taken to the operating room, did you ever

14   come to the conclusion as to why she --
15   MR. OGINSKI: Withdrawn.
16   Q.   Did you ever form an opinion as to
17   whether this patient had sepsis on
18   20th?
19   A.   According to my note, there is
20   nothing in the note.
21   Q.   Did you ever come to the conclusion
22   that the patient was in septic shock?
23   A.   It's not listed in my note.
24   Q.   Did you ever form an opinion or come
25   to the conclusion that the patient had

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1   , M.D.
2   peritonitis?
3   A.   I was a resident second year.
4   Q.   I understand.
5   A.   It's not up to my conclusion.
6   Q.   I'm only asking whether you did.
7   A.   It's not in the note at all.
8   Q.   Did you ever learn what the
9   intraoperative findings were on   20th
10   regarding the bowel perforation?
11   A.   I have no recollection. I don't
12   remember if I was in the service at that time.
13   Q.   How long was your rotation in ?
14   A.   It's usually for a week. So I don't
15   know. When it switched, I don't know.
16   MR. OGINSKI: Thank you you, Doctor.
17   MS. : No questions.
18   (Time noted: 12:25 p.m.)
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20
21
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24
25

0102

1   , M.D.
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3
4   A C K N O W L E D G M E N T
5
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8
9   I,   , M.D., hereby
10   certify that I have read the transcript
11   of my testimony taken under oath on the
12   23rd day of ,   , that the
13   transcript is a true, complete and
14   correct record of what was asked,
15   answered, and said during the deposition,
16   and that the answers on the record as
17   given by me are true and correct.
18
19

____
20 , M.D.
21 Signed and subscribed to before me
this ___ day of _____________, .
22
23 Notary Public
24
25
0103
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2
3 STATE OF NEW YORK)
) ss:
4 COUNTY OF NEW YORK)
5
6 I, , R.P.R., a Notary
7 Public in and for the County of New York and
8 State of New York, do hereby certify:
9 That I reported the proceedings in
10 the within entitled matter, and that the
11 within transcript is a true record of such
12 proceedings.
13 I further certify that I am not
14 related by blood or marriage to any of the
15 parties in this matter and that I am in no way
16 interested in the outcome of this matter.
17 IN WITNESS WHEREOF, I have hereunto
18 set my hand this ___ day of , .
19
20
21
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22
Notary Public
23
24
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2 I N D E X

3 WITNESS EXAMINED BY PAGE
4 Mr. Oginski) 4
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(none marked)

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3 CASE NAME:
DEPOSITION DATE: October 23
4 NAME OF WITNESS: , M.D.
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20
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, M.D.
21
Subscribed and sworn to before me
22 this ___ day of ___________, .
23 ____
(Notary Public) (commission expires)
24
25