

1 THE STATE of OHIO,  
2 : SS:  
3 COUNTY of CUYAHOGA.

4 -----

5 IN THE COURT OF COMMON PLEAS

6 -----

7 ARAZINE SMITH, executrix of the :  
8 ESTATE of CAROLYN YARBROUGH,  
9 plaintiff,

10 vs.

11 : Case No. 326850  
12 :

13 SAINT LUKE'S HOSPITAL,  
14 defendant.

15 -----

16 Deposition of INDU SONPAL, M.D.,  
17 a defendant herein, called by the plaintiff for the  
18 purpose of cross-examination pursuant to the Ohio  
19 Rules of Civil Procedure, taken before Constance  
20 Campbell, a Notary Public within and for the State  
21 of Ohio, at Reminger & Reminger, The 113 Saint  
22 Clair Building, Cleveland, Ohio, on TUESDAY,  
23 DECEMBER 30TH, 1997, commencing at 10:40 a.m.  
24 pursuant to agreement of counsel.  
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APPEARANCES:

ON BEHALF' OF THE PLAINTIFF:

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ON BEHALF OF THE DEFENDANT:

Gary H. Goldwasser, Esq.  
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I N D E X

WITNESS:

INDU SONPAL, M.D.

PAGE

Cross-examination by Miss Xolis

5

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PLAINTIFF'S EXHIBITS

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(FOR COMPLETE INDEX, SEE APPENDIX)

(IF' ASCII DISK ORDERED, SEE BACR COVER)

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1                                    INDU SONPAL, M.D.

2        of lawful age, a defendant herein, called by the  
3        plaintiff for the purpose of cross-examination  
4        pursuant to the Ohio Rules of Civil Procedure,  
5        being first duly sworn, as hereinafter certified,  
6        was examined and testified as follows:

7                                    -----

8                                    MRS. KOLIS:                    Dr. Sonpal, for  
9        identification purposes on the record my name is  
10       Donna Xolis, we've recently been introduced. I've  
11       been retained to represent the Estate of Carolyn  
12       Yarbrough. As you obviously are aware I named you  
13       as a defendant in a lawsuit we filed. My purpose  
14       today is hopefully to illuminate the factual  
15       information contained in the file so I can  
16       understand what transpired. Probably ask you some  
17       general medical questions.

18                                   If at any time you do not  
19       understand a question that I ask, which is highly  
20       likely given the **way** I ask questions, you can  
21       indicate that you would like me to rephrase it or  
22       some form of expression to let me know you need a  
23       better question; is that acceptable to you?

24                                   THE WITNESS:                    Yes.

25                                   MRS. XOLIS:                    If at any time

1     you have a need to confer with Mr. Goldwasser  
2     simply indicate so for the record, I have no  
3     objection to the same. If at any time you are  
4     paged, need to use the phone, that obviously takes  
5     precedence over this kind of proceeding.

6                     I'm certain that at some point you  
7     would have received at least a preliminary  
8     instruction that all your answers to my questions  
9     need to be verbal so we don't place the court  
10    reporter in the position of interpreting what  
11    either of us means; is that also acceptable to  
12    you?

13                    THE WITNESS:                Yes.

14                                     -----

15                    CROSS-EXAMINATION

16    BY MISS XOLIS:

17    Q.     With that in mind, you've already indicated  
18    your name for the record. I was handed this  
19    morning what is represented to be your curriculum  
20    vitae, can you identify that document?

21    A.     Yes, that is my curriculum vitae.

22    Q.     That will be Plaintiff's Exhibit A. We're  
23    not going to belabor your background, let's go  
24    through it generally.

25                    I gather you are of course licensed

1 to practice medicine in the State of Ohio?

2 A. Right.

3 Q. When did you obtain your licensure for the  
4 State of Ohio?

5 A. Around 1971.

6 Q. Do you hold licenses to practice medicine in  
7 any other states?

8 A. No, I do not.

9 Q. Has any disciplinary action ever been taken  
10 against your medical license in the State of Ohio?

11 A. No.

12 Q. Fair enough. Tell me about your medical  
13 education that led you to your occupation as a  
14 surgeon.

15 A. I went to medical school in Bombay, passed my  
16 Bachelor of Medicine exam in 1969. I went to the  
17 Saint Margaret Memorial Hospital in Pittsburgh for  
18 a rotating internship, then did four years of  
19 general surgical training at Saint Luke's  
20 Hospital.

21 Q. So you did a four year residency at Saint  
22 Luke's?

23 A. Right.

24 Q. Have you ever practiced medicine at any other  
25 hospital as a primary appointment other than Saint

1 Luke's?

2 A. Was on the staff at Saint Vincent Charity

3 Hospital.

4 Q. Meridia is a courtesy, Marymount?

5 A. Right.

6 Q. The majority of patients that you see and

7 treat are at which facility?

8 A. Saint Luke's Hospital.

9 Q. Do you have a private medical practice?

10 A. Yes.

11 Q. Who is in that practice?

12 A. Just myself.

13 Q. Are your offices located at the Saint Luke's

14 Medical Arts Building right next to the hospital?

15 A. Medical building next to the hospital, my

16 main office is there.

17 Q. Is that where you've been since June of 1995?

18 A. No, I've been there since actually 1978 or so

19 in that office.

20 Q. It's not important obviously where you were

21 previously.

22 You are certified of course in

23 surgery?

24 A. Yes.

25 Q. I see that you were recertified in 1987?

1 A. Correct.

2 Q. Are you Board eligible in any other  
3 subspecialty?

4 A. No.

5 Q. I notice there are a couple of publications,  
6 those are the only ones, do you have anything in  
7 press currently?

8 A. No.

9 Q. Dr. Sonpal, as a surgeon do you -- it's  
10 always a difficult question to ask -- you do  
11 general surgery, correct?

12 A. Correct.

13 Q. Is there a particular type of surgery that  
14 you consider you're a specialist in, something you  
15 do more than anything else?

16 A. No.

17 Q. Tell me the kind of surgery you perform.

18 A. We operate on gallbladders, colon, stomachs,  
19 hernias, thyroid, breast.

20 Q. Do you have teaching responsibilities at  
21 Saint Luke's Hospital?

22 A. Yes, I do.

23 Q. Please explain the nature of your teaching  
24 responsibilities, when it began?

25 A. I began as a teaching Fellow in 1975 when I



1 graduated from there. I've been in a teaching  
2 position since. We have a general surgical  
3 residency program. We involve ourselves in  
4 teaching the general surgical residents.

5 I'm not the only teaching faculty.  
6 There are many general surgeons who are involved in  
7 this teaching process, we take turns taking calls  
8 at night for the emergency room and any patient  
9 that comes in we take care of them with the help of  
10 the resident.

11 Q. Let me see if I understand this.

12 Does Saint Luke's Hospital have a  
13 surgical residency program?

14 A. They do until July of this year. After that  
15 they will not have any further residency program.  
16 They have had a general surgical residency program  
17 for a long time.

18 Q. I thought that was true, never specifically  
19 had the opportunity to speak with anyone about the  
20 program.

21 So you don't share rotating  
22 residents from other facilities, you actually  
23 recruit and train your own residents in surgery?

24 A. That's correct.

25 Q. Fair enough. Do you teach in any classroom

1 setting?

2 A. We used to have many didactic lectures,  
3 conferences on a regular basis. We have fewer of  
4 them now because we have less number of residents.

5 Q. How many residents were in your surgical  
6 residency program in January of 1994, if you  
7 recall?

8 A. I think there were 10 residents.

9 Q. I have perused this chart a couple of times,  
10 have you had the opportunity to review Carolyn's  
11 medical chart?

12 A. I've looked at it, yes.

13 Q. I want to ask you a couple of names, see if  
14 you can identify them as surgical residents or  
15 otherwise. Steven Muscoreil?

16 A. Surgical resident.

17 Q. Did I pronounce that correctly?

18 A. Yes.

19 Q. Dr. Cannova also a surgical resident?

20 A. Yes.

21 Q. Dr. Camp?

22 A. Dr. Camp, surgical resident.

23 Q. Fair enough. In anticipation of answering my  
24 questions today did you review medical records?

25 A. I reviewed the records of Carolyn Yarbrough,

1       yes.

2       Q.       When you say you reviewed the records of  
3       Carolyn, are you referring specifically to the  
4       Saint Luke's Hospital chart for the admission of  
5       1-9-96 through 1-25-96?

6       A.       That's correct.

7       Q.       Did you review any other medical records of  
8       Carolyn Yarbrough?

9       A.       I reviewed the pathology report from Huron  
10      Road Hospital, the autopsy.

11      Q.       Autopsy report?

12      A.       I also looked at the deposition of **Dr.** Bass,  
13      I think that is about it.

14      Q.       Have you had the opportunity to look at the  
15      nursing home records --

16      A.       **No.**

17      Q.       -- of Candlewood?

18      A.       **No.**

19      Q.       In anticipation of being deposed today, did  
20      you do a medical literature review of any sort?

21      A.       No, I did not.

22      Q.       Fair enough. Doctor, other than this one  
23      specific instance, have you been sued for medical  
24      negligence on a prior occasion?

