THE STATE of OHIO,
: SS:
COUNTY of CUYAHOGA.

IN THE COURT OF COMMON PLEAS

ARAZINE SMITH, executrix of the ESTATE of CAROLYN YARBROUGH,
plaintiff,

vs. : Case No. 326850

SAINT LUKE'S HOSPITAL,
defendant.

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

APPEARANCES:

ON BEHALF' OF THE PLAINTIFF:

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ON BEHALF OF THE DEFENDANT:

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I N D E X

WITNESS: **INDU SONPAL, M.D.**

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(IF ASCII DISK ORDERED, SEE BACR COVER)

INDU SONPAL, M.D.

of lawful age, a defendant herein, called by the plaintiff 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:

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

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

THE WITNESS: Yes.

MRS. XOLIS: If at any time

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

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

THE WITNESS: Yes.

CROSS-EXAMINATION

BY MISS XOLIS:

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

A. Yes, that is my curriculum vitae.

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

I gather you are of course licensed

to practice medicine in the State of Ohio?
A. Right.
Q. When did you obtain your licensure for the State of Ohio?
A. Around 1971.
Q. Do you hold licenses to practice medicine in any other states?
A. No, I do not.
Q. Has any disciplinary action ever been taken against your medical license in the State of Ohio?
A. No.
Q. Fair enough. Tell me about your medical education that led you to your occupation as a surgeon.
A. I went to medical school in Bombay, passed my Bachelor of Medicine exam in 1969. I went to the Saint Margaret Memorial Hospital in Pittsburgh for a rotating internship, then did four years of general surgical training at Saint Luke's Hospital.
Q. So you did a four year residency at Saint Luke's?
A. Right.
Q. Have you ever practiced medicine at any other hospital as a primary appointment other than Saint

Luke's?

A. Was on the staff at Saint Vincent Charity Hospital.

Q. Meridia is a courtesy, Marymount?

A. Right.

Q. The majority of patients that you see and treat are at which facility?

A. Saint Luke's Hospital.

Q. Do you have a private medical practice?

A. Yes.

Q. Who is in that practice?

A. Just myself.

Q. Are your offices located at the Saint Luke's Medical Arts Building right next to the hospital?

A. Medical building next to the hospital, my main office is there.

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

A. No, I've been there since actually 1978 or so in that office.

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

You are certified of course in surgery?

A. Yes.

Q. I see that you were recertified in 1987?

A. Correct.
Q. Are you Board eligible in any other subspecialty?
A. No.
Q. I notice there are a couple of publications, those are the only ones, do you have anything in press currently?
A. No.
Q. Dr. Sonpal, as a surgeon do you -- it's always a difficult question to ask -- you do general surgery, correct?
A. Correct.
Q. Is there a particular type of surgery that you consider you're a specialist in, something you do more than anything else?
A. No.
Q. Tell me the kind of surgery you perform.
A. We operate on gallbladders, colon, stomachs, hernias, thyroid, breast.
Q. Do you have teaching responsibilities at Saint Luke's Hospital?
A. Yes, I do.
Q. Please explain the nature of your teaching responsibilities, when it began?
A. I began as a teaching Fellow in 1975 when I

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

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

Q. Let me see if I understand this.

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

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

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

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

A. That's correct.

Q. Fair enough. Do you teach in any classroom

setting?
A. We used to have many didactic lectures, conferences on a regular basis. We have fewer of them now because we have less number of residents.
Q. How many residents were in your surgical residency program in January of 1994, if you recall?
A. I think there were 10 residents.
Q. I have perused this chart a couple of times, have you had the opportunity to review Carolyn's medical chart?
A. I've looked at it, yes.
Q. I want to ask you a couple of names, see if you can identify them as surgical residents or otherwise. Steven Muscoreil?
A. Surgical resident.
Q. Did I pronounce that correctly?
A. Yes.
Q. Dr. Cannova also a surgical resident?
A. Yes.
Q. **Dr.** Camp?
A. **Dr.** Camp, surgical resident.
Q. Fair enough. In anticipation of answering **my** questions today did you review medical records?
A. I reviewed the records of Carolyn Yarbrough,

yes.

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

A. That's correct.

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

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

Q. Autopsy report?

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

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

A. No.

Q. -- of Candlewood?

A. No.

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

A. No, I did not.

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

MR. GOLDWASSER: Objection. You

may answer.

