

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

Doc. 167

IN THE COURT OF COMMON PLEAS

LENORE LIND, et al.,
plaintiffs,

vs.

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

Case No. 93CV110798

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.

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Cross-examination by Mr. Kamp nski

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DR. FERGUSON DEPOSITION EXHIBITS

MARKED

1 - 9-9-94 letter from Mr. Scott
to Dr. Ferguson

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2 - 12-15-94 letter from Mr. Scott
to Dr. Ferguson

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(FOR EVERY WORD INDEX, SEE APPENDIX)

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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:

- - - - -

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

1 entire file, please?

2 A. These?

3 Q. Your entire file, whether that's those or
4 whether there is additional materials?

5 A. There is a box of additional parts of a
6 chart, I'd be happy to bring it in for you.

7 Q. I want to see everything that you got.

8 A. I will get it then. Excuse me one moment.

9

10 (Interruption in proceedings.)

11

12 BY MR. KAMPINSKI:

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

21 MR. SCOTT: Do you have
22 others?

23 A. I don't recall any other correspondence.

24 Q. Well, Doctor, in your report you refer to
25 correspondence that you had gotten from Mr. Scott,

1 where is it?

2 A. There's a letter **of** a telephone call, you
3 asked me if I would do this.

4 MR. SCOTT: Okay.

5 A. Well, I don't know. If it's not in with
6 this, I don't know where it is right now. If you
7 have a copy I could --

8 Q. How would I have a copy of what you have?
9 You're the one who refers to it in your report.
10 I'm asking for your entire file, so where did you
11 put it?

12 A. This is the file I worked with. I don't
13 recall where that is.

14 Q. Doctor, referring to the October 26, 1994
15 letter, the very first sentence, second sentence
16 says --

17 A. I am not denying that. I don't know where
18 the letter is right now. I may have -- not have
19 kept it.

20 Q. I don't know what the letter is. It says you
21 read over the letter.

22 A. If you would like me to, I could go look for
23 it.

24 Q. If you would, thank you, and any other
25 documents that are pertaining to this file?

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

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

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

9 Excuse me a minute.

10 MR. KAMPINSKI: Sure.

11 -----

12 (Interruption in proceedings.)

13 -----

14 BY MR. KAMPINSKI:

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

18 A. Yes.

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

22 A, As far as I can recall, yes.

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

1 A. That's the only correspondence.

2 Q. Is that the only report you prepared in
3 conjunction with this case?

4 A. Yes, **it** is.

5 Q. You didn't have any drafts or preliminary
6 reports that were changed?

7 A. No. I am not sure of the dictation, the
8 preliminary dictation may have been changed and
9 thrown away, but I don't recall what that was. It
10 would have been typographical errors corrected on
11 **it**.

12 Q. By yourself?

13 A. Yes .

14 Q. Did you discuss the contents of your report
15 with Mr. Scott before putting it in writing?

16 A. No .

17 Q. After dictating the initial report did **you**
18 discuss **it** with Mr. Scott?

19 A. Subsequently before coming here, yes.

20 Q. No .

21 Before actually --

22 A. From the draft to final stage?

23 Q. Yes .

24 A. No. I don't do **it** like that. It is only for
25 typographical errors that I make corrections,

1 Q. You said that your CV was not current, is
2 there anything else I need to know about any
3 additional publications or anything else?

4 A. There's a few publications, I honest to god
5 couldn't tell you what they were right now. Some
6 additional publications having to do with
7 hepatobiliary things, and the gallbladder, just
8 about gastroenterology.

9 Q. Any of them that would in any way pertain to
10 any of the issues involved in this case?

11 A. Not directly, or indirectly as far as I know,
12 no, other than gastroenterology.

13 Q. Did you make any notes or notations in any of
14 these records or depositions?

15 A. I don't think so.

16 Q. You didn't paginate anything or --

17 A. I don't believe so. Maybe I might have. I
18 may have underlined some things to bring it to my
19 attention, but I don't recall even doing that.

20 Q. Doctor, has anything been removed from the
21 reports that were provided to you?

22 A. Not my me.

23 Q. I'm looking at one of the folders and in the
24 portion that's label "orders," it goes up to
25 page 190, which is part of May the 7th; could you

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

3 A. Here is some additional orders right here,

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

5 A. Yes.

6 Q. Okay. All right.

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

9 A. Yes,

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

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

16 Q. Sure. Anywhere you want,

17 A. Thanks.

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

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

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

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

1 Q. To you?

2 A. To me or the group when I was at the
3 Cleveland Clinic,

4 Q. Which groups would you have occasion to meet
5 him at, which meetings?

6 A. Digestive Disease Week meetings where --
7 they're some of the courses the Cleveland Clinic
8 puts on, he would tend to come to those. The
9 November Gastroenterology meetings, it would be in
10 that context, in gastroenterology professional
11 meetings.

12 Q. When did you leave the Clinic?

13 A, January -- or December, 1992.

14 Q. How long had you been there?

15 A. 16 plus years,

16 Q. Why did you leave?

17 A. It was a good opportunity to come here, work
18 in a different venue, help set up a training
19 program, need some work done with it, variety of
20 reasons; none of which were professional reasons
21 other than just personal satisfaction,

22 Q. By whom are you employed at your current
23 employment?

24 A, Mount Sinai Medical Center.

25 Q. So you work directly for the hospital?

1 A. That's correct.

2 Q. Well, are you a member of a group?

3 A. It's the Friedman Center for
4 Gastroenterology, Friedman Center for Digestive
5 Disease and Liver Disorder.

6 Q. Is that a private group that's separate from
7 Mount Sinai?

8 A. No, we're all employees of Mount Sinai and we
9 use Mount Sinai facilities at the current time.

10 Q. So you get a paycheck from them?

11 A. That's correct.

12 Q. Is it at all dependent upon your billings?

13 A. No, it is not; it's a salaried position.

14 Q. You have a contract with them? You work for
15 them just like you did for the Clinic before?

16 A. That's correct,

17 Q. Does Dr. Patel refer patients to you here
18 since you moved from the Clinic?

39 A. I'd have to go back and really honest to god
20 look, I would be cloudy, I can't recall if I
21 received one from him since I left the Clinic or
22 it's -- I'd have to go back over all my records and
23 find out,

24 Q. How about Dr. Paresh Patel, do you know him?

25 A, No.

1 Q. How about Dr. D.C. Patel's wife, do you know
2 her?

3 A. No.

4 Q. Have you ever socialized with Dr. Patel?

5 A. No, I have not.

6 Q. Have you ever reviewed any other case on his
7 behalf?

8 A. Not that I am aware of, no.

9 Q. Have you testified as an expert before?

10 A. I have.

11 Q. How many times would you say?

12 A. Once as an expert.

13 Q. That's testifying?

14 A. Testifying. Well, let me think.

15 As opposed to deposition, you
16 mean?

17 Q. Well, I was going to make sure I covered
18 both, so you tell me.

19 A. It was once as an expert and it was
20 testimony; there was a deposition ahead of them,
21 and then testimony.

22 Q. What was the name of the case?

23 A. Now you're going to challenge me.

24 I have to go back and look.

25 Q. How long ago was it?

1 A. About two years ago.

2 Q. Where was it?

3 A. Here in Cleveland,

4 Q. Who was the judge, do you know?

5 A. I don't know.

6 Q. Who was the attorney that represented the
7 physician that retained you?

8 A. I want to say a Jim Malone.

9 Q. Jim Malone from Reminger's office?

10 A, I think it was him.

11 Q. What was the nature of the case?

12 A. Let me think about this a minute. This
13 was -- it was a -- okay, I'm not sure it was Jim
14 Malone,

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

17 Q. Sure.

18 A. It was Mark Modick's case, where the
19 gastroenterologist was charged, was the defendant
20 gastroenterologic practice, and I gave testimony on
21 his behalf or on his -- what he had done.

