2014 NATIONAL STUDENT TRIAL ADVOCACY COMPETITION (STAC)

OFFICIAL RULES

and

FACT PATTERN

Endowed by Baldwin & Baldwin, LLP
Important Dates:

Requests for fact pattern clarification due: January 17, 2014
Team Participant Registration due (students must be AAJ members): January 31, 2014
Regional Competitions: March 20-23, 2014
National Final Competition: April 10-13, 2014

AAJ’s 2014 Fact Pattern is authored by Maria Glorioso of The Glorioso Law Firm in New Orleans, LA. AAJ extends its thanks and appreciation to Ms. Glorioso for developing the 2014 Fact Pattern.

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Please note:

Information regarding the 2014 Student Trial Advocacy Competition is available at www.justice.org/STAC and will be updated frequently.

All questions and correspondence should be addressed to:

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American Association for Justice
Formerly the Association of Trial Lawyers of America (ATLA®)
777 6th Street, NW
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GENERAL INFORMATION

One of AAJ’s goals is to inspire excellence in trial advocacy through training and education for both law students and practicing attorneys. One way AAJ accomplishes this goal is by sponsoring a national student mock trial competition. This is an exceptional opportunity for law students to develop and practice their trial advocacy skills before distinguished members of the bar and bench.

Because the purpose of this competition is to give law students the opportunity to develop their trial skills, the actual merits of the plaintiff’s case and the defendant’s case presented are irrelevant to this purpose. Competition rounds are decided not on the merits of a team’s side but on the quality of a team’s advocacy.

Requests for Clarification

Requests for clarifications of the rules or fact pattern must be submitted via an online survey no later than 5:30 p.m. (EST) on January 17, 2014. A link to the survey will be posted online at www.justice.org/STAC after the fact pattern is released. Each school is limited to five (5) questions. No school, regardless of the number of teams it has in the competition, may submit more than five questions. Each subpart of a question is counted as a question.

RULE VIOLATION AND FILING OF COMPLAINTS

A competitor or coach violating any of the rules governing the national Student Trial Advocacy Competition may be penalized or disqualified. If a team wants to file a complaint under the rules, the team’s coach should immediately notify the regional coordinator at a regional competition or the final round coordinator at the final competition. The coordinator will review the complaint and make a ruling, which shall be binding for that round of competition. The coordinator’s rulings will be governed by the rules of the competition and the objectives of the program.

Complaints after a regional competition or after the national competition must be filed in writing with Emmah Schramke at the address on page 2 no later than the seven (7) days following the last day of the regional or final round, as appropriate. The AAJ Law Student Services Committee will promptly consider and rule on any such complaints.

LAW SCHOOL AND STUDENT ELIGIBILITY

The competition is open to all law schools nationwide. A law school may enter up to two teams. Each team shall be comprised of four law students. A school’s selection method of its trial team(s) is left for the school to determine. However, for a student to be eligible, he or she must be enrolled for a J.D. degree and be a law student member of AAJ.
Students who graduate in December 2013 are eligible to participate only if the competition counts toward their credits for graduation and they will not be admitted to practice prior to March 2014.

*Each student participant must be an AAJ student member by January 31, 2014 in order to participate.*

**REGISTRATION PROCEDURES**

**Refund Policy**

Requests for a refund of a school’s registration fee were due in writing before November 8, 2013. It is inevitable that a few teams drop out of the competition in the months leading up to the regionals. Teams placed on the waiting list because the competition is full will be contacted for participation in the order that their registrations were received. Teams on the waiting list will also be issued a refund check if it is determined that the team will not be competing. Schools that registered two teams but are only able to enter one team because the competition is full will receive a refund of the registration fee for the second team.

**AAJ Law Student Membership and Student Team Registration**

Student team members must be AAJ members by January 31, 2014 in order to participate. This year, all students must verify their membership and register for their respective team online at [www.justice.org/STACParticipantRegistration](http://www.justice.org/STACParticipantRegistration). AAJ Law Student membership dues are $15. If you have any questions about AAJ’s law student membership, or if you have any trouble becoming a member online, please call AAJ’s member hotline at (202) 965-3500, ext. 8611. If you have any questions about registering as a STAC team member, please call Nyle Grimes, STAC Coordinator, ext. 2877.

**Coach Registration**

AAJ must receive the names of the coach for each team. A coach must accompany each team to the regional competitions. A coach may be a law student, but may not be a student who is competing in the competition. Coaches do not need to be members of AAJ, and should not register for the STAC event. Coaches, and other administrators traveling with the team, must complete an online survey listing the team coach that will be travelling with the team by January 31, 2014. This is the information that will be sent to the regional coordinators to communicate logistics onsite.

**Student Substitution Policy**

Substitution of team members after January 31, 2014 is not permitted except in the case of personal emergencies. Requests for substitution after the January 31 deadline must be made in writing with an explanation of why the substitution is needed and sent to Emmah Schramke at AAJ for consideration.
REGIONAL AND FINAL COMPETITION ASSIGNMENTS

Entering teams will be assigned to one of 14 regional competitions based on geographical convenience to the extent possible. Teams from the same law school will be assigned to the same region. If a school’s second team is waitlisted, there is no guarantee that second team will be sent to the same region as the first team. Teams will be notified of any date changes when regional assignments are made. Please remember that a school’s second team will not be officially registered until one team from each law school has entered the mock trial competition. Then the second teams will be registered on a first-come, first-served basis until all the team slots are filled. If you paid for two teams and only one team is able to participate, you will receive a refund for the second team.

In order to officially compete in the competition, a team must receive its regional assignment. If a team is not informed by AAJ that it is able to compete, that team is not registered for the competition.

Coaches

A coach must accompany each team to the regional and the final competitions. The coach for a team that goes to the final competition does not have to be the person who coached the team at the regional competition.

A coach may be a law student, but may not be a student who is competing in the competition.

Only team coaches are permitted to attend the coaches’ meeting. If a coach is unable to attend, he or she must notify AAJ and the regional coordinator. Only then can students be permitted to attend in the coach’s absence.

Team Expenses

Travel expenses for the regional and final competitions are the responsibility of the participants. Teams competing in past competitions have obtained funds from law school deans and alumni associations, members of the local legal community, state and local trial associations, and AAJ law school chapters.

COMPETITION FORMAT

This is a trial skills competition. There is no motion or trial brief writing component. Each team will consist of four law students. Two students will be advocates and two students will play the witnesses for their side in each round. Advocates and witnesses may change their roles from round to round, but roles must remain consistent throughout each individual trial.
In the regional competitions:
- Each team will compete in three qualifying rounds
- The top four teams from the qualifying rounds will advance to a single elimination semifinal round
- The top two teams from the semifinal round will compete to determine which one team will advance to the National Final Competition

In the final competition:
- Each team will compete in three qualifying rounds
- The top eight teams from the qualifying rounds will advance to a single elimination quarter-final round
- The top four teams from the quarter-final round will advance to a single elimination semifinal round
- The top two teams from the semifinal round will advance to a single elimination final round

Regional Team Pairings in Qualifying Rounds

Pairing of teams in the qualifying rounds will be at random and conducted during the coaches’ meeting prior to each competition. Teams may also be pre-assigned by the regional coordinator prior to the coaches’ meeting; this practice is at the discretion of the regional coordinator. Each team will represent both plaintiff and defendant in the first two rounds. No two teams shall compete against each other more than once in the qualifying rounds. Teams from the same school will not compete against each other during any of the rounds of the regional competition or in the qualifying rounds of the national final competitions.

Team Rankings in All Other Rounds

In the semifinal round, the first-ranked team will meet the fourth-ranked team, and the second-ranked team will meet the third-ranked team.

Regional semifinal round (Normal pairings: 1 v. 4; 2 v. 3)

Situation 1: Teams ranked 1 and 4 are from the same school
New pairings: 1 v. 3; 2 v. 4

Situation 2: Teams ranked 2 and 3 are from the same school
New pairings: 1 v. 3; 2 v. 4

The ranking of teams to determine the semifinalists and finalists will be determined by the following factors (in this order):

1. Win/loss record
2. Number of winning votes
3. Number of total points awarded to the team
Each succeeding criterion above will be used only if the prior criterion does not fully rank the teams, and will be used only to break ties created by the use of the prior criterion. In the event that all three of these criterion are tied, the regional coordinator will announce a tie-breaker.

If paired regional semifinal teams have met in the qualifying rounds, they will each represent different sides than in the previous meeting. If they have not yet met, each team will take the side they represented only once in qualifying rounds. If matched teams represented the same side only once, the winner of a coin toss will choose sides.

In the regional finals, the teams will represent a different side than in the semifinal round. If two opposing teams each represented the same side in the semifinal round, the winner of a coin toss will choose sides. The two regional finals teams will represent a different side than in the semifinal round. If matched teams in the final round represented the same side in the semifinal round, the winner of a coin toss will choose sides.

When an odd number of teams compete at a regional competition, one randomly chosen team will receive a “bye” in each qualifying round. For ranking purposes, a bye will count as a win and the team with the bye will be deemed to have had three votes and the points equal to the average of the team’s points from the two other qualifying rounds.

**NATIONAL FINALS**

**Quarter-final round** (Normal pairings: 1 v. 8; 2 v. 7; 3 v. 6; 4 v. 5)

Situation 1: Teams ranked 1 and 8 are from the same school
New pairings: 1 v. 7; 2 v. 8; 3 v. 6; 4 v. 5

Situation 2: Teams ranked 2 and 7 are from the same school
New pairings: 1 v. 8; 2 v. 7; 3 v. 6; 4 v. 5

Situation 3: Teams ranked 3 and 6 are from the same school
New pairings: 1 v. 8; 2 v. 7; 3 v. 5; 4 v. 6

Situation 4: Teams ranked 4 and 5 are from the same school
New pairings: 1 v. 7; 2 v. 7; 3 v. 5; 4 v. 6

**Semifinal round** (Normal pairings: 1 v. 4; 2 v. 3)

Situation 1: Teams ranked 1 and 4 are from the same school
New pairings: 1 v. 3; 2 v. 4

Situation 2: Teams ranked 2 and 3 are from the same school
New pairings: 1 v. 3; 2 v. 4

If teams from the same school are matched to compete based on rank in the semifinal and final rounds of a regional competition, regional hosts will re-pair teams according to the following scenarios:
Determination of Team Representation

If the four national and regional semifinal teams have already met in the qualifying rounds, they will represent different sides from the previous confrontation. If they have not yet met, each team will take the side they represented only once in qualifying rounds. If matched teams represented the same side only once, the winner of a coin toss will choose sides.

