Doc. 167

THE STATE of OHIO, :
: SS:
COUNTY OF LORAIN. :

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IN THE COURT OF COMMON PLEAS

- - - - -

LENORE LIND, et al.,
plaintiffs,

vs. : Case No. 93CV110798

COMPREHENSIVE HEALTH CARE of OHIO, INC., et al.,
defendants.

Deposition of D, ROY FERGUSON, M.D., a witness herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Frank P. Versagi, Registered Professional Reporter, Certified Legal Video Specialist, Notary Public within and for the State of Ohio, at the Mount Sinai Medical Center, One Mount Sinai Drive, Cleveland, Ohio, taken on THURSDAY, JANUARY 5, 1995, commencing at 4:10 p.m. pursuant to notice.

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I N D E X

WITNESS: D. ROY FERGUSON, M.D.

(FOR EVERY WORD INDEX, SEE APPENDIX)

D. ROY FERGUSON, M.D.

of lawful age, a witness herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, being first duly sworn, as hereinafter certified, was examined, and testified as follows:

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CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Would you state your name, please?

A. D, as in David, Roy Ferguson, F-e-r-g-u-s-o-n.

Q. Do you have a CV, Doctor?

A. I do not in my -- not totally current, but I don't have it with me, but I do have one.

Q. Do you have one up here?

A. Yes.

MR. SCOTT: Can I ask somebody?

THE WITNESS: Yes, in the office, the glass office, Liz.

MR. SCOTT: Liz.

THE WITNESS: I'll see if she has a CV there.

Q. While we're waiting for that, can I see your

entire file, please?
A. These?
Q. Your entire file, whether that's those or whether there is additional materials?
A. There is a box of additional parts of a chart, I'd be happy to bring it in for you.
Q. I want to see everything that you got.
A. I will get it then. Excuse me one moment.

(Interruption in proceedings.)

BY MR. KAMPINSKI:

Q. Doctor, there are three bound volumes that are black, there are another three in the box, four black ones and then there are two black volumes containing partial depositions, then there is some looseleaf materials which constitute December 15th letter from Mr. Scott to you that include various depositions; where are the rest of the correspondence in your file?

MR. SCOTT: Do you have others?

A. I don't recall any other correspondence.
Q. Well, Doctor, in your report you refer to correspondence that you had gotten from Mr. Scott,

where is it?
A. There's a letter of a telephone call, you asked me if I would do this.
MR. SCOTT: Okay.
A. Well, I don't know. If it's not in with this, I don't know where it is right now. If you have a copy I could --
Q. How would I have a copy of what you have? You're the one who refers to it in your report. I'm asking for your entire file, so where did you put it?
A. This is the file I worked with. I don't recall where that is.
Q. Doctor, referring to the October 26, 1994 letter, the very first sentence, second sentence says --
A. I am not denying that. I don't know where the letter is right now. I may have -- not have kept it.
Q. I don't know what the letter is. It says you read over the letter.
A. If you would like me to, I could go look for it.
Q. If you would, thank you, and any other documents that are pertaining to this file?

A. Let's make sure first it's not here.

MR. SCOTT: You have them out, if there is -- there may be something else in your office?

THE WITNESS: It's possible my secretary may have filed it in the correspondence thing to make sure. I didn't remember putting it in here.

Excuse me a minute.

MR. KAMPINSKI: Sure.

(Interruption in proceedings.)

BY MR. KAMPINSKI:

Q. Doctor, you've found the letter that 1 was referring to, which is the September 9, 1994 letter from Mr. Scott to you?

A. Yes.

Q. Is that the only correspondence other than the December 15, 1994 letter from Mr. Scott to you that you have from him?

A, As far as I can recall, yes.

Q. And the only correspondence from you to him would then be the October 26th report, as well as a partial billing for your time spent?

A. That's the only correspondence.
Q. Is that the only report you prepared in conjunction with this case?
A. Yes, it is.
Q. You didn't have any drafts or preliminary reports that were changed?
A. No. I am not sure of the dictation, the preliminary dictation may have been changed and thrown away, but I don't recall what that was. It would have been typographical errors corrected on it.
Q. By yourself?
A. Yes.
Q. Did you discuss the contents of your report with Mr. Scott before putting it in writing?
A. No.
Q. After dictating the initial report did you discuss it with Mr. Scott?
A. Subsequently before coming here, yes.
Q. No.
Before actually --
A. From the draft to final stage?
Q. Yes.
A. No. I don't do it like that. It is only for typographical errors that I make corrections,

Q. You said that your CV was not current, is there anything else I need to know about any additional publications or anything else?
A. There's a few publications, I honest to god couldn't tell you what they were right now. Some additional publications having to do with hepatobiliary things, and the gallbladder, just about gastroenterology.
Q. Any of them that would in any way pertain to any of the issues involved in this case?
A. Not directly, or indirectly as far as I know, no, other than gastroenterology.
Q. Did you make any notes or notations in any of these records or depositions?
A. I don't think so.
Q. You didn't paginate anything or --
A. I don't believe so. Maybe 1 might have. I may have underlined some things to bring it to my attention, but I don't recall even doing that.
Q. Doctor, has anything been removed from the reports that were provided to you?
A. Not my me.
Q. I'm looking at one of the folders and in the portion that's label "orders," it goes up to page 190, which is part of May the 7th; could you

tell me if you received any other orders pertaining to this case or if that's it?

A. Here is some additional orders right here,

Q. Okay. Did they continue on past the divider?

A. Yes.

Q. Okay. All right.

So they're just in the section entitled "code blue" but continues with the orders?

A. Yes,

Q. Doctor, if at any time you need to refer to the records, it's okay. Sou know, fortunately they have been numbered and maybe even I can assist you with some of the numbers; but feel free to do so if at any time you need to look at them, all right?

A. Thank you. Can I put these down here?

Q. Sure. Anywhere you want,

A. Thanks.

Q. So it's easy reference to you, You put them where you can get them.

A. Okay. I'll start with this, let's see what you are going to ask.

Q. Do you know Dr. Patel, D.C. Patel?

A. I know him casually. I met him at -- seen him in meetings, that's about all. He's also referred patients occasionally.

Q. To you?
A. To me or the group when I was at the Cleveland Clinic,
Q. Which groups would you have occasion to meet him at, which meetings?
A. Digestive Disease Week meetings where -- they're some of the courses the Cleveland Clinic puts on, he would tend to come to those. The November Gastroenterology meetings, it would be in that context, in gastroenterology professional meetings.
Q. When did you leave the Clinic?
A, January -- or December, 1992.
Q. How long had you been there?
A. 16 plus years,
Q. Why did you leave?
A. It was a good opportunity to come here, work in a different venue, help set up a training program, need some work done with it, variety of reasons; none of which were professional reasons other than just personal satisfaction,
Q. By whom are you employed at your current employment?
A, Mount Sinai Medical Center.
Q. So you work directly for the hospital?

A. That's correct.
Q. Well, are you a member of a group?
A. It's the Friedman Center for Gastroenterology, Friedman Center for Digestive Disease and Liver Disorder.
Q. Is that a private group that's separate from Mount Sinai?
A. No, we're all employees of Mount Sinai and we use Mount Sinai facilities at the current time.
Q. So you get a paycheck from them?
A. That's correct.
Q. Is it at all dependent upon your billings?
A. No, it is not; it's a salaried position.
Q. You have a contract with them? You work for them just like you did for the Clinic before?
A. That's correct,
Q. Does Dr. Patel refer patients to you here since you moved from the Clinic?
A. I'd have to go back and really honest to god look, I would be cloudy, I can't recall if I received one from him since I left the Clinic or it's -- I'd have to go back over all my records and find out,
Q. How about Dr. Paresh Patel, do you know him?
A, No.

Q. How about Dr. D.C. Patel's wife, do you know her?
A. No.
Q. Have you ever socialized with Dr. Patel?
A. No, I have not.
Q. Have you ever reviewed any other case on his behalf?
A. Not that I am aware of, no.
Q. Have you testified as an expert before?
A. I have.
Q. How many times would you say?
A. Once as an expert.
Q. That's testifying?
A. Testifying. Well, let me think.
As opposed to deposition, you mean?
Q. Well, I was going to make sure 1 covered both, so you tell me.
A. It was once as an expert and it was testimony; there was a deposition ahead of them, and then testimony.
Q. What was the name of the case?
A. Now you're going to challenge me.
I have to go back and look.
Q. How long ago was it?

A. About two years ago.
Q. Where was it?
A. Here in Cleveland,
Q. Who was the judge, do you know?
A. I don't know.
Q. Who was the attorney that represented the physician that retained you?
A. I want to say a Jim Malone.
Q. Jim Malone from Reminger's office?
A, I think it was him.
Q. What was the nature of the case?
A. Let me think about this a minute. This was -- it was a -- okay, I'm not sure it was Jim Malone,

Do you want me to give you the name of the case, of the person?

Q. Sure.
A. It was Mark Modick's case, where the gastroenterologist was charged, was the defendant gastroenterologic practice, and I gave testimony on his behalf or on his -- what he had done.
Q. What was alleged that he had done?
A. They alleged there was a condition relative to a rare disease known as Gorhauf's syndrome that was missed and he had not done the appropriate

thing to make that diagnosis in a timely fashion,
Q. What was the name of the gastroenterologist?
A. Mark Modick.
Q. You don't remember the plaintiff's name then?
A. No, but I can find that out if you really need,
Q. That went to trial?
A. That did go to trial.
Q. Have you testified or have you been retained as an expert in any other case that where you either have not been deposed or hasn't been a trial?
A. I'm not sure. Some years ago I was asked -- was on a defensive side, we were dropped out of the case and I was asked by the plaintiff's attorney to provide expert testimony for him.
Q. In other words, you were sued, dropped, and he asked you?
A. Correct,
Q. To act as an expert?
A. I gave deposition, that was all I heard. I don't know if the case went anywhere else,
Q. Do you remember the name of the case?
A. I don't, I can remember the name, which was --

Q. Who was that?
A* Vic -- I can't remember. Veganoni or something like that. It was several years ago, V-e-g something, It may come back to me.
Q. What was the nature of that case?
A, Really -- I really don't remember that was so far long ago, Again, a malpractice case, I -- for the world I don't know why I was involved, I was sued, somebody else happened to see the patient, and I was subsequently dropped,
Q. Was that while you were at the Clinic?
A, Yes, several years ago, probably eight, nine,
Q. Those are the only two cases then that you have been involved as an expert?
A. That's correct, if you want to call the latter one an expert,
Q. Any where you've been involved as a defendant other than the one you just gave?
A. Once when --
MR. SCOTT: Objection, You may answer,
A. Once when the Clinic was involved in a lawsuit and I was member of the Clinic, I wasn't directly sued, I have not been involved in direct

suits.
Q. In other words, you weren't named separately?
A, Yes.
Q. But the suit involved conduct of yours?
A. Suit involved actions that happened at the Clinic that I had to give testimony about because I was involved in the case.
Q. What was the name of that case?
A, That was a relatively recent one. 1 can't remember the woman's name, Chiswick.
Q. Do you remember the attorney?
A. No, I got to think about it, that may have been Jim Malone, I'm sorry. I don't remember the attorney's name well. I have all these in the files, these are things I can really look it back up.
Q. Do you know who deposed you?
A. I do not,
Q. Do you recall what the allegations were in that case?
A. I do. Patient which -- he claimed the patient had got AIDS from a blood transfusion, 1 was involved in doing a procedure during that period of time she was in the hospital, and subsequently the allegation was that we had -- she

was given a medication that caused her to have a blood reaction that required the transfusion, and that's why she got AIDS and so forth. It was last Spring, I believe.