25                                   MR. GOLDWASSER:       Objection. You

1 may answer.

2 A. Yes.

3 Q. Do you happen to recall how many times you've  
4 been sued?

5 MR. GOLDWASSER: Objection. You  
6 may answer.

7 A. I've been sued twice.

8 Q. Were you represented by this law firm,  
9 Reminger & Reminger?

10 A. I don't think so.

11 Q. Both these lawsuits were in Cuyahoga County?

12 A. Correct.

13 Q. Were they resolved by way of payment or  
14 judgment against you?

15 MR. GOLDWASSER: Objection. You  
16 may answer.

17 A. I think they were settled out of court.

18 Q. Fair enough. Do you happen to recall how  
19 long ago these cases were?

20 A. About 10 years ago.

21 Q. We will do a docket check, we won't bother  
22 you anymore about that.

23 Have you had the opportunity since  
24 becoming Board certified in surgery to participate  
25 in a medical/legal case as an expert?

1 A. No.

2 Q. My understanding from Dr. Bass' depo, I want  
3 to see if it is the same situation for you, is that  
4 Carolyn Yarbrough would have become your patient  
5 vis-a-vis the hospital referring her to you?

6 A. That's correct.

7 Q. She was a staff patient; is that correct?

8 A. That's right.

9 Q. Not a private patient?

10 A. That's right.

11 Q. From your review of the records how is it you  
12 became involved in the care of Carolyn Yarbrough?

13 A. I was **on** call that night for the emergency  
14 room, I was called by the surgical resident,  
15 specifically Dr. Connova, he gave me the history of  
16 this patient, the fact that she appeared to have a  
17 perforated bowel.

18 Q. At that point, I'm inferring something from  
19 the record, was Dr. Cannova the senior surgical  
20 resident?

21 A. Correct.

22 Q. Finishing his fourth year?

23 A. Yes.

24 Q. Did you have other surgical residents on  
25 service that evening besides Dr. Cannova?

1 A. I believe Dr. Muscoreil was on call that day  
2 too.

3 Q. What I would like to do, I apologize for not  
4 being as organized as I customarily would be, I  
5 would like to start with the discharge summary.  
6 Mr. Goldwasser probably has this pretty well  
7 organized for you.

8 You can refer to that, I'll refer  
9 to my copy, I'll probably have the court reporter  
10 mark it as Exhibit B.

11 First of all, am I clear in my  
12 reviewing the chart that you were Carolyn's  
13 attending physician for the entire hospitalization?

14 A. Correct.

15 Q. That's an accurate characterization?

16 A. Right.

17 MR. GOLDWASSER: Talking of  
18 course 1-9 to 1-25-96.

19 Q. Yes. For clarification, 1-9-95 through 1-25,  
20 at any time, Doctor, during that confinement that  
21 we're discussing, January 9th forward, did you take  
22 it upon yourself to review the prior Saint Luke's  
23 Hospital record?

24 A. No, I did not.

25 Q. During the time that Carolyn was under your

1 care did you have any occasion to discussion her  
2 care and treatment or her prognosis with any family  
3 members that you can recall?

4 A. I do not recall.

5 Q. In reviewing these documents, probably also  
6 the surgical report, do you have a medical opinion  
7 as a surgeon as to the cause of the bowel  
8 perforation that led to her hospitalization of  
9 1-9-96?

10 MR. GOLDWASSER: I'm a little  
11 confused. Are you referring to the discharge  
12 summary, on the discharge summary?

13 MISS KOLIS: Leaving the  
14 document there in case he needs to refer to it for  
15 any reason.

16 MR. GOLDWASSER: You can refer  
17 to anything in the chart.

18 MISS KOLIS: Yes.

19 MR. GOLDWASSER: Connie, the  
20 question again.

21 -----

22 (Question read.)

23 -----

24 A. At the time it wasn't clear why the bowel  
25 perforated, but I would guess that she was

1       constipated and had enough obstruction, mechanical  
2       obstruction that led to the cecum being dilated and  
3       perforated.

4       Q.       When you say the time, at the time of the  
5       emergency room admission?

6       A.       At the time of the operation.

7       Q.       Based upon your surgical exploration of  
8       **Mrs.** Yarbrough's intestinal tract, you were able to  
9       rule out disease processes as having caused the  
10      perforation?

11      A.       Other than the fact that she was full of  
12      stool and constipated, I was unable to find any  
13      other obvious cause of her perforation.

14      Q.       So, I guess going back first of all to the  
15      discharge summary, I always use that as a point of  
16      reference to refer you to other issues I suppose,  
17      you indicated to me you received a phone call to  
18      the best of your recollection from Dr. Cannova?

19      A.       Correct.

20      Q.       **On** the evening of January 9th can you recall  
21      what Dr. Cannova told you?

22      A.       He gave me the history of the patient, she  
23      was in the emergency room, the x-rays had seen free  
24      air in the abdomen, presumably from the perforated  
25      bowel, she needed to be operated on emergently.



1 Q. Did you come to the hospital?

2 A. That's correct.

3 Q. Did you take your own medical history  
4 regarding this patient?

5 A. No, I did not.

6 Q. The first time you saw the patient was in the  
7 OR?

8 A. Probably just outside of the operating room.

9 Q. Dr. Cannova and Dr. Muscoreil assisted you in  
10 the surgery, correct?

11 A. Correct.

12 Q. I wanted to see if I can find it, I'm trying  
13 to do things in order, it's not always possible.  
14 Skip to the progress notes. If you want to hang on  
15 for a second if I can refer you to the first note  
16 written in the chart on 1-9-96 by Dr. Cannova.

17 A. Okay.

18 Q. Would you have reviewed this note at some --  
19 first of all, **do** you review all the notes written  
20 by your residents?

21 A. Usually try to review most all the notes. A  
22 lot of discussions take place verbally, we don't  
23 actually have to read each and every word of it.

24 Q. Sometimes you read the notes, sometimes you  
25 don't. Would you recall today if you had an

1 opportunity to review the note in the chart by  
2 Dr. Cannova?

3 A. I don't recall that.

4 Q. Would you agree or at that time based upon  
5 what you knew about the patient medically, with  
6 Dr. Cannova's sentence he's discussed what he told  
7 the family, "I further explained the poor prognosis  
8 in view of her overall condition," do you see that  
9 sentence close to the bottom?

10 A. Yes.

11 Q. Would you agree she had a poor prognosis at  
12 the time of the surgery due to her overall  
13 condition?

14 A. I would, yes.

15 Q. What overall condition would you be referring  
16 to?

17 A. Overall condition of the fact that she had  
18 overwhelming free air in the abdomen, we didn't  
19 know what the cause of the perforation was. Could  
20 have been a malignancy. She was also when she came  
21 she was hypotensive, she required a lot of fluid to  
22 resuscitate her. Mentally not alert and oriented.  
23 In those aspects of her general condition, the  
24 outlook would be poor in a situation like that.

25 Q. Once you were able to examine the abdominal

1 cavity vis-a-vis your surgery, would you say her  
2 overall prognosis was poor caused by the perforated  
3 cecum, caused by constipation?

4 A. Potentially, yes. It's a serious condition.

5 Q. Were you involved in the decision to  
6 discharge her on January 25th?

7 A. I was involved in the decision to discharge  
8 her **by** way of communication from the residents,  
9 yes.

10 Q. I gather you say by way of communication with  
11 a resident, you weren't there on the day she was  
12 discharged?

13 A. I wasn't there at that time.

14 Q. In reviewing the chart would you agree with  
15 me you did not see the patient on the 23rd, 24th  
16 or 25th of January?

17 A. In reviewing the chart I could say I did not  
18 write a note on those days, I don't know that I  
19 didn't see her.

20 Q. Since I guess we're on that issue, I would  
21 like some clarification. Is there something in the  
22 chart that leads you to believe you actually  
23 physically saw the patient on those three days?

24 A. I wouldn't remember if I saw her. The way we  
25 do this is we make rounds with the residents, go in

1 the patient's room, discuss their situation,  
2 resident writes notes in the chart. Sometimes they  
3 say seen the patient with Dr. Sonpal, sometimes  
4 they don't. Sometimes write discuss the situation  
5 with attending physician, sometimes they don't. If  
6 I see the patient when the resident is not around,  
7 then I would write a note myself.

8 Q. Let's see, you can certainly **look** at this  
9 chart, we're in no rush this morning or at least  
10 I'm not in a rush I guess, I did not see any  
11 indication first of all on the last three days of  
12 this confinement of a note being written by  
13 yourself.

