IN THE COURT OF COMMON PLEAS

OF ERIE COUNTY, OHIO

CONNIE FOCHT,

Plaintiff,

vs

Case No.

S.G. SHINDE, M.D.,

99 CV 268

Defendant.

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Deposition of METHOD A. DUCHON, M.D., called for examination under the statute, taken before me, Terri Grifo, a Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at 9500 Mentor Avenue, Mentor, Ohio, on Tuesday, March 13, 2001, at 10:00 o'clock a.m.

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APPEARANCES:

On behalf of the Plaintiff:

Greene & McQuillan
Co., L.P.A, by
JEAN McQUILLAN, ESQ.
1801 Bond Court Building
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(216) 687-0900

On behalf of the Defendant:

Marshall & Melhorn, L.L.C., by
JOHN BODIE, ESQ.
KENNETH J. WHITE, ESQ.
The Ohio Building
420 Madison Avenue, Suite 1100
Toledo, Ohio 43604
(419) 249-7100

ALSO PRESENT:

Connie Focht

METHOD A. DUCHON, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF METHOD A. DUCHON, M.D.

BY-MS.McQUILLAN:

Q. Doctor, could you please state your full name for the record?

A. It's Method A. Duchon. D U C H O N.

Q. Dr. Duchon, as we were introduced earlier, my name is Jean McQuillan and I'm one of the attorneys representing the plaintiff in this matter, Connie Focht who is here, and her husband Doug, who is working.

You have been identified by Mr. White and Mr. Bodie as an expert for Dr. Shinde in this matter. My purpose here this morning is to ask you questions and discover what your opinions are in this matter.

I know you've had your

deposition taken before, so if I ask you a question that is inarticulately phrased or you don't understand it, I will expect you to let me know and I'll be happy to rephrase it, is that fair?

A. Yes,

Q. Doctor, Mr. Bodie did send me your curriculum vitae. Is this a current copy of the CV?

A. As far as I know, yes.

Q. And just as of today do you still have any academic appointments at CWRU School of Medicine?

A. I do not.

Q. And the last appointment ended in 1998?

A. That's correct.

Q. Was that about the time that you joined the group out here in Lake County?

A. I came out here in Lake County in 96. I continued to teach, and still do occasionally at CWRU, Case Western Reserve. However, I have no appointment. It expired in 98.

Q. Now, I also in reviewing your CV noted that you have written a number of articles in the medical literature. Do any of them in your mind have any application to the issues raised by this case?

A. None that I'm aware of.

Q. Okay. In preparation for reaching your opinions in this matter, could you tell me what you have reviewed?

A. Okay. The office records of Dr. Shinde, office records of Dr. Steele, Firelands Community Hospital Records, and MCO, Medical College of Ohio admission records. Also depositions of Dr. Shinde, Mrs. Focht, Dr. Steele, Dr. Kligman and Dr. Donnish.

Q. Okay. Are there any other documents you've reviewed in preparation for giving your opinions in this matter?

A. Not that I'm aware of.

Q. Are there any documents that you have asked to see or wanted to see that you have not been provided?

A. No.

Q. Okay. In reviewing all of these documents, did you make any notes or summaries on your own?

A. No.

Q. Have you prepared any written reports or memos in this matter?

A. No,

Q. Can you tell me when you were first contacted by -- was it Mr. Bodie or Mr. White that contacted you or someone else?

A. I don't. remember, It's been a few months ago someone called me and asked if I'd look at a case.

Q. Have you ever done any work for Mr. Bodie or Mr. White --

A. No.

Q. __ as an expert witness?

I know that in the past __ had you ever served as an expert for Jacobson, Maynard, Tuschman, Kalur or PIE Insurance Company?

A. I worked in the past for Jacobson, Maynard, Tuschman, Kalur, yes.

Q. Have you ever served as an expert in the Cleveland area on behalf of a patient or a claimant?

A. No.

Q. Have you ever served as an expert on behalf of a patient or claimant at all?

A. Yes.

Q. Have they been outside of the city of Cleveland?

A. Yes.

Q. On about how many occasions?

A. Probably more than a dozen.

Q. Is that total expert witness testimony or total for plaintiff?

A. No, that's total for plaintiffs.

Q. On how many occasions for defense counsel for a doctor?

A. I'd say in general I do about 80 percent defense work and 20 percent plaintiff's work.

Q. Okay. Do you know Dr. Shinde?

A. No.

Q. Have you spoken to any of the physicians who were involved in Mrs. Focht's care at all?

A. No.

Q. Now, with respect to your own practice today, I understand that you are -- you are not only an obstetrician gynecologist. but you're also a perinatologist?

A. That's correct.

Q. And I know if I saw some of the brochures put out by Lake Hospital that you're the only perinatologist in Lake County?

A. That's true,

Q. Today what percentage of your practice is high risk obstetrics as opposed to gynecology?

A. I do about 60 percent obstetrical care and about 40 percent GYN care.

Q. How many babies do you deliver in a given year?

A. Somewhere between 130 and 150.

Q. Now your GYN practice, what does that include?

A. All phases of gynecologic surgery and office work.

Q. Has your percentage of obstetrics versus gynecology changed over the years?

A. The GYN component has increased since I've been in Lake County, yes.

Q. Now, I have not been given any information about what your opinions are in this case, neither interrogatory answers nor conversations with counsel, so I'm afraid I have to start from ground zero and ask you what will you be offering opinions about in this matter?

A. I'm sorry. That's a little overly broad.

Q. Well, I guess I'm kind of at loose ends here because I have no information about what your opinions are. I assume you're going to be offering some opinions regarding Dr.

Shinde's conduct in the matter?

A. Yes.

Q. Can you tell me what those opinions are?

A. It was perfectly fine.

Q. When you say it was perfectly fine, do you mean the care he rendered Mrs. Focht?

A. Yes, it met the applicable standard.

Q. Are you going to be offering opinions about the medical care offered by any of the other doctors involved in her care -- Dr. Kligman or Dr. Steele?