A. Yes.

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

MR. GOLDWASSER: Objection. You may answer.

A. I've been sued twice.

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

A. I don't think so.

Q. Both these lawsuits were in Cuyahoga County?

A. Correct.

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

MR. GOLDWASSER: Objection. You may answer.

A. I think they were settled out of court.

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

A. About 10 years ago.

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

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

A. No.
Q. My understanding from Dr. Bass' depo, I want to see if it is the same situation for you, is that Carolyn Yarbrough would have become your patient vis-a-vis the hospital referring her to you?
A. That's correct.
Q. She was a staff patient; is that correct?
A. That's right.
Q. Not a private patient?
A. That's right.
Q. From your review of the records how is it you became involved in the care of Carolyn Yarbrough?
A. I was **on** call that night for the emergency room, I was called by the surgical resident, specifically Dr. Connova, he gave me the history of this patient, the fact that she appeared to have a perforated bowel.
Q. At that point, I'm inferring something from the record, was Dr. Cannova the senior surgical resident?
A. Correct.
Q. Finishing his fourth year?
A. Yes.
Q. Did you have other surgical residents on service that evening besides Dr. Cannova?

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

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

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

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

A. Correct.

Q. That's an accurate characterization?

A. Right.

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

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

A. No, I did not.

Q. During the time that Carolyn was under your

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

A. I do not recall.

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

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

MISS KOLIS: Leaving the document there in case he needs to refer to it €or any reason.

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

MISS KOLIS: Yes.

MR. GOLDWASSER: Connie, the question again.

(Question read.)

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

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

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

A. At the time of the operation.

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

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

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

A. Correct.

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

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

Q. Did you come to the hospital?
A. That's correct.
Q. Did you take your own medical history regarding this patient?
A. No, I did not.
Q. The first time you saw the patient was in the OR?
A. Probably just outside of the operating room.
Q. Dr. Cannova and Dr. Muscoreil assisted you in the surgery, correct?
A. Correct.
Q. I wanted to see if I can find it, I'm trying to do things in order, it's not always possible. Skip to the progress notes. If you want to hang on for a second if I can refer you to the first note written in the chart on 1-9-96 by Dr. Cannova.
A. Okay.
Q. Would you have reviewed this note at some -- first of all, do you review all the notes written by your residents?
A. Usually try to review most all the notes. A lot of discussions take place verbally, we don't actually have to read each and every word of it.
Q. Sometimes you read the notes, sometimes you don't. Would you recall today if you had an

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

A. I don't recall that.

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

A. Yes.

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

A. I would, yes.

Q. What overall condition would you be referring to?

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

Q. Once you were able to examine the abdominal

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

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

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

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

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

A. I wasn't there at that time.

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

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

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

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

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

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

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

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

A. My last note was January 22nd.

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

A. That's correct.

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

or not you may have seen her on those three days?

A That's correct.

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

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

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

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

A. Yes

Q You're discussing a Candida and Enterococcus?

A. Right

Q. Those are in fact what was grown on the intraoperative surgical culture, correct?
A. That's correct.
Q. Taken on the 10th?
A. Right.
Q. The same two organisms are in existence based on a repeat culture from the 16th, right?
A. In a different location.
Q. Of course, she is closed at this point?
A. Right.
Q. Those cultures were taken from the fluid that was leaking, I'm going to call it leaking, draining, whichever you are comfortable with from the surgical incision?
A. No fluid or leakage from the surgical incision, those were taken from the surface of the wound without any drainage. You take a swab and culture the surface of the open wound. The wound was open.
Q. There was some drainage from the surgical incision?
A. I have to check the chart to see.
Q. That's fine.
A. Basically my understanding is that the culture was taken from the surface of the wound.

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

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

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

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

A. Right.

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

A. No.

Q. Why not?

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

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

postoperatively Carolyn Yarbrough demonstrated signs and symptoms of being septic?