22 Q. What was alleged that he had done?

23 A. They alleged there was a condition relative
24 to a rare disease known as Gorhauf's syndrome that
25 was missed and he had not done the appropriate

1 thing to make that diagnosis in a timely fashion,

2 Q. What was the name of the gastroenterologist?

3 A. Mark Modick.

4 Q. You don't remember the plaintiff's name then?

5 A. No, but I can find that out if you really
6 need,

7 Q. That went to trial?

8 A. That did go to trial.

9 Q. Have you testified or have you been retained
10 as an expert in any other case that where you
11 either have not been deposed or hasn't been a
12 trial?

13 A. I'm not sure. Some years ago I was asked --
14 was on a defensive side, we were dropped out of the
15 case and I was asked by the plaintiff's attorney to
16 provide expert testimony for him.

17 Q. In other words, you were sued, dropped, and
18 he asked you?

19 A. Correct,

20 Q. To act as an expert?

21 A. I gave deposition, that was all I heard. I
22 don't know if the case went anywhere else,

23 Q. Do you remember the name of the case?

24 A. I don't, I can remember the name, which
25 was --

1 Q. Who was that?

2 A* Vic -- I can't remember. Veganoni or
3 something like that. It was several years ago,
4 V-e-g something, It may come back to me.

5 Q. What was the nature of that case?

6 A, Really -- I really don't remember that was so
7 far long ago, Again, a malpractice case, I -- for
8 the world I don't know why I was involved, I was
9 sued, somebody else happened to see the patient,
10 and I was subsequently dropped,

11 Q. Was that while you were at the Clinic?

12 A, Yes, several years ago, probably eight,
13 nine,

14 Q. Those are the only two cases then that you
15 have been involved as an expert?

16 A. That's correct, if you want to call the
17 latter one an expert,

18 Q. Any where you've been involved as a defendant
19 other than the one you just gave?

20 A. Once when --

21 MR. SCOTT: Objection, You
22 may answer,

23 A. Once when the Clinic was involved in a
24 lawsuit and I was member of the Clinic, I wasn't
25 directly sued, I have not been involved in direct

1 suits.

2 Q. In other words, you weren't named separately?

3 A, Yes.

4 Q. But the suit involved conduct of yours?

5 A. Suit involved actions that happened at the
6 Clinic that I had to give testimony about because I
7 was involved in the case.

8 Q. What was the name of that case?

9 A, That was a relatively recent one. I can't
10 remember the woman's name, Chiswick.

11 Q. Do you remember the attorney?

12 A. No, I got to think about it, that may have
13 been Jim Malone, I'm sorry. I don't remember the
14 attorney's name well. I have all these in the
15 files, these are things I can really look it back
16 up.

17 Q. Do you know who deposed you?

18 A. I do not,

19 Q. Do you recall what the allegations were in
20 that case?

21 A. I do. Patient which -- he claimed the
22 patient had got AIDS from a blood transfusion, I
23 was involved in doing a procedure during that
24 period of time she was in the hospital, and
25 subsequently the allegation was that we had -- **she**

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

5 Q. Did you testified in court in that case?

6 A. Yes, I did.

7 Q. That was George Gore; was it not?

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

10 Q. Sure.

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

12 Q. By whom are you insured?

13 MR. SCOTT: Objection. You
14 can answer.

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

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

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

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

23 A. No.

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

1 regarding this case?

2 A. I have to ask Mr. Scott. I think we
3 telephoned, had telephone conversation before that
4 asking if I'd consider doing this and he would send
5 me the details, that would have been the first
6 contact.

7 Q. Do you recall how long prior to the letter
8 that would have been, a week, a month, a year?

9 A. It wouldn't have been a year, probably have
10 been a week or two.

11 Q. Have you had any contacts with any prior
12 attorneys regarding this case before Mr. Scott
13 called you?

14 A. No.

15 Q. So the first that you knew anything about
16 Lenore Lynn or anything involved is when you would
17 have heard from Mr. Scott?

18 A. That's correct.

19 Q. Doctor, in your report -- if you want you can
20 follow along with me.

21 A. Thank you.

22 Q. At no time in the report do you say anything
23 with respect to the propriety of the decision to
24 send Mrs. Lind for a CT scan without protecting her
25 airway .

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

4 MR. SCOTT: Objection.

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

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

15 In terms of --

16 A. Rephrase it then, please.

17 Q. That's fine,

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

21 A. That's correct.

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

24 A. Both highly subspecialized.

25 Q. Right.

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

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

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

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

19 MR. SCOTT: Objection.

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

22 Q. Sure.

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

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

4 Q. That's fine.

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

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

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

11 A. At that time, yes.

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

14 A. Yes.

15 Q. What is that?

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

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

1 field.

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

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

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

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

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

15 Q. Do you have a non-expert one?

16 MR. SCOTT: Objection.

17 MR. GALLAGHER: Objection.

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

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

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

8 MR. SCOTT: Objection.

9 A. Stop.

10 Q. I'll say it again.

11 A. Go ahead.

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

15 A. Right.

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

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

21 Q. It really isn't.

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

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

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

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

9 Q. What are orders for?

10 A. What are orders for?

11 Q. Yes.

12 A. To direct action.

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

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

1 don't clear it with the primary service.

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

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

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

16

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

21

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

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

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

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

6 A. 12:45?

7 Q. Yes .

8 A. Yes .

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

10 A. If I can.

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

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

17 A. That's correct.

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

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

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

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

1 Q. so --

2 A. I can't -- I don't know for sure. It looks
3 like a different handwriting to me.

4 Q. I think you're right.

5 The point you make in your report,
6 and I quote your report, sir, is "my only concern"?

7 A. Agree.

8 Q. "Is on the order of May 7, 1992, 12:45 p.m."

9 A. Right.

10 Q. "Which is the order time when she had been
11 there, which is on page 193 of your documentation,"
12 and the phrase, this is quoted by you.

13 A. Yes.

14 Q. "If okay with Dr. Dacha,"

15 A. Right.

16 Q. "To proceed with CT of abdomen and pelvis is
17 written in by D.C. Patel presumably when he
18 countersigned the orders, this could have been
19 written in at any time and may pose a potential
20 problem"; did I read that right?

21 A. You're absolutely correct in that,

22 Q. Why did you say it may pose a potential
23 problem, sir?

24 Am Because I don't know when it was written, if
25 he wrote it right at the time he countersigned it,

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

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

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

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

12 Again, if I were to come on a ward,
13 see that order, that wouldn't be a problem given my
14 philosophy that I already said. I don't have the
15 right to order somebody else's patient to have
16 anything done, I have to clear it, I've personally
17 done the same kind of thing when I give verbal
18 orders, they're taken -- you have to go and clear
19 it with the primary doctor, If I am not there
20 writing it at the time, that happens, sometimes you
21 write it 15 seconds later or 15 days later. If
22 that's his philosophy that's what should be done;
23 in other words, it has to be cleared with the
24 primary doctor is what I am saying, then that's
25 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

1 subsequently, I have no idea, but I --

2 Q. So I am not speculating anymore than you are?

3 A. I guess we're both speculating.

4 Q. In terms of asking you if in fact it was done
5 three days later, as you just mentioned, why would
6 that be a problem?

7 A* It wouldn't be for me. If I -- that was the
8 first time I reviewed the orders that were given
9 and then put that in.

10 Q. Why would you have to put that in if in fact
11 you were --

12 A. Because the nurses tend not to.

13 Q. Beg your pardon?

14 A. The nurses tend not to write that kind of
15 thing clearly, "clear with," that's the kind of
16 thing a physician tends to write when physicians
17 write the orders, that's why written orders are
18 always better than telephone orders.

19 Q. Well, is your concern as expressed in your
20 report that it would appear that Dr. Dacha came and
21 wrote that after the fact to try to cover himself
22 in terms of whose decision it was to send her down?