Q. Did you testified in court in that case?

A. Yes, I did.

Q. That was George Gore; was it not?

A. I'm sorry. You are right. That's correct. Thank you.

Q. Sure.

A. I bet I can remember the doctor's name.

Q. By whom are you insured?

MR. SCOTT: Objection. You can answer.

A. Good question. I'm under the blanket of Mount Sinai. I'm not sure who the insurance carrier is.

Q. You don't know if it's PICO or not?

A. I honest to god don't know. Good question.

Q. Prior to dictating your report in this case, did you discuss the case at all with any other physicians or anyone else?

A. No.

Q. Is the contact by Mr. Scott in this case of September the 9th the first contact that you had

regarding this case?
A. I have to ask Mr. Scott. I think we telephoned, had telephone conversation before that asking if I'd consider doing this and he would send me the details, that would have been the first contact.
Q. Do you recall how long prior to the letter that would have been, a week, a month, a year?
A. It wouldn't have been a year, probably have been a week or two.
Q. Have you had any contacts with any prior attorneys regarding this case before Mr. Scott called you?
A. No.
Q. So the first that you knew anything about Lenore Lynn or anything involved is when you would have heard from Mr. Scott?
A. That's correct.
Q. Doctor, in your report -- if you want you can follow along with me.
A. Thank you.
Q. At no time in the report do you say anything with respect to the propriety of the decision to send Mrs. Lind for a CT scan without protecting her airway.

Can we agree that that decision was inappropriate, that is sending her without protecting her airway?

MR. SCOTT: Objection.

A. That's really out of my purview actually because that would not be a decision that Dr. Patel -- my presumption is that I was asked to look at Dr. Patel, D.C. Patel's action as a consultant in gastroenterology; under that aspect, which is the only aspect I viewed it from, that would not be within his domain to make that decision.

Q. Let me ask you this: You changed the question a little on me.

In terms of --

A. Rephrase it then, please.

Q. That's fine,

The practice of gastroenterology is part of the practice of internal medicine; is it not?

A. That's correct.

Q. The practice of pulmonary medicine is part of the practice of internal medicine; is it not?

A. Both highly subspecialized.

Q. Right.

As an internal medicine physician, do you generically as an internal medicine physician have the ability to determine whether or not a patient's airway should be protected when they're sent down, for example, for a CT scan?

A. If you asked me that question 20 years ago I would have probably said yes. It's become specialized enough that I would defer to the subspecialist in that field at this point.

If you were in general internal medicine and the primary care doctor of the patient, I might have to take the responsibility; but if it was not within my subspecialty, no, I would not.

Q. So it is something at least from a training standpoint that someone in internal medicine regardless ultimately of their subspecialty is competent to make the decision on?

MR. SCOTT: Objection.

A. You are rephrasing a little what I said, so I'll go back to that, too.

Q. Sure.

A, I may not be -- I will not consider myself competent now to make that decision. They may have been versed in that at some point, yes, but they

may not be competent now depending on how long they've been away from general internal medicine to make that decision. I would judge it that way.

Q. That's fine.

I thought I said in my question by training they would have been competent?

A. By training they would have had experience with it, yes.

Q. So you yourself underwent training that would enable you to make that decision; is that correct?

A. At that time, yes.

Q. Well, is there something now that prevents you from making that decision?

A. Yes.

Q. What is that?

A. Evolution of the subspecialty of pulmonary medicine and critical care medicine, it has gone as far as gastroenterology has in that same 20 years,

As much as I hate to admit it, I would not feel comfortable in making a decision like that, nor would I judge any other gastroenterologist with the same degree of time under his belt to judge himself, unless he was taking courses in that, which I have not, and I presume he would not, to make a decision in that

field.

It has evolved far too much. The machinery that was used back then is not used today, techniques available to determine status of the patient are all knew.

Q. So that is why then your report doesn't address that issue; is that correct?

A. That's correct. It wasn't germane to the gastroenterology practice.

Q. So you have no opinion as we sit here today after having reviewed all these materials as to whether or not Mrs. Lind should in fact have been protected prior to being returned to x-ray?

A. I have no opinion that would be expert, no.

Q. Do you have a non-expert one?

MR. SCOTT: Objection.

MR. GALLAGHER: Objection.

A. Not really. I'd have to go over the whole case with respect to that. I don't deem myself competent to do that, competent to intubate, whether they should be intubated or not, whether one would or would not do intubation for a given situation like that. I'd have to go over it all, all over the days, but I'm not an expert in that field.

Q. Could you show me where in the chart or where in any of the depositions or documents Dr. Patel deferred that decision?

When I say "that decision,'' I'm referring now to the decision to send her back down without protecting her airway on May the 7th, 1992?

MR. SCOTT: Objection.

A. Stop.

Q. I'll say it again.

A. Go ahead.

Q. Could you show me anywhere in the chart where Dr. D.C. Patel, on whose behalf you wrote the report --

A. Right.

Q. -- deferred the decision to send Mrs. Lind back down to x-ray for a CT scan without protecting her airway, to Dr. Dacha or anybody else?

A. It's a bit like the question of how many times a week do I beat my wife.

Q. It really isn't.

A. I have to interpret it that way. I'm sure you don't.

But I don't think he is in a position to make the decision to send her down,

that was not his domain. He's not a primary care doctor.

He makes a recommendation that she should have whatever test, X, Y, or Z, then it has to be acted upon by the primary care doctor; so he may say the patient should go for an x-ray, but he can't send her down. He is a consultant, not the primary care doctor.

Q. What are orders for?

A. What are orders for?

Q. Yes.

A. To direct action.

Q. In other words, when you put an order in a chart and you make an order, you expect it to be followed, don't you?

A. Generally. Unless, again, to put an order to do something or to contact somebody, or I can write an order as a consultant and say thus and thus and thus should be done, clearance with primary doctor or whatever; but I've overstepped my bounds if I put an order say on a person in cardiology, is having -- a hypothetical issue -- has a heart problem, I think she should have a toe amputated and I write an order for amputation, even though as an expert in that I am overstepping my bounds if I

don't clear it with the primary service.

I have strong feelings about primary services, who the primary doctor is and who the advisers or consultants are, as I'm sure you do in law. If you were the primary attorney, you might have a staff advising you, but you damn want to be the one to make the final step because you're the primary attorney, not somebody else who is coming in and acting on your behalf without your expressed desire to let them go ahead and do that.

I'm presuming, but it's certainly true in medicine, if I'm not told expressly by the primary care doctor please proceed, I don't do it.

MR. KAMPINSKI: Frank, would you go back and read my question.

(Question read as follows: In other words, when you put an order in a chart and you make an order, you expect it to be followed, don't you?)

Q. So if I understand your answer, sometimes you expect it to be followed, sometimes you don't?

A, Yeah. You gave me a general question, I gave you a general answer.

If you have a specific question, then I'd be happy --

Q. On May the 7th of 1992, page 193, I believe, there is an order from Dr. Patel; is there not, of 12 --

A. 12:45?

Q. Yes.

A. Yes.

Q. Can you tell me what order he made at 12:45?

A. If I can.

Do not do follow studies on HIDA scan, proceed with CT abdomen, pelvis if okay with Dr. Dacha.

Q. You make an interesting point in your report about the last part of that order, that is the "if okay with Dr. Dacha"?

A. That's correct.

Q. That was not written by the nurse, this is a verbal order; is it not?

A. It's a verbal order recorded by the nurse, correct.

Q. She didn't write "if okay with Dr. Dacha," did she?

A. It's different handwriting, I presume that's correct.

Q. so --
A. I can't -- I don't know for sure. It looks like a different handwriting to me.
Q. I think you're right.
The point you make in your report, and I quote your report, sir, is "my only concern"?
A, Agree.
Q. "Is on the order of May 7, 1992, 12:45 p.m."
A. Right.
Q. "Which is the order time when she had been there, which is on page 193 of your documentation," and the phrase, this is quoted by you.
A. Yes.
Q. "If okay with Dr. Dacha,"
A. Right.
Q. "To proceed with CT of abdomen and pelvis is written in by D.C. Patel presumably when he countersigned the orders, this could have been written in at any time and may pose a potential problem"; did I read that right?
A. You're absolutely correct in that,
Q. Why did you say it may pose a potential problem, sir?
Am Because I don't know when it was written, if he wrote it right at the time he countersigned it,

if it was countersigned right shortly after he gave it when he arrived on the ward, it's not a problem; if it's written three days later, I view that as a problem.

I have no idea when he wrote it but this is somebody else's writing.

Q. Why do you view it as a problem three days later, if it's written three days later?

A, Because you have an event that happened afterwards, that would make it look like he wrote the order to send the person down.

Again, if I were to come on a ward, see that order, that wouldn't be a problem given my philosophy that I already said. I don't have the right to order somebody else's patient to have anything done, I have to clear it, I've personally done the same kind of thing when I give verbal orders, they're taken -- you have to go and clear it with the primary doctor, If I am not there writing it at the time, that happens, sometimes you write it 15 seconds later or 15 days later. If that's his philosophy that's what should be done; in other words, it has to be cleared with the primary doctor is what I am saying, then that's okay.

Q. Well, if that wasn't the order that he gave the nurse originally, and the only order he gave was proceed with CT abdomen and pelvis?

A. Yes,

Q. Then in fact it was his decision to do the CT scan in the absence of protecting her airway?

A. This is speculation on your part.

Q. No, it's not,

You're the one that pointed out in your report this was written later.

A. No. I pointed out it could have been written later. It could have been written 15 minutes later, it could have been a year later.

Q. That's right,

Then it was written later?

A. Yes.

Q. So it's speculation on your part as to when it was written?

A. It's not speculating --

Q. You said it could cause a potential problem and --

A. All right. I'm speculating, obviously he wasn't there when he gave the telephone order or there wouldn't be a need for a telephone order, He gave a telephone order, when it was written

subsequently, I have no idea, but I --
Q. So I am not speculating anymore than you are?
A. I guess we're both speculating.
Q. In terms of asking you if in fact it was done three days later, as you just mentioned, why would that be a problem?
A* It wouldn't be for me. If I -- that was the first time I reviewed the orders that were given and then put that in.
Q. Why would you have to put that in if in fact you were --
A. Because the nurses tend not to.
Q. Beg your pardon?
A. The nurses tend not to write that kind of thing clearly, "clear with," that's the kind of thing a physician tends to write when physicians write the orders, that's why written orders are always better than telephone orders.
Q. Well, is your concern as expressed in your report that it would appear that Dr. Dacha came and wrote that after the fact to try to cover himself in terms of whose decision it was to send her down?
MR. GALLAGHER: Objection. I think you said Dacha,
Q. I'm sorry, Dr. Patel, Let me say it again.

Is your concerned as expressed in your report that Dr. Dacha in fact tried to --

A. No.

Q. -- deflect --

A, Dr. Patel.

Q. Right.

-- tried to deflect responsibility from himself in ordering that test?

A, It could have that appearance.

Q. Yeah, Well, Mr. Scott in his letter to you of September 9, 1994 -- mark that, why don't you.

(Dr. Ferguson Deposition Exhibit 1 marked for identification.)

Q. In his letter of, which I now marked Exhibit 1, of September 9, 1994 on page 2 in the middle of the second page, basically sets forth a recitation of facts both from deposition and from the record.

