SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF SUFFOLK : PART 9

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PATRICIA SELVON, as Administratrix of the Estate of BONNIE SELVON, Deceased, and PATRICIA F. SELVON, Individually,

INDEX No. 7958/07

Plaintiffs,

-against-

CONTINUED JURY TRIAL

ROBERT N. PRICHEP, M.D. and BROOKHAVEN MEMORIAL HOSPITAL MEDICAL CENTER,

Defendants.

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TESTIMONY OF RALPH W. DeNATALE, M.D.

Friday, May 23, 2014
Suffolk Supreme Court
Riverhead, New York

B E F O R E: HONORABLE DANIEL MARTIN
Acting Supreme Court Justice

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THE CLERK: All rise. Part 9 of the Supreme Court, County of Suffolk, State of New York is now in session, the Honorable Daniel Martin presiding.

Good morning, Your Honor.

THE COURT: Good morning.

MR. RYAN: Good morning.

MS. HOWARD: Good morning.

THE COURT: Please be seated.

MR. FUCHSBERG: Good morning, Your Honor.

THE COURT: Good morning.

Everyone's ready to proceed.

MR. FUCHSBERG: Yes, Your Honor. I had just a couple of evidentiary questions. I showed Defense Counsel what's been identified as Exhibits 3, 4, 5 and 6 for demonstrative purposes and so I'm requesting, making an application to be able to use those Exhibits that have been marked for I.D. 3, 4, 5 and 6 for demonstrative purposes.

MR. RYAN: As long as the doctor identifies them and says yes, they're fair and accurate, that's fine. I would imagine he will, but.

MR. FUCHSBERG: Illustrative purposes.

MR. RYAN: Sure.

THE COURT: All right.

MR. FUCHSBERG: Secondly --

THE COURT: And what do you say?

MS. HOWARD: I say the same thing, Your Honor. I just want to put it on the record.

THE COURT: Okay.

MR. FUCHSBERG: I showed Defendants some of the lines from -- here they are. I wanted -- I was asking Defendants permission, as I am questioning the doctor, to use some pages from the record that we were discussing last week, but I actually have some of the lines highlighted. It would be easier for me to follow, maybe for the Jury to follow, and I believe I have a highlighted version in the computer and those were the same words that I had on that chart that I showed you that we decided not to use.

MR. RYAN: That's fine.

MR. FUCHSBERG: That's okay?

MS. HOWARD: I have no objection to that, but that will not go into evidence and will not going into the jury room because of the highlight. The original chart will be in there, but for purposes of his Direct Examination and Cross Examination, I have no objection to that, but I would object to it going into the jury room or being admitted into evidence.

THE COURT: Fine. The documents, or the pages you have in your hand aren't going to be shown to the Jury at all. That's just an aid to you, is that right?

MR. FUCHSBERG: No. That's my request, is to be

able to show them to the Jury for demonstrative purposes, but -- and I think that counsel's saying that he --

THE COURT: Don't go on. Just answer my questions. Don't interpret other people's comments to me. Okay.

I thought you said I have these documents, physical pieces of paper, and I also have them marked so that when it is projected on the screen, they will also be highlighted. Is that what you said to me?

MR. FUCHSBERG: That's what I said.

THE COURT: And the only thing that the Jury will see is what is projected on the wall highlighted?

MR. FUCHSBERG: Yes. They will see these actual pages.

THE COURT: Projected on the wall highlighted?

MR. FUCHSBERG: Correct.

THE COURT: The physical things in your hand will not be shown to the jurors.

MR. FUCHSBERG: No, but what's in the computer --

THE COURT: No buts are necessary. No answers the question. Thank you. Fine.

Then we have the record clear and yes. There's been no objection to it and the documents will not be marked and they will not be part of the record for purposes of the Jury having them available.

MR. FUCHSBERG: Thank you, Your Honor.

THE COURT: Okay.

COURT OFFICER: Jury entering.

(Whereupon, the Jury entered the courtroom.)

THE CLERK: You may be seated.

Does counsel waive reading the jury roll call?

MR. RYAN: Yes.

MR. FUCHSBERG: Yes.

MS. HOWARD: Yes.

THE COURT: Mr. Fuchsberg, do you have any evidence you wish to present?

MR. FUCHSBERG: I do, Your Honor. I'd like to call Dr. Ralph DeNatale to the witness stand.

COURT OFFICER: Doctor, just step up over here, please.

Right into this box, remain standing, face the clerk and raise your right hand.

R A L P H W. D e N A T A L E, after having been duly sworn by the Clerk of the Court, was examined and testified as follows:

THE CLERK: Be seated.

Please state your name, spelling your last name, and your address for the record.

THE WITNESS: Ralph W. De Natale. D-E space N-A-T-A-L-E. 11 Woodside Drive, Woodbridge, Connecticut.

THE CLERK: Thank you.

MR. FUCHSBERG: May I inquire, Your Honor?

THE COURT: Yes.

DIRECT EXAMINATION BY

MR. FUCHSBERG:

Q Good morning, everyone.

Sir, could you please tell us your occupation?

A I'm a vascular surgeon.

Q And could you please tell us, are you in practice at this time?

A I am in private practice in New Haven, Connecticut.

Q And for how long have you been a vascular surgeon?

A In private practice since 1986.

Q Before that?

A I was in training since 1979 and began medical school in 1973.

Q Where did you go to college?

A Fordham University.

Q Where did you go to medical school?

A University of Bologna in Italy.

Q And after medical school, what did you do?

A I did a general surgical residency for five years in New Haven, Connecticut and then following that two years of a vascular fellowship in Houston, Texas.

Q The five years of residency in New Haven, Connecticut, where was that?

A That was at Yale-New Haven Hospital Saint Raphael's Hospital.

Q And then you did two years of vascular fellowship?

A Yes. In Houston, Texas at Baylor.

Q And what did that involve?

A The two years of vascular fellowship involved the specialty of vascular and cardiac surgery and basically it involved all parts of the vascular tree including the heart, whether that be aneurysms, carotid surgeries, bypasses on hearts, bypasses on legs. Replacement of parts of the aorta. Operations for patients that required dialysis. Varicose vein surgery. Heart valve replacements. That's the gist of it.

Q What did you do after you finished that two year fellowship?

A I joined a group in New Haven, Connecticut, it's the same group I'm in now, and I specialized predominantly in non-cardiac vascular surgery since '86.

Q So what do you do by specializing in that practice?

A Again surgery on blood vessels now, excluding the heart and the brain, so again that includes all blood vessels in the chest, in the abdomen, legs, arms, neck and as well as venous surgery.

Q What do you do to maintain your training level?

A Well, initially you become board certified in general surgery and then following that I became board certified in

vascular surgery. That was in 1986 and again in 1990 and then every ten years following that you recertify in your specialty. I recertified once in general surgery although I do not do general surgery. And I recertified twice in vascular surgery. The most recent one being 2009.

You also have to maintain what is referred to as CME credits which means you have to go to a certain number of conferences each year, whether locally or nationally, you have to produce papers from time to time at Yale-New Haven and you're obligated to also be part of the training program for general surgeons and vascular fellows and occasionally give grand rounds, providing teaching conferences to medical students, things of that nature.

Q And you participated in those programs continuously since coming to New Haven after you finished your fellowship in Houston?

A Yes.

Q And what year did you say again that was?

A I completed my fellowship in 1986.

Q So it's fair to say you've been practicing continuously for close to 30 years?

A Yes.

Q In your practice as it now is?

A Correct.

Q And are you familiar with the standards of practice in

2004?

A Yes.

Q And did you review anything before coming to court -- before I go there, you published articles as well?

A Yes.

Q What kind of subjects have you published articles on?

A Well, within the field of vascular surgery. Most of the articles were accounts of -- well, publications related to aneurysm surgery. That was a -- that was a specialty within the fellowship program I was at in Houston. It was sort of the center for aneurysm surgery in the United States and most of the world at the time.

Q And what did you review before coming here to testify today?

A The medical records from the hospital.

Q And did you also look at Dr. Prichep's testimony yesterday?

A I did.

Q And have you also had numerous conversations with me?

A Yes.

Q And have you ever testified before?

A Yes.

Q Could you tell us a little bit about that?

A Approximately over the past 20 years or so I testified approximately five times as an expert witness and it was all

related to vascular surgical cases.

Q Are you being compensated for your time that you're spending on this case?

A Yes.

Q How are you being compensated?

A In preparation it was approximately $375 an hour and for today it will be $500 an hour.

Q Doctor, from now until we finish, until I finish asking you questions, I want you to assume that I'm asking you all questions to a reasonable degree of medical certainty. Okay?

A Yes.

Q What does that mean to you when I say all questions to a reasonable degree of medical certainty?

A Well, basically within the standard of care. In this case of 2004.