The national finals semifinal teams will represent a different side than in the quarter-final round. If matched teams represented the same side in the quarter-final round, the winner of a coin toss will choose sides. The two national final teams will represent a different side than in the semifinal round. If matched teams represented the same side in the semifinal round, the winner of a coin toss will choose sides.

THE TRIAL

The competition this year involves the trial of a civil lawsuit. The same fact pattern will be used in the regional and final competitions. The trial judge previously ruled that the case would be bifurcated, and the case being tried in the competition is the first phase of the case—the liability phase. Only evidence relevant to the liability issue will be received. There are no pending third-party claims.

The Federal Rules of Evidence (FRE) and Federal Rules of Civil Procedure (FRCP) are the applicable rules of evidence and civil procedure. Only these rules, and the law provided in the fact pattern, shall be used in argument. Specifically, no statutory, regulatory, or case law shall be cited unless such law is provided in the fact pattern.

Students may argue based upon the comments or advisory notes to both the Federal Rules of Evidence and Federal Rules of Civil Procedure but may not cite the cases contained therein. No written briefs or motions, trial notebooks, or other written materials may be presented to the judge hearing a case. No pretrial motions of any kind are allowed.

Motions for a judgment as a matter of law and evidentiary objections are permitted.

The trial will consist of the following phases by each team in this order:

- Opening statements for plaintiff followed by defendant
- Plaintiff’s case-in-chief
  - Plaintiff’s direct of plaintiff’s witness #1
  - Defendant’s cross of witness
  - Plaintiff’s redirect of witness
  - Similar for plaintiff’s witness #2
- Defendant’s case-in-chief
  - Defendant’s direct of defendant’s witness #1
  - Plaintiff’s cross of witness
• Plaintiff’s redirect of witness
• Similar for defendant’s witness #2
• Closing argument
• Plaintiff’s closing
• Defendant’s closing
• Plaintiff’s rebuttal closing

Each side is limited to two live witnesses whom they may call in any order.

• Plaintiff must call Dr. Scalia and Kerry Roosevelt
• Defendant must call Dr. Ginsberg and Dr. Sotomayor
• Both parties may use the deposition of Jesse Roosevelt at trial as they see fit. The party reading the deposition can ask only another member of their team to read it aloud.
• If a party decides to use all or a portion of Jesse Roosevelt’s deposition, judges will be instructed to incorporate the party’s use of the deposition into their scoring of each side’s direct examination of its lay witness. However, if a team decides not to use the deposition, it will not affect their scoring.

The trial has six (6) major advocacy opportunities for each team: opening statement; direct/redirect examinations (2); cross-examinations (2); and closing argument. Each member of a team must handle three of the six opportunities. Opening statement and closing argument may not be done by the same person, and may not be split between team members. Each team member must do a direct and cross.

During the competition, each team will represent both parties. Pairing in the qualifying rounds will be at random, with each team representing both plaintiff and defendant at least once in the three rounds.

Except in the final round, the courtrooms will be off-limits to all team members, coaches, friends, and family members who are not associated with either team competing, unless their team has already been eliminated from the competition.

No team may receive any coaching from anyone in any form during a round, including any recesses or breaks. The regional or national coordinator, as applicable, has the authority to punish any violation of this rule by disqualifying the team from the remainder of the competition.

A team may record its trial if: (1) no additional lighting is required; (2) recording of the trial does not interfere with or delay its conduct; and, (3) all participants of the round, including the presiding and scoring judges and the regional or national coordinator, as applicable, agree. All recordings are subject to the local courthouse policy and discretion.

**Timing of the Trial**

• Each team will have 80 minutes to complete its argument; time will be stopped during objections.
• The time limit will be strictly enforced, although it is not necessary that all time allotted be used.
• There will be no time limits for specific aspects of the trial.
• Time on cross-examination is charged against the team conducting the cross-examination.
• Time will be stopped for objections and responses to objections.
• Performance at trial will be evaluated by a panel of judges and/or attorneys, one of whom will preside over the trial as Judge, making rulings as necessary, and the remainder (up to three) of whom will act as the jury.

Facts Outside the Record

Advocates must confine the questions, and witnesses must confine their answers, to the facts given in the fact pattern and inferences which may reasonably be drawn therefrom, with the following qualifications:

(1) A reasonable inference is not any fact that a party might wish to be true; rather, it is a fact that is likely to be true, given all the facts in the case; and

(2) No inferred fact may be material, which is defined (a) as a fact that changes the merits of either side of the case or (b) that bears on the credibility of any witness or litigant. The latter is defined to include any background information about a witness or litigant.

There can be differences of opinion on:

(1) Whether an answer is already encompassed within, or is a fair reformulation of something within, a witness’s statement, and

(2) Whether an answer is a reasonable inference, as defined above.

For these reasons, the following mechanisms are employed in this case to regulate this rule:

I. Pretrial:

1. The fact pattern contains the following certifications requiring counsel to:

   (a) Have each witnesses review his/her statements and have the witness certify under penalty of perjury whether the information in those statements is correct and complete, and whether the witness has any information that is relevant to the matters discussed in his/her statement but which is not contained therein;

   (b) File the statements, with the certifications appended, with the Court no less than 14 days before trial.

   (c) Re-interview each witness on the eve of trial and personally certify to the Court whether the witness had any material information not in his/her statements.
2. The case file contains the statements and certifications filed with the court.

   (a) The witness certifications state that the witnesses have no additional material information.

   (b) The attorney certifications state the same. They are also dated a few days before trial. The signature lines are blank. Before each round, the advocates will sign their own names to the certifications and provide them to opposing counsel for use during trial. The signed certifications will be deemed the original certifications in the court file, and the only ones allowed.

II. Trial - Evidentiary phase:

   If a witness provides information in direct or cross-examination that is not contained in his/her statement, the opponent may not object; the opponent may however, rely on the following remedies during cross-examination1:

   (a) The cross-examiner may show the witness his/her statement and ask the witness, in substance, if the witness certified under penalty of perjury that his/her statement was true and correct and that the witness had no other relevant information. The witness must answer “yes,” without qualification.

   (b) The cross-examiner may ask the witness if the “new” information provided on direct or cross was in his/her statement. The witness must answer “no,” without qualification.2

   (c) The cross-examiner may ask the witness if the witness provided that information to the sponsoring counsel before the date specified in sponsoring counsel’s certification. The witness must answer “yes,” without qualification.

   (d) If the witness is making up facts on the re-direct, a re-cross should be permitted for the limited purpose of impeaching the witness.

1 If a witness fails to comply with instructions (a) through (d), the judges will be instructed to reflect this behavior in their scoring.

2 If counsel who sponsored the witness believes that the information was in fact encompassed in the statement, or was a reformulation of something in the statement, counsel can “rehabilitate” the witness on redirect examination by asking about what was in the statement.
Witnesses

Any witness may be played by a person of either gender. Before the opening statement, each team should notify the other team of the gender of each witness they intend to call and any witness they could call but are choosing not to call.

Assume that all witnesses have seen the exhibits and depositions. Witnesses know only the facts contained in the background information, exhibits, and depositions.

All depositions are signed and sworn. The same attorney conducting direct examination of a witness shall also conduct any redirect examination.

The only lawyer who may object during witness testimony is the lawyer who will be examining that witness.

Witnesses may not be recalled. Witnesses will not be sequestered.

JURY INSTRUCTIONS

The instructions provided in the fact pattern are the only instructions that will be given. The instructions are the only statements of the applicable substantive law. Instructions will not be eliminated or modified. No additional instructions may be tendered or will be given.

EXHIBITS

The use of demonstrative evidence is limited to that which is provided in the fact pattern, but participants are free to enlarge any diagram, statement, exhibit, or portion of the fact pattern if it is identical to the item enlarged, or if any changes provide no advantage to the party intending to use it.

Subject to rulings of the court, counsel and witnesses may draw or make simple charts or drawings in court for the purpose of illustrating testimony or argument. These materials may not be written or drawn in advance of the segment during which they are being used.

No demonstrative evidence, including charts or drawings, may reflect facts outside the record. Participants must clear all demonstrative evidence with the regional or national coordinator, as applicable, at the coaches’ meeting preceding the competition.

All exhibits are stipulated as authentic and genuine for purposes of trial.

SCORING CRITERIA

Performances at trial will be evaluated by a panel of three judges and/or attorneys, one of whom will preside as the trial judge, with the others sitting as jurors. The trial judge will rule on any objections or motions for judgment as a matter of law.

Each member of the jury may award up to ten points in each phase of trial for each party. A sample score sheet is attached.
If at the end of the trial, an evaluator awards the same number of points to both the plaintiff and the defendant, the evaluator will award one additional point to either the plaintiff or the defendant for effectiveness of objections and/or overall case presentation in order to break the tie.

Evaluators have been instructed not to score teams on the merits of the case.

The following criteria for scoring trial performances are set forth to assist both judges and student advocates. Evaluators are not limited to these criteria and may consider other aspects of strategy, technique, and so forth, which they view as important.

Evaluator Shortage

For each match, there must be three votes from evaluators. In the event that, due to circumstances beyond AAJ’s control, there are not three evaluators in a particular match, “ghost” evaluator(s) will be used to score the round. The vote of a ghost evaluator is determined by calculating the average of all other evaluators in the session.

Suggested Evaluation Criteria

OPENING STATEMENT

Did Counsel:
1. Generally confine statement to an outline of the evidence that would be presented?
2. Clearly present counsel’s theory of the case?
3. Persuasively present counsel’s theory of the case?
4. Personalize self and client?
5. Allow opposing attorney to make argument during opening statement?
6. Make unnecessary objections?

