DE-IDENTIFIED DEPOSITION OF A PODIATRIST IN A CASE INVOLVING A FAILURE TO TIMELY DIAGNOSE AND TREAT A BONE INFECTION LEADING TO DEATH CASE

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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX
INDEX NO.
- -x

Plaintiffs,

-against-

Defendants.
- -x

June 2,
10:10 a.m.

Examination Before Trial of
, pursuant to Order, held
at the offices of

, before ,
a Shorthand Reporter and Notary Public
within and for the State of New York.

0002

A P P E A R A N C E S :

LAW OFFICES OF GERALD M. OGINSKI
Attorneys for Plaintiff
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Great Neck, New York 11021
BY: GERALD M. OGINSKI, ESQ.

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BY: 10

REDACTED

STIPULATIONS

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

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

This deposition may be sworn to by the witness being examined before a Notary Public other than the Notary Public before whom this examination was begun, but the failure to do so or to return the original of this deposition to counsel, shall not be deemed a waiver of the rights provided by Rule 3116, C.P.L.R., and shall be controlled thereby.

The filing of the original of this deposition is waived.

IT IS FURTHER STIPULATED, a copy of this examination shall be furnished to the attorney for the witness being examined without charge.

* * *

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1
2 (Plaintiffs' Exhibit 1, chart,
3 marked for identification, as of this
4 date.)
5 , after having
6 first been duly sworn by a Notary Public
7 of the State of New York, was examined and
8 testified as follows:
9
10 EXAMINATION BY
11 MR. OGINSKI:
12 Q. Please state your name for the
13 record.
14 A.
15 Q. What is your present home
16 address?
17 A.
18
19 Q. Good morning, Doctor.
20 A. Good morning.
21 Q. What is osteomyelitis?
22 A. Infection of the bone.
23 Q. What is chronic osteomyelitis?
24 A. It's a nonactive infection.
25 Q. Sorry, you said nonactive?
0006
1
2 A. Right.
3 Q. Can you explain that?
4 A. Meaning that there are some
5 pathogens that might be present on the
6 bone but not -- your body is not currently
7 having a renal response to it.
8 Q. Before January of , did you
9 ever diagnose that this patient
10 ever had osteomyelitis?
11 When I say before , I'm
12 referring specifically to the time before
13 she is admitted to
14 Medical Center in January of .
15 A. No.
16 Q. What is debriedment?
17 A. Cleaning of the necrotic tissue.
18 Q. What is a bunionectomy?
19 A. Correction of a bunion.
20 Q. In the course of your career,
21 have you had occasion to perform
22 bunionectomies?
23 A. Yes.
24 Q. Have you had occasion to perform
25 debriedments?
0007
1
2 A. Yes.
3 Q. In the course of your career,
4 Doctor, have you had occasion to diagnose

patients who have had osteomyelitis?
A. Yes.
Q. What is cellulitis?
A. Inflammation or infection of the skin.
Q. Are you familiar with a term known as purulent drainage?
A. Yes.
Q. What does that mean?
A. Purulent drainage, pus draining.
Q. What is a differential diagnosis?
A. It would be a list of possible diagnosis.
Q. And is there any particular order to that list? Most likely to least likely or something else?
A. Yes. Your top differential would be your most likely diagnosis and your lower differential would be your least likely.

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Q. And in the course of your career, have you had occasion to evaluate patients to develop or formulate a differential diagnosis for the purposes of treatment?
A. Yes.
Q. What is a hyperkeratotic lesion?
A. It's a thickness of the upper level of the skin.
Q. How do you recognize that?
A. Just a thickness.
Q. Just on clinical exam looking at it?
A. Yes.
Q. Are you familiar with a term known as acanthosis, A C A N T H O S I S?
A. Yes.
Q. What is that?
A. That's another type of skin disorder.
Q. Can you be more specific?
A. It's a circular -- it can be a circular lesion following also on the epidermal layer and can be clinically

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painful.
Q. Have you had occasion to treat patients with that particular condition?
A. Yes.
Q. What is the hallux?
A. That would be a great toe.
Q. What is a deviated hallux?
A. One that's deviating from the normal angle.

Q. Can you tell me, Doctor, what is neoplasm?
A. A possible tumor.
Q. The term hallux abductovalgus, what is that?
A. That's when the hallux is in the abducted position as well as the valgus position.
Q. And can you explain to me in laymen's terms a possible -- when you say abducted position, is it out? Is it deviated laterally or --
A. It's pointing outwards.
Q. What is exostosis?
A. It's a bony prominence.

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Q. If I use the term calcaneal exostosis, what does that mean to you?
A. That would be a bony prominence of the calcaneus.
Q. What is a bunion, please?
A. A bunion is a deviation of the first metatarsal phalangeal joint.
Q. And can you tell me what an osteotomy is?
A. A cut in the bone.
Q. Have you had occasion to perform osteotomies?
A. Yes.
Q. What is a capsulotomy?
A. It's an incision over the capsule.
Q. When you use the initials MPJ, tell me what that refers to.
A. Metatarsal phalangeal joint.
Q. What is PIP?
A. Proximal interphalangeal joint.
Q. In terms of anatomy, Doctor, from the toe standpoint, where is the MPJ? Is that the first movable joint in the

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toe?
: Objection to the term first. Proximal and distal may be --
MR. OGINSKI: Fair enough.
Q. Tell me where the MPJ is in a particular toe.
A. Well, that depends on which way we're talking about.
Q. Go ahead.
A. Well, you ask the question.
Q. Referring to the second toe, for example?
A. That would be the third joint from the most distal.

Q. And the PIP joint would be where?
A. The second joint.
Q. What is the first joint considered?
A. The distal in the phalangeal.
Q. What is a dehiscence?
A. That's where your incision opens up and there are signs of drainage.

Q. Have you had occasion to treat patients whose wounds have dehiscence?
A. Yes.
Q. Are you familiar with a term known as fluctuance?
A. Yes.
Q. What is that?
A. That's where in the line of skin you feel there might be fluid.
Q. What is an ulcer?
A. An opening of the skin.
Q. Is there any distinction between a chronic ulcer compared to an ulcer?
MR. OGINSKI: I'll rephrase it.
Q. What is a chronic ulcer?
A. A longstanding ulcer.
Q. Can you tell me, Doctor, what is ischemia?
A. Where the soft tissue does not have adequate blood supply.
Q. And what is wound edge ischemia?
A. Where the wound does not have adequate blood supply.
Q. Can you tell me what are the

clinical signs of osteomyelitis?
: Note my objection.
Generally speaking?
MR. OGINSKI: Yes, generally.
A. In terms of swelling, pain.
Q. Anything else?
A. No.
Q. Would you expect to see redness in an area of osteomyelitis?
: Clinical?
MR. OGINSKI: Yeah.
A. Not necessarily.
Q. Would you expect to feel or see a patient exhibit warmth in the area with osteomyelitis?
: Again, note my objection. You had asked him about clinical and then you're asking about osteo, so there could be -- I'm sorry, chronic. If you keep the word chronic in your question, if that's what

you're asking, but I appreciate that.
Q. I'm sticking right now with general osteomyelitis.

A. Well, again, you have to break it down if it's acute or chronic.
Q. Let's talk about acute osteomyelitis.
A. Okay.
Q. Would you expect to see redness or warmth?
A. Yes.
Q. Would you expect the patient to develop a fever?
A. Yes.
Q. If a patient has acute osteomyelitis, would you expect to see elevated levels in, for example, white blood count?
A. Yes.
Q. Are you familiar with something known as sedimentation rate?
A. Yes.
Q. Would you expect to see an elevated or an abnormal sedimentation rate in a patient with acute osteomyelitis?
A. Yes.
Q. What is sedimentation rate?

A. Just a measurement of acute inflammatory.
Q. And, again, in a patient with acute osteomyelitis, would you expect to see pus in the wound?
A. No.
Q. Would you expect to see any type of fluid drainage?
A. Yes.
Q. What is necrosis?
A. Death of tissue.
Q. And would you expect to see tissue necrosis in acute osteomyelitis?
: Note my objection.
Over my objection, you may answer the question.
A. I'm not sure.
Q. Would you expect to see fluctuance?
A. No.
: In what?
MR. OGINSKI: In just acute osteomyelitis.
Q. Would you expect the patient to

have tenderness on palpation of the area?

A. Yes.
Q. Let's talk about chronic osteomyelitis, Doctor. What type of symptoms would you expect to see in a patient with chronic osteomyelitis?
A. Again, swelling, milder pain.
Q. Would you expect to see redness and warmth?
A. No.
Q. How about a fever?
A. No.
Q. Why is that? Why wouldn't you expect to see redness, warmth or fever in a chronic osteomyelitis?
A. There's no acute inflammatory process.
Q. In a patient with chronic osteomyelitis, would you expect to see abnormal white blood cell count in their blood work?
A. Depends.
Q. On what?
A. How chronic is it?

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Q. Would you expect to see an abnormal sedimentation rate?
A. Yes.
Q. Why?
A. Again, you're gonna have some sort of inflammatory process which might be above the norm.
Q. If you suspect a patient has osteomyelitis, what laboratory tests are available to you to help you diagnose that condition?
A. Sed rate is one and a C-reactive protein.
Q. In order to obtain those tests, what do you have to do? Do you have to draw bloods?
A. Yes, draw blood.
Q. In 2004 in the office in which you practiced, did you have the ability to draw patient's blood?
A. Yes.
Q. Were there any other tests that were available to you from the laboratory standpoint to help you or assist you in

0018

diagnosing osteomyelitis?
A. No.
Q. What imaging tests were available to you if you suspected a patient had osteomyelitis and you wanted to use various tests to assist you in making a diagnosis?

A. Is this in the office?
Q. No, anywhere. In other words, within your arsenal and knowledge of podiatric medicine, what was available to you in to assist you in coming to a diagnosis of osteomyelitis?
: Just asking generally speaking?
MR. OGINSKI: Correct.
A. X-ray, bone scan, MRI.
Q. In your opinion, Doctor, which is the best diagnostic tool to assist you in coming to the conclusion of whether a patient had osteomyelitis?
: Again, note my objection. Way too many variables, but over my objection, if you're able

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to answer the question, Doctor, you can.
A. A bone biopsy would be the most definitive.
Q. Sticking to the imaging tests that you just mentioned to me, the X-ray, the bone scan and the MRI, in your opinion, which is the best or the gold standard test that would help you in diagnosing osteomyelitis?
: Objection to form.
Q. When you have the option of an X-ray, bone scan or MRI, which is the best tool that you could use to come to a diagnosis of osteomyelitis?
: Again, note my objection. You may answer the question.
A. MRI.
Q. Why?
A. Because we can see bone marrow edema that might suggest there is an inflammatory response.
Q. If you wanted a patient to have

0020

an MRI, how would you go about accomplishing that?
A. We order an MRI.
Q. Tell me practically what you do. Do you tell them okay, I want you to go to this facility or this hospital to have it done, or is there someplace you send them to? How do you actually get that done or have them go for it?
: Back in ?
MR. OGINSKI: Correct.
A. I would use the requisition form that the office has and give her the

instructions to make an appointment and set up an MRI exam.
Q. And was there any particular facility that you would send them to?
A. I believe at that office we use .
Q. When you say "at that office," which one are you referring to?
A. The office I saw at.
Q. Can you just be specific,

Doctor, which one that was?
A. That's at .
: Give him the doctor's name.
A. Dr. .
Q. What is a bone scan?
A. Where they use nuclear tides.
Q. And if you wanted to send a patient for a bone scan, would you send them out also to some imaging facility to have a bone scan performed?
A. Yes.
Q. In the office in which you practiced in , did you have the ability to take X-rays?
A. Yes.
Q. If you had obtained or taken X-rays in that office, what was the practice as far as who would read those X-rays?
MR. OGINSKI: I'm sorry, I'm going to rephrase it.
Q. If you have X-rays taken of a patient, was it your custom and practice

to read and interpret those X-rays?
A. Yes.
Q. Did you also have a radiologist come in from time to time to also review the X-rays?
A. No.
Q. When you would review X-rays, was it your custom and practice that you would make entries in a patient's chart about your review and interpretation of those X-rays?
A. Yes.
Q. I notice, Doctor, in your chart that you have typed out or dictated the notes that you have, correct?
A. Yes.
Q. And were there ever occasions where you would handwrite your notes after seeing and examining a patient?

A. There are times.
Q. And under what circumstances would you handwrite a note as opposed to dictating a note?
A. If I -- if there are specific

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things that I want to try to remember, I'll just make a little note on the side and I'll try to incorporate that into my dictation later.
Q. When you dictated your note, was it done at the time the patient was still present in the room with you or after they had left or at the end of the day? Or tell me when you would typically do it.
A. It's usually after the patient leaves.
Q. Are you familiar with a term known as a draining sinus?
A. Yes.
Q. What is that?
A. Fluid coming from sinus.
Q. And the sinus would be what?
A. Some sort of cavity.
Q. How do you treat osteomyelitis?
: Just note my objection to the general nature of the question, but over my objection, if you're able to answer, you can.
A. Now, again, are we talking about

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chronic or acute?
Q. Let's say during the course of treating a particular patient you make a diagnosis that a patient has osteomyelitis. Do you make the distinction between acute osteomyelitis versus chronic osteomyelitis?
A. Yes.
Q. Let's say you come to the conclusion or it's your impression that the patient has acute osteomyelitis, how do you treat that?
A. Acute osteomyelitis can be treated with -- again, there are different scenarios.
: This is just generally speaking. Lots of variables, yes.
A. If it's acute, you can do a central debriedment of the infected bone. You can do -- you can start him on IV antibiotics. Those are probably the two main.
Q. If you determine that a patient

0025

has chronic osteomyelitis, how do you treat that?
A. Again, you can surgically excise the bone, treat them IV oral antibiotics.
Q. How would you determine whether to give the patient IV antibiotics versus oral antibiotics?
A. Depends on patient's compliance.
Q. In order to give a patient IV antibiotics, do you typically have to admit them to a hospital?
A. Not necessarily.
Q. Have there been instances in your career where you had treated patients for a type of osteomyelitis and you have treated them with IV antibiotics at home?
A. Not at home, but at a medical facility where they come in just for the IV antibiotics.
Q. I see. Have you debrieded patients who have had acute osteomyelitis?
A. Yes.
Q. And have you excised bone in patients who have had chronic

0026

osteomyelitis?
A. Yes.
Q. And when you do these debriedments, do you consider those to be surgical procedures?
A. Yes.
Q. And are those particular procedures typically done in a hospital or an ambulatory care center compared to an office setting?
: Just note my objection.
MR. OGINSKI: I'll rephrase it.
: The term debriedment --
MR. OGINSKI: I'll rephrase it.
: -- is broad.
Q. Where do you typically perform the debriedment?
: Again, same objection. Because of the level of the degree of debriedment, but over my objection, you can answer it, Doctor.
A. Well, that is true, it depends

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on what kind of debriedment we're talking about.
Q. And what type of debriedment would you need to see in order to perform this procedure in a hospital setting?

A. If it's a complicated debriedment.
Q. Now, you mentioned, Doctor, that a bone biopsy would be the best test to help you understand whether the patient had osteomyelitis, correct?
A. That's correct.
Q. Have you ever performed a bone biopsy?
A. Yes.
Q. And is that typically done in a hospital setting?
A. In terms of my experience?
Q. Yes.
A. Yes, it was done at the hospital.
Q. Before January of , when Ms. went into Medical Center, did you ever perform a

0028

bone biopsy on her?
A. No.
Q. At any time before January of , did you ever consider the possibility that this patient had osteomyelitis?
A. No.
Q. You told me a little earlier that an X-ray is one of the tools that you can use to evaluate osteomyelitis. How long did it typically take for osteomyelitis to show up on an X-ray?
: Just note my objection to the general nature of the question. Too many variables, but over my objection, you can answer it.
A. It can be weeks.
Q. I'm sorry, you said weeks plural?
A. Yeah, sorry. Again, I'm not sure.
Q. And what is it that you would actually see on an X-ray that would suggest to you that a patient had

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osteomyelitis of the bone?
: Again, same objection as before.
A. You can see bone erosion if there was no reason to have bone erosions.
Q. And, in fact, what is bone erosion?
A. Erosion of the bone cortical.
Q. What would that suggest to you, if anything, if you observed bone erosion?
A. Some sort of infectious or

inflammatory process.
Q. Under what circumstances, Doctor, would you order an MRI for a patient with a chronic infection?
: Note my objection to the general nature of the question. Too many variables.
A. Chronic soft tissue, chronic bone?
Q. I'll rephrase it.
In a patient who has a chronic longstanding infection that does not appear to improve with time, what are the

0030

circumstances under which you would order an MRI, if you would?
: Same objection as before. You can answer.
A. It's not necessary to order an MRI.
Q. Why?
A. Again, there's plenty of reasons why a wound might not close or not get better. It doesn't necessarily mean an MRI would help you with that information.
Q. If you suspect that the patient has an infection in the bone, under what circumstances would you order an MRI?
A. If I have a -- if I suspected if he had a bone infection.
Q. What are the clinical signs and symptoms that would lead you to believe --
MR. OGINSKI: Withdrawn.
Q. Let's try again.
A. Is there a question?
Q. No, not yet.
Have you ever ordered MRIs for your patients?

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A. Yes.
Q. Have you ever ordered an MRI to evaluate a patient's chronic infection?
A. Yes.
Q. And under what circumstances would you do that?
: Note my objection.
Over my objection, you can answer.
A. Could you rephrase that question? Or repeat that question.
Q. Sure.
You told me a moment ago that there had been occasions when you had ordered an MRI for a chronic infection. Tell me, generally, what are the occasions under which you would order an MRI.
: Same objection.

You can answer.
A. Well, if I believe a chronic infection is becoming active and if I want to see if there is a progression of any -- of erosion to the bone, there are -- if we wanted to see a treatment that we are rendering is working or not.

Q. If you suspect a patient has an infection to the bone and you take an X-ray and the X-ray is normal, does that confirm that there is no infection in the bone?
: Same objection as before.
A. No.
Q. Are you qualified to read an interpret MRIs?
A. What do you mean "qualified?"
Q. If you were shown an MRI, would you be able to read and interpret it?
: That's a little different than qualified.
MR. OGINSKI: I'll rephrase it.
: Objection.
Q. In the course of your training, Doctor, did you learn how to read and interpret MRIs?
A. Yes.
Q. In the course of your career, have you had occasion to read and interpret MRIs?

A. Yes.
Q. Despite that training --
: I assume you're limiting it to the foot?
MR. OGINSKI: Correct.
Q. Despite that training, would you rely on the interpretation of a radiologist?
A. I would discuss findings with the radiologist.
Q. When taking notes after seeing and examining patients, would you agree it's important to create accurate notes?
A. Yes.
Q. Why?
A. In terms of accurate?
Q. Yeah, why do you do it? Why do you keep accurate notes?
A. Well, helps me remember why or what we're treating.
Q. Is it also important for you to be as thorough as possible to record your findings and what you did during any

particular examination?

: Just note my objection to the word thorough.

A. Yes.

Q. Why?

A. Again, it's good to have enough information so I can recall what I'm doing with a patient.

Q. Now, in , tell me what your relationship was, professional relationship, with Dr. ?

A. I worked in his office.

Q. Tell me what you mean by that.

A. I was an independent contractor in his office.

Q. Tell me what you mean by independent contractor.

A. I would -- there were days I would come in and see patients.

Q. Did you have a contract with Dr. ?

A. Yes.

Q. And the office where Dr. practiced, was that, as far as you know, was that a professional corporation?

: Don't guess if you're not sure.

A. I'm not sure.

: What his professional status was?

Q. What was your understanding as to your agreement with Dr. as far as what your obligations would be for seeing and treating patients?

A. My obligation is to treat patients.

Q. And what was the arrangement that you had with him as far as how you would be compensated for that?

A. I was -- for patients being seen in the office, I would set a fee for the hours I worked.

Q. Would you be paid by Dr. or by the patient or by the patient's insurance company? How did that work?

A. I was paid by Dr. .

Q. And did you get paid based on the number of patients that you saw on any given day?

A. No.

Q. You got -- you were paid for a particular day that you were in the

office?
A. Yes.
Q. Did your name appear on the billing records?
A. I don't know.
Q. Did you have business cards with your name on it?
A. Yes.
Q. On your business card, whose name appeared? Was it Dr. 's office, your name or something else?
: Or both?
MR. OGINSKI: Correct.
A. I think it was both.
Q. And who set your vacation schedule?
A. I did.
Q. Were you required to obtain your own malpractice insurance coverage?
A. Yes.
Q. Did you receive a W-2 form?

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A. A 1099.
Q. How many days a week did you typically work in Dr. 's office?
: In '?
MR. OGINSKI: Yes.
A. Two days a week.
Q. Did you work elsewhere during the week?
A. Yes.
Q. Where?
A. At the hospital.
Q. What hospital?
A. .
Q. What did you do there and in what capacity?
A. At what time frame?
Q. I'm only talking about and .
A. -- I was no longer employed by the hospital.
Q. Now, just so we're clear, Doctor, you're referring to your curriculum vitae, your CV?
A. That's correct.

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MR. OGINSKI: Can I just mark that as Plaintiffs' 2?
(Plaintiffs' Exhibit 2, curriculum vitae, marked for identification, as of this date.)
Q. Before , when were you employed by ?
A. As soon as I finished my residency program.

Q. From when to when?
A. From --
: The residency or
the employment?
MR. OGINSKI: Residency.
Q. I want to know when you were
employed by ?
A. From to .
Q. What was your affiliation with
them at that time?
A. From -- from to ,
I was in their residency program. And
from -- as soon as I finished my resident
program, I was hired on as an assistant
residency director.

Q. Did that include clinical
treatment of patients?
A. Yes.
Q. Did you ever see
at Medical Center in
?
A. My first encounter with
was at Dr. 's office.
Q. So am I correct that you never
saw her at in?
A. That's correct.
Q. In, where else were you
working besides Dr. 's office those
two days a week?
A. I was also an independent
contractor at other facilities.
Q. How many?
A. Two.
Q. Can you just tell me who they
are and their addresses, please?
A. One is Dr.,
. That's in. And I also
worked in a clinic in Medical
Center.

Q. Is that a private facility?
A. Yes.
Q. What did you do there?
A. Treat patients.
Q. Were you -- give me a title, if
you had one.
A. Physician.
Q. Am I correct that you saw
patients who had problems with their feet?
A. That's correct.
Q. You didn't treat internal
medicine --
A. No.
Q. -- or GI or anything else? Only
dealt with podiatry, correct?
A. That's correct.