23 MR. GALLAGHER: Objection. I
24 think you said Dacha,

25 Q. I'm sorry, Dr. Patel, Let me say it again.

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

3 A. No.

4 Q. -- deflect --

5 A, Dr. Patel.

6 Q. Right.

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

9 A, It could have that appearance.

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

12 -----

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

15 -----

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

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

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

7 A. Yes .

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

13 MR. SCOTT: Objection,,

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

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

18 A. Yes .

19 Q. Were you told that by --

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

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

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

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

10 A. I believe that's correct.

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

13 A. 50, 463

14 Q. Somewhere around there?

15 A. It's page 50.

16 **a.** 50.

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

20 A. I have not determined.

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

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

1 same time,

2 Q. Do you?

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

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

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

8 A, It looks like a different color ink,

9 Q. It does, doesn't it,

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

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

16 Q. Sure, you can,

17 A, If my pen ran out or --

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

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

1 think is --

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

8 MR. SCOTT: Objection.

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

11 After which fact, written original
12 order?

13 Q. Yes.

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

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

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

1 A. After the fact, which fact?

2 Q. Both facts, that is the order --

3 A. Okay.

4 Q. -- that we have discussed, when that's done,
5 we don't know when after the fact.

6 A. Right.

7 Q. After the May 7th entry on page 50, that at
8 some point after that he came back and added this
9 in black pen, that's the quote that Mr. Scott
10 refers to in his letter?

11 A. At some point after he used the blue pen, he
12 used the black pen, correct.

13 Q. Correct.

14 A. Don't know when.

15 Q. Let's assume --

16 A. Either way.

17 Q. -- after she had her arrest that he at some
18 point after that, he adds these two entries.

19 A. It's an assumption. We're speculating after
20 that. Okay.

21 Q. I'm asking you to assume that. Obviously if
22 the assumption isn't true, the questions based on
23 that assumption wouldn't be true, nor would be your
24 answers.

25 A. Fair enough,

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

3 MR. SCOTT: About what?

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

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

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

13 MR. SCOTT: Objection.

14 A. Say it again.

15 -----

16 (Question read.)

17 -----

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

21 Q. I'm asking --

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

1 care doctor,

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

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

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

12 Q. So we agree then?

13 A, Yes.

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

16 A. If your assumption you have is correct.

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

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

22 MR. SCOTT: Wait for a
23 question,

24 Q. The question was did he read it,

25 MR. SCOTT: He doesn't

1 remember.

2 A. I don't remember.

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

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

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

12 A, I hope so.

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

17 A. Yes, I do a little bit.

18 Q. You do?

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

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

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

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

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

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

19 MR. SCOTT: From doing
20 what?

21 MR. MAMPINSKI: From making a
22 wrong decision.

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

25 A. If the navigator says fly into the glacier

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

6 Q. So the navigator is not responsible?

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

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

14 MR. SCOTT: Objection,

15 Q. Is that right?

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

18 Q. That's where we are,

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

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

1 do, does that change your opinion at all?

2 MR. SCOTT: Objection.

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

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

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

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

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

24 Q. Right.

25 a. And HIDA scan was stopped because the patient

1 developed a distress; is that correct?

2 Q. I believe that's correct,

3 A. So the HIDA scan I presume was stopped by the
4 people in radiology in a technical capacity
5 conducting the test,

6 Q. Who was involved with that?

7 MR. SCOTT: Do you need
8 nurses? notes?

9 A. I would need nurses' notes, Do you have a
10 page number for me?

11 Q. I'm sure I do,

12 MR. GALLAGHER: 1135, maybe,

13 MR. KAMPINSKI: It is going to
14 be 99 --

15 THE WITNESS: This is a nurse
16 note.

17 MR. KAMPINSKI: 992, I believe.

18 MR. SCOTT: 992?

19 MR. KAMPINSKI: I think so.

20 Yes.

21 THE WITNESS: I give you guys
22 a lot of credit to be able to read these things,
23 This is difficult,

24 BY MR. KAMPINSKI:

25 Q. The 10:45 entry,

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

3 Q. Starts with Dr. P. Patel?

4 A. Dr. P. Patel.

5 MR. SCOTT: Right here,

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

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

18 Anything specific here you want?

19 There's a further entry I think at
20 1:30, late entry, which is also off of ours,
21 indicating Dr. Dacha paged, patient placed in
22 reverse Trendelenburg.

23 MR. SCOTT: Wait for a
24 question.

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

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

4 A. I have no idea.

5 Q. You don't?

6 Does that correspond with the
7 orders in the chart?

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

12 That's 8:05 in the --

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

16 MR. SCOTT: Do you have a
17 correct page?

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

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

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

24 MR. SCOTT: All right.

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

1 that?

2 A. I believe so. I think that might be a
3 signature there.

4 Q. Good.

5 A. Something HIDA scan, this is page 190 in the
6 orders. If you turn to page 190 in the orders on
7 page 48 in the physician's notes.

8 Q. Yeah.

9 A. Page 48 in physician's notes has doctor, same
10 signature, that's on the order thing, says
11 recommended list of four or five things: CBC, free
12 and flatten upright abdomen, HIDA scan, amylase,
13 lipase, and two hour urine amylase; that signature
14 I presume is Dr. Patel's. The orders are then
15 written about the same time. I don't know if he
16 communicates the recommendation in the notes and
17 whether he was giving clearance to go ahead and
18 write the order, certainly the orders are signed by
19 him.

20 Q. Okay. Page 46 of Dr. Patel's deposition,
21 which I assume you read --

22 MR. SCOTT: Just listen.
23 It's all right.

24 Q. If you want to follow along, that's all
25 right.

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

4 44, question, she had respiratory
5 distress?

6 Answer, respiratory distress,
7 Question, that happened during the
8 HIDA scan?

9 Answer, that's right.

10 They were unable to complete the
11 HIDA scan?

12 That's right.

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

15 Answer, they called me?

16 Question, the nurse?

17 Answer, oh, yes,

18 Question, you told them to call
19 Dr. Dacha?

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

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

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

1 parts of that.

2 MR. SCOTT: Do you want to
3 repeat it?

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

6 Q. What happened, the nurse called you?

7 His answer was a question, they
8 call me?

9 Question, the nurse?

10 Answer, oh, yes.

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

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

16 So it was his decision, right?

17 MR. SCOTT: Just to stop
18 the HIDA scan?

19 MR. KAMPINSKI: Yes.

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

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

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

1 Do you understand the question?

2 MR. SCOTT: Testimony

3 before is that the x-ray people stopped the HIDA
4 scan.

5 Q. Do you understand the question, sir?

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

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

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

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

17 Q. I see what you're saying.

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

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

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

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

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

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

11 MR. KAMPINSKI: I beg your
12 pardon?

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

15 MR. KAMPINSKI: A
16 misstatement?

17 MR. SCOTT: Yes.

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

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

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

23 Q. No, Listen to my question.

24 A. Let's go back.

25 MR. KAMPINSKI: Could you find

1 it?

2 -----

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

11 -----

12 A. This is now?

13 Q. At three o'clock in the --

14 A. Afternoon?

15 Q. That's right.

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

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

24 Who is relying on who for her
25 respiratory status?

1 A, You want me to answer speculating on what --
2 Q. I'm not asking you to speculate, I'm asking
3 you to tell me why you ignored that fact in your
4 report and the analyzing of who was relying on who
5 for purposes of deciding what to do about
6 Mrs. Lind's airway?