In the middle of that paragraph he discusses Dr. -- or what are we talking about now -- okay, he said, I'm quoting, Dr. Patel told the nurse to contact Dr. Dacha to advise him of this condition, Dr. Patel's verbal order, "timed

at 12:45 p.m. on Nay 7th but believed to have been about 10:30 a.m." directed the nurse to discontinue the **HIDA** scan and also contains the further order to, I'm quoting now, or I mean Mr. Scott is quoting, to "proceed with **CAT** scan if okay with Dr. Dacha."

A. Yes.

Q. So Mr. Scott drew your attention to that particular entry that we're talking about now but at no point in the letter does he tell you that that was not originally in the verbal order, does he?

MR. **SCOTT:** Objection,,

A. No. I have no -- I didn't have any records at the time I received that letter.

Q. Did you discover that on your own in looking at that entry?

A. Yes.

Q. Were you told that by --

A. I was not told that by anybody. I just looked at it, it looked different to me.

Q. Mr. Scott goes on, and there is one other quote in that second paragraph, it's a little later in the paragraph here.

Well, Mr. Scott says Dr. **D.C.** Patel

relied upon Dr. Dacha in connection with the patient's respiratory status and ability to undergo the CAT scan procedure. Accordingly in his notes of the conference on May 7th, Dr. D.C. Patel concluded that, here is the second quote in his paragraph, "case discussed with Dr. Miclat and Dr. Dacha, and according to them, patient can go for CAT scan," and his quote is from the progress note of May the 7th, correct?

A. I believe that's correct.

Q. Page 50, I believe, or 46, something like that.

A. 50, 463

Q. Somewhere around there?

A. It's page 50.

a. 50.

In your review of that record and what he was quoting, did you determine when that was written?

A. I have not determined.

Q. When I say "that," I'm talking about the quote that is "case discussed with Dr. Miclat and Dr. Dacha, and according to them, patient can go for CAT scan"?

A. I have no -- I presume it was written at the

same time,

Q. Do you?

A, I do, but I don't know,

Q. I got a color copy of the chart, which I just handed to you of that same page.

Can you determine whether or not that was written in different ink, Doctor?

A, It looks like a different color ink,

Q. It does, doesn't it,

So if I look at this, Doctor, the two quotes that Mr. Scott directed your attention to that seem to exculpate Dr. D.C. Patel from the decision-making process in terms of sending her back down for CAT scan were both added later?

A, I can't actually say that this one was,

Q. Sure, you can,

A, If my pen ran out or --

Q. It's definitely blue ink which corresponds to the rest of the note, and the addition is in black ink, isn't it?

A. The addition is in black ink. I guess that's blue here, The addition -- certainly the statement "case discussed" is written in black ink, different from the preceding paragraph. The signature I

think is --

Q. But getting back to my question then: The two statements that would be exculpatory from Dr. D.C. Patel's standpoint in terms of the decision-making process that Mr. Scott directed your attention to on September 9, 1994, were both added after the fact certainly, weren't they, sir?

MR. SCOTT: Objection.

A. Again, I don't know that. I don't know how far after the fact you're talking about.

After which fact, written original order?

Q. Yes.

A, Yes, certainly written after the -- it certainly is because the order was a telephone order. If this was written after this note was completed, it's certainly written after that. If I changed pens at that point, if my pen ran out, it would be a different color ink. I don't know about the signature, if that's blue, black or how it was written in there.

You may be right, certainly written in different color ink, I'll give you that.

Q. Well, just assume with me for a moment that it was written after the fact.

A. After the fact, which fact?
Q. Both facts, that is the order --
A. Okay.
Q. -- that we have discussed, when that's done, we don't know when after the fact.
A. Right.
Q. After the May 7th entry on page 50, that at some point after that he came back and added this in black pen, that's the quote that Mr. Scott refers to in his letter?
A. At some point after he used the blue pen, he used the black pen, correct.
Q. Correct.
A. Don't know when.
Q. Let's assume --
A. Either way.
Q. -- after she had her arrest that he at some point after that, he adds these two entries.
A. It's an assumption. We're speculating after that. Okay.
Q. I'm asking you to assume that. Obviously if the assumption isn't true, the questions based on that assumption wouldn't be true, nor would be your answers.
A. Fair enough,

Q. Assuming that to be the fact, does that change your opinion at all?

MR. SCOTT: About what?

Q. About Dr. D.C. Patel's responsibilities for her going down to CAT scan in the absence of protecting her airway?

A. No, because he's a consultation role and he is consulting, giving advice.

Q. So that if he wrote these after the fact, that is after her arrest, and if he did so with the intention of deflecting his responsibility, that doesn't change your opinion at all?

MR. SCOTT: Objection.

A. Say it again.

(Question read.)

A. No, it doesn't. You are asking me what his intention was, I can't tell you that, but my opinion is --

Q. I'm asking --

A. -- as a consultant, his role is advisory, not -- what's the best word, declaratory order-wise. He's not the one -- he ought not to be the one writing the orders, he's not the primary

care doctor,

Q. So that if in fact he did write the order and didn't qualify it with "if okay with Dr. Dacha,'! then that would have been inappropriate on his part?

A, My view, the way I practice and I think consultants practice, he overstepped his bounds if he's ordering another person, unless he has the express privilege by the doctor.

I have had situations where primary care says please proceed as you feel fit.

Q. So we agree then?

A, Yes.

Q. That would have been inappropriate, below the standard of care if he would have done that?

A. If your assumption you have is correct.

Q. All right. Did you read the deposition of Dr. Miclat, you were provided with a Pot of materials, you may or may not?

A, I don't think I did but I'd have to look at it again. I suspect I --

MR. SCOTT: Wait for a question,

Q. The question was did he read it,

MR. SCOTT: He doesn't

remember.

A. I don't remember.

Q. You're aware, I take it, of the meeting prior to her being returned to radiology between Dr. D.C. Patel, P. Patel, Miclat, and Dacha?

A. From the notes we have just reviewed that would be my presumption, they discussed it.

Q. I take it you don't view your function as an expert as making up facts, rather it's to deal with the facts that are being testified to by the people who were there and involved?

A, I hope so.

Q. Well, so if in fact the four physicians themselves say that it was a joint decision to return her to x-ray, you don't quarrel with that, do you?

A. Yes, I do a little bit.

Q. You do?

A. Yeah. If I am the pilot of an airplane and I ask everyone's opinion about something, the navigator and everybody, sooner or later I make -- I know I have to make a decision what we're going to do with the airplane. I don't give a damn what the other people think, as to whether they -- how they come in or necessarily may agree what the best

thing to do is, because sooner or later one of the parties, the primary care doctor, whoever that may be, has to make the move; say, okay, this is what we'll do.

Again, the analogy to that as I said before is how you proceed with a case, you make the final argument, it's not a committee decision, we have to decide we're going to argue this, this way, it's your decision.

Q. Well, Doctor, the fact that the pilot may make a wrong decision doesn't exculpate the navigator for making a wrong decision as well, does it; if in fact they both make a wrong decision?

A. If it's the command decision and the final command decision, it still is.

Q. The pilot may be responsible for the command decision but you are saying that exculpates the navigator then?

MR. SCOTT: From doing what?

MR. MAMPINSKI: From making a wrong decision.

MR. SCOTT: But the navigator is not making that decision,

A. If the navigator says fly into the glacier

and the pilot says okay, and he does, it's the pilot's problem, the pilot's fault. The navigator is there but it's the pilot's problem, once you make a final decision to do it, you're charged with that, that is it,

Q. So the navigator is not responsible?

A. You can check with the FAA, I fly, that's absolutely true. The pilot is responsible, including putting gas in them,

Q. It's your opinion in Ohio that the captain of the ship is responsible for the actions of the navigator and anyone else that is involved in this steering of that ship?

MR. SCOTT: Objection,

Q. Is that right?

A, I'm not just speaking of Ohio, that's the way --

Q. That's where we are,

A, I'm giving you my practice, how I govern it, that ultimately that it's my decision what to do. If I make a wrong decision and was given good advice, well, I hang.

Q. Well, if the law hypothetically is that each physician is responsibility for his or her conduct independent of what the captain of the ship might

do, does that change your opinion at all?

MR. SCOTT: Objection.

A. I'm not sure I've gotten which hypothetical. I'm not sure where you are.

If my decision -- if I am an advisor in a case like this, or any case, I give the advice based on what I have to decide in the merits of my own problem, there's a lady or a man that has a medical problem, could be gastroenterological, this is what I need to do, and I give strong advice, I am responsible for that, I am giving someone advice, to that extent that I've given someone advice, I'm totally vulnerable,

If I say this person ought to have his or her hand chopped off and it's totally dumb, as Long as it's in my expertise and I advise, I'm responsible; for example, to do a CAT scan, it's my opinion that's the best way to get to a final diagnosis, doesn't mean it has to get done, it's just my advice to arrive at a diagnosis.

Q. All right, Doctor, who stopped the HIDA scan?

A. Let me go back and look at this. Refresh my memory. The HIDA scan was in the morning, right.

Q. Right.

a. And HIDA scan was stopped because the patient

developed a distress; is that correct?
Q. I believe that's correct,
A. So the HIDA scan I presume was stopped by the people in radiology in a technical capacity conducting the test,
Q. Who was involved with that?
MR. SCOTT: Do you need nurses? notes?
A. 1 would need nurses' notes, Do you have a page number for me?
Q. I'm sure 1 do,
MR. GALLAGHER: 1135, maybe,
MR. KAMPINSKI: It is going to be 99 --
THE WITNESS: This is a nurse note.
MR. KAMPINSKI: 992, I believe.
MR. SCOTT: 992?
MR. KAMPINSKI: I think so. Yes.
THE WITNESS: I give you guys a lot of credit to be able to read these things, This is difficult,
BY MR. KAMPINSKI:
Q. The 10:45 entry,

A. That's knocked off on mine. I haven't got times.

Q. Starts with Dr. P. Patel?

A. Dr. P. Patel.

MR. SCOTT: Right here,

A. Here and examined patient, husband -- attempt to locate husband to notify of possible surgery, was unsuccessful so far, will keep trying. Something BP remains 80/50, the patient had bed down and feet up, Dr. D.C. here and rectal exam done, patient something incontinent of large amount, I think, brown liquid BM, specimen sent for clostridium difficile.

Husband reached by phone and he's given updates, Dr. Dacha here and given updates, arterial blood gas results and orders received for Hespan, 500 cc's, and albumin to be infused.

Anything specific here you want?

There's a further entry I think at 1:30, late entry, which is also off of ours, indicating Dr. Dacha paged, patient placed in reverse Trendelenburg.

MR. SCOTT: Wait for a question.

Q. By the way, on that same page 992, the 8:05

entry says Dr. D.C. Patel here and examined patient, orders received for HIDA scan, that was Dr. Patel that ordered that?

A. I have no idea.

Q. You don't?

Does that correspond with the orders in the chart?

A. It's hard to say. It's a series of comments by the nurse and I am not sure it doesn't -- I'd have to look at the orders, back to the orders to see if it's his order.

That's 8:05 in the --

Q. If you go to his deposition, which I assume you read, page 21, 22, he says it was his decision for the HIDA scan to --

MR. SCOTT: Do YOU have a correct page?

Q. So I want to have HIDA scan to rule that out.

Question, page 22, you ordered that on the morning of the 7th?

Answer, that's right. That's a quote,

MR. SCOTT: All right.