Q And I want you to also assume that the questions I'm asking you apply not only to 2004, but are in the context and applicable to Mr. Bonnie Selvon who underwent surgery that year.

A Yes.

Q In his opening to the Jury, Mr. Ryan said that pulmonary embolism is a very rare event in this type of surgery. Do you agree or disagree?

MR. RYAN: Objection, Your Honor.

THE COURT: Sustained.

Q What type of surgery did Mr. Selvon have?

A He had repair of a ruptured abdominal aortic aneurysm.

Q Do you have an opinion whether pulmonary embolism is a very rare event of this type of surgery?

A Rare would not be a word I would use. It would be -- it would be infrequent, but always out there in our minds.

Q What do you mean by always out there in our minds?

A Well, that we know that these patients, especially a patient like this one, has a long road of recovery ahead of him and that it is a real, real pathological event, a blood clot to the lung that can occur, and that it is something that we take special precautions to minimize and avoid, so that it's one of the risks of the operation, and for that matter most surgeries, so it is frequently in our minds in post-operative management.

Q Could you tell the Jury -- can I ask you this? I'm starting with some general questions. What does the management of a patient mean by the attending physician/surgeon postsurgery while the patient is still in the hospital?

A Well, management -- management is basically the care of the patient after the operation. Surgeon did the surgery, but is also responsible for the daily care of that patient and the writing of orders and the management of any particular problem that may arise during that post-operative care.

In point of fact, you're sort of responsible for the patient long after that and even after discharge from the hospital where you -- you are vigilant in seeing the patient on

a daily basis while in the hospital, making sure that the proper orders and care are provided to the patient whether that be related to medications or whether it be controlling of the machines that the patient are hooked up to or whether that means calling in necessary consultants with expertise that you may not have to help you care for this patient.

Q What are -- what are the risks factors, if any, that Mr. Selvon had for DVT and can we be particular as to dates and times?

A Well, for one --

Q Now assuming the operation was on October 16, between then and when he passed away I believe in the morning of November 2.

A For one, he had a very major operation. Bigger than most operations that we do or for that matter any surgeon does. He had a ruptured aneurysm which is a very, very morbid, a very risky operation. There's no choice, the patient has no chance of survival without surgery, but it is an enormous operation, much akin to heart surgery of any kind. And that is one risk factor.

The length of the operation, it also plays a role.

Also as far as the fact that he required multiple transfusions which is expected with this type of surgery.

The other risk factors would be his age. He was greater than 60 years of age and that's risk factor.

And most importantly, of course is inactivity level while recovering in the post-operative period. He was a patient who, who was not very mobile. He was fairly weak. Was not up and about. Was not able to participate in physical therapy in the recovery period. Sometimes he refused to participate, so that in itself is a high risk factor. Your inability to really ambulate normally, walk normally and to be active. He was in bed a lot. He was sitting in the chair for long periods of time and those are all risk factors for developing blood clots in your leg.

Q I want you to assume that the nurses notes indicate that he is out of bed to chair and that also that he has bathroom privileges. How, if at all, does that affect the issue of mobility?

A Well, that's, that's a positive thing, however, we know from the medical records that getting out of bed to chair and then walking to a bathroom is not adequate in terms of rehabilitation or mobilization. Often times these patients sit for prolonged periods of time in a chair. That means he's out of bed, but sometimes sitting in a chair for long periods of time can actually be worse than anything else. It's just as bad as being totally immobilized.

In point of fact, it would probably be better just to be flat in bed with your legs elevated. It's actually dangerous to be sitting for prolonged periods of time which he did.

Getting up to a bathroom is fine, but it's not like walking outside into the nursing station or walking around the nursing station. That's what you strive to achieve. So he, although he was out of bed and getting -- and given bathroom privileges, he was not terribly active.

Q As of October 25, 2004, what was Mr. Selvon's risk of bleeding?

A That was, that was a ways out from surgery at that point so that --

Q And I just want to point out that October 25 -- I'm sorry to interrupt you -- is the date of the first pulmonologist note.

A Right. That is approximately eight or nine days post-operatively and at that point he was fairly stable in that regard. I would have anticipated that the risk of bleeding at that point would be very low.

Q Could you further explain your answer?

A Yes. So that if you needed to do certain things or provide certain medications or do certain tests, it would not be contraindicated. There would not -- you would not be putting this patient at increased risk of bleeding at this point. He was fairly stable now. Although he was not recovered from his surgery from a bleeding standpoint, which you worry about with this type of surgery, he was well beyond the point where that would be a strong consideration.

Q And why is that? Why do you call his risk of bleeding low?

A Well, he's now recovered from surgery. We know that his blood count has stabilized. His laboratory tests that check his blood clotting mechanism were normal. He had no evidence of requiring further -- no evidence of further bleeding. He was not requiring further transfusions. He was not requiring any type of blood products to correct his clotting mechanism. His incisions were not bleeding. He was not bleeding from anyplace else and so at this point he was sort of on autopilot as one could say.

Q What is the significance of having a consultation with other physicians in the care and treatment of the patient and in your management of the patient?

A Well, oftentimes, as I said earlier, you need some additional expertise that as a surgeon you may not have so that in this particular patient there was some issues with, with his heart, with his kidneys and with his lungs. And although as surgeons we have a working knowledge of certain things related to those organ systems, we sometimes require additional help.

So he was on the ventilator which was a breathing machine for awhile which is normal following this type of surgery, but Dr. Prichep needed some additional expertise as far as this patient's lungs were concerned. So he did call in a pulmonologist to help with the management of any lung problems.

He also brought in consults in renal and cardiology.

Q And if the pulmonologist writes a note, what responsibility does the managing attending physician have to review that note?

A Well, most importantly you need to read the note and then follow the recommendations of the consultant again because you need assistance, you're looking for additional help, and so when they make a recommendation, I think you should strongly consider those recommendations since, again, it's in an area that you don't have expertise in.

Q I want you to assume that the pulmonologist made two recommendations, the last line of her note on the 25th and the last note of the line on the 26th. The last note on the line on the 25th said -- maybe I should quote it exactly. Rye assess --

It says the last two lines are continue PCM's. What are PCM's?

A Those are those pneumatic compression --

Q I think it's PCB's.

A PCB's --

Q Or PCM's. I can't tell whether it's an M or a P.

A It's probably the pneumatic compression devices on the legs that we will often use to minimize the risk of deep venous thrombosis or blood clots in the leg.

Q So she wrote that and then her next line was reassess if able to use Lovenox?

A Yes. Again, that's, that's medication that we will often use in patients in the post-operative period to minimize the formation of blood clots in the legs and also therefore minimize those bloods clots from traveling to the lung so that it is a medication that is considered a blood thinner that is commonly used and was commonly used in 2004 and she was recommending its use at this point.

A pulmonologist does see a lot of patients and help in the management of many patients that develop blood clots to the lung and she was concerned over the fact that this patient was not being --

MR. RYAN: Objection, Your Honor, as to she is concerned. That's operation of her mind.

THE COURT: I will sustain the objection with respect to that testimony.

Q What are the considerations if one is having pneumatic compression boots --

A Right.

Q -- what would be the considerations of reassessing if able to use Lovenox as well?

A Well, that there are additional modalities we can offer this patient that would be better for the patient in terms of minimizing the risk of blood clots in the legs and therefore pulmonary embolism. She felt that that was not enough. They were not doing enough at that point.

Q So, doctor, I want you to assume that the testimony has been that at that time period, that a vascular surgeon would be using -- if they were to use a blood thinner and not necessarily with this patient, but that they would be using subacute (sic) heparin as opposed to Lovenox. Did you read that testimony by Dr. Prichep?

A Yes.

Q Could you comment on that?

A Well, I mean they were both being used in 2004. It depended on the comfort level of the surgeon for that matter or the medical doctors involved with the case, but sub Q heparin was being used in the post-operative period in 2004 as was Lovenox. Lovenox is a newer medication that was a little bit better, little bit easier to control than the sub Q heparin, so in 2004, it was replacing the use of sub Q heparin, but both medications are quite good. Both medications were being used to prevent blood clotting in the post-operative period.

Q I want you to assume that Dr. Prichep testified that Lovenox was more difficult to monitor and to control. Do you agree or disagree?

A I disagree. Actually Lovenox does not have -- is a little bit better in the sense that you have a set dosage that you can use based on the patient's weight. I don't necessarily have to -- you don't have to follow blood tests at all. It is something that causes fewer side effects than sub Q heparin does

and it is -- although not totally reversible, is partially reversible and actually carries the same low risk of bleeding complications as sub Q heparin does.

Q Are they both called anticoagulants?

A Yes.

Q They're both called pharmaceutical anticoagulants?

A Yes.

Q And if Dr. Prichep was more comfortable use being subacute (sic) heparin or more familiar with it in 2004, would it have been acceptable to reassess that patient for using that anticoagulant on that date that the pulmonologist wrote that note?