7 MR. SCOTT: Objection.

8 A. I don't interpret it that way.

9 Q. NO?

10 A, I interpret it to go see the patient.

11 Q. I'll read it --

12 A. You can read it again but I --

13 Q. I will, just so there's no confusion.

14 You told me that you deal with
15 facts, not stuff that you want to hear or want to
16 make up.

17 A, Fair enough.

18 Q. And I believe you --

19 A, Go ahead,

20 Q. Here are the facts, sir --

21 MR. SCOTT: There are some
22 of the facts,

23 Q. Here are the facts that D.C. Patel testified
24 to under oath that you were provided with.

25 Answer, called me around just

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

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

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

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

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

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

23 A. Well --

24 Q. Isn't that right, sir?

25 MR. SCOTT: Objection.

1 A, No,. I don't think so.

2 Q. You don't think what?

3 A, I don't think he was asked to go -- he was
4 asked to go check on a patient and he may have been
5 the choice, He is a doctor, I don't know where
6 Dr. Dacha was, he might have been in his office
7 four miles away, he may have been here, I don't
8 know where he was.

9 Q. So they were acting as a team then?

10 MR. SCOTT: Objection,

11 A, Right. They were acting together, yes.

12 I don't know what "team" implies,
13 but they were acting together, yes.

14 Q. What was the cause of her abdominal
15 complaints on May the 7th in your opinion prior to
16 the HIDA scan?

17 A. I don't know.

18 Q. Well, in the list of potential things that
19 could have been causing it, why don't you give me
20 some based on your review of the records?

21 A, Intra-abdominal catastrophe meaning a
22 perforated viscus,.meaning sepsis, meaning hollow
23 or solid organ infarction.

24 The abdomen encompasses the
25 stomach, bowel, liver, spleen injuries, infarctions

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

3 Q. Anything else that could have been causing
4 it?

5 A. Those are the ones I think of offhand.

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

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

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

14 A. That's correct.

15 Q. Did you review any films in this case?

16 A. I did not.

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

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

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

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

24 A. If you want me to comment on them.

25 Q. Sure, that was my question.

1 A. Let me, if he says --

2 MR. SCOTT: Yes.

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

5 Q. Yes, 40 -- no, It's in the 400's there.
6 413.

7 A. 413, thank you,

8 Q. Sure,

9 A. Okay, Now, the specific question?

10 Q. Any evidence of any intra-abdominal
11 emergency?

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

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

17 A. It could be normal, it could be because the
18 bowel is not -- or the emptying is slowed because
19 of poor uptake. Let me see, It doesn't say,
20 It could be just bowel bile duct of
21 the gallbladder hasn't contracted.

22 Q. So it's really a nonspecific --

23 A. That's correct.

24 Q. -- finding there, right?

25 A. That's correct.

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

3 MR. SCOTT: Objection.

4 THE WITNESS: Do you want me
5 to go ahead?

6 MR. SCOTT: Sure.

7 Q. Please.

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

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

15 A. Certainly did?

16 Q. Did not?

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

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

25 A. Good question, A surgical abdomen is

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

3 Q. Okay,

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

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

11 A, They did not --

12 Q. So she didn't have that?

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

15 Q. So the --

16 A. Ischemic bowel would be another one.

17 Q. Would be another what?

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

20 Q. Did she have ischemic bowel?

21 A, I don't know.

22 Q. Should you know?

23 A. How do I know? At this --

24 Q. By looking at the records.

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

1 Q. You know now though?

2 A. Retrospectively.

3 Q. Sure.

4 A. We know a lot more than we did at the time.

5 Q. That's fair.

6 A, Presuming putting me in their place,

7 Q. Right. So you know now that she --

8 A. I know now in looking at the rest of the
9 records, In fact, I didn't go through the total
10 records. I confined myself -- I did look at the
11 outcome, I was interested in knowing what happened
12 obviously, but I didn't review the detailed records
13 beyond the day of the event in any detail,

14 Q. What findings were there that you believe
15 support the existence of acute abdomen?

16 A. Patient has tachycardia, this would be in
17 support; doesn't mean necessarily the only reason
18 that would cause it, that's high, rapid
19 heartbeats; patient has hypotension, low blood
20 pressure, which is during the whole course, looking
21 at the whole course now.

22 Q. No. No.

23 A. Am I confining myself to before the HIDA
24 scan.

25 Q. Yeah. What led Dr. D.C. Patel on May

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

3 A. Okay,

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

6 MR. SCOTT: Objection,

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

8 Q. Which one do you want to read?

9 A, Turning to right now 5-7.

10 Q. What page?

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

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

15 Q. Did he see her on the 5th?

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

18 Q. I'm sorry?

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

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

1 A, Sure.

2 Q. Go ahead. Tell --

3 A, We're entitled to differences of opinions.

4 Q. Tell what you --

5 A, He's talking about abdomen pain.

6 Q. Who?

7 A, Dr. Dacha,

8 Q. On page 44?

9 A. On page 44.

10 Q. And he calls it, Dr. Paresh Patel --

11 A. Wait. Right here, 5-5-92, complains of

12 abdominal pain, indicates something breathing,

13 breathing okay, low grade temperature, he puts down

14 in notes something, maybe plan, surgical consult.

15 Dr. P. Patel will start antibiotic cultures, okay.

16 Dr. P. Patel note, that's P. Patel, not D.C. Patel.

17 Q. Right.

18 A, That's a surgeon.

19 Next note is by -- that signature I

20 don't know. It's probably Dr. P. Patel,

21 Q. Abdomen now soft, right?

22 A. Abdomen now soft.

23 Q. Is that consistent with an acute abdomen?

24 A. It may be, but it's not a surgical abdomen,

25 there's no peritonitis, no peritoneal signs.

1 Q. Excuse me, sir. Isn't a soft abdomen
2 inconsistent with acute abdomen?

3 A. No.

4 Q. So if you see a soft abdomen you would
5 consider that an acute abdomen?

6 A. That's not what I'm saying.

7 Q. So it's nonspecific?

8 A. If I find a soft abdomen it does not exclude
9 an acute abdomen; if you find a hard abdomen, it's
10 more consistent with it.

11 Q. What did Dr. Paresh Patel --

12 A. Which Patel? Does not -- I can't see, I
13 can't read this,

14 Q. Does not seem like any intra-abdominal
15 problem?

16 A. At this time,

17 Q. Right. Will observe?

18 A. Yes.

19 Q. So you wanted to go back to the 5th?

20 A. To see that that's the history.

21 MR. SCOTT: What's the
22 question?

23 A. I'm going to go ahead to the 7th.

24 Q. Go ahead.

25 A. Now we're at the 7th, abdominal pain.

1 Q. You wanted to do history, on the 6th there
2 was no abdominal pain, was there?

3 A. I don't know.

4 Q. Not a surgical abdomen?

5 A. I haven't got the notes of the 6th here.

6 Q. You don't? On page 45.

7 A, 45 is out of order here. One minute. Mine
8 are not in order.

9 Okay, On 5-6, looks better.

10 Q. Nontender?

11 A. At that time.

12 Q. No guarding or rebound?

13 A. Agreed.

14 Q. That's not acute abdomen, is it?

15 A. There no guarding or rebound, no peritoneal
16 signs. There's a specific finding of hypotensive,
17 looking for rebound, that's one form of acute
18 abdomen.

19 Q. Anything that you --

20 A. Abdominal pain, still complaining of
21 abdominal pain.

22 Q. I'm on the 6th.

23 A. Oh, no abdomen pain today, things got
24 better. I'm just going back. I'll go along with
25 this. They go on further. We start having more

1 abdomen pain.

2 Q. What do you mean "more"?

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

8 Q. Which page are you on?

9 A. Page 48.

10 Q. It's vague.

11 A, It's -- pardon me?

12 Q. Abdominal pain vague with --

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

14 Q. Vague, with something abdominal pain.

15 A. Mine is harder to read than yours probably.

16 Q. It says vague.

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

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

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

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

24 A. Yes.

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

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

4 A. Yes.

5 Q. -- doing?

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

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

12 Q. She wasn't crippled?

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

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

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

21 So that it's her pain --

22 A. That's bothering her the most.

23 Q. Let me finish.

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

1 because on the 5th no studies were done?

