

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.

- - - - -

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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## 1 APPEARANCES :

2  
3 On behalf of the Plaintiff:

4 Greene &amp; McQuillan

5 Co., L.P.A., by

6 JEAN McQUILLAN, ESQ.

7 1801 Bond Court Building

8 Cleveland, Ohio 44114

9 (216) 687-0900  
10

11 On behalf of the Defendant:

12 Marshall &amp; Melhorn, L.L.C., by

13 JOHN BODIE, ESQ.

14 KENNETH J. WHITE, ESQ.

15 The Ohio Building

16 420 Madison Avenue, Suite 1100

17 Toledo, Ohio 43604

18 (419) 249-7100  
19  
20

49 - - - -

21 ALSO PRESENT:

22 Connie Focht  
23  
24  
25

- - - -

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

7 EXAMINATION OF METHOD A. DUCHON, M.D.  
8 BY-MS.McQUILLAN:

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

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

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

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

25 I know you've had your

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

6 A. Yes,

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

10 A. As far as I know, yes.

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

14 A. I do not.

15 Q. And the last appointment  
16 ended in 1998?

17 A. That's correct.

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

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

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

7 A. None that I'm aware of.

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

12 A. Okay. The office records of  
13 Dr. Shinde, office records of Dr.  
14 Steele, Firelands Community Hospital  
15 Records, and MCO, Medical College of  
16 Ohio admission records. Also  
17 depositions of Dr. Shinde, Mrs. Focht,  
18 Dr. Steele, Dr. Kligman and Dr. Donnish.

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

22 A. Not that I'm aware of.

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

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1 A. No.

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

5 A. No.

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

8 A. No,

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

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

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

18 A. No.

19 Q. -- as an expert witness?

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

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

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

4 A. No.

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

8 A. Yes.

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

11 A. Yes.

12 Q. On about how many occasions?

13 A. Probably more than a dozen.

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

16 A. No, that's total for  
17 plaintiffs.

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

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

23 Q. Okay. Do you know Dr.  
24 Shinde?

25 A. No.

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

4 A. No.

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

10 A. That's correct.

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

15 A. That's true,

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

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

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

24 A. Somewhere between 130 and  
25 150.

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

3 A. All phases of gynecologic  
4 surgery and office work.

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

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

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

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

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

1 Shinde's conduct in the matter?

2 A. Yes.

3 Q. Can you tell me what those  
4 opinions are?

5 A. It was perfectly fine.

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

9 A. Yes, it met the applicable  
10 standard.

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

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

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

23 A. Not that I'm aware of.

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

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

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

9 Q. Yes.

10 A. The answer to that is no.

11 And the second part of  
12 the question was?

13 Q. The kind of repair that was  
14 done.

15 A. The kind of repair that was  
16 done?

17 Q. Right.

18 A. No.

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

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

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

5           A. Correct.

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

9           A. Yes.

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

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

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

19          A. Right.

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

22          A. I have no opinion about that  
23 care.

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

1 whether these complaints would be  
2 related.

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

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

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

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

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

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

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

10 A, That's correct.

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

15 A, I doubt it.

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

21 A. I think it was adequate.

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

25 A. Primarily office

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1 examinations, history, physical.

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

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

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

11 A. Yes.

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

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

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

23 A. I think that is standard  
24 practice, yes.

25 Q. What kind of information

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

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

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

9 A. I think it would have  
10 suggested that.

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

14 A. Yes,

15 Q. And what's that?

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

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

1 exploration?

2 A. I think that's likely.

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

8 MR. BODIE: Could you  
9 repeat that?

10 (Record read.)

11 A. Yes.

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

17 MR. BODIE: Objection.  
18 Go ahead.

19 A. Define palpable.

20 Q. Palpable in physical  
21 examination.

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

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

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

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

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

15 Q. What would suggest surgical  
16 management?

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

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

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

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

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

9 A. No.

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

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

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

1 or your operative planning?

2 A. Not necessarily.

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

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

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

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

21 Q. Would that have suggested a  
22 malignancy?

23 A. That would not have  
24 suggested a malignancy.

25 Q. Doctor, I assume in your

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

5 A. Yes, ma'am.

6 Q. That can be a very difficult  
7 situation?

8 A. You betcha.

9 Q. Very demanding situation?

10 A. Yes, probably,

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

14 A. Absolutely.

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

21 A. No.

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

25 A. No.

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

7 A, Yes, ma'am.

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

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

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

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

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

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

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

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

10              A.   Not that I'm aware of.

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

16              A.   That's what one tries to do.

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

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

25              Q.   What are the techniques that



1 are available?

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

6 Q. Any other techniques?

7 A. Not that I'm aware of.

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

11 A, Primarily, yes.

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

16 A. I'm sorry. Define  
17 obligation.

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

23 A. Yes.

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

1 appear?

2 A. It can appear in a variety  
3 of forms.

4 Q. What are those variety of  
5 forms?

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

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

11 A. Not necessarily.

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

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

1       employing contrast material.