A Using, using sub -- sub Q means subcutaneous, so that's just the way you inject or deliver the medication, but no, using sub Q heparin would have been acceptable as would have Lovenox.

Q And are there dosages that are given for long term therapeutic purposes to prevent DVT's that might be different than are given during an operation when using heparin?

A Yes.

Q Can you explain that?

A Well, during the operation, again it's surgeon's preference, but heparin is given IV to a patient and was given to this patient during the surgery and it was reversed at the end of the case by the surgeon and that's where it ended. There was not -- heparin was not given to this patient following that.

Q And then the common dosage that you give to heparin for prophylaxis, for DVT prophylaxis, is that the same or --

A It -- with sub Q heparin it's not so accurate. It can be given two or three times a day, but it's not necessarily based on weight. So that there's not -- there is not as much variation when using Lovenox. There's more of a standard dosage that most of us would use so there's a little more science to it.

Q Was there a standard dosage for DVT prophylaxis for using subcutaneous heparin in 2004?

A Yes.

Q And in your opinion, to a reasonable degree of medical certainty, were there risk factors with this patient that would counter using that medication in 2004?

A There would be. You would consider it early on in the process of -- in the post-operative period, but once you reach a certain point of stability where you know, where you know the patient is no longer bleeding, and you know that by examining the patient on a daily basis, by checking the blood count of the patient, by seeing if the patient required any additional transfusions, you sort of know at a certain period of time in the post-operative period when the patient is stable in that regard so that that is normally you're window of opportunity where you can, you can give this medication.

Q If you are making a reassessment of a patient for DVT

prophylaxis following the pulmonologist's recommendation to consider this, what would you expect the managing physician to do --

A Well, I think.

Q -- according to standard of care?

A Yes. If you've called in a consult, then you do value their opinion. It doesn't necessarily you have to agree with their opinion, but their opinion is based on, on their specialty, on their science so that if a consultant recommends something and he or she may -- and a surgeon may disagree with it, well then I think you at least need to address that in some fashion in the note in the chart indicating that appreciate, appreciate the recommendation, however I feel that this is too dangerous to use or contraindicated to use or unsafe to use so we're not going to use it. You should at least comment on that, I think, and give a reason why. I mean it's important to document that.

Q And is it -- could you tell us, is it in accordance with standard of care for doctors to document their findings, their conclusions, their assessments?

A Yes.

Q And why is that?

A Well, it's important not only for the medical record, but you also have other, other people involved with the care of this patient when you're not there, so it's sort of an outline

to help people in the management of this patient whether it be nurses, whether it be physicians, whether it be other consultants. Everyone that's involved with the care of the patient has access to this chart and is able to know what's in the mind of the surgeon and what's expected.

Q And based on that note, if you -- in accordance with standard of care, do you have an opinion to a reasonable degree of medical certainty, if the patient had been assessed for anti-coagulation therapy at that time, what, in your opinion, should the doctor have done?

A Well, at that point, at that point the patient was stable enough to have some type of heparin for prophylaxis whether it be sub Q heparin or Lovenox. At that point it would be safe to provide that to the patient especially in light of the fact that he had a significant risk here of developing blood clotting.

Q Do you agree or disagree with the following statement from page 79 of Dr. Prichep's testimony in trial.

"He was already on DVT prophylaxis, standard of care. In the years that I've been doing vascular surgery, we haven't given any anticoagulation because of the risk of post-op bleeding in these patients, so he was already on mechanical prophylaxis and he's been out of bed so he's been treated."

Do you have any comment?

A I don't --

MR. RYAN: Objection to the form. Any comment?

Q Do you agree --

THE COURT: The objection is sustained.

Go ahead, sir.

Q Do you agree or disagree with that?

A I disagree.

Q And why?

A It's, it's -- in 2004 it wasn't enough. I mean we had the science, we had the knowledge to know that the addition of sub Q heparin or Lovenox was far superior than just the elastic support stocking or the pneumatic compression devices. Far superior. So that that was a statement that, that the doctor made that would hold true maybe in the early '80's, but -- throughout the '80's, but not, not 2004. We knew at that point that it was important to supplement the pneumatic compression devices with heparin.

Q Why did we know that?

A Well, based on studies, pulmonary emboli, deep venous thrombosis was very well-known by most surgeons. It was -- we do know that it is a major cause of death in the post-operative period in all surgical patients, that there are many studies that were done through the years that have shown that sub Q heparin, Lovenox can minimize not only deep vein thrombosis or pulmonary embolism, but also minimize and, uh, fatal pulmonary

embolism, we knew that. It was science. It was done, done with studies, done on many patients.

Q I'd like to read you these questions and answers from page 159 of Dr. Prichep's testimony, line six.

"Question: All right, doctor. Bearing your experience from the days of vascular fellowship up to the point of 2004, prior to seeing Mr. Selvon, have you ever had a patient develop a pulmonary embolism? When I say a patient, I'm talking about a patient with a ruptured abdominal aortic aneurysm?"

It's a question from Mr. Ryan.

"Answer: No.

"Question: Did you ever have a patient develop a deep vein thrombosis?

"Answer: No."

Do you have an opinion about those answers to those questions?

MR. RYAN: Objection, Your Honor. That was his experience. Maybe he's got a different experience than the doctor.

THE COURT: Step up here.

(At which time there was a side-bar discussion held off the record.)

MR. FUCHSBERG: I'm going to withdraw the question based on the objection and ask this question.

Q What has been your experience with patients developing deep vein thrombosis?

A In general?

Q Yes, as a vascular surgeon.

MR. RYAN: Objection. I think it should be limited to this type particular of procedure, not general, because that was the testimony the doctor gave.

Q Limited to this kind of procedure.

A This specific patient? This patient?

Q No. This kind of procedure.

THE COURT: This type of surgical procedure.

A Okay. Well, it is something that we know happens. It may not happen as often in this particular patient as in certain other types of surgical patients, but it happens, so our surgeons, we're aware of it. When it does happen, we can't say we are necessarily surprised about it because we're aware it can occur. And if you've been in practice long enough, it happens.

MR. RYAN: Objection, Your Honor. Move to strike. I think he was asking for his experience.

THE COURT: The objection is sustained. The answer is unresponsive. Ladies and gentlemen, you're not to consider it.

I believe the question meant to secure an answer with respect to whether you've ever had an experience in that. Go ahead.

Q What is the general knowledge out there in 2004 with respect to the risk of pulmonary embolism following the repair of a ruptured abdominal aortic aneurysm?

MR. RYAN: Objection, Your Honor. He was asked the question. It was unresponsive. I think he should answer the question as posed unless it's withdrawn.

THE COURT: Do you understand that, sir?

MR. FUCHSBERG: I'm not show sure I understand --

THE COURT: You asked him what was his experience. He didn't answer that question. Unless you withdraw that question, he should answer it.

MR. FUCHSBERG: No, I don't withdraw that question.

THE COURT: We'll go back.

Q What was your experience?

A Yes, I've had this happen to my patients, yes.

Q And what is the general knowledge out there about that?

A That it can happen and it does happen and that sometimes when you look at something with my own personal experience, the numbers may not be great, but when you include everyone's experience that does the same operation, the numbers add up so that it's, it's real. It's not infrequent. There can be thousands of cases in a year across the country so that the number's not infrequent when you really take everyone into consideration.

Q What is the significance of that?

A Well, that it's, it's real, it's not as uncommon as we think and that it behooves one to pay attention to that and to treat those patients accordingly to try to minimize that. It's one of those entities that are -- actually the blood clot to the lung, it's one of those entities that the commonly the most common preventable cause of death of a hospital back then, in 2004, as it is now.

Q I'd like to read from page 148 to 149 of Dr. Prichep's testimony. Page 148 line four.

"Question: What reassessment of the patient did you do at that time to consider whether he may have be developing a DVT."

And it's in the context of the 29th. Let me read above. Page 147, line 25.

"Question: Did the patient become less comfortable, start having more pains in the legs, start becoming uncooperative as we get closer to the 1st?

"Answer: According to the notes, yes.

"Question: What reassessment of the patient did you do at that time to consider whether he may have, be developing a DVT?

"Answer: Well, he was showing some signs of some other things than being focused on a DVT.

"Question: He was showing a potential gall bladder problem, right?

"Answer: A gall bladder problem. Could have had a little colitis.

"Question: But we got the ultrasound so the covering doctor tried something and took an ultrasound of the abdomen, right?

"Answer: Correct.

"And what did you tell us earlier when we went over that report?

"Answer: That he just had sludge in the bladder, that that was not the issue.

"Question: That was not the issue?

"Answer: Correct.

"Question: So we have an issue?

"Answer: An issue. He started nausea and diarrhea. That was the issue.