EXAMINATION OF WITNESSES

Did Counsel:
1. Ask questions that generated minimal valid objections?
2. Make/fail to make objections with tactical or substantial merit?
3. Respond appropriately to objections?
4. Know the rules of evidence and express that knowledge clearly?
5. Develop rapport with the witness?
6. Maintain appropriate general attitude and demeanor?
7. Address the court and others appropriately?
8. Demonstrate awareness of ethical considerations?

Did Direct-Examiner:
9. Use leading questions unnecessarily?
10. Develop testimony in an interesting and coherent fashion?
11. Follow up on witness’ answers?
12. Present the witness in the most favorable light?

Did Cross-Examiner:
13. Appropriately use leading questions?
14. Control witness?
15. Follow up on answers and elicit helpful testimony?
16. Use impeachment opportunities?
CLOSING ARGUMENT

Did Counsel:
1. Present a cohesive theory of the case, pulling all the positive arguments together?
2. Deal effectively with the weakness(es) in his or her own case?
3. Make an argument that was persuasive?
4. Have an effective style of presentation?
5. Utilize the law effectively in the argument?
6. Inappropriately interrupt the argument of the opposing counsel?
7. Properly confine rebuttal to rebuttal matters?
8. Effectively counter the opponent’s speech in rebuttal

Discrepancies in Remaining Match Time

Often, bailiffs are unavailable to keep time for rounds. In such cases, one or more judges in each match should be instructed to keep time according to the timekeeping rules. Additionally, judges may ask the respective teams to assist with this process. Teams may also keep track of time used for their own purposes. They may not, however, report their time used or that of an opposing team to the bailiff or judge for any purpose, unless they were instructed to do so. Moreover, time use improperly reported by any team may not be considered or used by a bailiff or judge for any purpose.

Notwithstanding this limitation, in the event that the match judge or judges declare the time remaining as less than the team requires for closing or other parts of the trial, the coach or team member (whoever records the time discrepancy\(^3\)) should immediately consult with the Regional Coordinator during the break, who should then evaluate the circumstances and decide the amount of time remaining. Neither the team coach nor the team member should discuss the discrepancy with the match judge. Should the team be unable to consult with the Regional Coordinator before completion of the trial and the team requires additional time to complete the trial, the team may elect to complete the trial beyond the time allotted. When the trial is complete, the time will be evaluated by the Regional Coordinator. The team will lose two points from the number of total points for every five minutes—or fraction thereof—of time in excess of its allotment.

Viewing of Score Sheets by Teams

Viewing of the score sheets is done at the discretion of the Regional Coordinator. Each team will have the right to view their score sheets for each round. Team coaches may only view score sheets once the third round has commenced. This should be done one team at a time. Participating students should be unaware of how they were scored until the qualifying rounds are completed, and the semi-final teams are announced. Teams are not allowed to take score sheets with them or make any markings to the score sheets. Teams may view score sheets only in the presence of the Regional Coordinator. If team coaches require a copy of their score sheets, they should notify the Regional Coordinator and email AAJ staff.

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\(^3\) Note that coaches and team members may not communicate during rounds
2014 STUDENT TRIAL ADVOCACY COMPETITION (STAC)
JUDGE’S SCORE SHEET

Teams are to be scored on their trial skills only, NOT on the merits of the case.
Do not give half-points. Do not tie teams. There must be a winner.
Do not write your name on this score sheet, and do not share your score with the participating students or coaches.

ROUND:

REGIONAL LOCATION:_______________________

TEAM _____ -- PLAINTIFF

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<tr>
<th></th>
<th>Good</th>
<th>Average</th>
<th>Poor</th>
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<tbody>
<tr>
<td>Opening Statement</td>
<td>10</td>
<td>9</td>
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<tr>
<td>Direct Exam of</td>
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<td>Plaintiff’s Lay</td>
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<td>Witness*</td>
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<td>Direct Exam of</td>
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<td>Plaintiff’s Expert Witness</td>
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<td>Cross Exam of</td>
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<td>Defendant’s Expert Witness</td>
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<td>Summation</td>
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Total points awarded to PLAINTIFF ___________________________

TEAM _____ -- DEFENDANT

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Total points awarded to DEFENDANT ___________________________

*If a party decides to use all or a portion of Jesse Roosevelt’s deposition, you should incorporate the party’s use of the deposition into your scoring of each side’s direct examination of its lay witness. However, if a team decides not to use the deposition, it should not count against them or affect scoring.
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Visit www.justice.org/lawstudents for more information on law school scholarships.
2014 AAJ Fact Pattern

DAVID ROOSEVELT, WARREN ROOSEVELT, RANDALL ROOSEVELT, SR., LANA JOY ROOSEVELT, JESSE ROOSEVELT, KERRY ROOSEVELT, MARK ROOSEVELT, MARSHALL ROOSEVELT AND JANICE ROOSEVELT, INDIVIDUALLY AND ON BEHALF OF THEIR DECEASED MOTHER, EVELYN ROOSEVELT

V.

SYDNEY SOTOMAYOR, M.D., CLARENCE THOMAS, M.D., ANTHONY KENNEDY, M.D.
AND ALL SAINTS HOSPITAL

Prepared by Maria Glorioso of The Glorioso Law Firm

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF JUSTICE

NO. 123-456

DAVID ROOSEVELT, WARREN ROOSEVELT, RANDALL ROOSEVELT, SR., LANA JOY ROOSEVELT, JESSE ROOSEVELT, KERRY ROOSEVELT, MARK ROOSEVELT, MARSHALL ROOSEVELT AND JANICE ROOSEVELT, INDIVIDUALLY AND ON BEHALF OF THEIR DECEASED MOTHER, EVELYN ROOSEVELT

VERSUS

SYDNEY SOTOMAYOR, M.D., CLARENCE THOMAS, M.D., ANTHONY KENNEDY, M.D. AND ALL SAINTS HOSPITAL

FILED: ____________________________  DEPUTY CLERK

COMPLAINT

The Complaint of David Roosevelt, Warren Roosevelt, Randall Roosevelt, Sr., Lana Joy Roosevelt, Jesse Roosevelt, Kerry Roosevelt, Mark Roosevelt, Marshall Roosevelt and Janice Roosevelt, majors and residents of States other than that of Defendants, alleges as follows:

I. PARTIES

1. Plaintiffs are the children of Evelyn Roosevelt, deceased.

2. Defendants are:

   a. SYDNEY SOTOMAYOR, M.D., a person of the full age of majority, who upon information and belief was at all times pertinent herein doing business in the State of Justice;

   b. CLARENCE THOMAS, M.D., a person of the full age of majority, who upon information and belief was at all times pertinent herein doing business in the State of Justice;
c. Anthony Kennedy, M.D., a person of the full age of majority, who upon information and belief was at all times pertinent herein doing business in the State of Justice;

d. All Saints Hospital as a defendant in this matter as the employer of the nurses and other employees of All Saints Hospital, a Justice hospital, who at all times pertinent herein was licensed to do and doing business in the State of Justice.

II.

On November 6, 2001, Mrs. Roosevelt, then seventy-five years old, presented to the emergency department of All Saints Hospital with complaints of chest pain.

III.

A past surgical history of cholecystectomy and/or gallbladder removal was noted by the emergency room physician, triage nurse and admitting nurse.

IV.

Later that evening, Mrs. Roosevelt was admitted to All Saints Hospital by her family physician, Clarence Thomas, M.D. Dr. Thomas recorded a past history of kidney stone surgery and shoulder surgery; however, Dr. Thomas did not note or record that Mrs. Roosevelt had had prior gallbladder surgery.

V.

Dr. Thomas ordered an abdominal ultrasound, cardiology consult and gastrointestinal consult, which were all performed on November 7, 2001.
VI.

A radiologist, Dr. Anthony Kennedy, interpreted the abdominal ultrasound as follows:

"Instead of a normal fluid filled distended gallbladder, the
gallbladder region displays high level echoes with posterior
shadowing suspicious for a contracted gallbladder containing
stones, assuming that the gallbladder is still present . . . ."

VII.

On November 8, Mrs. Roosevelt was evaluated by Dr. Sotomayor, a general surgeon, at
the request of Dr. Thomas.

VIII.

Dr. Sotomayor noted a past surgical history of kidney stone removal and left shoulder
surgery. Dr. Sotomayor did not review the triage or E.R. record nor question any of Mrs.
Roosevelt's children.

IX.

Mrs. Roosevelt was seen in consult by gastroenterology specialist Dr. John Roberts who
noted midsternal chest pain—10 minutes and resolved. No nausea, vomiting—now pain free; on
physical exam he noted a small supra-umbilical scar, without hernia. His assessment was
possible esophageal spasm. He planned to do a gastroscopy.

X.

Dr. Sotomayor, a general surgeon selected by Dr. Thomas, saw Mrs. Roosevelt while she
was in the holding area awaiting the gastroscopy to be performed by Dr. Roberts. Dr. Sotomayor
noted mid-anterior chest pain radiating to mid-back, and some nausea but not vomiting or
diarrhea. He read only the “Impression” of the radiology report. He “called off” the gastroscopy for which Mrs. Roosevelt was being prepared and decided to do a laparoscopic cholecystectomy that same evening.

XI.

Prior to the surgery, Mrs. Roosevelt’s daughter, Jesse Roosevelt, advised Dr. Thomas that she thought Mrs. Roosevelt had had her gallbladder removed years earlier. Mrs. Roosevelt’s daughter suggested a review of Mrs. Roosevelt’s past medical records to confirm her past medical history prior to any surgery.

XII.

During the surgery, Dr. Sotomayor found that Mrs. Roosevelt had previously had her gallbladder removed, and he noted numerous surgical clips in the area of the gallbladder, and the surgery ended. Dr. Sotomayor’s post-op orders included resuming all pre-op medications.

XIII.