A. No, not necessarily.

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

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

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

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

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

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

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

attributed to the steroids.
Q. Did you make a note of that anywhere?
A. No, I don't think.
Q. Doctor, when did you see the CAT scan report?
A. When it arrived, I think it's usually the day of the CAT scan. The day it's done I get a report, the resident who checks it out reviews it with the radiologist.
Q. Let me ask this --
A. I don't know when the report arrived on the chart.
Q. Technical question: At Saint Luke's, January, 1996 if radiology performed an examination, would you agree with me the final typewritten report doesn't occur simultaneously with the radiologist reading?
A. It's usually dictated and transcribed and sent to the floor.
Q. Fair enough. We will deal with that issue in a second.
If the CAT scan report indicates it was transcribed on the 24th of January, does that seem a reasonable lapse in time between the taking and the transcription of the same?
A. I don't know that it's important because the

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

Q Silly as it sounds, to establish, the written report comes out the day the scan is taken. You get an oral report?

A We get an oral report We can access the written report by using a telephone that we can access, so the report is dictated and it s available

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

A Yes.

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

A. Right.

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

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

Q. There is something underneath that by neurology?

A. Right.

Q. Close to the end of your note, I think it says hypoglycemia secondary, is that what you mean, secondary to steroids?
A. Yes.
Q. Is that impression?
A. No, it's "Hyperglycemia secondary to the steroids, DM, which is diabetes mellitus, sepsis. Add bolus Heparin to SCD, physical therapy."
Q. Can you explain to me in the recitation you gave me, January 19th note that does say sepsis, right?
A. Right.
Q. I didn't misread you had an impression of sepsis on the 19th?
A. No, the fact the patient had sepsis before that is what I mean by that. Here is a patient diabetic, has been septic in the past, she has been on steroids, the question is whether the blood sugar levels are related to any one of those multiple factors.
Q. I needed some clarification because I saw that in the chart.
A. That doesn't necessarily mean she has a sepsis at this moment.
Q. When was she septic?

A. When she was admitted she had sepsis.
Q. The triple antibiotic therapy she was on, can you tell me what that was?
A. Yes. Cefotetan, Flagyl and Gentamycin.
Q. Once you knew what the culture results were, intra-abdominal cultures were Candida and Enterococcus you didn't change the antibiotic therapy; is that accurate?
A. That's correct.
Q. Do you agree with me that the three antibiotics that we just discussed do not specifically cover for Candida or Enterococcus?
A. The Enterobacter or Enterococcus is sensitive to Gentamycin, doesn't specifically cover Candida.
Q. As we move on through these notes, on the 19th I think we went over what your note was. There is a note on the 20th, if you want to turn a couple pages. That's your note at the top of the page, correct?
A. Yes.
Q. Can you read into the record what the note says?
A. WBC still up, would recommend CT abdomen and pelvis. CNS of urine, wound healing well, except for slight infection in central portion.

Q. You ordered a CT of the abdomen and pelvis on the 20th?
A. To look for the intra-abdominal source of infection.
Q. Have you had the opportunity to review the CAT scan?
A. No, I have not.
Q. The report, I'm not talking about the film.
A. I seen the report, I haven't reviewed it.
Q. Your opinion, did that report exclude the foreseeable possibility that she had an ongoing abdominal infection?
A. In my opinion, yes, it did.
Q. Why is that?
A. We were looking for abscess, it's specifically stated if I'm correct there were no signs of abscesses.
Q. You can look.
MR. GOLDWASSER: It is one of the last reports in there.
A. It's dated January 20, '96, I will just read the impression which says most significant finding some ascites, fluid throughout the abdomen, pelvis, fairly small in amount, no definite focal collection of fluid or gas indicated, abscess

identified.

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

A. Correct.

Q. What did you make of the ascites?

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

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

A. Probably that day or the next day.

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

A. Right.

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

A. I looked at it.

Q. What was the appearance of it?

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

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

Q. You've indicated to me you had the opportunity to review the autopsy report?
A. I have looked at the autopsy, yes.
Q. Would you agree with me the organism which caused her to be septic at the time of her death was both in fact Candida and Enterococcus?
A. No, I do not agree with that.
Q. Tell me what you think it is then.
A. I think she had -- just from the autopsy report I can't say that. I understand that there was a blood culture at Huron Road Hospital.
Q. Have you seen it?
A. No, I haven't seen it. I understand there was one, I don't recall whether I saw it in Dr. Bass' deposition or got that information, that was growing Enterobacter. I think that Candida had very little to do with it. She probably had sepsis secondary to Enterobacter from someplace. I also know now that she had, looking at a report from Huron Road, she had urinary tract infection with the same organism.
Q. She had the UTI at Saint Luke's, didn't she?
A. No, she did not. She had a urinary tract infection cultured at Huron Road, which maybe you have that report someplace in the Huron Road files,

that grew Enterobacter.