"Question: He had an issue that he was refusing to go to physical therapy?

"Answer: That was part of it because he was tired and weak.

"Question: So you had an issue, the covering doctor thought maybe gall bladder, that was not the issue, correct?

"Answer: Correct.

"Question: What else did you do? Do you know what the term differential diagnosis means?

"Answer: Yeah, I think so."

I'm going to stop there.

Have you had a chance to look at the record closely?

A Yes.

Q For all those days?

A Yes.

Q Do have an opinion within a reasonable degree of medical certainty whether that Dr. Prichep acted in accordance with the standard of care concerning DVT prophylaxis during that period of time?

A No.

Q No what?

A He did not, he did not follow the standard of care at that point. In fact this patient was clearly having issues and it seems like the evaluation of those issues stopped. I mean they didn't pursue other sources, other causes, other problems. Why was the patient feeling this way? There could have been other tests done, other investigations done. He was just not progressing at this point as nicely as you would have hoped.

Q By given that he had medical problems, why if at all -- how if at all does that interrelate with the issue of DVT prophylaxis?

A Well, I mean, as I indicated, at this stage of his convalescence he was fairly stable as far as his bleeding was concerned. He was not bleeding. Of course the biggest concern

one has in the post-operative period is bleeding especially if you're going to use a blood thinner which has the potential of causing bleeding, so you obviously can't give that if the patient is actively bleeding. This patient was not actively bleeding.

But this patient also had a myriad of complaints, not all identified. It was unclear why the patient was having problems. You can say that the patient was just recovering, that he went through a tremendous trauma, and that's the easy thing to say. There's no consequence of saying that, but there is a consequence to not investigating further on why the patient is this way. If it is due to patient's just tired and weak and recovering, then there's -- then time will cure this, but if there's something else going on, then you've missed it. You've lost your window of opportunity to treat it and correct it and then when it really hits the fan, then there's nothing you can do.

Q I want you to assume that on 10/29 that Dr. Prichep ordered some tests. Did you look at those orders?

A Yes.

Q What did he order?

A I believe that was the time he ordered the blood cultures, the C dif, some other blood tests and such, that type -- I think that's what you're referring to?

Q Yes.

A Yes. I remember that.

Q Why did he order those things?

A Well, the patient did have some diarrhea, so he was interested in making sure the patient did not have an antibiotic related colon problem. He had ordered some blood cultures because the patient did have a fever and an elevated white count at that time.

A white count indicates -- an elevated white count indicates the patient may have some underlying infection and so an effort was being made to try to determine the reason why the white count was high and why the patient had a fever and why the patient had diarrhea.

Q And then over the weekend did the covering physician do anything?

A There was some blood tests ordered by Dr. Prichep. I believe liver function test had came back abnormal. And the covering physician had ordered an ultrasound to look at the gall bladder to make sure that there was not some problem with the patient's gall bladder which can be a problem following any major operation, especially this one, so an effort was being made at least to try to rule things out.

So that was one test that was done to rule out acute call gall bladder disease. And that came back, I think they mentioned earlier, that the patient had sludge in their gall bladder, so they ruled out an inflammation of the gall bladder,

but it ended there. It stopped there.

Q So on 11/1, on 11/1, the first note on the page says at 10:00 A.M. says, safety maintained, weak, refused to go to physical therapy. That was a nursing note at 10:00 A.M.

And then follows a note from Dr. Prichep and it says, feel tired and weak, voiding spontaneously, afebrile, vital signs stable, abdomen benign, extremities pink and warm, creatinine 2.6, physical therapy and supportive.

MR. RYAN: Your Honor, objection. Can we approach?

THE COURT: Yes.

(At which time there was a side-bar discussion held off the record.)

THE COURT: Objection's overruled.

Q Do you have an opinion with a reasonable degree of -- and I want you to assume that no orders were made on November 1. Do you have an opinion -- by Dr. Prichep.

Do you have an opinion with a reasonable degree of medical certainty whether that note by Dr. Prichep reflects care within accordance with the standard of care for this patient at that time by the attending managing physician?

A Well, it's sort of a nondescript note, sort of a generic note in the sense that patient was having issues, but the issues really weren't identified. He never found out why the patient had a fever or why the patient had an elevated white count or if there was any other problem going on. You know, did

the patient have a pneumonia, did the patient have a urinary tract infection, did the patient have something else going on. I mean it needed to -- the evaluation needed to continue and the way to do that is to look for things and to indicate that in your notes, to ask the consultant to help out. There were a number of consultants involved on the case, so it was really not a helpful note in that sense. You would like someone to take the next step and to continue the investigation and try to find out why this patient just isn't progressing as you would like.

THE COURT: Just one second. Step outside, please.

(At which time there was a side-bar discussion held off the record in chambers.)

COURT OFFICER: Remain seated, come to order.

THE COURT: Go right ahead, sir.

Q Do you have an opinion within a reasonable degree of medical certainty what impact on this patient it had not to order an anticoagulant, whether it's Lovenox or the heparin we've been talking about, 25th, 26th, 27th, 28th?

A Well, it certainly increased the risk of this patient developing a deep venous thrombosis and a pulmonary embolism substantially.

Q When say substantially, can you tell us what we mean, what we know about that subject as opposed to just using compression boots?

A Well, we know the difference, the difference between

not using heparin and using heparin is real. We know that it's much far superior than just using compression boots alone. We know that it was not the standard of care back in 2004 because studies have shown that you can actually reduce the risk of fatal pulmonary embolism significantly with the addition of heparin. And we know that depending on how closely and you investigate these patients, that significant number of these patients, some studies even as high as 18 percent might show that this patient has blood clots in their legs.

MR. RYAN: Judge, I'm objecting to studies.

THE COURT: Sustained.

Ladies and gentlemen, the testimony with respect to studies that have been conducted is stricken and you are not to consider it.

Go ahead, sir, with your answer, if you were not done.

THE WITNESS: You can ask -- please ask another?

Q What's greenfield filter?

A Greenfield filter's a device that we will use. It's an implantable device that we actually place in the main, main vein in the patient's abdomen. It's the vein that drains blood from both legs and it's actually almost like an umbrella. It is an umbrella, but it has, it's sort of a screen that allows blood to pass through it, but it does not allow major blood clots to pass through. So it's sort of a protective device that is

implantable. It's a small procedure we do. It's not, not a major operation and it is a protective mechanism to keep blood clots from traveling to the patient's lungs. It's oftentimes used in patients that have deep venous thrombosis, blood clots in the leg, but for whatever reason we're unable to treat that with blood thinners, whether the patient is actively bleeding at the time or has some condition where the patient is losing blood and the patient also has blood clots in their legs and we can't put them on a blood thinner, which is the standard of care, so in light of that we will put a greenfield filter in place.

And then there are also patients that fail the use of blood thinners and the blood thinners don't work and they have blood clots in their legs and we have to put a filter in in those patients. Again, unable to treat the blood clots properly, so again it's a preventative mechanism to keep blood clots from traveling to the lung, so it traps the blood clots.

Q What is the practice of the use of ultrasound, Doppler ultrasound --

A It's --

Q -- in 2004?

A It's a non-invasive modality that we use, radiologists will use. We will order that, the test. It's a test that most of us are familiar with whether it's an ultrasound during pregnancy, whether it's an ultrasound to look at a gall bladder, whether it's an ultrasound look at blood vessels. An ultrasound

is a big part of what vascular surgeons actually rely upon.

In this particular patient, of course, an ultrasound was considered in the gall bladder and could have been considered to look for blood clots in other parts of the body. It's used often to look at blood clots in the leg. It's a great test for that. It's not invasive. It's a quick test. It's very accurate. It does not hurt the patient, it causes no harm and it gives us a lot of good, important information.

Q Did Mr. Selvon have the classic symptoms of a DVT?

A He had a myriad of symptoms, so no. There were not classic symptoms here, but again unless you're thinking of it and looking for it. Sometimes you don't have classical symptoms. In fact many patients do not have classical symptoms of deep venous thrombosis, so it's oftentimes something you must keep in the back of your mind and be attentive to and think of it. But again, many patients just don't have those classical symptoms.

Q If he had pain in the legs, what importance, if any, does that have?

A Well, pain in the leg is one of the symptoms of DVT. Certainly a week out from surgery, pain in the legs you have to consider a number of etiologies or a number of reasons why is there pain. It sometimes requires a physical exam coupled with some testing whether it be a blood testing or X ray testing or an ultrasound exam, but you have to try to figure out why this

patient is having pain.

So one of the things you look for in the post-operative patient, much like this that has not been terribly active, sort of immobilized, is that you must look for a deep venous thrombosis. If you do an ultrasound, it's easy to do, and it's negative, at least you've ruled that out and you could look for other sources of pain, but what you want to try to do always is to rule out the most life threatening, the most harmful of pathologies or problems and then work your way back.