A, Not that I'm aware, however, I can't speculate about my response to a given question that someone at this table or someone else in an arena may ask.

Q. Have you been asked to offer any opinions about any other physician's care besides Dr. Shinde?

A. Not that I'm aware of.

Q. Are you going to be offering any opinions with respect to the repair

that was done to Connie Focht's bowel injury as to whether that repair was appropriate or what caused the need for that repair?

A. That's a two part question. The first portion of it, if I may rephrase it, is that will I be offering opinions about the need for repair?

Q. Yes.

A. The answer to that is no.

And the second part of the question was?

Q. The kind of repair that was done.

A. The kind of repair that was done?

Q. Right.

A. No.

Q. With respect to the medical care that Mrs. Focht has received from Dr. Steele post-operatively, are you going to be offering any opinions about whether that care was proximately related to the injuries she suffered in the surgery or the surgery itself?

A. I'm sorry. I don't understand that question,

Q. Mrs. Focht has received medical care from Dr. Steele?

A. Correct.

Q. And I think you've identified you've either seen his records or read his deposition?

A. Yes.

Q. Are you going to be offering any opinions as to whether that care was proximately related to the surgery that Mrs. Focht had in 1998 and 1999?

A, I'm sorry. I'm not -- which one is --

Q. Dr. Steele is the family practitioner who has provided Mrs. Focht with manipulation and physical therapy.

A. Right.

Q. Are you going to be offering any opinions whether that care was --

A. I have no opinion about that care.

MR. BODIE: Jean, just so you aren't surprised, I will ask him

whether these complaints would be related.

MS. McQUILLAN: I guess that's what I was trying to get out of him.

MR. BODIE: Well, the care versus the complaints are different.

Q. Well, I assumed that the care was given in response to complaints and I guess my question for the doctor is are you going to be offering any opinions as to whether or not Mrs. Focht's surgeries that she had from Dr. Kligman and Dr. Shinde made that medical care necessary or appropriate, was there causative connection?

A. The things that Dr. Steele discusses, 1 am not familiar with and so I have no opinion.

Q. Doctor, you have said that your opinion in general with respect to Dr. Shinde's care was that it was perfectly fine. And I'd like to go through the portions, and kind of get

into a little more detail relative to your opinions about Dr. Shinde's care.

You have read Mrs. Focht's deposition, you've read Dr. Shinde's deposition and I'm sure from those two depositions you're aware that there are disputes of fact between these two parties as to what occurred prior to the operation?

A, That's correct.

Q. In rendering opinions, are you going to be resolving any of those disputes of fact in favor of one party or the other?

A, I doubt it.

Q. Okay. With respect to the actual surgery that was performed, do you have any opinion as to whether Dr. Shinde's work up prior to that actual surgery was appropriate or adequate?

A. I think it was adequate.

Q. Okay. Can you tell me what you understood the work up prior to the surgery to be?

A. Primarily office

examinations, history, physical.

Q. And what did you understand Dr. -- the actual surgery to be done?

A. I think the surgery was an exploration of the abdominal incision.

Q. Okay. And understanding that -- is it your opinion that the work up for an exploration of an abdominal incision was appropriate for Dr. Shinde?

A. Yes.

Q. Understanding that Dr. Shinde did enter the abdomen and operate on an ovarian mass, was the work up appropriate and indicated for the -- for a surgery involving an ovarian mass?

A. I think I would have imaged the pelvis prior to surgery.

Q. Would the standard of care have recommended that the pelvis be imaged by ultrasound prior to exploration of an ovarian mass?

A. I think that is standard practice, yes.

Q. What kind of information

would the ultrasound of an ovarian mass have given Dr. Shinde?

A. That an ovarian cyst existed and that she would have needed surgery.

Q. Would it have told both these parties that any surgery that they embarked upon would necessarily had to have been intra-abdominal in nature?

A. I think it would have suggested that.

Q. Is there any other way of dealing with an ovarian cyst rather than going inside the abdomen, doctor?

A. Yes,

Q. And what's that?

A. There are medical therapies that are -- that can be employed, but not in this situation. Surgery was indicated.

Q. So if Dr. Shinde had performed an ultrasound on the abdomen which indicated an ovarian mass, both Dr. Shinde and Mrs. Focht would have known that any surgery would have necessarily included intra-abdominal

exploration?

A. I think that's likely.

Q. In your opinion was it -- is a physical exam sufficient to rule out the presence of an intra-abdominal mass versus a hematoma or seroma in a previous surgical incision?

MR. BODIE: Could you repeat that?

(Record read.)

A. Yes.

Q. Doctor, if a patient presents in your practice with lower level quadrant pain and a palpable mass, what is your usual preoperative or your usual work up of that mass?

MR. BODIE: Objection. Go ahead.

A. Define palpable.

Q. Palpable in physical examination.

A. Palpable in the abdominal wall or in the abdomen itself?

Q. Well, in the area of the left lower quadrant.

A. Okay. I may or may not image it depending on some of its qualities on physical, and then depending on the patient's age, condition, other kinds of factors we're probably going to discuss either medical or surgical management.

Q. What would be the factors that would suggest medical management rather than surgical management?

A. Very young patient, woman who has not had previous surgery to preserve child bearing and things like that would suggest medical management.

Q. What would suggest surgical management?

A. Someone in her late 40s who already had a hysterectomy surgically.

Q. Why is the reason that a patient in their mid 40s who has already had a hysterectomy would suggest surgery?

A. Because it raises certainly the specter of neoplasm, and that would be of great concern. Medical management

would not necessarily be appropriate at this particular point in life.

Q. Other than performing an ultrasound to image the mass, would there usually in your practice be any other studies that you would perform before actually doing surgery on such a patient, mid 40s patient?