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

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

A. That's correct.

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

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

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

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

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

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

Q. Fair enough.

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

A. Correct.

Q Surgery service, written by Dr Muscoreil?

A Right

Q One line entry by yourself, 'As above patient seen " So I take it that Dr. MuscoreiL wrote to note, you confirmed to note?

A Right.

Q On the plan, check CT result. is that right?

A Yes.

Q. Check cultures?

A. On the plan it says check official CT result

Q. I can't make out that word.

A. Check cultures.

Q At that point what does that mean to you, check official results?

A. That means that there must have been an unofficial -- either the resident looked at the CAT scan, didn't see an abscess, told me that he was still waiting to get an official read from the radiologist

Q At the time of her hospitalization, her being Carolyn, did you ever look at that CT yourself?

A No, I did not

Q It says check cultures, does that mean to you the culture results were not yet available?

A. Whatever cultures were pending they were going to check on them, that's right.
Q. Did you see any indication on the chart from the time of January 21st through the end of the hospitalization the official results of the CAT scan were ever checked?
A. No, I didn't see a note to that effect.
Q. Did you ask about that before she was discharged?
A. I don't recall.
Q. We can go to the note on the 22nd. Once again a surgery note, once again looks like written by **Dr.** Muscoreil, I call it countersigned by yourself. At that point obviously the results of the culture were known, right?
A. Correct.
Q. It says will hold off on antibiotics until **ID** recommendation?
A. Correct.
Q. Tell me what the intention was in that regard, why would you hold off on the antibiotics at that point?
A. Because if you are asking a consultant to give an opinion, you want him to tell you whether the patient needs or does not need antibiotics for

these particular cultures.
Q. At this point she has been on antibiotics since I think January 10th or llth?
A. She has been on antibiotics since the 9th when she was admitted.
Q. Did you initially issue the orders for that coverage?
A. No.
Q. Someone else did?
A. Surgical residents usually do that.
Q. But on this date for some reason you decided she had enough antibiotics?
A. I think the antibiotics were stopped on the 20th or 21st.
Q. Go ahead, why would they have been stopped then?
A. She had a full course of 10 days worth of antibiotics, she was clinically doing well.
Q. When you say she was clinically doing well, in layman's terms what do you mean?
A. She looked good, awake, alert, she was not running any high fevers, her white count as we discussed previously, it was up but we were looking into the possibility of the white count being up from other sources other than infection.

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

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

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

A. Yes.

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

A. That's correct.

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

A. That's correct.

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

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

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

Q. Was Carolyn Yarbrough well enough to be discharged to home?
A. I think so.
Q. To home?
A. She went to an extended care facility as I recall.
Q. Are you familiar with Candlewood and what kind of services they provide?
A. No.
Q. You didn't make the decision where she would go?
A. That's correct.
Q. That's not a medical decision, what level of care the patient needs upon discharge?
A. It is in a way, depends more on the patient and their social needs than any other reason.
Q. Their social needs you indicated?
A. Their care, how much help they have at home. For example, if they have wound dressing changes that need to be done, you can have a visiting nurse or send them to a nursing home where the same services can be handled.
Q. As I read this note it says awaiting ID, neuro and psych, does that -- I don't think it says expert -- psych report, is that what it says?

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

A. That may be.

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

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

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

A. No, I did not.

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

A. No.

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

Were you made aware that was contained in that note?

A. Not at that time.

Q. At what time were you aware?

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

Q. Did you get a report from the resident?

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

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

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

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

A. I can only guess about what it means.

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

A. I don't know what that means.

Q. You are the attending physician, correct?

A. Correct.

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

indicating that you read the consult?
A. Correct.
Q. Frequently do you read the progress consult note versus having direct communication with a consultant?
A. Both. Usually if -- it could be either/or. If I run into the doctor he will talk to me, he'll pick up the phone and page me, let me know what he thinks. I will go and see the note after he has written it. There is no definite way of doing it.
Q. You are accustomed to doing it both ways; am I accurate?
A. Correct.
Q. If you were in the position you had to read the note without speaking to the consultant, what would that indicate to you?
A. What I would be interested in is his recommendation. I would not probably pay too much attention to his thinking at that time. That is his specialty and I would only be guessing at what he meant by that.
Q. Would you pick up the phone and call him to ask him what he meant by that?
A. I probably wouldn't.
Q. A person such as Carolyn Yarbrough -- how

about in Carolyn Yarbrough, with your medical background, it would not be a good thing health-wise for her to have an infection with a recent abdominal surgery, would you agree with that?