Q I want you to assume that Dr. Prichep testified in sum and substance that it was not justified for him to order a such an examination of Mr. Selvon. Do you agree or disagree?

A Yeah, in general, that is correct statement. I mean you don't want to just order a test without a good reason, but sometimes when you're not entirely clear on what's going on, sometimes certain tests are helpful to you. You certainly would be hesitant to order a test that was invasive, that would hurt the patient in some fashion or carry a risk with doing the tests. You certainty wouldn't want to be blasé about ordering a test like that unless you had good reason to, but an ultrasound again is a non-invasive test, quick to do, easy to do and gives you a lot of great information and can rule out life threatening issues such as his.

Q Do you have an opinion with a reasonable degree of medical certainty whether one should have been ordered for

Mr. Selvon?

A In this particular patient, yes.

Q Why?

A The risk factors involved, the fact that you don't always have classical signs of deep venous thrombosis, and he was a set up. This patient was a set up for the development of deep venous thrombosis, so I would have ordered it.

Q Why was he a set up?

A Basically a major operation in the post-operative period, not active, not really ambulating normally, sitting in a chair for long periods of time, not following through with physical therapy and it's real. It happens. We see it if it occurs.

MR. FUCHSBERG: I'd like to -- may I go to the computer and turn it on?

THE COURT: Yes, you may.

MR. FUCHSBERG: Well let me get that -- there's something -- okay. I got what I wanted. Okay.

Q Let's start with 10/24. There's a --

THE COURT: Mr. Fuchsberg, how much more examination do you have?

MR. FUCHSBERG: About 40 minutes, 30 minutes.

THE COURT: We'll take a break then.

MR. FUCHSBERG: Okay.

THE COURT: We'll retire the Jury, please.

COURT OFFICER: Follow me, please.

(Whereupon, the Jury exited the courtroom.)

MR. FUCHSBERG: Thank you.

THE COURT: We'll see everyone in five minutes.

(At which time there was a pause in the proceedings.)

COURT OFFICER: Remain seated, come to order, please.

THE COURT: We'll bring in the Jury.

COURT OFFICER: Jury entering.

(Whereupon, the Jury entered the courtroom.)

THE CLERK: You may be seated.

Does counsel waive reading the jury roll call?

MR. RYAN: Yes.

MS. HOWARD: Yes.

MR. FUCHSBERG: Yes.

THE CLERK: Doctor, please be reminded that you remain under oath.

THE WITNESS: Yes.

Q Doctor, if you'll forgive for me, and I think with the Court's permission, I'm going to be sitting here a little bit so I can control the computer while I'm asking you questions.

This is the same chart that the Jury was looking at yesterday, but I've got some notes highlighted in it, with the Court's permission.

So we're looking at a physical therapist note on 10/24 and what I highlighted is, it says, patient reporting numbness right thigh and pain in something thigh. In left thigh. What, if anything, does that mean?

A Sort of nondescript, but probably related -- probably related to the groin incisions.

Q A little further down it says patient complains of dizziness, increased complaints of dizziness. Does that mean anything?

A Not necessarily. I mean a patient that has not been terribly mobile and in bed a lot and sitting, probably the change in position might have brought that on, so nothing too concerning.

Q So now we have a note on 10/25. It says lower extremity weakness noted, positive pedal pulses. Felt warm. Felt warm -- I'm not sure what the -- mobile bilateral.

THE COURT: That's your interpretation of it, sir?

MR. FUCHSBERG: That's my -- I can't read the last word. That's my interpretation of it.

THE COURT: Here's what we should do. We should have some medical, professional interpretation of it.

MR. FUCHSBERG: Okay. I apologize.

THE COURT: What does that say to you, doctor?

THE WITNESS: I can make out lower extremity weakness. DP pulse, I think. Felt warm. Can't make out

the rest, actually, but lower extremity weakness is in -- what the nurse is doing there is making sure that the weakness is not related to poor circulation. Trying to find out why, why the patient has weaknesses.

Q And then on 10/25, this is the pulmonologist note that we were talking about earlier?

A Yes.

Q Correct?

And then this is a note the next day at 4:45 in the morning. Can you read it, doctor?

A Patient with complaints of thigh pain at 8:30 P.M. Let's see. It's about -- can make out some words. Ordered without -- can't make out much more than that. Morphine administered at 10:30.

Q I'm just looking for the page number so maybe I can give him the page.

MR. RYAN: Judge, maybe we can have the doctor read it right there from the original chart. Might be easier.

THE WITNESS: Sure. Patient complaints of pain.

COURT OFFICER: Counsel, do you know which one? It's here?

MR. FUCHSBERG: Yes. If you can give that to the doctor.

And thank you, Mr. Ryan.

COURT OFFICER: Plaintiff's 2 shown to the witness.

A Thank you. 10/26/04. I think I'm going to need a little help folks. Oh, here we go. Okay.

The middle highlighted area, patient complaining of pain in knee at this time. That nobody, nobody -- states nobody is helping me. I've been ignored.

That's the center highlighted section.

At the top, patient with complaints of thigh pain at 8:30 P.M. Darvocet administered and ordered without effect. At 9:30 P.M., morphine three milligrams IV push administered as ordered.

Q What, if anything, did those notes mean to you? I want you to assume that the next note on that page is written by Dr. Prichep.

A Okay. The interpretation of this note to me would be that the patient's having an awful lot of pain to require three milligrams IV push of morphine plus Darvocet, so he's in a lot of pain. That's my interpretation of that. So we have to find out why.

Q How, if at all, does that -- how, if at all -- can you tell us what a differential diagnosis is?

A Sure. You have a problem. You identify a complaint. Let's say patient has a complaint. So you have to determine what can cause that. So the patient has pain in the leg. So try to figure it out. Is the pain due to lack of circulation, from the arteries, is it due to just deconditioning meaning the

patient has been at bedrest for so long or not very active and just has inability to move and he's experiencing a lot of muscle cramps. Is it, is it something in the venous system. Is it a deep venous thrombosis. Is it something related to his back.

I mean you have to go through a step-wise process. In other words you come up with possible reasons why the patient is having pain and then each one you try to rule out in some fashion whether it's by physical exam or whether it's by a test. Sometimes by just prescribing narcotics you can sometimes mask certain things. Makes the patient feel better, but sort of hides or masks an underlying problem. Patient should not be in pain post-operatively at this stage anyway, this far down the line, so.

THE COURT: Is the question what is a differential diagnosis?

THE WITNESS: Yes.

THE COURT: Have we gone beyond that at this point?

MR. FUCHSBERG: Thank you, doctor.

Thank you, Your Honor.

THE COURT: Okay.

Q Now, when a doctor comes and looks at the chart, you see the pulmonologist note is actually on the page before, how far back, and according to the standard of care, is a doctor supposed to look when he comes and sees the patient on the 26th? I mean would it be within the standard to go back to a note from

the pulmonologist on 10/25?

A Yes. Yeah, you review -- you review all the notes that have come after your last note.

Q And then again we have the pulmonologist note on 10/26. Can we assume that the -- withdrawn.

Would it be, according to good and accepted practice, for the pulmonologist to review the notes that have preceded her last note?

A Yes.

Q And she wrote consider DVT prophylaxis?

A Yes.

Q Does DVT prophylaxis mean -- what does that mean?

A Well, again --

Q According to just common understanding of that term back in 2004.

A DVT prophylaxis in 2004 means intermittent compression boots and heparin.

Q Not DVT compression boots or heparin?

A And. And heparin.

Q Why "and" and not "or"?

A Well, it's like a belt with suspenders so to speak. You know. You're covering all bases. If you're asking me personally if one's better than the other? Yes. Heparin is.

THE COURT: You shouldn't give us your personal opinion, doctor. It should be an opinion that's generally

accepted by the medical community and --

THE WITNESS: Sure.

THE COURT: -- that's somewhat unresponsive to the question. Can we move on, sir?

Q What was the understanding in 2004 in the medical community?

A Both.

Q And 10/27, patient complaint of slight breathing difficulty, venti-mask times five minutes applied; does that mean anything to you?

THE COURT: Step up here for a second. Step outside.

(At which time there was a side-bar discussion held off the record in chambers.)

COURT OFFICER: Remain seated, come to order.

THE COURT: Would you read the last question back, please?

(Record read as requested.)

A Yes. Little bit unusual this far out to be having respiratory difficulties, so they went from a more concentrated amount of oxygen to help the patient, so that would not be -- that would be a little unusual at this point.

Q And if we go to 10/27? There's a note there.

A Right knee pain with ambulation. Patient refusing further treatment. Complaining of nausea. Refusing further

treatment. Let me see. Gait slow, unsteady.

Let me get it here on the chart. Unsteady with decreased endurance.

Q What, if anything, does that mean to you?

