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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

,

Plaintiff,

-against-

MEDICAL CENTER, ,
, , M.D.,
M.D., , M.D.,
, M.D., , M.D.,
, M.D., , M.D.,
, M.D. (FIRST NAME BEING FICTITIOUS) , M.D. (FIRST NAME BEING FICTITIOUS) , R.N. and , R.N.,

Defendants.

Index No. XXXXX/06

December 18, 2007
10:22 a.m.

EXAMINATION BEFORE TRIAL of , taken by Plaintiff, pursuant to Court Order, held at the offices of , P.C., Street, New York, New York before Wayne Hock, a Notary Public of the State of New York.

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

THE LAW OFFICE OF GERALD M. OGINSKI, LLC
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* * *

IT IS HEREBY STIPULATED AND AGREED by and between the attorneys for the respective parties hereto that all rights provided by the CPLR, and Part 221 of the Uniform Rules for the Conduct of Depositions, including the right to object to any question, except as to the form, or to move to strike any testimony at this examination, are 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 for, the trial or this action.

IT IS FURTHER STIPULATED AND AGREED that this examination may be signed and sworn to, by the witness being examined, before any Notary Public other than the Notary Public before whom the examination was begin, but the failure to do so, or to return the original of this examination, shall not be deemed a waiver of rights provided by Rules 3116 and 3117

of the CPLR and shall be controlled thereby.

IT IS FURTHER STIPULATED AND AGREED that the filing of the original of this examination shall be and the same hereby is waived.

* * *

MR. OGINSKI: Can you mark these.

(Whereupon, a medical chart was marked Plaintiff's Exhibit 1A for identification.)

(Whereupon, a medical chart was marked Plaintiff's Exhibit 1B

for identification.)
(Whereupon, a medical chart was marked Plaintiff's Exhibit 1C for identification.)
(Whereupon, a document entitled Curriculum Vitae of , was marked Plaintiff's Exhibit 2 for identification.)
, having been first duly sworn by a Notary Public of the State of New York, upon being

examined, testified as follows:

EXAMINATION BY
MR. OGINSKI:

Q. Please state your full name.
A. .
Q. What is your current address?
A. Avenue, apartment , New York, New York .
Q. Good morning, Doctor.
A. Good morning.
Q. Did you perform a shoulder reduction to on September 7, at Medical Center?
A. Yes.
Q. What is a shoulder dislocation?
A. It's when the humeral head, which normally is within the joint against the glenohumeral fossa, is displaced out of that fossa, out of that joint.
Q. How does that happen?
MS. : Note my objection.
You can answer over objection.
In other words, you want to know

every type of thing that could happen or physiologically how it happens?
Q. In general, how does someone dislocate their shoulder?
A. Well, there's different types of shoulder dislocations. There's dislocations that happen from trauma where you've had direct contact to the shoulder joint and then there's dislocations where you've strained the joint from lifting something, from trying to pull something up. There's different kinds of dislocations -- interior, posterior, inferior --- so each one, there's different things that can precipitate those.
Q. In the course of your career --
A. Those are the pain points.

Q. In the course of your career, have you had occasion to see patients who've had shoulder dislocations from different types of trauma and other sources?
A. Yes.

Q. And have you had occasion to treat those shoulder dislocations?
A. Many.
Q. What is shoulder reduction?
A. Shoulder reduction is taking the humeral head, which is not in the correct position for the shoulder joint, and putting it back into the correct position.
Q. Are you familiar with something known as an axillary sheath hematoma?
A. Yes.
Q. What is that?
A. The axillary area is the area under your what would commonly be known as the armpit area. Blood can form in that area and that becomes a hematoma when blood forms in that area.
Q. Are you familiar with a term known as "rhabdomyolysis?"
A. Yes, it comes from the breakdown of muscle tissue.
Q. What is nerve compression?
A. It's when -- any type of compression on the nerve.

Q. Are you familiar with a term known as ischemic neuritis?
A. Yes.
Q. What is it?
A. It's when there's decreased blood flow to the nerve.
Q. Can that occur from nerve compression?
A. It can.
Q. What is brachial plexopathy?
A. It's when you damage in the brachial area nerves.
Q. What is a compartment syndrome?
A. Compartment syndrome is when an area which is confined has expansion that becomes limited and causes compression. There are symptoms that are suggestive of that and it's part of the definition of it.
Q. And in your career, have you seen and examined patients who had compartment syndrome?
A. Yes.

Q. And as an emergency room physician, have you had occasion to treat compartment syndrome?
A. Yes.
Q. I'll go into more detail about compartment syndromes a little bit later.
What is a fasciotomy?
A. A fasciotomy is when you open the fascia so that you can release some of the pressure in the area where you have compartment syndrome.
Q. And what is the purpose of that?
A. To release the tension in the area which is causing the damage.
Q. And how does the compression cause damage?
A. Well, if you compress an artery, then there's no blood flow to the area. Compression of the vein means there's no blood flow away from the area. Decreasing the blood flow directly affects the muscles and the nerves and compression on the muscles and nerves themselves cause damage.
Q. What happens if there's compression on nerves that may be in that area?
A. It depends on how much compression. Prolonged severe suppression can cause nerve damage.
Q. Can you give me an estimate as to the number of shoulder reductions you've done in your career?
MS. : Up-to-date?
MR. OGINSKI: Yes.
A. More than a hundred.
Q. Now, all of my questions are going to be confined to the September, time period unless I indicate otherwise.
At that time you were working for Medical Center?
A. Yes.
Q. And you were an attending physician in the emergency room?
A. Yes.
Q. Am I correct that you are a , a doctor of ?
A. Yes, I am.
Q. How long had you been working at emergency department as of

September of ?
A. Approximately one year.
Q. Did you have a particular shift or number of days that you would work in the emergency room on any given week?
A. It varies because they have eight-hour and twelve-hour shifts, so depending on how many eight-hour or twelve-hour shifts you got, if you got more twelve hours, it might be less shifts for the month; eight-hour, more shifts for the month.
Q. Were there times that you took shifts back to back?
A. No, you're not allowed to do back-to-back shifts at .
Q. Who was the chief or head of the emergency room department at the time that you were working there in September of ?
A. The chairman is Steve Davidson.
Q. Now, I understand you left

in 2006?
A. Yes.
Q. And you currently work at Medical Center in ?
A. Yes.
Q. Also as an emergency room attending?
A. Yes.
Q. Did your leaving Medical Center in have anything to do whatsoever with the treatment and care rendered to ?
A. No.
Q. Going back to in September of , did the emergency room have documented policies and procedures for monitoring a preliminary imaging study performed by an emergency room physician?
MS. : Objection to the form.
MR. OGINSKI: I'll rephrase it.
Q. If you wanted to obtain let's say an MRI of a patient, describe for me whether there are certain written

documented policies and procedures about what actually happens once you want a film done, it gets taken, it gets read. I'm looking for procedures.
MS. : Objection to form.
You can answer over objection.
A. You have to determine if the

patient's actually suitable for an MRI.
MS. : He wants to know what, if anything, was in writing.
A. And so there's a form that you have to fill out to determine if the patient is actually even suitable, which is in the chart, requesting the patient to either answer questions or, if he's not able to, the physician to note if it seems reasonable that the patient has those things, such as a pacemaker, any other electronic devices. At the point that you determine that the patient is able to and that form has to be filled out before you request an MRI, you request an MRI through a computer system which then transmits it to the MRI department. And then the MRI

0014

department has to see how they can accommodate the patient. If there's a patient already in the MRI machine, they're not going to take that patient out and put somebody else in.
Once the MRI was done, there was a system in place where you could phone the radiology resident on call to get a preliminary reading.
MS. : Let me interrupt you for a second.
Is all of this in writing how do you do this? That's what he's asking you.
THE WITNESS: The form?
MS. : No, is there a rule that says first you fill out the form, then you do the next thing and then the next thing, that's what his question was. Is there a policy manual or something?
THE WITNESS: I don't know.
Q. Once an MRI is actually taken within the emergency room, was there any

0015

documented policy, written policy, rules or regulations, about what happens next in terms of getting a preliminary read and getting an official read by the radiologist and --
A. I don't know if it's a written policy.
Q. -- communicating that information to the doctor who ordered it in the emergency room?
A. I don't know that there's a written policy for that.

Q. At the time that you joined Medical Center, were you given some type of booklet or pamphlet or something that discusses the rules and regulations of the hospital, in general?
A. I believe there was a book in the emergency room available.
Q. So if you needed to consult it, you could go to it?
A. Yes.
Q. Do you know what that book is called?

A. I don't know what the name of that book was.
Q. Is that a compilation of rules and policies and procedures for the emergency room?
A. I know there was a policy and procedure book. I'm not sure that this was specifically in the book, but there's a policy and procedure book if you had difficulty with a situation and needed something.
Q. And where would that usually be kept?
A. There was one in the pharmacy area of the emergency room.
Q. Now, you told me that there was a protocol that you could phone the radiology resident to get a preliminary reading.
A. Yes.
Q. And how would you get notified that an MRI had actually been competed so that you could now contact the radiology resident to get that preliminary reading?

A. You wouldn't be contacted, you would contact them.
Q. Would you be told at some point, other than maybe the patient returning back to their bed or area in the emergency room, that the patient had had an MRI and now it was available to be read?
MS. : Note my objection to the form.
MR. OGINSKI: I'll rephrase it.
Q. After a patient is sent to the MRI for an MRI in the emergency room, other than you as the doctor picking up the phone and calling the radiology resident, is there any other way that you are notified about the fact an MRI was done for a patient that you had ordered an

MRI for?
A. No, you requested the reading, got the reading because they were around -- you initiated getting some form of result.
Q. Did the emergency room have a system for timely notification to the

emergency room doctor when there is a substantial discrepancy between the preliminary read and the official read?
MS. : Note my objection to the form. I think it's got a lot of qualifications.
MR. OGINSKI: I'll break it up.
Q. Am I correct that there was always a radiology resident available?
A. Yes.
Q. And what happens as far as the MRI film after the preliminary interpretation is done?
MS. : Note my objection.
What happens from a radiology point of view?
MR. OGINSKI: No, from an emergency room standpoint.
MR. : Off the record.
(Discussion held off the record)
Q. Once an MRI imaging study was done and a preliminary report was obtained from the radiology resident, how do you get notified or learn what the official

interpretation is?
MS. : Just note my objection to the form.
You can answer over objection.
A. If the patient was still in the emergency room when an official reading was made and the patient was not already admitted to another attending's service, then there would be a phone call made to the emergency room to notify them that there was a discrepancy in the reading. If the patient were already admitted to the hospital and was in a room somewhere else in the hospital, then that service would be notified of the change in the result. If the patient had been discharged from the hospital, there was a discrepancy book that was filled out so that the PA who was triaging that day could notify the patient to come back to the emergency room. So the notification is different for a patient gone, a patient

in the ER still under ER service, a service in the ER under another service

but being held because there's no bed available, and a patient upstairs under another service.

Q. You've mentioned that the emergency room would be called.

Would the doctor who ordered the MRI actually be called or would a message be left for that physician?

A. Neither.

Q. How would that work?

MS. : Off the record.

(Discussion held off the record)

Q. If the patient is still in the emergency room at the time that an official read is done, how do you get notified if you have ordered that MRI?

A. I actually answered that question. If the patient's in the emergency room but he's already admitted to another service, so the doctor record now is Dr. X, Dr. X will be notified. In the emergency room, we work limited shift hours so they would call the attending that was on during that shift that the

answer was changed if the patient was still listed as an emergency room patient.

Q. Now, to jump ahead to what your attorney had mentioned --

MR. OGINSKI: Withdrawn.

Q. At any time while you were caring for , did you ever talk to any radiology resident about a preliminary read that he had done while he was in the emergency room?

A. Yes.

Q. Who did you speak to?

A. Whoever was on call that night.

Q. Do you have a name?

A. I don't.

Q. Did you make a notation about your conversation with the radiology resident regarding the preliminary read?

MS. : You can look at the chart.

A. I called the radiology resident to confirm the preliminary reading that I had been told by the orthopedic because I had documented that in the chart. Because

there was no change in the reading, I did

not document it in the chart.
Q. The orthopedic resident you mentioned, do you know that individual's name?
A. Dr. .
Q. ?
A. Dr. , I'm sorry.
Q. Was this a telephone conversation with Dr. , was it in person, or something else?
A. Dr. came down to the emergency room and spoke to me about the MRI. I called the radiology resident to confirm that that reading was correct and then I documented in the chart that I had spoken to Dr. about the MRI results and that we were going to be admitting the patient to the hospital.
Q. To whose service?
A. Orthopedic service.
Q. What did Dr. tell you about his interpretation of the MRI?
MS. : Just for the

0023

record, it's her.
A. It's documented in the chart. There's an attending note. is my initials. Page seventeen. "MRI of the arm and shoulder with STS," which is soft tissue swelling. "No evidence of muscle tendon tear. There was no vascular injury." The preliminary report was from the ortho resident. And ortho was taking the patient to Dr. 's service for observation overnight.
Q. What time was that note?
A. 23:28.
Q. And that's on 9/7/ ?
A. Yes.
Q. What was your custom and practice back then about when you entered notes into the computer?
A. Notes were entered for different reasons. If I saw a patient but I was unable to write an entire note, I would write a small note to remind myself of a particular physical aspect or a particular reaction to a medication or a particular

0024

event that happened. Sometimes the notes are written as you're talking to somebody, if you happen to be logged onto a computer, we had telephones that worked only within the hospital. So if I was with a patient, I could receive a phone

call from another doctor but, if I was in the middle of a procedure, it may not get documented for quite some time because I was aware of the situation but not next to a computer.

Q. Did you personally review the MRI images of this patient?

A. No, I did not.

Q. What was the purpose of contacting the radiology resident who was on call after you spoke to Dr. about her interpretation of the images?