2 MR. SCOTT: Objection,

3 Q. Well, were they?

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

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

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

11 MR. KAMPINSKI: Read my
12 question again.

13

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

18

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

25 A. No. I think if I understand your question

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

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

9 I wish medicine were easy to --

10 Q. That's fine,

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

15 Q. The note you referred me to?

16 A. On page 48?

17 Q. Yes.

18 Whose notes was that, the first
19 one?

20 A. I think that's Dr. Patel.

21 **a.** D.C. Patel?

22 A. I believe so.

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

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

1 Q. So this was a vague complaint of pain they're
2 looking at here?

3 A, It's a -- he says vague abdominal pain,

4 Q. Then whose note is it then right after his?

5 A, I believe, if I am not mistaken, that's
6 Dr. P. Patel,

7 Q. The surgeon?

8 A, Right. Who says -- who puts a note down
9 about something needs further; is that resolution?

10 Q. Well, abdomen soft, right?

11 A, Abdomen soft, tender epigastrium with some
12 guarding, bowel sounds absent, these are all --

13 Q. That's not a good sign?

14 A, Right,

15 Q. If they were present, would that be a better
16 sign?

17 A. It would be a better sign, Could be a sign
18 that's something not necessarily going on with the
19 bowel, abdomen, Bowel sounds suggest other
20 systemic problems or possibilities.

21 Q. Such as?

22 A, Such as bowel obstruction.

23 Q. By what?

24 A. Adhesions, bowel obstruction by torsion,

25 Q. Feces?

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

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

14 Q. Is that what he has testified to?

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

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

18 Q. Did you read his deposition?

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

24 Q. Okay.

25 A. Which is the only place I can. Obviously

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

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

4 a. I presume that's Dr. Dacha. Anybody agree on
5 that?

6 MR. SCOTT: That's all
7 right.

8 A. Can I go on?

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

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

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

20 A. I believe so.

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

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

1 Q. This is after she returned from x-rays,
2 right?

3 A. That's correct,

4 Q. Is there any mention, by the way, in here of
5 his analyzing her respiratory problem?

6 MR. SCOTT: Dacha?

7 Q. Yes,

8 A. I can read the note that it says tachypnea, I
9 believe, due to abdominal pain. That's sort of an
10 assessment, it's his opinion that he thinks that,

11 Q. Where are you? I'm talking about the second
12 note.

13 A. Yes.

14 Q. After she returned from x-ray.

15 A. Okay, I'm sorry, I was reading the note
16 before,

17 Returned from x-ray, x-ray only
18 partially -- return from x-ray, only partially
19 done, respiratory rates 36 pels minute and 45 per
20 minute,

21 Q. Is that good?

22 A. That's tachypnea, that's rapid respiratory
23 rates, and he made an assessment of the respiratory
24 rates then.

25 Q. Is that good for a patient to be breathing

1 that fast?

2 A. It is if she needs to be breathing that fast,
3 that's one way of getting oxygen, and I don't want
4 you to think I'm being glib. It sounds like I'm
5 being glib, I'm not.

6 Q. That's normal?

7 A, It's not normal, it's rapid breathing; what's
8 causing it, I don't know.

9 Q. How about the blood pressure, is that --

10 A, Blood pressure is -- that's not horribly
11 below, but it is lower than normal. If I were dry,
12 my blood pressure may be there or if I'm septic it
13 might be acceptable, my blood pressure might be
14 down; but yes, that's hypotensive, mildly
15 hypotensive,

16 Q. Then the next note is Dr. D.C. Patel?

17 A. No, I think it is still Dr. Paresh, is it
18 not?

19 Q. On page 50?

20 A, You're right, it is D.C. Patel.

21 Q. This is after she returned from x-ray?

22 A. I don't have a time on here but I would
23 presume it is. It's a presumption, you may say.

24 Q. No. He testified that it is?

25 MR. SCOTT: Well --

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

3 A, You're right.

4 MR. SCOTT: This is before
5 x-ray?

6 A, Before the CAT scan.

7 Q. Before CAT scan, after HIDA scan?

8 A. Right .

9 Q. We're in agreement?

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

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

13 A, Okay.

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

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

18 Q. So the subjective findings were what?

19 A, Complains vague abdominal pain, and something
20 here .

21 Q. States feels better?

22 A* Could be, Better than that --

23 MR. SCOTT: After bowel
24 movement?

25 A. After .

1 Q. So she had a bowel movement, didn't she?

2 A. At some point, yes.

3 Q. Well now, not at some point?

4 A. At this point.

5 Q. Right. You already read the nurse's note a
6 few minutes ago about his being there, doing a
7 rectal exam and her passing a large amount of
8 stool?

9 A. Correct,

10 Q. And she felt better?

11 A. Liquid stools, yes,

12 Now, I can get --

13 MR. SCOTT: Wait a minute,

14 Q. Go ahead, We're not trying to play games
15 here. You can --

16 MR. SCOTT: Well, ask a
17 question,

18 MR. KAMPINSKI: I'm here for
19 discovery. He was about to explain why that is not
20 significant.

21 THE WITNESS: I wasn't going
22 to explain that.

23 Q. Is it significant?

24 A. It may be,

25 Q. Well, I mean, the lady's stomach hurt her,

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

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

5 I'll withdraw that.

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

9 MR. SCOTT: Go ahead,

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

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

16 MR. KAMPINSKI: Could you read
17 my question back,

18 -----

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

23 -----

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

1 A. It may be, but this is what I was starting to
2 say.

3 Q. Okay.

4 A. If I do a rectal exam, the patient may have a
5 liquid bowel movement, or large form bowel
6 movement, that may be reflexive, doesn't mean
7 there's not a bowel obstruction because I get some
8 kind of finding like that. Patient could have
9 transient relief, everybody feels better when your
P0 bowel is empty, but that doesn't get rid of the
11 underlying problem.

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

18 A. What obstruction? She didn't have an
19 obstruction, sir?

20 A. But I'm telling you, going back to this
21 specific case, yes, she can feel better after
22 having a bowel movement no matter what's causing
23 the abdomen pain.

24 Q. What if that was the cause of her abdominal
25 pain?

A. Would that make her better?

Q. Yes.

3 A. Yes, but I don't know that anymore than you
4 don't know if she had a bowel obstruction at that
5 point.

6 Q. Well, she felt better?

7 A. She felt better,

8 Q. And there was a reasonable explanation for
9 her feeling better in terms of her abdominal
10 complaints, wasn't there?

11 A. Partially, yes.

12 Q. Now, her respiratory status however did not
13 get better, did it, from the time she came back
14 from x-ray after the HIDA scan?

15 Am From the HIDA scan?

16 MR. SCOTT: Do you want to
17 look at the nurses' notes?

18 Q. Absolutely. Look at whatever you need to.

19 A. The nurses' notes, where are they?

20 HIDA scan we decide about what time
21 did she go back up? Can you help me out with that?

22 Q. Yes. I think it's around 10:45, something
23 like that.

24 A. Her respiratory --

25 Q. Tell me where you're referring to.

1 A. Page 988,

2 Q. Just give me a minute.

3 Okay,

4 A. Middle part, around 10:00 a.m.

5 Q. I believe she came back, at least according
6 to this, would have been the -- I mean, she'd have
7 to be there at the 10:15 entry otherwise they
8 wouldn't be able to chart this?

9 A, Correct, So 10:00 and 10:15 you got the
10 blood pressure when they come back.

11 Q. Right.

12 A. At that point she had blood pressures in the
13 range that we said down there roughly 74 to 80, 70
14 to 80 or 90, and 40 to 60; and respiratory rate
15 stays about the same, decreasing slightly; pulse
16 goes down slightly.

17 Q. Let's stop for one second before you do this
18 to me.

19 a, I'm not trying to do anything to you.