A. No.

Q. Would the ultrasound give you information that would allow you to consider whether or not the mass is a neoplasm? Are there certain ultrasound appearances that would suggest the mass is benign versus others that suggest it's malignant?

A. There are certainly ultrasound findings that suggest benign versus malignant masses that have characteristics. Doesn't change the fact that exploration is going to occur.

Q. If you have an ultrasound appearance that suggests that malignancy is present, does that change what you're going to do when you do the operation

or your operative planning?

A. Not necessarily.

Q. Does it change what you actually do in the operation versus how extensive a dissection you may do in the area?

A, May change who does the procedure. I may refer the patient to an oncologist for the procedure. If there were certain findings that highly suggested malignancy, I would probably refer the patient to an experienced surgical oncologist.

Q. Doctor, in your opinion if Dr. Shinde had performed an ultrasound on Mrs. Focht, do you believe he would have discerned this was an ovarian mass?

A. I think he would have seen the cystic structure that was simple and fluid filled.

Q. Would that have suggested a malignancy?

A. That would not have suggested a malignancy.

Q. Doctor, I assume in your

practice, you have had an opportunity to operate a second time on a patient who you knew had adhesive disease in their pelvis?

A, Yes, ma'am.

Q. That can be a very difficult situation?

A. You betcha.

Q. Very demanding situation?

A. Yes, probably,

Q. Probably I would imagine some of the most difficult operations you've done?

A. Absolutely.

Q. In those types of patients when you know that you're going into a pelvis that is full of adhesions, do you do anything extra in operative preparation, such as bowel prep or preoperative antibiotics?

A. No.

Q. Have you ever given a bowel prep to someone who you knew had adhesive disease?

A. No.

Q. Have you in your practice undertaken operations where the ovarian mass found is similar to that that was found with Connie Focht; in other words, an ovarian mass involved in the sigmoid colon?

A, Yes, ma'am.

Q. And how do you prevent injury to the colon in that circumstance?

A. One works hard to try to prevent injuries to adjacent structures, sometimes it's quite difficult.

Q. With respect to the bowel, what are techniques used to prevent injury to that structure?

A. Careful dissection, visualization, all the techniques that go into surgical practice.

Q. Can you explain to me what is visualization as far as the surgical practice?

A. You make sure your incision is adequate, you can see what you're doing, you trace the various structures

that you are trying to either dissect out and remove, and/or the ones that you want to avoid, and try to do the things that you want to do.

Q. Are there any particular techniques for, let's say, marking a structure such as a bowel if it crosses through the cystic area you're trying to dissect?

A. Not that I'm aware of.

Q. Is it basically making sure you know where it comes in and where it goes out and you've identified where it courses through the mass that you're dissecting?

A. That's what one tries to do.

Q. Are there any techniques when you have completed dissection of the cystic mass to again check and make sure you have not injured the bowel that crosses that area?

A. There are techniques available. I have personally not employed them.

Q. What are the techniques that

are available?

A. One can put contrast material into the gut as into other structure to see if they are leaking. There's things like that.

Q. Any other techniques?

A. Not that I'm aware of.

Q. Is the basic techniques again just visualization and looking at the structures themselves?

A, Primarily, yes.

Q. Do you also as an operating surgeon in this area have an obligation to recognize that you have injured the bowel?

A. I'm sorry. Define obligation.

Q. Well, is it one of your duties as a surgeon to check and recognize that you have done an injury to the bowel to the best of your ability?

A. Yes.

Q. And how do you recognize injury to the bowel, how does it

appear?

A. It can appear in a variety of forms.

Q. What are those variety of forms?

A. Well, you can abrade it, you can cut it, things like that.

Q. Do all of those kinds of injuries have specific appearances that you're taught to look for?

A. Not necessarily.

Q. I mean if you -- I assume you had academic appointments, you have taught people in fellowships and training in obstetrics. I mean when you're teaching someone doing ovarian cyst surgery what do you tell them about how do you recognize an bowel injury?

A, I think it has to do with teaching them surgical technique. When one does inspection, one does tracing of various structures and throughout their course recognizing when there has been interruptions. And as I said, sometimes

employing contrast material.

Q. In your experience, have you ever caused an injury to a bowel while you've been dissecting an ovarian cyst?

A. Yes.

Q. What kinds of injuries have you encountered in your experience?

A. One was a large bowel injury during a tubal ligation.

Q. Okay. What kind of injury was that?

A. Necrosis of the entire colon.

Q. Mesenteric ischemia?

A. Yes, ma'am.

Q. Any other types of injuries?

A. I've had a couple of small bowel injuries, laparoscopies. Doing other surgical explorations.

Q. The small bowel injuries, how did those appear?

A. Hmm?

Q. How did the small bowel injuries appear, did you recognize them?

A. As small bowel injuries.

There was concern that maybe something happened, so they were sought and they were recognized.

Q. Would they have been abrasions or perforations or --

A. Both.

Q. Are those kinds of injuries that you as the operating gynecologist can repair yourself?

A. Some I have, Some I have sought consultation for.

Q. Have you ever encountered a transection of a sigmoid colon?

A, No, ma'am.

Q. Have you ever encountered a transection of the small bowel?

A. Personally, no.

Q. Have you ever heard of transsection of the small bowel?

A. Yes, ma'am.

Q. Okay. In what context?

A. GYN surgery.

Q. Was the transsection recognized and repaired?

A. Yes.

Q. Have you ever, either in your experience or your training, heard of the transection of sigmoid colon that was not recognized?

A. No.

Q. How large is the sigmoid colon in the area of the ovaries -- I mean in diameter?

A, Can vary very widely. Can be very narrow in its flumen, can be quite large. Depends on the patient, history of any bowel problems. It can vary widely.

Q. Do you know how long the sigmoid colon was in Connie Focht's case?

A. Not off the top, no, and the surgeons didn't exactly describe it either.

Q. Would the pathology specimen be of any assistance in determining what the size was?

A. I don't think so.

Q. Why not?

A. Do you mind if I look for a

second?