A The knee pain again is nondescript. A lot of patients, when they refer knee pain, it can be anywhere. Could be behind the knee, in front of the knee. You have to sort of question the patient further concerning that.

Again, another episode of leg pain regardless in this stage of his recovery, which wouldn't be usual. As far as the endurance is concerned, you wouldn't expect this patient to be able to run a marathon, but you certainly would expect him to be walking around the nursing station at this point. So that's unusual.

Q What, how, what if at all would be in terms of significance to you as an attending physician and the issues that we're discussing in this case?

A Well again, you have figure out why, so the easiest thing to figure out right now is to just look at his legs with an ultrasound. I mean that's something you have to rule out. You have to rule out a clot in his leg.

Q And on the next page, 10/27?

A Patient appears fatigued. Can't make it all out. Complaints of difficult with sleeping I think that says. Sorry I can't do better at that.

Q Okay. I want to go back to that other one, mobility?
A Yes.
Q It says out of bed to chair?
A Yes. Patient appears fatigued. I see that.
Q Does that resolve the issue of mobility in your opinion?
A No. I mean, we know the patient's fatigued. I still think the inability to get around and to -- and the complaints of leg pain still have to be investigated. You have to figure out why. This is a great time to do an ultrasound.
Q Does the restlessness mean anything or could be anything?
A Well, the restlessness coupled with the fact that the patient had increased oxygen requirements would have a significance and you have to start wondering now why that's the case. So again, in the differential diagnosis, is the patient having trouble breathing because the patient has a touch of congestive heart failure. I'm going to a differential here. Has the patient had a pulmonary embolism. Again, those are things, as part of a differential diagnosis, you would follow through to figure out why. And again, this patient's a set up for that.
Q Then we get to the next note. Says comfort. I'm sorry. I shouldn't be reading it. The top of October 27. The next page.

A All right.

THE COURT: Not absolutely sure that's the next note.

MR. FUCHSBERG: I'm not absolutely sure.

THE COURT: I believe it's a continuation.

MR. FUCHSBERG: Oh, yeah, it's a --

A Okay, I can read it.

MR. FUCHSBERG: I don't know. It's at a different time, Your Honor.

THE COURT: I see. Okay.

Q Same handwriting?

A Yeah. Positive restlessness, confused.

Q What does confused mean?

A Uh --

Q Why don't you finish the whole note.

A Yeah. Let's see. They gave some vital signs, blood pressure 160 over a hundred. Pulse 76. Respiratory rate 18. Ambien held. So this was a sleep medication that was ordered that was held. Continue to observe.

And then below that, pain in both lower extremities on a scale of seven. Described it as squeezing pain. Given percocet tablets PO, by mouth. Continue observe.

So again now, now the pain is different. Now it's a squeezing pain in the legs. So again, unusual at this stage of his recovery. You have to think of a deep venous thrombosis.

Q And the confusion?

A Well, now you have to wonder if, if the confusion has anything to do with his breathing. I mean you need some additional information here to kind of iron that out. Are his oxygen -- is his oxygen saturation low which is what you would measure to make sure they're getting enough oxygen. There easy ways to measure that. Is his oxygen saturation low. Is he in congestive heart failure. They held the Ambien possibly with the thought that that might be causing his confusion, but again, holding the Ambien is an easy thing to do, but if there is something more serious going on, you know, you have to look at that. You have to figure this out.

Q And that's Dr. Prichep's note right after that. Can you read that?

A That's going to be rough. Feels tired. Not sleeping. Sleepy. I'm not going to do well with this note here.

I can see hematocrit 32 percent, creatine, 2.2, C dif question. WBC 7 -- I think that's a 17.2.

I'm reading what I can read.

Stool cultures. Supportive care. That's all I can read.

Q What does that note -- significance of that note?

A Well, it doesn't have much significance. I mean it just sort of -- doesn't help. Doesn't help determine what the problem is, why the patient's having restlessness, why the

patient's having leg pain. If the team is, if the team is looking for direction here, we're not getting any.

Q And 10/28. Where it -- again where it's highlighted.

A Percocet for pain PRN. Above that pain in legs.

Q Significance to you, if any?

A Well, on a daily basis he has this leg pain and there's been no investigation of why the pain is occurring. Once again, to repeat myself, in this immobilized patient, check a DVT study, get an ultrasound.

Q I want you to assume that Dr. Prichep testified that pain in the legs is not a symptom of a DVT. Do you agree or disagree?

A Disagree.

Q Could you explain your answer?

A Well, patients have pain from deep venous thrombosis and sometimes they don't. So you just need -- you know, nothing, nothing we do is in a cookbook, so you have to always be thinking. There's not a step by step process necessarily that tells us what to do in a situation like this. We just have to know from our training and our experience that pain in the legs, 12 days out, has to be explained and it has not been at this point.

Q And the last note is Dr. Prichep's. Can you read that?

A Feels weak. Afebrile. Abdomen -- sorry. Supportive care on the bottom. Stable. I can read supportive care. I

think that's stable above it. That's the best I can do.

Q Do you have an opinion about that note?

A Just a nondescript note. Sort of going through the motions indicating -- basically this indicates he saw the patient, but doesn't help.

MR. RYAN: Objection, Your Honor.

THE COURT: Pardon?

MR. RYAN: Objection, Your Honor. He can't read what the note says. It seems he's making --

THE COURT: The objection's sustained. The answer is stricken.

Q Okay. So reading from page 116 of the deposition.

THE COURT: I'm sorry?

MR. FUCHSBERG: Reading from page 116 of the deposition.

MR. RYAN: Of whose deposition?

MR. FUCHSBERG: I'm sorry. Of the trial testimony of Dr. Prichep. I believe he reads his own note. I believe it's this note.

Q So if I can read it to you. Feels weak, afebrile; what does afebrile mean?

A No fever.

Q And bowel sounds positive. Soft and non-tender. What does that mean?

A A normal exam of the abdomen.

Q Incision is clean and dry.

A Incision is healing and healthy. No evidence of infection.

Q He was stable.

A Stable is no issues basically. No ongoing issues at this point.

Q Do you agree with that?

A No.

Q Why don't you agree with that?

A Well, he has pain in his legs, he has been restless, he's required -- he's been confused. That's just not the case. It's not -- it's not what was described in the other notes.

Q And the last note is supportive care?

A Supportive care, as in the other notes, again, sort of a nondescript thing. In other words nothing to be done. Continue as you've been doing and no suggestions, no recommendations.

Q Now, I want you to assume that Dr. Prichep testified if he comes and sees a patient and the patient says he's feeling fine and the nurses may say otherwise, who do you believe? That's more or less what his answer was. I want you to assume that hypothetically. I'm not reading from the testimony. Do you have an opinion about that?

A Yes.

Q What is your opinion?

A Well, you read the nurses notes and you specifically ask those questions. I mean, usually you don't ask the patient how you're feeling. I mean if you have evidence from nurses notes prior or other notes prior that there are issues, you go directly to that and you ask them, tell me about your leg pain. As an example. Tell me about your thigh numbness. You go right to the, right to the point. I mean you can ask how you're doing, but you want to really focus, focus in on the specific complaints the patient had before. Just makes it easier for the patient to answer.

Q Okay. The next page.

A Patient alert and oriented times three without complaints. Not feeling well with --

Q C dash zero?

A Yeah. Complaining of not feeling well. So that is not without complaints. It's not -- complaining of not feeling well. Sorry.

Q Same note at the bottom there.

A Complaining of increased endurance. Yeah, this is the writing style of the physical therapist.

Q Arrow down.

A Yes.

Q Complaining of --

A Complaining of decreased endurance. That's what the arrow down means.

Q This is not the first time that's been noted, is --
A No.
Q -- that correct?
And now we're on 10/29. Could you read the second note? Before you read the yellow, what does it say above that? Right on the line above that.
A Yeah. I think it says alteration and comfort. Let me see if I can get it on the chart here.
Here. Alteration in comfort.
Q And then what does it say?
A Complaining of pain in both legs.
Q And what significance does that note have to you again?
A Well, again, he's complaining. Complaining of pain in both legs and why? So, once again, it's something that needs to be investigated and you have to be certain that there isn't a deep venous thrombosis.
Q And is there any investigation done by that?
A No.
Q I want you to assume that after -- that he was seen by the covering surgeon over the weekend for two days. And what is your opinion about -- and that the covering surgeon over the weekend who saw him for two days did not do an ultrasound of the legs. What is your opinion about that?
A Well, this is a covering physician, so sort of at a bit of a disadvantage in the sense that the covering physician

doesn't really know this patient as well as the primary surgeon does, so you need a little bit of help as a covering doctor from that surgeon to be brought up to speed in the progress of the patient, so you'd like a little bit of a head's up on the patient's condition. The covering physician sort of looks at the -- looks at sort of the whole picture, but doesn't have a firm grasp of let's say the previous week, so what you're there for is to be available, to pick up any major problems, but not necessarily without some head's up at least to pick up the fact that may be this patient has something bad going on in his legs, so I can't -- it's a little hard sometimes to fault a covering doctor.