20 Q. Well, I don't want to be unfair with you and
21 I am sure you don't want to be unfair with me.

22 You went back to the 5th to set
23 sort of baseline for what was going on with this
24 lady, If we go back even a day to the 6th, she was
25 on a ventilator.

1 A, Can you tell me what page you're on?

2 Q. Sure. 980.

3 A. There's a --

4 Q. If we go back to 972, how is that?

5 A. All right.

6 MR. SCOTT: One more.

7 A. Whoops.

8 Q. You look at both of them,

9 A. 972, got you.

10 Q. Just for general purposes, I mean at 972 her
11 respirations are for the most part in the 20's,
12 correct?

13 A, Yes. Upper -- mid and upper 20's.

14 A. Her blood pressure basically is 100 to 120,
15 I'm going to say over let's say it's 60 to 70?

16 A. Right.

17 Q. Then if we go over to 980, her respirations
18 now are in the 30's?

19 MR. SCOTT: You mean 9883

20 MR. KAMPINSKI: No, 980. Page
21 980 on the 6th.

22 MR. SCOTT: On the 6th?

23 MR. KAMPINSKI: Yes.

24 MR. SCOTT: All right.

25 Q. Her respirations now are high 20's, low 30's,

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

5 A. Um-hum.

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

8 A. Right.

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

12 A. Okay. Yes.

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

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

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

21 A. I agree. Creeping down a little.

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

1 A. Okay .

2 Q. Dr. Dacha -- or Dr. Patel doesn't want them
3 to continue it, do you know why?

4 A. They said they had stopped it, come back up,
5 there wasn't anything further to be gained.

6 Q. Why didn't he send her back down for the
7 completion of it?

8 A. I think probably although it was an
9 incomplete test, he probably had complete enough
10 information that he didn't think he can gain
11 anything further.

12 Q. Wasn't she originally sent down to rule out
13 cholecystitis?

14 A. To rule out cholecystitis and obstruction of
15 the bowel.

16 Q. And pancreatitis, wasn't it?

17 A. Can't tell about that by HIDA scan. HIDA
18 scan won't help that,

19 Can I ask a question?

20 Q. Yes .

21 A. How much longer are we going to be roughly.

22 Q. Half hour maybe, You need to break?

23 A. I need to get out.

24 Q. I'll do it as quickly as I can.

25 A. Fair enough. Let me make a quick call.

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(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 --

1 A. I would not do a HIDA scan for that,

2 Q. Right. So if he said that, he wouldn't know
3 what he is doing?

4 MR. SCOTT: Objection,

5 A. Or he misstated himself. I don't want -- I'm
6 not sure you can say he did.

7 Q. If he's the one who ordered the HIDA scan, he
8 ordered it for the wrong thing, didn't he?

9 MR. SCOTT: Objection.

10 A. No. Again, if he was ordering because he was
11 looking for gallstones, he thought the person had
12 gallstones and he was looking for the cause of it,
13 fine; if he's doing it to rule out pancreatitis and
14 he didn't misstatement -- misstate himself, then I
15 would say that's not what I would do a HIDA scan
16 for, the HIDA scan is not done for that reason.

17 You know, you have Dr. Miclat here
18 calling Dr. Dacha or Dr. Patel or Dr. -- I don't
19 know, he maybe misstated. I don't know if he did
20 or not, that's a possibility, whatever.

21 Q. Or it's possible he may have made a mistake
22 not knowing what to order for what disease process?

23 MR. SCOTT: Objection.

24 A. It is possible.

25 Q. Okay. We were talking about her respiratory

1 status when she came back from the HIDA scan.

2 A. Okay.

3 Q. We now looked at what it was for a few days
4 prior to that.

5 A. We stated what we were finding, what we were
6 seeing in that time.

7 Q. Well, I think we were seeing a worsening --

8 A. Okay.

9 Q. -- respiratory status, weren't we?

10 A. I thought that's what we said, I agree.

11 Q. As a matter of fact, it's worse when she
12 comes back from the HIDA scan, we can agree on
13 that?

14 A. What is worse?

15 Q. Both her blood pressure and her respiration?

16 A. Blood pressure, respirations, and I'm looking
17 at all the numbers. You consider 48 to 52 as a
18 range, it is running around that, it's a little
19 higher.

20 Q. It's 56?

21 A. Then right back down to 52, it is about --
22 it's no better for sure, and maybe a little worse.

23 Q. Well, if she experienced respiratory
24 difficulty when she was having the HIDA scan, could
25 you tell me what it is that you see in those

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

4 A. There's three questions loaded in one,

5 Q. Yes.

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

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

16 A. Her respiratory status?

17 Q. Did it get better?

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

22 Q. It's not acceptable?

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

25 Q. Right

1 A. Now, the question is?

2 Q. She goes back down to x-ray for the purpose
3 of a CAT scan at approximately 2:00 p.m. now.

4 A. Okay .

5 Q. I'm going to assume that the 95 over 50,
6 which is the 2:00 p.m. entry is the one before they
7 take her down to CAT scan, the reason I'm going to
8 assume that is because they couldn't put that in
9 there if in fact she was down in x-ray?

10 A. That's correct.

11 MR. SCOTT: Objection.

12 A. Unless the nurse that was -- had the same
13 sheet that went from the floor down with her, I
14 don't know. I don't know what their practice is
15 there .

16 Q. That's about when they take her is right
17 after they take this blood pressure reading, so
18 could you explain to me how in the world Dr. D.C.
19 Patel could have approved her to go back down given
20 the respiratory status -- well, withdraw that.

21 How any doctor, whether D.C. Patel,
22 Dr. Miclat, Dr. Dacha, Dr. P. Patel, or
23 Dr. Ferguson could in good conscious say this lady
24 can go back down and have a procedure where they
25 just brought **her back from** a procedure and **she**

1 sustained respiratory distress without protecting
2 her airway?

3 MR. QUANDT: Objection, form
4 of the question,

5 MR. SCOTT: Objection,

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

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

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

1 was stable under any circumstance?

2 A. That's fine, I would take that under
3 advisement and I'd listen to it. I might still
4 want the information even though he's not going to
5 operate without her being stable.

6 Q. What is the downside of protecting her airway
7 when you're getting your information?

8 MR. SCOTT: Objection.

9 A. Again, the short answer is I don't know what
10 the downside is except the risks of intubation.
11 I'm not qualified to make that decision, intubate
12 or not intubate, Presumably there's minimum risk
13 in good hands but the problem is that's not my
14 decision as a gastroenterologist. I haven't got
15 the right, it's out of my domain to make a decision
16 whether she needs to be intubated for respiratory
17 status.

18 I'm giving my advice that she needs
19 a CT of the abdomen to rule out intra-abdominal
20 problems, the rest of the decision is not mine.

21 Q. Her abdomen had gotten better, hadn't it, at
22 least according to the notes that we read?

23 MR. SCOTT: Which note?

24 MR. RAMPINSKI: The May 7th
25 notes in between the HIDA scan and CAT scan.

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

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

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

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

10 MR. SCOTT: Ordered what?

11 MR. KAMPINSKI: CT scan.

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

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

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

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

22 Why don't you
23 let him --

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

1 A, I will have to Listen to the question again:

2 Q. The question is her abdomen got better,
3 didn't it?

4 A. Her abdomen got better when -- at the time he
5 examined her after the HIDA scan when she had a
6 bowel movement. I don't know what transpired
7 between 10:00 a.m. and the time of the CAT scan,
8 which is two o'clock, as far as the abdomen.

9 Q. The abdomen got better, decreased
10 respirations, got or stayed the same at a minimum,
11 and by the "same" they weren't good, the same as
12 when she was brought back from x-ray, right?