14 **MR. GOLDWASSER:** When was she  
15 discharged, the 25th?

16 Q. The 23rd, 24th or 25th I didn't see any notes  
17 written by yourself.

18 **A.** My last note was January 22nd.

19 Q. That was my reading in the chart. I'm not  
20 really very good with doctor's signatures, I want  
21 to make certain there are no notes written **by**  
22 yourself.

23 **A.** That's correct.

24 Q. You're indicating to me at this moment you  
25 don't have an independent recollection of whether

1 or not you in fact may have seen Her on those three  
2 days?

3 A That's correct.

4 Q Fair enough answer. In reviewing this chart,  
5 Doctor, today as we sit here, can you tell me the  
6 purpose for which you called Dr. Bass in on a  
7 consult?

8 A. I think the 22nd we asked to have Dr. Bass  
9 see the patient, the reason for that was that there  
10 were a couple of cultures, urine cultures and wound  
11 cultures, urine culture had grown Candida, wound  
12 culture had grown Candida and Enterococcus, I  
13 wanted clarification on whether or not there should  
14 be any further treatment for these conditions.

15 Q. Let me try to break these questions out as  
16 simply as I can.

17 The wound cultures that you are  
18 referring to, that led you to ask for the  
19 consultation on or about the 22nd, we will go  
20 through the note to clarify, that was from the  
21 wound culture taken on January 16th; do you agree  
22 with that?

23 A. Yes

24 Q You're discussing a Candida and Enterococcus?

25 A. Right

1 Q. Those are in fact what was grown on the  
2 intraoperative surgical culture, correct?

3 A. That's correct.

4 Q. Taken on the 10th?

5 A. Right.

6 Q. The same two organisms are in existence based  
7 on a repeat culture from the 16th, right?

8 A. In a different location.

9 Q. Of course, she is closed at this point?

10 A. Right.

11 Q. Those cultures were taken from the fluid that  
12 was leaking, I'm going to call it leaking,  
13 draining, whichever you are comfortable with from  
14 the surgical incision?

15 A. No fluid or leakage from the surgical  
16 incision, those were taken from the surface of the  
17 wound without any drainage. You take a swab and  
18 culture the surface of the open wound. The wound  
19 was open.

20 Q. There was some drainage from the surgical  
21 incision?

22 A. I have to check the chart to see.

23 Q. That's fine.

24 A. Basically my understanding is that the  
25 culture was taken from the surface of the wound.

1 Q. I guess we'll probably go through the notes.  
2 I'm trying to get background here.

3 When you say "seeking  
4 clarification," what do you mean when you say that?

5 A. I wanted his opinion as an infectious disease  
6 consultant to tell me if the patient needed to be  
7 treated for these conditions.

8 Q. Those two conditions were in -- we will call  
9 them conditions, for the record the two organisms  
10 we're discussing are Candida, Enterococcus, those  
11 were in existence as of January 10th, correct?

12 A. Right.

13 Q. Between January 10th and January 22nd you  
14 didn't need clarification on those two organisms by  
15 infectious disease?

16 A. No.

17 Q. Why not?

18 A. The reason for that was those two organisms  
19 were growing out of the abdominal cavity where we  
20 had cultured the stool in the abdomen, in addition  
21 to multiple other organisms that grew at the same  
22 time. She had been treated with multiple  
23 antibiotics at the time.

24 In a situation like that, it is  
25 more of a response of the patient to the treatment

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17 postoperatively Carolyn Yarbrough demonstrated  
18 signs and symptoms of being septic?

19 A. No, not necessarily.

20 Q. Explain what you mean by no, not  
21 necessarily.

22 A. She did have an elevated white count, which  
23 we attribute to the fact she had been on steroids.  
24 We did get a CAT scan of her abdomen and pelvis to  
25 look for hidden infection. We cultured her urine,



1     cultured her wound to see if there was any sign of  
2     infection. The only positive cultures we received  
3     were from the urine and wound as mentioned above.  
4     By septic if you mean she was sick from it, I would  
5     say no.

6     Q.     While I'm looking for a piece of paper, in  
7     your answer I believe you indicated to me that you  
8     drew the conclusion that her white blood count was  
9     attributed to her corticosteroids; is that right?

10    A.     I would say that I was aware of the fact she  
11    had a white count that was elevated. I was also  
12    aware of the fact she was on steroids, which could  
13    give you an elevated white count. I wanted to make  
14    sure that she didn't have any other sources of  
15    infection, therefore she was cultured and CAT  
16    scanned.

17    Q.     Based upon the culture and CAT scan you  
18    determined the elevation in white blood count was  
19    attributed to the steroids?

20    A.     Based upon the CAT scan report I felt  
21    comfortable there were not intra-abdominal  
22    abscesses we were missing. When the steroids were  
23    tapered the white count started coming down.  
24    Clinically she looked good. I did not feel that  
25    the -- I felt comfortable the white count could be

1 attributed to the steroids.

2 Q. Did you make a note of that anywhere?

3 A. No, I don't think.

4 Q. Doctor, when did you see the CAT scan report?

5 A. When it arrived, I think it's usually the day  
6 of the CAT scan. The day it's done I get a report,  
7 the resident who checks it out reviews it with the  
8 radiologist.

9 Q. Let me ask this --

10 A. I don't know when the report arrived **on** the  
11 chart.

12 Q. Technical question: **At** Saint Luke's,  
13 January, 1996 if radiology performed an  
14 examination, would you agree with me the final  
15 typewritten report doesn't occur simultaneously  
16 with the radiologist reading?

17 A. It's usually dictated and transcribed and  
18 sent to the floor.

19 Q. Fair enough. We will deal with that issue in  
20 a second.

21 If the CAT scan report indicates it  
22 was transcribed on the 24th of January, does that  
23 seem a reasonable lapse in time between the taking  
24 and the transcription of the same?

25 A. I don't know that it's important because the

1 way we do things at Saint Luke's, the radiologist  
2 and the residents see the actual x-rays and go over  
3 the report, the report is reported to me in a  
4 timely fashion

5 Q Silly as it sounds, to establish, the written  
6 report doesn't come out the way the scan is taken.  
7 You get an oral report?

8 A We get an oral report. We can access the  
9 written report by using a telephone tape recording  
10 system that we can access, so the report is  
11 pictorial and it's available

12 Q. That was going to be my next question. At  
13 Saint Luke's in January of 1996 you had the  
14 capability of telephone access for reports?  
15 A Yes.

16 Q What I'm going to mark as Plaintiff's  
17 Exhibit C is your progress note of the 19th, if you  
18 can find that.

19 A. Right.

20 Q. Is this note completely written by yourself,  
21 Doctor?

22 A. The first half which is signed by me, yes.

23 Q. There is something underneath that by  
24 neurology?

25 A. Right.

1 Q. Close to the end of your note, I think it  
2 says hypoglycemia secondary, is that what you mean,  
3 secondary to steroids?

4 A. Yes.

5 Q. Is that impression?

6 A. No, it's "Hyperglycemia secondary to the  
7 steroids, DM, which is diabetes mellitus, sepsis.  
8 Add bolus Heparin to SCD, physical therapy."

9 Q. Can you explain to me in the recitation you  
10 gave me, January 19th note that does say sepsis,  
11 right?

12 A. Right.

13 Q. I didn't misread you had an impression of  
14 sepsis on the 19th?

15 A. No, the fact the patient had sepsis before  
16 that is what I mean by that. Here is a patient  
17 diabetic, has been septic in the past, she has been  
18 on steroids, the question is whether the blood  
19 sugar levels are related to any one of those  
20 multiple factors.

21 Q. I needed some clarification because I saw  
22 that in the chart.

23 A. That doesn't necessarily mean she has a  
24 sepsis at this moment.

25 Q. When was she septic?

1 A. When she was admitted she had sepsis.

2 Q. The triple antibiotic therapy she was on, can  
3 you tell me what that was?

4 A. Yes. Cefotetan, Flagyl and Gentamycin.

5 Q. Once you knew what the culture results were,  
6 intra-abdominal cultures were Candida and  
7 Enterococcus you didn't change the antibiotic  
8 therapy; is that accurate?

9 A. That's correct.

10 Q. Do you agree with me that the three  
11 antibiotics that we just discussed do not  
12 specifically cover for Candida or Enterococcus?

13 A. The Enterobacter or Enterococcus is sensitive  
14 to Gentamycin, doesn't specifically cover Candida.

15 Q. As we move on through these notes, on the  
16 19th I think we went over what your note was.  
17 There is a note on the 20th, if you want to turn a  
18 couple pages. That's your note at the top of the  
19 page, correct?

20 A. Yes.

21 Q. Can you read into the record what the note  
22 says?

23 A. WBC still up, would recommend CT abdomen and  
24 pelvis. CNS of urine, wound healing well, except  
25 for slight infection in central portion.