Q. Was this a multispecialty medical center?
A. Yes.
Q. Can you give me an idea of how many other physicians also worked there?
A. I don't know the answer.
Q. More than ten?
A. I don't know.

Q. Did you see at either Dr. 's office or the clinic in Medical Center?
A. No.
: You mean as an outpatient as opposed to the procedure which was done there?
MR. OGINSKI: Correct.
Q. In, Doctor, did you have admitting privileges to any hospital?
A. Yes.
Q. Which ones?
A. and I'm not sure if I was affiliated with at that time.
Q. In July of , was admitted to Medical Center, correct?
A. That's correct.
Q. Did you admit her or you sent her to the hospital to be admitted?
A. I sent her in the hospital to be admitted under medicine.
Q. Under medicine?

A. That's correct.
Q. Tell me the distinction as to why she would be admitted to the medicine service as opposed to your service?
A. That's the policy at the hospital.
Q. Were there ever occasions where you could admit and treat a patient under your service?
A. Not at.
Q. And if a patient was admitted to the medicine service, you would then be considered what, a consultant?
A. That's correct.
Q. Who is Dr.?
A. I believe that's ' primary physician.
Q. Do you recall having any conversations with Dr. in about this patient?
A. No.
Q. What was your custom and

practice as far as making notes in the patient's chart if you speak to a

patient's primary care physician?

A. I would document I did speak to.

Q. What is a hammertoe, Doctor?

A. A contracture of the digits.

Q. Can that be corrected with conservative treatment?

A. Yes.

Q. At any time before you performed surgery on in April of , did you ever attempt any conservative treatment before taking her to the operating room?

A. Well, she had plenty conservative treatment prior to my visit.

Q. How did you learn that information?

A. From her history.

Q. What made you believe that additional conservative treatment would not work?

A. We tried debrieding one of the painful lesions in her foot, and that's conservative treatment.

Q. Did you ever try recommending any type of orthotics for her prior to surgery?

A. Those were done.

Q. Where or by who?

A. By her other physician.

Q. What was your understanding as to whether they did work or did not work?

A. She was still having pain.

Q. When first came to you in, did she have any orthotics in her shoes?

A. No.

Q. That's something you specifically remember?

A. I don't recall seeing any.

Q. Is there anything -- if you can, please, turn to your first note that you saw this patient.

A. Okay.

Q. And that is on -- what's the date, Doctor?

A. April 10.

Q. Is there anything contained within your record to indicate whether the patient did or did not have any orthotics at that time?

A. It does not mention it.
Q. How was it that the patient came to you on that visit? In other words, what brought her to you as opposed to anybody else?
A. I do not recall.
Q. Just look, please, at the subjective first paragraph last line.
A. Okay.
Q. You see --
A. Dr. , right.
: Off the record.
(A discussion was held off the record.)
Q. Do you know a Dr. ?
A. No.
Q. Did you ever obtain copies of the patients prior podiatry records from this Dr. ?
A. No.
Q. On this first visit April 10, , am I correct that the patient had a

0046

lesion to her heel?
A. That's correct.
Q. And she complained of pain regarding that lesion?
A. That's correct.
Q. This lesion, this was not open, was it?
A. No.
Q. It was not leaking?
A. No.
Q. Was it draining fluid?
A. No.
Q. In your opinion, was it infected?
A. No.
Q. Was it swollen?
A. No.
Q. Was it red?
A. No.
Q. Am I correct that if those conditions had existed, you would have recorded those findings in your note?
: Note my objection to the general nature of the recording

0047

findings, but you can answer.
A. Well, I specifically wrote no erythema or edema.
Q. And if you had observed that, am I correct you would consider that to be a significant finding?
: Note my objection.
You can answer it.

A. Yes.
Q. Tell me why. Why is that a significant finding?
A. Because it's out of the norm.
Q. And why would it be important for you to record that in any note?
A. Well, this is what she was complaining of.
Q. But on your examination, Doctor, if you found that she did have erythema, redness, swelling, tell me why you would make a note of that in your chart?
: Note my objection.
A. I would have treated as much.
Q. How many patients did you typically see in any day that you were at

0048

Dr. 's office?
A. I don't know, ten.
Q. Would you agree that it's important to record significant findings?
: Note my objection to the form of the question.
Q. When you see and treat patients, Doctor, you've told me it's important to keep accurate records. My question now is what things do you choose to make entries about during the course of your examination?
: Again, objection. That's a vague question. There's too many variables.
Q. If you observe erythema, in your opinion, Doctor, is that a significant finding?
: Again, over my objection, it's too broad. You can answer.
A. Yes.
Q. Why would you note that in a patient's chart if you observe it?

0049

: Again, note my objection.
A. If I wanted to treat that erythema.
Q. Am I correct that that would also help refresh your memory at a later date to look back and see what it was that you observed at any given date?
A. Yes.
Q. If any physician were to treat the patient in Dr. 's office, they would also have a written record of exactly what you observed at that particular time?

A. Yes.
Q. Were there occasions when other doctors in Dr. 's office saw and treated ?
A. No.
Q. How many other podiatrists worked in Dr. 's office in ?
A. One.
Q. Who was that?
A. Dr. .

Q. Spell it.
A. .
Q. And if a patient saw you, for example, in the first visit, would they continue to see you for the duration of treatment?
A. Yes.
Q. Did you ever consult with Dr. about ?
A. I don't recall.
Q. Did you ever consult with this other podiatrist, Dr. about

A. I don't recall.
Q. Were there any other podiatrists that you consulted with about at any time in or ?
And I'm sorry, I should clarify.
Other than doctors at Medical Center during her two admissions, did you ever consult with any podiatrist regarding ' care and treatment for and ?
A. I don't recall.

Q. During your care and treatment of this patient in , did you ever refer to any textbooks or medical literature to assist you in treating her condition?
: Note my objection.
A. Textbook as a reference.
Q. I'm asking a specific question. I'm going to rephrase it.
: He's asking if you have a recollection of specifically referring to any particular textbook while you treated her for her condition.
MR. OGINSKI: That's exactly what I meant to say.
A. No.
Q. While you were treating , was there ever a time when you used something known as an algorithm

or a checklist to determine what treatment the patient should receive?
A. A written down algorithm?
Q. Yes.

A. No.
Q. In , were you board certified in any field of medicine?
A. Internal medicine?
Q. In any field of medicine.
A. Board qualified.
Q. So am I correct that the answer is no that you were not board certified in ?
A. That's correct.
Q. Currently, in , are you board certified?
A. No.
Q. Have you ever been board certified?
A. No.
Q. Have you taken the oral examination --
A. No.
Q. -- to obtain your board certification?
A. No.
Q. You have taken the written examination, correct?

A. That's correct.
Q. And you have passed that?
A. Correct.
Q. And what is the reason that you have not yet taken the oral examination to obtain your board certification?
A. The policy to obtain multiple boards in unique type of surgery is needed and I don't feel it's necessary for me to experiment different types of procedure just to qualify for sitting for the oral examination.
Q. The organization that in which you took the written examination, was that the American Board of Podiatric Surgery?
A. That's correct.
Q. Was it a subspecialty or a sub board?
A. Not that I know of.
Q. When you took the written examination, Doctor, did you have to take it more than once?
A. No.
Q. According to your CV, you have

two publications, correct?
A. Well, one, the most recent one has not been published yet.
Q. So you have one in and one that's just been submitted?
A. Yes. Well, submitted --
Q. For publication?
A. Yes.
Q. Other than the topic of calcaneal plantar fasciotomy, have you published anything in the form of diagnosis and treatment of patients who have osteomyelitis?
A. No.
Q. Have you given any lectures to any podiatrist in any setting about the diagnosis and treatment of patients with osteomyelitis?
A. No.
Q. Are you an officer of any podiatry organization?
A. No.
Q. The affiliation you have with the

0055

, is that as a member?
A. Yes.
Q. And same with the New York State

A. That's correct.
Q. And in order to become a member, am I correct you have to fill out a form and pay your fee, your dues?
A. That's correct.
Q. The
, you are a member in that?
A. Yes.
Q. Again, for any of these three organizations, do you have to take any qualifying examinations to become a member?
A. No.
Q. You're licensed to practice in New York?
A. Yes.
Q. Has your license to practice podiatry ever been suspended?
A. No.
Q. Has it ever been revoked?

0056

A. No.
Q. You've been licensed since ?
A. Yes.
Q. Let's turn, please, to the April 10, visit. Did you take any photographs of what 's

condition looked like at that time?
A. No.
Q. At the bottom of your page in your plan you write "if patient continues to have symptoms, may consider biopsy of the lesions in two weeks." Tell me why that was your plan.
A. I wanted to give her significant amount of time to see if she responded to the debriedment of the lesion.
Q. What did you intend to accomplish by debrieding that lesion?
A. To see if she became asymptomatic.
Q. What was it about the lesion itself that was causing her pain?
A. It's on the bottom of the foot.
Q. And why would that be painful or

0057

cause pain?
A. You're standing on it, walking on it.
Q. In the first paragraph at the top of the page on the third line, second line, you write "patient continues to have severe pain and stiffness to that toe." Which toe were you referring to?
A. There was a toe that had surgery done previously.
Q. Which one was that?
A. Not sure.
Q. And the history form that the patient filled out that you were just referring to, looking at it, Doctor, is there anything in there to suggest which toe you are referring to?
A. It just says left foot.
Q. Was it your understanding that the patient had surgery to whatever toe on her left foot by this Dr.?
A. Yes.
Q. Do you know why she had surgery to a toe?

0058

A. For -- I don't recall.
Q. Is there anything in the note that indicates why she had surgery to a toe on her left foot?
A. Not in my notes.
Q. Now, in the objective portion of the exam you write "previous incision site noted to the plantar aspect of the second and third met heads of her left foot." Was this surgery to the heel or was that to the toe or someplace else?
A. That was to the second and third

met heads.
Q. And this is anatomically speaking, Doctor, if you can just tell me where that is.
A. By the metatarsal phalangeal joint.
Q. Is that the ball of the foot or someplace else?
A. The ball of the foot.
Q. Is that what you were referring to when you mentioned at the top that she had surgery to the toe, or is that

0059

something different?
A. I'm not sure.
Q. The hyperkeratotic lesions that you mentioned surrounding that wound, which wound are you referring to? The lesion on the heel?
A. Yes.
Q. And that would be the thickening of the skin?
A. That's correct.
Q. The fact that she had palpable pedal pulses, what does that mean to you?
A. I can feel her pulses.
Q. When you say that it's two slash four bilateral, tell me what that means.
A. Two out of four means it's pretty normal.
Q. Did you obtain any history from the patient?
MR. OGINSKI: Withdrawn.
Q. Was this patient diabetic?
A. Not that I know of.
Q. Did you learn that the patient was hypertensive?

0060

A. Yes.
Q. Or had longstanding hypertension?
A. I know the patient had hypertension.
Q. What is arthritis?
A. Inflammation of the joint.
Q. Was there any particular part of her body that she was aware that she had arthritis?
A. Her knee.
Q. As far as you know, did this patient ever have any surgical treatment to her knee?
A. Yes.
Q. What was that?
A. An arthroscopy.
Q. You write orthopedic

examination. What is that?
A. That would be the examination of the bones and joints.
Q. And how do you actually perform that examination?
A. You palpate the bones and we put

0061

some of the joints through range of motion.
Q. When you say that "it's dorsally contracted digits two to five bilaterally," what does that mean?
A. That would be that digits at that the proximal phalangeal joint were dorsally contracted.
Q. Tell me, if you can, in any other way what that means.
A. There's a deviation on the joint at the proximal phalangeal joint.
Q. When you perform the debriedment, do you give the patient an anesthetic?
A. You mean her or --
Q. You're right, I'm referring to her specifically.
A. I don't think so.
Q. If you do give the patient some form of anesthetic, you typically write down what you give them?
A. Yes.
Q. There's nothing that appears

0062

here about any anesthetic, correct?
A. That's correct.
Q. Does that suggest to you that no anesthetic was used?
A. That suggests it, yes.
Q. In order to perform a debriedment of this lesion, am I correct that you have to open the skin?
A. Not open.
Q. What do you have to do?
A. Clean out any necrotic or thickening of the skin.
Q. Is there evidence that she had any necrosis at this time?
A. No.
Q. So the thickening of the skin, what is it, a scraping?
A. Right.
Q. Do you break the skin at all in order to perform this debriedment?
A. Yes.
Q. And the patient is left with some type of open wound at that point?
A. Depending on how deep your

0063

scraping is. In terms of this, it was not to the level where there's an open wound.
Q. Now, the patient returned one week later on April 17th. Do you have a referral note, by the way, to Dr. or any type of letter to Dr. ?
A. There was one here.
Q. Before the patient returned --
MR. OGINSKI: Let me go back, I'm sorry.
Q. April 10th you see her on the first visit. You indicate that if she has symptoms you may consider biopsy of the lesion in two weeks. On April 12th, you sent a note to Dr. . And under treatment you write "will schedule patient for surgical biopsy of lesion," correct?
A. On the note?
Q. Right here under treatment.
A. Okay.
Q. It says "will schedule patient for surgical biopsy of lesion," correct?
A. Correct.
Q. Now, that's before the two weeks

0064

had gone by, right?
A. That is before the two weeks, yes.
Q. Can you explain that? So here you're telling the patient in the note will consider a biopsy in two weeks if you still have symptoms, but two days later there's a note to Dr. saying that you will schedule the patient for surgical biopsy of a lesion?
A. This could be as anticipation that the debriedment did not help. Instead of writing two letters, we put down what might happen.
Q. And what if the patient had no symptoms and you didn't need to perform a biopsy?
A. Then no biopsy would have been done.
Q. But the letter would have been sent?
A. That's okay.
Q. Was it your intention on April 12th that you would perform a biopsy of

0065

the patient?
A. No.
Q. When the patient returns to your office on April 17th a week later from the

initial visit, what symptoms does she have?
A. She had basically the same pain she had prior to the debriedment of the lesion and now she was complaining of all sorts of pain.
Q. By the way, do you have an independent memory of separate and apart from what's contained in your notes?
: Do you know her?
A. I do know her, yeah.
Q. Do you have a memory of what she looked like?
A. Yes.
Q. Describe her for me, please.
A. She was a heavyset black or African American woman.
Q. Did she speak with an accent?
A. Slight southern.

0066

Q. Do you know where she originally came from?
A. Either North or South Carolina.
Q. On any of the visits that you saw her, was she accompanied by any family member?
A. Never.
Q. Was she accompanied by any aide or assistant?
A. Never.
Q. On the occasions when you saw her in -- when I say your office, the office in which you practice in, did you have any assistant or nurse or anybody else in the room with you?
A. Yes.
Q. Who would you have in the room with you?
A. We have a medical assistant named .
Q. What is 's function or what was 's function?
A. Medical assistant.
Q. Tell me briefly what

0067

would do for you.
A. If I needed some supplies or if I knew the patient needs help to get into the chair.
Q. Would stay in the room the entire duration?
A. No.
Q. You mention in your April 17 note that, the last sentence in the top paragraph, "pain consistently with

ambulation and shoe gear and also Ms.
  continue to have pain to her left
foot." Where specifically did she tell
you that she had this pain?
    A. I don't recall.
    Q. Is there anything in your note
to indicate the specific location in her
foot where she was experiencing pain?
    A. Not on the note, no.
    Q. Do you have an independent
memory as you sit here now as to where she
specifically had the pain?
    A. I believe she was having pain in
the same lesion of the left heel as well
0068

as pain to her bunions and hammertoes.
    Q. And that's something that you
remember as you sit here now?
    A. Something I recall, yes.
    Q. By the way, Doctor, before
today, you had an opportunity to review
your chart for this patient, correct?
    A. These charts, yes.
    Q. Did you review the
 Medical Center record?
    A. Yes.
    Q. For both admissions, July and
January of ?
    A. Yes.
    Q. Did you review any other medical
records in preparation for today?
    A. Well, just my office notes, the
 notes and the
 Medical Center notes.
    Q. And that would be the time that
you performed surgery on the patient?
    A. That's correct.
    Q. Did you review any medical
textbooks in preparation for today?
0069

    A. No.
    Q. Any medical literature in
preparation?
    A. No.
    Q. Did you review the
deposition transcript?
    A. No.
    Q. Did you ask Ms. whether
she needed to take any type of pain
medication in order to relieve her pain?
          : At what point?
          MR. OGINSKI: When she returned
    on April 17.
    A. No.
    Q. Did she tell you that she was
having difficulty sleeping or performing

activities as a result of the pain that she expressed to you?
A. I don't recall.
Q. Is there anything in your note to suggest that her activities were impaired because of the pain she was experiencing?
A. Not from my notes.

Q. Where was her bunion located?
A. Her left foot.
Q. And that's what you have written under "HAV, left foot?"
A. Yes.
Q. And "hammer digits two through four left foot," what does that mean?
A. That means that those digits were contracted.
Q. And you then write "benign neoplasm left foot versus hypertropic scar." Tell me what you mean by that.
A. Well, some sort of lesion on the bottom of the foot. It's specifically a very general term.
Q. And when you say benign, meaning that it's not cancerous?
A. That's correct.
Q. You had blood drawn at that time or you wanted to have the patient have bloods drawn?
A. I believe we drew blood.
Q. And you write CBC, which is complete blood count?

A. That's correct.
Q. And what is BMP?
A. Basic metabolic profile.
Q. What was your intention at that point after talking to the patient as to what you would do for her?
A. We would try to correct her problems.
Q. And specifically what were her problems?
A. Painful bunion, painful hammertoes and the painful lesion.
Q. At the top paragraph you write "patient also wished to correct her bunion and correct her recurrent problem to her third toe." What was that recurrent problem to the third toe?
A. I could have been referring to the surgery that was performed.
Q. In the past?
A. That's correct.
Q. Did you ever obtain a copy of

any operative note from any prior podiatrist or surgeon about any treatment

she had to her toes?
A. No.
Q. When you write in the objective portion of your exam "laterally deviated hallux with bony prominence to medial aspect first MPJ left foot," tell me what you mean.
A. Trying to describe the bunion.
Q. Have you treated patients with that type of bunion before?
A. Yes.
Q. And how did you intend on treating that particular bunion?
A. ' bunion?
Q. Yes.
A. We were going to surgically correct that.
Q. Do you have a memory as to what you discussed with as to how you would accomplish that? And I'm not asking generally what you discussed. I'm asking specifically the conversation that you had with about this particular procedure.
A. I do not recall specifically.

Q. When you tell the patient that you're going to perform bunion surgery, do you give them any type of written materials or pamphlets or brochures?
A. I believe there is a brochure in the office and they must have read it.
Q. What makes you believe when you say "they must have read it?"
A. Don't know.
Q. Those are printed brochures you're talking about?
A. Yes.
Q. That explains in basic terms what a bunionectomy is?
A. That's correct.
Q. When you discuss with a patient a bunionectomy, do you use that brochure to explain to them what the procedure involves?
A. They're explained their basic bunion.
Q. Do you use any written brochure to assist you when you explain that to them?

A. Sometimes.
Q. Do you have any memory as to

whether you used anything to help explain to ?
A. Not sure.
Q. What are the risks of the bunionectomy?
A. Swelling, pain, infection, nonunion, malunion, delayed union, stiffness of the joint, recurrence of pain. Those are the most common.
Q. As of , can you tell me how many bunionectomies you had performed in your career?
A. Don't know exactly.
Q. Can you estimate?
A. Four to five hundred.
Q. During the course of your second examination, did you ever learn from this patient whether she had any difficulty healing following any surgical procedure?
A. She had history of the surgery that was performed by Dr. and she showed me no -- she never discussed any

0075

problems with that.
Q. Just to be clear, Doctor, as of the second visit on April 17th, you had no knowledge that she had ever experienced any difficulty healing with any type of incision or wound before, correct?
A. That's correct.
Q. Do you record in your note specifically what is it about the third toe that is giving her a problem other than stating that she's having a recurrent problem?
A. You're referring to the first two?
Q. Yeah, April 17th.
A. Oh, April 17th. I just noted that she had a contracted digit.
Q. And the pain that she had with ambulation and shoes, again, do you identify where the pain was that she was complaining of?
A. No.
Q. Do you make any notation about any orthotic or inserts that she had?

0076

A. No.
Q. You write in the top "paragraph pain consistently with ambulation and shoe gear." What does shoe gear mean?
A. Any type of shoe.
Q. Because of the pain she was experiencing, did you observe her walk with any type of limp?

A. I don't recall.
Q. Did you make any observation about her gait?
A. I don't recall.
Q. Is there anything in your note to suggest that you observed and recorded anything about her gait?
A. No.
Q. As of this date on April 17, was there any sign that this patient had an infection in her left foot?
A. No.
Q. Was there any sign she had necrosis?
A. No.
Q. Was there any observation that

0077

you made of swelling?
A. No.
Q. Or erythema?
A. No.
Q. Was there any drainage observable anywhere from any part of her left foot?
A. No.
Q. Did you make any observation of any leaking fluid?
A. No.
Q. Doctor, did you practice under a professional corporation in ?
A. I don't recall. I'm not sure.
Q. Was there ever a time that you practiced under the title of , PC or Podiatry PC or something to that effect?
A. Did I ever practice under that name?
Q. Let's go to the April 12, letter you sent to Dr. .
A. Okay.
Q. On the top left it says

0078

DPM, PC, do you see that?
A. Yes.
Q. At that time with that address at , tell me why you had a PC.
A. I'm not sure.
Q. What was your affiliation, in other words, were you an officer, a shareholder of this PC?
A. Once I became PC.
Q. When was that?
A. I don't recall.
Q. When you were given a 1099 form by Dr. , was it given to you

personally or was it to the PC?
A. I don't recall.
Q. When you obtained your own malpractice coverage, was it for both yourself personally and for the PC?
A. I believe so.
Q. Let's turn, please, to the operative report of April 28, . You have a copy of that in your original chart, correct?

A. That's correct.
Q. Did you have any assistant?
A. No.
Q. You had performed surgical procedures at this ambulatory surgery center?
A. This was my first procedure.
: At that facility?
THE WITNESS: At that facility.
Q. Did you encounter any complications during this procedure?
A. No.
Q. Did any of the nurses or assistants at the ambulatory surgery center --
MR. OGINSKI: Withdrawn.
Q. Was there a nurse who provided instruments to you during your procedure?
A. Yes.
Q. Did that individual or individuals do anything else during the course of this surgery?
A. Not that I'm aware of.
Q. Did you have any conversations

with any family member that may have come with Ms. prior to her surgery?
A. I don't recall.
Q. On the second page of the operative report --
By the way, you dictated this report, correct?
A. That's correct.
Q. Do you have a signed copy?
A. I don't have one personally.
Q. What was the practice at that time? You would dictate a report and how would you receive that copy?
A. They usually give me a folder for me to review and sign.
: Off the record.
(A discussion was held off the record.)
Q. Doctor, turning to the second page of your operative report, the second

to last paragraph you write "the patient is to remain partial weightbearing to the left foot using the assistive use of a cane as well a surgical shoe."