A. To make sure there were no other further comments that I needed to be aware of.

Q. Did the radiology resident review them while you were on the telephone?

0025

A. He had just reviewed them with Dr. and was aware of the case.

Q. Was there anything in your review of this patient's chart that would suggest to you who that radiology resident was?

A. No.

Q. Other than the notes that are contained within this patient's record, do you have any handwritten notes separate and apart from the patient's record about care and treatment during his admission to ?

A. I don't know.

Q. Back in September of , were there occasions when you made handwritten notes into the patient's emergency room record?

A. Not into the patient's emergency room record.

Q. What would you make handwritten notes about or where would they be?

THE WITNESS: Can I answer it?

MS. : Yes.

0026

A. I try, on most shifts, to keep the name, the diagnosis of the patient. Sometimes there may be something interesting about the patient I want to go back and review for academic purposes to review with residents to teach them about unusual presentations, sometimes just to follow up because it's something you don't see very often, and so I tend to keep a listing of the patients that I've seen. The only thing that I keep consistently on

every patient is the name, the date, and the diagnosis so I can remind myself at later dates if somebody asks did I see the patient. I don't know if I had written anything else on that patient.

Q. Did you ever present Mr. situation or his case to any of the residents either informally or at rounds or at grand rounds?

A. I had a resident on the case with me.

MR. OGINSKI: Let me rephrase the question.

0027

Q. At any point after you treated Mr. in September of , did you ever have a discussion with the residents for teaching purposes about what treatment he received and anything else that happened during his time he was at ?

A. Not after he left the emergency room.

Q. Were you ever asked to prepare a written statement by anyone from the hospital after Mr. had left the emergency room other than the notes that you made within this chart?

A. No.

Q. Going back to the rules or policies of the emergency room, were there any written documented policies regarding the notification going from a radiology resident on call to an official read by the attending radiologist that you are aware of?

MS. : Can I hear that back?

0028

MR. OGINSKI: I'll rephrase it.

Q. Was there a written policy in the emergency room as to how much time an attending radiologist had in order to perform an official read of an MRI that was taken in the emergency room?

A. I don't know.

Q. Were you aware, regardless of whether or not it was written, as to how long a radiologist had to occasionally interpret an MRI that was taken in the emergency room?

MS. : Just note my objection to the form. You're presuming that -- the way it's worded.

Q. Was there any type of unofficial

policy as to how long a radiology attending would have to perform an official read of an image taken in the emergency room?
A. In general, if they were performed after regular daytime hours, they would be looked at the next morning. That was my understanding.

Q. Were there occasions when you would speak to a radiology attending to read or interpret a particular imaging study in the evening hours?
A. If the radiology resident was unclear about something or told me they couldn't interpret something, then the attending could be contacted.
Q. Now, did , back in , have the ability to send images to radiologists who were not physically within the hospital?
A. I don't know.
Q. Are you familiar with whether the hospital had the ability to send images by teleradiology?
A. I don't know what the radiology department has the ability to do.
Q. I'm just asking your knowledge.
A. I don't know if the radiology department had that ability.
Q. Were there any documented policies for the emergency room regarding making notes in a patient's chart as to

when notes were to be made?
MS. : Specifically a written policy as to when the notes had to be made in relation to when the attending saw the patient?
MR. OGINSKI: Correct.
A. No.
Q. Were there any written policies regarding the fact that notes had to be made if the patient was seen by a nurse or a physician or somebody else?
A. Notes had to be completed within twenty-four hours of the patient being seen.
Q. And what was the purpose of that, if any, if you know?
A. To ensure accurate documentation.
Q. If a nurse --
MR. OGINSKI: Withdrawn.
Q. Were there occasions when nurses

in the emergency room would take patients' vital signs?
A. Yes.

Q. Do you know if the nurses had any obligation to make notations in the chart about vital signs that they obtained?
MS. : Just note my objection.
You can answer over objection.
A. I don't know what the nursing department's policy is.
Q. Did the nurses, to your knowledge, use the computer to make entries in the chart?
A. They do use the computer, yes, that's how they enter the notes for the patients.
Q. Let's go back to shoulder reduction.
A. Okay.
Q. I'd like to ask you how you actually perform the reduction.
A. It depends on what technique you're using.
MS. : You're talking in this particular case or in general?

Q. I'm going to focus on cases just like this one. I'm not asking specifically yet, I'm just asking shoulder dislocations as a result of some type of trauma.
MS. : Note my objection to the form. I think we have a lot of discrepancy as to exactly what happened. If you want to ask her specifically as to what she did here, I don't have a problem with that.
A. There's three general --
MS. : Wait for a question.
Q. Tell me the different ways you can reduce a shoulder dislocation.
A. There's three generally accepted techniques for anterior dislocations, which would be the Stimson, the traction/countertraction, and the Hennepin technique.
Q. What's the last one?
A. Hennepin.
Q. Can you spell it?

A. H E N N E P I N.
Q. And what is the Stimson method?
A. The Stimson method is used by having the patient lie prone with the affected arm over the side of the stretcher and you take a ten to fifteen-pound weight and attach it to the wrist. Obviously if it's a child, less of a weight. And you wait about twenty or thirty minutes until the muscles of the joint are fatigued and you manipulate the humeral head back into the joint.
Q. And what is the traction/countertraction method?
A. The traction/countertraction method is used by applying traction to the arm and applying countertraction in the axillary area in the opposite direction to separate the area enough that the humeral head can go back into the joint.
Q. You have to pull it out almost to put it back in; is that a layman's way of understanding it?
A. You're performing traction,

0034

you're not -- it's a gradual traction, it's not a sudden movement.
Q. And the Hennepin method, what is that?
A. It's a method where you flex the elbow to ninety degrees and slightly externally rotate and lift the arm up over the head so that the humeral head can then replace itself back into the joint.
Q. How do you decide which of those procedures is appropriate for an adult?
A. It depends on if the adult is able to cooperate, whether or not you have more than one person available to assist you, and the body habitus of the patient.
Q. In 's case, did you have anybody to assist you in performing the reduction?
A. Yes.
Q. Who?
A. I had the resident who was assigned to the resuscitation area.
Q. And who was this resident?
A. Dr. .

0035

Q. ?
A. Yes.
MS. : Is his first or last name?
THE WITNESS: That's his last

name.
Q. Do you know Dr. first name?
A. It's in the chart. I don't remember. .
Q. And do you know what -- was Dr. an emergency room resident or --
A. Yes.
Q. Do you know what year he was in?
A. I believe he was second year resident.
Q. And what, if anything, did Dr. do --
MS. : Can I interrupt you for a second.
Did you finish your answer as to who was assisting you?
A. There were other people who assisted.

Q. Other than the anesthesiologist, who else assisted you?
MS. : Objection to the form.
A. There's no anesthesiologist.
Q. Who else assisted you?
A. Dr. .
Q. Anybody else?
A. She had a colleague that accompanied her whose name I don't remember.
Q. Was that also a resident?
A. No.
Q. Do you know what --
A. He was an orthopedic PA.
Q. What did Dr. do?
A. Dr. provided countertraction.
Q. What did Dr. do?
A. Dr. assisted in traction.
Q. And what did the ortho PA do?
A. He assisted Dr. .
Q. And what were you doing during the reduction?

A. I attempted, with Dr. , to reduce the shoulder twice. We were unsuccessful. I had the orthopedic resident come down to assist us. The third attempt was by Dr. and her PA, and I believe Dr. assisted just with the countertraction. When that was unsuccessful, the fourth and the fifth attempt were made with Dr. , myself, and I believe Dr. . The fourth and

fifth, I monitored the shoulder joint and determined whether or not I could feel the humeral head moving and at what point the humeral head went back into place.
Q. And at which attempt was it that the humeral head went back into place?
A. The fifth.
Q. How would you describe Mr. body habitus?
A. I described it in here many times. He's extremely muscular and large.
Q. Did you learn he was a bodybuilder?
A. He told me he went to the gym a

0038

lot.
Q. Did you perform any opinion at that time as to why you were unable to reduce the shoulder after the first attempt?
A. Yes.
Q. What was your opinion?
A. The shoulder had been dislocated for approximately two days by the patient's description and he was extremely muscular.
Q. How does that affect the attempt to reduce the dislocation?
A. The muscles around the joint tend to spasm when there's been an injury, which makes it more difficult to manipulate the area. Also the thicker the muscle, the harder to manage any manipulation of the area.
Q. In general, I'm going back to general questions regarding a dislocated shoulder, is it painful?
A. It is. That's why we give you pain medication and sedation.

0039

Q. In other words, to reduce it?
A. Conscious sedation, which is what he had, is making someone not feel the procedure or feel it less.
Q. I'm sorry, I wasn't clear.
A. That's the standard.
MR. OGINSKI: Let me rephrase it.
Q. At the time that you dislocate a shoulder from trauma, for example, is it generally painful?
A. It's painful.
Q. Is movement limited with a dislocated shoulder?
A. Yes.
Q. Why?

A. Because you are unable to -- because the ball of the humeral head no longer being in the socket of the glenohumeral fossa makes it so that it cannot rotate for the muscles to be able to lift it up.
Q. It's a mechanical problem?
A. It's a mechanical problem.
Q. Does the pain contribute to the

0040

limitation of motion?
A. Even with pain, if you don't have a dislocated shoulder, there's a limited number of injuries that would cause you not to be able to lift your arm up.
Q. Is a dislocated shoulder typically seen with -- do you see swelling?
A. Yes, that's the number one physical exam sign.
Q. Do you also see discoloration?
A. Depending upon how it occurred, you may see some bruising, you may see some redness.
Q. Can you have interruption of blood flow to the hand as a result of a dislocation?
A. Yes.
Q. Can you have possibly decrease -- the possibility of a decreased blood flow to the hand from a dislocation?
A. Yes.
Q. And I think you mentioned

0041

earlier that you could also have possible nerve involvement from a dislocation?
A. Yes.
Q. Are you able to tell on exam the difference between sensory nerves and motor nerves?
A. Yes.
Q. When examining a patient who has a shoulder dislocation, do you examine the hand?
A. You examine the entire arm, which include the hand, the forearm, and the shoulder.
Q. As part of the examination, do you also check the patient's neurovascular condition?
A. Yes.
Q. What is involved? What do you look for?
A. Well, you can compress the nail

beds which causes a change in the color, release it and see how long it takes for the nail beds to go back to a normal color. That's called capillary refill.

You can also check a radial pulse, which is very simple to do.

Q. How do you check for motor or sensory nerve involvement?

A. If they can move whatever you're checking.

Q. And as far as sensory, ask them to touch, if they can feel?

A. You can touch it and see if they feel it, yes.

Q. Going back to the MRI, if a patient was still in the emergency room and had not yet been transferred to another service, was there ever a time when you would actually receive a written report of a preliminary finding of an MRI?

A. No.

Q. Was there ever a time when you would receive a written report of an official radiology interpretation?

MS. : Are you talking about written on a piece of paper?

MR. OGINSKI: Yes. I'm not talking about in the computer.

A. No.

Q. Was there some procedure that was available to you that, once an official interpretation was done of an MRI image, that you would be notified, e-mailed, or something else if the patient still was in the emergency room and had not yet been sent to another service?

A. There was -- generally they would call the emergency room if, on the computer, it was noted that the patient was still an emergency room patient.

Q. Other than by telephone -- somebody from radiology calling the emergency room by telephone, was there any other method of notifying you as the doctor who had ordered the MRI imaging study about the results and other than you actually going and checking the computer?

A. Not that I'm aware of.

Q. Do you recall who made the decision to admit this patient overnight, to keep him?

A. I did and Dr. together.

Q. What was the reason for admitting the patient for overnight observation?
A. Because he still had a significant amount of swelling in the upper extremity that I was concerned about and felt that he needed observation to make sure that he didn't develop any complications.
Q. Am I correct that initially he was going to be discharged after his initial shoulder reduction?
MS. : Note my objection to the form.
MR. OGINSKI: I'll rephrase it.
Q. Am I correct that the original feeling was that he would be sent home in the early afternoon?
MS. : Note my objection to the form.
You want to be more specific when you say the original thing? Are you asking her or somebody else?
MR. OGINSKI: Right.

0045

A. When I saw --
MS. : Let him rephrase the question.
Q. Had you formed an opinion after performing the shoulder reduction as to when this patient would be discharged?
A. I formed an opinion before the reduction.
Q. What was your opinion?
A. The opinion was that he was going to have to be monitored for several hours after the reduction because he was at higher risk for developing complications because he had waited so long to come to the emergency room.
Q. Is Dr. still working at ?
A. I have no idea.
Q. Have you ever spoken to Dr. after you left in 2006?
A. No.
Q. As a result of somebody suffering a shoulder dislocation, can they also tear their muscle?

0046

A. That's one of the common complications.
Q. Can they tear their tendon?
A. That's another common

complication.
Q. Did the dislocation cause trauma to the axillary artery or axillary vein?
A. The longer a dislocation is out the more chance they damage the axillary artery, nerve, muscles, and tendons.
Q. Explain what you mean by that.
A. If a shoulder's been dislocated for twelve hours, it's much more likely that there will be damage than if it's been dislocated for one hour.
Q. Why is it that the extended length of time would likely cause additional harm or injury?
A. Because you're altering the normal structure of the area.
Q. Are there times when a patient may dislocate their shoulder and not recognize that they have a dislocation?
MS. : Note my objection

0047

to the form.
Q. In your experience.
MR. : They don't diagnose themselves?
MS. : If they don't know they have a dislocation, they may not come into the hospital at all so she wouldn't know that. You want to know didn't know he had a shoulder dislocation, you can ask her that. But whoever's out there that doesn't come into the hospital I think is --
Q. Of the patients that you have seen in the emergency room over the years, have there been times when they didn't know that their shoulder had been dislocated, they just felt that they had some pain?
MS. : Note my objection to the form.
You can answer over objection.
A. People come in and complain they have shoulder pain, that's what they complain of.