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

5               A.   Yes.

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

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

10              Q.   Okay.  What kind of injury  
11      was that?

12              A.   Necrosis of the entire  
13      colon.

14              Q.   Mesenteric ischemia?

15              A.   Yes, ma'am.

16              Q.   Any other types of injuries?

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

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

22              A.   Hmm?

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

25              A.   As small bowel injuries.

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

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

6               A.   Both.

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

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

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

14              A.   No, ma'am.

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

17              A.   Personally, no.

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

20              A.   Yes, ma'am.

21              Q.   Okay.   In what context?

22              A.   GYN surgery.

23              Q.   Was the transsection  
24       recognized and repaired?

25              A.   Yes.

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

5 A. No.

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

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

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

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

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

23 A. I don't think so.

24 Q. Why not?

25 A. Do you mind if I look for a

1 second?

2 Q. Please look.

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

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

12 A. That's what it says.

13 Q. About how large is that,  
14 doctor?

15 A. About an inch.

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

18 A. In relation to the usual  
19 size --

20 Q. To the usual size of an  
21 ovary.

22 A. About the same.

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

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

4 A. I think it was injured.

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

8 A. I have an opinion.

9 Q. Okay. What is your opinion?

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

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

14 A. I think it was cut.

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

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

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

25 A. That postoperatively she

1        didn't get that sick.

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

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

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

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

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

16               A.    Yes, ma'am.

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

23               A.    I think probably the back  
24       wall.

25               Q.    Half of it or three quarters



1 of it?

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

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

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

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

18 A. They weren't.

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

23 A. Correct.

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

1 differing rates of development of an  
2 acute abdomen?

3 A. Yes.

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

7 A. I'm not a vascular surgeon.

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

12 A. Yes, ma'am.

13 Q. And some people became very  
14 toxic very quickly?

15 A. Yes, ma'am.

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

18 A. Not when you're leaking  
19 bowel contents.

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

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

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

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

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

6           A. Yes, ma'am.

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

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

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

16          A. Yes.

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

20          A, Yes, ma'am.

21          Q. How do you account for that?

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

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

1 remaining quarter of the bowel came  
2 loose from the adhesions?

3 A. Yes, ma'am.

4 Q. How does that happen?

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

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

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

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

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

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

22 A. I think that can occur, yes.

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

25 A. I think injury to adjacent

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

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

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

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

17 A. It can be, yes.

18 Q. Was it in this case?

19 A. Yes.

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

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

4 A. Yes, ma'am.

5 Q. How?

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

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

22 A. Can be, yes.

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

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1 cut through?

2 A. Yes.

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

5 A. Yes, ma'am.

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

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

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

18 A. They can be.

19 Q. Is that reported in the  
20 medical literature?

21 A, I'm sure it is somewhere,

22 Q. Have you ever seen it?

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

25 Q. Have you seen bowel injuries

1 of this nature reported in the medical  
2 literature?

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

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

8 A. I'd be happy to.

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

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

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

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

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



1 primarily?

2 A. I do not have an opinion.

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

5 A. Yes, ma'am.

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

13 A. That's correct.

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

19 A. I don't know that answer.

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

24 A, What do you mean?

25 Q. I mean was it medically

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

3               A.   What do you mean urgent?

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

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

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

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

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

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

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

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

3           Q. I'm using your definition,  
4 doctor.

5           A. At what time was it  
6 emergent?

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

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

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

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

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

1 A. At what time?

2 Q. On October 22nd, in the  
3 operation?

4 A. During the operation?

5 Q. Yes.

6 A. Yes.

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

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

14 Q. Why was it incumbent upon  
15 him to continue?

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

21 Q. Why did he need to continue?

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

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

1           A. When the patient is asleep,  
2       yes.

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

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

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

19          A. He was certainly prepared to  
20      do surgery.

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

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

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

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

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

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

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

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

20              A. Yes.

21              Q. What was the reason for  
22      that?

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

1       ovary also.

2               Q.   Why?

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

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

11                       MR. BODIE:       Which one,  
12      Jean?

13                       MS. McQUILLAN:       The  
14      right.

15               A.   Not that I'm aware of.

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

21               A.   That.

22               Q.   Okay.

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

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

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

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

10 A. May or may not be.

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

14 A. It does seem to decline,  
15 yes.

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

21 A. Declining.

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



1 A. Yes.

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

6 A. Very, very small.

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

9 A. May or may not be.

10 Q. Does an ovary ever become  
11 totally nonfunctional?

12 A. May or may not.

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

16 A. It can.

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

22 A. It does provide some  
23 hormones.

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

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

4               A.    Yes.

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

12                   MR. BODIE:        Objection.

13              Q.    Assuming her testimony is  
14      correct.

15                   MR. BODIE:        Objection.  
16      Go ahead.

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

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

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1 and enter her abdominal cavity?