Did I read that correctly?
A. Yes.
Q. What is a surgical shoe?
A. It's a strap shoe that has a very rigid insole.
Q. When you say "partial weightbearing," what does what mean?
A. To try to put most of his weight elsewhere. Not to put the full weight on the foot.
Q. Why do you tell them that?
A. To decrease the amount of swelling.
Q. Are there any other postoperative instructions you give to the patient other than telling them that they are to remain partial weightbearing and to use the use of a cane as well as a surgical shoe?
A. There's usually a post-op instructions when they leave

Q. And that's a preprinted form? That's a form that the surgery center

gives to the patient?
A. Right, and I usually fill out some information.
Q. So other than the standard follow-up with your doctor in X number of days, take pain medication, call your doctor if there's a problem, is there anything else specifically that you told after this surgical procedure?
A. I don't recall.
Q. Is there anything else that you recorded anywhere about any additional postoperative instructions?
A. I don't know.
: Other than what's reflected on the discharge instructions?
MR. OGINSKI: Correct. Can I just take a look, please?
: Just let the record reflect he was looking at a page from the records entitled Discharge Instructions.

MR. OGINSKI: Yeah, let's mark it.

(Plaintiffs' Exhibit 3, records entitled Discharge Instructions, marked for identification, as of this date.)

Q. Doctor, this is the Medical Center postoperative instruction sheet, and on the bottom right it says "companion ." Do you have any memory of talking to following the surgery?

A. I don't recall.

Q. Under physical activity you have checked off partial weightbearing -- I'm sorry, it's written "partial weightbearing left foot," correct?

A. That's correct.

Q. Now, did you fill out this form or does a nurse?

A. No, I filled out the form.

Q. You indicate that she is to return to your office on Saturday, May 1st at 10 a.m. on the bottom left, correct?

0084

A. That's correct.

Q. By the way, Doctor, before this patient was scheduled to have surgery, you sent her for pre-op labs?

A. Medical clearance.

Q. Yes. And she was cleared medically to have the surgery?

A. That's correct.

Q. If you can, please, look at the labs for April 17th, , the pre-op labs.

A. Okay.

Q. Specifically, Doctor, can you tell me is there anything abnormal?

A. She had elevated white count.

Q. What is the significance of that, if anything?

A. That she might be having some sort of an infection going on.

Q. Did you ask whether she was being treated for any type of infection?

A. I don't recall.

Q. Is it appropriate to perform surgical procedure --

0085

MR. OGINSKI: Withdrawn.

Q. Is it appropriate to perform an elective surgical procedure when a patient has an elevated white blood count?

A. In general?

Q. Yes.

A. It depends.
Q. On what?
A. Some patients might have an abnormal elevated white count that's a normal baseline for them. So at that point -- or there might be medications that could increase the elevated white count and those are not contraindications for surgery.
Q. Before performing the surgery on April 28th, did you see and review this patient's lab work dated April 17 or reported April 18?
A. I might have.
Q. Tell me what you mean.
A. I would have reviewed it.
Q. What was your practice once labs were requested, blood work was requested

0086

and you received a lab report back? Was it your custom and practice to initial it or sign it before it gets put in the patient's chart to indicate you had reviewed it?
A. Sometimes.
Q. And under what circumstances would you not make a notation on the lab report?
A. That sometimes I just don't to it.
Q. Is there anything in the lab report that you have in front of you, which I understand is a faxed copy, to suggest that you did review it prior to April 28th?
A. No.
Q. If you had seen this particular lab report prior to April 28th, is it your opinion, Doctor, that this patient was still a surgical candidate and her elected procedure can go forward?
A. I think I might have felt that there might be an error in the lab.

0087

Q. Why?
A. Because there's an abnormal number.
Q. What would you have done if you saw that?
A. Probably asked for a repeat CBC or I would have spoke to the medical doctor who was clearing the patient.
Q. And if a repeat CBC came back also showing abnormal white blood count, would you have continued forward with this elective surgical procedure?

A. Again, I would have discussed that case with the clearing medical doctor.
Q. Now, the medical doctor, that's Dr. Dove, correct?
A. No, .
Q. Could you spell that.
A. .
Q. Do you have clearance from Dr. ?
A. Yes.
Q. Where is that?

A. I believe in the Medical Center file.
Q. Just tell me what document you're referring to, please.
A. It's the ambulatory surgery center of Medical Center, patient history and physical examination form.
Q. Do you know Dr. ?
A. Yes.
Q. What is his specialty?
A. Internal medicine.
Q. Did you ever receive a copy of this clearance form before April 28th?
A. Received it in Dr. 's office?
Q. In any office. Did you ever see it before performing surgery on April 28th?
A. Yes.
Q. When did you see it for the first time?
A. The day of the surgery.
Q. And is there anything in here

that reflects that Dr. saw and took note of the patient's elevated white blood count?
A. Yes.
Q. Can you point out where, please?
A. Well, he mentioned also to repeat the lab work.
Q. Why?
A. Well, he doesn't state why.
Q. What does it say there in impression number one, lymphocytosis?
: Where are you looking?
A. Where do you see that?
: On the front, okay.
I was looking at the back.
A. That's the hospital.
Q. Medical Center,

April 20,   ?
                    : Show me which one you're looking at again.
    A.   I don't remember seeing that.
                    : On the record, Counsel, it appears as if you have a

document from the   Medical Center that they did not provide to us when we sent them the authorization for the records. So if you can show it to the doctor, I'd appreciate that. I would like to request a copy of it.
          MR. OGINSKI: Sure.
    Q.   Under the impression in the middle of the page it says "lymphocytosis" what is that?
    A.   An elevated white count.
    Q.   Underneath that it says "repeat CBC" and what?
    A.   Differential.
    Q.   Do you know why he wanted that repeated?
    A.   Probably for the same reason.
    Q.   Can you look, please, at the lab report drawn on April 20,   , recorded April 22,   , there is Medical Center.
    A.   Okay.
    Q.   Can you tell me what the white blood count was at that time?

    A.   11.7.
    Q.   Is that also abnormal?
    A.   That is elevated.
    Q.   What does that suggest to you, if anything?
    A.   Well, comparing to the previous white count, it does show that whatever's causing the elevated white count is improving.
    Q.   She had a white count of 12.3 on April 17th and now on April 20th she has a white count of what was that?
    A.   11.7.
    Q.   Is that a dramatic difference?
                    : Objection to the term dramatic.
    Q.   How would you characterize the difference, if any?
    A.   That she is improving.
    Q.   Did you ever see that lab report prior to the April 28th surgery?
    A.   Yes.
    Q.   When did you see that?
    A.   Probably prior to surgery.

0092

Q. What makes you believe you saw that prior to surgery?
A. That's something I would have done.
Q. As your normal custom and practice, you review the prior labs, right?
A. Yes.
Q. Is there anything noted on this report or any other report that you have, specifically the lab report, for the April 20th blood labs --
A. No.
Q. -- to suggest that you had seen and reviewed it?
A. No.
Q. Assuming that you saw and reviewed this lab report, the April 20th lab report showing also an elevated white blood count, is it still your opinion that you would have --
MR. OGINSKI: Withdrawn.
Q. Assuming that you saw both blood lab values from April 17th and also April

0093

20th showing the elevated white blood count, is it still your opinion that this patient was a surgical candidate?
A. After speaking with Dr. and reviewing the lab, in my judgment, I thought it was appropriate.
Q. When did you speak with Dr. ?
A. Prior to the surgery.
Q. Can you be any more specific? Was it the day of surgery?
A. I don't recall.
Q. Days before, week before or any other time?
A. I don't recall.
Q. What makes you believe that you spoke to Dr. ?
A. Because of the abnormal labs.
Q. Do you have a specific memory as to what Dr. said to you in response to your call about the abnormal labs?
A. No.
Q. Did you ever --
: Hang on one second.

0094

Is there an open question?
(The requested portion was read back.)
Q. Did Dr. ever tell you

where he thought the patient might have an infection or the cause for the patient's elevated white blood count?
A. I don't recall.
Q. Is there anything in any of your notes to indicate anything Dr. told you or said to you during this conversation?
A. No.
Q. Is there anything in Dr. ' note of his examination, the history and physical or the pre-op work up that indicates his comments or thoughts as to why this patient's labs were -- I'm sorry, why this patient's elevated white blood count was abnormal?
A. No.
Q. At the page you're looking at, Doctor, on the second page, the back of it it says "this patient is cleared for left

0095

foot surgery pending repeat CBC slash differential EKG, chest X-ray and urinalysis," correct?
A. That's correct.
Q. And once those tests were done, do you see any written documentation from Dr. clearing this patient for this procedure?
A. Yes.
Q. Where?
A. On the bottom of the same note.
Q. May I see that?
MR. OGINSKI: See, I don't have this where there's an addendum, but there's nothing on mine.
: It's got his stamp too.
MR. OGINSKI: Yeah, you're right.
Q. So according to this note on April 28th, he cleared the patient for surgery?
A. That's correct.
MR. OGINSKI: Let me get a copy

0096

of that too.
Q. Doctor, let's turn, please, back to your note of May 1st. The patient returned to your office as instructed, correct?
A. Correct.
Q. You took X-rays at that visit, right?
A. Yes.
Q. What was the purpose of

obtaining X-rays at that visit?
A. To make sure that the internal fixations are in place and to see the osteotomy sites in rectus position.
Q. In what position?
A. Rectus anatomical position.
Q. Did the patient have any complaint on May 1st?
A. Some pain.
Q. Where was the pain?
A. In the foot that underwent surgery.
Q. Could you be anymore specific as to where she was experiencing the pain?

0097

A. It was not mentioned in my notes of a specific spot.
Q. And there was no drainage that you observed, correct?
A. Correct.
Q. The sutures were intact?
A. Yes.
Q. When you say that the incision was coapted, what does that mean?
A. The skin margins --
Q. They were together?
A. Yes.
Q. The observation that you made of edema and mild erythema, that's normal following this surgery one week out?
A. Yes.
Q. There was no evidence of infection at that time?
A. No.
Q. And how many X-rays did you take? Based on the note, are you able to tell?
A. No.
Q. If you look down, Doctor, at the

0098

plan, you write "X-ray left foot two views?"
A. Oh, two views, yes.
Q. And did you read and interpret those X-rays?
A. Yes.
Q. Did you record your findings?
A. Yes.
Q. And is that in the objective portion in the middle?
A. Yes.
Q. When you write that the K wire in the second digit is mildly displaced superiorly, what does that mean?
A. It means that distal -- the distal fragment is slightly above the

proximal bone.
Q. And am I correct that that is an abnormal finding?
A. Yes.
Q. And why is that an abnormal finding?
A. Well, it just means that the position of the K wire is not the best

0099

position, but it was enough.
Q. What is the significance of that finding, if any?
A. Nothing. It's just a notation for myself.
Q. And why is it important for you to know that this is mildly displaced? In other words, what could happen to the patient because of this, if anything?
A. It was more just to show what I saw on the X-ray.
Q. Can you take out those two X-rays, please?
What do you call these particular views that you obtained?
A. I got an oblique view and a lateral view.
Q. Can you just point out to me, please, where you observed the mildly displaced K wire in the second digit, which view?
A. On both the oblique and lateral view.
Q. Can you just point to me with

0100

your finger, show me where that is?
A. This would be on the oblique view and this one coming down this way the lateral view. [Indicating.]
Q. Did you form any opinion as to why the patient was experiencing pain when she returned to your office on May 1st?
A. Yes.
Q. Why?
A. Postoperative pain.
Q. Did you record that anywhere as to the reason for her pain?
A. No.
Q. Had she been taking any type of pain relief or pain reliever during the week leading up to this visit?
A. Yes.
Q. What was she taking?
A. Tylenol number 3.
Q. That's what you call the Vicoprofen?
A. No.

Q. What is that?
A. Tylenol number 3 is with 30

milligrams of codeine.
Q. And that was something you prescribed to her after surgery?
A. Yes.
Q. Did she ever call you in between the date of the surgery and this visit on May 1st?
A. I believe it's practice for the office to call.
Q. You mean just to checkup on the patient?
A. Yes.
Q. My question is did the patient ever call you to let you know that she was having a problem at any time during that week?
A. No.
Q. Was there any sign of infection on this visit?
A. No.
Q. Now, during the surgery, did you give the patient any antibiotics, any prophylactic antibiotics?
A. Yes.

Q. What did you give her?
A. Gamma-vena. [Ph.]
Q. Was that by IV or oral or something else?
A. IV.
Q. And that was just during the surgery?
A. Prior to the surgery.
Q. Immediately prior, correct?
A. Maybe about half hour prior.
Q. And did you give her a prescription for antibiotics postoperatively --
A. No.
Q. -- after she left?
Was it customary to give antibiotics following this type of surgical procedure?
A. No.
Q. Are you aware of any podiatrist who practiced in Manhattan, Brooklyn, Queens, New York that prescribe antibiotics for this type of procedure postoperatively?

an improper question.

Q. Tell me why you don't prescribe antibiotics following this type of procedure.

: Generally speaking, yes? Perhaps there's a specific case that's different.

Q. In general, Doctor, can you tell me why you choose not to give antibiotics following this type of surgery?

A. We're not treating any infection.

Q. Are you aware of something known as giving a patient prophylactic antibiotics in anticipation of or trying to prevent future infection?

A. Yes.

Q. Have you ever had occasion to give a patient prophylactic antibiotics?

: Objection. He told you he gave her gamma-vena which is an antibiotic.

MR. OGINSKI: Yes, sir.

0104

Q. In general, have you ever had occasion to give a patient prophylactic antibiotics?

A. Yes.

Q. According to your note, you wanted the patient to elevate the foot as much as possible, correct?

A. Yes.

Q. Why?

A. Bring down the swelling.

Q. Where did you observe -- you said the patient had edema and mild erythema?

A. That's correct.

Q. How would you characterize the edema that you observed?

A. Non pitting edema, swelling.

Q. Define pitting edema, please.

A. Pitting edema is when you press on the soft tissue and you get an imprint.

Q. And non pitting edema?

A. When you press down the soft tissue, you don't see an imprint.

Q. How would the elevation of the

0105

foot reduce or minimize the swelling?

A. Well, it's helping to bring back any of the remaining blood that might be pulling in the foot back to the upper extremity.

Q. Did you form any opinion before April 28th as to whether this patient had any vascular problem?

A. No.
Q. I'm sorry, I should rephrase that.
Did this patient have any vascular problem before April 28th, ?
: Objection to form.
You can answer.
A. Not on my physical examination.
Q. And as of May 1st, , did you form an opinion as to whether this patient had any vascular problem?
A. No.
Q. No, you had no opinion or no, this patient did not have?
A. The patient did not.
Q. Okay, thank you.

0106

: That's his fault.
MR. OGINSKI: Yeah, it was my fault, sorry.
Q. Are there instances where you would perform a bunionectomy and tell a patient that you want them to be non weightbearing?
: Note my objection to the general nature, but you can answer it.
A. What kind of bunionectomy?
Q. Let me rephrase it.
What type of bunionectomy did you perform on this patient?
A. An Austin bunionectomy.
Q. Are there times where you have performed an Austin bunionectomy and directed that a patient be non weightbearing following surgery?
A. No.
Q. What is an Austin bunionectomy?
A. That's where a V osteotomy is performed with a capital fragment.
Q. Following an Austin

0107

bunionectomy, if a patient walks on it, is there a risk that the surgery site will --
: I'm going to object to the form, when you say walk on it. Because he's indicating partial and full and so forth.
MR. OGINSKI: Okay. Withdraw that.
Q. Now, you write in the first paragraph that "the patient was doing fine two days after surgery and then 23 hours ago experienced severe pain." Was there any experience that you asked her about that brought on this pain?

A. Not that I recall.
Q. And you told her to return in one week, correct?
A. Yes.
Q. Now, the Vicoprofen, what is that? Is that like Vicodin?
A. With an antiinflammatory.
Q. That's a pain reliever, correct?
A. That's correct.
Q. Had you told her to stop taking

0108

the Tylenol with codeine, the Tylenol number 3?
A. Yes.
Q. She returned to your office not one, but two weeks later, correct?
A. That's correct.
Q. As a result of that one extra week delay, did this patient suffer any type of injury because of that one week delay in returning to your office?
A. Meaning if she had an injury?
Q. Yeah, in other words, you told her to come back to you in one week. She didn't come back in one week. Instead she came back in two weeks. So my question is the fact that she showed up now two weeks after you told her to, did that play any part in any of the problems or symptoms that she was having, specifically the one week delay?
: Do you understand his question?
THE WITNESS: No.
: Off the record.

0109

(A discussion was held off the record.)
Q. You told the patient to return in one week. She shows up two weeks later. The fact that she showed up in two weeks later and not one week, did that cause her any injury?
A. Not sure.
Q. Tell me why you're not sure.
A. Not sure why she didn't come back in a week?
Q. I'm sorry, that wasn't my question. I want to know the problems that she did have that she presented to with you on May 15th, were they the result of not coming back to your office a week earlier?
: Objection. He said he wasn't sure.
MR. OGINSKI: Right. I'm trying

to probe. I just want to know whether it's because of a delay in coming back to your office or is this a natural progression of whatever she was

having.

: Or if you don't know.

MR. OGINSKI: Correct.

A. I don't understand the question. Maybe I'm --

MR. OGINSKI: I'll rephrase it.

Q. What complaints did the patient have on May 15th?

A. She was still having mild pain.

Q. And as far as you know, did she have that pain a week earlier?

A. Yes.

Q. So that pain, as far as you know, did not change because it now is two weeks later?

A. Well, it's been improving, according to my notes.

Q. Did she have any other complaints?

A. No.

Q. Was she still taking the medication that you had prescribed for her, the pain reliever with the

antiinflammatory?

A. Yes.

Q. When you write "dressing left foot," meaning that you took the dressing off and you changed it?

A. That's correct.

Q. Was there any time where you told her to change the dressing herself up until that point?

A. No.

Q. And CDI, that's clear, dry and intact?

A. That's correct.

Q. And no drainage, right?

A. That's correct.

Q. Was there any evidence of infection at this point?

A. No.

Q. You made a note that there was left foot edema and mild erythema, correct?

A. That's correct.

Q. And that, again, you said is normally seen postoperatively?

A. That's correct.
Q. And it's common to see it two weeks after the surgery?
A. That's correct.
Q. Had it changed in any way from the time that you last saw her two weeks earlier on May 1st?
A. I didn't make note of that.
Q. The sutures intacted, that means they were still in place?
A. That's correct.
Q. And the well coapted skin margins means that the skin was still together?
A. Yes.
Q. They were still touching, right?
A. That's correct.
Q. When you wrote "no purulent drainage noted," meaning there was no pus?
A. That's right.
Q. Is it common for to you write down no purulent drainage if you don't see pus following surgery?
A. I don't do that all the time.

Q. In other words, why do you write a negative?
A. I just chose to at that point.
Q. Did you take any X-rays on this visit?
A. No.
Q. The CFT. That's capillary fill time?
A. That's correct.
Q. Why do you test that?
A. Again, make sure that the vascular is intact.
Q. The pedal pulses, did you record what they were like you had done in the prior visit?
A. No.
Q. The fact that you did not record what they were, but merely that they were present, does that suggest to you that they were the same?
MR. OGINSKI: Withdrawn.
Q. Are you able to tell what her pedal pulses were just looking at the note?

A. No.
Q. If they had improved or worsened, would you have expected to make a note of that?
A. If it has worsened, yes.
Q. Now, on the subjective portion

on the second line you write "times fourteen days," meaning that she had the surgery fourteen days earlier, correct?
A. That's correct. Well --
Q. In fact, it's not exactly fourteen days, right?
A. That's correct.
Q. Because she had it on April 28th?
A. Right.
Q. And there were thirty days in that month so that would be two days plus the fifteen, that would be seventeen days out; is that fair?
A. That sounds right.
Q. Where was the pain that the patient was experiencing that you noted in the first paragraph?

A. It was the left foot.
Q. Where specifically?
A. Not mentioned in there.
Q. Was this incisional pain?
A. I don't know.
Q. How would you describe incisional pain?
A. The pain, incisional pain would be more superficial.
Q. And the pain that she was telling you about, what was that?
A. I don't know.
Q. Did you determine what the cause of her pain was on May 15th?
A. I determined that it's most likely still postoperative pain.
Q. What made you believe that?
A. It's only two weeks out.
Q. Did you remove any sutures on this visit?
A. No.
Q. You write at the bottom under your plan "will keep sutures intacted for one more week." Typically, how long do

you wait before removing sutures after this type of surgical procedure?
: Again, just note my objection to the general nature of the question. Every patient is an individual, but you can answer.
A. Right, it really depends on if you say in general, usually we like to keep sutures on the dorsum side about 14 days.
Q. And the dorsum would be which part of the foot?

A. The top side.
Q. And that's where her sutures were?
A. Yes.
Q. Tell me why you like to keep them in for fourteen days.
A. To make sure there was adequate healing across the incision.
Q. Was there anything that you observed on this visit that you recorded to suggest that there was not adequate healing?

A. Nothing in my notes.
Q. And why did you elect to keep the sutures in for another week?
A. Probably felt that she needed to keep it for one more week.
Q. Are you able to tell from your note why?
A. No.
Q. Is there anything that you recorded in your note to suggest that the patient simply wasn't healing either with the incision or the wound or anything else that she required another week?
A. There's nothing in my notes.
Q. Do you have any independent memory, as you sit here now, as to why you wanted to keep those sutures in for another week?
A. No.
Q. Is there any risk to the patient of keeping sutures in longer than you typically keep them in, assuming there's no problem with their wound or their incision?