0048

Q. Now, shoulder dislocation can cause trauma to associated nerves; correct?
A. Yes.
Q. What tests --
MR. OGINSKI: Withdrawn.
Q. When a patient comes into the emergency room and you suspect a shoulder dislocation, what tests, if any, can you

perform to rule out whether there's been a muscle tear?
A. It depends on whether you think it was a critical injury or not to the muscle.
Q. Tell me what you mean by that.
A. If you are able to easily reduce the shoulder and they're moving the arm relatively well, you would observe them, they would follow up with the orthopedic. If there was an obvious injury or you suspected an obvious injury, again you could observe and see how they do as the pain medications wear off, as swelling goes down, and see how the patient does

and if not, if they don't improve, you may order an MRI.
Q. And is an MRI a good tool to use to determine whether or not there's a muscle or a tendon tear?
A. Yes.
Q. Are there any other tools that you have available to you that would assist you in determining whether or not a patient had a muscle or a tendon tear?
A. The MRI would be the best available test at the time that this person had his injury.
Q. Mr. asked earlier whether or not, when an MRI is done, films are actually produced or they're computer generated images.
In , did you know which one was available at ?
A. I don't know what films were available.
MR. : For the record, I didn't ask, I just pointed out that you assumed.

Q. If you suspect there's been an injury to the axillary artery, are there any tests that you could perform to allow you to rule in or rule out whether there's been such an injury?
A. A Doppler duplex.
Q. And that was done in this case; is that right?
A. Yes, it was.
Q. And based upon your recollection of the reading of the chart, what was the result of the Doppler?
A. The most distal artery, the radial artery, had sufficient flow. The

brachial artery had sufficient flow. The axillary artery had sufficient flow. And if you will let me look up, I will let you know if the subclavian was documented on it but I don't remember off the top of my head. But there was no significant compromise of arterial flow that was dangerous at that time.

Q. Is that pre-reduction or post reduction?

0051

A. It's post reduction.

Q. And does the Doppler also look at any possible compromise to the veins?

A. Yes, it did.

Q. And were there any compromises to the veins during that Doppler duplex study?

A. There were none that were noted.

Q. Was a Doppler duplex study done pre-reduction?

A. No.

Q. Did you come to any opinion or working impression before you attempted the shoulder reduction as to whether there was any type of hematoma, axillary hematoma, as a result of the dislocation?

A. There's always a risk that there can be one. He had a large amount of swelling in the area circumferentially, and so it was difficult to tell from a physical exam whether there was or not.

Q. Did Mr. have any discoloration around the shoulder area pre-reduction?

0052

A. No.

Q. Did he have pain on palpation?

A. Yes.

Q. And am I correct that his pain was graded on a scale of ten out of ten when he first arrived in the emergency room?

A. That's the generally accepted pain scale.

Q. And ten would be the maximum; correct?

A. Ten would be the maximum.

Q. Would you agree, Doctor, that in a patient who has a history of a shoulder dislocation, it would be important to obtain a detailed history of the patient?

A. Yes.

Q. And what's the purpose of obtaining a detailed history?

A. To determine whether or not there are factors that may affect your ability to reduce it, to find out if there's any factors that would affect his ability to recover from the injury, and

for complications that you may try to anticipate from the injury.

Q. Other than reviewing this particular chart, did you review any textbooks or literature in preparation for today?

A. No.

Q. Do you have a distinct memory of Mr. , what he looks like and certain conversations you may have had with him?

A. Yes.

Q. Do you recall --

MR. OGINSKI: Withdrawn.

Q. Did you have any conversations with any family member of Mr. on September 7?

A. The person that was --

MS. : Just note my objection to the form.

A. The person that was with him claimed to be his girlfriend in the emergency room.

Q. Do you recall on how many

different occasions you spoke to that individual?

MS. : The girlfriend?

MR. OGINSKI: Yes.

A. I don't know how many times I spoke to her.

Q. At the time that you were --

MR. OGINSKI: Withdrawn.

Q. When Mr. came into the emergency room, was he coherent, was he conscious?

A. Yes.

Q. Aware and oriented?

A. Yes.

Q. Did he examine him in the presence of his girlfriend?

A. I don't remember.

Q. Did you speak to Mr. about your findings in the presence of his girlfriend?

A. I don't remember if she was in the room.

Q. When you spoke to him about the need to perform a shoulder reduction, was

0055

his girlfriend present in the area where you were talking to him?
A. I don't remember.
Q. What did you tell Mr. about the need for the shoulder reduction?
A. I told him that a shoulder dislocation that does not get reduced will likely result in permanent disability. I also told him because it appeared to have been dislocated for approximately two days, that it was likely he already had some damage from the amount of time that it had been dislocated.
Q. Were you able to determine at that point what type of damage he might have sustained other than the acute phase?
A. No.
Q. At the time that you had talked to him about the need for the shoulder reduction, had Dr. examined Mr. ?
A. No.
Q. Had any other physician in the emergency room examined Mr. before

0056

you performed your shoulder reduction?
A. Not a full physical exam. He was examined by the PA at triage.
Q. Other than the emergency room PA, was there any other doctor, other than yourself, who examined Mr. before the reduction was attempted?
A. Dr. .
Q. And what, if anything, did Dr. do before the reduction?
A. We examined the patient, reviewed the films, and it was determined that he needed to have his shoulder reduced.
Q. Was it your opinion, before doing the reduction, that he actually did have a shoulder dislocation?
A. Yes.
Q. And was that visible on the x-rays that you had ordered and obtained prior to making that decision?
A. The decision is partly clinical and partly radiologic.
Q. And did the x-rays confirm that

0057

there was a shoulder dislocation?
A. The x-rays suggested a shoulder dislocation.

Q. And did your clinical examination confirm that?
A. Yes.
Q. Now, again in a patient with a history of a shoulder dislocation, would you agree that it's important to perform a thorough clinical assessment?
A. Yes.
Q. Why?
A. Because you're going to be giving medication that has other side affects. When you examine the patient, if you see something that's contraindicated to give that medication, that would be important to know.
Q. And other than a medical history, is it important to actually perform a physical examination on the patient?
A. Yes.
Q. And what's the purpose of the

0058

physical exam?
A. To ensure that there are no other injuries, to determine if you're going to have any other complications from another deformity that he may have.
Q. And as part of your clinical exam, is it important for you to ascertain whether or not the patient has good pulses?
A. Yes.
Q. As well as the patient's neurovascular status as well; correct?
A. Yes.
Q. Are there any risks associated with shoulder reduction?
A. Yes.
Q. I'm going to ask you certain questions about possible risks.
A. Okay.
Q. And I'm going to ask you generally what the risks are.
A. Okay.
Q. Can shoulder reduction cause damage to the shoulder or arm?

0059

A. It's already damaged from --
MR. OGINSKI: I apologize, my mistake.
Q. Can a reduction cause additional damage to the patient's shoulder or arm?
A. It can, yes.
Q. How?
A. You're manipulating an area

that's already been damaged, so it's already not in its correct physiologic state, anatomical state.
Q. Can tear or injury to the muscle occur during shoulder reduction?
A. Yes, as can from the dislocation itself.
Q. We've established already that the possible injuries that can occur from the dislocation.
A. Okay.
Q. My question now is just focused on the actual reduction itself.
A. Okay.
Q. I'm just trying to find out what can actually happen from the reduction.

A. Okay.
Q. Can you suffer tendon damage or even cartilage damage during the reduction?
A. Yes.
Q. Can you suffer damage to an artery or a vein during reduction?
A. Yes.
Q. As well as injury to the nerve?
A. Yes.
Q. Or a nerve.
Can the patient experience additional bleeding?
A. Yes.
Q. Can the patient experience swelling from the reduction or as a consequence of the reduction?
A. From manipulation, yes.
Q. Can the patient experience compression of either an artery, a vein, a muscle, or a tendon as part of the reduction?
A. It's possible.
Q. Doctor, is there any way to

prevent or minimize those possibilities during an attempted reduction?
A. By using the appropriate technique for that patient; by relaxing the patient so that his muscles are more compliant with your manipulation.
Q. And that would be by giving them some sort of sedative?
A. Yes.
Q. And pain medication as well?
A. Yes.
Q. Assuming that's done, that a patient is now sedated and anesthetized in

some fashion, is there any further way to try to reduce the risks associated with doing the reduction, and again assuming the correct procedure is used?
A. I'm not sure exactly what you're asking.
MR. OGINSKI: I'll rephrase it.
Q. You've told me that there are inherent risks with doing a shoulder reduction.
A. Yes.

Q. My question is: Is there any way to minimize those risks?
MS. : Aside from what she's already testified to?
MR. OGINSKI: Sure.
A. If you're aware of something that needs to be corrected prior to, such as a coagulopathy, then that would reduce the risk of injury and bleeding.
Q. Aside from having any preexisting knowledge of any prior condition, in terms of physical damage to an artery, vein, a nerve, tendon, or muscle, is there any way to physically minimize those risks when doing a reduction?
MS. : Note my objection.
You can answer over objection.
You're talking now about a general patient?
A. You're looking for a specific answer and I'm not sure what you're looking for.
Q. I'm just asking, is there any

way to minimize those risks; that if you do a particular technique, it's less risky than doing a different technique for a patient?
A. There's several acceptable techniques. Each is for a different type of patient. If you try to use the technique that's best for that patient, that decision alone helps minimize the risks.
Q. Am I correct that, in this particular case, you used the traction/countertraction technique?
A. Yes.
Q. How did you determine that that was the best procedure for Mr. ?
A. Because of the amount of musculature that he had, I did not feel

that either of the other two techniques would work as well or be as successful. For the Hennepin, the patient has to actually be able to cooperate which means he needs to also be not resisting.
Q. Awake and in pain; right?

A. Not awake and in pain but it's a little bit different.
For the Stimson, you can only apply a certain amount of weight and his musculature made it so that that didn't seem probable that ten pounds of weight was going to relax this very large arm.
Q. In each of the five attempts that were made, was it done using the traction/countertraction technique?
A. Yes.
Q. If an axillary artery has been damaged as a result of the original dislocation, can delayed recognition of the damage lead to nerve deficits?
MS. : Can I hear the question back, please.
(Whereupon the requested portion was read back by the reporter)
MS. : You can answer.
A. Yes.
Q. How?
A. The longer you have compromised blood flow, the longer the tissue and the

nerves to the area have decreased blood flow.
Q. Is that also known as ischemia?
A. Yes.
MR. OGINSKI: Let's take a two-minute break.
(Whereupon a break was taken)
Q. Doctor, who made a decision about the amount of sedation the patient would receive during the attempted reduction?
A. I did.
Q. And I understand, from looking at the sedation flow form, the patient received a total of eighty milligrams of propofol; correct?
MS. :
A. That's a standard adult dose.
Q. Can you tell, from looking at the note, please, as to how much Versed the patient received, please?
A. A total of seven.
Q. Seven milligrams?

A. Uh-huh.

Q. Is that a standard dose as well?
A. The standard dose is five. I made a note in the chart that, because of his size, we gave an additional two milligrams because five was not enough.
Q. In terms of the size, are you talking about his overall body size or something else?
A. His overall body size.
Q. Can you turn to page sixteen of the emergency room note.
Before we do that, go back, please, to the sedation flow form.
Based upon the timing that appears on this form, when did the procedure, the reduction, actually start?
A. According to this, 11:32 to 11:55.
Q. And who made notes on this particular form?
A. Whoever's signature that is.
Q. That would be a nurse?
A. The nurse does the flow sheet, yes.

Q. And at some point afterwards you countersigned that sheet?
A. I signed the sheet for the medications that were given, yes.
Q. Now go back, please, to page sixteen of the emergency room record.
A. I just want to look at one thing.
(Reviewing).
THE WITNESS: I have to actually say something.
MS. : You want to amend a prior answer?
THE WITNESS: No, not amend a prior answer. I think there was an error on a flow sheet. It's not possible that the patient got the medications on the time there. I think she's got the time wrong.
Q. Tell me why.
A. Because the patient was triaged at 11:25. You couldn't have even unaddressed the patient, put an IV in, and filled the form out for the time that's on

here. It's not physically possible.
Q. Sitting here looking at the

patient's chart, do you know what the times were as to when the procedure started and when the procedure finished. And if you can, just tell me what page you're referring to.
A. I'm looking at page three. And at 12:07, we put the patient in the bed.
MR. : What's the question?
MR. OGINSKI: When did the procedure start and when did it end.
A. The procedure would have started at 13:08.
Q. And what are you looking at to --
A. Because the propofol and the midazolam, having been given -- actually, at 12:42.
Q. What page, Doctor, are you looking at?
A. Page six.
Q. And what is it that you're specifically looking at?

0069

A. The medications that are given for the conscious sedation were given at 12:42.
Q. And those were the ones that you had ordered stat?
A. Yes, for sedation. When there wasn't enough relaxation, I ordered an additional two milligrams of Versed at 13:09.
Q. Do you have any knowledge, as you sit here now, as to how it is the times on the sedation flow sheet are incorrect?
A. I didn't fill the times out.
Q. I'm just asking you whether you know why that might be inaccurate. I don't want you to guess.
A. I don't know.
Q. Based upon the medication timing as to when it was given, are you able to also determine when it was that the procedure finished?
A. Before 13:44.
Q. And what is it that you're

0070

looking at that would tell you that?
A. Because the patient went down to get the Doppler duplex at 13:44. At 13:40, the patient went to get vascular studies done and that was post reduction.
Q. The additional Versed that was given, was that for the purposes of

relaxation or for pain relief?
A. It does both. You relax the muscle and you have less pain.
Q. Now, if you can, please, turn to page sixteen to your note that appears on the bottom of the page timed at 15:47.
A. Uh-huh.
Q. Right above that is a note that says, "ortho called" timed at 11:57.
A. Yes.
Q. Who were you referring to?
A. The orthopedic resident.
Q. That would be Dr. ?
A. Yes.
Q. Do you have any notation about your conversation with Dr. after the orthopedist was called?