Q. So can we agree that Dr. D.C. Patel ordered

that?
A. I believe so. I think that might be a signature there.
Q. Good.
A. Something HIDA scan, this is page 190 in the orders. If you turn to page 190 in the orders on page 48 in the physician's notes.
Q. Yeah.
A. Page 48 in physician's notes has doctor, same signature, that's on the order thing, says recommended list of four or five things: CBC, free and flatten upright abdomen, HIDA scan, amylase, lipase, and two hour urine amylase; that signature I presume is Dr. Patel's. The orders are then written about the same time. I don't know if he communicates the recommendation in the notes and whether he was giving clearance to go ahead and write the order, certainly the orders are signed by him.
Q. Okay. Page 46 of Dr. Patel's deposition, which I assume you read --
MR. SCOTT: Just listen. It's all right.
Q. If you want to follow along, that's all right.

Page 45, question, and you told them to call -- well, I'll go back and put it in context,

44, question, she had respiratory distress?

Answer, respiratory distress,

Question, that happened during the HIDA scan?

Answer, that's right.

They were unable to complete the HIDA scan?

That's right.

Skipping question, then what happened, the nurse called you?

Answer, they called me?

Question, the nurse?

Answer, oh, yes,

Question, you told them to call Dr. Dacha?

Answer, he asked me whether they should follow that, can he follow-up HIDA scan, I said no.

So it was his decision to stop the HIDA scan then, wasn't it?

A. Read the -- some more. Read on. I caught

parts of that.

MR. SCOTT: Do you want to repeat it?

A. I took it as parts of the nurses and I didn't get the whole thing.

Q. What happened, the nurse called you?

His answer was a question, they call me?

Question, the nurse?

Answer, oh, yes.

Question, and you told them to call Dr. Dacha, that's my question to him.

Answer, they asked me whether they should follow that, can we follow-up HIDA scan. I said no.

So it was his decision, right?

MR. SCOTT: Just to stop the HIDA scan?

MR. KAMPINSKI: Yes.

MR. SCOTT: His decision not to proceed with the HIDA scan?

MR. KAMBINSKI: Are you going to ask the questions?

Q. I read that accurately. You want to look at it?

Do you understand the question?

MR. SCOTT: Testimony before is that the x-ray people stopped the HIDA scan.

Q. Do you understand the question, sir?

A. I think I understand the question, but is this before? Well, I'm trying to figure out, He didn't answer the question that you asked him, I don't believe,

Q. I asked him if he's the one that stopped the HIDA. scan.

They said can we follow-up with HIDA scan, I said no; what don't you understand?

A. So he said he didn't stop the HIDA scan, he didn't follow it up, the HIDA scan. He wasn't there at the time the HIDA scan was done.

Q. I see what you're saying.

In other words, you're saying he doesn't want them to continue it?

A. It's already stopped, that is the domain of the radiologist who is the responsible physician for the purpose of that test, doing the test for the primary care giver.

What he's saying is don't go on and do it again. They already stopped it. So he is

not ordering something, he is just going along with no continuation of that study,

Q. For a physician who is limited to gastroenterology and isn't involved in the respiratory status of this patient, don't you find it curious, sir, that after she had her arrest that it was he that was called by Dr. Dacha to go see Mrs. Lind to check on the respiratory status?

MR. SCOTT: Objection, I think that's a misstatement of the record,

MR. KAMPINSKI: I beg your pardon?

MR. SCOTT: That's a misstatement of the record.

MR. KAMPINSKI: A misstatement?

MR. SCOTT: Yes.

MR. FELTES: Mr. Kampinski, you said arrest.

MR. KAMPINSKI: Yes, that's what I said. That's exactly what I said.

A. You're talking about the HIDA scan now?

Q. No, Listen to my question.

A. Let's go back.

MR. KAMPINSKI: Could you find

it?

(Question read as follows: For a physician who is limited to gastroenterology and isn't involved in the respiratory status of this patient, don't you find it curious, sir, that after she had her arrest that it was he that was called by Dr. Dacha to go see Mrs. Lind to check on the respiratory status?)

A. This is now?

Q. At three o'clock in the --

A. Afternoon?

Q. That's right.

A. Is Dr. Dacha asking him to check on the respiratory status or asking him to see the patient?

Q. Page 58, call me around just before three o'clock in my office, the nurse called him as patient was brought back from CAT scan because of respiratory trouble and he wanted me to go check it out.

Who is relying on who for her respiratory status?

A, You want me to answer speculating on what --
Q. I'm not asking you to speculate, I'm asking you to tell me why you ignored that fact in your report and the analyzing of who was relying on who for purposes of deciding what to do about Mrs. Lind's airway?
MR. SCOTT: Objection.
A. I don't interpret it that way.
Q. NO?
A, I interpret it to go see the patient.
Q. I'll read it --
A. You can read it again but I --
Q. I will, just so there's no confusion.
You told me that you deal with facts, not stuff that you want to hear or want to make up.
A, Fair enough.
Q. And I believe you --
A, Go ahead,
Q. Here are the facts, sir --
MR. SCOTT: There are some of the facts,
Q. Here are the facts that D.C. Patel testified to under oath that you were provided with.
Answer, called me around just

before 3:00 p.m. in my office, the nurse called him as patient was brought back from CAT scan because of respiratory trouble and he wanted me to go check it out.

A. Okay. I see what you're saying, and I am not sure. I can't tell you what he was thinking. I can tell you that I believe he is asking go check out the total patient, check it out.

If he meant respiratory status, then I'd have to say you got a valid point; if he didn't mean respirator status, go back, check out the patient, patient comes back in distress, I'm not sure he's checking out the respiratory status you're asking specifically for. I just couldn't tell you.

Q. He came back or she came back because of respiratory distress, didn't she?

A. She came back because she was unstable, that is correct, respiratory distress and hypotension.

Q. It was Dr. D.C. Patel who was asked to go see her not because she had an abdominal complaint, right?

A. Well --

Q. Isn't that right, sir?

MR. SCOTT: Objection.

A, No,. I don't think so.
Q. You don't think what?
A, I don't think he was asked to go -- he was asked to go check on a patient and he may have been the choice, He is a doctor, I don't know where Dr. Dacha was, he might have been in his office four miles away, he may have been here, I don't know where he was.
Q. So they were acting as a team then?
MR. SCOTT: Objection,
A, Right. They were acting together, yes.
I don't know what "team" implies, but they were acting together, yes.
Q. What was the cause of her abdominal complaints on May the 7th in your opinion prior to the HIDA scan?
A. I don't know.
Q. Well, in the list of potential things that could have been causing it, why don't you give me some based on your review of the records?
A, Intra-abdominal catastrophe meaning a perforated viscus,. meaning sepsis, meaning hollow or solid organ infarction.
The abdomen encompasses the stomach, bowel, liver, spleen injuries, infarctions

or infections, any one of these are possible, which is the reason that generated the CAT scan.

Q. Anything else that could have been causing it?

A. Those are the ones I think of offhand.

Q. What is the difference between a HIDA scan and a CAT scan?

A. A HIDA scan is a radioisotope scan and it really detects the uptake of the liver and excretions of the isotope into the biliary tree, gallbladder, and further excretion into the duodenum.

Q. Part of the HIDA scan was done, wasn't it?

A. That's correct.

Q. Did you review any films in this case?

A. I did not.

Q. You read the reports though on the HIDA scan?

A. I looked at the reports. I'd have to look at them again.

MR. SCOTT: You're asking what the reports are?

MR. KAMPINSKI: I know what the reports are. He said he had to review them.

A. If you want me to comment on them.

Q. Sure, that was my question.

A. Let me, if he says --

MR. SCOTT: Yes.

A. Do you happen to know the page number of that to save us time?

Q. Yes, 40 -- no, It's in the 400's there. 413.

A. 413, thank you,

Q. Sure.

A. Okay, Now, the specific question?

Q. Any evidence of any intra-abdominal emergency?

A. I can't answer that question. 1 can answer the question of any evidence of hepatobiliary pathology, and I can say that there is some of that emptying from the liver into the small bowel,

Q. What does that mean? Can that be normal?

A, It could be normal, it could be because the bowel is not -- or the emptying is slowed because of poor uptake. Let me see, It doesn't say,

It could be just bowel bile duct of the gallbladder hasn't contracted.

Q. So it's really a nonspecific --

A. That's correct.

Q. -- finding there, right?

A. That's correct.

Q. Do you believe that she had an acute abdomen on the morning of the 7th?

MR. SCOTT: Objection.

THE WITNESS: Do you want me to go ahead?

MR. SCOTT: Sure.

Q. Please.

A. From what I can ascertain from reading the other notes, yes, there was something going on in the abdomen or appeared to be something going on in it, and I haven't examined -- I know that's a copout always, but it's the truth -- what it is that makes them believe she had an acute abdomen,

Q. Well, I mean the surgeon certainly didn't?

A. Certainly did?

Q. Did not?

A. Didn't, meaning a surgical abdomen? Well, it was acute, he didn't know why because he was considering going in for surgery later on during the day. It's something that evolves over time, something that goes -- they felt something was going on in the abdomen.

Q. What is the distinction between a surgical abdomen and an acute abdomen?

A. Good question, A surgical abdomen is

something I can correct over the course of opening up the bowel and doing an operation.

Q. Okay,

A, Acute, that's not surgical. Might be acute pancreatitis, where there is no surgical intervention unless it's severe pancreatitis, where you have severe abdominal pain, all the findings of a surgical abdomen,

Q. Did she have elevated serum amylase that would suggest acute pancreatitis?

A, They did not --

Q. So she didn't have that?

A. -- have that then. At the time the amylase came back, then yes.

Q. So the --

A. Ischemic bowel would be another one.

Q. Would be another what?

A, Another case where an acute abdomen that would be surgically amenable if necessary.

Q. Did she have ischemic bowel?

A, I don't know.

Q. Should you know?

A. How do I know? At this --

Q. By looking at the records.

A* You mean on May the 7th, if I put myself --

Q. You know now though?
A. Retrospectively.
Q. Sure.
A. We know a lot more than we did at the time.
Q. That's fair.
A, Presuming putting me in their place,
Q. Right. So you know now that she --
A. I know now in looking at the rest of the records, In fact, I didn't go through the total records. I confined myself -- I did look at the outcome, I was interested in knowing what happened obviously, but I didn't review the detailed records beyond the day of the event in any detail,
Q. What findings were there that you believe support the existence of acute abdomen?
A. Patient has tachycardia, this would be in support; doesn't mean necessarily the only reason that would cause it, that's high, rapid heartbeats; patient has hypotension, low blood pressure, which is during the whole course, looking at the whole course now.
Q. No. No.
A. Am I confining myself to before the HIDA scan.
Q. Yeah. What led Dr. D.C. Patel on May

the 7th to decide she had an acute abdomen on that day?

A. Okay.

Q. Causing him to order a NIDA scan and then wanting her to have a CAT scan?

MR. SCOTT: Objection,

A. I can go back and read Dr. Patel's --

Q. Which one do you want to read?

A. Turning to right now 5-7.

Q. What page?

A. Try page -- start at page 52, I think around there, Let me see. Go back a little bit more.

Let's go back to the 5th, that's page 44.

Q. Did he see her on the 5th?

A. No, I'm coming to that, though, That's when the call goes in.

Q. I'm sorry?

A. That's the time when Dr. Dacha's seeing the patient, talking about complaints and abdominal pain, that is the history coming to Dr. Patel, agreed?

Q. Well, okay. If you want to do that, then don't you have to also include Dr. Paresh Patel's finding?

A, Sure.
Q. Go ahead. Tell --
A, We're entitled to differences of opinions.
Q. Tell what you --
A, He's talking about abdomen pain.
Q. Who?
A, Dr. Dacha,
Q. On page 44?
A. On page 44.
Q. And he calls it, Dr. Paresh Patel --
A. Wait. Right here, 5-5-92, complains of abdominal pain, indicates something breathing, breathing okay, low grade temperature, he puts down in notes something, maybe plan, surgical consult. Dr. P. Patel will start antibiotic cultures, okay. Dr. P. Patel note, that's P. Patel, not D.C. Patel.
Q. Right.
A, That's a surgeon.
Next note is by -- that signature I don't know. It's probably Dr. P. Patel,
Q. Abdomen now soft, right?
A. Abdomen now soft.
Q. Is that consistent with an acute abdomen?
A. It may be, but it's not a surgical abdomen, there's no peritonitis, no peritoneal signs.