A. They have a higher chance of scarring.
Q. These sutures, were they absorbable sutures?
A. No.
Q. So they needed to come out at some point?
A. Yes.
Q. And you told the patient to return in one week, correct?
A. That's correct.
Q. And the patient did, in fact, return on May 24th?
A. That's correct.
Q. As far as you know, Doctor, was she compliant with your instructions?
: Which instructions?
Q. With any of the instructions up

until this point?
: Do you know?
A. I don't know.
Q. Is there anything in your notes to suggest that as of May 24th this patient was not compliant with any of your
0119
instructions?
A. Besides missing an appointment.
Q. Fair enough. Was there anything else?
A. No.
Q. On the May 24th visit, you write that the patient is now -- in subjective paragraph, you have the patient is twenty-one days out, right?
A. Right.
Q. Again, that's not totally accurate because she had the surgery April 28th. So if you had the two days plus the 24, that actually puts her 26 days, correct?
A. Correct.
Q. You write "still has mild pain upon ambulation." Can you tell from your note where the pain was located?
A. No.
Q. Is it common for a patient to have this type of pain twenty-six days after this type of surgery?
A. Yes.
0120
Q. And how long do you expect a patient to have continued pain relating to the surgery itself?
A. Anywhere up to six months.
Q. And what is it that causes or brings about such pain?
A. Everybody heels differently.
Q. Did you make any determination whether this was a pain associated with the incision?
A. No.
Q. You write in your note that there was mild serosanguineous discharge, correct?
A. That's correct.
Q. What is serosanguineous --
I'm sorry, let me be clear, you write "mild serosanguineous drainage." What is that?
A. Normal lymphatic fluid that's seeping in from the wound.
Q. The fact it's serosanguineous, does that mean that it's blood tinged?
A. Sometimes.

0121

Q. Where did you observe this drainage?
A. From the wound.
Q. Now, I want to be clear, Doctor, this is one wound that we're talking about on the top of the foot?
A. Yes.
Q. Are you able to show me using your hand as a reference point as to where on the patient's foot she had this wound?
A. This -- on top of the first ray.
Q. For example, for purposes you're showing me by the thumb area close to -- how would you describe the area using your hand, if you can?
A. It would be on top of the first MPJ, first metatarsal phalangeal joint.
Q. You also write "mild wound dehiscence left foot?"
A. That's correct.
Q. Tell me what you meant.
A. Meaning there's drainage coming from the wound. The skin is no longer -- the skin margins are no longer intact.

0122

Q. And am I correct that in all of the prior visits after the surgery, she did not have this?
A. That's correct.
Q. The patient still had not removed -- as of May 24th, you were the only one who has taken the bandages off and changed them, correct?
A. That's correct.
Q. And the patient would have no way to know whether there was any leakage or fluid until you take the dressing off, correct?
A. That's correct.
Q. Did you form any opinion as to why she experienced dehiscence at that time?
A. Yes.
Q. Why?
A. Again, it can be from the swelling. It can be from swelling or it can be from an infection.
Q. What test cans you perform to assist you in determining whether the

0123

dehiscence is from swelling or an infection?
A. A wound culture.
Q. How do you perform a wound

culture?
A. You did a swab and send that out.
Q. What is the purpose of that?
A. To see what kind of bacteria might be growing, if there is any bacteria.
Q. Did you do a wound culture on May 24?
A. No.
Q. Is there any reason why you did not do a wound culture on May 24th?
A. It was not necessary.
Q. Tell me why.
A. Again, it did not show an active infection. It shows that there was some drainage. Maybe the start of an infection or because of the open wound that there is a site for an infection.
Q. Why did you prescribe

0124

antibiotics for the patient on this date?
A. This is to treat a possible infection.
Q. How did you determine that Augmentin would be your antibiotic of choice as opposed to any other antibiotic?
A. It's pretty broad spectrum.
Q. You removed all the sutures?
A. Except over the first ray.
Q. Can you tell me how many sutures there were?
A. No.
Q. This is all from the same incision site, correct? I just want to be clear --
: What is all?
Q. This patient had how many different incision sites?
A. Four.
Q. The one, the wound that is dehisced, that was over the first ray?
A. That's correct.
Q. And by the first MPJ?
A. That's correct.

0125

Q. And you removed the sutures from all the other incision sites?
A. That's correct.
Q. Those were healing nicely?
A. That's correct.
Q. But it was the first ray, first MPJ area that had dehisced?
A. That's correct.
: Off the record.
(A discussion was held off the

record.)
Q. Were you able to tell for how long the wound had been dehisced, had opened up and been leaking?
A. No.
Q. When you took the dressing off, did you observe fluid on the dressing?
A. Yes.
Q. Was there any suggestion at that point the patient had not been keeping the dressing dry?
A. No.
Q. Did you ask her, did you ask Ms. whether she had been elevating

0126

her foot as you had instructed?
A. I don't recall.
Q. Why did you not withdraw and remove the sutures over the area where there was dehiscence?
A. By keeping these sutures intact will prevent a worsening of the scar to occur.
Q. How?
A. By keeping the wounds more coapted.
Q. If this patient had an infection in that area where this suture was located by keeping the suture in, does that cause any problem as far as accumulation of fluid or any pus that might accumulate and need to get out?
A. No.
Q. Does it prevent fluid from coming out if the suture is still in keeping the wound closed?
A. Well, there were fluid coming out already.
Q. Was it your opinion that the

0127

patient had an infection as of May 24, ?
A. No.
Q. Tell me what the signs of an infection are, Doctor.
A. Pain, redness, swelling.
Q. According to your note the patient had pain, correct?
A. Yes.
Q. And according to your note, she had edema, which is swelling, correct?
A. Yes.
Q. And she also had mild erythema which is redness, correct?
A. Yes.
Q. And she also had this mild

serosanguineous drainage, correct?
A. Yes.
Q. According to your definition, that would be considered to be an infection, correct?
A. That's not the only definition.
Q. Okay.
: Just note my
0128
objection. You asked him what signs were, not definitions. So the signs are different than definition.
Q. What was it about this patient's clinical condition that suggested to you that the patient did not have an infection on this date?
A. There was no increased temperature of the foot. There's no redness that's stemming away from the wound site.
Q. Anything else?
A. No.
Q. Now, the redness stemming away from the wound site, what do they call it tracking?
A. Or cellulitis.
Q. Can you still have an infection without an increase in temperature, localized infection?
A. In general?
Q. Yeah, in general.
A. Yes.
Q. Can you have an infection
0129
without a cellulitis, without tracking or the redness stemming away from the wound site?
A. It's possible.
Q. If you felt that the patient did not have an infection, would it be appropriate to give her antibiotics?
A. Yes.
Q. Why?
A. Again, we're -- this is where the prophylaxis would come in. We could, again, we could also treat to prevent and if there was an infection, it would also help.
Q. Other than redressing the foot at that time on May 24th, did you provide her with any other treatment for this open wound?
A. No.
Q. Did you take a wound culture at that time?
A. No.

: Asked and answered.
MR. OGINSKI: I'm sorry.

Q. The purpose of placing sutures is to keep the skin together, correct --
A. That's correct.
Q. -- following surgery?
Now, if the wound -- how can a wound dehisce if the sutures are there keeping it closed?
A. There's enough drainage coming through.
Q. If a wound dehisces, is it good practice to remove the suture to allow the leakage and drainage to occur?
A. Not necessarily.
Q. Under what circumstance would you remove a suture in order to allow drainage, leakage of the fluid to occur?
A. If there was an abscess inside the wound or there's enough tension along the suture line causing ischemia.
Q. Are there any other reasons you would take out a suture if you observe a dehiscence of a wound?
A. No.
Q. If the suture is not removed,

Doctor, and the infection is present and progresses, where is the infection likely to go if the suture still remains? Are you able to tell?
: Objection. I don't understand your question. Could you rephrase it?
MR. OGINSKI: Um-hum.
Q. Going back to the May 15th visit, Doctor, are you removed both K wires at that time?
A. That's correct.
Q. Why did you do that?
A. Because patient is still having swelling.
Q. Customarily, how long do you leave the K wires in, assuming there's no complication?
A. About four to six weeks.
Q. What is the purpose of keeping the K wires in for that period of time?
A. Just to keep the toes splinted.
Q. Does it provide stability?
A. Stability in terms of?

Q. Well, you said "keep the toes splinted." Why is that important?

A. Try to keep it straight.
Q. When you removed the K wires, what is the effect, if any, on the patient and the surgical site?
A. Well, they could get a recurrence of the contracture of the digits.
Q. What made you believe that the patient's swelling was in any way related to the K wires?
A. I was more worried -- probably because if there was swelling, the K wires, would just make the situation worse.
Q. How?
A. Because at this time, with the K wires intact and the digits in straight position, there's a possibility for ischemia to the digits.
Q. Can you be more specific and explain why?
A. Swelling, the swelling could cut
0133
off circulation.
Q. What is it about keeping the K wires in there that would cause that ischemia? In other words, I'm not clear on the process of how that works.
A. It's not going to allow the toes to move adequately.
Q. Was it your opinion, Doctor, that as of May 24th when the wound had dehisced for the first time, that it was appropriate to keep the suture at the location of the first ray by the first MPJ?
A. You're asking if it's appropriate?
Q. Was it appropriate in this case?
A. Yes.
MR. OGINSKI: Why don't we take a break?
(A short recess was taken.)
Q. Doctor, when do you take postoperative X-rays to evaluate the wound?
: Objection to the
0134
general nature of the question. It can vary from patient to patient.
A. Usually postoperatively the first week.
Q. And do you then take additional postoperative X-rays at any time after that?
A. Sometimes.

Q. And under what circumstances would you take another set?
A. If I feel that it's necessary.
Q. Tell me why you changed the patient's pain relief to Vicodin on May 24th?
A. We changed from Vicodin extra strength to Vicodin. We were trying to lower the pain medication.
Q. Did you learn from the patient whether she had had any relief when taking the Vicodin, in other words, was it helping, working?
A. I don't recall.
Q. Is there anything in your note to suggest that the pain relievers were

0135

working?
A. No.
Q. Is there anything to suggest that the erythema, the edema was affected or changed in any way from -- as a result of the antiinflammatory medication?
A. No.
Q. Let's turn, please, to the next visit, June 7th, . You had told the patient to return in one week, which would be the end of May or the beginning of June and she returns instead two weeks later, correct?
A. That's correct.
Q. Because she came to you two weeks later, did she suffer any injury or problem that you can attribute to her not returning to your office a week earlier?
A. Not sure.
Q. What complaints, if any, did she make on June 7th?
A. Well, she's still having the same pain on ambulation.
Q. What exact pain was that?

0136

A. Left foot pain.
Q. Where?
A. Don't have a specific location.
Q. And is it important for you as a podiatrist who is treating the patient postoperatively to understand and to know exactly where the pain is, whether it's superficial skin pain or whether it's something more significant?
A. Not necessarily.
Q. Tell me why.
A. Well, most of the pains we're seeing now we're still under the assumption that it's still postoperative

pain and it can be anywhere within the left foot.
Q. The fact that she only had the pain upon ambulating, what does that tell you, if anything?
A. Swelling.
Q. That the pain is related to the swelling?
A. That's correct.
Q. But yet, on your examination,

0137

you observed there was decrease swelling and erythema?
A. That's correct.
Q. On May 24th, the edema and erythema that you observed, that was over specifically the first ray of the left foot, right?
A. That's correct.
Q. And on June 7th you observed that that swelling and erythema was decreased in comparison to the prior visit, right?
A. That's correct.
Q. Was there drainage when you took off the dressing that you observed?
A. I don't recall.
Q. Was there any fluid collection noted on the dressing, on the bandages?
A. I don't recall.
Q. The wound incisions for the second digit and third digit and left heel, these wounds were healing nicely, correct?
A. That's correct.

0138

Q. You wrote "sutures," plural, "still intacted first ray?"
A. That's correct.
Q. That tells you that more than one suture was still in, correct?
A. On the first ray.
Q. Yes. And this is the ray that had the dehiscence?
A. That's correct.
Q. Are you able to tell me how many sutures were still in?
A. No.
Q. And can you tell me why you did not remove that or those sutures on June 7th?
A. There was no need to.
Q. What was the purpose of keeping those sutures in place on June 7th?
A. Again, to keep the wound or the incision site well coapted.

Q. Is there anything in your note to indicate that the wound was not coapted?
A. There's nothing in my note that

says the dehiscence has disappeared.
Q. If you look in your assessment, Doctor, the second to last paragraph on the bottom, it says "mass left foot" --
I'm sorry, let me read the whole thing.
"Status post bunionectomy, arthroplasty second and third digits and excision ST. Mass left foot resolved wound dehiscence." Okay.
Does that refresh your memory that the wound dehiscence that you had observed on the last visit May 24th has resolved?
A. That might have been a mistake. It could mean resolving. It doesn't necessarily mean the wound -- there must have been a reason or something that would have made me decide to keep the sutures intact.
Q. If the wound which had dehisced on the first ray at the first MPJ area had resolved and the wound was no longer open, would you agree that it would be

appropriate at that point to take out the sutures?
MR. : Can you read that back, please, ?
(The requested portion was read back.)
MR. : Are you asking him whether it would have been appropriate to remove the sutures at the prior visit?
MR. OGINSKI: No.
Q. On June 7th, if you saw that there was no longer a dehiscence and that had resolved, would you agree that it would be appropriate at that time to remove the sutures?
A. No.
Q. Why?
A. Again, it depends.
Q. On what?
A. If I felt that the wound is not -- if I take the sutures out, it would open up the incision site again. I wanted -- the sutures right now is just to

keep tension along the skin. There is no contraindications to keep sutures in longer.

Q. You indicated, Doctor, in your observation or in your objective paragraph you said "sutures still intacted first ray. And digits two and three and left heel are good skin coaptation." Did the coaptation refer to the second and third digits or also the first ray?

A. It only refers to the second, third and left heel.

Q. Are you able to tell from reading your note under the assessment when you write "resolved wound dehiscence" whether that refers to the only dehiscence that you had observed at the first ray?

A. Yes, that would refer to only the first ray.

Q. So if there is no longer a dehiscence, what would make you keep the sutures in in this particular patient's case?

A. I've answered that. I felt that

0142

the wound needed to continue to be contracted or coapted.

Q. Why?

A. Otherwise the incision might have opened.

Q. And is there anything in your note to reflect those thoughts?

A. No.

Q. Did you form any opinion as to whether this patient had any type of infection?

A. Well, I had an opinion that she might have an infection.

Q. And what, within your notes, suggests that the patient might have an infection as of June 7th?

A. Well, on June 7th I don't believe she had an infection.

Q. That's what I'm asking. Maybe I wasn't clear, sorry.

As of June 7th, did this patient have an infection?

A. No.

Q. As far as you know, had the

0143

patient taken the Augmentin that you had prescribed for her?

A. Yes.

Q. Was there any purulent drainage that you observed on this visit?

A. No.

Q. Was the area surrounding the first ray first MPJ joint, was it warm to the touch as in an infection?
A. I don't recall.
Q. Did the patient have any fever?
A. I don't recall.
Q. Did you observe any necrosis on June 7th?
A. No.
Q. Did you observe any fluctuance?
A. No.
Q. Did the patient have an ulcer at that point at that location, the first ray, first MPJ?
A. No.
Q. Did the patient express to you any feelings of malaise or just feeling tired or fatigued?

A. I don't recall.
Q. Did the patient have evidence of cellulitis?
A. No.
Q. Was the patient still taking the antibiotics as of the June 7th visit? This is now two weeks after the May 24th visit.
A. I don't recall how long I had her on the antibiotics for.
Q. When you prescribe a medication for the patient, do you actually give them a script or do you call it into their pharmacy?
A. I give her a script.
Q. Do you make copies of that script?
A. No.
Q. By the way, are you still affiliated with Dr. 's office?
A. No.
Q. When did your affiliation with him end?
A. .

Q. Do you recall when?
A. Not exactly.
Q. Winter, spring, summer, fall?
A. I can't recall.
Q. Did your affiliation with Dr. end as a result of anything involving his particular patient?
A. No.
Q. Where do you currently work?
A. I have a private practice.
Q. Where?
A. , New York.

Q. What's the address, please?
A. , ,
New York .
Q. What is the name of your practice?
A. , DPM, PC.
Q. Were you born in the United States?
A. Yes.
Q. Your last name , what is its ancestry? It's unusual.
MR. : Objection. Don't

0146

ask that on the record. Then I'm going to start handing you with Batz objections.
MR. OGINSKI: That's fine.
Q. Doctor, how long have you been at your office in ?
A. Four years.
Q. Are you affiliated with any hospitals now?
A. Yes.
Q. Which ones?
A. ,
.
Q. And what are your affiliations with those hospitals?
A. As an admitting attending.
Q. In podiatry?
A. That's correct.
Q. Have you ever testified before?
A. Yes.
Q. How many times?
A. Twice.
Q. In what capacity? Expert, witness, somebody who's been sued or

0147

something else?
A. Once as an expert. Once as a defendant.
Q. And when you testified as an expert, was that at trial or in a deposition like we're doing now?
A. No. At a trial.
Q. And was that on behalf of a patient or on behalf of a doctor who's being sued or something else?
A. On behalf of a patient.
Q. Do you recall what county that was in?
A. New York.
Q. How long ago?
A. Maybe six years ago.
Q. And the case where you testified as a defendant, did you testify at trial?

A. No, deposition.
Q. How long ago was that, approximately?
A. Three years ago.
Q. As of June 7th, the patient is now five weeks postoperative. Is it

customary to keep sutures in that long?
MR. : Objection. Asked and answered. You've gone through the reasons why he would have kept them in longer. You've gone through the reasons why they would have been kept in a different time period. I think you've questioned about that already.
Q. When did you intend on removing this patient's sutures?
A. When it was necessary.
Q. Did you have an opinion on June 7th as to when you expected to remove those sutures?
A. Yes.
Q. When?
A. When it was ready.
Q. Did you have an opinion as to when that might be?
A. In the near future.
Q. Did you record anything in your note as to when that would be?
A. No.
Q. You wanted the patient to

continue to remain partial weightbearing, correct?
A. Yes.
Q. And to remain in the surgical shoe?
A. That's correct.
Q. Why did you still want her to remain partial weightbearing?
A. She just started to resolve the swelling.
Q. Was there any evidence, in your mind, that the bone was not healing properly or correctly at that time?
A. No.
Q. And did you learn from Ms. that your instructions for her to elevate her leg, did you learn that she was doing as you instructed?
A. I don't recall.
Q. You told her to return to your office in one week and she returned to your office three weeks later on June 28th. Again, the same question: Did any of the problems that she presented with on

0150

June 28th, were they a result of the additional two week delay in returning to your office?
A. I don't know.
Q. Are you able to tell from any of the complaints that she had on June 28 whether they were a result of not returning to your office two weeks earlier?
A. She started to soak her foot.
Q. Did you ever tell the patient to soak her foot in Epson salt?
A. No.
Q. What is Epson salt?
A. It's a salt.
Q. Have you ever told patients to soak their feet in Epson salt?
A. Have I ever told any patient?
Q. Yes.
A. Yes.
Q. Why do you do that? What is the purpose of that?
A. Therapeutic.
Q. What does that accomplish?

0151

A. I guess the same thing you get when you get a massage.
Q. It's temporary superficial relief?
A. Yes.
Q. What did she tell you as to why she was unable to return to your office, as you indicated to come back a week later?
A. Well, I wrote down that she's having transportation issues.
Q. Did you ask her what she meant by that?
A. She can't afford to get to the office and when she calls a like Access-A-Ride or one of those services, it takes forever. And she just can't make it to the office.
Q. Did you suggest that she go to somebody more local to her or closer to her?
A. I don't recall if I suggested that.
Q. The fact that she started

0152

soaking her foot in Epson salt, what did that mean to you, if anything?
A. Well, that could soften up the wound edges and could have caused the

dehiscence again.
Q. Is there any other risk for using Epson salt soak for her condition as it existed when you last saw her on June 7th?
A. Could you --
Q. Sure. Other than softening up the edges of the wound, is there any other risk to her for doing a soak like this?
A. Sure. The incision is not completely closed, which is why the sutures are still intact, yes, soaking it in any water can cause problems.
Q. Now, you told me a little earlier on the June 7th note that the dehiscence had resolved?
A. That's correct.
Q. And the sutures were still in. So what would lead you to believe that the wound might still be open?

0153

A. That's why I leave the sutures in.
Q. I'm not clear, Doctor, I'm sorry.
The sutures caused the skin to be closed, correct?
A. No, it does not cause the skin to be closed.
Q. It allows the skin to close?
A. No. It keeps the skin coapted.
Q. And as of the time you saw her on June 7th, there was no indication that that wound was open, correct?
A. No, there was no indication that it was completely closed.
Q. Is there anything in your note to suggest that the wound was open in any fashion at all?
A. The note prior to that visit.
Q. I'm only talking about the June 7th visit where you have the sutures still intact and the wound dehiscence has resolved.
A. That's correct.

0154

Q. Is there anything in your notes to suggest that that wound on the first ray, the first MPJ was open in any regard?
A. There's nothing in my notes.
Q. Did the patient have any complaints of pain on June 28th?
A. No.
Q. You observed mild serosanguineous drainage again, correct?
A. That's correct.

Q. Where did you observe this?
A. From the first ray.
Q. Was this in the same location that you had originally observed it on the 24th of May?
A. I'm not sure.
Q. Was it in a different incision or was it the same incision?
A. Same incision.
Q. Are you able to describe the dehiscence as to how much opened?
A. I did not mention it.
Q. Did you take any photographs at that time?

A. No.
Q. You noted something new that was not present before. You say that the patient had necrotic tissue?
A. That's correct.
Q. And where did you observe the necrotic tissue?
A. Probably surrounding the wound on the incision.
Q. Was it on the wound edges or somewhere else?
A. I did not describe that.
Q. What was the significance of that finding to you, if any, the fact that now the patient has necrotic tissue where before there was none?
A. That the wound might be getting worse.
Q. Did you form an opinion as to whether this patient's dehiscence came about as a result of her Epson salt soaks?
A. Yes.
Q. What was your opinion?
A. That it's possible.

Q. What else is possible as to what could have caused the dehiscence other than the Epson salt soak?
A. Her -- because of her history of missing appointments, we don't know what she's been doing.
Q. Did you ask her whether there was anything she did during those two weeks that could account for opening up of the wound?
A. I don't recall.
Q. You wrote "started soaking foot in Epson salt last week." Did you ask her why she did that?
A. I don't recall.
Q. Is there anything in your note

that would indicate why she did that?
A. Nope.
Q. Is that something you would have expected to ask her why did you do it?
A. If I would expect to ask?
Q. No. A patient tells you now she's missed two weeks --
I'm sorry.