On November 9, Mrs. Roosevelt’s hematocrit dropped to 26.9. Despite the drastic drop in Mrs. Roosevelt’s hematocrit, Dr. Sotomayor and Dr. Thomas did not suspect a gastrointestinal hemorrhage until the evening of November 10. On the evening of November 10, Mrs. Roosevelt’s pulse dropped to the 40s, and she appeared pale and weak. The drop in her pulse was not noted by the nursing staff because the monitor showed rates in the 80s. Mrs. Roosevelt’s pulse was eventually checked manually at the request of her family.
XIV.

On the evening of November 10, 2001, Dr. Thomas noted, after manually checking her pulse, that it was in the 40s, although the monitor showed rates in the 80s.

XV.

Mrs. Roosevelt’s deteriorating condition went unnoticed by the medical staff for two days following the surgery, thus causing a delay in critical medical care.

XVI.

Post operatively, Mrs. Roosevelt developed multiple complications, including internal bleeding, respiratory complications, and renal failure. However, medical intervention was not initiated until the late evening of November 10, 2001.

XVII.

Petitioners submit that the medical complications suffered by Mrs. Roosevelt could have been treated earlier had Mrs. Roosevelt’s abnormal vital functions been detected sooner.

XVIII.

On November 11, 2001, Mrs. Roosevelt suffered renal failure and required dialysis. During dialysis, she coded and was resuscitated.

XIX.

Following the code, exploratory surgery was performed by Dr. Sotomayor to determine the source of her internal bleeding.

XX.

Mrs. Roosevelt’s condition continued to decline because she suffered neurologic dysfunction from the hypoxia during the code.
XXI.

On November 14, 2001, all supportive measures were removed, and Mrs. Roosevelt died on November 15, 2001.

XXII.

Petitioners submit that All Saints Hospital’s nurses and the defendant physicians failed to properly monitor Mrs. Roosevelt’s vital signs, allowing Mrs. Roosevelt’s condition to deteriorate without detection, thereby causing and/or contributing to her wrongful death.

XXIII.

Petitioners submit that Dr. Sydney Sotomayor deviated from the standard of care during his treatment of Mrs. Roosevelt in the following non-exclusive acts and omissions:

1. Failing to take an appropriate past medical history;
2. Failing to properly diagnose her condition;
3. Misreading the abdominal ultrasound report;
4. Performing an unnecessary surgical procedure;
5. Failing to delay an elective surgical procedure while Mrs. Roosevelt was on several medications that would thin her blood;
6. Failing to timely recognize and diagnose post-operative complications including intra-abdominal bleeding; and
7. Other acts of negligence which may become known through the course of discovery.
XXIV.

Petitioners submit that Dr. Clarence Thomas deviated from the standard of care during his treatment of Mrs. Roosevelt in the following non-exclusive acts and omissions:

1. Failing to take an appropriate past medical history;
2. Failing to obtain past medical records when advised by a family member of their existence;
3. Failing to timely recognize and treat post-operative complications including intra-abdominal bleeding; and
4. Other acts of negligence which may become known through the course of discovery.

XXV.

Petitioners submit that Dr. Anthony Kennedy deviated from the standard of care during his treatment of Mrs. Roosevelt in the following non-exclusive acts and omissions:

1. Failing to properly perform an abdominal ultrasound;
2. Misinterpreting the abdominal ultrasound; and
3. Other acts of negligence which may become known through the course of discovery.

XXVI.

Petitioners submit that All Saints Hospital, through the acts and/or omissions of its nurse employees, who are alleged to have departed from the standard of care by failing to properly monitor and report Mrs. Roosevelt’s vital signs and changing status following surgery, resulting
in delays in medical treatment, thereby caused or contributed to Mrs. Roosevelt’s ultimate demise.

XXVII.

All Saints Hospital, as employer of the nurses attending Mrs. Roosevelt, is responsible for its employees’ actions and omissions, pursuant to the doctrine of respondeat superior.

XXVIII.

Sydney Sotomayor, M.D., Clarence Thomas, M.D., Anthony Kennedy, M.D. and All Saints Hospital are liable individually, jointly and in solido for their acts of negligence which caused personal injuries to and the wrongful death of Evelyn Roosevelt.

XXIX.

As a result of defendants’ negligence, petitioners have suffered, and continue to suffer, mental anguish, loss of consortium and society, loss of love and affection, and loss of services; Mrs. Roosevelt’s family incurred medical and related expenses and burial expenses; Mrs. Roosevelt, before her death, experienced pain, suffering and mental anguish, and petitioners suffered additional damages, and they pray for all damages as are reasonable in the premises.

XXX.

This action arises under the State of Justice’s Medical Malpractice Act, and the medical review panel process is complete.

XXXI.

Plaintiffs request trial by jury on all issues.
WHEREFORE, petitioners David Roosevelt, Warren Roosevelt, Randall Roosevelt, Sr.,
Lana Joy Roosevelt, Jesse Roosevelt, Kerry Roosevelt, Mark Roosevelt, Marshall Roosevelt and
Janice Roosevelt pray that Dr. Sydney Sotomayor, Dr. Clarence Thomas, Dr. Anthony Kennedy,
and All Saints Hospital be served with a copy of this Complaint, be duly cited to appear and
timely answer, and after all legal delays and due proceedings had, that there be judgment herein
in favor of petitioners, David Roosevelt, Warren Roosevelt, Randall Roosevelt, Sr., Lana Joy
Roosevelt, Jesse Roosevelt, Kerry Roosevelt, Mark Roosevelt, Marshall Roosevelt and Janice
Roosevelt and against defendants for all sums as are reasonable in the premises, together with
legal interest on all amounts from the date the request for review was filed, November 6, 2001,
until paid, for all costs of these proceedings and for all general and equitable relief and for trial
by jury on all issues.

Respectfully submitted:

[Signature]
Counsel for Plaintiffs
IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF JUSTICE

NO. 123-456

DAVID ROOSEVELT, WARREN ROOSEVELT, RANDALL ROOSEVELT, SR., LANA JOY ROOSEVELT, JESSE ROOSEVELT, KERRY ROOSEVELT, MARK ROOSEVELT, MARSHALL ROOSEVELT AND JANICE ROOSEVELT, INDIVIDUALLY AND ON BEHALF OF THEIR DECEASED MOTHER, EVELYN ROOSEVELT

VERSUS

SYDNEY SOTOMAYOR, M.D., CLARENCE THOMAS, M.D., ANTHONY KENNEDY, M.D. AND ALL SAINTS HOSPITAL

FILED: ____________________________

DEPUTY CLERK

ANSWER TO COMPLAINT

Now into court come defendants, Sydney Sotomayor, M.D., Clarence Thomas, M.D., Anthony Kennedy, M.D. and All Saints Hospital, who answer the Complaint as follows:

I.

The allegations of paragraph I of the Complaint are admitted.

II.

The allegations of paragraph II of the Complaint are denied as written.

III.

The allegations of paragraph III of the Complaint are denied as written.

IV.

The allegations of paragraph IV of the Complaint are denied as written.
V.
The allegations of paragraph V of the Complaint are admitted.

VI.
The allegations of paragraph VI of the Complaint are denied as written.

VII.
The allegations of paragraph VII of the Complaint are admitted.

VIII.
The allegations of paragraph VIII of the Complaint are denied as written.

IX.
The allegations of paragraph IX of the Complaint are denied as written.

X.
The allegations of paragraph X of the Complaint are denied as written.

XI.
The allegations of paragraph XI of the Complaint are denied as written.

XII.
The allegations of paragraph XII of the Complaint are denied as written.

XIII.
The allegations of paragraph XIII of the Complaint are denied as written.

XIV.
The allegations of paragraph XIV of the Complaint are denied as written.
XV.
The allegations of paragraph XV of the Complaint are denied.

XVI.
The allegations of paragraph XVI of the Complaint are denied as written.

XVII.
The allegations of paragraph XVII of the Complaint are denied.

XVIII.
The allegations of paragraph XVIII of the Complaint are denied as written.

XIX.
The allegations of paragraph XIX of the Complaint are denied as written.

XX.
The allegations of paragraph XX of the Complaint are denied as written.

XXI.
The allegations of paragraph XXI of the Complaint are denied as written.

XXII.
The allegations of paragraph XXII of the Complaint are denied.

XXIII.
The allegations of paragraph XXIII of the Complaint are denied.

XXIV.
The allegations of paragraph XXIV of the Complaint are denied.
XXV. The allegations of paragraph XXV of the Complaint are denied.

XXVI. The allegations of paragraph XXVI of the Complaint are denied.

XXVII. The allegations of paragraph XXVII of the Complaint are denied.

XXVIII. The allegations of paragraph XXVIII of the Complaint are denied.

XXIX. The allegations of paragraph XXIX of the Complaint are denied.

XXX. The allegations of paragraph XXX of the Complaint do not call for an answer by defendants. However, out of an abundance of caution, these allegations are denied for lack of sufficient information to justify a belief therein.

XXXI. AND NOW FURTHER ANSWERING plaintiffs Complaint, defendants Sydney Sotomayor, M.D., Clarence Thomas, M.D., Anthony Kennedy, M.D. and All Saints Hospital aver that they are qualified healthcare providers pursuant to the State of Justice’s Medical Malpractice Act, and as such, are entitled to the protections contained therein including, but not limited to, the $100,000.00/$500,000.00 limitations of liability provisions of the statute.
XXXII.

Further answering plaintiffs’ Complaint, defendants Sydney Sotomayor, M.D., Clarence Thomas, M.D., Anthony Kennedy, M.D. and All Saints Hospital aver that at all relevant times herein they did possess that degree of knowledge and skill ordinarily possessed by physicians licensed to practice their respective specialties in the State of Justice, that they did at all relevant times employ reasonable care and diligence along with their best judgment in the application of that skill and knowledge and that the alleged injuries and damages described by the plaintiffs in their Complaint were not caused by the failure on their part to meet the applicable standard of care.

XXXIII.

Further answering plaintiffs’ Complaint, defendants Sydney Sotomayor, M.D., Clarence Thomas, M.D., Anthony Kennedy, M.D. and All Saints Hospital aver that the plaintiffs’ injuries and damages, if any, were caused by intervening acts of omission or commission of third persons over whom doctors had no authority or control or for whom they bear no liability or responsibility.