Q. Excuse me, sir. Isn't a soft abdomen inconsistent with acute abdomen?
A, No.
Q. So if you see a soft abdomen you would consider that an acute abdomen?
A. That's not what I'm saying.
Q. So it's nonspecific?
A. If I find a soft abdomen it does not exclude an acute abdomen; if you find a hard abdomen, it's more consistent with it.
Q. What did Dr. Paresh Patel --
A, Which Patel? Does not -- I can't see, I can't read this,
Q. Does not seem like any intra-abdominal problem?
A. At this time,
Q. Right. Will observe?
A. Yes.
Q. So you wanted to go back to the 5th?
A, To see that that's the history.
MR. SCOTT: What's the question?
A, I'm going to go ahead to the 7th.
Q. Go ahead.
A. Now we're at the 7th, abdominal pain.

Q. You wanted to do history, on the 6th there was no abdominal pain, was there?
A. I don't know.
Q. Not a surgical abdomen?
A. I haven't got the notes of the 6th here.
Q. You don't? On page 45.
A, 45 is out of order here. One minute. Mine are not in order.
Okay, On 5-6, looks better.
Q. Nontender?
A. At that time.
Q. No guarding or rebound?
A. Agreed.
Q. That's not acute abdomen, is it?
A. There no guarding or rebound, no peritoneal signs. There's a specific finding of hypotensive, looking for rebound, that's one form of acute abdomen.
Q. Anything that you --
A. Abdominal pain, still complaining of abdominal pain.
Q. I'm on the 6th.
A. Oh, no abdomen pain today, things got better. I'm just going back. I'll go along with this. They go on further. We start having more

abdomen pain.

Q. What do you mean "more"?

A. She has abdominal pain 5-7 now. Go to page 48, Dr. P. Patel has seen patient on 5th and 6th, and on 7th Dr. Paresh Patel, who is the surgeon, says chief complaint abdomen pain, so we're back to pain.

Q. Which page are you on?

A. Page 48.

Q. It's vague.

A, It's -- pardon me?

Q. Abdominal pain vague with --

A. I can't read that, Can you?

Q. Vague, with something abdominal pain.

A. Mine is harder to read than yours probably.

Q. It says vague.

A, Vague, I got that part. I don't know what it says,

Q. So you don't know what he said about it?

A. The chief complaint of abdomen pain. I can't read the note, vague something.

Q. So I understand, so far what you've done by taking me back to the 5th --

A. Yes.

Q. -- and talking about the patient's complaints,

that is important in determining then whether the patient has an acute abdomen; am I correct in what you're --

A. Yes.

Q. -- doing?

A. Took you back to the 5th because the complaints of pain abates, then it comes back.

If you had biliary complaints, another hypothetical, that would be a very common problem, severe pain enough to cripple you, temporarily going away entirely and then --

Q. She wasn't crippled?

A. Well, she wasn't. I'm telling you what happens.

You can have a very severe acute abdomen, it gets better, gets worse, gets better, that's the kind of history, an evolving thing. It's not a clean, easy, clearcut decision you have to make. By the 4th we're back to pain.

Q. I want to make sure, Let's go slow.

So that it's her pain --

A. That's bothering her the most.

Q. Let me finish.

It's her pain that is the primary determinant as to whether or not tu do the study

because on the 5th no studies were done?

MR. SCOTT: Objection,

Q. Well, were they?

MR. SCOTT: The Doctor hasn't testified the pain was the only determinant,

MR. KAMPINSKI: That's why I am asking. That's why I ask him, so he gives the answers.

MR. SCOTT: You said that it was. The Doctor has not testified to that.

MR. KAMPINSKI: Read my question again.

(Question read as follows: It's her pain that is the primary determinant as to whether or not to do the study because on the 5th no studies were done?)

Q. Is it the pain that's the primary determinant for the doing of studies to follow-up as to whether or not that pain is in fact acute abdomen, a surgical abdomen, an abdominal emergency; if she's not complaining of pain, do you do the studies anyhow?

A. No. I think if I understand your question

correctly, the pain is one of the determinants that determine whether he did not do studies, but there's other things as well. They were looking at several other things as well,

Their notes on the 6th of -- about having to do with vaginal discharge, that's another consideration for causing an acute abdomen; pelvic inflammatory disease, those kind of things8

I wish medicine were easy to --

Q. That's fine,

A. There's a number of possibilities they're looking at all along, They're finding other findings, they have abdominal pain, that's the precipitating thing but not the only thing8

Q. The note you referred me to?

A. On page 48?

Q. Yes.

Whose notes was that, the first one?

A. I think that's Dr. Patel.

a. D.C. Patel?

A. I believe so.

Q. He found no rebound pain; is that right?

A. That's no rebound pain, no rebound tenderness, whatever you want to call it.

Q. So this was a vague complaint of pain they're looking at here?
A, It's a -- he says vague abdominal pain,
Q. Then whose note is it then right after his?
A, I believe, if I am not mistaken, that's Dr. P. Patel,
Q. The surgeon?
A, Right. Who says -- who puts a note down about something needs further; is that resolution?
Q. Well, abdomen soft, right?
A, Abdomen soft, tender epigastrium with some guarding, bowel sounds absent, these are all --
Q. That's not a good sign?
A, Right,
Q. If they were present, would that be a better sign?
A. It would be a better sign, Could be a sign that's something not necessarily going on with the bowel, abdomen, Bowel sounds suggest other systemic problems or possibilities.
Q. Such as?
A, Such as bowel obstruction.
Q. By what?
A. Adhesions, bowel obstruction by torsion,
Q. Feces?

A. No. Bowel obstruction could conceivably be by feces, that would be extremely uncommon. Bowel obstruction usually would not be feces because it's liquid there unless it's really twisted there. A twisted bowel doesn't get the blood supply and that could do it.

So this -- a patient like this who is tachycardia, hypoxic, needs further, I don't know what the word is, resolution I thought it was, resuscitation, I don't know; probably exploratory lap today if general condition permits, So here the surgeon's now thinking something is going on in the belly and she needs surgery.

Q. Is that what he has testified to?

MR. SCOTT: Well, that's what it says.

A. That's what he says in his notes.

Q. Did you read his deposition?

A. Dr. P. Patel, I don't believe I read his deposition. Did I? If I did, I didn't read it then. I don't recall reading it, but you know, I'd have to go by what he says at the time. I'm putting myself in his place at that time.

Q. Okay.

A. Which is the only place I can. Obviously

when he gives his deposition he has a chance to reflect perhaps, I don't know.

Q. Then the next note on the 7th is?

A. I presume that's Dr. Dacha. Anybody agree on that?

MR. SCOTT: That's all right.

A. Can I go on?

Continues to have abdominal pain, so he's got a picture where the pain was there, that's why I went back to the 5th, cleared, it's back, it's getting worse.

Now Dr. Patel, P. Patel has changed what he believes is going on. He's considering surgery. It's a typical patient problem, it's coming and going, coming, going, we don't know what it is.

Q. Are those two notes of his on the 7th on page 49?

A. I believe so.

Q. So when he says abdomen not as tender on the second one, that's not inconsistent then with continuing problem, right?

A. It's not inconsistent with a continuing problem, that's correct.

Q. This is after she returned from x-rays, right?
A. That's correct,
Q. Is there any mention, by the way, in here of his analyzing her respiratory problem?
MR. SCOTT: Dacha?
Q. Yes,
A. I can read the note that it says tachypnea, I believe, due to abdominal pain. That's sort of an assessment, it's his opinion that he thinks that,
Q. Where are you? I'm talking about the second note.
A. Yes.
Q. After she returned from x-ray.
A. Okay, I'm sorry, I was reading the note before,
Returned from x-ray, x-ray only partially -- return from x-ray, only partially done, respiratory rates 36 pels minute and 45 per minute,
Q. Is that good?
A. That's tachypnea, that's rapid respiratory rates, and he made an assessment of the respiratory rates then.
Q. Is that good for a patient to be breathing

that fast?
A. It is if she needs to be breathing that fast, that's one way of getting oxygen, and I don't want you to think I'm being glib. It sounds like I'm being glib, I'm not.
Q. That's normal?
A, It's not normal, it's rapid breathing; what's causing it, I don't know.
Q. How about the blood pressure, is that --
A, Blood pressure is -- that's not horribly below, but it is lower than normal. If I were dry, my blood pressure may be there or if I'm septic it might be acceptable, my blood pressure might be down; but yes, that's hypotensive, mildly hypotensive,
Q. Then the next note is Dr. D.C. Patel?
A. No, I think it is still Dr. Paresh, is it not?
Q. On page 50?
A, You're right, it is D.C. Patel.
Q. This is after she returned from x-ray?
A. I don't have a time on here but I would presume it is. It's a presumption, you may say.
Q. No. He testified that it is?
MR. SCOTT: Well --

MR. KAMPINSKI: I'm not trying to trick the Doctor,

A, You're right.

MR. SCOTT: This is before x-ray?

A, Before the CAT scan.

Q. Before CAT scan, after HIDA scan?

A. Right.

Q. We're in agreement?

A. Yes. He mentioned some comment about the abdomen.

Q. That's what I was going to ask you.

A, Okay.

Q. It's got SOAP, that's the way a physician sets forth --

A. That's subjective, objective, assessment, plan,

Q. So the subjective findings were what?

A, Complains vague abdominal pain, and something here.

Q. States feels better?

A* Could be, Better than that --

MR. SCOTT: After bowel movement?

A. After.

Q. So she had a bowel movement, didn't she?
A, At some point, yes.
Q. Well now, not at some point?
A. At this point.
Q. Right. You already read the nurse's note a few minutes ago about his being there, doing a rectal exam and her passing a large amount of stool?
A. Correct,
Q. And she felt better?
A. Liquid stools, yes,
Now, I can get --
MR. SCOTT: Wait a minute,
Q. Go ahead, We're not trying to play games here. You can --
MR. SCOTT: Well, ask a question,
MR. KAMPINSKI: I'm here for discovery. He was about to explain why that is not significant.
THE WITNESS: I wasn't going to explain that.
Q. Is it significant?
A, It may be,
Q. Well, I mean, the lady's stomach hurt her,

she had a bowel movement and she felt better; isn't that significant to you as a physician?

MR. SCOTT: To what? If you're discharging the patient?

I'll withdraw that.

MR. KAMPINSKI: She might have been better off if he would have done that actually, Mr. Scott.

MR. SCOTT: Go ahead,

MR. KAMPINSKI: You want to be glib, I can be glib.

MR. SCOTT: I don't, Better as to what, that's what I'm trying to figure? It's a discovery deposition, I'm not trying to play games, just as you aren't.

MR. KAMPINSKI: Could you read my question back,

(Question read as follows: Well, I mean, the lady's stomach hurt her, she had a bowel movement and she felt better; isn't that significant to you as a physician?)

Q. Isn't that significant to you as a physician in explaining her abdominal pain?

A. It may be, but this is what I was starting to say.
Q. Okay.
A. If I do a rectal exam, the patient may have a liquid bowel movement, or large form bowel movement, that may be reflexive, doesn't mean there's not a bowel obstruction because I get some kind of finding like that. Patient could have transient relief, everybody feels better when your bowel is empty, but that doesn't get rid of the underlying problem.