Q. Please look.

A. It was described here as 2.2 centimeters in greatest diameter. This is a single portion of colon. This is the Medical. College of Ohio -- of Toledo pathology report from the reparative surgery that was done.

Q. So that would suggest to you that the colon was probably 2.2 centimeters in diameter?

A. That's what it says.

Q. About how large is that, doctor?

A. About an inch.

Q. How large is that in relation to the usual size of an ovary?

A. In relation to the usual size --

Q. To the usual size of an ovary.

A. About the same.

Q. Is it your information from Mrs. Focht's medical records and. from what was found at the Medical College

of Ohio that her sigmoid colon was transected during the original surgery by Dr. Shinde?

A. I think it was injured.

Q. Do you have any information that the injury was anything but transsection?

A. I have an opinion.

Q. Okay. What is your opinion?

A. I think the colon was divided, not entirely transected.

Q. Okay. What do you mean when you say divided?

A. I think it was cut.

Q. Well, we know that transsection means cut in two. What is your opinion about how far divided is between cut in two and --

A. I think there were still remnants of the colon approximated after her surgery and in the original hospital.

Q. Okay. What is the basis of that opinion?

A. That postoperatively she

didn't get that sick.

Q. And how does the fact that postoperatively she didn't get that sick correlate with dividing of the colon rather than transecting?

A. I think the colon was not leaking into her abdominal cavity after her original surgery.

Q. You believe the colon was in fact intact at the end of the surgery?

A. No, ma'am, I didn't say that.

Q. Okay. So you believe that there was an injury through some part of the diameter of the colon?

A. Yes, ma'am.

Q. Do you have an opinion as to what percentage of the diameter -- I mean, if we drew a circle, if we know transsection is completely through it, how much of the colon was still intact of the --

A. I think probably the back wall.

Q. Half of it or three quarters

of it?

A. Three quarters of it was transected, I think. It was cut.

Q. Okay. And do you -- can you explain why the colon then wasn't leaking if it was cut three quarters of the way through?

A. Because I think there was a mass of adhesions and things that held it together.

Q. Okay, I'm not quite understanding you, doctor. If it was cut through three quarters of its diameter, and I assume that means that the lumen was open through three quarters of its diameter, how could contents not be leaking out?

A. They weren't.

Q. Okay. And you say they weren't based upon Mrs. Focht's clinical presentation in the 24 hours post surgical?

A. Correct.

Q. Isn't it true, doctor, that patients do have differing reactions and

differing rates of development of an acute abdomen?

A. Yes.

Q. And can't a patient with severe vascular compromise present with very minimal symptoms?

A. I'm not a vascular surgeon.

Q. Can't a patient -- there is a whole spectrum of symptoms that can occur during the development of peritonitis, correct?

A. Yes, ma'am.

Q. And some people became very toxic very quickly?

A. Yes, ma'am.

Q. And some people take longer to present with toxic symptoms, correct?

A. Not when you're leaking bowel contents.

Q. When do you believe Mrs. Focht began leaking bowel contents?

A. After her Gastrografin enema at the Medical College of Ohio,

Q. Okay. And what did the Gastrografin enema do?

A. I think it ruptured the final portion of the colon.

Q. So now instead of being three quarters open, it's a hundred percent open?

A. Yes, ma'am.

Q. Forgive me, I'm still not quite clear. What was keeping the three quarters open from leaking bowel contents?

A. The adhesions that were present at the time of her surgery and had been present prior to her surgery.

Q. You've read Dr. Kligman's testimony?

A. Yes.

Q. Dr. Kligman testified that he found the two ends free with minimal adhesions?

A, Yes, ma'am.

Q. How do you account for that?

A. As I said, from the enema I think the two ends were then separated.

Q. What about -- you mean that having been given the enema, the

remaining quarter of the bowel came loose from the adhesions?

A. Yes, ma'am.

Q. How does that happen?

A. From the pressure of the enema that was given.

Q. Have you ever seen that occur in the past or seen it reported in the medical literature?

A. I've seen reports of it certainly. I haven't personally seen that in a patient of mine.

Q. So you've seen reports in the medical literature where Gastrografin enema will cause --

A. Can cause distension and disruption of the bowel, certainly.

Q. Do you believe it's within the standard of care to have caused an injury to three quarters of the diameter of a bowel and failed to recognize it?

A. I think that can occur, yes.

Q. Do you believe it's within the standard of care?

A. I think injury to adjacent

structures can occur during a surgical procedure in which the physician functions up to the standard of care, yes.

Q. So it's your opinion that disrupting three quarters of the diameter of the bowel and failing to recognize it in the sigmoid colon is within the standard of care?

A. I think a reasonable physician can exercise sound surgical judgment, have a disruption such as this and fail to recognize it, yes.

Q. So for Dr. Shinde to fail to recognize that disruption is within the standard of care?

A. It can be, yes.

Q. Was it in this case?

A. Yes.

Q. If Dr. Shinde had carefully observed the bowel and done what you and I have talked about, making sure that when he's done dissecting that he's got the top of he bowel to the bottom of the bowel, where it comes into and

out of, in continuity how could he miss disruption of three quarters of the bowel? Can you explain that?

A. Yes, ma'am.

Q. How?

A. She had a lot of adhesions. He goes over in his operative note his inspection of the various structures, his dissection, his turning to the other side and removing the other ovary, his coming back and looking again. That to me says a careful physician, employing sound surgical Judgment, he didn't see it. I think that's easily explainable if you've ever been in the operating room.

Q. Well, I guess I'm having trouble understanding, doctor, we've got a structure that I guess is about the size of a garden hose, in the shape of a garden house?

A. Can be, yes.

Q. Roughly. And you're acknowledging that there was an injury that literally three quarters of it was

cut through?