XXXIV.

Further answering plaintiffs’ Complaint, defendants Sydney Sotomayor, M.D., Clarence Thomas, M.D., Anthony Kennedy, M.D. and All Saints Hospital aver that the plaintiffs’ own negligence was a contributory factor in this matter, said negligence consisting of, but not limited to, the following particulars:

a. Failure to follow doctors’ orders;

b. Failure to timely seek medical care and/or treatment;
c. Any and all other acts of negligence which will be shown at the trial on
the merits.

XXXV.

Further answering plaintiffs' Complaint, defendants Sydney Sotomayor, M.D., Clarence
Thomas, M.D., Anthony Kennedy, M.D. and All Saints Hospital aver that the Medical Review
Panel which reviewed this matter and rendered its decision determined that the evidence did not
support the conclusion that they failed to meet the applicable standard of care as alleged in the
Complaint, all as more specifically set forth in the Medical Review Panel Opinion attached
hereto as Exhibit "A."

XXXVI.

Further answering plaintiffs' Complaint, defendants respectfully request trial by jury.

WHEREFORE, defendants Sydney Sotomayor, M.D., Clarence Thomas, M.D., Anthony
Kennedy, M.D. and All Saints Hospital pray that their answer be deemed good and sufficient,
that this matter be tried by a jury, and that after due proceedings had, there be a judgment herein
dismissing plaintiffs' suit at plaintiffs' costs and for all general and equitable relief.

Respectfully submitted:

[Signature]
Counsel for Defendants
IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF JUSTICE

NO. 123-456

DAVID ROOSEVELT, WARREN ROOSEVELT, RANDALL ROOSEVELT, SR., LANA JOY ROOSEVELT, JESSE ROOSEVELT, KERRY ROOSEVELT, MARK ROOSEVELT, MARSHALL ROOSEVELT AND JANICE ROOSEVELT, INDIVIDUALLY AND ON BEHALF OF THEIR DECEASED MOTHER, EVELYN ROOSEVELT

VERSUS

SYDNEY SOTOMAYOR, M.D., CLARENCE THOMAS, M.D., ANTHONY KENNEDY, M.D. AND ALL SAINTS HOSPITAL

FILED: ________________________________  A. Jones
DEPUTY CLERK

STIPULATIONS

AND NOW come the parties to this matter, and file the within Stipulations to be used at trial, which shall have the binding effect of being taken as established facts if so offered:


2. The depositions are deemed signed and sworn to by each respective deponent as being accurate as written and authentic. All witnesses including experts have reviewed all documents and depositions contained in the fact pattern.

3. Jesse Roosevelt passed away from heart failure in early 2005. Excerpts or complete testimony from Jesse Roosevelt’s deposition may be read into the record by either side, subject to the Federal Rules of Evidence and Civil Procedure. Time will run against teams that elect to read in excerpts.
4. Plaintiff must call Dr. Scalia as the expert. (Dr. Scalia’s deposition has three attachments consisting of Exhibits marked Scalia 4, 5, 6.) Plaintiff must also call Kerry Roosevelt.

5. Defendant must call Dr. Ginsburg as the expert. Defendant must also call Dr. Sotomayor, the defendant.

6. Dr. Ginsburg and Dr. Scalia are deemed qualified as experts to render opinions in the field of general surgery.

7. Dr. Breyer and Dr. Alito are experts in the field of radiology.

8. “Specialty” rule applies to experts; those not of the same specialty as defendant are deemed “not qualified” to opine on the subject matter of the litigation.

9. All defendants except Dr. Sotomayor have been dismissed through summary judgment.


11. The Medical Review Panel Opinion is self-admitting and if admitted must be done during the admitting team’s case-in-chief.

12. No pre-trial motions or pre-admitting of evidence is allowed.

13. This is a bifurcated case where the parties will try the liability phase only.

14. The Complaint was filed timely.

15. There are no statute of limitations issues.

16. This case involves multiple theories of recovery. Students representing the plaintiffs may present all or choose which theories to present at trial. Students may change theories of recovery from round to round. The defense teams have to be prepared to defend the theories of recovery that are presented at trial.
Glossary of Some of the Medical Terms Used in the Fact Pattern

**Bile duct:** Any of the excretory ducts in the liver that convey bile between the liver and the intestine, including the hepatic, cystic, and common bile ducts. Also called *gall duct*.

**Biliary cholic:** A term used to describe a type of pain related to the gallbladder that occurs when a gallstone transiently obstructs the cystic duct and the gallbladder contracts.

**Bilirubin:** A red bile pigment derived from the degradation of hemoglobin during the normal and abnormal destruction of red blood cells.

**Cholecystectomy:** Surgical removal of the gallbladder.

**Cholecystitis:** Inflammation of the gallbladder.

**Cholelithiasis:** The presence of or formation of gallstones in the gallbladder or bile ducts.

**Coagulopathy:** A disease affecting the coagulability of the blood.

**DD:** Dictated date.

**Diaphoresis:** Perspiration, especially when copious and medically induced.

**Diuresis:** Discharge of urine, especially in unusually large amounts.

**Dyspnea:** Difficulty in breathing, often associated with lung or heart disease and resulting in shortness of breath.

**Endoscopy:** Examination of the interior of a canal or hollow organ by means of an endoscope.

**Esophagogastroduodenoscopy:** A procedure in which a thin scope with a light at the end is used to look at the upper digestive tract.

**Gallbladder:** A small, pear-shaped muscular sac, located under the right lobe of the liver, in which bile secreted by the liver is stored until needed by the body for digestion.

**Gastroscopy:** A procedure wherein an endoscope is used for examining the inner surface of the stomach.

**H & P:** History and physical.

**Hematocrit:** Abbr. Hct. The percentage by volume of packed red blood cells in a given sample of blood after centrifugation.
**Hemoglobin**: Abbr. Hb. The red respiratory protein of red blood cells that transports oxygen as oxyhemoglobin from the lungs to the tissues, where the oxygen is readily released and the oxyhemoglobin becomes hemoglobin.

**Hemorrhage**: An escape of blood from the blood vessels, especially when excessive.

**Hiatal hernia**: A hernia in which part of the stomach protrudes through the esophageal opening of the diaphragm.

**Hyperlipidemia**: An excess of fat or lipids in the blood.

**Hypertension**: 1. Persistent high blood pressure. 2. Arterial disease in which chronic high blood pressure is the primary symptom.

**Hypovolemic shock**: Shock caused by a reduction in the volume of blood, as from hemorrhage.

**Hypoxia**: Insufficient levels of oxygen in blood or tissue.

**Laparoscopic**: A surgical procedure wherein a slender, tubular endoscope is inserted through an incision in the abdominal wall to examine or perform minor surgery within the abdominal or pelvic cavities.

**Laparotomy**: Incision into the abdominal cavity through the loin or flank.

**Platelet**: A minute, irregularly shaped, disklike cytoplasmic body found in blood plasma that promotes blood clotting and has no definite nucleus, no DNA, and no hemoglobin.

**Pro time**: A method for determining prothrombin concentrations in blood based on the clotting time of oxalated blood plasma in the presence of thromboplastin and calcium chloride.

**Renal**: Of or in the region of the kidneys.

**SOB**: Shortness of breath.

**Supra-umbilical**: An area just above the navel.

**TD**: Transcribed date.

**Thrombocytopenia**: An abnormal decrease in the number of platelets in the blood.
All Saints Hospital

Roosevelt, Evelyn

Med Rcd:

Arrival: 11/6/2001 9:28am

Mode of Arrival: Wheelchair

Medications: ALTACE, VOLTAIRE, LIPITOR, NORVASC, PLAVIX

Allergy: KEFLEX

Pt Acct:

Age/DOB: 9/25/1926

MD ED:

NURSING CHART

Patient: Roosevelt, Evelyn

Age/DOB: 9/25/1926

Sex: F

Acuity: 1

Chief Complaint: Chest Pain

Medications: ALTACE, VOLTAIRE, LIPITOR, NORVASC, PLAVIX

Drug Allergy: KEFLEX

RN Template: Triage

Gwen Pezant RN Created: 11/6/2001 9:39pm Last Entry: 9:39pm

NURSING TRIAGE AND ASSESSMENT

HPI:

TRIAGE INFO: C/O CHEST PAID MID STERNUM WHICH SHE DESCRIBES AS DEEP PAIN DENIES RADIATING, DENIES SOB, NO DIAPHORESIS

Symptoms:

ROS:

OBGYN-LMP:

Pain Scale: 8/10

Last Tetanus:

Immunizations:

PREHOSPITAL CARE: none.

PMH: HTN.

Surgeries: GALLBLADDER.

SOCIAL HISTORY:

PHYSICAL EXAM:

DEVELOPMENTAL MILESTONES: appropriate for age.

GENERAL APPEARANCE: comfortable, alert.

MENTAL STATUS: oriented X 3

EYES:

LUNGS:

ABDOMEN:

EXTREMITIES:

SKIN: dry, warm.

NURSING DIAGNOSIS: (+) Alteration in Comfort.

SPECIAL CONSIDERATIONS: family/friend present.

NURSING INTERVENTION: triage to main ED.

Lisa McCorkle PCT Created: 11/6/2001 9:33pm Last Entry: 9:36pm

VITALS (BP P R T): 190/120, 70/20, 97.6 (36.4) oral temp, pulse ox 99% on RA.

HEIGHT:

WEIGHT: 224 LBS.