1 Q. You ordered a CT of the abdomen and pelvis on  
2 the 20th?

3 A. To look for the intra-abdominal source of  
4 infection.

5 Q. Have you had the opportunity to review the  
6 CAT scan?

7 A. No, I have not.

8 Q. The report, I'm not talking about the film.

9 A. I seen the report, I haven't reviewed it.

10 Q. Your opinion, did that report exclude the  
11 foreseeable possibility that she had an ongoing  
12 abdominal infection?

13 A. In my opinion, yes, it did.

14 Q. Why is that?

15 A. We were looking for abscess, it's  
16 specifically stated if I'm correct there were no  
17 signs of abscesses.

18 Q. You can look.

19 MR. GOLDWASSER: It is one of  
20 the last reports in there.

21 A. It's dated January 20, '96, I will just read  
22 the impression which says most significant finding  
23 some ascites, fluid throughout the abdomen, pelvis,  
24 fairly small in amount, no definite focal  
25 collection of fluid or gas indicated, abscess

1 identified.

2 Q. At that time there was not a specific  
3 abscess?

4 A. Correct.

5 Q. What did you make of the ascites?

6 A. We see ascites after surgery a lot of times,  
7 it doesn't have any diagnostic meaning to it.

8 Q. When do you think you were aware of that CAT  
9 scan result?

10 A. Probably that day or the next day.

11 Q. Your note of the 20th there was in fact a  
12 slight infection in the central portion of the  
13 surgery wound?

14 A. Right.

15 Q. Tell me how you knew there was infection  
16 there?

17 A. I looked at it.

18 Q. What was the appearance of it?

19 A. Usually -- I'm trying to recollect what I  
20 saw, it's difficult to say exactly what since I  
21 didn't actually write it down.

22 It had to be a minor exudate in the  
23 middle of the incision which was otherwise healing  
24 nicely, needed a little more local care in terms of  
25 dressing changes, stuff like that.

1 Q. You've indicated to me you had the  
2 opportunity to review the autopsy report?

3 A. I have looked at the autopsy, yes.

4 Q. Would you agree with me the organism which  
5 caused her to be septic at the time of her death  
6 was both in fact Candida and Enterococcus?

7 A. No, I do not agree with that.

8 Q. Tell me what you think it is then.

9 A. I think she had -- just from the autopsy  
10 report I can't say that. I understand that there  
11 was a blood culture at Huron Road Hospital.

12 Q. Have you seen it?

13 A. No, I haven't seen it. I understand there  
14 was one, I don't recall whether I saw it in  
15 Dr. Bass' deposition or got that information, that  
16 was growing Enterobacter. I think that Candida had  
17 very little to do with it. She probably had sepsis  
18 secondary to Enterobacter from someplace. I also  
19 know now that she had, looking at a report from  
20 Huron Road, she had urinary tract infection with  
21 the same organism.

22 Q. She had the UTI at Saint Luke's, didn't she?

23 A. No, she did not. She had a urinary tract  
24 infection cultured at Huron Road, which maybe you  
25 have that report someplace in the Huron Road files,



1 that grew Enterobacter.

2 Q. I'm sorry, I was confused about what you were  
3 saying.

4 You discharged Carolyn Yarbrough  
5 from Saint Luke's on no antibiotics; is that  
6 accurate?

7 A. That's correct.

8 Q. Why did you elect not have her on antibiotics  
9 at that time?

10 A. That was the recommendation of the infectious  
11 disease consultant.

12 Q. Were you looking for Dr. Bass to conclude for  
13 you whether or not she needed to be continued on  
14 antibiotics?

15 A. I was looking to Dr. Bass to give me an  
16 opinion, yes.

17 Q. Do you agree with me there is no formal  
18 consult report written by Dr. Bass in the chart?

19 A. The only report I saw was a progress note,  
20 yes.

21 Q. Fair enough.

22 If you would turn in the progress  
23 notes to January 21st I think we might be, if I can  
24 read upside down, yes, on the same page. At the  
25 top of the page there is a surgical note, correct?

- 1 A. Correct.
- 2 Q Surgery service, written by Dr Moscorail?
- 3 A Right
- 4 Q One line entry by yourself, 'As above patient
- 5 seen " So I take it that Dr. Moscoreil wrote to you
- 6 note, you confirmed to you not?
- 7 A Right.
- 8 Q On the plan, correct CM result. is that right?
- 9 A Yes.
- 10 Q. Check cultures?
- 11 A. On the plan it says check official CT result
- 12 Q. I can't make out that word.
- 13 A. Check cultures.
- 14 Q At that point what does that mean to you,
- 15 correct official results?
- 16 A. That means that there must have been an
- 17 unofficial -- either the resident looked at the CAT
- 18 scan, didn't see an abscess, told me that he was
- 19 still waiting to get an official report from the
- 20 radiologist
- 21 Q At the time of her hospitalization, her being
- 22 Carolyn, did you ever look at that CT yourself?
- 23 A No, I did not
- 24 Q It says check cultures, does that mean to you
- 25 the culture results were not yet available?

1       A.       Whatever cultures were pending they were  
2       going to check on them, that's right.

3       Q.       Did you see any indication on the chart from  
4       the time of January 21st through the end of the  
5       hospitalization the official results of the CAT  
6       scan were ever checked?

7       A.       No, I didn't see a note to that effect.

8       Q.       Did you ask about that before she was  
9       discharged?

10      A.       I don't recall.

11      Q.       We can go to the note on the 22nd. Once  
12      again a surgery note, once again looks like written  
13      by **Dr. Muscoreil**, I call it countersigned by  
14      yourself. At that point obviously the results of  
15      the culture were known, right?

16      A.       Correct.

17      Q.       It says will hold off on antibiotics until **ID**  
18      recommendation?

19      A.       Correct.

20      Q.       Tell me what the intention was in that  
21      regard, why would you hold off on the antibiotics  
22      at that point?

23      A.       Because if you are asking a consultant to  
24      give an opinion, you want him to tell you whether  
25      the patient needs or does not need antibiotics for

1     these particular cultures.

2     Q.     At this point she has been on antibiotics  
3     since I think January 10th or 11th?

4     A.     She has been on antibiotics since the 9th  
5     when she was admitted.

6     Q.     Did you initially issue the orders for that  
7     coverage?

8     A.     No.

9     Q.     Someone else did?

10    A.     Surgical residents usually do that.

11    Q.     But on this date for some reason you decided  
12    she had enough antibiotics?

13    A.     I think the antibiotics were stopped on the  
14    20th or 21st.

15    Q.     Go ahead, why would they have been stopped  
16    then?

17    A.     She had a full course of 10 days worth of  
18    antibiotics, she was clinically doing well.

19    Q.     When you say she was clinically doing well,  
20    in layman's terms what **do** you mean?

21    A.     She looked good, awake, alert, she was not  
22    running any high fevers, her white count as we  
23    discussed previously, it was up but we were looking  
24    into the possibility of the white count being up  
25    from other sources other than infection.

1 Q. When she was hospitalized, you had access to  
2 the Saint Luke's prior records if you wanted to  
3 look at them, correct?

4 A. If I wanted to look at them, yes. I didn't  
5 know the day she was admitted, I was not aware she  
6 had been previously hospitalized.

7 Q. At some point in time during this lengthy  
8 stay you would have known she had just previously  
9 been in Saint Luke's?

10 A. Yes.

11 Q. So if I get this clearly, at this point what  
12 this note means is you are going to hold off on  
13 antibiotics until you get a recommendation one way  
14 or the other from Dr. Bass?

15 A. That's correct.

16 Q. Then you don't see her again, there is no  
17 note that indicates that you see her again.

18 A. That's correct.

19 Q. On the 23rd there is a surgery note on the  
20 bottom of the page, I think you are probably  
21 following along with me. It says planning  
22 discharge for Friday.

23 Did you have input in that decision  
24 there was going to be a discharge plan for Friday?

25 A. On that particular day, I don't recall.

1 Q. Was Carolyn Yarbrough well enough to be  
2 discharged to home?

3 A. I think so.

4 Q. To home?

5 A. She went to an extended care facility as I  
6 recall.

7 Q. Are you familiar with Candlewood and what  
8 kind of services they provide?

9 A. No.

10 Q. You didn't make the decision where she would  
11 go?

12 A. That's correct.

13 Q. That's not a medical decision, what level of  
14 care the patient needs upon discharge?

15 A. It is in a way, depends more on the patient  
16 and their social needs than any other reason.

17 Q. Their social needs you indicated?

18 A. Their care, how much help they have at home.  
19 For example, if they have wound dressing changes  
20 that need to be done, you can have a visiting nurse  
21 or send them to a nursing home where the same  
22 services can be handled.

23 Q. As I read this note it says awaiting ID,  
24 neuro and psych, does that -- I don't think it says  
25 expert -- psych report, is that what it says?