A. Yes.

Q. And a careful physician, checking top to bottom, would miss that?

A. Yes, ma'am.

Q. Have you ever seen any reports in the medical literature of surgeons who have missed that three quarters cutting through of the bowel?

A. We know that bowel injuries occur, It's been reported for hundreds of years. It's been reported in the gynecological literature, it's reported in the surgical literature.

Q. Are the bowel injuries that are reported transsections or three quarter cut throughs of bowel?

A. They can be.

Q. Is that reported in the medical literature?

A, I'm sure it is somewhere,

Q. Have you ever seen it?

A. I have said I have seen bowel injuries during surgery, yes.

Q. Have you seen bowel injuries

of this nature reported in the medical 1iterature?

A. I can't quote you the journal at the moment, no.

Q. Okay. If you find the journal, could you please provide the name to Mr. Bodie or Mr. White?

A. I'd be happy to.

Q. Doctor, if Dr. Shinde had recognized that he had cut the bowel through three quarters of the way, what would have been the appropriate approach at that point in time?

A. For myself it would have been to seek surgical consultation.

Q. Okay. Would it be because that depth of injury to the bowel was one that you would feel more comfortable having a general surgeon handle?

A. Injury to the bowel, I often seek surgical consultation.

Q. Do you have any opinion as to whether or not if this injury had been recognized in Dr. Shinde's surgery whether it could have been fixed

primarily?

A. I do not have an opinion.

Q. That would be something you would defer to a general surgeon about?

A. Yes, ma'am.

Q. However it's your opinion that in the operation that Dr. Shinde performed, understanding that he may have cut three quarters through the bowel, it was not leaking at that time and it was not leaking until the Gastrografin enema'?

A. That's correct.

Q. And is it your general understanding that sometimes it's the amount of contamination that occurs that controls whether or not a primary or secondary repair has to be done?

A. I don't know that answer.

Q. Doctor, in your opinion was the removal of the left ovarian mass in Connie's case an urgent or emergent situation?

A, What do you mean?

Q. I mean was it medically

urgent situation that she had the ovarian mass removed that day?

A. What do you mean urgent?

Q. Well, what do you understand when someone says an operation is urgent?

A. I don't know. I don't use that word. If you have a definition, give it to me. I'll answer.

Q. An operation that medical necessity requires to be done at that point in time and no later.

A. That's very vague. I can't respond to that.

Q. What about emergent? Do you have a medical understanding of what the term emergent means?

A. In general it means it should be done that day or sometime in the near future, but these terms are very vague.

Q. I understand, In your opinion was the removal of this ovarian mass for Connie Focht an emergent matter?

A. Once again, what do you mean by emergent?

Q. I'm using your definition, doctor.

A. At what time was it ernergent?

Q. I mean on October 22nd, was it an emergent procedure to remove that ovarian mass for Connie Focht?

A. I don't think that has any relevance to anything.

Q. I understand that, doctor! but do you have an opinion about whether or not it was emergent for her to have had that ovarian mass removed that day?

A. I'm sorry. I don't understand the question. Would you rephrase it?

Q. Well, doctor, using your definition of emergent, in other words something that had to be done right that day or very soon, was the removal of this ovarian mass in Connie Focht an emergent medical matter?

A. At what time?

Q. On October 22nd, in the operation?

A. During the operation?

Q. Yes.

A. Yes.

Q. Why was it an emergent matter during the operation?

A. Once Dr. Shinde did not see anything in the incision that he explored and he felt there was stili a mass present, I think it was incumbent upon him to continue.

Q. Why was it incumbent upon him to continue?

A, Because he had definite physical findings of a mass and he did not explain it to what he thought he was going after, and I think continuing was correct.

Q. Why did he need to continue?

A. Because you had a painful mass in a patient.

Q. Okay. Is removing a painful mass an emergent matter in a patient?

A. When the patient is asleep, yes.

Q. Other than pain, that this mass was painful for the patient, is there any other reason why it was emergent to remove it in this operation?

A. Well, I don't think you subject the patient to all of the other attendant things with surgery, such as anesthesia, you don't wake them up and say, well, we didn't do this but we're going to go back and do this now. That is not correct procedure.

Q. In your opinion was Dr. Shinde prepared to remove an intra-abdominal mass? I mean had he done an appropriate work up to explore an intra-abdominal mass in this patient?

A. He was certainly prepared to do surgery.

Q. Did he have any idea what this mass was before he opened her abdomen?

A. He had. thought previously it was in the abdominal mass, may have

been a hematoma. That did not materialize so he went further.

Q. My question was in your opinion did he have any idea what this mass was he was going into the abdomen to explore?

A. I don't know what he was thinking at that time.

Q. From your perspective, would you rather have some information about an intra-abdominal mass before you open a patient's abdomen?

A. As I said, I probably would have imaged this prior to surgery but continuing his exploration was perfectly appropriate.

Q. Doctor, in your opinion was it appropriate for Dr. Shinde to remove Mrs. Focht's right ovary?

A. Yes.

Q. What was the reason for that?

A. As an operating gynecologist, one gets into a cystic mass on the left side, one would always remove the right

ovary also.

Q. Why?

A. Because of its potential for causing similarly formed cysts, because of cancer potential in this situation it was standard practice.

Q. Was there anything -- other than the adhesive process around the ovary, was there any abnormalities in this ovary?

MR. BODIE: Which one, Jean?

MS. McQUILLAN: The right.

A. Not that I'm aware of.

Q. Doctor, do you believe it was -- you said it's standard practice to remove the ovary -- it would have been standard practice to remove the right ovary because of the cancer risk?

A. That.

Q. Okay.

A. Cyst formation risk. The difficulties of surgery with adhesive disease such as this.

Q. What causes the ovaries to form cysts in a patient like Connie?

A. They become bound up with adhesions, they still may have some metabolic activity, and patients form cysts.

Q. Is the -- are the cysts formed by the hormonal activity of the ovaries?

A. May or may not be.

Q. Isn't it true that as a patient reaches and passes menopause, the cyst forming activity usual ceases?

A. It does seem to decline, yes.

Q. So if you're operating on a patient who is in either perimenopause or menopause what is risk that an ovary that has not previously formed cysts will form it in the future?