Reviewed By: (MD)

STAC 22
<table>
<thead>
<tr>
<th>PAST MEDICAL FAMILY HISTORY:</th>
<th>PAST-SURGICAL HISTORY:</th>
<th>SOCIAL HISTORY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>have you or any members of your immediate family have or had any of the following conditions? (Please explain on the lines below):</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>PE/Phlebitis</td>
<td>Diabetes</td>
<td>Occupation:</td>
</tr>
<tr>
<td>COPD</td>
<td>Diverticulitis</td>
<td>Tobacco Use?</td>
</tr>
<tr>
<td>Asthma</td>
<td>PUD</td>
<td>Amount and Type Per Day:</td>
</tr>
<tr>
<td>CHF</td>
<td>Cancer</td>
<td>Alcohol Use?</td>
</tr>
<tr>
<td>CAD/Angina</td>
<td>HIV (AIDS)</td>
<td>Amount and Type Per Day:</td>
</tr>
<tr>
<td>A. M. S.</td>
<td>Kidney Problems</td>
<td>Drug Use?</td>
</tr>
<tr>
<td>MI</td>
<td>Psych Problems</td>
<td>Amount and Type Per Day:</td>
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<tr>
<td>High Cholesterol</td>
<td>Seizures</td>
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<tr>
<td>HTN</td>
<td>Strokes</td>
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<tr>
<td>Vascular Disease</td>
<td>Migraines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VD/PID</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
STAC 24

SYSTEM ABNORMALITIES
24-85102

ORGANS

Orders

Nursing Orders:

Physician/Facility Consult

Differential Diagnosis:

STAC 24
ADMISSION SUMMARY
FOR ADULT PATIENTS

ADMISSION DATE: 11/7/91 TIME 24:39 Information from interview obtained from: ☐ Patient ☐ Other:
Admitted from: ☐ Home ☐ ER ☐ MD Office ☐ Other:
ARMBAND: ☐ Applied
PREVIOUS ADMISSION: ☐ No ☐ Yes If "yes," and less than 5 years ago, give date 5/10/91
Reason for this admission according to patient/significant other: ☐

Treatment in progress:
IV Solution: ☐ None Site: ☐ Hand
☐ Catheter
☐ Drainage Tube
☐ Oxygen 02L NC 100% 02 024S
☐ Feeding Tube
☐ Other:

ALLERGIES:
Drugs: ☐ Koflex, ☐ Salt, ☐ Drugs, ☐ Codeine

Latex:
Food:
Other:

Valuables Brought To Hospital: ☐ No ☐ Yes (If "yes," please complete applicable information below.)
Money At Home Kept by Pt. Sent Home With: ☐ Cashier Comments:
Hearing Aids: ☐ Left ☐ Right
Dentures: ☐ Upper ☐ Lower Denture Cup In Room ☐
Eyeglasses:
Contacts:
Jewelry/Describe: ☐ Rings, ☐ Watch, ☐ White
Hair Accessories:
Equipment/Describe:
*Bio-Med Notified ☐ *Rehab Notified ☐
Other/Describe:

PERSONAL HABITS:
Do you use tobacco? ☐ No ☐ Yes (currently) ☐ Yes (in the past) If yes, what type? ☐ How often? ☐ How long in use?
How long have you been tobacco-free?
Do you use alcohol? ☐ No ☐ Yes (currently) ☐ Yes (in the past) If yes, what type? ☐ How often? ☐ How long in use?
How long have you been alcohol-free?
Do you take any drugs that are not prescribed? ☐ No ☐ Yes
If "yes," please explain:

Blood Pressure: 150/72

Height: 5'5" Weight: 162 lbs
Temperature: 98.6" Oral/rectal/axillary
Pulse: 55 Regular/irregular/Verified
Blood Pressure: 22
Quality of Respiration:
☐ Regular ☐ Non-laborated
☐ Laborated ☐ Shallow

Respiratory Rate: 22

CURRENT MEDICATIONS:
☐ See Medications listed in Physician Orders section of chart.

This list obtained from:
☐ Bottle Labels Available ☐ Patient Interview
☐ Retail Pharmacy ☐ Other MAR

Were medications brought to hospital? ☐ No ☐ Yes
If "yes," disposition: ☐ To Pharmacy
☐ Sent Home With: ☐ Daughter

STAC 25
PAIN/COMFORT SCREENING

Location of Pain
(Mark area with an "X")

Pain: □ No □ Yes

Pain Scale Reviewed: □ No □ Yes

New Pain: □ No □ Yes (< 6 months)

Chronic Pain: □ No □ Yes (> 6 months)

If "yes," Location of Pain:

Origin of Pain:

Pain Intensity (on scale of 0 to 10):

Patient Unable to Evaluate?

Quality of Pain: □ Sharp □ Stabbing □ Dull

□ Burning □ Tingling □ Constant

□ Intermittent □ Throbbing □ Tender

□ Cramping

Frequency (How often does your pain occur?):

□ All of the Time □ Following Activity □ Daytime

□ Late Afternoon □ Bedtime

Onset:

Causative/Aggravating Factors:

□ Body Position □ Movement/Activity □ Anxiety/Stress

Comfort/Measures Used to Relieve Pain:

□ Change in Body Position:

□ Taking Medication [List]:

□ Walking/Activity:

Were the measures effective? □ No □ Yes

Comments:

Acceptable Level to Perform Daily Functions [Pain Goal]:

Comments:

Elimination:

Do you have trouble urinating? □ No □ Yes, Explain:

Are you a dialysis patient? □ No □ Yes

If "yes," and not urgent, notify Dialysis at ext. 2201.

Do you have trouble with bowel movements? □ No □ Yes

If "yes," explain:

Do you require laxatives? □ No □ Yes

If "yes," what type and how often?

Date of last BM: 1/6/01

* If > 3 days, must be addressed/docummented. For patients on routine meds that cause constipation, address if no BM for 2 days.

FAMILY MEDICAL HISTORY

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>FAMILY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

1. Hypertension
2. Kidney Disease
3. Anemia
4. Cancer
5. Heart Disease
6. Ulcer
7. Emphysema/COPD/Asthma
8. Diabetes
9. Arthritis
10. Seizure Disorder
11. Thyroid
12. Glaucoma
13. Sickle Cell Anemia
14. Anesthesia Complications
15. Other:

Surgeries/Major Trauma (Explain): 1/6/01

Comments:

Educational Assessment

Factors that may influence the patient's/significant other's ability and readiness to learn (if any of the following are checked, explain in comments):

□ Cultural

□ Motivation

□ Cognitive Limitation

□ Hearing/Vision/Speaking Impairment

□ Language Barriers

□ Religious Practices

□ Psychosocial Factors

□ None

Comments:

Patient Able to read: □ No □ Yes □ Print Only

How would you like your education provided?

□ Explanation □ Audioc □ Visual

□ Demonstration □ Booklet

Reminder: Implement Patient Education Tool.
BRADEN SCALE

If Braden score is 17 - 23, pressure ulcer prevention precautions will be implemented.
If Braden score is 12 - 16, moderate pressure ulcer prevention precautions will be implemented.
If Braden score is 0 - 11, strict pressure ulcer prevention precautions will be implemented.

Clinical Condition Parameters

1. Sensory Perception: Response to Pressure-Related Discomfort
   - Completely Limited (unresponsive, sedated, coma) 1
   - Very Limited (Responds only to painful stimuli, paraplegic, senile dementia) 2
   - Slightly Limited (Responds to sensory impairment CVA) 3
   - No Impairment (No limiting sensory deficit) 0

2. Moisture: Degree To Which Skin Is Exposed To Moisture
   - Constantly Moist (Always incontinent, 2 or more linen changes every 8 hours) 1
   - Moist (Seldom incontinent, linen change every 8 hours) 2
   - Occasionally Moist (Seldom incontinent, linen changes 2 every 24 hours) 3
   - Rarely Moist (Skin is dry, routine linen change) 0

3. Activity: Degree Of Physical Activity
   - Bed rest (Confined to bed) 1
   - Chairrest (Minimal weight bearing, ambulatory w/ assist) 2
   - Walks Occasionally (Ambulatory short distance, sits mostly) 3
   - Walks frequently (Ambulatory outside room, BID) 0

4. Mobility: Ability To Control, Change Body Position
   - Completely Immobile (Cannot move self) 1
   - Very Limited (Makes insignificant movement) 2
   - Slightly Limited (Makes slight changes independently) 3
   - No limitations (Makes major, independent changes) 0

5. Nutrition: Usual Food Intake Pattern
   - Very Poor: (IPO, IV > 5 days, < 1/3 meals) 1
   - Problem inadequate (Nasal feeding, < 1/2 meals) 2
   - Adequate (TPN, enteral feeds 1/2 meals) 3
   - Excellent (No supplement, eats most meals) 0

6. Friction and Shear: Ability To Maintain Body Position
   - Problem (Requires complete assist, slides down in bed/Chair) 1
   - Potential Problem (Requires maximum assist, sometimes slides down in bed/Chair) 2
   - No Apparent Problem (Moves independently, maintains good position in bed/Chair) 3

Score: 13

If all information not obtainable, please explain:
- Patient Non-verbal
- Patient Poor Historian
- No Family at Bedside
- Other

SKIN ASSESSMENT
- No abnormalities noted.
- Abnormalities present. See "Skin Injury/Wound Assessment Flowsheet."
- WOC notified for Skin Alteration.

Note: Abnormalities include, but are not limited to, skin tears, surgical incisions (does not include healed scars), lacerations, decubitus ulcers, rashes, bruises, and hematomas.

DISCHARGE INFORMATION
Who do you live with? [ ] Other
Number of children at home and ages: [ ]
Who will take care of you after discharge? [ ]
Where will you go at discharge? [ ]
- Home
- [ ] Home w/Home Health
  - Name of Current Home Health:
- [ ] Nursing Home:
  - Name of Current Nursing Home:

- [ ] Other:
  - Medical equipment used at home? [ ] No [ ] Yes
  - Does patient use specialty bed? [ ] No [ ] Yes
  - Name of Company:
    - Community Resources used:
  - Anticipated needs at discharge:
    - Equipment (explain):
    - Supplies (explain):
    - Transportation:
    - Other:

Signatures
- Admit Nurse: [ ] Date: [ ] Time: 2400
- Reviewing RN: [ ] Date: [ ] Time: 2400

STAC 28
All Saints Hospital

Roosevelt EVELYN

DATE: 11/07/2001

Dr. Girremlion

CC: Dr. Thomas

CONSULTATION

HISTORY OF PRESENT ILLNESS: This 75-year-old white female, followed by Dr. Thomas and known to Dr. Delaney, was admitted with a chest pain syndrome. A somewhat well localized, left of the sternum pain was noted. It was sharp in its origin, became more dull, was somewhat improved by splinting, but worsened by direct pressure over the area. There was no associated diaphoresis, dyspnea or nausea. She began to have a similar discomfort earlier today. Further, on Telemetry, she has been noted to have an arrhythmia. Cardiology was asked to see the patient.