1 MR. GOLDWASSER: Looks like  
2 input, I'm not sure.

3 A. That may be.

4 Q. Mr. Goldwasser is better at reading medical  
5 notes than I am. What need was there for the ID,  
6 neuro, psych input prior to discharge?

7 A. Usually the process is that before a patient  
8 is discharged we need to let all the consultants  
9 agree upon the fact she is okay to be discharged.  
10 That there are no discharge or follow-up  
11 instructions that need to be given if they come and  
12 see the patient, give the proper instructions,  
13 arrange for follow-up, give prescriptions, things  
14 like that.

15 Q. In this instance, if you want to turn the  
16 page, take a look at Dr. Bass' progress note, about  
17 the middle of the page, Doctor, did you talk to  
18 Dr. Bass directly about Carolyn Yarbrough prior to  
19 discharge?

20 A. No, I did not.

21 Q. Have you had a discussion with Dr. Bass  
22 subsequent to me filing this lawsuit?

23 A. No.

24 Q. In the middle of the page, the note I believe  
25 says patient at high risk for super infection.

1 Were you made aware that was contained in that  
2 note?

3 A. Not at that time.

4 Q. At what time were you aware?

5 A. Since then I reviewed the chart, I looked at  
6 the notes.

7 Q. Did you get a report from the resident?

8 A. I got a report from the resident that the  
9 recommendation was to keep her off antibiotics.

10 Q. Do you know why the recommendation was to  
11 keep her off antibiotics?

12 A. From reading his note, it was apparent he  
13 felt that the infection was not significant enough  
14 to require antibiotics.

15 Q. What does it mean to you when the ID consult  
16 writes patient is at high risk for super  
17 infection?

18 A. I can only guess about what it means.

19 MR. GOLDWASSER: I don't want  
20 you to do that. Unless you know as a general  
21 proposition, I don't want you to guess.

22 A. I don't know what that means.

23 Q. You are the attending physician, correct?

24 A. Correct.

25 Q. There *is* no note from this point forward



1 indicating that you read the consult?

2 A. Correct.

3 Q. Frequently do you read the progress consult  
4 note versus having direct communication with a  
5 consultant?

6 A. Both. Usually if -- it could be either/or.  
7 If I run into the doctor he will talk to me, he'll  
8 pick up the phone and page me, let me know what he  
9 thinks. I will go and see the note after he has  
10 written it. There is no definite way of doing it.

11 Q. You are accustomed to doing it both ways; am  
12 I accurate?

13 A. Correct.

14 Q. If you were in the position you had to read  
15 the note without speaking to the consultant, what  
16 would that indicate to you?

17 A. What I would be interested in is his  
18 recommendation. I would not probably pay too much  
19 attention to his thinking at that time. That is  
20 his specialty and I would only be guessing at what  
21 he meant by that.

22 Q. Would you pick up the phone and call him to  
23 ask him what he meant by that?

24 A. I probably wouldn't.

25 Q. A person such as Carolyn Yarbrough -- how

1 w>out in Carolyn Yerprough, with your medical  
2 background, it would not be a good thing health  
3 wise for her to have an infection with a recent  
4 abdominal surgery, would you agree with that?

5 MR. GOLDWASSER: An infection,  
6 infection of any kind?

7 Q. Right.

8 A. It's not a good thing to have infection for  
9 anybody.

10 Q. For a person with her medical problems that  
11 were in existence at the time of this confinement,  
12 recent bout with sepsis, steroid induced diabetes  
13 mellitus -- do you agree that is what caused her  
14 diabetes mellitus?

15 A. Based on what? I would be guessing

16 A. Based on what is contained in the medical  
17 chart?

18 A. Based on the chart and other people's  
19 opinions that are mentioned in the chart

20 Q You brought in a couple consultants on this  
21 case, Dr. Nic --

22 A. Nicolacakis.

23 Q. What specialty?

24 A. It's a lady doctor, she is a pulmonar  
25 specialist.

1 Q. You brought in Dr. Jill Barry?

2 A. Jill Barry is an internist.

3 Q. Did you bring in Dr. Barry to evaluate the  
4 diabetes issue?

5 A. To evaluate her medical care, including  
6 diabetes.

7 Q. Fair enough. The next note is on 1-24.  
8 That's a signature that I didn't actually recognize  
9 from previous. Can you tell me which resident that  
10 is?

11 A. Dr. Donna Krummen, K-r-u-m-m-e-n.

12 Q. This is the first involvement that  
13 Dr. Krummen had with Carolyn Yarbrough?

14 A. I think so.

15 Q. She is observing her or assessing her at that  
16 point, right?

17 A. Correct.

18 Q. Did Dr. Xrummen call you regarding the  
19 discharge plan to a rehab facility?

20 A. I do not recall that specifically.

21 Q. At the time of surgery you did a right  
22 hemicolectomy?

23 A. Correct.

24 Q. You did an ileostomy?

25 A. Correct.

1 Q. In terms of function of the ileostomy at the  
2 time of discharge, what would you want the function  
3 to be before this lady went to a rehab facility?

4 A. I would like for the ileostomy to be  
5 functioning. It is putting out liquid stool  
6 basically.

7 Q. When you say liquid stool, tell me what you  
8 are describing.

9 A. Describing stool.

10 MR. GOLDWASSER: I'm sorry, I  
11 missed that myself.

12 Q. I'm trying to ask a different question. The  
13 same question but ask you the right question.

14 What, based upon the output, will  
15 indicate to you the state of health of the  
16 intestinal tract?

17 MR. GOLDWASSER: Healing or  
18 health?

19 Q. We can use both. Healing and/or health of  
20 the intestinal tract.

21 A. There is nothing specific that I would be  
22 looking for except the fact it's not obstructed,  
23 it's functioning, there is bowel content coming out  
24 into the bag.

25 Q. Is there a specific color that the bowel

1 content should be at this point in time?

2 A. Not particularly, greenish brown or yellow.

3 Q. That doesn't give rise to any concern in your  
4 mind?

5 A. No.

6 Q. On the 25th, obviously focusing on the  
7 surgery note, Dr. Muscoreil writes a note, right?

8 A. Yes.

9 Q. Does this look like it's discharge planning  
10 to you?

11 A. Yes.

12 Q. He's going to recommend she follow-up as an  
13 outpatient in surgery; is that right?

14 A. Correct.

15 Q. What would you be doing with her follow-up?

16 A. Examining her, looking at her wound, making  
17 sure it's healing properly.

18 Q. Anything else?

19 A. Overall you make sure that she is doing well,  
20 physical exam that they have.

21 Q. What did you determine at that point in time  
22 to be her neurological status?

23 A. I did not. I was not involved in her  
24 neurology status. I had a neurologist follow her  
25 along with that. From the chart it's my

1 understanding that they didn't know exactly what  
2 her neurological problem was, except the fact they  
3 suspected it was some kind of myelitis.

4 Q. I didn't mean to imply I thought you did the  
5 neurological workup. The better way to ask the  
6 question is was it your understanding of the  
7 conclusion of the neurologist, was it clear to you  
8 based upon the charting that you reviewed what the  
9 cause was for her apparent mental confusion?

10 A. You are talking about a specific day about  
11 her mental confusion?

12 MR. GOLDWASSER: Where do we  
13 establish she's mentally confused?

14 Q. Would you agree with me during the  
15 confinement subsequent to surgery that  
16 Mrs. Yarbrough had episodes of mental confusion?

17 A. I was aware of one noted in the chart where  
18 she was agitated. Unless you point out a note to  
19 me, I'm not --

20 Q. I'm just asking what you recall. There was  
21 also, **do** you recall that at a point in time around  
22 January 15th, that Dr. Muscoreil had a concern  
23 based upon clinical symptoms that Mrs. Yarbrough  
24 might be experiencing clinical pancreatitis from  
25 the peritonitis; do you remember that at all?

1 A. I would have to look at that.

2 Q. I think January 15th?

3 A. There is a note by Dr. Muscoreil **on**  
4 January 15th which questions chemical  
5 pancreatitis.

6 I'm sorry, I said clinical, I meant  
7 chemical. Why did he have that concern?

8 A. I suspect that because the amylase and lipase  
9 were slightly elevated -- amylase was normal,  
10 lipase elevated.

11 Q. Did you draw a conclusion what caused that to  
12 be elevated?

13 A. I did not.

14 Q. What was in your possible differential for  
15 that lab value?

16 A. There are patients that can get pancreatitis  
17 postoperatively without a definite defined reason  
18 for it. It's basically idiopathic, it resolves.

19 **We** don't know exactly what caused it. We treat it  
20 as pancreatitis, usually the patient gets better.

21 Q. In reflecting upon the chart, thinking about  
22 what happened, I think you already indicated for me  
23 you did not **speak** with **Dr.** Bass before Carolyn was  
24 discharged?