If the underlying problem were obstruction, you can -- could have a bowel movement, feel temporarily better, that's not uncommon, then rapidly going back into severe pain as the obstruction continues depending on where the obstruction is, okay.

Q. What obstruction? She didn't have an obstruction, sir?
A. But I'm telling you, going back to this specific case, yes, she can feel better after having a bowel movement no matter what's causing the abdomen pain.
Q. What if that was the cause of her abdominal pain?

A. Would that make her better?
Q. Yes.
A. Yes, but I don't know that anymore than you don't know if she had a bowel obstruction at that point.
Q. Well, she felt better?
A. She felt better,
Q. And there was a reasonable explanation for her feeling better in terms of her abdominal complaints, wasn't there?
A. Partially, yes.
Q. Mow, her respiratory status however did not get better, did it, from the time she came back from x-ray after the HIDA scan?
Am From the HIDA scan?
MR. SCOTT: Do you want to look at the nurses' notes?
Q. Absolutely. Look at whatever you need to.
A. The nurses' notes, where are they?
HIDA scan we decide about what time did she go back up? Can you help me out with that?
Q. Yes. I think it's around 10:45, something like that.
A. Her respiratory --
Q. Tell me where you're referring to.

A. Page 988,
Q. Just give me a minute.
Okay,
A. Middle part, around 10:00 a.m.
Q. I believe she came back, at least according to this, would have been the -- I mean, she'd have to be there at the 10:15 entry otherwise they wouldn't be able to chart this?
A, Correct, So 10:00 and 10:15 you got the blood pressure when they come back.
Q. Right.
A. At that point she had blood pressures in the range that we said down there roughly 74 to 80, 70 to 80 or 90, and 40 to 60; and respiratory rate stays about the same, decreasing slightly; pulse goes down slightly.
Q. Let's stop €or one second before you do this to me.
a, I'm not trying to do anything to you.
Q. Well, I don't want to be unfair with you and I am sure you don't want to be unfair with me.
You went back to the 5th to set sort of baseline for what was going on with this lady, If we go back even a day to the 6th, she was on a ventilator.

A, can you tell me what page you're on?
Q. Sure. 980.
A. There's a --
Q. If we go back to 972, how is that?
A. All right.
MR. SCCTT: One more.
A. Whoops.
Q. You look at both of them,
A. 972, got you.
Q. Just for general purposes, I mean at 972 her respirations are for the most part in the 20's, correct?
A, Yes. Upper -- mid and upper 20's.
Q. Her blood pressure basically is 100 to 120, I'm going to say over let's say it's 60 to 70?
A. Right.
Q. Then if we go over to 980, her respirations now are in the 30's?
MR. SCOTT: You mean 9883
MR. KAMPINSKI: No, 980. Page 980 on the 6th.
MR. SCQTT: On the 6th?
MR. KAMPINSKI: Yes.
MR. SCOTT: All right.
Q. Her respirations now are high 20's, low 30's,

then later on in the last shift they start to get up in the 40's and high 30's; the blood pressure is about the same as it was on the previous day, right?

A. Um-hum.

Q. Now we go over to the 7th, which was page 988?

A. Right.

Q. Prior to her going down for the HIDA scan, even prior to that her respirations have increased, they're now in the high 40's, correct?

A. Okay. Yes.

Q. Is that a worsening of her condition in terms of her ability to breathe? She's fighting for more air?

A. Those sure are tachypneic, correct, breathing more.

Q. And her blood pressure is probably about the same, although one may argue it's creeping down a little?

A. I agree. Creeping down a little.

Q. Now, she comes back from the x-ray department where we know she has had an episode of respiratory distress because they stopped the HIDA scan because they were concerned?

A. Okay.
Q. Dr. Dacha -- or Dr. Patel doesn't want them to continue it, do you know why?
A. They said they had stopped it, come back up, there wasn't anything further to be gained.
Q. Why didn't he send her back down for the completion of it?
A. 1 think probably although it was an incomplete test, he probably had complete enough information that he didn't think he can gain anything further.
Q. Wasn't she originally sent down to rule out cholecystitis?
A. To rule out cholecystitis and obstruction of the bowel.
Q. And pancreatitis, wasn't it?
A. Can't tell about that by HIDA scan. HIDA scan won't help that,
Can I ask a question?
Q. Yes.
A. How much longer are we going to be roughly.
Q. Half hour maybe, You need to break?
A. E need to get out.
Q. I'll do it as quickly as I can.
A. Fair enough. Let me make a quick call.

(Recess had.)

BY NR. KANPINSKI:

Q. So it's your testimony that any competent gastroenterologist would know that you can't do a HIDA scan to determine whether somebody has pancreatitis?

A. It's not used for pancreatitis, it's used for biliary tract disease, but one of the things that that can cause pancreatitis are gallstones, which if you're saying I'm going to try to exclude gallstones as a possible cause for pancreatitis, then I'd have to say that's legitimate.

Q. So if he's saying I want to do a HIDA scan to rule out pancreatitis, he doesn't know what he's doing?

MR. SCOTT: He just said that's legitimate.

Q. Is it?

A. Well, you're saying if you read that statement that he is going to do the HIDA scan to rule out pancreatitis?

Q. Yes, infection of the pancreas called pancreatitis, that's what --

A. I would not do a HIDA scan for that,
Q. Right. So if he said that, he wouldn't know what he is doing?
MR. SCOTT: Objection,
A. Or he misstated himself. 1 don't want -- I'm not sure you can say he did.
Q. If he's the one who ordered the HIDA scan, he ordered it for the wrong thing, didn't he?
MR. SCOTT: Objection.
A. No. Again, if he was ordering because he was looking for gallstones, he thought the person had gallstones and he was looking for the cause of it, fine; if he's doing it to rule out pancreatitis and he didn't misstatement -- misstate himself, then I would say that's not what I would do a HIDA scan for, the HIDA scan is not done for that reason.
You know, you have Dr. Miclat here calling Dr. Dacha or Dr. Patel or Dr. -- I don't know, he maybe misstated. E don't know if he did or not, that's a possibility, whatever.
Q. Or it's possible he may have made a mistake not knowing what to order for what disease process?
MR. SCOTT: Objection.
A. It is possible.
Q. Okay. We were talking about her respiratory

status when she came back from the HIDA scan.
A. Okay.
Q. We now looked at what it was for a few days prior to that.
A. We stated what we were finding, what we were seeing in that time.
Q. Well, I think we were seeing a worsening --
A. Okay.
Q. -- respiratory status, weren't we?
A. I thought that's what we said, 1 agree.
Q. As a matter of fact, it's worse when she comes back from the HIDA scan, we can agree on that?
A. What is worse?
Q. Both her blood pressure and her respiration?
A. Blood pressure, respirations, and I'm looking at all the numbers. You consider 48 to 52 as a range, it is running around that, it's a little higher.
Q. It's 56?
A. Then right back down to 52, it is about -- it's no better for sure, and maybe a little worse.
Q. Well, if she experienced respiratory difficulty when she was having the HIDA scan, could **you tell me what it is that you see in those**

numbers that causes you to believe that she can go back and have a CAT scan in the absence of having her airway protected?

A. There's three questions loaded in one,

Q. Yes.

A. There is three questions loaded in one, You are assuming that I have to intubate her for respiratory -- I'm not even going to address that, I'm not. That's not my field of expertise to decide whether she needs to be intubated before she has something else done, that's pulmonologists. You incorporated that in your question. I can't answer without --

Q. Answer this for me: Did her respiratory status get any better?

A. Her respiratory status?

Q. Did it get better?

A. The 56 is at a time of increased temp, which would be acceptable, You would expect -- it's a poor word. Not acceptable, Expectable, I mean you expect that to happen if her temperature goes up.

Q. It's not acceptable?

A. It's not acceptable, not -- not normal, it's too high a number,

Q. Right

A. Now. the uestion is?
Q. She goes back down to x-ray for the purpose of a CAT scan at approximately 2:00 p.m. now.
A. Okay.
Q. I'm going to assume that the 95 over 50, which is the 2:00 p.m. entry is the one before they take her down to CAT scan, the reason I'm going to assume that is because they couldn't put that in there if in fact she was down in x-ray?
A. That's correct.
MR. SCOTT: Objection.
A. Unless the nurse that was -- had the same sheet that went from the floor down with her, I don't know. I don't know what their practice is there.
Q. That's about when they take her is right after they take this blood pressure reading, so could you explain to me how in the world Dr. D.C. Patel could have approved her to go back down given the respiratory status -- well, withdraw that.
How any doctor, whether D.C. Patel, Dr. Miclat, Dr. Dacha, Dr. P. Patel, or Dr. Ferguson could in good conscious say this lady can go back down and have a procedure where they just brought her back from a procedure and she

sustained respiratory distress without protecting her airway?

MR. QUANDT: Objection, form of the question,

MR. SCOTT: Objection,

A. Let me rephrase your question. If I don't do it fairly, tell me.

If you're asking can I conceive doing that to a patient with these kind of numbers, the answer is yes, I can, if I thought the patient had something going on in the abdomen that might be corrected or at least approached surgically and I can find that answer out. by CT scan, and I thought the 95 over 50 was a reasonable blood pressure, not good, but in the preceding half hour I have had 116 over 58, 100 over 55, it's a good pressure and it went down or had been going down with a patient who in the morning had those numbers, then I -- I can conceive saying bring the patient down if I thought the CAT scan is going to give me information that would make a dramatic change in the course of therapy; so I guess my answer is yes, I can conceive of that,

Q. What if the surgeon had told you that you weren't -- he wasn't going to operate unless she

was stable under any circumstance?
A. That's fine, I would take that under advisement and I'd listen to it. I might still want the information even though he's not going to operate without her being stable.
Q. What is the downside of protecting her airway when you're getting your information?
MR. SCOTT: Objection.
A. Again, the short answer is I don't know what the downside is except the risks of intubation. I'm not qualified to make that decision, intubate or not intubate, Presumably there's minimum risk in good hands but the problem is that's not my decision as a gastroenterologist. I haven't got the right, it's out of my domain to make a decision whether she needs to be intubated for respiratory status.
I'm giving my advice that she needs a CT of the abdomen to rule out intra-abdominal problems, the rest of the decision is not mine.
Q. Her abdomen had gotten better, hadn't it, at least according to the notes that we read?
MR. SCOTT: Which note?
MR. RAMPINSKI: The May 7th notes in between the **HIDA** scan and CAT scan.

MR. SCOTT: Well, but there's multiple notes in there, notes by P. Patel that he's going to do a surgery in the afternoon.

MR. KAMPINSKI: The notes of D.C. Patel, her abdomen had gotten better.

MR. SCOTT: Just listen to his question, it's D.C. Patel now.

MR. KAMPINSKI: Yes, he's the one who ordered it.

MR. SCOTT: Ordered what?

MR. KAMPINSKI: CT scan.

Anymore questions, Mr. Scott? I'd be happy to go under oath and testify if that's what you want.

MR. SCOTT: That's a misstatement as well.

MR. KAMPINSKI: I thought, correct me if I am wrong, that I was the one asking questions of the Doctor.

MR. SCOTT: You are. It's a misstatement.

Why don't you let him --

MR. SCOTT: It's a misstatement to say that he ordered it.