The patient is known to Dr. Delaney from a previous evaluation. He had seen the patient, noted her chest discomfort, and on 5/3/01 the patient underwent cardiac catheterization. Normal coronary arteries, normal left ventricular function was found. The patient was having a chest pain syndrome at that time. However, this pain would radiate to her arms and occur with anxiety. She had had a previous evaluation in GENEVille and a stress test did reproduce her pain. Risk factors for heart involvement were noted.

She has not had fever, chills, or sweats. There has been a mild headache, but no focal signs. No vision or hearing change. Mild shortness of breath has been noted. She denies diarrhea or constipation. Indigestion has been noted infrequently. No difficulty with urination.

PHYSICAL EXAMINATION:
GENERAL: Concerned white female, complaining of chest pain.
VITAL SIGNS: Blood pressure 136/70, pulse 64 and irregular, respirations are unlabored.
NECK: Jugular venous distention is not elevated. Carotids are decreased. Distant bruits are heard.
CHEST: Adequate air exchange. Palpation of the left side of the chest does reproduce a discomfort.
HEART: Regular rate and rhythm, with extra beats. Apical impulse is diffuse. S1 and S2 are soft. Cannot clearly hear a systolic murmur or S3.
ABDOMEN: Obese.
LOWER EXTREMITIES: No edema.

LABORATORY FINDINGS: Basic chemistries show abnormalities with a glucose of 137, BUN 24. CPK and MB so far are negative. Abdominal ultrasound is abnormal. Liver profile has abnormalities with a bilirubin of 1.3, albumin 3.5. CBC – White count 6.9, hemoglobin and hematocrit 12.1 and 36.0, MCV 85.6, platelet count 208-K. Chest x-ray shows COPD, heart is felt to be enlarged, but the pulmonary vascularity is normal.
DISCUSSION: This patient has been found to have normal coronary arteries, normal left ventricular function, and presents with a chest pain that is not actually cardiac. I feel that the chest pain should be evaluated in detail for noncardiac causes. The gallbladder abnormality is noted and GI medicine is following the patient.

RECOMMENDATIONS: I am concerned about the arrhythmia, however. Additional laboratory work has been obtained, particularly thyroid values. I will observe her rhythm with you. At the present time, it does not clearly imply the need for a pacemaker. We will follow at this time.

IMPRESSION: Atrial arrhythmias.

V# 13739 / D# 5068
D: CTN/ T: fn

Dr. Girreminion
REASON FOR CONSULTATION: Chest pain.

HISTORY OF PRESENT ILLNESS: Ms. Roosevelt is a 75-year-old white female, admitted to the hospital yesterday for chest pain. The patient reports she had an acute attack of midsternal chest pain that lasted about 10 minutes yesterday and spontaneously resolved. It was not associated with any nausea, vomiting, or diaphoresis. She had a repeat episode while here in the hospital. That one lasted about 5 minutes. She is currently pain free, not having any problems at all. She had similar type episodes to this in May of this year and underwent cardiac angiogram which revealed completely normal coronaries.

PAST MEDICAL HISTORY: Significant for hypertension.

PAST SURGICAL HISTORY: Reportedly a kidney stone surgery.

MEDICATIONS: Lovenox, Ecotrin, Norvasc, Plavix, Voltaren, Altace, Lipitor.

ALLERGIES: Keflex.

SOCIAL HISTORY: Negative for tobacco and alcohol.

FAMILY HISTORY: Negative for gastrointestinal malignancy.

REVIEW OF SYSTEMS: GENERAL: Positive fatigue. PULMONARY: Positive shortness of breath. CARDIAC: Positive chest pain. GI: She denies gastrointestinal bleeding, changes in bowel habits, changes in weight. Remainder of review of systems is normal.

PHYSICAL EXAMINATION:
VITAL SIGNS: Blood pressure 160/80, pulse 72, afebrile.
GENERAL: No acute distress.
HEENT: Eyes – Nonicteric sclerae. Mouth and pharynx normal.
NECK: Supple. No nodes.
HEART: Regular rate and rhythm. No murmurs, gallops, or rubs.
LUNGS: Clear bilaterally.
ABDOMEN: Soft, nontender, nondistended. No hepatosplenomegaly. There is a small supraumbilical scar, without hernia. No other obvious masses noted, etc.
SKIN: Normal inspection.
NEUROLOGIC: Cranial nerves II-XII are grossly intact.
PSYCHIATRIC: Normal insight and judgment.

LABORATORY FINDINGS: Basic metabolic panel is within normal limits. No other labs are available.

ASSESSMENT AND RECOMMENDATIONS: Unexplained chest pain. The patient has had normal recent angiogram. Symptoms sound suggestive of possible esophageal spasm. Plan for further evaluation with upper endoscopy. Will also place her empirically on proton pump inhibitor. Feel this less likely represents possible biliary type pain but will check gallbladder ultrasound for completeness. Further recommendations pending above.

Thank you for allowing me to participate in this patient's care.

John Roberts, MD
V# 13511 / D# 5041
D: DJB / T: fh
All Saints Hospital

Roosevelt, EVELYN

DATE: 11/08/2001

Dr. Sotomayor

CC: Dr. Thomas

CONSULTATION

HISTORY OF PRESENT ILLNESS: This is a 75-year-old, white female, who presented to the emergency room on 11/6/01, with a several hour history of mid anterior chest pain. The pain radiated into the midback at times as well. The pain was associated with some nausea, but no vomiting, diarrhea, hematemesis, melena or bright red rectal bleeding. The patient had a similar episode of pain in May of this year and had an extensive cardiac workup, which did not reveal any abnormality with the coronary arteries.

The patient does relate a three-month history of what she described as heartburn and indigestion. She usually takes Rolaids or drinks milk and often will obtain some relief.

Since admission, she has had a negative cardiac workup to date. She had had gastrointestinal and cardiology consultations. Ultrasound revealed the presence of an abnormal gallbladder with contraction and stones. No dilated biliary ducts were identified.

PAST MEDICAL HISTORY: Positive for hypertension, arthritis and hyperlipidemia.

PREVIOUS SURGERY: - Kidney stone removal and left shoulder surgery.

MEDICATIONS: Norvasc, Plavix, Voltaren, Altace and Lipitor.

ALLERGIES: Keflex and Sulfa drugs.

SOCIAL HISTORY: The patient is a retired nurse. She denies alcohol or tobacco abuse.

FAMILY HISTORY: Positive for heart transplant in one of her daughters, secondary to cardiomyopathy, also positive for high blood pressure and diabetes.

REVIEW OF SYSTEMS: Essentially negative recently, except as described above.

PHYSICAL EXAMINATION:

VITAL SIGNS: Blood pressure 150/60, respirations 18, temperature 98 degrees, pulse 76.

GENERAL: Well-developed, well-nourished, 75-year-old, female in no acute distress.
HEENT: Normocephalic. No scleral icterus. Throat is clear.
NECK: Supple. No palpable masses, no jugular venous distention.
CHEST: Lungs clear bilaterally.
HEART: Normal sinus rhythm, no murmur or gallop.
ABDOMEN: Soft. Mild tenderness to deep palpation in the right upper quadrant. No guarding, rigidity or rebound. No organomegaly. Bowel sounds are active.
PELVIC: Deferred.
RECTAL: Nontender.
EXTREMITIES: No cyanosis or edema.
NEUROLOGICAL: Grossly intact bilaterally.

LABORATORY FINDINGS: White blood cell count 6,900, hematocrit 36%, total bilirubin 1.2, alkaline phosphatase, SGPT and SGOT within normal limits. Indirect bilirubin was also 1.2. Amylase and lipase within normal limits. The EKG negative for any acute changes. Troponin levels normal.

IMPRESSION:
Chronic cholecystitis with cholelithiasis and recent biliary colic.

RECOMMENDATIONS: Laparoscopic cholecystectomy is indicated. We will proceed with a laparoscopic cholecystectomy later today. The patient has been explained the procedure in detail and the risks involved (including bleeding, infection, possible need to revert to standard open cholecystectomy, possible postoperative jaundice requiring second operation and death). The patient states that she understands the discussion and consent will be signed.

Thank you very much for this consultation.

Sydney Sotomayor, M.D.
NAME: Roosevelt, Evelyn
DOB: 09/25/25
MED REC: 243562
K-RAy #: 0131000439
FOLDER #: 243562
TECH: McCourley, Crystal
Roosevelt, Evelyn

ABDOMINAL ULTRASOUND: 11/7/01

CLINICAL HISTORY: 75-year-old female with abdominal pain.

INTERPRETATION: No comparison study.

Instead of a normal fluid filled distended gallbladder, the gallbladder region displays high level echoes with posterior shadowing suspicious for a contracted gallbladder containing stones, assuming that the gallbladder is still present. No dilated bile ducts or ascites or pleural fluid or aortic aneurysm or pancreatic mass or enlargement. Liver and spleen do not appear enlarged or demonstrate mass. The right kidney measures 10.1 cm in length and the left kidney 11.3 cm with possible mild prominence or distention of the left renal pelvis. No evidence of hydrenephrosis or suspicious mass or shadowing calcification.

IMPRESSION:
1. ABNORMAL GALBLADDER REGION SUSPICIOUS FOR CONTRACTED GALBLADDER POSSIBLY CONTAINING SHADOWING STONES. NO DILATED BILE DUCTS. CONSIDER GENERAL SURGERY CONSULTATION.