25 A. Correct.

1 Q. Is there anything in Dr. Bass' note that  
2 indicated he had an opinion one way or another as  
3 to whether or not this patient was ready for  
4 discharge?

5 A. He doesn't give an opinion whether the  
6 patient was ready for discharge or not. I can't  
7 tell from looking at his note that he has given an  
8 opinion.

9 Q. Fair enough. As I recall it, the indication  
10 that she was going to be discharged, planning  
11 discharge for Friday, that actually occurred before  
12 the ID consult was had; is that right?

13 A. There is a note on the 23rd, the same day,  
14 that she was going to be discharged that Friday.

15 Q. I'm saying chronologically that was in the  
16 thinking of the surgical service, Dr. Muscoreil's  
17 note?

18 A. Right.

19 Q. As a matter of routine, Dr. Sonpal, did you  
20 obtain an ID consult for dealing with the cecal  
21 perforation?

22 A. Not as a matter of routine, no.

23 Q. You take it upon yourself to function as an  
24 ID doctor for a perforation and contaminant?

25 MR. GOLDWASSER: He's not an ID



1 doctor, he's a surgeon, functions as a surgeon and  
2 orders antibiotics.

3 Q. Right. We will go with Mr. Goldwasser's it's  
4 a better question.

5 MR. GOLDWASSER: Why don't we  
6 reask it.

7 Q. I didn't mean to say do you function as an ID  
8 doctor. You feel comfortable, based upon your  
9 experience with cecal perforations, in ordering the  
10 antibiotics to cover what grows out of those  
11 cultures without an ID consult?

12 A. Yes.

13 Q. Under what circumstances if any do you order  
14 an ID consult at the time of perforation?

15 A. We usually do not get a consultation at the  
16 time of the perforation. Usually there is no time  
17 for consultation at the time of perforation. By  
18 the time the cultures come back, usually four or  
19 five or **six** days down the line, the patient has  
20 been on antibiotics, treated with surgical  
21 procedure, usually getting better by then. We did  
22 not feel that it's necessary to get a consult. If  
23 the patient is not doing well, or there is a  
24 question, we do not hesitate to get an opinion from  
25 an ID person.

1 Q. Given the CAT scan findings in this case,  
 2 we're not going to ask how to speculate as to  
 3 anyone else's CAT scan finding, based upon the  
 4 report of some scattered ascites, how difficult  
 5 would it be to draw fluid from the abdomen in order  
 6 to culture those areas?

7 A. From my understanding, the fluid was not a  
 8 lot of fluid, it was minimal fluid, I think it  
 9 would be quite difficult, potentially dangerous to  
 10 stick needles in this patient at that time.

11 Q Would you be the person who would actually  
 12 draw the fluid or who would do that?

13 A Does any radiologist

14 Q Invasive radiologist?

15 A Correct.

16 Q Do you agree with the testimony of Dr. Bass,  
 17 I don't have the page, that corticosteroids can in  
 18 fact prevent the formation of a localized site of  
 19 fluid, are you aware of that effect?

20 A No, I'm not

21 Q Do you have any reason to believe that  
 22 Carolyn Yarborough would have failed to respond to  
 23 anti-infective that would have directly addressed the  
 24 Candida and Enterococcus<sup>us</sup>

25 A. Could you rephrase that question, please?

1 Q. In other words, you are aware at least by  
2 autopsy of organisms that grew out of the same type  
3 at autopsy as in the hospitalization?

4 A. The organism that was reported in the autopsy  
5 report is Candida. They do not mention any other  
6 organism.

7 Q. We'll just confine it to that since that is  
8 **one** area we're looking to.

9 Do you have any reason to believe,  
10 based upon responses that Carolyn Yarbrough had at  
11 Saint Luke's to medical therapy, she would have  
12 failed to respond to antibiotics administered to  
13 address that particular organism?

14 A. I still don't understand the question or at  
15 least I don't know how to answer that question.

16 **MR. GOLDWASSER:** I caution you,  
17 I don't know what you know or don't know about this  
18 subject. Make sure you stay within your area of  
19 expertise. If you know the answer. I believe you  
20 said you don't understand. I'll ask you to repeat  
21 it.

22 **MISS XOLIS:** I don't know  
23 how else to say it.

24 **MR. GOLDWASSER:** We'll read it  
25 back.

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(Question read.)

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MR. GOLDWASSER:           Objection.    I  
don't know what medical therapy has to do with it.

Q.       You don't understand the ques ion, you don't  
have to answer it.   Fair enough.

A.       I don't.

Q.       Explain to me why you did not change the  
antibiotic regimen in Carolyn Yarbrough once you  
discovered from the first culture organisms that  
were not covered by that triple antibiotic  
prescription?

A.       It's not unusual to grow multiple organisms  
in a patient like this.   The triple antibiotics she  
was on were helping her recover from the  
infection.   We did not know that Candida and  
Enterobacter, I suppose that's what you are  
referring to, were specific pathogens responsible  
for infection or just the normal flora of the  
bowel.   It's not always necessary to treat each and  
every organism with a specific antibiotic that  
grows out of the organism, that grows out of one of  
the cultures.

Q.       That is why you just left the coverage as it

1 was?

2 A. Correct.

3 Q. Have you had an opportunity in addition to  
4 the autopsy to look at the death certificate?

5 A. I've not seen the death certificate.

6 Q. Fair enough. As you read the autopsy, do you  
7 agree with me the cause of death was anoxic brain  
8 damage caused by respiratory failure due to septic  
9 shock from the intra-abdominal infection?

10 MR. GOLDWASSER: You're asking  
11 his interpretation of the pathology report?

12 Q. Yes, if you have some other opinion or you  
13 disagree that is what it says.

14 MR. GOLDWASSER: I object. If  
15 you want to render an opinion in that regard you  
16 can.

17 A. I really do not want to render an opinion on  
18 that because it is a multiple question in one.

19 Q. Fair enough. Referring you I guess to the  
20 autopsy, I'm going to have to find it. You might  
21 want to look yourself.

22 The abscess that was found, the  
23 abdominal abscess at the time of autopsy, do you  
24 agree with me that that abscess grew out Candida?

25 A. I don't know they cultured Candida out, it

1       grew out of it. There was mention of an organism  
2       consistent with Candida species discovered they  
3       might have seen under the microscope.

4       Q.       You haven't looked at the Huron Road chart?

5       A.       No, I have not.

6       Q.       Do you agree that steroids can blunt signs  
7       and symptoms of peritonitis?

8       A.       I have seen that happen, yes.

9       Q.       It's something you understand can and does  
10      happen?

11      A.       It can.

12      Q.       When people are on steroids?

13      A.       Yes.

14      Q.       Do you agree with me or disagree that over  
15      the course of her hospitalization after the surgery  
16      she did in fact demonstrate a postop fever?

17      A.       I think she had a low grade postop fever for  
18      a few days immediately after surgery, which  
19      resolved eventually.

20      Q.       Does increasing fever and increasing white  
21      blood count indicate or is consistent with systemic  
22      infection?

23      A.       In general, yes. Could be localized  
24      infection, doesn't have to be systematic infection.

25      Q.       Consistent with or indicative of either local

1 or systemic infection to clarify?

2 MR. GOLDWASSER: Consistent with  
3 and indicative of are two separate statements. Are  
4 we talking consistent with?

5 Q. We will start with consistent with.

6 A. I think elevated white count and/or fever  
7 could come from infection, yes.

8 Q. In this particular patient, you had a postop  
9 low grade fever. By the way, do you know what  
10 effect steroids have on fevers?

11 A. No, I don't.

12 Q. In this patient, given she had -- I don't  
13 know if you consider -- do you consider the  
14 condition she presented with as an intra-abdominal  
15 catastrophe? I always see that in medical  
16 records. In other words, she has a perforated  
17 cecum, correct, she's got fecal contamination?

18 A. Right.

19 Q. In the situation where you've got a low grade  
20 postop fever, increasing white blood counts, can  
21 you do anything other than culture the wounds to  
22 determine if there is infection going on?

23 MR. GOLDWASSER: Are you talking  
24 about when the abdomen is open?

25 MISS KOLIS: No, I'm talking

1 postoperatively.

2 MR. GOLDWASSER: Postoperatively,  
3 sorry.

4 A. I don't know she has an increasing white  
5 count. I would have to check that to see if she  
6 did.

7 I think that we did the time that I  
8 saw her on the 20th, I believe she had a white  
9 count, we did culture her wound, we did culture her  
10 urine, we did get a CAT scan of the abdomen,  
11 pelvis, she had a chest x-ray to look for a source  
12 of infection.

13 Q. Can you think of any other kinds of tests  
14 that you could have done at that time to determine  
15 whether or not there was a systemic infection?