She comes to your office three weeks after being told to come back one week. She tells you that only last week she soaked her foot in an Epson salt soak. Would you expect to ask her why did you do that?
A. I might have.
Q. Did you ask her whether she changed the dressing in order to soak her foot in an Epson salt?
A. I believe I had her start changing the dressing herself. Yeah, back in May 24.
Q. And where do you indicate that, Doctor?
A. Change dressing every other day.
Q. Okay. On the third line of your objective paragraph you write "full ROM," that's range of motion?
A. Third line?
Q. Yes, right there.
A. Oh, yes.
Q. "First MPJ mild wound dehiscence to dorsal first MPJ left foot," where does

that actually refer to?
A. The top of the joint.
Q. Is that any different from the location of the dehiscence that you observed back on May 24th?
A. That's still in the same incision site.
Q. Now, in your assessment, do you write wound dehiscence left foot with mild cellulitis? You told me at the beginning that a cellulitis was a localized infection?
MR. : Or inflammation, he said.
MR. OGINSKI: Thank you.
Q. In this particular case on June 28th, what was your understanding or impression as to whether this was an infection, inflammation or something else?
A. Well, there's a possibility for an infection again.
MR. : Anything else

besides a possible infection?
THE WITNESS: And patient not
0159
compliant.
Q. In what way, that she didn't return?
A. She's doing stuff that I did not tell her to do.
Q. How could an Epson salt soak cause cellulitis, if at all?
A. Because it weakens the skin integrity and pathogens are now able to enter the wound.
Q. You told her specifically don't soak her foot in Epson salt?
A. That was my initial post-op instruction.
MR. : On the 28th.
Q. On the 28th?
A. Yes.
Q. Did she indicate to you or verbalize to you that she would follow that instruction?
A. It's not written in my notes.
Q. How many times did she soak her foot in Epson salt prior to her arrival on June 28th?
0160
A. I don't know.
Q. Are you able to tell from your note how many times she did that?
A. No.
Q. And would she still be susceptible to the softening of the wound edges with just one soak?
A. Sure.
Q. Did she have an infection on June 28th?
MR. : Objection. Asked and answered. He said it was a possible infection.
Q. Why did you prescribe Augmentin?
A. Because it worked before.
Q. Did you obtain a wound culture?
A. No.
Q. Did you take X-rays to evaluate the patient's wound or bone?
A. I took one in the prior visit.
Q. On June 7th you took X-rays?
A. That's correct.
Q. How many X-rays did you take?
A. I don't know.
0161
It looks like I took one X-ray.
Q. What is the date of that X-ray?

A. June 7th.
MR. : Let the record reflect in response to the question, Dr. took out the original X-rays and looked at the dates June 7th.
Q. What view is that, Doctor?
A. The DP.
Q. Have you ever been able to observe evidence of osteomyelitis on an X-ray?
MR. : In this patient?
Q. In your career.
A. Yes.
Q. Looking at this June 7th X-ray, Doctor, is there any evidence of osteomyelitis anywhere in the patient's foot?
A. No.
Q. Am I correct that an X-ray is not a useful diagnostic tool to diagnose or help you diagnose infection, correct, soft tissue infection?

0162

A. Right.
Q. Was the patient still using a cane as of June 28th?
A. I'm not sure.
Q. Did you still want her to continue partial weightbearing on June 28th?
A. Yes.
Q. Do you indicate that anywhere in your note?
A. No.
Q. Had the edema or erythema that you saw on June 28th, had it changed at all from any of the prior visits?
A. I don't know.
Q. Is there anything in your note to suggest that the edema or erythema had changed in any regard?
A. No.
Q. Were the sutures still in on June 28th.
A. Yes.
Q. Did you remove the sutures on June 28th?

0163

A. No.
Q. Why not?
A. Still did not think it was necessary.
Q. Tell me why.
A. Again to keep the wound coapted.
Q. Where was the serosanguineous drainage that you observed coming out of?

A. The incision site on the first left MPJ.
Q. What made you think that by keeping the sutures in that would benefit the patient?
A. Again, it's to limit a scar and to help resolve whatever issues she's having with this wound.
Q. If she did, in fact, have an infection, is it appropriate at this point to continue to leave the wound with those sutures in?
A. Yes.
Q. Tell me why.
A. Again, it's not a contraindication to remove sutures at this

0164

point.
MR. : Did you mean a contraindication to keep it in?
THE WITNESS: Right.
Q. Did you debried any of the necrotic tissue that you observed?
A. Yes.
MR. : Lunch is here.
(A lunch recess was taken from 1:15 to 1:40 p.m.)

0165

, resumed the stand and testified further:
EXAMINATION BY
MR. OGINSKI:
Q. Doctor, once started to observe drainage, would it be good medical practice to remove the sutures to allow continued drainage so that complete drainage can occur?
MR. : In this case Mrs. ?
MR. OGINSKI: Yes.
A. Not necessarily.
Q. Not necessary or not

necessarily?
A. Not necessarily.
Q. Why?
A. Because at this time I don't believe the sutures were inhibiting any of the drainage.
Q. In instances where the sutures did inhibit drainage, would you agree you would then remove the sutures to allow complete drainage?

0166

A. Yes.
Q. Why?
A. Because then the suture would be inhibiting the drainage.
Q. What effect could it have on the patient if the drainage was inhibited?
A. It can build an abscess.
Q. What is an abscess?
A. The collection of fluid in soft tissue.
Q. What could that cause?
A. An infection, a deep infection.
Q. Can you tell me, Doctor, when you did take out the sutures on the first ray, the first MPJ joint?
A. I'm not sure. It might have been at the hospital.
Q. Let's just go through it and then I'm going to go through in detail. On the July 10, visit, is there any notation that you removed the sutures on that visit?
A. July 10th?
Q. 10th.

0167

A. No.
Q. And as of the following visit July 26th, she's already postoperative from being in , correct?
A. That is correct.
Q. Doctor, going back to the Epson salt soak, if the patient has an underlying infection in the wound, would the wetness cause the wound to reopen?
A. Could you repeat that question?
Q. Sure.
You've told me that the Epson salt soak can cause the wound edges to soften and to open, correct?
A. That's correct.
Q. Now, can that occur in the absence of any infection?
A. Yes.
Q. Can it also occur in the

presence of an infection?
A. Yes.
Q. Based upon your observation, she had necrotic tissue, she had bloody

0168

drainage, she had redness and swelling and now she had an open wound. Is it your opinion that as of June 28th, this patient did not have an infection in the wound?
A. That she had a possible infection in the wound.
MR. : Objection. Asked and answered. He answered that.
Q. What did you determine to definitively diagnose whether she had an infection in the wound?
A. I did not perform any definitive test to prove that she had an infection.
Q. You did not take any X-rays on the 28th of June, correct?
A. That's correct.
Q. You did not take any wound culture?
A. No.
Q. You did not draw bloods for a CBC or sedimentation rate, right?
A. Correct.
Q. Would it have been good practice

0169

to draw bloods to obtain a CBC and sed rate at that time to evaluate her possible infection?
A. It was not necessary at that time.
Q. Why?
A. There was no evidence of any systemic infection at this time.
Q. Describe what you mean by systemic infection.
A. Fever, malaise.
Q. And is that what you would have needed to see in order to draw bloods?
A. Well, that would have gave me a better understanding that an infection might be present.
Q. But in order to draw bloods, I'm trying to find out what -- what are the criteria that you use in order to draw bloods in a suspected infection?
MR. : Objection. I think he answered that before. He said if there were evidence of any systemic infection.

0170

Q. Are there occasions when a patient does not have evidence of systemic infection and you will still draw bloods?
A. No.
Q. Under what circumstance would you obtain a wound culture?
A. If I see a purulent type drainage with maybe a possible sinus tract.
Q. And what would you see if there was a drainage tract?
A. You will see a separation within the soft tissue line.
Q. What would that suggest to you, if anything?
A. That the infection is traveling along a track. It's making a track.
Q. Did you observe any purulent drainage on June 28th?
A. No.
Q. Did you observe any drainage tract at that time?
A. No.
Q. The cellulitis that -- it was

0171

your assessment that she had a mild cellulitis. Is that a localized infection, inflammation or something else specifically as it relates to on June 28th?
A. Yes, it was a localized either inflammation or an infection of the soft tissue.
Q. Are there instances where a patient will develop necrotic tissue with an infection?
A. Yes.
Q. And are there instances where a patient will development necrotic tissue without an infection?
A. Yes.
Q. Did you form any opinion on June 28th that the patient had a compromised blood supply to the tissues where you observed the necrotic tissue?
A. I did have an opinion but there was, again, no evidence that suggested that she was vascular compromised.
Q. What was your opinion?

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A. My opinion was she had multiple surgeries done and, if there was any compromise of her vascular status, that the digits would be the first -- the lesser digits would be the first to show signs of ischemia.

Q. I may have asked you this, sorry if I did: Why would a patient develop necrotic tissue so many weeks postoperatively?
A. Again, if the wound is open, if it's dried, that could cause necrosis.
Q. Anything else?
A. An infection can cause necrosis.
Q. And on June 28th, did you form an opinion as to why this patient had necrotic tissue, whether it was from an infection or the wound had been open and dried?
A. Well, it could be all of that.
Q. We know, based upon your note, that she had an Epson salt soak which would obviously make her foot wet. We know that there was necrotic tissue. Were

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you able to tell whether the necrotic tissue occurred after the soak or before the soak?
A. No.
Q. Once you clean away the dead tissue, if you continue to see necrotic tissue, what does that suggest to you?
MR. : Objection. I don't understand. You're saying you can remove the dead tissue and there's still dead tissue?
MR. OGINSKI: No.
MR. : I didn't follow that.
Q. Once you debried the necrotic tissue and on another visit you see new necrotic tissue, what does that suggest to you?
A. At what time frame?
Q. Within a few weeks later?
A. A lot of things can happen in a few weeks.
Q. Could one of the things indicate that --

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MR. OGINSKI: Withdrawn.
Q. Let's go, please, to the next visit July 10th. You write that "the patient missed last week's appointment because of transportation issue," correct?
A. That's correct.
Q. Did you again have a conversation with her about what she could do to try to resolve the transportation issue?
A. That conversation might have occurred with my office staff at the time.

Q. Do you know how that was resolved, if it was?
A. No.
Q. She told you that she continued to soak her foot in Epson salt last week?
A. That's correct.
Q. Did she tell you why or did you ask her why?
A. I'm sure I might have asked why.
Q. Did you record what she said?
A. No.
Q. You write down "still notice

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large amount of drainage and wound getting larger." Is that your observation or the patient's observation?
A. That would be the patient's observation.
Q. Again, you observed mild serosanguineous drainage, correct?
A. That's correct.
Q. When you write positive wound dehiscence, what does that mean?
A. That the wound is open.
Q. Left foot measuring 2 centimeters. That's the size of the dehiscence?
A. Correct. But I probably did not record all the dimensions. Because there's only one measurement here.
Q. You have a memory as to what the size was at that time?
A. No.
Q. This was something larger than what you had observed at the last visit?
A. I'm not sure.
Q. Based upon the fact that you

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actually noted a measurement, does that suggest that this is somewhat larger than the last observation on June 28th?
A. That's possible.
Q. Again, you observe edema and mild erythema, correct?
A. That's correct.
Q. Where do you observe that?
A. Surrounding tissue.
Q. Of the first ray, first MPJ?
A. That's correct.
Q. And again, you see this time mild purulent drainage?
A. That's correct.
Q. And just to be clear, Doctor, on the last visit, did you not observe purulent drainage?
A. That's correct.

Q. Did you form an opinion on this visit that the patient had an ongoing infection?
A. Yes.
Q. Did you record that information?
A. No.

Q. Is there a reason why you did not?
A. I mean, there are a lot of times where informations are not put on to the notes.
Q. I'm just asking if there is a specific reason that you remember --
A. Not that I recall.
Q. -- as you sit here now?
Okay. Did you ask her whether she had taken the antibiotics that you had prescribed for her, the Augmentin on June 28th?
A. I'm sure I must have asked that.
Q. As of July 10th, had she finished her dose of antibiotics?
A. No.
Q. She was still taking it?
A. Yes.
Q. Was it your opinion that the antibiotics were not effective in treating this infection?
A. That's correct.
Q. What was it about your

observations that suggested this antibiotic was not effective in treating this infection?
A. The wound is getting larger.
Q. What effect, if any, did her soaking her foot in Epson salt, again, have on her wound getting larger?
A. It could be -- the soaking can be a very large role in her problem. Again, we don't know her situation at home. Once the wound is open and been soaked, was she dressing it? Was she leaving it open? Again, we don't know if she's using what type of water, if it's sterile water, dirty water and the fact is she is soaking it. There is a higher chance of pathogens to enter the foot.
Q. Even with sterile water, right?
A. Well, yes. I mean her foot's not sterile. So there could be debris floating in the water.
Q. And, likewise, on the other side, Doctor, is it possible that the Epson soak had nothing to do with

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continuing to open up her wound?
A. That is also possible.
Q. When you mentioned in your assessment that she had mild cellulitis, was it your opinion that this was a greater form of cellulitis than you had observed on the last visit, June 28th?
A. That I can't give you an answer on that.
Q. This cellulitis that you describe, at this point, you would indicate that this is an infection, correct?
A. Yes.
Q. Did you observe any necrotic tissue on this visit?
A. No. Well, yes, I did.
Q. Look down at the second line.
A. Yes.
Q. Where did you observe the necrotic tissue?
A. Again, it could have been at the wound entrance.
Q. Did you form an opinion as to

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why she continued to develop necrotic tissue?
A. Yes.
Q. What was your opinion?
A. That she might have an ongoing infection.
Q. Did you obtain a wound culture?
A. No.
Q. Is there a particular reason why you did not?
A. Because we were planning to admit her to the hospital.
Q. Did you obtain X-rays?
A. At this point, no.
Q. Did you feel that this infection impacted her healing ability and any bone problem?
MR. : Objection, compound. Could you split it up, please?
MR. OGINSKI: Sure.
Q. Did you form an opinion as to whether the infection she had as of July 10th was impacting her ability to heal her

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bone properly?
A. There's never been a point where we thought the bone wasn't healing.
Q. Was it your opinion that this

infection was a soft tissue infection?
A. Yes.
Q. Was there any sinus tract or drainage that you observed?
A. No.
Q. The tenderness to the first MPJ of the left foot, did you attribute that tenderness to be the infection or to something else?
A. It could be either swelling or infection.
Q. In comparison to prior visits, did you make any observation that you recorded about whether the swelling was the same as prior visits, worse or better?
A. No.
Q. Why did you want to admit the patient to the hospital?
A. To start her on IV antibiotic and to remove the hardware.

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Q. Why did you want to remove the hardware?
A. Well, that's an implant that's in the deep soft tissue that could contribute to some of the infection.
Q. And the hardware you're referring to are the screws?
A. One screw.
Q. Is there any way for you to determine whether there was an infection in the area of the screw without removing the screw?
A. No.
Q. Would repeat blood work have assisted you in determining whether or not there was an ongoing infection?
A. A repeat blood work?
Q. A CBC and a sedimentation rate, would that have helped you for purpose of diagnosis and treatment?
MR. : When you say "repeat," you mean repeat from the time of surgery?
MR. OGINSKI: Correct.

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A. If I was planning this as an elective removal of a screw fixation, yeah, repeat CBC would be ordered.
Q. Why?
A. Again, to make sure that the patient's hemodynamically stable and make sure if there is a white count that might be affecting this infection.
Q. Now, the patient came to you on July 10th. Tell me why you did not admit

the patient or send the patient to the hospital to be admitted on July 10th?
A. We did not feel that there was an emergency admission. There might have been situation -- well, I can only speculate from here.
Q. I don't want you to speculate. Just tell me either based on your note or what you specifically remember.
A. We were planning for a removal of the screw. That's probably the date that we were given for the OR.
Q. Are there instances where you will or can obtain an operating room on an

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emergency basis?
A. Yes. If it's an emergency.
Q. It was your opinion that this did not need to be removed on July 10th?
A. That's correct.
Q. Did you obtain any X-rays on this date, on July 10th?
A. No.
Q. Did you ever consider the possibility --
A. I don't know.
MR. : Do you want to double check that?
THE WITNESS: Yeah, let me double check that.
A. No, we did obtain X-ray on July 10th.
Q. You did or did not?
A. We did.
Q. Is there anything in your note to confirm that you took X-rays and read them at that time?
A. There's nothing in my notes.
Q. And the X-ray that you are

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looking at now, Doctor, that's dated July 10th, ?
A. That's correct.
Q. How many views?
A. Two views.
Q. Which ones?
A. D P and a lateral.
Q. Why did you obtain X-rays at that time?
A. Looking to see what might be causing this infection.
Q. Why would an X-ray assist you in evaluating whether or not there was an infection or the etiology of an infection?
A. Well, again, we're looking for the integrity of the hardware to see if

there's any erosion around the area and looking at the bone itself.
Q. Did you record your interpretation of the X-rays anywhere in your office record?
A. I did not.
Q. Is one of the reasons that an interpretation does not appear there,

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could it be that you did not read and interpret those X-rays at the time that they were taken?
A. No.
Q. Is there any reason that you know of, as you sit here now, as to why your note or your interpretation of those X-rays do not appear anywhere in your office chart?
A. I don't recall the reason.
Q. What do those X-rays show, Doctor, the July 10, ?
A. Again, we got good bone union between the osteotomy site. The internal fixation is intact and good position.
Q. In terms of correlating infection with anything that's going on, what, if anything, can you conclude from looking at those X-rays?
A. That the most likely cause of the infection is not coming from the bone.
Q. Is there any evidence of osteomyelitis on either of those two views?

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A. No.
Q. Just to be clear, on July 10th, there's no indication that you removed the patient's sutures on this visit, correct?
A. That's correct.
Q. Can you tell me why the patient's sutures were not removed on this visit?
A. It was not necessary.
Q. You told me earlier, Doctor, that if there's purulent drainage where a drainage tract is present that it would be appropriate to remove the sutures, correct?
A. No. I said if there's an abscess.
Q. Thank you.
And did you form any opinion as to whether this patient had an abscess?
A. There was no abscess.
Q. How would you recognize if there was an abscess, what would you see?

A. Well, you would feel fluctuance.
Q. And that's the fluid?

A. That's correct.
Q. Under the skin or in the area of the wound?
A. Underneath the soft tissue, yes.
Q. Would you agree that this infection that you observed on July 10th was more than a superficial infection?
A. I agree it's getting worse.
Q. And when I say superficial infection, I'm talking about something relating to the skin?
A. Right.
Q. Now, these findings, except for the purulent drainage, were all present on the prior visit on June 28th, correct?
A. June 28 we did not have any purulent drainage.
Q. That's right, that was the only difference between your findings on the 28th and the 10th?
A. That's correct.
Q. Would you agree, Doctor, that the earlier that you recognize and treat an infection, the better it is for the

patient?
MR. : Note my objection.
A. In general?
Q. Yes.
A. Yes.
Q. Why?
A. The earlier we start treatment.
Q. Do you have an opinion with a reasonable degree of medical probability as to whether this patient needed to be admitted to the hospital for IV antibiotics on June 28th?
MR. : Objection to form.
You can answer the question.
A. I did have an opinion and I did not believe it was necessary to admit the patient at that time.
Q. Did you attempt to change the patient's antibiotics before sending her into the hospital for IV antibiotics?
A. No.
Q. Would it have been beneficial for the patient to try --
MR. OGINSKI: Withdrawn.

Q. You told me a little while ago that the Augmentin you did not feel was

working as of July 10th. In order to determine what antibiotics work appropriately, is it good practice to obtain a wound culture?
MR. : Note my objection.
Are you asking generally speaking --
MR. OGINSKI: Generally.
MR. : -- or at a particular time for this patient?
MR. OGINSKI: General.
A. In general there's not going to be any antibiotics that's gonna work with the conditions in this situation.
Q. Tell me why.
A. Because she's exposing her wound to a dirty environment.
Q. So why don't antibiotics help her?
A. Because as quickly as you're killing the bacteria, you're probably getting other microorganisms.
Q. Did you explain that to her?

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A. I'm sure I might have -- I'm sure I would have.
Q. And to your -- was it your impression that she understood whatever it was that you were explaining to her?
A. I'm sure each time we gave her strict instructions she appeared she understood what we were talking about.
Q. Did you have to give the patient a note to go to the hospital in order for her to be admitted?
A. I'm sure I might have gave her the directions and instructions.
Q. And did you make a copy of that for your file?
A. No.
Q. I'd like you to turn, please, to the hospital record for for the July admission.
MR. : For the record, we can use my copy for him to look at of the hospital chart. Obviously, he can't testify as to whether it's complete or not. But we'll work on

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whatever documents they gave us pursuant to authorization.
MR. OGINSKI: Okay.
Q. Did you see the patient on each day that she was in the hospital?
A. I'm not sure.
Q. I'm going to go through the dates, but, just off the top of your head,

after having reviewed the chart, do you remember whether you saw her each day?
MR. : If you don't remember, Doctor, take your time to go through the chart.
Q. If you don't remember, I'll come back to that later.
A. Yeah, I don't remember.
Q. Did you ever learn from either during this hospital admission or at any time while you were treating her up until July 12 that she used marijuana on occasion?
A. She did not relay that information to me.
Q. Did you learn during this

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hospital admission that she had a history of using marijuana?
A. I might have seen it.
Q. Did you learn that the reason she used it was to help the pain that she was experiencing in her left foot?
A. No.
Q. Did you read any notes in the hospital record to indicate that the reason she was using marijuana was to alleviate the pain? Specifically let me direct you to the history and present illness on the bottom left of that page, Doctor.
A. Sure. It says "to help her pain." It doesn't say from what pain.
Q. Did you ever ask Ms. whether she had pain from any other source for which she was using marijuana?
A. I didn't perform this.
Q. I understand that. But at any time did you ever ask her while she was in the hospital?
A. Was she having any other pain?

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Q. Is it fair to say, Doctor, when you are seeing and evaluating a patient in a hospital setting that it's customary for you, as the treating physician, to read and review the patient's note, the notes of her doctors in the hospital record?
A. That's correct.
Q. And during the course of this hospital admission, did you read and review the patient's history of present illness at some point?
A. I might have reviewed it, yes.
Q. When you saw in the history that, at least it's recorded that she used

marijuana to help her pain, did you ever have a discussion with the patient as to what pain that referred to?
A. No.
Q. Did you ever determine for yourself as to whether there was any other pain she was experiencing other than the foot pain for which she used this marijuana?
A. No.

Q. With regard to alcohol consumption, where it's recorded that she was consuming two to three beers per day, did you ever learn that information either from reviewing the history or from talking with the patient?
A. I knew from past history that she did drink.
Q. Did you ever form an opinion up until July 12th, , whether her alcohol consumption in any way contributed to what was going on with her foot condition?
A. I did have an opinion.
Q. What was that?
A. But I don't believe that was the cause.
Q. Did you form an opinion as of July of as to whether the patient's marijuana usage contributed to anything involving the patient's foot condition as it existed in July of ?
A. Again, I believe that I did have an opinion.
Q. What was the opinion?