0071

A. I make references to the orthopedic being involved in the case with me. The note below says, "ortho still following the patient." I have another note on the next page that I had gotten a report from the ortho resident for the MRI and that they would be taking it to Dr. 's service. And I gave a report to Dr. at 23:39 that I was signing off the case. And I would have to review to see if there are any others, but there are references that ortho is still involved with the emergency room.
Q. Let's go to your 15:47 note for September 7.
You write that the shoulder was reduced after multiple attempts.
Do you indicate anywhere in there the actual number?
A. I don't, but I remember the actual number.
Q. Do you indicate in your note who participated in the procedure with you?
A. I don't know, I'd have to review

0072

through the chart.
Q. No, I'm just asking in this note.
A. In this note? No.
Q. On the second line you indicate that the patient still with palpable radial pulse able to move fingers; correct?
A. Yes.
Q. Sensory was intact?
A. Sensory was intact.
Q. Tell me what you meant by that.

A. I had examined the fingers and the sensory was intact on the fingers.
Q. He was able to feel?
A. He was able to feel his fingertips.
Q. What's written after intact?
A. I suspect that the bicep was torn and hemorrhaging to the muscle because it was causing swelling and pain in the upper extremity. He still had significant swelling in the upper arm.
Q. At the time that you wrote the

0073

note, was this additional swelling that you observed beyond what you had seen when the patient initially came in pre-reduction?
A. No. Based on the information I had at the time, I had ruled out a significant vascular injury because the Doppler duplex was negative, but he still had significant swelling that had not changed and was still complaining that he had pain which, after the reduction, should have, to some degree, decreased.
Q. Had the manipulation, the five attempts to put the shoulder back in, caused additional swelling?
MS. : Note my objection.
You can answer over objection.
MR. OGINSKI: I'll rephrase it.
A. There may have been some minimal additional swelling.
Q. You continued by saying that vascular studies reveal patent arteries to radial?
A. Yes.

0074

Q. That means there was no diminishment of flow?
A. What that means is that the flow was adequate.
Q. Was there any caution or concern about the flow other than it being adequate?
A. That's why we did the Doppler duplex. We wanted to ensure that there was flow because of the swelling in the upper arm.
MS. : Just note my objection to the form of that question. I'm not sure what you mean, was there any concern.
You're talking about after the Doppler was done, was there any

concern? I'm not sure what you were asking her.
MR. OGINSKI: Fair enough.
Q. The reason why you ordered the Doppler was to assess the flow?
A. When the patient presented, the degree of swelling was significant and, in

0075

order to rule out that there was significant arterial injury which would have been the more serious injury, I ordered, after reduction, an arterial and venous Doppler duplex.
Q. If a patient has a nerve injury from a dislocation, would you agree that the sooner treatment is given the better chances or the better outcome for the patient with earlier treatment?
MS. : Objection to form.
You can answer.
A. If you mean the sooner the shoulder's put back into the joint, yes.
Q. After you performed the reduction, after the fifth attempt and you finally get the shoulder back into place, was there an absence of the distal pulse?
A. There was no absence of the distal pulse, no.
Q. Was there a diminution of the distal pulse?
A. At one point it felt less than the other side, but there was still always

0076

a radial pulse.
Q. What was the significance of that finding to you?
A. That either soft tissue swelling, which could be muscle, or any other soft tissue in the area may be causing some compression.
Q. And what, if anything, is done when that condition is observed?
A. You continue to check the pulse and then you decide whether or not this is something that is ongoing and needs more aggressive testing, treatment to be evaluated in a different way.
Q. Did you make any observation as to whether there was any axillary hematoma following the reduction?
A. He had a large degree of swelling in the upper extremity when he presented circumferentially.
Q. Did you ever determine whether that swelling was due to tissue perfusion,

hematoma, or something else?
A. That's why we were ordering the
0077
studies, to try to determine whether it was just soft tissue or whether it was from something else.
Q. If a determination is made that the swelling is due to a hematoma, what, if anything, is done to treat that condition?
A. If I was aware of a hematoma into the area, then vascular would have been asked to join us in the management of the case.
Q. And if you had called in the vascular consult, would you have typically relied on their suggestions or recommendations?
MS. : Well, note my objection to the form.
Q. Is it typically vascular who addresses trying to relieve a hematoma?
A. They would be involved in it.
Q. If the patient was still in the emergency room, would you also participate in relieving a hematoma?
A. If an urgent limb-saving
0078
fasciotomy that could not wait for the vascular surgeon to come was indicated, then the emergency room doctor would be involved in the management of that.
Q. And can a fasciotomy be performed at bedside?
A. If it's urgent, yes.
Q. Have you performed a fasciotomy in an emergency room setting?
A. No.
Q. Now going back to history, obtaining a patient's history when they come in, as part of that history I think you mentioned it's also important to find out what medications they were on, taking?
A. Yes.
Q. To see if there are any contraindications?
A. Uh-huh.
Q. Did you ask Mr. what medications, if any, he had been taking prior to his arrival?
A. Yes.
Q. What was his response?
0079
A. That he was not taking any

prescribed medication.
Q. Other than prescription medication, did you ask him if he was taking any nonprescription medication?
A. Yes.
Q. What was his response?
A. That he wasn't.
Q. Did you ask his girlfriend a similar question about any prior medication, prescription or otherwise?
A. I don't remember specifically.
Q. Do you have a specific memory of asking him whether he had ever taken any type of --
MR. OGINSKI: Withdrawn.
Q. You observed that Mr. was I think you said extremely large?
A. Yes.
Q. And you knew that he had been to the gym a lot?
A. Yes.
Q. Did he tell you that he lifted weights?

0080

A. He told me that he went to the gym a lot.
Q. And what did you understand that to mean, if anything?
A. That he works out a lot at the gym.
Q. Did you ever ask Mr. specifically whether he had any type of steroid use?
A. Yes, I did.
Q. Can you show me where in the chart you asked that specific question?
A. On page seven. No history of bleeding --
MS. : Just for the record, you're reading under where it says, "constitutional" at the bottom of the page.
A. "No history of bleeding disorders. No steroid use. Denies any drug use. And no aspirin use."
Q. That's ASA?
A. ASA is aspirin.
Q. Was Mr. able to converse

0081

easily with you during your history?
A. Yes, I took the history before I decided whether we were going to reduce and at that time he was alert and able to give me information.
Q. And was it your impression that

he was able to understand your questions?
A. Yes.
Q. Tell me why it's important to ask whether the patient was taking any type of steroids.
A. Steroids have a lot of effects on your body that can change your decisions that you make in how you're going to take care of the patient and what needs to be done after you've taken care of the patient.
Q. Are you aware of any literature that connects steroid use with shoulder dislocation?
MS. : Just note my objection to the form. I'm not sure what you mean.
A. There are many articles out

0082

there --
MR. : Are we talking about anabolic steroids, corticosteroids?
Q. When you asked him whether he was taking any type of steroids, what kind of steroids were you asking him about?
MS. : Note my objection to the form.
Did you say steroid?
THE WITNESS: I said any steroids.
Q. And what specifically did you mean by steroids?
A. Any steroids.
Q. Can you give me the different options?
MS. : Note my objection to the form. She asked him steroids. What she had in her mind is somewhat irrelevant.
MR. OGINSKI: I want to know what she was thinking.
MS. : Over objection, you can answer.

0083

Q. Doctor, let me do it this way.
When you asked Mr. whether he had been taking any type of steroids, what type of information were you looking for from him with that question?
A. I wanted to know if he had been taking any anabolic steroids and also if he had been on any prescribed steroids.
Q. And is there a difference?
A. There is a difference, yes.

Q. What is the difference?
A. One is a glucocorticoid that's prescribed and easily controlled and you can have an idea of how much the patient has gotten and the other one is most likely illegally obtained and much less likely easy for me to tell what effects the patient has from it.
Q. Which is which, is it the anabolic steroids that are --
A. Generally illegally obtained and much more difficult for me to determine, how much, how long, what the effects have

0084

been because it's not as well controlled. You're not getting it prescribed let's say prednisone for an asthmatic would be.
Q. What is creatine?
A. Creatine is a supplement used by bodybuilders.
Q. Is that something that you would want to know about when treating a patient?
A. He told me he was taking some vitamins.
Q. Is creatine a supplement that might affect your decision-making process on treatment or medication?
A. It's something you would factor in. It affects your muscles. It can also affect your kidneys. And so it would have been something that, if he had specifically said creatine instead of vitamin supplements, I would have kept it in the back of my mind for additional information of things that I may want to consider when treating him.
Q. Did you learn at a later time

0085

after you had seen Mr. in the emergency room that other physicians had spoken to him and he had told them that he had some type of steroid use?
MS. : Are you asking while he was still at the hospital?
MR. OGINSKI: Yes.
MS. : While he still at the hospital, did you ever learn from somebody else that he had taken steroids.
A. I did not learn while he was still in the emergency room, no.
Q. At some point after leaving the emergency room did you learn from anybody, other than your lawyer, about whether he

had taken steroid use?
A. I believe that the next time that I saw Dr. in the emergency room she mentioned she had gotten additional information from him afterwards.
Q. And what did she tell you, what type of information?
A. That what we had -- that she had

asked him about steroids and he had said no and then later confirmed that he was on steroids.
Q. If you had known that Mr. had taken anabolic steroids prior to his admission, how would your treatment have changed, if at all?
A. It increases the coagulation in the body and so it would have made me more suspicious or more careful in evaluating vascular.
Q. But other than being a little more careful, how --
MR. OGINSKI: Let me rephrase it.
Q. What about your treatment would have changed regarding the procedures you did, the tests you ordered, or anything else to monitor Mr. ?
A. If I had known he was on creatine and steroids, I would have ordered a CPK in the emergency room.
Q. And why would you do that?
A. It's an indication of diffuse -- if it was very elevated, it would have

been an indication of some diffuse muscle injury.
Q. If that, in fact, was done and he had a high CPK, would that have changed your treatment plan?
A. He still would have required a reduction of the shoulder.
Q. Are you aware of any medical literature that connects anabolic steroid use with shoulder dislocation?
MS. : Can I ask you to clarify what you mean, connecting it with.
Q. Any cause and effect, any causation.
MS. : In other words, does anabolic steroid cause a shoulder dislocation?
MR. OGINSKI: Yes, cause or contribute to shoulder dislocation.
A. Anabolic steroids don't cause

dislocations but they do cause alterations in the tendons and the muscles and they do cause alterations in your coagulation.

Q. Does that apply for chronic usage or short-term usage? Over what period of time are you referring to?
A. Any usage. You're putting something in your body that wasn't meant to be there. There's going to be some alteration that goes along with it. Whether it's short term and so there's a short period of change or whether it's long term and there's permanent. It would be different for each situation.
Q. Let me go back. My question asked whether you were aware of any specific studies that connect the use of anabolic steroid with shoulder dislocation.
A. I've read studies on complications associated with it. I can't name off the top of my head the name of the study.
Q. What I'm looking for is specifics, if you have them.
MS. : I think your question is a little vague as to a

connection.
A. I can't name off the top of my head the name of the article but I have read articles on complications from dislocations from anabolic steroid use.
Q. Are you aware of any medical literature connecting anabolic steroid use with development of axillary sheath hematomas?
A. Yes.
Q. Specifically do you recall what the literature was or where you observed it or read it, what journal, what textbook?
A. It's a medical journal. I read several medical journals every week.
Q. I understand. I'm just asking if you know specifically.
A. I don't know the specific name of the article, but yes.
Q. Are you aware of again medical literature connecting anabolic steroid use with either stroke, clot, thrombus, or embolus?

A. Absolutely.
Q. Are you aware of any medical literature that connects anabolic steroid use with compartment syndrome?
A. Yes.
Q. Do you have the specifics?
A. I would not be able to name the title of the article off the top of my head.
Q. During your conversation with Dr. about the information you learned that he had used steroids, did you have any further conversation about whether his use of steroid -- by the way, did they tell you whether it was anabolic or any other kind of steroids?
A. It was not on the day that Mr. was in the emergency room. I don't remember whether it was the next ay or the day after. It was the next time I saw Dr. on another shift that she mentioned it.
Q. But was she specific as to what type of steroids?

0091

A. No. We were discussing another patient so it was a passing comment.
Q. Did the two of you have any discussion about whether that use of steroids might have contributed to his condition in any way?
A. No.
Q. Did you form an opinion at that point as to whether his use of any type of steroids may have contributed to his condition, either pre-reduction or post reduction?
MS. : Did she have an opinion then?
Q. At that time when you spoke to Dr. and learned that he had some type of steroid use before.
A. It certainly -- that he was taking steroids and had these complications seemed to connect.
Q. What do you mean?
A. When she said he had been on steroids, I said, well, that seems to explain some of the problems that we

0092

encountered.
Q. Can you be more specific as to which problems you're referring to.
A. Some of the problems that he had with the -- with subsequent injuries which

I'm not as familiar with that didn't occur in the emergency room. I have limited knowledge of the rest of his course outside the emergency room.

Q. Again, I'm only asking about your knowledge and I only want to know, did you form an opinion at the time that you spoke to Dr. -- a day or two, whenever it was that you spoke to her after he's out of the emergency room -- whether the information you got about his steroid use caused or contributed to any of the conditions that you observed while he was in the emergency room.

A. It probably contributed to the size of the musculature of the patient which contributed to the difficulty in reducing the shoulder.

Q. You're saying that whatever

0093

steroids he was taking bulked him up and increased the size of the muscles?

A. I'm saying it contributed. I didn't ask for the specifics as to the steroid use. We were not discussing him in depth.

Q. I understand. I just want to know of your opinion at that point.

A. Okay.

Q. Has your opinion changed up until the present time regarding whether any steroid use may have caused or contributed to his condition that existed during the time that you were treating him?

MS. : Note my objection. I think what she thinks now is irrelevant and may be influenced by things we've talked about. That may not be a fair question because it encroaches the attorney-client privilege.

Q. How long does it take for someone who takes anabolic steroids to

0094

develop large muscles from the steroid use?

A. It depends on how much you're working out.

MR. : Forever if you're not working out.