16 A. We could have done blood cultures I suppose.

17 Q. Are any blood cultures contained in this  
18 chart?

19 A. I don't know. I haven't looked.

20 Q. Would you **look**.

21 A. There was a blood culture on the initial, on  
22 the 10th of January.

23 Q. Subsequent to the 10th?

24 A. Subsequent to the 10th I have **not** seen any.  
25 There is on the 20th one done, yes.



1 Q. You don't have a Bates stamped page?

2 MR. GOLDWASSER: Page 50 of the  
3 lab reports, you did order one on the 20th.

4 A. I didn't order one personally. When we do  
5 rounds we discuss these things, the resident makes  
6 notes and orders the tests.

7 Q. When were the results of that available?

8 A. Probably on the 26th.

9 Q. Can you show me --

10 MR. GOLDWASSER: Says on the  
11 21st.

12 A. Completed on the 21st, correct.

13 Q. What page are you looking at?

14 MR. GOLDWASSER: Page 50 of the  
15 lab studies.

16 A. That one right there at the bottom, middle of  
17 the page.

18 Q. One drawn on the 20th, right?

19 A. Correct.

20 Q. There was no report on it until the 26th; **is**  
21 that right?

22 A. No, completed on the 21st. I see. I'm  
23 sorry.

24 Q. Someone did order a blood culture on that  
25 day.

1 A. Right.

2 Q. Do you agree that ascites in the abdominal  
3 cavity could be related to infection?

4 A. Usually not in my practice at least.

5 Q. Once again, I probably asked it, maybe I  
6 didn't ask this question directly, the purpose of  
7 the consult by Dr. Bass, was it directly to  
8 evaluate the wound, was it for the overall picture  
9 of infection?

10 A. The reason for the consult was the fact that  
11 she was growing Candida in her urine, she had a  
12 wound culture which was also positive. It was  
13 not -- when a consultant is asked to see the  
14 patient, we do not restrict them to a specific  
15 point or specific thing. We ask them to see the  
16 patient, consult on the patient.

17 In this particular patient, the  
18 reason for asking Dr. Bass to see the patient was  
19 from looking at the chart, the fact she has  
20 positive cultures, that I as a general surgeon  
21 didn't want to -- needed some help with. Wanted  
22 his opinion on.

23 Q. So you didn't specifically ask him only to  
24 evaluate the positive culture from the wound?

25 A. That was the reason for asking him to see the

1 patient.

2 Q. You had some expectation he was going to  
3 render a more global opinion than just the wound,  
4 is that what you are telling me?

5 A. I didn't have an expectation. What I meant  
6 by that was he was not restricted to just giving an  
7 opinion on the culture reports. He was free to  
8 look at the patient, look at the chart, review and  
9 give a global opinion if he felt it was necessary.

10 Q. I want to ask you a couple more questions I  
11 think.

12 We prepared previously, might as  
13 well mark it as an exhibit, give you a copy,  
14 Mr. Goldwasser is going to say where is that piece  
15 of paper again. I charted the white blood counts,  
16 pulled them into a report. You can assume these  
17 are accurate, if we find out they are inaccurate  
18 later it may effect your answer.

19 If we look at January 20th.

20 A. Correct.

21 Q. At this point her white blood count is the  
22 highest since her admission; do you agree with  
23 that?

24 A. Yes. Excuse me, I don't agree with that. On  
25 the 16th it was 26,000.

1 Q. You're right. We will go back to this. On  
2 the 15th it's 26-12?

3 A. On the 16th it was 26.2.

4 Q. This is what I get for reading upside down.

5 Looking back at the chart, to what  
6 did you attribute that rise in her white blood  
7 count?

8 A. I don't recall that particular white blood  
9 count.

10 Q. While she was in during this hospitalization  
11 she was undergoing a steroid tapering wasn't she?

12 A. She was given steroids. I don't know whether  
13 she was undergoing steroid tapering. I think it  
14 was much later in her course.

15 Q. You drew no conclusion what caused her white  
16 blood count six days or so postop to go that high?

17 A. I **do** not recall that particular white count  
18 six days postop. I would have --

19 Q. When she has this increase in the number,  
20 decreases a little, then goes back up to 20.36 on  
21 the 20th.

22 A. Okay.

23 Q. What was your concern at that point what was  
24 causing that white blood count number?

25 A. I was under the impression that the white

1 count was actually coming down from its high of  
2 26. I was concerned about it. To the extent she  
3 had been on steroids I wondered if the steroids had  
4 anything to do with it or whether there was an  
5 infection.

6 Q. You didn't know at the time of her  
7 hospitalization what if any baseline white blood  
8 count number this woman had? Do you understand  
9 what I mean when I ask that?

10 A. When you say baseline, are you talking her  
11 admission white count?

12 Q. No, you weren't aware of what her white blood  
13 count would have been in a situation where she was  
14 not sick, correct?

15 A. Correct.

16 MISS XOLIS: I'm going to  
17 confer with Mrs. Garson one minute. That might be  
18 all we have.

19 -----

20 (Discussion had off the record.)

21 -----

22  
23 (Plaintiff's Exhibits A through D  
24 marked for identification.)

25 -----

1 BY MISS KOLIS:

2 Q. At the time of Mrs. Yarbrough's discharge  
3 from Saint Luke's, what did you feel was her  
4 prognosis in terms of ability to survive what  
5 occurred at the hospital?

6 MR. GOLDWASSER: Survive the  
7 perforation of her colon?

8 MISS KOLIS: Right.

9 MR. GOLDWASSER: You may  
10 answer.

11 A. She had a fair prognosis.

12 Q. When you say fair prognosis, so I understand  
13 what you mean by that, what do you mean by a fair  
14 prognosis?

15 A. She had other medical problems. If a healthy  
16 person has a perforation, they have a better chance  
17 than her case, she had a fair prognosis.

18 MISS KOLIS: That's all the  
19 questions I have.

20 MR. GOLDWASSER: As my custom I  
21 will not waive signature on behalf of my client.

22 -----

23 (Deposition concluded; signature not waived.)

24 -----

25

1

ERRATA SHEET

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NOTATIONPAGE/LINE

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I have read the foregoing

22

transcript and the same is true and accurate.

23

24

25

INDU SONPAL, M.D.

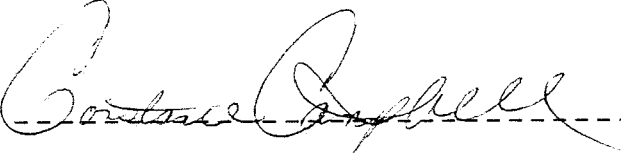
1 The State of Ohio,  
2 County of Cuyahoga.

CERTIFICATE:

3 I, Constance Campbell, Notary Public within  
4 and for the State of Ohio, do hereby certify that  
5 the within named witness, INDU SONPAL, M.D. was by  
6 me first duly sworn to testify the truth in the  
7 cause aforesaid; that the testimony then given was  
8 reduced by me to stenotypy in the presence of said  
9 witness, subsequently transcribed onto a computer  
10 under my direction, and that the foregoing **is** a  
11 true and correct transcript of the testimony so  
12 given as aforesaid.

13 I do further certify that this deposition was  
14 taken at the time and place as specified in the  
15 foregoing caption, and that I am not a relative,  
16 counsel or attorney of either party, or otherwise  
17 interested in the outcome of this action.

3.8 IN WITNESS WHEREOF, I have hereunto set my  
19 hand and affixed my seal **of** office at Cleveland,  
20 Ohio, this 6th day of January, 1997.

21   
22 -----

23 Constance Campbell, Stenographic Reporter,  
24 Notary Public/State of Ohio.  
25 Commission expiration: January 14, 1998.



**Look-See Concordance Report**

--  
 UNIQUE WORDS: **1,069**  
 TOTAL OCCURRENCES: **3,276**  
 NOISE WORDS: **385**  
 TOTAL WORDS IN FILE: **10,179**

--  
 SINGLE FILE CONCORDANCE  
 ---

CASE SENSITIVE

---  
 PHRASEWORD LIST(S):  
 ---

NOISE WORD LIST(S): **NOISE.NOI**  
 ---

COVER PAGES = 4  
 --

INCLUDES ONLY TEXT OF:

**QUESTIONS**  
**ANSWERS**  
**COLLOQUY**  
**PARENTHEICALS**  
**EXHIBITS**

--  
 DATES ON

---  
 INCLUDES PURE NUMBERS

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 POSSESSIVE FORMS ON

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 MAXIMUM TRACKED OCCURRENCE  
 THRESHOLD: 50

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RESIDENCY

GENERAL SURGERY

ST. LUKES HOSPITAL,  
11311 Shaker Blvd. Cleveland, Ohio 44104  
July 1971 to June, 1975.

American Board of Surgery

Certified September, 1976

Recertified October, 1987.

Fellowship

American College of Surgeons.

Present Staff Appointments

St. Lukes Medical Center, Director, Division of General Surgery.