A. I do believe that her use of a substance or a substance such as marijuana can influence better judgment and could have caused some of her missed office visits as well as her lack of following my instructions.
Q. And that's based upon what, Doctor? What do you base that upon?
A. Because marijuana is known to impair judgment.
Q. Short-term or long-term?
A. I don't know.
Q. And other than her ability to possibly have an impaired judgment from use of marijuana, did you ever form an opinion as to whether the use of marijuana itself caused or contributed to the infection or opening of her wound?
A. I do have an opinion regarding marijuana and I do believe that because

she used marijuana it would have affected her judgment.
Q. Aside from judgment.
A. Her judgment of what she did

postoperatively could have caused the infection.
Q. I'm not talking about actions that she took. I'm only asking whether you have an opinion as to whether the marijuana itself may have caused or contributed to any infection or worsening of her wound?
MR. : Excluding its effect on her behavior and judgment?
MR. OGINSKI: Yes.
A. You're talking about just the chemical?
Q. Yes.
A. Then, no, it does not contribute to it.
Q. Can you turn, please, to the physical exam?
MR. : Whose?
MR. OGINSKI: This would be, I imagine, the history and physical.
MR. : Just show me which page you're on.
MR. OGINSKI: Same one he's on

now.
Q. Physical exam, it has a pain intensity scale but under general appearances "obese female. Patient in severe pain." Do you see that? Did I read that correctly, first line?
At the time that you saw her on July 10th, did she make any expression to you about the pain she was in?
MR. OGINSKI: I should rephrase that.
Q. Did you record anything about whether or not the patient had pain at that time?
A. I did not document that.
Q. And did you form an opinion on July 12 when the patient was admitted to the hospital as to the reason for her severe pain?
A. Did I see her on the 12th? I did not see her on the 12th.
Q. Is there any particular reason that you're aware of as to why you did not see her on that first day of admission?

A. Because I will be an acting consultant, even though it is a patient I'm bringing to the hospital, I am not allowed to really see that patient until I have been called on as a consult.
Q. It was your intention to perform surgery to remove the screw, correct?
A. It was to -- that was part of the admission.
Q. And was it your intention that the screw removal would be done on the same day that the patient was originally admitted?
A. No.
Q. Was it your intention that the patient would be started on IV antibiotics prior to doing surgery?
A. That's correct.
Q. Now, going back, Doctor, to the physical exam, the one where it says "extremities." Keep going. Right. At the bottom it says "an ulcer six by." Can you read that number?
A. It looks like four.

Q. Centimeters size. Can you read the rest of that sentence?
A. "Size toe on the medial aspect of the left leg. Metatarsals are exposed. Some pus positive, negative blood, negative edema, negative varicosities."
Q. The size that's recorded here, 6 by 4 centimeters, did that refresh your memory as to the size of this patient's open wound?
A. Those are incorrect. I mean, this physical examination was done by a medical resident who probably doesn't know how to document wounds.
Q. How do you know that?
A. Well, they're saying left leg and a toe. There's already a lot of inconsistencies there.
Q. Do you have any personal knowledge as to the individual who actually made this observation, made this notation?
A. Well, I went through the same residency program and I know first year --

Q. I'm only ask you whether you specifically know --
MR. : Who this person is.
A. I don't know this person.
Q. Other than noting that the person recorded left leg instead of left

toe or left foot, do you have any other reason to believe that the measurement that's recorded here is inaccurate?
A. Yes, I believe it's inaccurate.
Q. What other -- what do you base that upon?
A. Well, I never observed any large wound.
Q. Would you agree that a six by four centimeter wound would be considered large?
A. Yes.
Q. And what was -- did you record on your last visit on July 10th the size of this wound?
A. Again, I only have one measurement on July 10th and I wrote down measurement 2 centimeters.

Q. When this individual wrote metatarsals are exposed, what does that mean to you?
A. It means the bone is exposed.
Q. Did you make similar observation on July 10th?
A. No.
Q. Is that a significant finding, Doctor?
A. Yes.
Q. Why?
A. Exposed bone can lead you to a diagnosis of osteomyelitis.
Q. Is it possible that this patient's wound increased in size from the time that you saw her on July 10th until the time that she presented on July 12th?
A. I don't think it's possible.
Q. Why?
A. None of our notes suggesting while we were preoperatively seeing the patient saw any exposed bone or a lesion of that size.
Q. The individual who performed

this particular history and physical, do you know this person named , , S. or ?
A. Again, I do not know this individual.
Q. Do you know what year resident this individual was?
A. No.
Q. Other than the comment you told me about, no other observations prior to surgery concerning the exposed metatarsals, do you have any other --

MR. OGINSKI: Withdrawn.
Q. Would you expect a medicine resident of any year to be able to recognize whether bone was exposed or not, an open wound?
MR. : Objection. He's not a medical doctor, so he can't comment about what the medicine standard of care would be for a medical resident.
Q. Doctor, you told me you went through similar training at the same

0204

hospital?
MR. : As a podiatry resident.
MR. OGINSKI: I'll rephrase it.
Q. Is it your opinion that a medical resident would not be able to recognize exposed metatarsals?
MR. : Again, I'm going to object on standard of care questions. If he wants to, you know -- if you can answer that question as a layperson commenting on observations, he can.
MR. OGINSKI: No, this is not a standard of care question. He made a comment that he doesn't think that it's accurate. So I'm only trying to find out why.
MR. : I'm going to let him answer the question but the way you phrased it is a standard of care question for a medical doctor and that a podiatrist can't give expert opinions on. With that qualification, he can answer the question.

0205

A. From my experience at the hospital, I don't believe the medical residents are trained adequately to evaluate wounds of any sorts. They don't usually document accurately.
If you're asking if they can see a metatarsal, most likely. But they also could probably make an error if they saw a tendon as opposed to a bone.
Q. Why do you say that?
A. Again, that's my observations with the medical residents.
Q. On the other hand, there are residents who would be able to distinguish the difference between a tendon and a bone, correct?
A. That's correct.
Q. I would like you to turn please,

to the admission note dated July 13, .
MR. : Show me, please.
Q. A progress report.
A. Okay.
Q. Are you able to tell whose note this is based upon the next page?

A. Yes.
Q. Who is that?
A. Dr. .
Q. Spell it, please.
A. .
Q. Who is Dr. ?
A. He's a medical attending.
Q. I'm going to ask you to read Dr. ' note, recognizing that it's not your note. And as best you can, I would like you to read what it says, Doctor.
MR. : The most important thing, Doctor, is if you can't decipher a word, don't guess. Okay?
THE WITNESS: Sure.
Q. By the way, if there's an abbreviation, you don't have to read the abbreviation, just tell me what it means?
MR. : If you know it.
A. "Patient is a middle age black female with history of hypertension admitted for pain to left great toe. Patient on meds."
Q. Does that say hypertension?

A. I don't know.
Q. Go ahead.
MR. : Now we're looking at the word before hypertension.
A. Patient on meds. I don't know what that is. I don't know what that is. I don't know.
Q. Just tell me what line it is that you are able to continue and start reading on.
A. Sure. Okay, on the fourth line she missed -- on the fifth line again she writes "patient had bunion surgery April ," with question mark something, "for the suture site if," something, "stitches busted."
Q. Does it say patient?
A. I don't know.
Q. Go ahead.
A. "Stitches busted with pus," something "no" -- I don't know.
Q. Let's go down to the second page of his note, please, to the impression. Number one, it says "cellulitis slash

0208

questionable abscess?"
A. That's correct. "Number two, hypertension."
Q. And under podiatry, it says "for Dr. " or something else?
MR. : Where?
Q. A couple of lines down.
A. "For Dr. , will examine further with podiatry."
Q. What is ESR that appears right under that?
A. Underneath ESR?
Q. No, what is ESR?
A. Sed rate.
Q. Question mark, I.D. CX?
A. Yes, consult.
Q. Did you have any conversation with Dr. on July 13th?
A. I don't recall.
Q. Turn, please, to the July 12, medicine admission note.
A. Okay.
MR. : July what?
MR. OGINSKI: July 12th.

0209

Q. The first full paragraph that appears in the bottom third of the page, again, I'm going to ask you to read that note, Doctor, as best you can.
A. Okay. "Patient admitted as direct admission under Dr. due to the left foot cellulitis. As per patient she had recently April surgery to connect left" --
Q. Correct?
A. "Correct left toe deformity, but" --
Q. Since?
A. Okay, "that time wound is still open and very difficult to heal. There is an open wound on the metatarsal area dorsum right foot. Approximately 1.5 by point 8 centimeter, deep point 5 centimeter and partial with skin change 2 centimeters."
Q. I'm sorry, Doctor, does it say painful or partial?
A. It says partial.
Q. Go ahead.

0210

A. "Partial with skin change two centimeter around above-mentioned central area. As per patient, sometimes pus came out of the wound. She has been followed

up by Dr.   ."
Q. What does it mean to you where he's recording the measurements it says "approximately 1.5 by point 8 centimeters, deep point 5 centimeters and partial with skin changes 2 centimeters?"
A. I believe the first two measurement, the point 5 is the length.
Q. 1.5?
A. 1.5 and the point 8 is the width and the point 5 centimeters is how deep.
Q. And the reference to partial what does that mean?
A. Partial, I believe he's talking about the skin around the wound has some changes.
Q. Okay. By the way, Doctor, in the course of your training in the podiatry training, did you learn how to treat patients with wound care?

0211

A. Yes.
Q. And over the course of your career up until the time that you were seeing Ms. , you had treated patients who had had infections in the past, correct?
A. That's correct.
Q. Go, please, to the second page of this physician's note.
By the way, do you know this Dr. ?
A. No.
Q. Are you able to tell if this was a resident or an attending?
A. Usually medical admission note is done by a second year.
MR. : Second year resident?
THE WITNESS: That's correct.
Q. And in the middle of the page under skin and extremities, it says "left foot open wound." Can you read the rest of it?
A. Yes. Again, "1.5 by point 8

0212

centimeter surrounded by skin change dark."
MR. : Do you want him to keep reading?
MR. OGINSKI: Yeah.
Q. Go down to assessment and plan please, number one.
A. "Left foot cellulitis open wound. Start IV Ancef one gram cube six hours. Wound care by podiatry. Blood

cultures, x-ray left foot to rule out osteomyelitis. Hypertension under control. Start hydrochlorothiazide and ACE inhibitor. Obesity dietary evaluation HG 1 AC."

Q. Did you form any opinion on July 13th that this patient might have osteomyelitis?

A. I did have an opinion and it's a possibility.

Q. What led you to that possibility?

A. Again, we have an open wound for a long period that is worsening.

0213

Q. If a patient had an acute osteomyelitis, would you expect evidence of that to show up on an X-ray?

A. Yes.

Q. How long does it take for evidence of acute osteomyelitis to show up on an X-ray?

MR. : Objection, asked and answered. You asked that a few hours ago and he said weeks.

Q. Doctor, at the bottom of this page that we are reading from, it says podiatry consult and the date, is that July 13?

A. Yes.

Q. And that's your note?

A. That's correct.

Q. It says "full consult in chart?"

A. That's correct.

Q. Before we get to your note, Doctor, I would like you to turn, please, to another note titled MS3 also in the progress report for July 13.

A. Okay.

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Q. Can you determine who wrote this note?

A. Well, MS3 stands for medical student third year. And it looks like it's a Daniel Barron.

Q. Did you ever tell the patient that she had poor circulation?

A. No.

Q. Did you ever suggest to Ms. that the reason why she had necrosis or necrotic tissue that you observed on two different occasions was because of poor circulation?

A. No.

Q. Did you ever form an opinion that the reason she had necrotic tissue on

two prior occasions was because of poor circulation?
A. I did have an opinion but I did not believe it was due to poor circulation.
Q. This individual, this medical student writes on the second line "complaints of pain ten out of ten in left

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foot due to infected surgery wound since two months ago." Do you agree or disagree with that statement?
A. That is ten out of ten, I'm not sure what scale he's using, but in terms of the surgery, it was a little more than two months ago.
Q. What scales are there, Doctor, for evaluating pain?
A. Again, I don't know what scale he's using.
Q. What scale do you typically find in a hospital setting that somebody --
A. It's usually the same scale that's in the history and physical form which is he noted five out of ten.
Q. Five to six out of ten?
A. That's correct.
Q. And that's in the graphical?
A. Right, the pain intensity scale.
Q. And the following day, do you have any reason to believe that the patient's pain was not as severe as described here as being ten out of ten?

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A. Can you repeat that question?
Q. Sure. The pain intensity scale we talked about was on the admission date July 12th. This is now the following day and someone, this medical student is recording a pain of ten out of ten.
A. That's correct.
Q. Do you have any reason to believe that that is not an accurate reflection of the patient's extent of pain?
A. I think that's a subjective observation.
Q. Who's subjective, the medical student?
A. The medical student.
Q. Or the patient?
A. The medical student.
Q. Typically, Doctor, when a doctor or a nurse asks a patient well, how bad is your pain on a scale of one to ten with ten being the worst, one being the least,

if the patient replies that it's a ten, is that the same thing? Is that subjective

in the sense that it's not coming from the person recording it but the person who answered it?

A. Again, it could be the situation. I'm not sure if Ms. knew who this person was. It could have been a nurse. Maybe she was asking for pain meds. Maybe she was just exaggerating the pain to get more pain medication. I don't know the situation.

Q. Have you ever known Ms. to exaggerate her condition in order to seek drug medication or pain relievers?

A. No. But she has been on pain medication for quite a bit.

Q. Do you have any objective reason to believe that the patient's reported pain condition as of July 13 is not as it was reported here as a ten out of ten?

A. No, I don't have any.

Q. Continuing the sentence, it says -- continuing the next sentence, "the wound is in metatarsal area and has not healed for two months." Do you agree or

disagree with that statement?

A. Disagree.

Q. What do you disagree with?

A. Well, the wound was healing and it was healing fine.

Q. And at what point do you believe the wound was healing fine?

A. May 24, , the patient was doing much better. We put her on some antibiotic and on June 7th, the wound seems to be healing very fine, doing fine.

Q. And it was the next visit on the 28th that you recognize there was a dehiscence?

A. That's correct.

Q. Did you learn during this hospital admission that the patient smoked cigarettes?

A. Yes.

Q. Did you form an opinion during --

MR. : Objection to form. Did he learn again or did he learn for the first time? The form of the

question wasn't clear.

Q. At any time before the patient's

hospital admission, did you learn that the patient was a smoker?
A. Yes.
Q. Up until her admission on June 12th, did you form an opinion whether her smoking caused or contributed to her worsening wound condition in her left foot?
A. I believe a smoker or smoking can cause a worsening of her wound.
Q. I just want to be clear that I understand your answer, Doctor.
Specifically in this patient's case, did her smoking cause or contribute to worsening of her wound condition on her left foot before July of ?
A. I don't have it documented that she was smoking actively.
Q. Is there anything in your notes to indicate that you had an opinion at that time in May or June of to indicate that any smoking she may have

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done caused or contributed to worsening of her foot condition?
A. I do have an opinion. And I do --
Q. I'm only asking if you record anything?
A. I do not record it in my notes.
Q. Now what is your opinion?
MR. : About the impact of smoking on wound healing?
Q. Yes, for this patient.
A. My opinion has never changed. I've always thought that smoking can contribute to wound complication.
Q. In this patient's case, do you have an opinion as to whether her smoking, if she was smoking, caused or contributed to degradation or the deteriorating condition of her wound on her left foot?
A. Yes.
Q. What is your opinion?
A. My opinion that, if she was actively smoking, it can complicate her wound.

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Q. How?
A. Well, there would definitely decrease her circulation to the extremity and would increase her likelihood of getting an infection.
Q. Would it matter the amount that she was smoking in order to arrive at the conclusion that you told her about, that

it might impact her ability to heal her wound?
MR. : Generally speaking --
MR. OGINSKI: Yes.
MR. : -- would more smoking be worse than less is that what you're asking?
MR. OGINSKI: Yeah.
A. I don't know.
Q. Let's turn, please, to the second page of the medical student note. On the top paragraph five lines down, it says "skin slash extremities left foot has open wound approximately 2 centimeters in length and 0.5 centimeters in width,

leaking pus and the surrounding skin is darker." Did I read that correctly?
A. That's correct.
Q. Was that consistent with your observations on July 13th?
A. I did not make any note of any darkened wound edges or surrounding skin.
Q. Tell me why you elected to proceed forward with surgery on July 13th but not on the 12th.
You told me a little while ago that you wanted to give her a chance to have IV antibiotics. Why is it that you chose the 13th to proceed and not any other particular day?
A. I have to see when I did the surgery. I did it on the 13th, okay. I wanted her -- on my consult I do mention that I do want her to be medically clear for the surgery.
MR. : The surgery is on the 14th.
A. No, that's post-op note. Oh, yeah, the 14th.

Q. Let's turn, please, again before reading your note, go to the pre-op note dated July 13, .
A. Okay.
Q. This Dr. , do you know Dr. ?
A. I do.
Q. Is he an attending or a resident?
A. He was a resident.
Q. What year?
A. I don't recall.
Q. Does Dr. work at currently?

A. No.
Q. Do you know where Dr. works?
A. No.
Q. I would like you to read the first paragraph in this note.
A. "Fifty-three-year-old female admitted on direct admission for left foot cellulitis with status post wound dehiscence. After surgical correction

bunion April 28, , patient states the surgical site opened up."
Q. One week?
A. "One week after surgery. Patient stated that past treatment of local wound care involving soaking with Epson salt and warm water and application of LidaMantle and antibiotics."
Q. What is LidaMantle?
A. It's a mixture of hydrocortisone and lidocaine in a cream.
Q. And did you recommend that for her?
A. I did.
Q. When did you recommend that for her?
A. I don't recall.
Q. For what reason did you recommend that for her?
A. For pain and swelling.
Q. Is there any notation that we have read so far that reflects when it was or for what reason it was that you gave her or recommended LidaMantle?

A. It was not noted in any of my notes.
Q. Let's go down to the middle of the page beginning with "positive open lesion."
A. Okay. "Positive open lesion left foot. Positive pus on dressing. Positive pain on palpation. No mal odor. Positive signs infection. Positive sign edema left foot at surgical site."
Q. Now, the patient had X-rays on admission, correct, to evaluate her foot?
A. That's correct.
Q. Did you read and interpret those X-rays?
A. Yes.
Q. And do you have a note reflecting that you interpreted those X-rays?
A. No.

Q. Is there a radiology note in this hospital chart confirming or interpreting the X-ray taken on July 12th?
MR. : He has the report.

Q. What is the date of that report?
A. July 13, .
Q. What is the impression of the report, Doctor?
A. "Postoperative changes over the distal first metatarsal bone. There is a metallic screw at the osteotomy site. There is absence of the distal end of the proximal fundus of the second and fifth toes. No radiographic evidence of a destructive process is identified."
Q. What does that mean to you?
A. There's no signs of any active osteomyelitis.
Q. And did you read and interpret the X-ray before doing surgery?
A. I'm sure I would have went over that.
Q. Did you discuss your findings and interpretation with the radiologist?
A. No.
Q. Were your conclusions after reading the X-ray consistent with what the radiologist reported?

A. Say again.
Q. When you read the X-rays, did you come to the same conclusions that you just told me about in the radiologist's report?
A. Well, I'm not completely sure about the absence of the distal end of the proximal fundus because I believe we worked on the second and third toe. Not the second -- well, second and fifth toes.
Q. What about the observation about that there was no destructive bony process?
A. I agree with that.
Q. And it was your interpretation that there was nothing to suggest that the patient had osteomyelitis based on the X-ray?
A. That's correct.
Q. Why would you then still proceed forward with the removal of the screw?
A. My impression at the time the infection was becoming a deeper type of infection. Leaving a hardware in a bone

can compromise the bone.
Q. Before doing the surgery on July 12th and July 13, did the patient still have the sutures in place in the first ray in the first MPJ joint?
A. Prior to the surgery?
Q. Yes.
A. I don't recall.
Q. Is there anything in any note that you have for July 13th to suggest that the sutures had been removed either on July 12 or July 13?
A. Well, there's nothing suggesting that there are sutures in tact.
Q. There's no note anywhere to indicate when, if ever, the sutures were removed, correct?
A. That's correct.
Q. Let's turn, please, to your consult note.
Do you have a time associated with your note of July 13?
A. No.
Q. Do you remember when it was that

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you wrote your note or saw the patient that day?
A. No.
Q. I'd like you to read your note in its entirety, please.
A. "A 53-year-old black female with history of hypertension and status post bunionectomy left foot times five weeks. Patient presents with an open wound to the left foot with mild cellulitis times three weeks."
Q. Does it say with or and cellulitis?
A. And.
"Patient complaining of severe pain to her left foot and currently on Augmentin."
Q. I'm sorry, Doctor, if you can just read it word for word. You wrote to her foot and currently on Augmentin, correct?
A. That is correct.
Q. Go ahead.
A. "Vitals afebrile, vital signs

0230

stable. Dressing left foot intact with purulent drainage."
Q. Doctor, let me stop you dressing left foot intacted?
A. Intacted.
Q. Go ahead.

A. "With purulent drainage. Positive open wound, dorsal first MPJ possible 2 centimeters by 2 centimeters with mal odor and afebrile issues. DPPT 2 over 4 bilateral. Local -- mild localized erythema and edema."
Q. Let me stop you, Doctor, the mal odor, what does that suggest to you?
A. Bad smell.
Q. What is that from?
A. Either a necrotic tissue or an infection.
Q. And the pedal pulses, is that two over two or two over four?
A. Two over four.
Q. What is next to that with the initials?
A. That's bilateral.

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Q. Okay.
A. Do you want me to continue?
Q. One second. Had your observation of the patient's open wound changed since you last saw her on July 10th?
A. No.
Q. She now had mal odor. On July 10 you made no notation of any mal odor, correct?
A. That's correct.
Q. What is the significance that now she does have the mal odor in terms of changes?
A. The mal odor just signified that the infection is destroying any viable tissue.
Q. Before we get to your assessment and plan, can you go to the labs, please?
A. Sure. We have a white count of 13.3.
Q. That's abnormal, correct?
A. That's elevated. Hemoglobin at 12.3. Hematocrit at 38.8. Platelets 2 4

0232

4. Sodium of 1 4 3. Chlorides of 1 0 9. CO2 at 25. Potassium 93.6. BUN of 9. Creatinine of 0.8 and the glucose 74.
Q. And the X-ray --
A. Pending.
Q. Let's go to your assessment and plan.
A. "Cellulitis left foot with possible infected screw. Will schedule patient for debriedment of left foot and removal hardware tomorrow. Will need medical clearance. Agree with Ancef one

gram Q, is it, six hours."
Q. That's to be given by IV?
A. That's correct.
Q. Was it your opinion that this patient had an active ongoing infection at that time?
A. Yes.
Q. What is the risk to the patient to performing a surgical screw removal in light of her active infection with an elevated white count?
A. Say that -- can you repeat that?