A. You can take steroids all day long if you don't go to the gym and take the steroids.

Q. Can you tell me, does it take a

few days, does it take a week, a month, a year? Give me some idea how long it takes.
A. If you take a shot of steroids today, you would not be a muscle man tomorrow.
Q. Is there any other method to injection or take anabolic steroids other than an injection?
A. Yes.
Q. How?
A. Pills.
Q. Let's talk about compartment syndrome.

What are the clinical findings that you observe on an examination when there is a compartment syndrome?
A. There are the five P's of compartment syndrome which is pallor, pain, paraesthesia, piokothermia (sic).
Q. Spell it, please.
A. P I O K O T H E R M I A. Basically a cold hand. And pulselessness.
Q. How do you treat a compartment syndrome once you make the diagnosis that the patient has it?
A. The patient needs -- if it's severe enough, the patient needs to go to the emergency room and have a fasciotomy.
Q. Are there times when you will obtain compartment pressures?
A. Not generally in the emergency room, no.
Q. Are you aware of a procedure or something that can be done to actually take the pressures within the particular compartment?
A. Yes, but if you diagnose

compartment syndrome in the emergency room, the patient would be admitted.
Q. Did Mr. have any evidence of compartment syndrome in his left upper extremity in the emergency room before the reduction was done?
A. Did he have the five symptoms of compartment syndrome? No.
Q. Did he have evidence of compartment syndrome in his left upper extremity in the emergency room after the reduction had been done?
MS. : At any time after?
MR. OGINSKI: While he still remained in the emergency room.

A. Not of the five symptoms that we look for.
Q. Do you recall specifically as to whether he had any of those five symptoms post reduction?
A. When the pulse seemed to be a little less than the other arm, there was some concern and we watched him. We had applied some ice to see if we could

0097

decrease some of the swelling of the shoulder area, which I think is documented in one of the nurse's notes, and discussed if this was something that continued, we needed an MRI and would have to consider aggressive treatment and vascular would be involved.
Q. Am I correct that he did experience pain post reduction?
A. Everyone has pain post reduction.
Q. At any time while the patient was in the emergency room, was there ever any evidence of compartment syndrome in his right lower extremity before he had the reduction to his left shoulder?
A. No.
Q. Was there any evidence of a compartment syndrome in his right lower extremity in the emergency room post reduction?
A. I would not have checked.
Q. At any time while you cared for Mr. , did you ever observe any

0098

evidence at all of any compartment syndrome in his right lower extremity?
MS. : Can I hear that back, please.
(Whereupon the requested portion was read back by the reporter)
A. No.
Q. In your career, Doctor, have you ever seen or treated a compartment syndrome in an upper extremity?
A. Yes.
Q. How many times?
A. Maybe three or four.
Q. Are you licensed to practice medicine in the State of New York?
A. Yes.
Q. When were you licensed?
A. In 2000.
Q. Are you licensed anywhere else?
A. No.

Q. Has your license ever been suspended?
A. No.
Q. Has your license ever been revoked?
A. No.
Q. Are you Board certified in emergency medicine?
A. No.
Q. Have you ever applied to take your emergency room Boards?
A. No.
Q. I notice you are Board certified in internal medicine; right?
A. And osteopathy.
Q. And what is the board name for the internal medicine?
A. American Board of Internal Medicine.
Q. And in order to become Board certified with that board, did you have to take a written and an oral examination?
A. It is a written exam only.
Q. Did you have to take that exam more than once?
A. I took that exam twice.
Q. And when did you become Board certified in certainly medicine?
A. .
MR. : ?
THE WITNESS: Yes.
Q. And when was the first time that you took the exam for the Board certification?
A. .
Q. And the diplomate in osteopathy, what is the organization that governs that?
A. American Osteopathic Association.
Q. And in order to become a diplomate in that organization, do you need to take a written examination?
A. It is a written completion of training designation.
Q. So once you complete the training requirements, you automatically receive the diplomate in osteopathy?
A. If you completed them satisfactorily.
Q. You don't have to take any additional examinations or tests; correct?

A. It's during the training.
Q. Hands-on clinical training; correct?
A. It's a clinical training.
Q. When did you receive that diplomate of --
A. 1997.
Q. Do you have any publications to your name, Doctor?
A. No.
Q. Have you given any lectures to any national body of physicians at any national organizational meeting?
A. No.
Q. Have you ever testified before?
A. No.
Q. This is the first time testifying in your career?
A. Yes.
Q. Have you ever reviewed records as an expert either for a patient or on behalf of a hospital or a doctor?
MS. : As an expert witness, he's asking.

0102

A. Not a peer review?
Q. No.
A. No, not as an expert witness, no.
Q. Currently in your work at Medical Center, other than as an attending emergency room physician, do you have any other title or what you're known as, any academic title?
A. No, I'm an attending.
MS. : A faculty appointment, he means.
A. We're not affiliated with a medical school.
Q. When you were at from 2004 to 2006, did you have any academic title or faculty appointment?
A. Just attending.
Q. Were your privileges at ever suspended?
A. No.
Q. Were they ever revoked?
A. No.
Q. At any of the hospitals you

0103

worked for before , had your privileges ever been suspended?
A. No.
Q. Ever been revoked?

A. No.
Q. Did you learn from any doctor at , while the patient was still there in September of , that he had undergone a shoulder fasciotomy on September 8?
A. No.
Q. Other than reviewing the patient's chart in preparation for today, did you review any deposition testimony given by Mr. ?
A. No.
Q. Did you ever have a conversation with a Dr. , the orthopedist, about any treatment he rendered to Mr. ?
A. No.
Q. Did you have any further conversation with Dr. , other than the one you told me about, about any care or treatment that was rendered to Mr.

after leaving the emergency room?
A. No.
Q. Before doing the reduction --
A. Yes.
Q. -- you told me that you observed circumferential swelling around the shoulder; correct?
A. He had circumferential swelling around the upper extremity and interior fullness of the shoulder.
Q. Can you characterize the amount of swelling that you observed?
MS. : Meaning like how wide?
Q. Can you describe it in any other way other than telling me he had swelling?
A. It was visibly larger than the other arm.
Q. Was Mr. right-hand dominant or left-hand dominant?
A. I don't remember. I would have to review all my notes.
Q. You mentioned that ice was applied after the reduction?

A. At one point when there was still some swelling, ice was applied to the area anteriorly.
Q. And was ice applied before reduction as well?
A. I don't remember.
Q. Would it be good practice, in light of Mr. findings and the diagnosis of a shoulder dislocation, to

apply ice?
MR. : Objection to form.
MS. : Note my objection as well.
A. Every patient is different.
Q. In this particular case, would it be acceptable to apply ice to the affected shoulder?
MS. : Over objection you can answer.
A. The injury was already two days old so the effect of ice on an older injury is less so it would have minimal effect.
Q. Was Mr. coherent after

0106

the reduction procedure?
A. After the reduction procedure, he was able to talk but not as coherent as before. He was sedated still with the medications that we had given him so that he would not experience the reduction.
Q. Am I correct he was also given morphine following the procedure?
A. Yes.
Q. And how would you describe --
MR. OGINSKI: Withdrawn.
Q. Morphine is a narcotic pain reliever; right?
A. Yes.
Q. Is there anything stronger than morphine in terms of pain relief?
A. There are some -- it's a subjective things. Fentanyl and morphine are both narcotics. Depending upon the dose that you give, they could have the same effect.
Q. At what point was --
MR. OGINSKI: Withdrawn.
Q. Did you make the decision to

0107

order an MRI for this patient?
A. It was in conjunction with the orthopedist.
Q. With Dr. ?
A. Yes.
Q. And describe for me the discussion that occurred leading to that decision that he needed an MRI.
A. I was concerned because there wasn't more improvement in the function of his arm and wanted to be able to take a closer look at the musculature of the arm. I think I put a note in that I was concerned about rupture of the bicep

muscle.
Q. What made you think that?
A. He still had considerable amount of discomfort in the upper extremity with the swelling and it's one of the -- the tendon of the bicep muscle is one of the tendons that can be affected with a shoulder dislocation and alteration of the area.
Q. Was there any time emergency

0108

associated with the request of the MRI?
MS. : Note my objection to form.
You can answer over my objection.
A. It's an emergency request procedure to be done as soon as can be done.
Q. The MRI that the emergency room patients would use, is that the same device, the same MRI machine that is used for patients throughout the hospital?
A. Yes.
Q. Do emergency room patients take priority for other patients that may be waiting for other imaging studies from other areas?
A. Unless the patient from the other area has a more critical life-threatening diagnosis, such as an acute hemorrhagic CVA that the patient is likely to die from it if they don't get some form of treatment, that would take precedence over the ER. Otherwise the

0109

emergency room generally gets some accommodation as a priority.
Q. Who makes the decision as to which patients get their imaging studies on a priority? Is it the radiologist, is it a technician, who makes that decision?
A. I'm not exactly sure. I don't have access to the other patients' requesting so I don't know if it's the radiology himself, if it's the radiology resident. I'm not sure.
Q. What was the purpose of obtaining post-reduction x-rays?
A. To ensure that the humeral head had -- was well placed, to ensure that there wasn't a humeral head fracture or any other type of fracture that can be associated with reducing a joint.
Q. Did you personally review the

x-rays pre and post reduction?
A. Yes, I did.
Q. In addition to your review of them -- by the way, were they on the computer or actual films?

A. I don't remember.
Q. Did the orthopedic resident also review them and discuss them with you?
A. Yes.
Q. Did a radiology resident review them and discuss them with you?
A. I don't believe so.
Q. Was it Dr. who reviewed those films as well?
A. Yes.
Q. Can you tell me, over the course of your career, on how many patients whom you have diagnosed a shoulder dislocation and performed a reduction you've ordered a follow-up MRI on.
A. This is the first one. I have suggested patients get them for follow-up through their doctor for non-urgent suspected rotator cuff injuries though.
Q. You had given me a time that the patient came into triage.
What time was that?
A. 11:25.
Q. And was he brought in by

ambulance or did he walk in?
A. He walked in.
Q. What time did Mr. remain in the emergency room until the following day?
A. I don't know. My shift ended at eleven, I left around midnight, and he was still there at midnight.
Q. Of September 7?
A. Yes. I stayed specifically to disposition Mr. .
Q. Tell me what you mean by disposition him.
A. He was being observed because there was concern in the emergency room and to decide whether he was going to be admitted to one service, another service, or just be observed for twelve hours had not completely been decided yet. When I got the MRI results, the decision was made to admit to the orthopedic service so he could continue to have observation because we were still concerned.
Q. When you were leaving that

0112

evening, what was your understanding as to what service he would be going onto?
A. Orthopedic.
Q. And had they actually made the transfer by the time you had left that evening?
A. I stayed to ensure that that got done.
Q. At the time that you left, as far as you know, he was transferred to the orthopedic service?
A. I know he was.
Q. Am I correct that he still remained in the emergency room under the orthopedic service for a period of time?
A. When there's not a bed available, patients stay in the emergency room.
Q. When was the next time you returned to the hospital for your next shift?
A. I don't know. It would not have been before 1:00 the next day.
Q. Do you know Dr. ,

0113

?
A. Not personally.
Q. Do you know or have you ever talked to him about Mr. ?
A. No.
Q. Do you know a Dr. , ?
MS. : Do you know who he is?
A. No, not personally.
Q. I'm just asking if you know them from .
A. They're attendings at .
Q. Did you ever have any conversation with Dr. about this patient?
A. I don't believe so.
Q. Do you know Dr. ?
A. I know who he is.
Q. Who is he?
A. He's one of the vascular surgeons.
Q. Did you ever have any

0114

conversations with Dr. about Mr. ?
A. I don't believe so.

Q. How about a doctor named ,
, ?
A. I don't recognize the name.
Q. Dr. ?
A. I don't recognize the name at all.
Q. Do you know a Dr. ,
?
A. I'm not sure. I don't think so.
Q. Do you know a nurse by the name of ?
A. I'm not sure.
Q. Do you know a nurse by the name of ?
A. She was one of the emergency room nurses.
Q. And from your review of the notes, did you see that she made entries in the patient's chart?
A. I wouldn't know exactly who made them. A few of the initials I recognize

but they're not the person's name, it's just three initials.
Q. Do you have any memory of having any conversations with Nurse about Mr. ?
A. I don't remember a specific conversation with the nurse.
Q. Was it your custom, Doctor, that after you read and you reviewed a patient's lab work, you would make a note indicating that you had read it or some type of check mark or something on the computer indicating that you had read that?
A. I don't think that there's anything that check marks if you looked at it or not.
Q. If you had read a patient's lab, would you have made some indication that you would have looked at it?
MS. : You're talking about would she have made an entry in the computer?
MR. OGINSKI: Yes.

A. I don't think that there's a place for you to make an entry for that. Yes, it was reviewed.
Q. Did you see, on anything, that the patient's hemoglobin was noted to be 11.8?
MS. : Did she see that then or now?

MR. OGINSKI: No, at the time.
A. Yes.
Q. And is that hemoglobin level, is that normal for a twenty-nine year-old?
A. It's slightly decreased but it's not a critical level.
Q. Does it have any medical significance, that finding, in and of itself?
A. It's not critical enough to cause me immediate emergent concern.
Q. What would a significantly abnormal hemoglobin suggest to you?
A. If it was significantly decreased, I would think of a few things. He was African-American, I would be

0117

concerned about sickle-cell anemia, I would be concerned about internal bleeding, I would be concerned about any other chronic illnesses, like chronic renal failure, anyone who has an infiltrating bone disease that cause you not to make enough blood, anybody who's a chronic drinker. I mean, there's probably several hundred diagnoses if it was low enough to be significant in the emergency setting.
Q. And what range would you consider to be low enough to be considered significantly decreased?
A. If he had a hematocrit below thirty, I would have been concerned enough to start some emergency investigation into it.
Q. And how about hemoglobin?
A. Hemoglobin is generally a third of the hematocrit, so ten.
Q. What was Mr. 's ethnicity?
A. African-American.