Q Is that -- how, if at all, does that relate to the importance of the detail and the guidance of the surgeon's notes that he leaves in the chart?

A Well, it's important. The covering doctor will often go back with questions and look at the notes and try to get a sense of what the patient has been doing this past week, make sure that the current exam, that day that he's covering, there isn't some information or clues that might help in making the diagnosis of a problem on that weekend, Saturday, as an example. So you would go back and read notes.

Q And on 10/30, at 4:00, he's -- there is the ultrasound, the report is back, full report to follow. GB sludge. Left renal cyst and then after that -- can you read the note after

that?

A Yeah. Patient complains of back pain.

Q And then focus again is, the words are --

A Lab values.

Q Says alteration in comfort on the of left that? A-L-T dot in comfort? The patient's not comfortable, right?

A I'm not sure where --

THE COURT: Sir, sir.

MR. FUCHSBERG: I'm going to withdraw the question.

Q Does that have any significance to you, the back pain?

A No.

Q And then on eleven -- on 11/1, there's a note at 2:00 A.M. by the nurse?

A I see it.

Q The part that I yellowed.

A Says slight restlessness. No. I see difficulty in sleeping. I think that says slight restlessness.

Q Does that mean anything?

A Again, nondescript.

Q Let's go to the next page, 11/1 at 10:00 A.M., the part that I yellowed.

A Refused to go to PT. Refused, meaning refused to go to physical therapy.

Q And then there's Dr. Prichep's note. Can you read his note?

A Yes. I think it says feels tired. Afebrile. Vital signs stable. Abdomen benign. Creatinine 2.6. Supportive care. PT. That is it. That's all I can read.

Q What is your opinion about that note?

A It doesn't address, doesn't say anything, really, of significance as it relates to the patient's complaints before.

Q Do you have difficulty reading that note as well as his earlier notes?

A Some of it, yes.

Q And you're a doctor; you look at charts all the time?

A Yes.

Q And you rely on the notes that are written?

A Yes.

Q Is there a standard of care for a physician to write notes in a chart in a legible form?

A There is. Unfortunately, we're awful with writing notes.

Q If you would turn to the orders. If you can find the order section. Just give me a moment, please.

Now, doctor, did Dr. Prichep also -- let's go back from the 25th. 26th now. Well, let's go back to the 26th. We're all getting used to Dr. Prichep's handwriting. I think we know which are his notes.

MR. RYAN: Objection.

MR. FUCHSBERG: I'll withdraw that.

Q Can you look at the note that I've got up on the screen of 10/26 at 9:00 A.M.?

A I see it.

Q Can you read that?

A Dulcolax suppository this A.M. Regular diet. That's the IV at KVO, so it's whatever the IV is and KVO means keep vein open, so it's a small amount of fluid going into the patient. To an IV.

Q So Dr. Prichep did write an order, right?

A Yes.

Q And we might as well go back one more day to the 25th just to see if any records were written. Not sure.

How about that one at 14:05?

A What date is that? Let's see.

Q 10/25 at 16:05.

MR. RYAN: 10/25. You're looking for Dr. Prichep?

MR. FUCHSBERG: Yes. Is that it?

MR. RYAN: No. It's the first note of the day, so just go -- there you go.

Q Is that Dr. Prichep's first note at 10/25?

A Those are transfer orders?

Q Yes. Are those the transfer orders?

A That's what it looks like, yes. Transfer orders, correct.

Q What did he order? Did he order the consults or were

they already ordered? Take a moment to look at them.

A He orders a list of the medications that the patient is to be on. Orders some lab work. Orders for the -- his diet. Looks like it remove NG tube. That's a tube that's basically down into his stomach until he resumes -- patient resumes bowel functions, so they removed that, ordered a diet. Out of bed. An IV order. Some blood work. And looks like TPN. So that's a form of nutrition that you get through a vein, total parenteral nutrition.

Q So that's his transfer note out of the ICU, correct?

A Yes.

Q And that's his note too --

A That's a voice order.

Q Okay. What does he order over the phone?

A Nitroglycerin, lopressor, blood sugar checks, that's the Accu-checks, and you can see the numbers below that, that's a sliding scale we call it to, based on the blood sugar on how much insulin to give the patient.

Q And then the next note, is that Dr. Prichep too, on 10/26 at 16:05?

MR. RYAN: 10/25 at 16:05.

Q Is that 10/25?

MR. FUCHSBERG: Thank you.

A I'm not sure that's Dr. Prichep. It is some medications being ordered, Lopressor with parameters on when to

hold it if the blood pressure is below a certain number and the heart rate is below a certain rate.

Q Can you order heparin to be given subcutaneously with it to be held or not held depending on rates? How do you order it?

A You order it, you order it either 5,000 units, sub Q twice a day or three times a day. That's just standard. It's not based on necessarily weight of the patient, so it's either twice a day or three times a day.

Q Do you order any monitoring with it? Can you?

A Not really, no. You can order monitoring. You generally don't. You would order some blood work if you were concerned that it was in a smaller patient, let's say, where the sub Q heparin, might have, might have an affect on the coagulation system, so you can order a PTT. That's a blood test easily drawn and it can be ordered.

Q And what about -- okay.

And so and if you had risk of bleeding at that time or you were concerned about risk of bleeding, how would that effect the order?

A Well, if you were concerned with bleeding, you probably would not want to start any kind of heparin. With the sub Q heparin, if you give too much, it can prolong the bleeding. The PTT. Lovenox not so much. That's -- that doesn't have to be followed and monitored.

Q Was his bleeding a concern at this time on October 25 when he was transferred out of the ICU?

A No.

Q And I'm asking you in accordance with standards for vascular surgeons in 2004?

A Yes.

Q And that seems to be another note of his. Is that another 10/26 -- that's, I think, 10/26 at 9:00 A.M.

A Yes. Dulcolax suppository this A, regular diet and again the IV and KVO.

Q And is that another note of his on 10/27?

A Yes.

Q What does that say?

A I don't know.

Q D slash C something?

A That's DC -- yeah, I can read that. DC. I don't know what that means. I don't know. Could be triple lumen catheter, could be something to that effect, but I actually don't know.

Q Now, there's a note T-O, what does T-O mean?

A Telephone order.

Q So says Dr. Prichep and then a slash? But in any event, what's that telephone order?

A D/C morphine sulfate. So that's D/C the pain medication. They changed it percocet by mouth. D/C Reglan which is a medication to decrease acid secretion in the stomach

and they started the patient on Pepcid which is for the stomach.

Q Do you know why they discontinued the morphine and they would have switched him to the percocet?

A It's generally what you do as you progress along in your post-operative care you try to -- you try to go to an IV, from an IV form of medication or an injection, a muscular injection of pain medication to something by mouth. That's fairly standard.

Q That's his note, I believe, on the bottom of 10/28 at 9:40 A.M.?

A I can read the stool for C dif. That's the second line.

Q So that meant culture of the stool?

A That's correct.

Q Or sent to lab to look at?

A That's correct.

Q Can you just briefly tell us what C dif is?

A C dif is -- C is a laboratory test checking for antibiotic associated colitis which is an inflammation of the intestine, the large intestine. You can sometimes have that with antibiotic use, something that's easily treated, can cause diarrhea and if left untreated can cause significant problems with the colon.

Q It says D slash C Foley, I think? Am I misreading? Does that say discontinue Foley?

A That's what it looks like. D/C Foley catheter.

Q That was taking his urine out?

A That's the catheter that's inserted through his penis into his bladder to measure your urinary output. That's fairly standard and you're usually with that for sometime following this type of operation.

Q And then under that it says something CBC?

A Yeah. CBC and something else. In A.M. So laboratory work ordered for the A.M.

Q That would be blood laboratory work?

A BMP? Don't know what that means.

Q Okay. CBC?

A Blood count.

Q Why would you order that?

A Something to check on while you're hospitalized. Don't necessarily have to check it everyday. Maybe he was looking -- as part of the CBC you look for a white count which is important when there's possible evidence of infection. If you're concerned about C dif, you want to know what the white count is.

Q And on 10/28 there's another note?

A What time was this? Which note is this now? The 24-hour urine?

Q Yeah. The last note at the bottom of 10/28 appears to be in his handwriting in the orders --

MR. RYAN: Objection.

A Yeah, I don't think that's his handwriting.

THE COURT: Sustained. Let's not get --

MR. FUCHSBERG: Sorry.

THE COURT: Well, I'm going to accept your apology this one last time. Don't do it again.

MR. FUCHSBERG: I'm trying to do the same.