A. Declining.

Q. With respect to the cancer risk, is it standard practice in gynecology to remove ovaries for cancer risk alone?

A. Yes.

Q. What sort of decrease in cancer risk does that provide a patient? What percentage decrease in cancer risk?

A. Very, very small.

Q. Okay. Are ovaries in women in their mid to late 40s nonfunctional?

A. May or may not be.

Q. Does an ovary ever become totally nonfunctional?

A. May or may not.

Q. Even after menopause doesn't an ovary continue to provide some hormonal balance for a woman?

A. It can.

Q. Doesn't it happen in a vast majority of patients that an ovary continues, even though nonfunctioning as a reproductive organ to provide other hormones?

A. It does provide some hormones.

Q. Doctor, I referred earlier to the issue of consent and the dispute

between these two parties about what was -- what was discussed prior to this operation?

A. Yes.

Q. If we assume that Mrs. Focht's testimony is correct and that she expressly limited her consent to the extra abdominal operation for Dr. Shinde, was it within the standard of care for him to violate that consent and enter her abdomen?

MR. BODIE: Objection.

Q. Assuming her testimony is correct.

MR. BODIE: Objection. Go ahead.

A. As I said, I'm not going to resolve that dispute.

Q. I'm not asking you to resolve the dispute. I'm going to ask you a series of questions. I'm asking you, first, assuming Mrs. Shinde -- Mrs. Focht's testimony is correct, would it be beneath the standard of care for a physician to violate her limited consent

and enter her abdominal cavity?

A. Yes.

MR. BODIE: Objection.

Q. And your answer was --

A. Yes.

Q. Doctor, you've read Mr. Focht's testimony?

A. Yes.

Q. And her stated reason for limiting her consent in this situation was concern about Dr. Shinde's physical stamina because of his recent heart transplant. In your opinion would that be a valid concern?

MR. BODIE: Objection.

A. I don't know. I don't think I have an answer.

Q. You have no opinion one way or the other?

A. No.

Q. And, doctor, again assuming that Mrs. Focht's testimony is correct, and she limited her consent to the surgery to extra peritoneal surgery, would you agree with me that Dr.

Shinde's note in his chart from October 10th is not consistent with that testimony?

MR. BODIE: Objection. Go ahead.

A. I agree that the two are inconsistent, yes.

Q. And that if in fact Mrs. Focht had limited her consent to extra peritoneal surgery then Dr. Shinde's note is probably false?

MR. BODIE: Objection.

A. I have no basis to think Dr. Shinde's note is false.

Q. Well, I'm asking you, assuming that Mrs. Focht's testimony is correct that her conversation with Dr. Shinde ended with her limiting the surgery to extra abdominal surgery and extra abdominal wall, then Dr. Shinde's note dated 10/19 discussing laparotomy and entering the abdomen would be inconsistent with her testimony and their conversation?

MR. BODIE: Objection.

Go ahead.

A. As I said, I'm not going to resolve this dispute, and I think Dr. Shinde wrote a reasonable note concerning his proposed surgery.

Q. My question is, however, if you believe Mrs. Focht, that's not a reasonable note, if the conversation was the surgery is going to be limited to outside my abdomen?

MR. BODIE: Objection.

MR. WHITE: Jean, you've asked and answered the question three times now, plus you're ignoring written informed consent she signed that gives authority to go beyond.

MS. McQUILLAN: I'm getting to that, Ken.

MR. BODIE: Let's include it in your hypothetical then.

MS. McQUILLAN: I'm asking the questions here today.

MR. BODIE: That's the basis for my objection.

Q. Doctor, can you answer my

last question?

MS. McQUILLAN: Can you read it back, please?

(Record read.)

MR. BODIE: Objection.

A. Could you say it again. I don't understand the question.

Q. If you believe Mrs, Focht's testimony that the conversation between her and Dr. Shinde was that the surgery was limited to outside her peritoneum, then Dr. Shinde's 10/19 note discussing intra-abdominal surgery is inconsistent with that conversation?

A. That's correct,

MR. BODIE: Objection. Go ahead,

Q. Now, doctor, assuming that Dr. Shinde's testimony is correct -- you've read his deposition?

A. Yes.

Q. He's acknowledged that Mrs. Focht was very uneasy about him doing intra-abdominal surgery on her, correct?

A. Yes.

Q. She was reluctant to have that done?

A. That's your word.

Q. Was that your understanding from his testimony, that she was reluctant to have intra-abdominal surgery done?

A. I wouldn't use the word reluctant.

Q. She -- what word would you use?

A. She was a patient who had some anxieties about undergoing surgery. It's perfectly normal.

Q. Dr. Shinde acknowledged that she said to him do not open my peritoneum and he talked her out of it, that's his testimony, correct?

MR. BODIE: Objection. If you want to read exactly what he says and you want to quote it in context, then do so.

Q. Doctor, you've read Dr. Shinde's testimony?

A. Yes.

Q. Didn't he acknowledge in his testimony that Mrs. Focht said to him do not open my peritoneum?

A. Do you know where that occurred?

Q. I believe it is about page 64, 65 perhaps. I left my copy on my desk.

A. What was the question again?

Q. I was asking, Dr. Shinde did not in fact acknowledge in his deposition that Mrs. Focht said to him do not open my peritoneum or you will not open my peritoneum. If I've given you the wrong reference, let me know.

MR. BODIE: It's not there on 64, 65.

Q. Then my memory -- you don't remember that from the deposition, doctor?

MR. BODIE: Give me just a second.

A. Page 43, question, line 3, doctor, isn't it true that the reason it wasn't mentioned was because Connie

did not give you consent to enter her peritoneum?

Answer. That is not true.