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

Q. Right.

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

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

A. Based on what? I would need to be guessing

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

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

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

A. Nicolacakis.

Q. What specialty?

A. It's a lady doctor, she is a pulmonary specialist.

Q. You brought in Dr. Jill Barry?
A. Jill Barry is an internist.
Q. Did you bring in Dr. Barry to evaluate the diabetes issue?
A. To evaluate her medical care, including diabetes.
Q. Fair enough. The next note is on 1-24. That's a signature that I didn't actually recognize from previous. Can you tell me which resident that is?
A. Dr. Donna Krummen, K-r-u-m-m-e-n.
Q. This is the first involvement that Dr. Krummen had with Carolyn Yarbrough?
A. I think so.
Q. She is observing her or assessing her at that point, right?
A. Correct.
Q. Did Dr. Xrummen call you regarding the discharge plan to a rehab facility?
A. I do not recall that specifically.
Q. At the time of surgery you did a right hemicolectomy?
A. Correct.
Q. You did an ileostomy?
A. Correct.

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

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

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

A. Describing stool.

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

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

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

MR. GOLDWASSER: Healing or health?

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

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

Q. Is there a specific color that the bowel

content should be at this point in time?
A. Not particularly, greenish brown or yellow.
Q. That doesn't give rise to any concern in your mind?
A. No.
Q. On the 25th, obviously focusing on the surgery note, Dr. Muscoreil writes a note, right?
A. Yes.
Q. Does this look like it's discharge planning to you?
A. Yes.
Q. He's going to recommend she follow-up as an outpatient in surgery; is that right?
A. Correct.
Q. What would you be doing with her follow-up?
A. Examining her, looking at her wound, making sure it's healing properly.
Q. Anything else?
A. Overall you make sure that she is doing well, physical exam that they have.
Q. What did you determine at that point in time to be her neurological status?
A. I did not. I was not involved in her neurology status. I had a neurologist follow her along with that. From the chart it's my

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

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

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

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

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

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

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

A. I would have to look at that.
Q. I think January 15th?
A. There is a note by Dr. Muscoreil on January 15th which questions chemical pancreatitis.
I'm sorry, I said clinical, I meant chemical. Why did he have that concern?
A. I suspect that because the amylase and lipase were slightly elevated -- amylase was normal, lipase elevated.
Q. Did you draw a conclusion what caused that to be elevated?
A. I did not.
Q. What was in your possible differential for that lab value?
A. There are patients that can get pancreatitis postoperatively without a definite defined reason for it. It's basically idiopathic, it resolves. We don't know exactly what caused it. We treat it as pancreatitis, usually the patient gets better.
Q. In reflecting upon the chart, thinking about what happened, I think you already indicated for me you did not speak with Dr. Bass before Carolyn was discharged?
A. Correct.

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

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

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

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

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

A. Right.

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

A. Not as a matter of routine, no.

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

MR. GOLDWASSER: He's not an ID

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

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

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

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

A. Yes.

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

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

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

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

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

A Done by a radiologist

Q Invasive radiologist?

A Correct.

Q Do you agree with the testimony of Dr. Ross, I don t have the page, that corticosteroids can in fact prevent the formation of a localized site of fluid, are you aware of that effect?

A No, I'm not

Q Do you have any reason to believe that Carolyn Yarbrough would have failed to respond to antibiotics that would have directly addressed the Candida and Enterococcus?

A. Could you rephrase that question, please?

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

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

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

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

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

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

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

MR. GOLDWASSER: We'll read it back.

(Question read.)