A, I will have to Listen to the question again.
Q. The question is her abdomen got better, didn't it?
A. Her abdomen got better when -- at the time he examined her after the HIDA scan when she had a bowel movement. I don't know what transpired between 10:00 a.m. and the time of the CAT scan, which is two o'clock, as far as the abdomen.
Q. The abdomen got better, decreased respirations, got or stayed the same at a minimum, and by the "same" they weren't good, the same as when she was brought back from x-ray, right?
A. The respiratory status was the same, roughly the same or worse as when brought back from x-ray,
Q. Her abdomen got better?
A. No, I'm not so sure, The abdomen got better transiently after the bowel movement.
Q. That's better?
A. She didn't have any bowel sounds,
Q. She didn't?
A. She did not have bowel sounds the last note I remember.
Q. That's a good point, because I want you to find Br. Patel's discussion about whether she had bowel signs or not when she came back from x-ray,

A. Came back from x-ray, the HIDA scan?

Q. Yes. 5-7-92, this is D.C. Patel, lungs -- the top part of the page, page 49? got

Am Actually I interpreted that, read down, says lungs, see lung decrease, arrow down, that's breath sound, both bases got a part. Are you with me, top of the part, page 49?

Q. Whose note is that?

A. I'm sorry,

Q. That's Dacha.

A. I thought that was Patel before. I apologize. I read that as Patel, it's not. It's a comment by Dr. Dacha.

Q. Right.

A. Dr. Dacha, I cannot appreciate bowel sounds. I read that as Dr. Patel, so I have to look. I made a mistake.

Q. That's all right. Look for -- to see Dr. --

A. Abdomen protuberant, I can't read the next line.

Q. Page 50 now, this is one.

A. Bowel sounds I guess plus, hypoactive. I can't read that one either. I'm not sure what it says. That's not clear in the writing. It didn't come across very well.

Q. Bowel sounds present?
A. But hypoactive.
Q. Right. Before hypoactive?
A. That's B.S., it looks like, plus -- I can't.
Q. Yes. I'm reading from his deposition, page 49. He's reading the note, says bowel sounds present?
A. But hypoactive, so he's saying hypoactive, Dr. Dacha couldn't hear anything, he has liquid stool here.
Q. Doctor, you just told me that if the bowel signs were not present, that would be a reason to continue the study?
A. Yes, they were present; but it's not the only reason that --
Q. Everything you keep telling me, I keep pointing out to you indicates she's getting better and you --
A. I disagree. You're not pointing out everything that indicates she's that much better. She's tachypneic.
Q. But tachypneic goes along with her respiratory distress?
A. Or it could go along with sepsis, abdominal sepsis, respiratory distress, abdominal

catastrophe.

Q. Did she come in with an infection to the hospital?

A. I don't think so.

Q. Pneumonia?

A. Agreed.

Q. What is that?

A. It's an infection, pulmonary infection.

Q. Can that cause respiratory distress?

A. Yes, it can. So can intra-abdominal abscess, so can intra-abdominal catastrophe. I can't say it's wrong. I think he's trying to find out. Again, I'm putting myself back where he is, where they are.

Q. Yes?

A. Trying to ascertain what is going on. I have to say that yes, could be a lung problem, could be abdominal problem, could be PID.

Q. How do you ignore her lung problem while trying to deal with the problem, which apparently has decreased at a minimum in observability, by the time she comes back from x-ray?

MR. SCOTT: Ignore the lung problem?

MR. KAMPINSKI: Yes, that's

what I said.

MR. SCOTT: What do you mean? Who ignored the lung problem?

MR. KAMPINSKI: These fine physicians taking care of her.

A. I can't -- I'm not -- when you're asking ignore the lung problem, my role as a GI consultant is pointing out what possibilities that existed abdominally to cause problems. If you want to take into account a high white count, fine; you can take into account the tachypnea, take into account hypertension, or some kind of abdomen problem; what's causing it, I don't know. Maybe it's the lung problem causing it, I don't have that information right now.

In my capacity as a consultant in GI, that's not what I should be commenting on. I should be commenting on possible abdominal problems that could lead to this, hypotension, sepsis as being a possibility, or things going on in the abdomen that can cause this. That's all I can say if I somebody asked me to come see a patient, could this be an abdomen problem causing that. I'd have to say yes, it could be, here's how you find out if it is; and we do these three tests, but you leave

it up to the primary doctor under those circumstances,

Q. So she had bowel sounds, correct?

A. Hypoactive bowel sounds, yes.

Q. And she was feeling better, correct?

MR. SCQTT: Objection.

A. At this point, I don't know, She's in respiratory distress, that's not feeling a hell of a lot better.

Q. That's feeling better from an abdominal standpoint, at least that's what the chart indicates, sir?

MR. SCOTT: Objection.

A, Well, I'm not sure. She may be feeling a little better, yes; there's a lapse in there.

Q. She was feeling better after the bowel movement, that's the note?

A. That's correct.

Q. The May 7th notes in between the x-ray and CAT scan?

A, There several more notes beyond. She becomes unresponsive. This is before I think her arrest.

Q. Becomes unresponsive?

A. Maybe this is after, I don't have a time, I'm sorry, That's 3:00, 1 think,

Abdomen exam on 5-7-92 looks like D.C. Patel, last exam.

Q. On page 50?

A. On page 50, question ileus, couple things in that, rule how gallbladder disease, rule out pancreatitis. At that point questioning ileus, A complete ileus is no bowel sounds, an incomplete -- I'm not playing with words here -- hypoactive bowel sounds are en route to being absent, that could be causing abdominal problems, could be a result of abdominal problems.

Again, infection in the abdomen can cause an ileus, pancreatitis can cause an ileus, ileus can cause besides primary bowel failure, either poor function or some obstruction.

Q. Is a CAT scan going to show whether there's an infection in the abdomen?

A. It may if there's a collection of pus or something, it could help that -- help show that as a mass, it could.

What exactly his thinking was, I have no way of knowing.

Q. It says pancreatitis and --

A. Ileus.

Q. **Excuse me. He orders a serum amylase, that's**

going to tell him whether or not th
pancreatiti

A. Yes.

Q. So he didn't have to do the CAT scan to rule to rul that out if the serum amylase comes back and -- id --

A. Wait. He's getting an increase in serum erum amylase, he's saying an increased serum amylase, lase, that's this arrow up, S amylase. Wait, that's not t's no

Assessment he's got SOA, assessment, increased arrow up, S ar .

Q. Where are you looking at?

A. Page 50.

Q. Yes.

A. Down two-thirds, the 2 --

Q. The 201 sodium increase?

A. Where e sodium?

MR. SCOTT: lines

le bottom.

Okay?

A. Then increase S amylase.

Q. Then see what?

A. See to RF pancreas, or see something. Question pancreas.

Q. Where is the serum amylase study that was

saying it was increased?

A. I don't know. I have to go back through and look for it.

Q. Let's do it.

A. I have to act on what he believed.

The laboratories?

MR. SCOTT: This is April.

A. Okay. 65 on 5, May, 201.

Q. Which page?

A. Page 314, first; then page 315 unnumbered, dates go across the top.

At the far column serum amylase, 65 S, 65; next page goes from the 6th to the 7th, and amylase -- next amylase we have is 201 on the 7th, so it's up; may not be sky high, but it's up.

Q. Well, is 201 evidence of pancreatitis?

A. Could be.

MR. SCOTT: Pardon me?

Q. Beg your pardon?

A. Could be, yes.

MR. SCOTT: Just wait for a question.

Q. I thought you told me that was nonsurgical abdomen in any case?

A. I beg your pardon?

Q. That was a nonsurgical case under any event if she had pancreatitis?

A. If she has pancreatitis?

Q. That's right.

A. It would not necessarily be surgery, that's correct. I mean, I would not go surgical for that.

Q. And you treat that with fluids; do you not?

A. That's one of the things that is used to treat it, yes.

Q. So that would not be an indication -- you could treat that even in the absence of doing a CAT scan presuming that she had it, couldn't you?

A. You can treat pancreatitis without a CAT scan, is that the question?

Q. Yes.

A. Yes, you could.

Q. What else was he doing the CAT scan to try to find out if she had?

A. I don't know.

Q. So far we have infection and pancreatitis?

A. Those are the two that I mentioned as an example. I don't know what he was thinking.

Q. What does he say he was doing it for?

A. He wrote down ileus, he questioned pancreatitis.

Let me go back to the note. Wrong page.

Rule out gallbladder disease, rule out pancreatitis.

Q. I thought you told the gallbladder disease had been ruled out by the --

A. I didn't say that.

Q. -- HIDA scan?

A. I said a HIDA scan doesn't rule out. If you do not see a gallbladder, it means probably gallbladder disease, but that test was incomplete or didn't have time to complete it.

Q. And a CAT scan would do that for you?

A. It will help because you can see stones in the gallbladder; or ultrasound, yes.

Q. Anything else that he was doing it for?

A. Other than the ones that he mentioned. I don't know what all he may have mentioned other -- other than those. These are the ones that he mentioned specifically.

Q. I apologize if this is repetitive.

A. 1 wouldn't remember by this time.

Q. If the surgeon had indicated that he was or he did not believe that she was or had a surgical abdomen, would that make any difference in terms of

the urgency of doing the CAT scan?
A. Fair question.
To some extent it probably would make a differential in what degree of urgency, and I -- if he said I'm not going to operate, well, under any conditions, not just for resuscitation and maybe the patient's stabilized, but I see no reason to go in the belly whatsoever, then I'd have to think what difference in medical therapy it would make; a major differentiate would be infection versus inflammatory process, that's not infection because I'd be using antibiotics or not using antibiotics, and it would be probably a little less urgency, I might be able to buy more time.
Q. In other words, to stabilize her from a respiratory standpoint prior to doing the CAT scan?
A. Not necessarily. Sou mean from -- if the surgeon says there's no reason to do this whatsoever?
Q. That's right.
A. If the surgeon says no, I would not operate under any conditions, then I would have to think.
I don't know whether the respiratory status would be a deciding factor. My

deciding factor as a gastroenterologist, what I am going to do with the information I've obtained has nothing to do with respiratory status, that's not my decision,

My decision would be am I going to act and do something dramatically different from what I am going to if I don't have -- have that information; if I say yes, I have to decide; if I say no, I don't have to do it.

Q. Given the differentials that Dr. D.C. Patel put down, if Paresh Patel indicated he did not believe she was a surgical candidate, that's not consistent with an intra-abdominal problem, is it?

A. If he said that on the 7th?

Q. That's right.

A. If he says that, I can buy that, but he didn't say that. He said he may have to be doing -- or do a surgical procedure this afternoon, I'm putting myself into it and --

Q. But that's not what he says.

MR. SCOTT: That's what the notes say.

A. I could have sworn that's what the notes say.

P. Patel, this is 5-7 -- 5-5, he says wasn't intra-abdominal, I agree with that;

come back with his note he has on 5-7, he says something resuscitation, probably exploratory lap today, general conditions permit.

Q. If general conditions permit?

A. That's legitimate. That's saying to be resuscitated but saying probably exploratory lap. He's telling, I think, of an exploratory lap and we have to get her in shape for that, that's 5-7, page 48.

I wish it was easy in foresight. Always is in hindsight.

Q. Well, let's see if we can't make it easier.

MR. SCOTT: We have talked about his deposition.

MR. KAMPINSKI: No, we haven't talked about his deposition. As a matter of fact, this is the first time I pulled out Dr. Paresh Patel's deposition.

Anything else you got to say?

MR. SCOTT: Yes, and we have talked about what the doctor commented, his reflections after treatment.

Q. Page 42, you did say you don't recall whether you --

A. This?

Q. No, no, this is off his deposition.
A. I don't recall if I read Dr. Paresh Patel.
Q. Since you didn't or don't recall, this is what he said, when you saw her on the 7th, did you have a conversation with Dr. Dacha and Dr. D.C. Patel?