Q. It would come back to it a couple times, but that's okay, it's my fault I don't have the deposition with me marked, so I will go on.

In a patient who was -- you will agree with me that the sense of Mrs. Focht -- or Dr. Shinde's testimony is that Mrs. Focht was concerned and somewhat reluctant to have the surgery enter her abdomen?

MR. BODIE: Objection.

A. I think she expressed concerns like anyone having surgery.

Q. Doctor, when you have a patient who is concerned about the extension of an operation to a laparotomy, which is what we're talking about, don't you put that on the consent form if you have, in fact, obtained the patient's consent for that procedure?

A. May or may not,

Q. Why wouldn't you put it on the consent form?

A. You try to but it doesn't always happen.

Q. What are the reasons why it wouldn't happen in a patient who you know to be reluctant to allow you to do a possible laparotomy?

MR. BODIE: Objection.

A. It may or may not happen.

Q. In your practice, would a patient who is reluctant to have you proceed to a laparotomy, would you make sure if you have her consent to do it, you would put it on the consent form?

MR. BODIE: Objection.

A. I don't use the term reluctant. You keep using the term, and I will not accept that term.

Q. In a patient who is concerned about having a laparotomy at all, and you have discussed with that patient and convinced her that she should allow you to do a laparotomy if

you need to, isn't that the patient you want to put possible laparotomy on the consent form?

MR. BODIE: Objection.

A. I have no answer to that question because I think it's an unfair question.

Q. Let me ask you in your practice, doctor, when you are discussing surgical options with a patient?

A. Yes,

Q. And you're dealing with a mass and you don't know whether it's extra abdominal or intra-abdominal, would you put on a consent form possible laparotomy?

A. Yes.

Q. You have looked at the consent form that Mrs. Focht signed in this case?

A. Yes,

Q. In your opinion was that consent form, as filled out by Dr. Shinde, adequate to cover the operation

that he did?

A. Yes.

Q. Now, in the part that he filled out he only lists painful lump in the left abdominal wall. Now that doesn't refer to something intra-abdominally, does it, doctor?

A. No, it does not.

Q. And he lists excision of lump and exploration. Does that cover the operation that he did?

A. Not exactly.

Q. What part of this form covers the operation that he performed?

A. The subsequent part: Wherein the course of procedures deemed appropriate -- you know there is all that legal talk.

Q. Yes. Let me ask you -- I mean it's legal talk, doctor?

A. That's correct.

Q. In your practice as a physician, what does that paragraph mean to you?

A. That you do what you think

is right.

Q. And is it -- what you think is right, is it controlled by what's necessary or what's convenient? What's the standard that you use when you rely on that paragraph rather than what you've discussed with the patient or written on the consent form?

A, You do what you think is going to help the patient.

Q. Now, do you explain -- do your hospital consent forms contain a similar paragraph?

A. I'm sure it does.

Q. Have you ever had to explain that paragraph to a patient?

A. Not that I recall.

Q. Okay. Do you think you could?

MR. BODIE: Objection.

A. Possibly.

Q. You would -- would you agree with me, however, that if a patient in fact limited -- like if Mrs. Focht, in fact, limited her consent to an extra

abdominal operation, would that paragraph in your opinion allow Dr. Shinde to go in and do an intra-abdominal operation?

A. Yes.

Q. Regardless of -- even assuming that the conversations between he and Mrs. Focht before this was her saying I do not want you to enter my peritoneum, this paragraph would allow him to do so?

A. Dr. Shinde says that was not the conversation, but it would allow him, yes.

Q. Other than Dr. Shinde's office note of October 19th, is there anywhere in the medical record or chart that indicates that a laparotomy was a possibility before Dr. Shinde decided to do it intra-operatively?

A. One second. What was the question again?

Q. My question was other than Dr. Shinde's office note of October 19th, is there any other part of the

medical record that indicates a laparotomy was being considered prior to Dr, Shinde actually doing one?

A, Well, whenever you're exploring the abdomen, whatever that means, a laparotomy is a possibility.

Q. Okay. Is there anything in the medical record prior to the operative note that talks about exploration of the abdomen?

A. No,

Q. Doctor, in your experience is removal of both ovaries something that you, if it's a possibility, you discuss it with a patient before a surgery?

A. Yes.

Q. And if you're talking about removal of an ovarian mass, does that discussion necessarily involve the possibility *of* removal *of* the ovary?

A. Yes.

Q. And in a woman of Mr. Focht's age, if you're going in to explore for an ovarian mass, do you

also discuss removal of the other ovary?

A. Yes.

Q. And you explain what you explained to me before, that it's a standard medical practice to remove both if one needs to come out?

A. Yes.

Q. Have you ever in your practice removed both a woman's ovaries when the matter had not been discussed by you before surgery?

A. Yes.

Q. Can you explain to me what circumstance that occurred in?

A. Come across situations where there is disease present and they need to be removed.

Q. What kind of disease was present?

A. There can be infection.

Q. What kind of disease was present in the situation where you removed both ovaries having --

A. There has been adhesions, there has been infection, there has been

cysts present, there has been a number of occasions where ovaries have come out that it wasn't anticipated, but they had to.

Q. And you did not discuss it with the patient prior to the operation?

A. Yes.

Q. Is that something you do -- is that an occasional happening or is that common practice?

MR. BODIE: Objection. Go ahead.

A, However you want to define the term occasional, I would describe it as an occasional happening.

Q. Would it be fair to say that you usually like to have discussed that with a patient before they go into surgery if there is a risk they may lose their ovaries?

MR. BODIE: Objection.

A. Yes.

Q. Has it been your experience that women are not happy to find they lost their ovaries when they didn't know

that was going to happen?

MR. BODIE: Objection.

A. Not necessarily. Some have been quite pleased.

Q. Doctor, in your practice have you ever discussed a possible laparotomy for the removal of an ovarian cyst or mass and not discussed with the patient loss of the ovary at the same time?