0118

Q. Going back to the post-reduction x-rays that you reviewed, am I correct that those showed good alignment?
A. Yes.
Q. Can you view a hemorrhage on an x-ray?
A. If there's a very large hemorrhage in the joint space itself, you may be able to see that.
Q. And if it's outside the joint, are you able to on an x-ray?
A. It's very difficult to see.
Q. With an MRI, are you able to

view a hemorrhage or a fluid collection?
A. The radiologist would.
Q. Is it possible to visualize it using an MRI?
A. That was one of the -- that, looking for the muscle, and looking to see if there was anything that was torn, is one of the reasons that we did the MRI.
Q. Is there --
MR. OGINSKI: Withdrawn.
Q. Are you aware if a radiologist

0119

can distinguish between a fluid collection from a hemorrhage on an MRI?
MS. : Note my objection to the form.
You can answer.
A. It depends on how old it is. I mean, the intensity is different for different substances and so you can tell the difference between water and blood. If it's a cyst that's mostly filled with serosanguinous fluid, then it would look different than something that was filled with pure blood.
Q. There was a note identified that the timing was at 2:00 p.m. which would be 14:00 showing that at that time the patient had a normal pulse but weak intrinsics.
Do you recall seeing a note about the weak intrinsics?
A. That I believe was on the consultation note that Dr. wrote which was written after 2:00 p.m.
Q. Do you know what the weak

0120

intrinsics refer to, are they hand muscles or something else?
A. They're finger movements.
Q. Was there any discussion as to why the patient might be experiencing that particular weakness?
MS. : Did she have any discussion with Dr. about that?
MR. OGINSKI: Yes.
A. No.
Q. I'm going to jump back to pre-reduction.
Did you perform any opinion, after you saw and examined Mr. but before doing the reduction, as to whether he had any evidence of any axillary artery damage?
A. The only conclusion you can make

from the physical exam is that his arteries were patent enough to create a good radial pulse which would be approximately a pressure of ninety. He had again significant swelling so I would not be able to feel pulsation in the

0121

axillary area.

Q. Did you form any opinion as to whether he had any evidence of nerve damage pre-reduction?

A. He had -- the axillary nerve, he had evidence of sensation.

Q. I'm sorry, you said there was or there was not evidence?

A. There was evidence of sensation from the axillary nerve.

MS. : Can I hear the question back.

(Whereupon the requested portion was read back by the reporter)

A. There was evidence of sensation. That's all I can comment on.

Q. And the fact that there was evidence of sensation, were you able to tell whether there was a diminishment in sensation?

A. It's difficult to tell because he was in pain.

Q. And were you able to form an opinion pre-reduction whether there was

0122

any vascular damage?

A. I think we answered that. He had a good brachial pulse which means there had to have been a pressure of at least approximately ninety.

Q. At the time that you got off your shift at 11:00 or 12:00 p.m. and left the hospital, had you contacted the radiology department to determine whether an official read was done on the MRI?

A. I had talked to the orthopedic -- to the radiology resident that was on call to confirm what Dr. had told me.

Q. Was there any discussion with the radiology resident about hematoma?

A. We asked if there were any masses and did the vasculature look good, was there muscle tear, and any significant tendon damage.

Q. And the response was what?

A. That there was -- the significant finding was soft tissue

swelling --

Q. What page are you on?
A. Page seventeen.
Q. You're looking at the note on the top timed at 23:28?
A. Yes.
Q. That you read already; correct?
A. Right.
Q. And under diagnosis, after dislocation of the shoulder anterior left closed, you wrote edema.
A. Yes.
Q. Are you able to recall how --
MR. OGINSKI: Withdrawn.
Q. Can you characterize the amount of edema that was present at that time?
A. The left arm was larger than the right arm.
Q. Any other way to characterize it?
A. The left arm was larger than the right arm. I mean, it visually was larger than the other arm.
Q. Can you what you observed at that time at 11:00, 11:30

d to pre-reduction earlier in the morning?
A. There was no decrease in the swelling which was concerning which is one of the reasons he was admitted.
Q. Was there more swelling than what was originally seen when he presented to the emergency room?
MR. : That was asked and answered. I'm not objecting, I'm just noting that we've been over this.
MR. OGINSKI: Off the record.
(Whereupon a break was taken)
Q. Doctor, did you ever become aware that, when the MRI had been ordered and attempted, Mr. was unable to complete the MRI because of the bulk of his shoulders, he couldn't fit in the machine?
MS. : During the time that she was in the hospital?
MR. OGINSKI: Yes.
A. We had questioned whether he would fit in the machine originally

because there is a size and weight limit of the MRI. I was not aware that there

was a problem upstairs.
Q. Did you ever learn from any doctor at Medical Center that the official read of the MRI images were different than the preliminary interpretation by either the radiology resident or the orthopedic resident?
A. No.
Q. Did you ever review the official radiology report for the MRI that was taken in the emergency room?
MS. : At what point, during the treatment?
A. This morning.
Q. At any point before this lawsuit was started?
A. No.
Q. When the patient was admitted for overnight observation, who decided how frequently neurovascular checks should be done?
A. Once they're admitted, the

0126

responsibility of care goes to the service they're admitted to.
Q. When they're in the emergency room, what is the frequency with which a patient is checked from a neurovascular standpoint?
A. Whatever's ordered by the admitting doctor.
MR. OGINSKI: Let me go back.
MS. : He's talking about while they're still in the emergency room before they're admitted into the service.
A. It depends on what the patient's problem is. If it's not something that is neurologic, it may be twice a shift.
Q. Did you specifically --
MR. OGINSKI: Withdrawn.
Q. Are there any rules or regulations for the hospital indicating how often neurovascular checks are to be performed?
MS. : In the ED?
MR. OGINSKI: Yes.

0127

A. I don't know if there's a specific policy for neuro checks for all comers.
Q. Did you specifically ask or enter an order or write an order that neurovascular checks should be performed on Mr. for any particular

frequency?
A. I didn't order specific, but he stayed in the resuscitation area which is only four beds, and I was in and out of the room every hour.
Q. Was this a cubicle or a contained room that had a door?
A. It's one room about twenty feet long with four open areas. The entrance is in the middle so there's two beds on each side when you enter the door and you can see all four beds from any point in the room.
Q. Was Mr. hooked up to any condition with us monitoring, like EKG?
A. Everybody in that room is hooked up to a monitor that does blood pressure,

0128

heart rate, pulse-oximetry, and rhythm.
Q. Does that information get stored anywhere in the patient's chart?
A. Gets stored in the machine that can be reviewed for any abnormalities. What's in the chart may be once an hour or once every two hours, but it generally checks -- most of those check every fifteen minutes a vital sign and it records on the machine.
Q. Is there a nurse's station, a central nursing area where, if you're at that nurse's area, you can visualize and observe all those beds?
A. The nurse's station was right in front of his bed.
Q. Is there a central monitoring station like a nurse's station where you can watch the EKGs and the pulse ox and everything else that he was on?
A. It's only a twenty-foot room, so you can see all those monitors from the nurse's station.
Q. In addition to that equipment,

0129

did the hospital have any type of video equipment that was monitoring that section of the emergency room?
A. I don't believe video would be allowed in the resuscitation area.
Q. I'm just asking if there was, if you are aware.
A. I don't think so.
Q. Did you ever have any conversation with any doctor at about whether the official reading of the MRI that was originally done in the

emergency room on 9/7 was read in a timely manner?
A. No.
Q. Did you -- now, I know you told me you don't recall the name of the radiology resident.
A. I don't.
Q. In reviewing this patient's chart, did you see any notations, any entries, from any radiology resident that might refresh your memory as to who it was you were referring to?

A. I did not review Dr. 's notes. I don't know if she did. I know she also spoke to the radiology resident. There's only one senior resident on per night.
Q. And in radiology, is there anything above senior resident?
A. I mean, there's attending.
MS. : Who's there at night?
THE WITNESS: No, not at night.
Q. Did you have any conversation with any attending radiology physician at any time while Mr. was in the emergency room from the time he arrived until the time you left at 11:00 or 12:00 at night?
A. No.
Q. Did you ever speak to any attending radiologist after September 7 when you left your shift that evening about Mr. and his MRI?
A. No. I wasn't aware there was a change in the reading.

Q. Doctor, I want to go back for a moment. We talked about steroids earlier and your knowledge of certain literature involving the connection between steroid use and other possible complications.
In any of the literature that you recall reading, did they address the distinction between short-term steroid use d to long-term steroid use?
A. The longer you use steroids, the more severe the effect.
Q. Let's turn, please, to the emergency room record which is marked as Plaintiff's 1A.
Starting with the triage note, the information that's obtained in triage, is that from a nurse or a PA or someone

else?
A. That's a PA.
Q. And it indicates that, "patient states on Monday this week he injured his left bicep while playing with a friend;" correct?
A. Yes.

Q. "Today swelling and pain worse to said arm?"
A. Right.
Q. And directly under that it says, "swelling noted to entire left arm. The patient also states he has a 'bump' under his left arm plus strong radial pulse."
What does that mean, about a strong radial pulse and a plus sign?
MS. : Note my objection. You're asking her to read an entry made by somebody else and to interpret it. I have a problem with that.
MR. OGINSKI: Fair enough. I'll rephrase it.
Q. Doctor, during the course of your function as an emergency room attending, do you, from time to time, review other people's entries in the patient's chart?
A. Yes.
Q. And when you review patients' entries, are you called upon to interpret and try to understand what it is they

wrote?
MS. : Note my objection to the form.
You can answer over my objection.
A. Yes.
Q. Looking at this particular note, can you tell me what it is it means to you?
A. The patient had abnormal swelling to the arm but it did not appear that there was significant vascular compromise at that moment.
Q. And a little further down it says, "pain scale, currently a ten over ten. Terrible pain to the left arm;" correct?
A. Yes. You'll also note that it says, "not taking any medication."
Q. Where do you see that?
A. It's also stating the patient told triage he's not taking any

medication.
Q. Turn, please, to page three of
eighteen.
At the top, the 12:07 note under objective data, whose note is that?
A. That's the nurse.
Q. She observes right shoulder --
A. That's a male nurse.
Q. Thank you.
He observes "right shoulder deformities evident with swelling to right shoulder and arm, faint radial pulse, color equal with noted warmth to right shoulder and arm?"
I read that right; right?
A. Yes.
Q. The fainted radial pulse, did you observe that when you examined him?
A. It's a subjective thing. You may feel that it should be stronger. He's a young, healthy-looking guy. He had a radial pulse. I can tell you that this particular nurse was looking to see if there's signs of compartment syndrome; he's a well-trained nurse which is why he wrote color equal and that the shoulder was warm. Because those are two things that you would be looking for that the patient did not have.
Q. And what's the name of this nurse?
A. .
Q. Do you know the first name?
A. I think is the first name.
Q. Do you know the last name?
MR. : Off the record.
(Discussion held off the record)
Q. Can you turn, please, to page four of eighteen.
And toward the bottom half of the page starting at 4:22, that would be a.m., correct, on 9/8/05?
A. Uh-huh.
Q. Is this a nurse's note, a nurse's observation?
A. I don't know who CCAF is. I'd have to look in the back. But I was no longer in the emergency room at that time.
.
Q. That's a nurse; right?

A. Uh-huh.
Q. Doctor, under the 4:22 a.m. note for 9/8, it indicates left arm swollen and then it has three plus signs. "Patient unable to close fingers in pulse-oximetry readings similar to right hand. Patient medicated for pain, morphine, five milligrams IV."
This observation about left arm swollen with three plus signs, what, if anything, does that mean to you?
MS. : Note my objection.
You can answer over my objection.
A. The three plus signs doesn't mean anything. Plus sometimes means positive. She may have meant to hit it just once. The pulse-oximetry reading similar to the right hand means that she still was able to get a pulse good enough.
Pulse-oximetry picks up oxygen through hemoglobin concentration picked up in pulsation in the finger, so she was

0137

letting you know that he had difficulty closing the hand but you could still pick up a pulse-oximetry reading, meaning that there was an adequate flow to the fingertip.
Q. The three plus signs, could that also represent her as to the extent of the swelling that she observed?
A. I don't know.
MS. : Again, note my objection.
A. I don't know.
Q. At the time that you left Mr. on the evening of 9/7, was he able to close his fingers, he was able to move them?
A. He was able to move his fingers. He had some difficulty completely closing his hand because of pain in the arm.
MS. : This is before reduction, you mean?
THE WITNESS: Uh-huh.
Q. Did he also have that post reduction?

0138

A. He had swelling in his arm. Your arm interacts completely, everything is connected.
Q. But I'm asking specifically did he make any observation post reduction about whether he was able to close his

hand, his left hand?
A. "He was able to flex his fingers fifty percent but not fully closed." Page eight.
Q. What time are you referring to?
A. This was the initial exam.
Q. I'm talking now about post reduction.
A. I'm giving you the baseline.
Q. Sure.
A. There is some timed intermittent notes.
At 15:47 on page sixteen he was able to move his fingers.
Q. Is that different than being able to make a closed fist?
A. He was sedated at that time and so my comment to move the fingers meant

that -- your following instructions and your ability to do things when you're sedated is different than when you're fully awake. I was documenting that he was able to move his fingers. And you can note it's very clearly -- you asked me before about the nurses being able to observe him. On page three, "call light is not needed because the patient is visible to the nursing staff."
Q. Is Dr. still affiliated with ?
A. I don't know.
Q. Have you had any conversations with Dr. about this patient?
A. No.
MS. : You mean after he left the hospital?
MR. OGINSKI: Yes.
Q. Going back to your history of present illness on page seven, you indicate that, on the third line, that he is unable to fully close his hand into a fist because of pain in his arm; correct?

A. That's what he told me.
Q. In the first line, you indicate that he has a history of lifting a person over his head Monday?
A. The reason I wrote the word "person" is because he had given me multiple different stories.
Q. "Felt pop and pain in the left shoulder but thought he pulled a muscle;" correct?
A. Right.