13 A. The respiratory status was the same, roughly
14 the same or worse as when brought back from x-ray,

15 Q. Her abdomen got better?

16 A. No, I'm not so sure, The abdomen got better
17 transiently after the bowel movement.

18 Q. That's better?

19 A. She didn't have any bowel sounds,

20 Q. She didn't?

21 A. She did not have bowel sounds the last note I
22 remember.

23 Q. That's a good point, because I want you to
24 find Br. Patel's discussion about whether she had
25 bowel signs or not when she came back from x-ray,

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

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

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

9 Q. Whose note is that?

10 A. I'm sorry,

11 Q. That's Dacha.

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

15 Q. Right.

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

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

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

22 Q. Page 50 now, this is one.
23 plus, hypoactive. I

24 A. Bowel sounds I guess. I'm not sure what it
25 can't read that one either the writing. It didn't
come across very well.

1 Q. Bowel sounds present?

2 A. But hypoactive.

3 Q. Right. Before hypoactive?

4 A. That's B.S., it looks like, plus -- I can't.
deposition'

5 Q. Yes. I'm reading from his says bowel sounds
6 page 49. Be's reading the note,
7 present?

8 A. But hypoactive, so he's saying hypoactive,
9 Dr. Dacha couldn't hear anything, he has liquid
10 stool here.

11 Q. Doctor, you just told me that if the bowel
12 signs were not present, that would be a reason to
13 continue the study?

14 A. Yes, they were present; but it's not the only
15 reason that --

16 Q. Everything you keep telling me, I keep
17 pointing out to you indicates she's getting better
18 and you --

19 A. I disagree. You're not pointing out
20 everything that indicates she's that much better.
21 She's tachypneic.

22 Q. But tachypneic goes along with her
23 respiratory distress?

24 A. Or it could go along with sepsis, abdominal
25 sepsis, respiratory distress, abdominal

1 catastrophe.

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

4 A. I don't think so.

5 Q. Pneumonia?

6 A. Agreed.

7 Q. What is that?

8 A. It's an infection, pulmonary infection.

9 Q. Can that cause respiratory distress?

10 A. Yes, it can. So can intra-abdominal abscess,

11 so can intra-abdominal catastrophe. I can't say

12 it's wrong. I think he's trying to find out.

13 Again, I'm putting myself back where he is, where
14 they are.

15 Q. Yes?

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

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

23 MR. SCOTT:

Ignore the lung

24 problem?

25 MR. KAMPINSKI:

Yes, that's

1 what I said.

MR. SCOTT:

What do you

2 mean? Who ignored the lung problem?

MR. KAMPINSKI:

These fine

3 physicians taking care of her.

4
5 A. I can't -- I'm not -- when you're asking
6 ignore the lung problem, my role as a GI consultant
7 is pointing out what possibilities that existed
8 abdominally to cause problems. If you want to take
9 into account a high white count, fine; you can take
10 into account the tachypnea, take into account
11 hypertension, or some kind of abdomen problem;
12 what's causing it, I don't know. Maybe it's the
13 lung problem causing it, I don't have that
14 information right now.

15
16 In my capacity as a consultant in
17 GI, that's not what I should be commenting on. I
18 should be commenting on possible abdominal problems
19 that could lead to this, hypotension, sepsis as
20 being a possibility, or things going on in the
21 abdomen that can cause this. That's all I can say
22 if I somebody asked me to come see a patient, could
23 this be an abdomen problem causing that. I'd have
24 to say yes, it could be, here's how you find out if
25 it is; and we do these three tests, but you leave

1 it up to the primary doctor under those
2 circumstances,

3 Q. So she had bowel sounds, correct?

4 A. Hypoactive bowel sounds, yes.

5 Q. And she was feeling better, correct?

6 MR. SCOTT: Objection.

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

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

13 MR. SCOTT: Objection.

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

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

18 A. That's correct.

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

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

23 Q. Becomes unresponsive?

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

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

3 Q. On page 50?

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

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

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

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

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

23 Q. It says pancreatitis and --

24 A. Ileus.

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

1 going to tell him whether or not th
2 pancreatitis.

A. Yes.

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

A. Wait. He's getting an increase in serum
7 amylase, he's saying an increased serum amylase,
8 8 that's this arrow up, S amylase. Wait, that's not
9 9 t's no

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

12 Q. Where are you looking at?

13 A. Page 50.

14 Q. Yes.

15 A. Down two-thirds, the 2 --

16 Q. The 201 sodium increase?

17 17 A. Where e sodium?

18 MMR. SCOTT: lines

19 19 ie bottom.

20 Okay?

21 A. Then increase S amylase.

22 22 Q. Then see what?

23 23 A. See to RF pancreas, or see something.

24 24 Question pancreas.

25 25 Q. Where is the serum amylase study that was

1 saying it was increased?

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

4 Q. Let's do it.

5 A. I have to act on what he believed.

The laboratories?

6 MR. SCOTT:

This is April.

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

8 Q. Which page?

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

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

15 Q. Well, is 201 evidence of pancreatitis?

16 A. Could be.

17 MR. SCOTT:

Pardon me?

18 Q. Beg your pardon?

19 A. Could be, yes.

20 MR. SCOTT:

Just wait for a

21 question.

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

24 A. I beg your pardon?

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

3 A. If she has pancreatitis?

4 Q. That's right.

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

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

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

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

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

15 Q. Yes.

16 A. Yes, you could.

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

19 A. I don't know.

20 Q. So far we have infection and pancreatitis?

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

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

24 A. He wrote down ileus, he questioned
25 pancreatitis.

1 Let me go back to the note. Wrong
2 page.

3 Rule out gallbladder disease, rule
4 out pancreatitis.

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

7 A. I didn't say that.

8 Q. -- HIDA scan?

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

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

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

16 Q. Anything else that he was doing it for?

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

21 Q. I apologize if this is repetitive.

22 A. I wouldn't remember by this time.

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

1 the urgency of doing the CAT scan?

2 A. Fair question.

3 To some extent it probably would
4 make a differential in what degree of urgency, and
5 I -- if he said I'm not going to operate, well,
6 under any conditions, not just for resuscitation
7 and maybe the patient's stabilized, but I see no
8 reason to go in the belly whatsoever, then I'd have
9 to think what difference in medical therapy it
10 would make; a major differentiate would be
11 infection versus inflammatory process, that's not
12 infection because I'd be using antibiotics or not
13 using antibiotics, and it would be probably a
14 little less urgency, I might be able to buy more
15 time.

16 Q. In other words, to stabilize her from a
17 respiratory standpoint prior to doing the CAT scan?

18 A. Not necessarily. Sou mean from -- if the
19 surgeon says there's no reason to do this
20 whatsoever?

21 Q. That's right.

22 A. If the surgeon says no, I would not operate
23 under any conditions, then I would have to think.

24 I don't know whether the
25 respiratory status would be a deciding factor. My

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

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

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

14 A. If he said that on the 7th?

15 Q. That's right.

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

20 Q. But that's not what he says.

21 MR. SCOTT: That's what **the**
22 notes say.

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

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

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

4 Q. If general conditions permit?

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

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

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

13 MR. SCOTT: We have talked
14 about his deposition.

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

19 Anything else you got to say?

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

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

25 A. This?

1 Q. No, no, this is off his deposition.

2 A. I don't recall if I read Dr. Paresh Patel.

3 Q. Since you didn't or don't recall, this is
4 what he said, when you saw her on the 7th, did you
5 have a conversation with Dr. Dacha and Dr. D.C.
6 Patel?

7 Answer, yes.

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

10 Answer, we talked about the
11 patient.

12 What specifically?

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

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

17 Answer, right.

18 Did you read or were you told that?

19 A. I don't recall that. I believe I read that.
20 I don't recall reading Dr. Paresh Patel's
21 deposition. I read the notes and I am going again
22 at the time of the information I have from his
23 notes on the 7th in the chart.

24 Q. Are you suggesting that he would somehow
25 change his testimony to try to exculpate himself

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

3 A. No, I hope not.

4 Q. Okay.

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

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

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

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

14 -----

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

17 -----

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

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

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

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

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

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

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

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

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

1 primary lung failure.