Q. Sure. Were there any risks to the patient to undergo a screw removal with an active infection and an elevated white count?
A. No.
Q. Was it your opinion that by removing the screw it would improve her ability to treat the infection?
MR. : Improve her ability to treat the infection? Objection to form.
MR. OGINSKI: I'll rephrase it.
Q. What was it about the hardware itself that suggested to you that that might be contributing to her infection?
A. I did not say that it contributed to an infection.
Q. Let me rephrase it then. Did you have an opinion that this hardware was contributing to her infection?
A. No.
Q. Then why remove the screw?
MR. : Objection. Asked and answered. He gave the reason why

he would remove the screw. If you want to read it back again because now we're starting to repeat the same questions so, , if you want to find that testimony.
MR. OGINSKI: No.
Q. Did you make any observation of being able to visualize the bone?
A. No.
Q. Let's turn, please, to the July 14 note by Dr. .
MR. : Preoperative, postoperative?
MR. OGINSKI: Let's hold that section. Let's go to the infectious disease consult July 13.
A. Okay.
Q. Do you know the doctor who

performed that Dr. , ?
A. I do.
Q. What is Dr. ?
A. She's head of infectious disease.
Q. In the second paragraph of the

consult report it says "she underwent left foot surgery April 28, ." Can you read the next part?
MR. : Where are you looking?
MR. OGINSKI: Second paragraph.
MR. : That's probably the resident's note. Her note's probably underneath that.
Q. Okay. Do you know the name of the resident?
A. No. It looks like it's Dr. , but I don't know that person.
Q. In any regard, are you able to read what it says in the second paragraph?
A. She underwent left foot surgery?
Q. Yes.
A. "On April 28, to second left hallux deformity. She was advised non weightbearing by the patient."
Q. Continue?
A. "Continue weightbearing."
Q. Let me stop you for a second. We know from reading your records, Doctor,

that that is not accurate?
A. That is correct.
Q. In fact, the patient was partial weightbearing?
A. That's correct.
Q. Continue, please.
A. "A week after surgery, she."
Q. Noted?
A. "Noted surgical" -- what's that.
Q. Disruption?
A. "Disruption of sutures with purulent drainage."
Q. Do you agree or disagree?
A. Disagree. She's seen something podiatrist Dr. who had prescribed her with PO antibiotics times two months with no improvement.
Q. Do you agree or disagree with that?
A. I disagree.
Q. Was it your impression that the first round of antibiotics you had administered was effective?
A. That is correct. And she was

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not on continuing two months of antibiotics.
Q. Your notes do not indicate the length of time for which the patient was on antibiotics either the first or second time, correct?
A. Well, the first time -- well, yeah, I did not put down the exact time frame. Do you want me to continue?
Q. Go down, please, to the extremities portion of the exam.
A. Okay.
Q. Left first?
A. "Left first metatarsal with one by 1.5 centimeter. Open ulcer on dorsum, positive purulent drainage. Positive tenderness. Something ulcer positive black discoloration of dorsum first -- first something toe. No pedal pulses."
Q. When you examined this patient, she had pedal pulses?
A. That's correct.
Q. This is the first time we see anything described about an ulcer on the

0238

dorsum?
A. Well, an open wound can be considered an ulcer.
Q. Now, go down, please, to Dr. 's note if you can read that, please.
A. "Patient seen evaluated with Dr. . Agree with above history and something. Patient status post surgery 4/28/ had non healing ulcer since her sutures dehisced. Has been on prolonged antibiotic. Still with purulent discharge. Exam middle-age female. Awake, alert." I don't know. "Lungs clear. Afebrile." What's that? Cardiac?
MR. : That's probably cardiac.
A. Something "negative abdomen nontender. Extremity decrease pulse."
Q. To be clear, Doctor, there's two arrows pointing down. What does that signify to you?
A. That there's decrease pulse.
Q. Go ahead.

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A. "Left first met open wound with discharge. Positive hyperpigmented skin with tenderness."
Q. Let's go, please, to the

podiatry note July 14th, 8:55 a.m. by Dr.
.
A. July what? 14?
Q. 14.
A. Okay.
Q. The middle of the note it says "positive open wound left foot at surgical site, positive drainage, mild fibrotic tissue and wound. Positive pain. Mild edema. Positive erythema. Positive signs of infection." Did I read those correctly?
A. That's correct.
Q. Did you agree and were those consistent with your findings on that date?
A. That's correct.
Q. Were there any complications associated with the screw removal?
A. No.

0240

Q. The medical attending note that appears directly under Dr. 's July 14 impression it says "infected hardware slash abscess left foot."
A. That's correct.
Q. And that's Dr. again, right?
A. That's correct.
Q. Are you able to read his note four lines from the bottom it says "patient is acceptable risk?"
A. For podiatric procedure in the OR. I.e. no medical contraindication something procedure may blank -- I don't know. May resume PO meds with -- I don't know.
Q. Who is Dr. , , the assistant during your procedure?
A. He was one of the residents.
Q. Does he still work at ?
A. No.
Q. Do you know where he works?
A. No.

0241

Q. Who is Dr. , ?
A. He was another resident.
Q. How would you describe the complexity or difficulty of doing this procedure on July 14 to remove the screw?
A. Very low complexity.
Q. Did you ever learn whether the wound culture taken was positive?
A. Yes.
Q. What was it?

A. Well, it was multiple organism.
Q. Staphoreus, I believe?
A. No.
MR. : Let him just find it.
A. It grew out a couple organism.
Q. Which one?
A. One was lycro proteus probalus. And the other one was lycro proteus morganii.
Q. Do you recall any conversation you had with Ms. prior to the surgery during her hospital admission?
A. No.

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Q. Did you have any conversations with any of her family members during this hospital admission?
A. No.
THE WITNESS: Let me go to the bathroom.
(A short recess was taken.)
Q. Doctor, when you removed the screw during surgery on July 14th, did you obtain a bone culture?
A. No.
Q. Would bone culture have assisted you in evaluating whether there was any infection in the bone?
A. It was not necessary.
Q. Why?
A. When we took out the screw, the bone seems to be viable -- there was no signs of any infection in the bone.
Q. In your operative report, did you describe the quality or the appearance of the bone?
A. No, I did not describe it.
Q. Is there any reason why you did

0243

not describe the quality of the bone?
A. It's impossible to put every detail in every note.
Q. I'm only asking is there any particular reason you did not include a description of the bone?
A. No, there is no reason.
Q. Do you have an independent memory of what the bone looked like during surgery July 14, ?
A. No.
Q. Healthy bone is what color?
A. White.
Q. Necrotic bone or unhealthy bone is what color?
A. Yellowish.

Q. Or gray?
A. Grayish.
Q. Healthy bone is hard, typically?
A. That's correct.
Q. And unhealthy bone tends to have a softer texture?
A. That's correct.
Q. The specimen that was submitted

0244

to pathology only included the screw and the skin, correct?
A. The screw and skin, yes.
Q. There was no bone submitted for pathology?
A. That's correct.
Q. Can you turn to the patient's lab reports, please, for this hospital admission?
A. Okay.
Q. What was the patient's sedimentation rate on admission?
MR. : Do you have the page with the ESR?
MR. OGINSKI: I'm looking for it.
MR. : Do you have it? I haven't found it yet.
MR. OGINSKI: No. I have the July 17 lab note.
MR. : Where is it in your copy? Because I don't know if our copy is in the same order.
MR. OGINSKI: A hematology

0245

report blood cell count reporting July 12, 14 and 15.
MR. : It's not on that page, though.
MR. OGINSKI: No.
A. I can't find the sed rate.
Q. Is it possible to do blood work without obtaining a sedimentation rate?
MR. : Objection.
MR. OGINSKI: I'll rephrase it.
Q. In the lab values that you recorded on your consult note on July 13th, do you report on the patient's sedimentation rate?
A. Not on my consult.
Q. Is there any doctor's note that you saw in this chart that reports on the patient's sedimentation rate?
A. No.
Q. Is there any hematology or blood report that reports the sedimentation rate for this patient during this hospital

admission?
A. No.

Q. Does sedimentation rate help you in evaluating whether or not this patient had osteomyelitis?
A. It doesn't.
Q. It does or does not?
A. Does not.
Q. Why not?
A. All it does is tell us if there's an acute inflammation or an infection going on.
Q. Doctor, does an elevated sedimentation rate, is that an indicator of a bone infection?
A. No.
Q. Are you aware of osteomyelitis being present in cases where the sedimentation rate is over a hundred?
MR. : Objection.
THE WITNESS: I can answer that?
MR. : I'm sorry, over my objection. I object to the general nature of the question, but over objection, you can answer it.
A. Yes.

Q. Did you order an MRI after the screws were removed?
A. In terms of this visit at the hospital?
Q. Yes.
A. I don't think so.
Q. Would an MRI have assisted you in evaluating whether or not there was any infection to this patient's bone?
A. No.
Q. Tell me why.
A. Because we just removed the screw. The patient will have some bleeding in the bone which can give you a false positive.
Q. And if the patient does, in fact, have osteomyelitis, would you also see that on an MRI?
A. Rephrase that.
Q. Sure.
Are there instances where osteomyelitis will be present but not visible on an X-ray?
A. Yes.

Q. And in those instances where osteomyelitis is present in the bone but

you can't see it on X-ray, can you see it on an MRI?
A. Yes.
Q. Did you ever consider ordering an MRI for this patient to evaluate the extent of the infection?
A. During this visit?
Q. Yes, during this hospitalization.
A. No.
Q. Now, at the time of this patient's discharge, you discharged her to be placed on oral antibiotics, correct?
A. That's correct.
Q. And you placed her on Augmentin, correct?
A. That's correct.
Q. Why did you choose to use Augmentin, the medication that did not work for her previously as of the last visit before she arrived at the hospital?
A. Because when she arrived in the

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hospital, she was on Ancef, which is a lesser antibiotic than Augmentin, but in the same family.
Q. On June 28, , you prescribed Augmentin for her?
A. That's correct.
Q. According to your note. On July 10th, you told me that she was still taking the Augmentin and in your opinion it was not working and not effective to treat her infection?
A. That's correct.
Q. So now my question is why did you return her to an oral antibiotic that you knew a few weeks earlier had not been effective in treating her infection?
A. There are two reasons. First reason the Ancef was working at the hospital. Second reason we took her out of the environment of her soaking and cleaned out the wound. So the wound has been cleaned out. And we got a sensitivity of her bacteria that's sensitive to Augmentin.

0250

Q. Do you have any knowledge -- can you tell me why the Augmentin was not working back between June 28th and July --
A. I can only speculate.
Q. At the time the patient was discharged, did she have any evidence of infection?
A. No.

Q. Was it your opinion that her infection was totally cleared up and she was free of any infection?
A. She was responding to the treatment.
Q. Is that different than --
A. Cleared, yes.
Q. Tell me the difference.
A. Well, we would need a clear culture.
Q. Were repeat cultures taken before her discharge?
A. No.
Q. Is there a reason why repeat cultures were not taken?
A. It wasn't necessary.

Q. Why not?
A. It wouldn't have changed our treatment plan.
Q. And would repeat blood work with a white blood count have assisted you in determining whether or not she had an ongoing infection at the time of discharge?
A. It would be only a piece of the clue.
Q. Was a repeat blood count drawn the day of admission or the day before admission?
MR. : Was a repeat drawn the day of admission, is that what you said?
MR. OGINSKI: Sorry, thank you, thank you. The day of discharge or the day before discharge.
A. When was she discharged?
Q. She is discharged on July 17th so either the 16th?
A. No.
Q. Was there a reason why repeat

bloods were not drawn on either the 16th or the 17th to evaluate her white blood count?
MR. : He obviously can only speak for himself.
MR. OGINSKI: Correct.
MR. : He doesn't know why the medical attending and the IV attending who were treating this patient didn't.
MR. OGINSKI: I understand. I'm only asking whether it was done.
A. Repeat CBC was not done prior to her discharge.

Q. Did you ever recommend or request that a repeat CBC be done prior to the patient's discharge?
A. There was one order prior to her discharge.
Q. What was the order for?
A. For a CBC and BMP.
Q. What date was that?
A. July 16th.
Q. Do you have any knowledge --

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A. I don't have the results in here.
Q. Do you have any knowledge to know where those -- number one, do you know whether that was done?
A. No.
Q. Did you ever see any lab report for July 16th for a CBC?
A. No.
Q. Did you ever request a repeat CBC to be done either on the 16th or 17th?
A. I did not request.
Q. That order that you see in there, was that because of an order you requested or one of the medicine residents or doctors?
A. I can't read the handwriting. Well, it looks like the medical resident.
Q. And if you had wanted the white blood count done, would you actually write the order or would you have one of the medicine residents do it for you?
A. I would suggest it to the medical if we wanted a repeat CBC.

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Q. And did you ever request a sedimentation rate be done prior to the patient's discharge?
A. I believe a sedimentation rate was requested by not only -- by the medical attending himself.
Q. When was that?
A. The date of admission.
Q. And did you see any notation, any report anywhere in this chart that that was actually carried out?
A. No.
Q. Did you ever ask or inquire of any physician as to why there was no sed rate seen in the patient's hospital record?
A. No. I don't recall.
Q. Did you request that the patient have repeat X-rays prior to her discharge to evaluate her foot?

A. No.
Q. Would repeat X-rays have assisted you in treating her condition?
A. No.

Q. I don't think I asked the following question this way: Would an MRI have assisted you in treating this patient's condition as of the time of her discharge either on the 16th or 17th?
A. No.
Q. Why not?
A. Again, there would be postoperative change and we would have gotten a false positive.
Q. And with what likelihood would you expect to see a false positive if an MRI were done?
A. Very likely.
Q. Can you be any more specific in terms of quantifying that?
A. Better than half.
Q. Doctor, there is a report dated July 16th, saying "cancelled tests" and one of them is a CBC. Do you have any reason to know why those tests were cancelled?
A. No.
Q. Did you have any conversation

with any doctor at the hospital during this hospital admission to determine, who came to the conclusion or impression that this patient had evidence of osteomyelitis?
A. No.
Q. How would you know if this patient had osteomyelitis?
A. A bone biopsy.
Q. Is there any other way you would know the patient had osteomyelitis?
A. Not at this time.
Q. Did you observe any necrosis at any time while the patient was at the hospital ?
Better than that, I'm sorry. Let's go back.
The next note that you have for this patient after your consult note of July 13, specifically any progress note that you have.
A. On July 15th.
: There's a 14th.
After the 14th, you said?

MR. OGINSKI: After the 13th.
A. The 14th was my consult.
MR. : Oh, oh, okay.
MR. OGINSKI: No, the 13th was your consult.
THE WITNESS: The 13th?
: 13th was the consult. Oh, I know. There's probably a post-op note.
MR. OGINSKI: Surgery was the 14th.
THE WITNESS: I don't see any other notes. July 15 is the only one I see.
Q. What is morphine?
A. It's an opioid analgesic.
Q. How would you characterize morphine in comparison to say Vicodin or Tylenol number 3?
A. Much stronger.
Q. It's a narcotic?
A. That's correct.
Q. On July 14 to July 15 a nursing note describes the patient describing foot

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pain on a scale of eight to nine?
: Show me where you're reading.
Q. See that?
A. I see.
Q. And morphine was ordered, correct?
A. Yes.
Q. The note underneath that, is that July 15?
A. That's correct.
Q. Podiatry note, again, by Dr. ?
A. Yes.
Q. Underneath his note, Doctor, is your note there?
A. That's correct.
Q. What time did you write your note?
A. I don't have a time on mine.
Q. Is there a reason why there's no time there?
A. No reason.
Q. Are you aware of any hospital

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rule or regulation that existed at that time requiring date and timing of the note?
A. I'm not sure.
Q. Can you read your note, please?
A. "Patient is status post screw

removal and debriedment of left foot. Wound looks clean with mild active bleeding. No purulent drainage. Will await wound culture sensitivity. DC home," discharge home.

Q. Do you know a Dr. , ?

A. No.

Q. On June 16, at 6:15 p.m. there's a podiatry note?

A. 6:15 a.m.?

Q. Yes, thank you.

By the way, can you tell who wrote that note?

A. No.

Q. Can you read beginning with the second paragraph "left foot dressing?"

A. "Left foot dressing clean --

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dry, clean, intact. Wound dorsal of left foot, first MPJ no drainage, no erythema, no edema, no signs of infection. Positive hyper pigmentation around excision site. Positive pain on palpation. Wound culture non latus fermenters."

You want me to continue?

Q. Yes, please.

A. Left foot --

Q. Assessments and plan, go ahead.

A. "Left foot wound dehiscence cellulitis status post surgery. Status post removal of hardware. Continue IV antibiotics. Awaiting sensitivity. Will follow. Will plan on discharging patient once culture sensitivity results are completed."

Q. Do you have a note for July 16?

A. No.

Q. Did you have a partner or anybody who would make rounds on your patients in the event you weren't able to attend to your patient on any given day?

A. The residents do the rounds.

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Q. Anybody in Dr. 's office or anybody you work with there who would cover you when you wouldn't be able to make on any particular day?

A. Dr. would cover me.

Q. Does Dr. 's notes appear anywhere in this patient's chart?

A. No.

Q. Did you see and examine the patient on July 16?

A. No.

Q. If you had seen and examined the

patient, you would have written a note, correct?
A. Yes.
Q. Did you call anyone at Medical Center on July 16 to inquire about the status of your patient?
A. I might have.
Q. I'm not asking you to speculate or guess, Doctor.
A. I don't know.
Q. Let's turn, please, to the July 17 note.

: Whose note, his note?
MR. OGINSKI: That's what I was going to ask.
Q. Do you know who wrote this July 17 podiatry note?
A. Dr. .
Q. Did you see the patient on July 17?
A. No.
Q. Is there a reason why you did not see her on July 17?
A. She was being discharged before I could get to the hospital.
Q. What are retention sutures?
A. Those are sutures but we don't completely close the wound. We just use it as tension.
Q. What is its purpose?
A. To keep the wounds contracted and somewhat approximated.
Q. Is it to allow drainage?
A. It's to prevent an abscess.
Q. How does that happen? How does

that prevent abscess?
A. Because the wound can still be open and drainage can occur.
Q. Drainage can occur regardless whether the wound is open or closed, correct?
A. No. A wound is closed, drainage would first turn into an abscess before it drains. Or it has to go through the incision.
Q. Tell me why the wound was not closed.
A. Because we just did a IND of the wound. I did not want to close a wound that has a potential of still having some sort of infection.
Q. So you wanted to allow for drainage, if it occurred, correct?

A. Okay.
Q. I'm just asking.
A. Sure.
Q. At the bottom, Doctor, you would note under assessment and plan says "will discuss with Dr. ." Do you have any

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memory of any discussion that you had with Dr. about the patient on the day of discharge?
A. It doesn't say will. It says discuss with. Discuss with Dr.
Q. The word before it "will discuss with Dr. ?"
A. On the bottom it says "discuss with Dr. ."
Q. Oh, okay. Looking at the same thing different places.
A. I don't recall the conversation.
Q. Okay. Did the patient still have an ulcer on the first ray at the time of discharge?
A. The wound was never closed.
Q. So that open wound is synonymous with the word ulcer, correct?
A. That's correct.
Q. The patient was scheduled to follow-up with you in one week?
A. I don't know when.
Q. Just look at this, Doctor.
A. Yes.

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Q. Doctor, can you turn, please, to your July 14 operative report?
A. Okay.
Q. I'm sorry, before I ask you a question about that, going back to the July 10th office visit.
A. Okay.
MR. OGINSKI: Withdrawn.
Q. Did you ever come to the conclusion after this patient was discharged on July 17, , that her infection was totally cleared and healed?
A. Again, I cannot say that it was totally clear.
Q. What test would you have needed to perform in order to confirm whether or not her infection was totally cleared and healed?
A. Repeat wound culture.
Q. Did you ever do that?
A. No.
Q. Any reason why?
A. We were planning.
Q. When?

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A. When she had a course of antibiotics.
Q. When she completed it?
A. That's correct.
Q. For how many days did you intend for her to continue with the oral antibiotics following her discharge? Let me show you the plan and discharge summary.
: We have it.
A. Ten days.
Q. So around the 27th -- I'm sorry, around the 27th you expected her to be finished with the antibiotics, correct?
A. That's correct.
Q. And at that time your intention was to perform a repeat wound culture?
A. If we were planning to do a repeat to plan for a second surgery to close the wound.
MR. OGINSKI: I'm sorry, can I have that read back, please?
: Did you say "if we were?"

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(The requested portion was read back.)
A. Let me just rephrase what I'm saying. Once she -- the plan was, once she completed her antibiotic, we repeat the culture and plan for secondary or primary closure of the wound.
MR. OGINSKI: Off the record.
(A discussion was held off the record.)
Q. Doctor, the patient returns to your office on ?
A. That's correct.
Q. And you report that she still has pain and that swelling has improved. Where did she have the pain?
A. In the left foot.
Q. Where?
A. I didn't describe it on the note.
Q. She was discharged home with a visiting nurse or was supposed to have a visiting nurse following her discharge?
A. Visiting nurse was sent to her

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home.
Q. Right, why?
A. For wound care.
Q. What type of wound care would

she need?
A. Someone to clean the dressing -- change the dressing clean the wound.
Q. And you instructed her to ambulate with a cane?
A. Again, partial ambulating with a cane.
Q. Who received a call, you received a call from visiting nurse?
A. I received a call.
Q. And when did you receive a call?
A. Sometime during the week.
Q. In response to that, did you call Ms. ?
A. I relayed the message to the office to speak to her.
Q. Can you be more specific just what you mean?
A. Since I don't have her information with me, I called Dr. 's

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office to let know that she has to follow her instructions.
Q. What did it mean to you when you got a call from visiting nurse saying she was seen without a dressing several times?
A. It means that she wasn't following her instructions, walking around with the wound open.
Q. When you say open, meaning what, without a dressing?
A. Without a dressing.
Q. And did you ever receive a response from the patient as to why she was walking around without a dressing?
A. I'm sure I did get a response.
Q. Did you record any reason why?
A. No.
Q. What was the purpose of keeping the dressing on during the time that she's at home?
A. Keeping it clean.
Q. And the fact that she had the dressing off, what made you believe that the wound was not being kept clean?