THE WITNESS: That his note now. 10/29. LFT's for liver function test. I'm not familiar with the middle appreciate of BMP's. It's lab work, but I couldn't tell you what that means. Something I don't use. CBC is a blood count.

Q What is the significance of him ordering that?

A Well, he's obviously concerned about something going on. A liver function test I do know from his -- I know from his testimony why, in retrospect why he ordered this. He was concerned about a gall bladder problem and what he was looking for is something called acalculous cholecystitis or a gall bladder disease which you can have following major surgery like this. You may have it even without gallstones. It can develop. And that would be something you'd want to know about.

Q I want you to assume that from the highlighted notes we've been reading to you earlier today, there were notes on 10/27, pain in both lower extremities scoring 7, described as squeezing pain. There was a note on 10/28, pain in legs. There was a note on 10/29 complaining of pain, back and legs.

In your opinion, do these orders address those issues?

A No.

Q But would it be satisfactory that he was exploring at least this gall bladder issue to justify the fact that he wasn't exploring?

A Not by itself. I mean it's good that he was exploring the gall bladder issues, but you needed to explore the leg issues as well.

Q This was the weekend.

THE COURT: Are you going to testify anymore, sir, this morning, or this afternoon?

MR. FUCHSBERG: I'm sorry.

Q Now, is there a note there on November 1?

A Yes.

Q So in fact there is an order from the doctor on November 1?

A Yes. He ordered Ambien, sleep medication. I can make out Boost, which is a nutritional supplement. I can make out CBC in A.M. That's all I can make out.

Q Is he addressing any particular problem with those notes?

A The ones I can interpret, no.

Q And that's the last order?

A There is a telephone order after that. Looks like a telephone order from the physician's assistant in the hospital

at 1:05 A.M. That was his last order.

Q What is the physician's assistant order at 1:05 A.M.?

A He's ordering something for nausea, something for -- not sure why he would order -- I can't make out why Restoril would be order, but what was ordered. Restoril.

Q What is Restoril for?

A It's a drug I'm not overly familiar with, I don't use it, but it can be, it can be. I'm not sure why he would use it.

Q The last drug?

A Tigan. It's a form of -- it's a long the lines of antacids, Reglan, that type of thing.

Q Okay. We'll briefly go through some -- I marked some things for illustrative purposes, with the Court's permission.

MR. FUCHSBERG: Is there an easel that I can use? One of those, Your Honor?

THE COURT: Yes, there is and yes you may.

MR. FUCHSBERG: Thank you. Just that little wooden one would be fine. That will make it easier. Thank you. Let me put it so the Jury can see it, Counsel can see it.

MR. RYAN: Put it here. We'll move.

MR. FUCHSBERG: Is that good?

Q Just, these are -- what is that?

THE COURT: This is a document or a drawing that has been marked as --

MR. FUCHSBERG: Exhibit 3 for demonstrative

purposes with the Court's permission.

A Well, the larger picture is a picture of the lungs, two lungs, right and left lung, and --

THE COURT: Sorry to interrupt you.

Step up here for a second, please.

(At which time there was a side-bar discussion held off the record.)

THE WITNESS: Your Honor, I can talk loud enough. Can I go up there and point to things?

THE COURT: Depends on whether your attorney wishes you to do that, or the attorney for the Plaintiff.

MR. FUCHSBERG: If it helps, if you're requesting it.

THE WITNESS: May I?

MR. RYAN: You have to ask him.

MR. FUCHSBERG: You have to ask the Judge.

THE COURT: No, no.

THE WITNESS: He deferred to you.

MR. FUCHSBERG: Okay. Well, that's --

THE WITNESS: All right.

(Witness steps down from witness chair.)

THE COURT: Having now done that, make sure that you speak so the court reporter can hear.

THE WITNESS: I will.

MR. FUCHSBERG: Thank you, Your Honor.

THE WITNESS: So what you have is a picture of the right and left lung.

Q Wait, wait.

Is this a fair and accurate schematic, illustration of, of what?

A What they're trying to describe here is a pulmonary embolism which is a blood clot that has traveled from down below, legs being down here, lower part of the body down here, traveling up from below, through this vein, which is the inferior vena cava, that's that vein where we would put that filter in, that Greenfield filter.

THE COURT: Let's not get into -- just answer the question, Doctor.

A Yes, sir. So, and up travels the blood clot. You don't see the heart, but you see part of the heart. So you see the pulmonary veins -- I'm sorry. The pulmonary arteries. You see one going to the left, one going to the right. The blood clot travels up to where the heart is, this is the right side of the heart, and you can see the clot has broken up and traveled out into the lung itself.

This dark area down here basically is lung that is without blood supply and therefore dying or infarcted as we say. And as you see here on the right-hand side, my right, your left, you see the veins from the leg traveling up into this vein here, the inferior vena cava, going up into the heart and the lungs,

so this is an expanded area, this part here is an expanded area of that, but this down here it just shows you the extension of where the veins drain from.

Q You're aware that Dr. Prichep testified in his opinion that the cause, the principal cause of death were pulmonary thromboembolism?

A Yes.

Q And did you also review the autopsy report?

A Yes.

Q And do you have an opinion as to the principal cause of death?

A He was correct. It was from a pulmonary embolism.

Q And do you have an opinion within a reasonable degree of medical certainty as to the source of the pulmonary embolism?

A Yes. In almost all cases it comes from the legs. From the veins of the leg.

MR. RYAN: Objection, Your Honor.

Q Did you examine the autopsy --

MR. RYAN: He didn't answer the question specifically. He said in almost all cases. We're looking at this case.

THE COURT: The objection is sustained. The answer is stricken. Will you read the question back, please?

(Whereupon, the record was read as requested.)

THE WITNESS: Yes. In greater than 90 percent of

the cases, it comes from the legs.

MR. RYAN: Objection, Your Honor.

THE COURT: That may be the case, but do you have an opinion with respect to this case?

THE WITNESS: That's my opinion. I mean that it came from the legs.

THE COURT: So then you gave us an explanation as to why you believe that?

THE WITNESS: A lot of what we do, Your Honor, is based --

THE COURT: No. It's just yes or no, sir.

THE WITNESS: Yes.

THE COURT: I've heard you extrapolate on every question that's been asked. Go ahead. Yes. Okay. Go ahead, sir.

Q Can you explain your answer?

A Yes. Statistically, scientifically, it comes from the legs. We know this.

MR. RYAN: I'll object to that as well, Your Honor.

THE COURT: I'll sustain the objection. The answer is stricken. Talking about you, sir, also. Don't answer in the plural; we. What we think. It's what you think.

Go ahead.

Q Did you have an opportunity to examine the autopsy in this case?

A I read the report, yes.

Q How, if at all, did that affect your opinion?

A It did not change my opinion.

Q Did you look at the autopsy to see if there were any other reasons or sources of the pulmonary embolism?

A Yes. They did not find any.

Q Did you consider all the anatomical findings in the autopsy report as to whether there could have been another source for a pulmonary embolism?

A Yes.

Q What did you consider?

A Well, based on the examination of the abdomen, I was looking to see if there was any evidence of a pelvic vein clot, things of that nature. There was no mention of it. There was no mention of any, anything else.

Q Did they do a dissection of the legs?

A No.

Q If you wanted to see if somebody had a DVT, how would you look for it?

A Well, you would have to examine the legs.

MR. RYAN: Well, objection, Your Honor, unless they're going to qualify this gentleman as a pathologist who does autopsies.

THE COURT: Step up here for a second. You can step back.

(At which time there was a side-bar discussion held off the record.)

THE COURT: I will sustain the objection.

We're going break in one minute, sir, so.

Q Do you ever sit in review -- do you ever have opportunities to review causes of death that occur in the hospital?

A Yes.

Q What are the opportunities to review them?

A Usually at morbidity and mortality conference.

Q Could you end explain what the morbidity and mortality conference is?

MS. HOWARD: Objection.

A Every surgical department is required to have a morbidity and mortality conference. It's where we go over cases on the surgical service, in my case of death, or complications related to an operation, and so any case that does not go perfectly, where there's a post-op complication or death gets presented there.

THE COURT: We'll break now for lunch.

COURT OFFICER: Follow me, please.

THE COURT: Just one second, Officer.

You can sit down, Doctor.

(Whereupon, the Witness resumed the stand.)

THE COURT: Okay. Thank you. Retire the Jury.

COURT OFFICER: Okay. Follow me, please.

(Whereupon, the Jury exited the courtroom.)

THE COURT: Let me see the attorneys in chambers. You can step down, Doctor.

THE WITNESS: Thank you.

THE COURT: Don't discuss your case with anyone over the luncheon break, please.

THE WITNESS: Fine.

(At which time there was a luncheon recess.)

(Whereupon the following was reported by Diane Hansen, Senior Court Reporter.)

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