Q. What were the other stories that he mentioned that he told you other than this one?
A. You know, he had gone to the gym. He told me at one point he lifted his niece over his head, then he had some altercation with a friend. I understand he told Dr. another story, also. Since the story was not completely consistent but lifting seemed to be the more consistent portion of it, I put lifting person since I don't know if it was the friend, the niece, or something

that was done at the gym.
Q. Were you any more specific in any other part of your notes about these different versions he gave to you, about lifting his niece, going to the gym, or an altercation with a friend?
A. Do you mean in stating that he was inconsistent?
Q. Yes, other than having this line in the --
A. I remember specifically he gave several stories.
Q. Other than remembering the information you just told me, do you note it anywhere here in the patient's chart about those different stories that he told you?
MS. : Note my objection to the form.
You can answer.
A. I don't believe that I documented it, no.
Q. If another doctor is -- say a doctor in the emergency room is looking at

the patient's chart, is there any way for him to know, without talking to you, about these different stories that he described to you about how the injury occurred?
A. If he reads the various doctors', PAs', and consultants', there's inconsistency in what he said on their description of the incident, also.
Q. I understand that but I'm asking specifically, looking at --
A. From mine?
Q. Yes, is there any way to see any inconsistencies?
A. I don't think so. I'd have to review each of my notes, but I don't think so.

Q. Turn, please, to page eight.
Under your exam of his left shoulder, you observed the patient had muscle spasm?
A. Yes.
Q. And you also observed -- again, I'm taking excerpts out of your note -- he had limited motion, thirty percent of what

0143

would be normal or expected?
A. Of the elbow.
Q. And was that part of the pain that he was experienced from the shoulder?
A. When I got to thirty percent of what would be expected, he did not want me to continue because of the pain. That was passive. Passive means I'm moving him.
Q. Was he --
MR. OGINSKI: Withdrawn.
Q. Was he actively able to move his elbow?
A. He did not want to because of the pain, which is why I tested it passively.
Q. Did you ask Mr. what medications, if any, he had taken for the pain before arriving in the emergency room?
MS. : Objection. Asked and answered.
You can answer again.
A. He stated that he didn't like to take medications. And in fact, when I

0144

asked him why it took so long for him to come to the emergency room, he stated that he doesn't like hospitals, doctors.
Q. You continue on by saying, "radial pulse palpable with no NS deficit in hand."
What is NS?
A. Neurosensory.
Q. "Good capillary refill. Able to flex fingers fifty percent but not fully closed due to pain in upper arm;" correct?
A. That's right.
Q. Now, you made a separate observation that his hand was not swollen.
Why was that important to you?
A. Because I was evaluating for compartment syndrome.
Q. And if he had a compartment syndrome in the upper extremity, would you have expected to see swelling in the hand?
A. I would have expected to see

some sign in the hand.
Q. And when you say, "some sign," any one of the five P's you were referring
0145
to?
A. I would have expected to see some signs in the hand that there was a compartment syndrome above that.
Q. How many compartments are in the upper extremity?
A. It depends on what you're talking about. There's vascular, there's muscular --
MR. OGINSKI: I'll withdraw the question.
Q. Can you turn, please, to page nine.
In the second entry, there's a cancellation that appears for the MRI of the shoulder.
Do you see that?
A. Yeah.
Q. Tell me what that means, what this entry means.
A. It was a duplicate order. It was ordered twice. If we were to leave two orders in, there's a possibility that it A, would either get done twice or he
0146
would get billed twice. We cancelled duplicate orders so it's less confusing for people reviewing the chart.
Q. Directly underneath appears to be orders made by Dr. .
A. Yes.
Q. Do you have a memory of talking to Dr. about these orders that she wanted to have done?
A. Dr. , once she admits the patient, doesn't review her orders with me, she reviews them with her attending.
Q. In this particular case, were you present for any discussion she had with any doctor about the orders that were to be done for this patient?
A. No.
Q. Under the fourth order, it says, "inform M.D. change in neuro status."
A. Yes.
Q. What does that mean to you?
MS. : Note my objection.
You can answer over objection.
A. It's a very broad -- if a
0147

patient is having any change in sensation of an extremity, unable to move an extremity, it also means the alertness of a patient. If you're unable to wake a patient, he seems confused, acting bizarre.

Q. For whose benefit are these orders for? In other words, who are they directed to?

A. They're for the benefit of the patient, but they're directed towards the nursing staff.

Q. Toward the bottom of the orders it says, "neurovascular checks Q2H."

Is that every two hours?

A. Yes.

Q. And what is done when somebody does a neurovascular check as indicated in this particular order?

MS. : Note my objection. You're asking her now about orders that are directed at nurses not in her area on a service.

MR. OGINSKI: I'll rephrase it.

0148

Q. Are there occasions when you will order neurovascular checks on your patients?

A. Yes.

Q. If you order them to be done every two hours, what is it you expect to be done during those neurovascular checks?

A. There needs to be a palpable pulse and adequate color to the area that's being checked which would give me an idea of the vasculature's function and there need to be some evaluation of movement and sensation in the area that's being checked.

Q. And if a nurse had done that neurovascular check, would you expect to see a notation somewhere in the chart indicating that the nurse had actually done that and recorded the findings?

A. It depends on how busy the nurse was. If, as is seen in the emergency room, if you're busy with something else critical and you can do a neurovascular check in less than five minutes but you

0149

have to go back to a critical patient, you may not document it at the time that you did the neurovascular.

Q. We understand that emergency rooms can get busy.

If you want to patient to be checked, their neurovascular status to be checked every two hours and a nurse actually does check it, at some point, not immediately, would you expect to see some note about that check at some point in time?

MS. : Note my objection.

You can answer over my objection.

A. I'm not sure how the nurses document it since I'm not a nurse. I would expect, if I need to go back at some point during the shift, there should be something noted on that shift.

Q. Do you have an opinion again within a reasonable degree of medical probability that if there's no documentation about a neurovascular check

0150

that was done as to whether that complies with any standards of either the hospital or for good medical practice?

MS. : Note my objection.

We're talking about what's done in the ED while she's there?

MR. OGINSKI: Yes.

MS. : Not this particular case because these orders are written afterwards?

MR. OGINSKI: That's absolutely right, just for her in the emergency room at .

MS. : Over objection, you can answer.

THE WITNESS: Can you repeat that question?

(Whereupon the requested portion was read back by the reporter)

MS. : I have an objection to the way you phrased it.

MR. OGINSKI: I'm going to change it.

Q. Can we agree that there are

0151

times when a nurse will obtain let's say vitals and, for whatever reason, not make a note of it in the chart?

MS. : Generally speaking?

MR. OGINSKI: Yes, generally.

A. Of course.

Q. And there are times when a nurse may not obtain vitals for a particular patient, for whatever reason, even though

there may be an order to do so on a frequent basis?
MS. : Note my objection.
MR. OGINSKI: I'm just setting up a --
MS. : I understand. But you're asking her to assume that maybe something happens that she maybe doesn't have experience with. I don't think it's a fair question.
Q. Are you familiar with the nursing protocol as to the documentation for documenting neurovascular checks?
A. I don't know what the nurses'

protocols are.
Q. Are there written protocols in the emergency room for the frequency with which documentation should be made for neurovascular checks?
A. I don't know if there's a written for documentation, but certainly in an emergency room it's not always feasible to make it to a computer to log on to get into a chart to make a note of something that you did when there's other emergencies going on.
Q. And would you expect, Doctor, that at some point after those emergencies are taken care of that the nurse would then at some point later on make a notation about what it is they observed?
MS. : Note my objection.
I think you are putting in an assumption that the emergencies are taken care of. It's an emergency room that patients are coming and going all the time.
A. This is New York City, there's

always an emergency.
Q. Can you turn, please, to Dr. 's handwritten note. It's part of I guess her history and physical for admission.
A. Uh-huh.
Q. Does the note indicate when this history and physical was done?
A. This only indicates the time that she wrote the note.
Q. And what time is that?
A. Midnight.
Q. Were you present for any part of her examination of the patient?
A. She assisted in the reduction of

the shoulder. She examined the patient before assisting in the reduction.

MR. : Doctor, where are you getting the midnight from?

THE WITNESS: On the very last sheet. It says 00:00.

MR. : I thought that was a 01:00.

MS. : I thought that was

0154

a pre-drawn line. It's not completely clear. It's either midnight or one.

A. Not at 12:30 when she saw the patient.

Q. Let me ask you to turn, please, to the request for consultation for ortho dated September 7, also a handwritten note by Dr. .

At the top of the notation it's timed at 14:00.

Is that the time of the consultation or it was requested?

A. That's probably the time she was able to sit down.

Q. And there's also a notation with an arrow to the left indicating if:00.

A. That's probably when she was able to come back and complete it.

Q. In the middle of the page there are certain findings and it says in the middle, "patient seen initially after ED attempted reduction."

A. Uh-huh.

Q. Duplex arterial is to the right

0155

of that. And it says, "patient not responding to verbal stimuli;" is that right?

A. Yes.

Q. Was that when the patient was sedated post reduction? Can you tell from this note as to --

MS. : Over objection, you can answer.

Q. -- when in time this occurred?

MR. : When what occurred?

MS. : Not responding to verbal stimuli.

Q. "Patient not responding to verbal stimuli after anesthesia for adduction left shoulder."

MS. : We don't know that's all the same.

What specifically do you want to know?

Q. Let's go down to the middle of her note under assessment and plan, number one.
Does that say, "follow-up this

week with Dr. or ortho clinic?"
MS. : Over objection, you can answer.
A. A consultation is a consultation at their suggestion. The decision was made not to discharge the patient.
Q. I'm just asking if that's what it says.
MS. : If you know.
A. It looks like that.
Q. Did you see this written note at any time before you left the hospital?
A. No.
Q. At the bottom it says, "discussed with attending."
Do you know which attending it refers to? Would that be the orthopedic attending?
MS. : Again, note my objection.
You can answer over objection.
A. I would assume, since the attending that signed it was an orthopedic attending, that that's who she's talking

about.
Q. And that's Dr. ?
A. That's what it looks like.
Q. Did you have a conversation with Dr. on the seventh while you were still in the hospital?
A. No.
Q. Let's go back, please, to her history and physical examination.
Does Dr. 's note under the procedure of where at the top it says, "additional studies," it says, "procedure."
MR. : What page are you on?
MR. OGINSKI: It looks like this (referring).
Q. Does she make any notation in this note about the multiple attempts to reduce the shoulder?
MS. : Right there specifically?
MR. OGINSKI: Yes.
A. Under additional studies?

Q. Yes.
A. Not under additional studies.
Q. That was my next question.
Is there anywhere else in this history and physical note that she documents the multiple attempts for reduction?
A. She --
Q. I'm not talking about the consult, I'm just talking about the history and physical.
A. On that particular piece of paper, no.
Q. Or anywhere in the multiple pages of history and physical.
A. She alludes to it in the history of present illness.
Q. Where?
A. After "initial attempt to relocate shoulder." That implies there was more than one attempt.
Q. But that is singular, there's no plural there; correct?
MS. : We're splitting
0159
hairs. You're asking her to interpret and get into somebody else's mind. It says what it says.
Q. Doctor, in her consultation note, is there anything that relates to or indicates more than one attempt at reduction?
A. Yes.
Q. Where?
A. The "ED attempted reduction" and then "after reduction of the left shoulder." Again it implies if the ED attempted reduction and then it was subsequently reduced, there had to have been at least another attempt.
Q. Does it indicate anything more than that or the multiple attempts that were made?
MS. : Specifically here does it say that. That's all he's asking.
A. No.
Q. Before today, did you ever review the orthopedic attending note dated
0160
September 8, at 12:30 p.m., that's Dr. 's note?
A. No.
Q. If a nurse --

MR. OGINSKI: Withdrawn.
Q. Are there any notes contained on this page, page four, which appears to be nurse's notes, that any physician saw Mr. from 21:18 until 4:22 a.m.?
MS. : Can I hear the whole question back, please.
(Whereupon the requested portion was read back by the reporter)
MS. : He's asking does it say that or is there --
MR. : 21:18 until what?
MR. OGINSKI: Until 4:22 the next day.
A. Not on this page, no.
Q. On September 7 at 21:18, the information that's contained in this assessment, this nursing assessment here, is that a neurovascular assessment?
MS. : Where are you

0161

looking?
MR. OGINSKI: The 21:18, the three lines beginning with "assessment, neurological."
MS. : Awake and oriented?
MR. OGINSKI: Yes.
MS. : What are you asking?
MR. OGINSKI: Is that considered to be a neurovascular check.
A. That is a form of neurovascular check. There is neuro and vascular included in that assessment.
Q. When is the next neurovascular documented observation?
MS. : That's documented?
MR. OGINSKI: Yes.
A. 4:22.
Q. And is that also what you would consider to be a form of neurovascular check?
A. It is a form of neurovascular check.

0162

Q. And at the very bottom there's a notation also timed at 4:22, it says, "still awaiting bed for admission;" correct?
A. Yes. That's a physical bed.
Q. Did you see Dr. come in to see Mr. on September 7?
A. No.
Q. Do you know Dr. ?

A. I don't know what he looks like. If he didn't introduce himself to me, he may have been in the emergency room. I don't know if he was seeing someone else or not. I don't know what he looks like.
Q. Let me ask you, going back to Dr. 's history and physical under procedure, it says, "post procedure, patient initially able to weakly flex fingers."
Does that mean open the fingers?
A. Yes.
MS. : Note my objection.
She's testifying about what somebody else wrote.

Q. It says, "extrinsics weaker than intrinsics."
What is that referring to?
A. Spreading the fingers out.
Q. "Patient re-examined hours post procedure." There's an arrow. "Able to extend wrist EPL."
What is EPL?
A. It's her abbreviation for something.
Q. And it also says, "addendum, patient to be transferred to vascular service."
At the time you left the hospital did you ever learn from anyone that the patient was going to be transferred to vascular?
A. Not to my knowledge.
Q. There is a -- at the end of Dr. 's history and physical note, it says, "attending of record," it says , there's a slash and another name that appears there under case discussed with.