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A. Again, I can only speculate.
Q. Let me go back.
: Off the record.
(A discussion was held off the record.)
Q. When you got a call from the visiting nurse, was it a man or a woman?
A. A woman.
Q. Do you know the name?
A. No.

Q. Did this person call you once or more than once?
A. She called me I think twice.
Q. Did you record each of those calls?
A. Well, each time the call wasn't down in this office. It was done when I was somewhere else.
Q. How did you get the call if you were somewhere else?
A. They were able to reach me. I forget how.
Q. What did you tell the visiting nurse in response to this observation that

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she called to tell you about?
A. Well, I told the nurse that it was nice of her to let me know, but she has to really instruct the patient the consequences of her actions.
Q. When the patient came to you on , was there evidence of an infection?
A. There's no evidence of an active infection.
Q. Was there redness?
A. Yes.
Q. Was there -- and that's erythema, correct?
A. That's right.
Q. Was there swelling?
A. Yes.
Q. Was it warm to the touch in comparison to the rest of her foot or skin?
A. I didn't document that.
Q. Was there any tracking that you observed, any travelling of any redness?
A. I don't recall.

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Q. Where was the redness located?
A. Surrounding the wound.
Q. Again we're only talking about the first ray and the first MPJ joint?
A. That's correct.
Q. Was there pain on palpation?
A. I don't recall.
Q. When the patient came into your office, did she have a cane with her?
A. I don't recall.
Q. The serosanguineous drainage, that's something that you expected to see?
A. That's correct.
Q. So this was not an unusual finding, correct?
A. That's correct.

Q. And the open wound left foot, again, this is something you intentionally left open following the debriedment and the removal of the screw?
A. That's correct.
Q. The wound granulating well means it's healing properly?
A. That's a good sign, yes.

Q. The pedal pulses, she still had pulses at that time?
A. That's correct.
Q. Had those pulses changed at all from any of the prior evaluations of her pedal pulses at any other time?
A. I don't believe so.
Q. Now, you're assessment was wound dehiscence left foot. Tell me what you meant by that.
A. That was just a note diagnosis.
Q. Not that it had opened any further?
A. That's correct.
Q. It's still the same as when you left it after the surgical procedure at the hospital?
A. As I recall, yes.
Q. What was the Bactroban cream for?
A. It was, again, just as a wound care product.
Q. That's an antibiotic cream?
A. That's correct.

Q. A topical, right?
A. That's correct.
Q. Did you tell her to put that in the open wound area or someplace else?
A. Probably surrounding the wound.
Q. Is there ever an occasion where you will tell a patient to put the Bactroban into the or on to the open wound?
A. Not deep into the wound, no.
Q. No, just superficially you apply it on top of it?
A. That's correct.
Q. So it's okay to do that?
A. With a bandage, yes.
Q. You mean a bandage on top?
A. With a sterile dressing, yes.
Q. Just to be clear, Doctor, you have the open wound with the retention sutures, correct? And you can then put the Bactroban as a cream on top of that open wound and then put a sterile dressing

on top?
A. That's correct.

Q. Was there any evidence that this patient had cellulitis on ?
A. No.
MR. OGINSKI: Off the record.
(A discussion was held off the record.)
MR. OGINSKI: What was the last question?
(The requested portion was read back.)
Q. Doctor, did you form an opinion on as to whether the patient's noncompliance of walking around without a dressing caused or contributed to any further injury that she had as of ?
A. I did form an opinion.
Q. What was it?
A. That she is not improving her situation by doing or deviating from our instructions.
Q. When you say not improving her situation, what do you mean?
A. She could worsen her situation.
Q. I'm not asking about could. Did

she, by not following your instructions to keep the dressing covered and clean, as of the time you saw her on , was there evidence that because she hadn't kept the dressing on that it had compromised her condition in any regard?
: Are you able to give an opinion or you don't know? You do know.
A. I do not know.
Q. You requested that she follow up in a week, correct?
A. That's correct.
Q. And she returned to your office on , which is about, I think thirteen days later.
: Fourteen. July has 31 days.
MR. OGINSKI: Thank you, how many? July has 31 days.
Q. Again, the same question because she now comes to you a week beyond the time you instructed her, did you find her to have any additional problem with her

foot directly attributable to that one week delay in showing up in your office?

A. I don't know.
Q. On , where did she tell you that she was experiencing pain?
A. It's the left foot.
Q. Did you record where specifically she had pain in her left foot?
A. No, I did not record specifically.
Q. When you examined her, did you identify where she had pain?
A. I'm sure I have.
Q. Was this pain on ambulation or only pain on palpation?
A. I don't recall.
Q. Now, she told you that she was applying the Bactroban on a daily basis, correct?
A. That's correct.
Q. Did you have any repeat calls from the visiting nurse indicating that she was noncompliant anymore?

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A. Not at this time.
Q. Was there anything that the patient told you to suggest that she was not compliant with any of your instructions from the last visit other than showing up a week later than you told her to?
A. No.
Q. Again, there was still mild serosanguineous drainage, correct?
A. That's correct.
Q. Was this any different than the drainage you had observed two weeks earlier?
A. I don't know.
Q. What was your plan, as far as when you would take out the retention sutures?
A. When I find that the wound continues to improve or if it's continued to granulate well, it might not be a need for a primary closure.
Q. Am I correct that the retention sutures have to be removed; they're not

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absorbable?
A. These are nonabsorbable, correct.
Q. Again, the patient had edema and erythema, correct?
A. That's right.
Q. Was there any difference than what you had observed two weeks earlier?

A. I don't recall.
Q. Was the swelling, in other words, the edema and the erythema different than what you had observed on my other visit when which you noted this condition?
A. I don't recall.
Q. Again, you observed that the wound is continuing to granulate well?
A. Yes.
Q. In your opinion the wound was healing?
A. It was doing better.
Q. In your assessment you write "mild cellulitis left foot." What was it about this patient's condition that now

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suggested to you that she now had a mild cellulitis whereas you had the same observations two weeks earlier but you did not record that there was any cellulitis?
A. I didn't document that well.
Q. Was it your opinion, Doctor, that she had a cellulitis on ?
A. No.
Q. Was it your opinion that she had a cellulitis on ?
A. ?
Q. Yes.
A. Yes. No, no, no. I'm getting confused.
: Why don't you back up. Read back the question and answer.
(The requested portion was read back.)
Q. You recorded on in your note that she had a mild cellulitis of the left foot, correct?
A. That's correct.
Q. And the reason you reported that

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she had a mild cellulitis was because it was your opinion at that time that she had a cellulitis, correct?
A. That's correct.
: So the testimony before was in error, you were referred to a different date?
THE WITNESS: That's correct.
Q. Can you tell me what is it about the condition on the patient's foot on August 9th that it was not present on the visit before on ?
A. Whatever I saw I did not document it.

Q. For which date?
A. .
Q. Can you be more specific?
A. No.
Q. You indicated that you did a debriedment of necrotic tissue?
A. That's correct.
Q. Where was there evidence of necrotic tissue?
A. Again, I did not document well.

Q. Now, what was your opinion at that time as to why the patient had necrotic tissue? Was it from infection? Was it from swelling or from something else?
A. I don't know.
Q. And what tests could you have performed at that point in order to tell you or help you determine whether or not it was from infection or from swelling or something else?
A. A wound culture can help.
Q. Did you obtain a wound culture on that date?
A. No.
Q. Would an MRI have assisted you in evaluating whether or not there was an ongoing infection or whether the basis for the necrosis?
A. Of the soft tissue?
Q. Yes.
A. No.
Q. Would a CAT scan have assisted you?

A. No.
Q. You wrote removal of sutures under your plan. Was that something that was going to be done in the future or had you done that on that visit?
A. I think what we might have done was done some of the sutures but not all of them.
Q. Why would you take out some but not all?
A. If I find that some of the sutures are not ready to come out.
Q. Yet your note only says removal of sutures?
A. That's correct.
Q. Is there anything in the note to suggest that you did not remove all of them?
A. No.
Q. And was the wound still open at

the time that you removed sutures?
A. Yes.
Q. And the patient was instructed to return in two weeks, correct?

A. That's correct.
Q. Did you form an opinion as to why the patient was still having pain on ?
A. I believe she was just having an ongoing complication from the surgery.
Q. Which surgery?
A. The bunionectomy.
Q. Going back to the --
A. Yes, that's correct.
Q. -- surgery?
A. That's correct.
Q. What was it about the bunionectomy that was responsible for this pain?
A. Could be joint stiffness. Could be pain from the infection that she had. Soft tissue changes.
Q. And the joint stiffness, could her arthritis be affecting that at all?
A. The arthritis of her knee?
Q. Yes. Let me go back.
Were you aware of her having arthritis in any other part of her body

besides her knee?
A. No.
Q. The bunionectomy that you performed on , could that cause arthritic changes?
A. Arthritic changes where?
Q. In her foot?
A. Yes.
Q. How would you be able to determine whether the pain she was experiencing was either from the joint stiffness or from soft tissue changes or from infection?
A. Can't.
Q. Are there any tests that you could perform at that time that would assist you in ruling out or determining whether the pain she's having was from an infection as opposed to anything else?
A. Again, the only definitive test at this time would be a wound culture.
Q. Would blood tests assist you in determining whether or not there's an ongoing infection?

A. Yes.
Q. And that includes the CBC and the sedimentation rate?
A. That's correct.
Q. Did you draw bloods on ?
A. No.
Q. The patient returned to you not two weeks later, but, in fact, a number of weeks later on , correct?
A. That's correct.
Q. She told you that she missed her visits because of transportation problems?
A. That's correct.
Q. When you write that she presents with a chronic ulcer to the left great toe, is that a different location than where she had the dehiscence in the past?
A. Where did I write this?
Q. First line in the subjective paragraph.
A. No, not a different location.
Q. That's the same thing?

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A. That's correct.
Q. Had the wound gotten better, worse or stayed the same since you had last seen her on ? It's now a month and a half later.
A. The wound has gotten worse.
Q. In what way?
A. Again, I did not document that well.
Q. How do you know the wound is worse now?
A. Because I started her on antibiotics.
Q. Why did you choose to give her the Augmentin as opposed to any other antibiotic?
A. Again, it's a broad spectrum antibiotic.
Q. What made you believe that she had an infection on this visit?
A. I don't recall.
Q. You note the same observation that you had on the last two visits including the mild serosanguineous

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drainage, correct?
A. That's correct.
Q. The positive wound dehiscence which we talked about. And you observed the edema and mild erythema, correct?
A. That's correct.

Q. What is it about her condition on that is different from the visit or the visit that suggests that she now has an infection?
A. Again, it's not documented well in the chart.
Q. Again, your assessment is that she has a mild cellulitis, correct, the same as the last visit?
A. That's correct.
Q. How would you characterize the infection that you prescribe her antibiotics for?
A. Say again.
Q. You prescribed antibiotics for her on . Are you able to characterize the infection, severe, mild,

something else?
A. I don't recall.
Q. Again, you debrieded necrotic tissue?
A. That's correct.
Q. Where was this necrotic tissue?
A. Probably surrounding the wound.
Q. Did you form an opinion as to why she continued to experience the necrotic tissue?
A. I did.
Q. What was your opinion?
A. The foot is probably getting reinfected.
Q. Now, at the top paragraph, you again report that you received a call from visiting nurse, right, that she was without a dressing to her foot many times, correct?
A. That's correct.
Q. There's also information that there is cat hair floating around the house, correct?
A. That's correct.

Q. And why is that a significant fact for you to know and record?
A. Again, she's being very incompliant and now we have possibility of having more pathogens entering the wound.
Q. When you examined her on , did you find any evidence of cat hair in any part of the wound?
A. Again, I did not document well.
Q. Is there anything you recorded to suggest that cat hair --
: You want to laugh

too.
MR. OGINSKI: I have to ask.
Q. Is there anything in your note to suggest that you found cat hair in her wound?
A. No.
Q. Did you believe on the fact that she walked around without a dressing caused or contributed to the condition of her foot?
A. Yes.
Q. And other than her noncompliance

with the dressing, is there anything else that would account for why she's now redeveloping an infection?
A. Could you repeat that?
Q. Sure. You've told me that leaving the wound open makes her susceptible to pathogens in the home, correct?
A. That's correct.
Q. Is there anything else that might contribute to her developing infection that you recognize on ?
A. Her missing appointments.
Q. How would missed appointment contribute to an infection?
A. Well, if there were noticeable change, we could correct and treat at a more rapid pace and since we did miss about three weeks of visits, again, a lot of things can happen and probably affected her wound.
Q. Other than diagnosis and treatment of an infection, is there

anything about the fact that she didn't appear that caused or contributed to the infection?
: Objection. He's already answered that multiple times.
Q. Did you culture the patient's wound on ?
A. I did.
Q. You did or did not?
A. I did.
Q. Where do you note that you cultured the wound?
A. Third line on plan: "x-ray left foot two views, wound cultures taken."
Q. Why did you obtain X-rays at that time?
A. Again, to see the integrity of the bone.

Q. What date is on there?
A. .
Q. Which views did you take?
A. DP and medial oblique.
Q. What do you observe on those X-rays, Doctor?

A. That there are some erosive changes seen at the first metatarsal head.
Q. Are these new findings?
A. Yes.
Q. What do they mean to you?
A. It means it could be postoperative changes when we removed the screw.
Q. What else could it mean?
A. Possible infection.
Q. In the bone?
A. That's correct.
Q. Also known as osteomyelitis?
A. That's correct.
Q. And the wound cultures showed staphoreus, correct?
A. That's correct.
Q. Did you change the antibiotics based upon the wound culture results?
A. I did.
Q. What did you change it to?
A. No, I did not change it.
Q. Is staphoreus responsive to Augmentin?

A. Yes. I'm sorry, I did not change the antibiotic.
Q. Did you draw bloods on ?
A. No.
Q. Would blood work have assisted you in determining whether or not she has an infection at that time?
A. It wasn't necessary at the time.
Q. Why?
A. She did not have any systemic signs of infection.
Q. And again, the systemic infection would be the fever?
A. That's correct.
Q. And the tracking of the wound?
A. No.
Q. Tell me what else.
A. Again, fever, fatigue, malaise, rapid heart rate.
Q. How are you able to tell whether or not this patient's infection was in her bone on ?
A. I did not say that she had an

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infection in her bone.
Q. Right, you've now told me based upon her X-rays that she has erosive changes to the first metatarsal head which could possibly be an infection to the bone?
A. As well as possible changes from the screw removal.
Q. Correct. So what do you do as a physician to determine or rule out the possibility of osteomyelitis -- now that there's the possibility it can occur or the possibility it's present?
A. If that was -- again, in my judgment I did not believe she had an infection in the bone.
Q. What led you to that conclusion?
A. Because the wound -- well, the wound in February was not deep enough. It wasn't tracking to bone.
Q. How would you know that if you don't -- I'm sorry. If you don't open up the wound to investigate, how would you know that it was not deep enough?

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A. The wound was open.
Q. You said the wound was not deep enough. My question is how would you know how deep the possible infection went to make that conclusion?
A. Because I would have examined that. I would have probed. I would have checked to see if there was any tracking.
Q. Is there any other way that you could evaluate and determine for sure whether or not the patient had a bone infection?
A. Generally speaking now?
Q. No, no, in this case.
A. Again, I had at no point where I decided she had a bone infection. So I didn't come up with any plan to try to prove or disprove that she had a bone infection.
Q. Here's my trouble I'm having. You've told me now based upon the X-rays that she could have an infection to the bone or it could be changes from the surgery to remove the screw.

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A. That's correct.
Q. You now have two different possibilities based upon the X-ray?
A. That's correct.

Q. Would it be good medical practice at this point to now attempt to do any tests that are available to you to rule out the most serious of those possibilities?
A. But clinically there was --
: Let him finish his answer and then you can make whatever statements you want. Go ahead, Doctor.
A. Clinically, there was no evidence to show that it's more likely to be a bone infection.
Q. Yet, radiographically, there is some suggestion or possibility that it could be a bone infection. And my question to you, Doctor, is once you recognize that possibility, is it good medical practice to now do tests to evaluate the possibility of the most

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likely or, I'm sorry, the most serious possibility?
: In other words, are you asking him did he need to do more tests than he already did on this day, the cultures sensitivity and the clinical assessment?
MR. OGINSKI: Correct.
: Did you need to do more tests.
THE WITNESS: It wasn't necessary to do more tests.
Q. Now if this patient had a bone infection, what are the clinical signs you would expect to see, other than the ones that were present and observable?
Objection. I don't understand.
MR. OGINSKI: I'll rephrase.
Q. You told me that clinically there was no evidence of a bone infection. So my question to you is if the patient did have a bone infection, what other clinical things would you expect to see in

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the event she had a bone infection?
: Objection. Other than what he's told you? He told you he looked for tracking. There was no tracking. He looked for a deep infection. There was no evidence of a deep infection, so other than that, is that what you're asking for?
MR. OGINSKI: Let me go back.
Q. When you debried a wound, did

you just debried the wound edges?
A. That's correct.
Q. You did not delve deep into the wound, correct?
: Objection. He said he probed deep in the wound. That's a different question than did he debried deep into the wound.
Q. Okay, you told me that you probed into the wound?
A. That's correct.
Q. Do you have that recorded anywhere in your note?
A. No, I don't.

Q. And why did you probe into the wound?
A. Again, to inspect that there was a deep infection.
Q. And if there was an infection deep in the wound, what would you have expected to see?
A. Either tracking or probing to the bone.
Q. What was that, Doctor, sorry?
A. Probing to the bone.
: Tracking or probing to the bone.
Q. What do you mean probing to the bone?
A. If the probe hits the bone.
Q. What would that tell you?
A. That there's a deep infection.
Q. And why would the probe hitting the bone indicate an infection?
A. It doesn't indicate if there is an infection. It indicates if there's a deep infection. Okay, there could be an infection, but not deep.

Q. I'm sorry. What is the fact that the probe is going deep into the wound have to do with whether or not there's an infection?
A. Because if I probe deep into the wound and if it's tracking, then the infection's in deep tissue. And if it probes to the bone, hits the bone, then it has violated the deep tissues.
Q. I see. Now, is it possible that even though the infection does not allow the probe to go down to the bone that the patient can still have a bone infection?
A. It's possible for anything.
Q. So now given the patient's radiographic evidence that you observed of

the possibility that there can be bone infection, would it be good medical practice to now run whatever tests you can to rule out for sure whether or not the infection is in the bone?

: Objection. Asked and answered. He already told you it wasn't necessary.

Q. You have indicated to me, Doctor, that a patient can still have a bone infection even if the infection does not go down to the bone on wound inspection, correct?

A. That's correct.

Q. So now do you rule out whether or not the patient has infection in the bone then in light of radiographic evidence of the possibility of that?

A. But I wasn't there to rule out a bone infection.

Q. I understand that.

A. Okay.

Q. On , you determine the patient had an infection, correct?

A. Yes.

Q. You gave her antibiotics?

A. That's correct.

Q. You debrieded the wound and you probed the wound, correct?

A. I inspected the wound, yes.

Q. You took an X-ray that showed erosive changes to the first metatarsal head?

: Are you going to review all the testimony again?

MR. OGINSKI: No. I want to establish instead of going right into it.

: Just ask the question because now you're doing this two and three times again. If he doesn't understand it, he'll let you know.

MR. OGINSKI: Okay.

Q. Is it good medical practice in light of your finding of an infection and in light of the possibility on X-ray that the patient could have osteomyelitis to now take it one step further, to now rule out whether the patient has osteomyelitis?

: Over my objection since it's been answered three times, he can answer it one more time.

A. It was not necessary at the

time.
Q. My question is different. I'm
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asking whether it's good medical practice to take it one step --
A. But then you're talking about a general question.
: Don't argue.
Q. I'm asking, based upon the facts as they existed and your observations on , whether it's good medical practice at that time to order additional tests to rule out osteomyelitis at that time?
MR. : He already answered your question and said it's not necessary. Are you looking for him to say the answer is no, it was not necessary to do that medical practice that day.
MR. OGINSKI: If that's what his answer is.
MR. : Is that what you mean?
THE WITNESS: Yes.
MR. : Let's take a quick break for a second.
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(A short recess was taken.)
Q. Will oral antibiotics treat osteomyelitis?
A. It can.
Q. Is it as effective as IV antibiotics?
A. For a chronic osteo or acute osteo?
Q. Let's take them separately.
A. Neither treatment has shown to be a definitive treatment in terms of IV or oral. There are suggestions that an oral antibiotic can be as penetrating as IV antibiotics.
: For chronic?
THE WITNESS: For chronic.
Q. Is there a particular study that you're referring to?
A. No.
Q. What is the effect on a patient if they have osteomyelitis and it is untreated, what can happen?
A. The infection can get worse and other -- I mean, you can get necrosis of
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any amount of viable tissue.
Q. You had told me earlier that the

treatment for acute osteomyelitis included debriedment and IV antibiotics and the treatment for chronic osteomyelitis was to excise bone and give either IV or oral antibiotics, right?

A. That's correct.

Q. Just a moment ago you told me that antibiotics is not the definitive treatment for treatment of osteomyelitis?

A. For active osteomyelitis, that's right.

Q. What is definitive treatment?

A. Excising an infected bone.

(Continued on the next page to include the jurat.)

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MR. OGINSKI: We're going to stop today and continue at a date that's convenient for everyone.

(Time noted: 4:33 p.m.)

_____

Subscribed and sworn to before me on this _____ day of _____, 2009.

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NOTARY PUBLIC

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C E R T I F I C A T E

STATE OF NEW YORK)
) ss:
COUNTY OF NEW YORK)

I, , Shorthand Reporter and Notary Public within and for the State of New York, do hereby certify:

That , the witness whose Deposition was held on , 2009, as hereinbefore set forth, was duly sworn by me, and that this transcript of such examination is a true and accurate record of the testimony given by such witness.

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

IN WITNESS WHEREOF, I have hereunto set my hand this day of June, 2009.

_____

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ERRATA SHEET

REPORTING, LLC

CASE NAME:
DATE OF DEPOSITION: , 2009
WITNESS' NAME:

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SUBSCRIBED AND SWORN TO
BEFORE ME THIS______DAY
OF_______________, 2009.

____
NOTARY PUBLIC
MY COMMISSION EXPIRES__________________