2 A. Yes.

3 MR. BODIE: Objection.

4 Q. And your answer was --

5 A. Yes.

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

8 A. Yes.

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

15 MR. BODIE: Objection.

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

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

20 A. No.

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

1 Shinde's note in his chart from October  
2 10th is not consistent with that  
3 testimony?

4 MR. BODIE: Objection.  
5 Go ahead.

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

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

12 MR. BODIE: Objection.

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

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

25 MR. BODIE: Objection.

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1 Go ahead.

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

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

11 MR. BODIE: Objection.

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

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

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

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

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

25 Q. Doctor, can you answer my

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1 last question?

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

4 (Record read.)

5 MR. BODIE: Objection.

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

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

15 A. That's correct,

16 MR. BODIE: Objection.  
17 Go ahead,

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

21 A. Yes.

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

25 A. Yes.

1 Q. She was reluctant to have  
2 that done?

3 A. That's your word.

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

8 A. I wouldn't use the word  
9 reluctant.

10 Q. She -- what word would you  
11 use?

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

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

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

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

25 A. Yes.

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

4 A. Do you know where that  
5 occurred?

6 Q. I believe it is about page  
7 64, 65 perhaps. I left my copy on my  
8 desk.

9 A. What was the question again?

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

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

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

21 MR. BODIE: Give me  
22 just a second.

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



1 did not give you consent to enter her  
2 peritoneum?

3 Answer. That is not  
4 true.

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

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

15 MR. BODIE: Objection.

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

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

1 A. May or may not,

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

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

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

10 MR. BODIE: Objection.

11 A. It may or may not happen.

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

17 MR. BODIE: Objection.

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

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

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

4                       MR. BODIE:           Objection.

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

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

12              A.   Yes,

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

18              A.   Yes.

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

22              A.   Yes,

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

1       that he did?

2               A.    Yes.

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

8               A.    No, it does not.

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

12              A.    Not exactly.

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

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

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

21              A.    That's correct.

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

25              A.    That you do what you think

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1 is right.

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

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

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

14 A. I'm sure it does.

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

17 A. Not that I recall.

18 Q. Okay. Do you think you  
19 could?

20 MR. BODIE: Objection.

21 A. Possibly.

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

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

5 A. Yes.

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

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

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

21 A. One second. What was the  
22 question again?

23 Q. My question was other than  
24 Dr. Shinde's office note of October  
25 19th, is there any other part of the

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

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

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

11 A. No,

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

17 A. Yes.

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

22 A. Yes.

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

1 also discuss removal of the other ovary?

2 A. Yes.

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

7 A. Yes.

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

12 A. Yes.

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

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

18 Q. What kind of disease was  
19 present?

20 A. There can be infection.

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

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



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

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

7               A.   Yes.

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

11                       MR. BODIE:       Objection.  
12       Go ahead.

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

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

21                       MR. BODIE:       Objection.

22               A.   Yes.

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

1       that was going to happen?

2                               MR. BODIE:       Objection.

3               A.   Not necessarily.   Some have  
4       been quite pleased.

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

11              A ,   Yes.

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

17              A.   Yes.

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

22              A.   Yes.

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

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

3 A. Yes.

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

7 A. No. I know physicians who  
8 have.

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

13 A. Yes.

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

19 A. To follow up on that.

20 Q. How would you usually follow  
21 up?

22 A. Probably seek surgical  
23 consultation.

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

1 surgical opinion is obtained  
2 expeditiously?

3 A. Depends on the clinical  
4 condition of the patient.

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

9 A. Yes.

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

16 A. Could be.

17 Q. In what circumstance?

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

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

24 A. That would be fine.

25 Q. Would that be taking a risk

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

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

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

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

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

19              A. No.

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

24              A. Probably two weeks ago.

25              Q. Doctor, other than this case

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

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

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

14 A. I didn't recall that.

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

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

20 Q. That matter was settled?

21 A. Yes, ma'am.

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

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

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

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

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

11 EXAMINATION OF METHOD A. DUCHON, M.D.

12 BY-MS. McQUILLAN:

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

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

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

1 me .

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

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

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

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

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

19 Q. Have I covered your  
20 opinions?

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

23 Q. Have I covered the opinions  
24 that you hold?

25 A. As I said, I can't promise

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

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

8                A.    I think I have.

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

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

21               Q.    I have no further questions  
22       at this time.

23                                MR. BODIE:                And again  
24       we'll reserve.

25

CEFARATTI GROUP FILE NO. 5312

CASE CAPTION: CONNIE FOCHT VS. S.G.

SHINDE, M.D.

DEPONENT: METHOD A. DUCHON, M.D.

DEPOSITION DATE: ^, 2001

( 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

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ERRATA SHEET

<u>PAGE</u>	<u>LINE</u>	<u>CORRECTION</u>
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## CERTIFICATE

State of Ohio )

SS.:

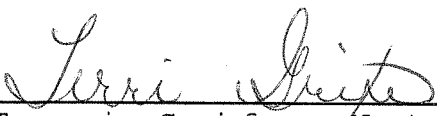
County of Cuyahoga. )

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, Notary Public  
within and for the State of Ohio

My commission expires August 25, 2001.

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