Can you recognize that name?
A. I don't recognize it.
Q. Did you ever learn from any doctor at that Mr. was diagnosed with a compartment syndrome in his right lower extremity?
A. No.
Q. Did you ever learn from any doctor at that Mr. was diagnosed with an axillary sheath hematoma?
A. No.
Q. Or that he had a compartment syndrome in his left upper extremity?

A. No.
Q. Were you present for any type of rounds or any discussion about Mr. given by any other physician during any teaching rounds?
A. No.
Q. Now I'd like you to take a look, please, at the MRI official interpretation which is a computer-generated document with a time of September 8, -- a date

0165

of September 8 and a time of 15:51.
MS. : You're looking at the MRI now?
MR. OGINSKI: Yes.
Q. Based upon this particular note which apparently says, "interpreter ," are you able to tell when this report was generated? In other words, what I want to know is does the 15:51 time refer to the time the entry was made?
MS. : If you know. Don't guess.
A. I don't know.
Q. Did you ever see these results relating to the official read?
A. Today.
Q. Do you recall any other conversations you had with Mr. after his shoulder was reduced and before you left for the night?
A. I had multiple conversations with him.
Q. Tell me -- I'd like to ask you about all of them. But, if you can, tell

0166

me what it is you discussed specifically; what it was you asked, what you said to him, and what he said to you over the course of the day.
MS. : In other words, go chronologically as much as you can.
A. At some point he asked me if we had fixed his shoulder. I told him we were able to put the bone back in place. I try to talk so that the patients can understand what I'm saying. But that his arm was still very swollen and we wanted to watch him to make sure that there wasn't anything else that we needed to be concerned about. There were other conversations during the course of the shift where I would go in and just check and see what his pain level was. I think there's a note at one point I gave him

some more medication. I would ask him how the arm was feeling. Clinical questions for the most part.

Q. When you performed this traction/countertraction in an attempt to

0167

reduce the dislocation, is it something that requires a lot of physical exertion?

A. You have to have traction, some mechanical force pulling on, and a countertraction, some mechanical force pulling away, so there is some mechanical force being exerted. I mean, we're not using enough force to break a bone, obviously, but you have very tight muscles holding a bone in a place where it's not supposed to be and you need to be able to move that back in place which requires some force.

Q. You need some strength in order to move it into position?

A. Yes.

Q. Did you ever form an opinion after the five attempts at reduction as to whether those attempts contributed or caused any damage to either an artery or a vein?

A. Not specifically. In general, reducing the shoulder assists in reducing the number of injuries that are going to

0168

continue forming versus the joint being still dislocated.

Q. I'm moving away from generally. Now I'm asking specifically in this case.

After you had finally managed to put the bone back into place, had you formed on opinion at that point as to whether those multiple attempts caused or contributed to an injury to the patient, where it be artery, nerve, vein, muscle, tendon as distinct from what he came in with?

A. There's always a risk that you can exacerbate injuries that are already there, but there could be some injuries that come from the reduction of the joint. That's one of the reasons we watch patients afterwards. I did not observe any specific injury after the reduction.

Q. Would it be fair to say then that your opinion was the multiple attempts at reduction, in your opinion, did not cause or contribute to any further injury or damage?

0169

A. I wouldn't be able to say that either.
Q. Did Dr. tell you whether she had experience performing shoulder reduction before you actually performed Mr. reduction?
MR. : Off the record.
(Discussion held off the record)
MS. : Read it back.
MR. OGINSKI: I'll rephrase it.
Q. When Dr. came down after you called for assistance for the reduction, did you ever learn from her as to how many of these reductions she had performed before that one?
A. No.
Q. Did you learn since then how many times she had performed shoulder reductions?
A. No.
Q. From your performing the other attempts to reduce the shoulder, were you able to determine whether or not she seemed or appeared to be experienced in

0170

performing a shoulder reduction?
MS. : Note my objection.
You can answer over my objection.
A. She appeared to be knowledgeable of the correct technique used to reduce a shoulder.
Q. Did you ever learn from any doctor that the MRI taken in the emergency room on September 9 revealed that the patient had an axillary sheath hematoma?
MS. : Can you hear that back.
(Whereupon the requested portion was read back by the reporter).
MS. : Over objection you can answer.
A. I actually answered that already. No.
Q. What is a subluxation?
A. A subluxation is also a disruption of the normal physiology of a joint.
Q. Is that synonymous with the term

0171

"dislocation?"
A. No.
Q. What is the difference between

the two?
A. A subluxation does not need to be reduced.
Q. Do you know a Dr. , a neurologist at ?
MS. : Do you know what he is?
THE WITNESS: I don't believe so.
(Discussion held off the record)
Q. Doctor, can you determine from the record when Mr. MRI was actually done?
A. Not the actual time.
Q. Can you give me a range? We had an off-the-record discussion as to when it most likely occurred. You mentioned after 7:57.
A. Sometime between 7:27 and 10:59.
Q. P.m.?
A. P.m. It was between 21:19 and

0172

22:59.
Q. And do you have a memory as to when it was that you spoke to Dr. about the MRI?
A. I know exactly when. I was waiting for it to be done and I spoke to her at I would assume two minutes before I wrote the note that I spoke to her because I was waiting, so I would say somewhere around 23:20, twenty-five.
MR. OGINSKI: Off the record.
(Discussion held off the record)
Q. Was there any discussion with Dr. about whether the patient would have contrast or not have contrast for this MRI?
A. I'm sure there was because it's my standard practice to discuss the options. I just don't remember the specific conversation.
Q. Do you have any memory now, as you sit here, as to why the MRI without contrast was requested as opposed to one with contrast?

0173

A. Probably because, for his age, his creatinine of 1.2 is higher than I would have expected and one of the side effects of the dye is it affects the kidneys. We may have also felt that we could get a good enough look without stressing the kidneys.
Q. The creatinine level that you

just mentioned, you said it was a little high?
A. It's in the normal range so it's not something that need to be emergently addressed. But in considering whether I want to give a patient something that may affect current organs and their function, I would have looked at that and said, you know, it's in the normal range but I don't want to push this patient into an abnormal range and he was on the higher side of normal. That would be my standard practice, to evaluate that.
Q. And is it your opinion that, if the contrast dye was administered, that there was a good likelihood that it would

0174

then pushed his creatinine to an abnormal level?
MS. : Note my objection.
You can answer.
A. It could. That's one of the risks of getting contrast, so it's part of your assessment of what tests you want to order on a patient for every patient.
Q. Did you ever make a determination while you were caring for Mr. whether he had any evidence of ischemic neuritis?
MS. : Note my objection to form.
You can answer.
A. Not in the emergency room care that I provided.
Q. Did he have any evidence of brachial plexopathy?
A. It was unable to determine completely because of the distortion of his anatomy and his inability to completely cooperate with his initial exam because of pain.

0175

MR. OGINSKI: Thank you, Doctor.
MR. : Doctor, I just have one or two questions.
EXAMINATION BY
MR. :
Q. As I told you off the record, I represent Dr. .
Have you ever met him?
A. I'm sure I met him in the emergency room. I don't recall what he looks like.
Q. So the record's clear, in answering some questions, you had the

benefit the records before you.
A. Yes.
Q. That's the original records; right?
A. Yes.
Q. And you used them; true?
A. I used them today, yes.
Q. And some of the answers you gave were based on memory?
A. Yes.
Q. Do you have a memory of this

0176

patient?
A. Yes, I do.
Q. In terms of memory, I'd like to know, did the patient give you a history that you can remember about any trauma or precipitating event that was associated with the onset of his pain?
A. He did not tell me, but I understand from subsequent physicians' descriptions of the incident that at one point he said he was fighting with someone.
MR. OGINSKI: I'm going to object.
THE WITNESS: It's written in the chart.
MR. OGINSKI: My objection is to the observation because they were not observed during the time that you cared for the patient on September 7. That's after the fact.
Q. Do you recall what, if anything, he told you? Forget everybody else.
A. Initially he told me that he was

0177

at the gym and he was working without at the gym and felt a pop in the shoulder. But then the story changed to it might have been when he was horsing around with a friend and lifted his friend over his head and felt a pop. And then at a later point he said his niece. He was lifting -- I don't remember if it was his niece or the girlfriend's niece, but a niece over his head. Either way there was some form of lifting over the head and a pop sensation was consistent in all three stories so I used that in my chief complaint.
Q. Were each of those three stories verbally relayed by Mr. to you on September 7?
A. Yes.

MR. : Thank you.
EXAMINATION BY
MS. :
Q. I believe earlier, when you were asked about the use of steroids in response to Mr. Oginski's question, you

testified, in sum and substance, that if you had known about the steroids you might have been more suspicious or more careful in evaluating the vasculature.
Could you explain what you meant by that?
A. Steroids actually increase calcification in arteries and I probably would have suggested, when he was admitted, some type of follow-up Doppler duplex or an MRA or a CT angiogram if he continued to have the symptoms.
MR. OGINSKI: Of what part of his body?
THE WITNESS: The arm.
Q. Was Mr. in the ED for a typical period of time for a patient who dislocates his shoulder or was it longer or shorter?
MR. OGINSKI: Objection.
A. No.
Q. In what way was this not a typical period of time for a shoulder dislocation?

A. Typical shoulder dislocations come to the emergency room relatively quickly after the dislocation. We put the joint back in place and we observe for a short period of time, one hours or two hours. When he came in, he was already presenting two days after the incident with swelling which made the physical exam not as easy to determine afterwards how easy his course was going to be. So already the idea was in my head that he was going to have to be observed for a loner period of time and/or be admitted for more intense observation and testing. It's not typical to order blood work on a shoulder dislocation, but we ordered it.
Q. Why is that?
A. So that, if there was a problem with the Doppler duplex or any subsequent studies and he did need some type of intervention, the patient had already been assessed for pre-op.
Q. Do you remember how many times

you actually checked Mr. , did any
0180

type of physical examination, while he was in the ED?
A. I was covering the resuscitation area that day, so I was in and out of the room virtually every hour. And every time I would go in, I ask -- my standard practice is I ask all my patients how they're doing and do some form of assessment.
Q. Do you remember what you did in terms of some form of assessment on Mr. ?
A. If he was sleeping comfortably, I may have woken him up enough to see if he could squeeze my hand and feel my hand. If he was awake, it may have been more detailed.
Q. Do you have a memory of any of those events, either he was asleep or he was awake?
A. He was in the emergency room under my care for almost twelve hours. There was several times he was awake and several times I had to wake him up to do
0181

an assessment.
Q. Did you observe Dr. doing any other examinations than the ones we talked about already?
A. Dr. went in the room several times. I wasn't there for the physical exams, but he was the only orthopedic patient in that room.
MS. : Nothing else.
Thank you.
EXAMINATION BY
MR. OGINSKI:
Q. Doctor, when you said you would make some form of assessment on your patients, other than asking them if they were okay, would you also examine them physically?
A. As I said, if he was sleeping, I would wake him up and at the very least have him squeeze my hand and see if he could feel the hand. Something to let me know that he still had neurovascular. I would check a radial pulse.
Q. You would expect to make a note
0182

in the patient's record about that assessment and about that finding?

A. And when he was admitted, I noted that he was stable for admission.
Q. After each assessment that you made, not cumulatively or collectively in a summary fashion, would you expect to make an individual entry in the chart for each and every time that you made such an assessment?
A. Not always.
Q. In some instances would you?
A. I believe I did on two occasions.
Q. And those two occasions we already read those notes?
A. Correct.
Q. Other than those two occasions, were there any other instances where you made separate observations while he was in the resuscitation area of the emergency room that you noted in the chart?
A. I did not.
MR. OGINSKI: Thank you.

0183

EXAMINATION BY
MR. :
Q. Doctor, what is the resuscitation area?
A. The resuscitation area is an area of the hospital where you can perform advanced procedures that require conscious sedation under monitoring. It's also an area where we do resuscitation for cardiac arrests, intubations. Any patient who is critically ill, there are only four beds in the area so there's close monitoring and close nursing care, and there is a dedicated resident assigned to that one room with the four patients for the entire shift.
Q. And that's part of the emergency department?
A. It's part of the emergency room, it's a special area of the emergency room.
Q. And he was there because he had been sedated?
A. I did conscious sedation and then he was in there so that he could have

0184

continued monitoring.
MR. : Thank you.
(TIME NOTED: 2:01 p.m.)
_____ (Signature of witness)
Subscribed and sworn to
before me this_____
day of_____,

2007.

_____

* * *

I N D E X

WITNESS	EXAMINED BY	PAGE
	Mr. Oginski	5, 181
	Mr.	175, 183
	Ms.	177

E X H I B I T S

	PLAINTIFF'S FOR IDENTIFICATION	PAGE
1A	Medical record	4
1B	Medical record	4
1C	Medical record	4
2	Document entitled Curriculum Vitae of , DO	4

ATTORNEY OGINSKI HAS RETAINED ALL EXHIBITS

INSERTIONS

Page	Line
(NONE)	

I N D E X (continued)

REQUESTS

Page	Line
(NONE)	

RULINGS

Page	Line
(NONE)	

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0187

CERTIFICATION BY REPORTER

I, Wayne Hock, a Notary Public of the State of New York, do hereby certify:

That the testimony in the within proceeding was held before me at the aforesaid time and place;

That said witness was duly sworn before the commencement of the testimony, and that the testimony was taken stenographically by me, then transcribed under my supervision, and that the within transcript is a true record of the testimony of said witness.

I further certify that I am not related to any of the parties to this action by blood or marriage, that I am not interested directly or indirectly in the matter in controversy, nor am I in the employ of any of the counsel.

IN WITNESS WHEREOF, I have hereunto set my hand this day of , 2007.

_____

0188

ERRATA SHEET

VERITEXT/NEW YORK REPORTING, LLC

CASE NAME: V.

DATE OF DEPOSITION: December 18, 2007

WITNESS' NAME:

PAGE/LINE(S)/	CHANGE	REASON
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WITNESS

SUBSCRIBED AND SWORN TO
BEFORE ME THIS_____DAY
OF_____,2007.

_____
NOTARY PUBLIC

MY COMMISSION EXPIRES_____

* * *