St. Vincent Charity Hospital

Meridia Hillcrest Hospital, Courtesy Staff

MaryMount Hospital, Courtesy staff.

Awards

Teacher of the year awards for  
July 57 to June 88  
July 59 to June 90  
July 94 to June 95

Publications

Pseudotumor of the lateral Duodenal Wall  
American Journal of Gastroenterology, October, 1988.

The Rational for Incidental Cholecystectomy during Major Abdominal  
Vascular Surgery.  
The American Surgeon, October, 1990.

Breast Cancer in Women Following Mantle Irradiation for Hodgkin's  
Disease.  
The American Surgeon, September 1995.

**PLAINTIFF'S  
EXHIBIT**

A 12-30-97



YARBROUGH, CAROL  
0362224  
INDUKUMAR M SONPAL, M.D.

01/09/96 01/25/96

DISCHARGE SUMMARY

REASON FOR ADMISSION: Bowel perforation.

HISTORY OF PRESENT ILLNESS: This is a 51-year-old Slack female with a past medical history of hypertension, asthma, and a questionable cervical myopathy, who presented to the Emergency Room for a change in mental status. She was found to have a glucose in the 600 range, non-acidotic, ruling out hyperosmolar coma; however, they asked for a surgical consult for a distended abdomen. A nasogastric tube was placed in the Emergency Room and fecal material, which was guaiac positive, was returned.

PHYSICAL EXAM: Blood pressure 114/79, pulse 140, respirations 9, temperature 37.9. The patient was unresponsive and responded to deep pain only. Lungs: Revealed a few rhonchi bilaterally. Heart: Irregular rate and rhythm. Abdomen: Grossly distended with a few hyperactive bowel sounds, which was tympanic. There was a well-healed cholecystectomy scar in the right upper quadrant. There was questionable pain on deep palpation. Rectal Exam: Revealed stool in the vault, which was guaiac positive.

LABORATORY DATA: Abdominal series revealed free air with questionable air in the portal system. The CT scan of the head was negative. The electrocardiogram was sinus tachycardia. The urinalysis revealed no ketones. The CBC with differential revealed a white blood cell count of 4.5, hemoglobin 13, hematocrit 40. The electrolytes revealed a sodium of 137, potassium 4.8, chloride 99, bicarb 25, BUN 38, creatinine 1.5. Repeat glucose was 459 with an alkaline phosphatase of 109, AST 14, ALT 28. The arterial blood gases on 40% revealed a pH of 7.42, pCO2 40, pAO2 119, bicarb 26.

HOSPITAL COURSE: The patient was taken immediately to the Operating Room where she underwent an exploratory laparotomy and a right hemicolectomy and ileostomy for a ruptured cecum x 2. Postoperatively, the patient remained intubated. A Pulmonary/ICU consult was obtained and it was their recommendation to keep the patient fluid restricted, continue Tylenol for fever and continue intravenous corticosteroids. The patient was eventually weaned over the course of a few days and the patient was extubated on January 12, 1996. She was continued on triple antibiotic therapy with Cefotan, Gentamicin and Flagyl. She was made NPO and we awaited return of her bowel function. Over the course of the next few days, her ostomy started to function. On approximately day #3, she was started on tube feeds of Osmolite at 30 cc per hour. Cultures from the abdominal wound grew out Enterococcus fecalis and Candida albicans. A neurology consult was obtained and they recommended having the patient obtain a T-spine MRI and L-spine MRI to evaluate her leg weakness. The patient gradually improved and was transferred to the floor on January 15, 1996. Her lungs continued to improve and frequent room air pulse oximetry were obtained. The patient's oxygenation remained 90% or better on room air. Her steroid were then weaned over the course of the next couple of days. The

CONTINUED:

PLAINTIFF'S  
EXHIBIT

12-30-97

000399

SIGNATURE OF HOUSE STAFF:

SIGNATURE OF VISITANT:



YARBROUGH, CAROL  
0362224  
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DISCHARGE SUMMARY

Page 2

patient was eventually discharged on a steroid wean as an outpatient. The patient's aerosols were also changed to MDI inhalers. Over the next couple of days, the patient eventually was sent for a MRI on January 22, 1996, which revealed a negative examination of the thoracic spine and negative impression of lumbosacral spine for any pathology. A psychiatric consultation was obtained for competency and it was their impression that the patient had mild cognitive deficits and doubted competence. A medical consult was also obtained for management of the patient's hypertension and diabetes mellitus. It was their impression that the new onset diabetes mellitus and was secondary to the Prednisone and that the requirements of Insulin will decrease over the period of Prednisone wean. The patient was discharged on January 25, 1996 to a rehabilitation hospital.

CONDITION ON DISCHARGE: Improved.

DISPOSITION: The patient was discharged to an extended care facility/rehabilitation facility.

FOLLOW-UP: Follow-up in General Surgery Clinic in one week, follow-up with Medicine Clinic for blood pressure and blood sugar/Insulin adjustment, and follow-up in the Neurology Clinic in three months.

FINAL DIAGNOSIS:

CECAL PERFORATION X 2 WITH RIGHT HEMICOLECTOMY AND ILEOSTOMY.

HYPERTENSION.

ASTHMA.

STEROID-INDUCED DIABETES MELLITUS.

MYOPATHY, UNKNOWN ETIOLOGY.

STEVEN MUSCOREIL. M.D.

SM/MRC#30/SLH/4903

D: 01/29/96

T: 01/30/96

cc: STEVEN MUSCOREIL, M.D.  
INDUKUMAR M SONPAL, M.D.

SIGNATURE OF HOUSESTAFF:

SIGNATURE OF VISITANT:

000400

Date

1/19/96 After VSS

No c/o excepts wants her meds <sup>Darvocet</sup> <sup>? Theodor</sup>  
 One Aerosol / Prednisone  
 with <sup>132</sup> <sup>95</sup> <sup>368</sup>  
 re: Theodor <sup>4.1</sup> <sup>27</sup>

Darvocet reordered

Andromen Soft

Leostomy functioning

WBC 18.64

8.7 / 25.7

Colon being cleaned out

from below

Local care for wound

Surgical

Diet should be ADA diet? Hypoglycemia

2° to steroids, ins. severe

Add sugar heparin to B.D.

Surgical

physical therapy

1/19/96 Neurology

Paraplegia as before. despite MRI  
 reviewed - no lesion seen. The scan goes  
 down to T5. Suggest we obtain

Thoracic & lumbar MRI scan

1-2 to the compression lesions lower in  
 spine (ordered in dent)

/ Alan Linn

PLAINTIFF'S  
 EXHIBIT

000282

12-3-97



CAROLYN YARBROUGH

WHITE BLOOD COUNT 1/9/96 - 1/25/96

REFERENCE RANGE 4 - 11.5

<u>DATE</u>	<u>TIME</u>	<u>RESULT</u>
1-9-96	1915	5.48
1-9-96	1951	4.54
1-10-96	0130	2.13
1-11-96	0401	8.13
1-12-96	0401	10.02
1-13-96	0401	12.96
1-14-96	0401	19.96
1-15-96	0401	20.32
1-16-96	0645	26.12
1-17-96	0501	17.35
1-18-96	0645	17.80
1-19-96	0630	18.64
1-20-96	0645	20.36
1-21-96	0645	19.72
1-22-96	0530	19.69
1-23-96	0530	13.38
1-24-96	0601	12.84
1-25-96	0601	11.08

**PLAINTIFF'S  
EXHIBIT**

D 12-30-97

82366 P- 850311  
 REED, MARY J 11-14-93  
 365Y 1-06-28 WAUGH, JAMES  
 WHEEL

# ROBINSON MEMORIAL HOSPITAL

## PROGRESS RECORD

Date	Note progress of case, complications, consultations, change in diagnosis, condition of discharge, instruction to patient
11/23/93	<p>11/23/93</p> <p>(5) normally responsive</p> <p>(6) Chest x-ray shows - lower</p> <p>Heart S<sub>2</sub> and aortic</p> <p>Also ventr. removed arteries</p> <p>→ Arrange for breast infection</p> <p>(A) Hemodynamically less stable on dialysis</p> <p>(1) Dialysis today tomorrow. possibly for 3rd</p> <p><i>[Signature]</i></p>
11-23-93	<p>11-23-93 - Hemodialysis</p> <p>4.0 hr. to completed, hypertension tied to 1000grams. Albumin and Dopamine drip. Fluid balance = - 500 cc. See flow sheet. g. mayner MD PCAS @ RMH</p> <p><i>[Signature]</i></p>
11/23/93	<p>11/23/93 CT scan showed appears to have relatively large fluid collection in lesser sac just below and inferior &amp; posterior to duodenum. Paracentesis performed fluid sent for stat gram stain with discuss to Dr. Cook concerning incision of drain. Dr. Cook will drain this evening.</p> <p><i>[Signature]</i></p>