2 Q. Was there any evidence of that, that you saw?

3 A. No, that's what we're searching for. That's
4 why as a gastroenterologist I'd be called in, could
5 it be a metabolic acidosis induced by something
6 going on in the abdomen,

7 Q. But I mean, you didn't find any evidence of
8 that?

9 A, NO .

10 Q. Why do you think Dr. Stiller said that?

11 A. I don't know.

12 MR. FELTES: Objection.

13 Q. Do you think he's making it up?

14 MR. FELTES: Objection.

15 MR. SCOTT: Objection.

16 Let's go home, come one

17 A, I don't know.

18 Q. I'd like --

19 A. I don't know.

20 MR. KAMPINSKI: Mr. Scott, you
21 know, you're the one that pointed it out to him.
22 You made it fair game.

23 MR. SCOTT: Is he making it
24 up? How can a doctor who never even talked to
25 Dr. Stiller, how the hell would he know.

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

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

5 MR. KAMPINSKI: You in a
6 hurry?

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

9 MR. KAMPINSKI: Can I get an
10 answer then.

11 MR. SCOTT: Is he making it
12 up?

13 THE WITNESS: I have no
14 idea.

15 MR. SCOTT: Is that
16 helpful?

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

21 MR. SCOTT: Let's go.

22 BY MR. KAMPINSKI:

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

1 you agree with that?

2 A, That's his opinion. I really don't feel I
3 needed to comment on that, The decision was made
4 by the primary care doctor, I'd have to go into
5 his head to try find what they're thinking of, I
6 don't know now if I'd give it significant scrutiny
7 or not, He give an opinion based on nonexpertise.

8 Q. Do you know Dr. Martin, Lawrence Martin?

9 A. From here, yes,

10 Q. That's one of the reports that Mr. Scott sent
11 you?

12 A, That's correct,

13 Q. Do you read that report too?

14 A, Did I read it?

15 Q. Do you --

16 A. Very quickly, Read it very quickly. I
17 didn't feel -- feel it was germane to what I was
18 asked to comment on,

19 I mean, I was interested to know,
20 in other words, what he discussed,

21 Q. Dr. Martin says and E quote, page 7, because
22 of her overall condition Drs. D.C. Patel and P.
23 Patel decided to do the HIDA scan and CT scan
24 first; do you disagree with that?

25 MR. SCOTT: Objection.

1 A, Do I disagree with the --

2 Q. With them making a decision to do those
3 tests?

4 A, No. Their suggestions were they do the tests
5 to try to delineate the diagnosis.

6 Q. He said decided to do the HIDA scan, CT scan
7 first?

8 A, That's his opinion. He thinks if he made
9 the -- he thought they made a decision,

10 Q. Yeah,

11 A, Then he has to defend himself. I can't tell
12 you why he said that, I -- I don't think they made
13 that decision, it was not theirs --

14 Q. So you disagree with him?

15 A. So I disagree. They did not make a decision
16 to do that, They made the decision it was
17 necessary to reach -- to have discussion, they made
18 a recommendation.

19 Decision to do it is what I've been
20 saying, is not germane to me as a
21 gastroenterologist.

22 Q. Doctor --

23 A* I hope --

24 Q. Doctor --

25 A* -- I'm not playing with words,

1 Q. If you disagree with him, then fine. I don't
2 have a problem with that.

3 A. I think there's a difference in what we're
4 saying.

5 Q. Between you and Dr. Martin?

6 A, Yes.

7 Q. He also says her physicians chose -- numbers
8 4 and 8, 4 and 8, don't re-intubate and send her to
9 HIDA or other radiographic studies; and 8, don't
10 re-intubate and send her for CT scan. Dr. Dacha
11 and D.C. Patel saw the patient and thought she was
12 stable enough in I.C.U. after the HIDA scan to go
13 back to radiology for the CT scan.

14 A, Yes.

15 Q. You agree with that?

16 A. I would respectfully disagree. I don't think
17 it's the two of them. I think the advice was
18 given. I don't think it's their decision
19 together.

20 Again, it's that point I made at
21 the very beginning, it's not their domain to --

22 Q. So you disagree with what he said, okay,
23 that's fine.

24 A, He is entitled to his opinion.

25 Q. I'm almost done.

1 A. Fair enough.

2 Q. Do you have any opinion on the care rendered
3 by the emergency room physicians in this case?

4 MISS MOORE: Objection.

5 A. I have not reviewed that.

6 Q. Do you have any opinion on the care -- well,
7 do you have any opinion on the nurse having given
8 Demerol to Miss Lind on the evening of the 6th and
9 the early morning of 7th in the face of an order by
10 Dr. Dacha not to give sedatives?

11 MR. FELTES: Objection.

12 Q. Do you have any opinion on that?

13 A. I have no opinion on that either.

14 Q. This may be repetitive. This comes close to
15 my last question: Do you disagree with
16 Dr. Paresh Patel when he said that it was the
17 decision of Dr. Dacha, Dr. D.C. Patel, Dr. Miclat,
18 and himself to send her for the x-ray studies?

19 MR. QUANDT: Objection.

20 MR. SCOTT: Objection.

21 Q. Do you disagree with that?

22 A. That is in his deposition?

23 Q. Deposition, yes, it is.

24 MR. SCOTT: Are you quoting
25 that?

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

3 Answer, all of us.

4 A4 What was the answer?

5 Q. Answer, all of us.

6 Who is all of us?

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

9 MR. QUANDT: Objection.

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

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

19 MR. SCOTT: Objection.

20 Q. Do you think that that's appropriate?

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

24 Q. That is correct.

25 A. -- to specifically try to exculpate

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

3 Q. Sure.

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

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

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

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

19 MR. SCOTT: Objection,

20 Q. If it was done for purposes of exculpation?

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

24 Q. Go ahead,

25 MR. SCOTT: The doctor does

1 not get to know what your question means?

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

4 A. In terms of --

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

9 MR. KAMPINSKI: Read the
10 question back.

11 -----
12 (Question read as follows: Would that in
13 your opinion constitute a conscious
14 disregard for the right of the patients?)

15 -----
16 A. I don't think it constitutes disregard for
17 the right of the patients. I think it's unethical
18 behavior, it is -- if it were done to exculpate the
19 doctor.

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

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

1 done to them?

2 MR. SCOTT: Again, I object
3 because context of the note, that is whether
4 accurate or not, has not been given to the doctor,
5 Q. Go ahead.

6 A. I have to think about it.

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

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

17 MR. KAMPINSKI~ Okay. Anything
18 else?

19 That's all I have.

20 MR. SCOTT: Anybody else?

21 MR. FELTES: No .

22 MISS MOORE: NO.

23 MR. QUANDT: No .

24 MR. SCOTT: Thank you very
25 much .

ERRATA SHEETPAGELINE

I have read the foregoing

transcript and the same **is** true and accurate.

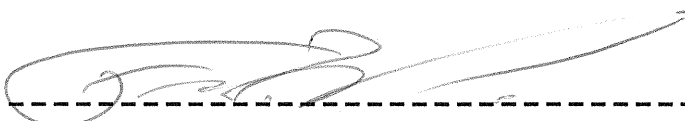
D. ROY FERGUSON, M.D.

1 The State of Ohio, .

2 County of Cuyahoga. : CERTIFICATE:

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

19 IN WITNESS WHEREOF, I have hereunto set my hand and
20 affixed my seal of office at Cleveland, Ohio, this
21 9th day of January, 1995.

22 
23 -----

24 Frank P. Versagi, RPR, CLVS, Notary Public/State of
25 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
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DATES ON

INCLUDES PURE NUMBERS

POSSESSIVE FORMS ON

MAXIMUM TRACKED OCCURRENCE
 THRESHOLD: 50

NUMBER OF WORDS SURPASSING
 OCCURRENCE THRESHOLD: 9

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