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

Q. You don't understand the question, 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

was?
A. Correct.
Q. Have you had an opportunity in addition to the autopsy to look at the death certificate?
A. I've not seen the death certificate.
Q. Fair enough. As you read the autopsy, do you agree with me the cause of death was anoxic brain damage caused by respiratory failure due to septic shock from the intra-abdominal infection?
MR. GOLDWASSER: You're asking his interpretation of the pathology report?
Q. Yes, if you have some other opinion or you disagree that is what it says.
MR. GOLDWASSER: I object. If you want to render an opinion in that regard you can.
A. I really do not want to render an opinion on that because it is a multiple question in one.
Q. Fair enough. Referring you I guess to the autopsy, I'm going to have to find it. You might want to look yourself.
The abscess that was found, the abdominal abscess at the time of autopsy, do you agree with me that that abscess grew out Candida?
A. I don't know they cultured Candida out, it

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

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

A. No, I have not.

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

A. I have seen that happen, yes.

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

A. It can.

Q. When people are on steroids?

A. Yes.

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

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

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

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

Q. Consistent with or indicative of either local

or systemic infection to clarify?

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

Q. We will start with consistent with.

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

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

A. No, I don't.

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

A. Right.

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

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

MISS KOLIS: No, I'm talking

postoperatively.

MR. GOLDWASSER: Postoperatively, sorry.

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

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

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

A. We could have done blood cultures I suppose.

Q. Are any blood cultures contained in this chart?

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

Q. Would you look.

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

Q. Subsequent to the 10th?

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

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

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

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

Q. When were the results of that available?

A. Probably on the 26th.

Q. Can you show me --

MR. GOLDWASSER: Says on the 21st.

A. Completed on the 21st, correct.

Q. What page are you looking at?

MR. GOLDWASSER: Page 50 of the lab studies.

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

Q. One drawn on the 20th, right?

A. Correct.

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

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

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

A. Right.
Q. Do you agree that ascites in the abdominal cavity could be related to infection?
A. Usually not in my practice at least.
Q. Once again, I probably asked it, maybe I didn't ask this question directly, the purpose of the consult by Dr. Bass, was it directly to evaluate the wound, was it for the overall picture of infection?
A. The reason for the consult was the fact that she was growing Candida in her urine, she had a wound culture which was also positive. It was not -- when a consultant is asked to see the patient, we do not restrict them **to** a specific point or specific thing. We ask them to see the patient, consult on the patient.

In this particular patient, the reason for asking Dr. Bass to see the patient was from looking at the chart, the fact she has positive cultures, that I as a general surgeon didn't want to -- needed some help with. Wanted his opinion on.
Q. So you didn't specifically ask him only to evaluate the positive culture from the wound?
A. That was the reason for asking him to see the

patient.

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

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

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

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

If we look at January 20th.

A. Correct.

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

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

Q. You're right. We will go back to this. On the 15th it's 26.12?
A. On the 16th it was 26.2.
Q. This is what I get for reading upside down. Looking back at the chart, to what did you attribute that rise in her white blood count?
A. I don't recall that particular white blood count.
Q. While she was in during this hospitalization she was undergoing a steroid tapering wasn't she?
A. She was given steroids. I don't know whether she was undergoing steroid tapering. I think it was much later in her course.
Q. You drew no conclusion what caused her white blood count six days or so postop to go that high?
A. I do not recall that particular white count six days postop. I would have --
Q. When she has this increase in the number, decreases a little, then goes back up to 20.36 on the 20th.
A. Okay.
Q. What was your concern at that point what was causing that white blood count number?
A. I was under the impression that the white

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

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

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

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

A. Correct.

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

(Discussion had off the record.)

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

BY MISS KOLIS:

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

MR. GOLDWASSER: Survive the perforation of her colon?

MISS KOLIS: Right.

MR. GOLDWASSER: You may answer.

A. She had a fair prognosis.

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

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

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

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

(Deposition concluded; signature not waived.)

ERRATA SHEET

NOTATION	PAGE/LINE

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

_____

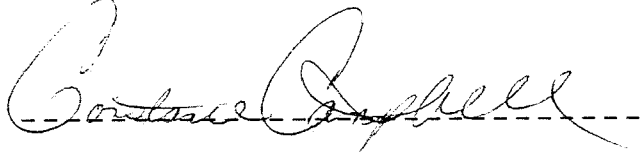
INDU SONPAL, M.D.