A, Yes.

Q. Now, have -- we know from the testimony in this case that Dr. Shinde discovered that there had been injury to the bowel with a call from the pathologist?

A. Yes.

Q. And you have had an opportunity to take a look at the pathology report in this case from Firelands?

A. Yes.

Q. Where the pathologist reports multiple segments of full thickness bowel, in your opinion would that be

consistent with the injury that was done to the bowel as you understand it?

A. Yes.

Q. Have you ever received that kind of call from a pathologist in your experience?

A. No. I know physicians who have.

Q. Is the import of that kind of a call that you potentially have a perforation of the bowel in place inside a closed abdomen?

A. Yes.

Q. As the operating gynecologist, what are your obligations in that circumstance once you get that kind of a report that there is full thickness bowel in your pathology?

A. To follow up on that.

Q. How would you usually follow up?

A. Probably seek surgical consultation.

Q. In your opinion, do you have any obligation to make sure that that

surgical opinion is obtained expeditiously?

A. Depends on the clinical condition of the patient.

Q. In your experience can you rely on the clinical condition of the patient to tell you how serious the injury is to the bowel?

A. Yes.

Q. Doctor, in your opinion would it be within the standard of care to order a clear liquid diet for a patient in whom you've discovered there is full thickness bowel in the pathology?

A. Could be.

Q. In what circumstance?

A. If the patient is clinically progressing satisfactorily, you can give her clear liquids,

Q. Even if you have full thickness bowel in the pathology specimen you've removed?

A. That would be fine.

Q. Would that be taking a risk

that the clear liquid diet would in fact perforate the bowel?

A. No, it's not taking any risk.

Q. Doctor, if you have a patient that has known adhesive disease and you anticipate that surgery to remove a potential ovarian mass will be complex, are there occasions when you may refer the case to another type of surgeon or another type of gynecologist for operation?

A. As I said, in the case of a strongly suspected malignancy, I would refer them out.

Q. Other than strongly suspected malignancy, would you refer that kind of a case out?

A. No.

Q. When was the last time you did an operation on an cystic ovarian mass in a patient who has significant adhesions?

A. Probably two weeks ago.

Q. Doctor, other than this case

have you ever given expert testimony in a case involving the same type of issues presented here, the dissection or removal of an cystic ovarian mass?

A. Not that comes to mind at the moment, but that doesn't mean you might not find one, you know, from a number *of* years ago.

Q. And, doctor, the case you referred to before, the case of mesenteric ischemia, our office was plaintiff's counsel in that matter, if you recall?

A. I didn't recall that.

Q. And as I recall, the case involved a delay in diagnosis of the bowel injury, correct?

A. That was an element of that case, yes.

Q. That matter was settled?

A. Yes, ma'am.

Q. Other than that case, have you had any other medical malpractice cases brought against you in which the matter was settled?

A. I have been named in four. Two of which I didn't even know about. The other one besides the one under question was settled.

Q. I don't believe I have any further questions for you. Thank you,

MR. BODIE: Thank you. We'll reserve.

MS. McQUILLAN: Excuse me I do. Let me ask -- wait.

EXAMINATION OF METHOD A. DUCHON, M.D.

BY-MS.McQUILLAN:

Q. I asked you a lot of questions. Let me ask you the wrap-up questions.

We discussed a lot of your opinions regarding Dr. Shinde's care. I just want to make sure we have covered the opinions you have with respect to why Dr. Shinde's care met the standard of care?

A. Well, as I said previously, I can't promise you what I may or may not say or have an opinion about given other questions that may be asked of

me.

Q. Have the questions I asked you pretty much covered what you have discussed with Dr. Shinde's lawyers in forming your opinions in the matter?

A. I can't always respond -- I mean I can't promise what I might say in response to certain questions so...

Q. All I'm asking is have I asked you to date basically the same questions you have discussed with Dr. Shinde's lawyers?

MR. WHITE: That's probably work product, doctor, you don't have to --

MS. McQUILLAN: Probably, right. To the extent I'm discovering his opinions.

Q. Have I covered your opinions?

A. I think you asked me a lot of questions about my opinions, yes,

Q. Have I covered the opinions that you hold?

A. As I said, I can't promise

what I may or may not have an opinion about given some question by somebody. I just don't know.

Q. Have you explained to me why in your owned mind you believe Dr. Shinde met the standard of care in this case?

A. I think I have.

Q. Okay. And you have given me your opinions about the nature of the injuries to the bowel and what has happened there. Did you have any other opinions about what had happened in Dr. Shinde's surgery or what happened prior to the repair surgery?

A. Once again, I -- you know, I told you my opinions in response to your questions. I can't promise what I may or may not say in response to your other questions.

Q. I have no further questions at this time.

MR. BODIE: And again we'll reserve.

CEFARATTI GROUP FILE NO. 5312
CASE CAPTION: CONNIE FOCHT VS. S.G. SHINDE, M.D.
DEPONENT: METHOD A. DUCHON, M.D.
DEPOSITION DATE: ^, 2001

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(SIGN HERE)

The State of Ohio,)
County of Cuyahoga) SS:

Before me, a Notary Public in and for said County and State, personally appeared METHOD A. DUCHON, M.D. who acknowledged that he/she did read his/her transcript in the above-captioned matter, listed any necessary corrections on the accompanying errata sheet, and did sign the foregoing sworn statement and that the same is his/her free act and deed.

IN TESTIMONY WHEREOF, I have hereunto affixed my name and official seal at_____, this _____ day of_____, A.D. 2001.

_____ _____

Notary Public Commission Expires

ERRATA SHEET

PAGE	LINE	CORRECTION

CERTIFICATE

State of Ohio)
SS.:
County of Cuyahoga.)

I, Terri Grifo, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, was duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand this 15th day of March, 2001.

Terri Grifo

Terri Grifo, Notary Public
within and for the State of Ohio

My commission expires August 25, 2001.