Answer, yes.

What did you talk about? What did you guys talk about then?

Answer, we talked about the patient.

What specifically?

Probably finding the source of sepsis to see whether it's in belly or not.

Question, did you tell him it was your opinion that it wasn't in the belly?

Answer, right.

Did you read or were you told that?
A. I don't recall that. I believe I read that. I don't recall reading Dr. Paresh Patel's deposition. I read the notes and I am going again at the time of the information I have from his notes on the 7th in the chart.
Q. Are you suggesting that he would somehow change his testimony to try to exculpate himself

from this lawsuit if it wasn't accurate in terms of what he believed at the time, sir?

A. No, I hope not.

Q. Okay.

A. I'm not trying to put -- I can't tell you what his mindset or what he was thinking.

Q. I don't think we're doing that.

A. Okay. I can tell you what I'll say tomorrow about this conversation is probably going to be different than this instant, because it will be based on the whole experience.

Q. Mr. Scott in his December 15th letter to you pointed out specifically -- well, mark this.

(Dr. Ferguson Deposition Exhibit 2 marked for identification.)

Q. Pointed out or he sent you the reports of Drs. Martin, DiMarco, and Stiller, said these probably are most significant to the care rendered by Dr. D.C. Patel.

You will note that Dr. Stiller on behalf of Elyria Hospital states that in my opinion the decision to transport the patient to radiology in the absence of any additional evaluation

requires further scrutiny, when taken together the available information suggests that a persistent metabolic acidosis which prompted increased respiratory efforts led to progressive ventilatory muscle fatigue and the subsequent arrest.

Why out of all the reports and all the records did Mr. Scott point that out to you?

MR. SCOTT: Objection. He has no way of saying.

MR. KANPINSKI: He talked to you afterward, I assumed you asked him that.

MR. SCOTT: No, that's not the case.

A. His pointing it out doesn't make a damn bit of difference. Actually I'd have to go back through all of them to try to put it together what they were thinking.

The thing I did strike a comment about was the metabolic acidosis, which is kind of interesting. He's saying it's not a primary respiratory failure but some kind of systemic problem like sepsis; or I could be dead wrong, just look at the rest of it, could be primary respiratory difficulty and the metabolic acidosis he's talking about is something secondary to the

primary lung failure.
Q. Was there any evidence of that, that you saw?
A. No, that's what we're searching for. That's why as a gastroenterologist I'd be called in, could it be a metabolic acidosis induced by something going on in the abdomen,
Q. But I mean, you didn't find any evidence of that?
A, NO.
Q. Why do you think Dr. Stiller said that?
A. I don't know.
MR. FELTES: Objection.
Q. Do you think he's making it up?
MR. FELTES: Objection.
MR. SCOTT: Objection.
Let's go home, come one
A, I don't know.
Q. I'd like --
A. I don't know.
MR. KAMPINSKI: Mr. Scott, you know, you're the one that pointed it out to him. You made it fair game.
MR. SCOTT: Is he making it up? How can a doctor who never even talked to Dr. Stiller, how the hell would he know.

MR. KAMPINSKI: I assume you pointed it out to him for a reason.

MR. SCOTT: I did. Ask a question. Did he make it up, come on, let's go.

MR. KAMPINSKI: You in a hurry?

MR. SCOTT: The Doctor is. I think it's fair to him.

MR. KAMPINSKI: Can I get an answer then.

MR. SCOTT: Is he making it up?

THE WITNESS: I have no idea.

MR. SCOTT: Is that helpful?

MR. KAMPINSKI: I'll tell what would be helpful, what would be helpful to our moving along, getting the Doctor out of here, would be your not interrupting, that would be helpful.

MR. SCOTT: Let's go.

BY MR. KAMPINSKI:

Q. His statement that the decision to transport the patient to radiology in the absence of any additional evaluation requires further scrutiny, do

you agree with that?
A, That's his opinion. I really don't feel I needed to comment on that, The decision was made by the primary care doctor, I'd have to go into his head to try find what they're thinking of, I don't know now if I'd give it significant scrutiny or not, He give an opinion based on nonexpertise.
Q. Do you know Dr. Martin, Lawrence Martin?
A. From here, yes,
Q. That's one of the reports that Mr. Scott sent you?
A, That's correct,
Q. Do you read that report too?
A, Did I read it?
Q. Do you --
A. Very quickly, Read it very quickly. I didn't feel -- feel it was germane to what I was asked to comment on,
I mean, I was interested to know, in other words, what he discussed,
Q. Dr. Martin says and E quote, page 7, because of her overall condition Drs. D.C. Patel and P. Patel decided to do the HIDA scan and CT scan first; do you disagree with that?
MR. SCOTT: Objection.

A, Do I disagree with the --
Q. With them making a decision to do those tests?
A, No. Their suggestions were they do the tests to try to delineate the diagnosis.
Q. He said decided to do the HIDA scan, CT scan first?
A, That's his opinion. He thinks if he made the -- he thought they made a decision,
Q. Yeah,
A, Then he has to defend himself. 1 can't tell you why he said that, I -- I don't think they made that decision, it was not theirs --
Q. So you disagree with him?
A. So I disagree. They did not make a decision to do that, They made the decision it was necessary to reach -- to have discussion, they made a recommendation.
Decision to do it is what I've been saying, is not germane to me as a gastroenterologist.
Q. Doctor --
A* 1 hope --
Q. Doctor --
A* -- I'm not playing with words,

Q. If you disagree with him, then fine. I don't have a problem with that.
A. I think there's a difference in what we're saying.
Q. Between you and Dr. Martin?
A, Yes.
Q. He also says her physicians chose -- numbers 4 and 8, 4 and 8, don't re-intubate and send her to HIDA or other radiographic studies; and 8, don't re-intubate and send her for CT scan. Dr. Dacha and D.C. Patel saw the patient and thought she was stable enough in I.C.U. after the HIDA scan to go back to radiology for the CT scan.
A, Yes.
Q. You agree with that?
A. I would respectfully disagree. I don't think it's the two of them. I think the advice was given. I don't think it's their decision together.
Again, it's that point I made at the very beginning, it's not their domain to --
Q. So you disagree with what he said, okay, that's fine.
A, He is entitled to his opinion.
Q. I'm almost done.

A. Fair enough.
Q. Do you have any opinion on the care rendered by the emergency room physicians in this case?
MISS MOORE: Objection.
A. I have not reviewed that.
Q. Do you have any opinion on the care -- well, do you have any opinion on the nurse having given Demerol to Miss Lind on the evening of the 6th and the early morning of 7th in the face of an order by Dr. Dacha not to give sedatives?
MR. FELTES: Objection.
Q. Do you have any opinion on that?
A, I have no opinion on that either.
Q. This may be repetitive. This comes close to my last question: Do you disagree with Dr. Paresh Patel when he said that it was the decision of Dr. Dacha, Dr. D.C. Patel, Dr. Miclat, and himself to send her for the x-ray studies?
MR. QUANDT: Objection.
MR. SCOTT: Objection.
Q. Do you disagree with that?
A. That is in his deposition?
Q. Deposition, yes, it is.
MR. SCOTT: Are you quoting that?

Q. Page 47, quote, question, whose idea was that to send her to x-ray studies?

Answer, all of us.

A4 What was the answer?

Q. Answer, all of us.

Who is all of us?

Dr. Dacha, Dr. D.C. Patel, Dr. Miclat, and me.

MR. QUANDT: Objection.

Ae I'm not going to argue it was an idea, obviously it was their idea to send her to x-ray; but the final decision who actually committed the action belongs to the primary care doctor, period.

Q. Do you think it is -- that it is appropriate for a physician to add notes and entries in a record in an attempt to exculpate himself after the -- after a person has suffered an arrest, such as Mr. Lind did?

MR. SCOTT: Objection.

Q. Do you think that that's appropriate?

A. Do I think it's appropriate to add a note after something has occurred that wasn't there in an attempt --

Q. That is correct.

A. -- to specifically try to exculpate

something -- good word -- I think that's wrong; but I think, if I can go further.

Q. Sure.

A. I think if you add a note after you read your note or have written a note, right in that same time frame, 20 minutes, looking -- looking at it at that point, that's fine; ideally one should jot down the time, often times that's not done.

For example, if an order is given by telephone, as the case may be here, you put in "if okay with somebody" and you add that when you read the notes and sign off, 1 think that's legitimate, if that's what you said,,

If you're doing it just to get yourself out from something and it's not what you said, that's wrong and it's unethical.

Q. Would that in your opinion constitute a conscious disregard for the right of the patients?

MR. SCOTT: Objection,

Q. If it was done for purposes of exculpation?

MR. SCOTT: Are we talking about the contents of that note or just any other note?

Q. Go ahead,

MR. SCOTT: The doctor does

not get to know what your question means?

MR. KAMPINSKI: He's got the question. He's been doing fine.

A. In terms of --

MR. SCOTT: Objection. I suppose you don't want to give him the question in the context of whether it's true or not, what is stated in the note, you just want --

MR. KAMPINSKI: Read the question back.

(Question read as follows: Would that in your opinion constitute a conscious disregard for the right of the patients?)

A. I don't think it constitutes disregard for the right of the patients6 E think it's unethical behavior, it is -- if it were done to exculpate the dactor.

In other words, it doesn't -- I'm not sure what you mean by the rights of the patient. I think in terms of the rights of the patients as medical care, treatment6

Q. Aren't the rights of the patients to be able to accurately assess and analyze what in fact was

done to them?

MR. SCOTT: Again, I object because context of the note, that is whether accurate or not, has not been given to the doctor,

Q. Go ahead.

A. I have to think about it.

I'm not sure you're violating the rights of the patients, may or may not be. I would not view it in that context, but you may well have a point certainly about rights under the law, might have some implication there, I don't know. 1 am not a lawyer, obviously, but that's an interesting question.

In the context of medical care, I don't see it interferring with the care, the ongoing care.

MR. KAMPINSKI~ Okay. Anything else?

That's all I have.

MR. SCOTT: Anybody else?

MR. FELTES: No.

MISS MOORE: NO.

MR. QUANDT: No.

MR. SCOTT: Thank you very much.

ERRATA SHEET

PAGE LINE

I have read the foregoing transcript and the same is true and accurate.

_____

D. ROY FERGUSON, M.D.

The State of Ohio, :
County of Cuyahoga. : CERTIFICATE:

I, Frank P. Versagi, Registered Professional Reporter, Certified Legal Video Specialist, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, D. ROY FERGUSON, M.D., was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid. I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 9th day of January, 1995.

Frank P. Versagi, RPR, CLVS, Notary Public/State of Ohio. Commission expiration: 2-25-98.

Look-See Concordance Report

UNIQUE WORDS: 1,543
TOTAL OCCURRENCES: **5,848**
NOISE WORDS: 385
TOTAL WORDS IN FILE: 19,104

SINGLE FILE CONCORDANCE

CASE SENSITIVE

PHRASE WORD LIST(S):

NOISE WORD LIST(S): NOISE.NOI

COVER PAGES = 6

INCLUDES ONLY TEXT **OF:**
QUESTIONS
ANSWERS
COLLOQUY
PARENTHETICALS
EXHIBITS

DATES ON

INCLUDES PURE NUMBERS

POSSESSIVE FORMS ON

MAXIMUM TRACKED OCCURRENCE THRESHOLD: 50

NUMBER **OF** WORDS SURPASSING OCCURRENCE THRESHOLD: **9**

LIST **OF** THRESHOLD WORDS:

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