The State of Ohio,
County of Cuyahoga. CERTIFICATE:

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

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

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



Constance Campbell, Stenographic Reporter,
Notary Public/State of Ohio.
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

PHRASE **WORD** LIST(S):

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

COVER PAGES = 4

INCLUDES ONLY TEXT **0F:**
QUESTIONS
ANSWERS
COLLOQUY
PARENTHETICALS
EXHIBITS

DATES **ON**

INCLUDES PURE NUMBERS

POSSESSIVE FORMS **ON**

MAXIMUM TRACKED OCCURRENCE THRESHOLD: 50

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air [2]
17:24; 19:18
alert [2]
19:22; 37:21
amount [1]
31:24
amylase [2]

* * B * *

* * C * *

* * D * *

* * E * *

* M *

* N * *

* * Q * *

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* * X * *

* * Y * *

Indu M. Sonpal, M.B.B.S., F.A.C.S.,

Date of Birth	Feb.18 1944
Premedical Education	Elphinstone College. Bombay. India.
Medical Education	King Edward Memorial Hospital, Seth G.S. Medical School, University of Bombay. India
INTERNSHIP	King Edward Memorial Hospital, Jan.69 to Dec. 69 St. Margaret Memorial Hospital, Pittsburgh. Pa
RESIDENCY GENERAL SURGERY	ST. LUKES HOSPITAL, 11311 Shaker Blvd. Cleveland, Ohio 44104 July 1971 io June. 1975.
American Board of Surgery	Certified September. 1976 Recertified .October, 1987.
Fellowship	American College of Surgeons.
Present Staff Apppointments	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

SAINT LUKE'S
MEDICAL CENTER

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-vear-old Slack female with a past medical history of hypertension, asthma, ana questionabie 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 hyperosmoiar 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. Hearr: Irregular rate and rhythm. Abdomen: Grossly distended with a few hyperactive bowel sounds, wnich was tympanitic. 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 electiocaraiogram 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 expiorarory laparotomy ana a right hemicolectomy and ileostomy for a ruptured cecum x 2. Postoperativeiy, the patient remained intubated. A Pulmonary/ICU consult was obtained ana 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 oximerries 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
B

SIGNATURE OF HOUSE STAFF:

SIGNATURE OF VISITANT:

DISCHARGE SUMMARY

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, wnich 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 Generai 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.**
LNDUKUMAR M SONPAL, M.D.

SIGNATURE OF HOUSE STAFF:

SIGNATURE OF VISITANT:

Date

1/19/96 Afeb VSS
No c/o excepts wants her meds < Darvocet ? Theodur
On Aerosol / Prednisone
132	95	368
4.1	27	
WBC 18.64		
8.7	25.7	

Will c̄ pulmonary service re: Theodur
Darvocet reordered
Abdomen soft
Ileostomy functioning
Colon being cleansed out from below
Local care for wound
Sousay
Diet should be ADA diet ? Hyperglycemia 2° to steroids, [illegible] [illegible]
Add [illegible] heparin to BID. Sousay
ō physical therapy

1/19/96 Neurology

Paraplegia as before. C-spine MRI reviewed ~ no lesion seen. The scan goes down to ~T5. Suggest we obtain Thoracic & lumbar MRI scan 1/2 to r/o compressive lesions lower in spine (ordered on chart).
Alan [illegible]

000282

PLAINTIFF'S EXHIBIT
C
12-3-97

CAROLYN **YARBROUGH**

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

REFERENCE **RANGE 4 - 11.5**

DATE	TIME	RESULT
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

82366 P-550311
REED, MARY J 11-14-93
065Y 1-06-28 WAUGH, JAMES
WHEE

ROBINSON MEMORIAL HOSPITAL

PROGRESS RECORD

Date	Note progress of cases, complications, consultations, change in diagnosis, condition of discharge, instruction to patient
11/23/93	Renal
	(S) minimally responsive
	(O) Chest with rales in bases
	Heart S1 S2 and no murmur 135/52 | 43/25 65/28 80
	Abd recent removal ostomy
	with drainage from wound infection
	(A) Hemodynamically less stable on dialysis
	(P) Dialysis today tomorrow. possibly fri & sat
	[signature]
11-23-93 -	Hemodialysis:
	4.0 hr. tx completed, hypotension txd c 100 grms Albumin
	and Dopamine drip. Fluid balance = -5075cc. See flow
	sheet. J. Maynew RN ACAS @ RMH
11/29/93	CT scan reviewed appears to have relatively
16:00	large fluid collection in lesser sac just
	~~behind and~~ inferior & posterior to liver tube.
	Paracentesis performed fluid sent for
	stat gram stain will discuss c Dr. Cook
	concerning insertion of drain.
	Dr. Cook will drain this evening.
	C. [signature]

OVER

000266

087185