2. PROBABLY SLIGHTLY PROMINENT LEFT RENAL PELVIS AS AN ANATOMIC VARIANT.

11/07/01 SM /MP
14:56

Anthony Kennedy, MD

STAC 35
All Angels Hospital

Patient Name: Roosevelt, Evelyn
Clinic Number: 853915
Date of Procedure: 09/26/91

OPERATIVE NOTE

<table>
<thead>
<tr>
<th>SURGEON:</th>
<th>JOHN, C., MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASSISTANT:</td>
<td>ROBERT, W., MD</td>
</tr>
<tr>
<td></td>
<td>THOMAS, E., MD</td>
</tr>
<tr>
<td>PREOPERATIVE DIAGNOSIS:</td>
<td>BILIARY PANCREATITIS.</td>
</tr>
<tr>
<td>POSTOPERATIVE DIAGNOSIS:</td>
<td>BILIARY PANCREATITIS.</td>
</tr>
<tr>
<td>OPERATION:</td>
<td>LAPAROSCOPIC CHOLECYSTECTOMY.</td>
</tr>
<tr>
<td>ANESTHESIA:</td>
<td>General.</td>
</tr>
</tbody>
</table>

INDICATIONS: The patient is a 64 year old white female who presented to All Angels with complaints of a five day history of general malaise. The patient also noted mid epigastric right upper quadrant pain which radiated to the back. The patient on physical examination was noted to be tender over the right upper quadrant and mid epigastrium. Significant labs revealed an elevated white count of 16,000 and amylase of 19,000. An ultrasound was done which revealed cholelithiasis with normal common bile ducts and a diagnosis of biliary pancreatitis was subsequently made. The patient was also noted to have an elevated alkaline phosphatase. The patient underwent ERCP which revealed a normal common bile duct and pancreatic ducts. The patient was then placed on antibiotics and the amylase returned to normal. The patient is now to undergo laparoscopic cholecystectomy.

PROCEDURE IN DETAIL: After formal consent was obtained, the patient was brought to the Operating Room and placed supine upon the Operating Room table. General anesthesia was induced; see Anesthetic Report for details. The patient's abdomen was subsequently Betadine prepped and steriley draped in the appropriate manner. The patient had placement of a nasogastric tube and Foley catheter. A supraumbilical incision was made and carried down to the fascia. The Verres needle was subsequently introduced without complications. Normal saline flushed well and the drop test was positive. The abdomen was then insufflated with CO2 to approximately 15 mm Hg. This was done without complications. A 10 mm trocar was subsequently introduced through the incision. The camera was introduced and on gross inspection of the abdomen there was no evidence of gross pathology.

The two lateral 5 mm trocars were then placed in the right anterior flank of the abdomen and the 10 mm trocar was then placed just inferior to the xiphoid to the right of the falsiform ligament. The gallbladder was identified and retracted with grasping forceps.

STAC 36
The gallbladder was then removed from the gallbladder bed using the electrocautery unit. This was done without complications. Hemostasis was maintained with the electrocautery unit. Copious amounts of irrigation were used. The gallbladder was then removed from the umbilical incision after removing several stones with the grasping forceps. On last inspection of the abdomen, there was no evidence of bleeding and all trocars were removed under direct vision with no evidence of bleeding. Air was then removed from the abdomen and positive inspiratory breaths were done to insure adequate removal of the CO₂ from under the diaphragm. A 0 Vicryl stitch was placed in the fascia at the umbilicus and the skin was closed with interrupted 4-0 Dexon. Steri-Strips were then placed. The patient was subsequently extubated and taken to the Recovery Room in stable and satisfactory condition. There were no complications. Estimated blood loss was approximately 5 cc.

Dictated By: ROBERT, W. MD
CONSENT FORM ATTACHMENT FOR
TRANSFUSION OF BLOOD
AND BLOOD COMPONENTS

Dx : R/O MI

Iso: 
Smk: UNK
Sgy: 11/08/01 LAPRASCOPIC EXPLORATI
Type: I/P
3207-B 000243562 0131000439
Adm : 11/06/01 Dob: 09/25/26 75Y
Phys: Thomas, C.
Level: Roosevelt, EVELYN
Sex: F

The Justice Medical Disclosure Panel has identified the following risks associated with Transfusion of Blood and Blood Components:

1. Fever.
2. Transfusion reaction which may include kidney failure or anemia.
3. Heart failure.
4. Hepatitis.
5. AIDS (Acquired Immune Deficiency Syndrome).
6. Other infections.

Other risks, if any, associated with this procedure are:
1. Death.
2. Kidney failure indicated in #2 above may involve permanent failure.

I acknowledge that I have received and read the above list of risks associated with Transfusion of Blood and Blood Components.

Signature of Patient __________________________ Date 11/10/01

Signature of Representative (where required) X Jesse Roosevelt
Relationship to Patient Daughter
Witness __________________________
PATIENT CONSENT TO MEDICAL TREATMENT

OR SURGICAL PROCEDURE AND

ACKNOWLEDGMENT OF RECEIPT OF MEDICAL INFORMATION PAGE 1

READ CAREFULLY BEFORE SIGNING

TO THE PATIENT: You have been told that you should consider medical treatment/surgery. JUSTICE law requires us to tell you (1) the nature of your condition, (2) the general nature of the medical treatment/surgery, (3) the risks of the proposed treatment/surgery, as defined by the JUSTICE Medical Disclosure Panel or as determined by your doctor, (4) reasonable therapeutic alternatives and material risks associated with such alternatives, and (5) risks of no treatment.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

In keeping with the JUSTICE law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. We wish to inform you as completely as possible. Please read the form carefully. Ask about anything you do not understand, and we will be pleased to explain.

1. PATIENT NAME: Evelyn Lawrence

2. TREATMENT/PROCEDURE: Laparoscopic cholecystectomy
   (a) Description, nature of the treatment/procedure: Make small cuts on
   (b) Purpose: The abdomen
       to remove the gallbladder

3. PATIENT CONDITION:
   Patient's diagnosis, description of the nature of the condition or ailment for which the medical treatment, surgical procedure or other therapy described in item number 2 is indicated and recommended:
       Choleystitis, Cholelithiasis

4. MATERIAL RISKS OF TREATMENT PROCEDURE:
   (a) All medical or surgical treatment involves risks. Listed below are those risks associated with this procedure that we believe a reasonable person in your (the patient's) position would likely consider significant when deciding whether to have or forego the proposed therapy. Please ask your physician if you would like additional information regarding the nature or consequences of these risks, their likelihood of occurrence, or other associated risks that you might consider significant but may not be listed below.
   X See attachment for risks identified by the JUSTICE Medical Disclosure Panel
   ___ See attachment for risks determined by your doctor

HBOC #5032

- 2 -
PATIENT CONSENT TO MEDICAL TREATMENT

Dx: R/O MI

OR SURGICAL PROCEDURE AND

ACKNOWLEDGMENT OF RECEIPT OF MEDICAL

INFORMATION PAGE 2

(b) Additional risks (if any) particular to the patient because of a complicating medical condition are:

(c) Risks generally associated with any surgical treatment/procedure, including anesthesia are: death, brain damage, disfiguring scars, quadriplegia (paralysis from neck down), paraplegia (paralysis from waist down), loss or loss of function of any organ or limb, infection, bleeding, and pain.

5. REASONABLE THERAPEUTIC ALTERNATIVES AND RISKS ASSOCIATED THEREWITH, RISKS OF NO TREATMENT:

5. ACKNOWLEDGMENT

AUTHORIZATION AND CONSENT

(a) NO GUARANTEES: All information given me and, in particular, all estimates made as to the likelihood of occurrence of risks of this or alternate procedures or as to the prospects of success, are made in the best professional judgment of my physician. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is and can be no guarantee, either express or implied, as to the success or other results of the medical treatment or surgical procedure.

(b) ADDITIONAL INFORMATION: Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.

(c) PARTICULAR CONCERNS: I have had an opportunity to disclose to and discuss with the physician providing such information, those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.

(d) QUESTIONS: I have had an opportunity to ask, and I have asked, any questions I may have about the information in this document and any other questions I have about the proposed treatment or procedure, and all such questions were answered in a satisfactory manner.

(e) AUTHORIZED PHYSICIAN: The physician (or physician group) authorized to administer or perform the medical treatment, surgical procedures or other therapy described in item 2 is:

(Name of authorized physician or group) Sotomayor

(f) PHYSICIAN CERTIFICATION: I hereby certify that I have provided and explained the information set forth herein, including any attachment, and answered all questions of the patient, or the patient's representative, concerning the medical treatment or surgical procedure, to the best of my knowledge and ability.

Physician's Signature: Sotomayor Date/Time 1/1/01

STAC 40
CONSENT: I hereby authorize and direct the designated authorized physician/group, together with associates and assistants of his choice, to administer or perform the medical treatment or surgical procedure described in item 2 of this Consent Form, including any additional procedures or services as they may deem necessary or reasonable, including the administration of any general or regional anesthetic agent, x-ray or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure, and I hereby consent thereto.

I have read and understand all information set forth in this document, including any attachment, and all blanks were filled in prior to my signing. This authorization for and consent to medical treatment or surgical procedure is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask any questions about the contemplated medical procedure or surgical procedure described in item 2 of this consent form, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

Witness

Patient or person Authorized to Consent

Date/Time

If consent is signed by someone other than the patient, state the reason and relationship

---

STAC 41

- 4 -
A blood transfusion is the infusion of blood or a blood component into the body through a vein. Some of the reasons for a blood transfusion are to replace lost blood volume and the oxygen-carrying capacity of the circulatory system, and to treat low "blood counts" (hemoglobin and hematocrit levels).

Your physician has prescribed the following:

A nurse with special training will administer the blood transfusion and monitor you while you are receiving your transfusion.

Every effort has been made to ensure that the blood you are receiving is correct and safe. However, sometimes allergic reactions to the blood occur. Listed below are some symptoms of transfusion reactions. If any of these occur, tell your nurse immediately. After you leave the hospital if any of these symptoms occur, contact your physician. If the physician cannot be reached, call the emergency room or return to emergency room (E.R. #230-6180).

Fever or chills
Flushing of the face
Hives, rash, or itching
Difficulty in breathing or shortness of breath
Pain or oozing of blood from I.V. needle site or a large bruise increasing in size. (Elevate the arm and apply pressure to the I.V. needle site to control bleeding, call physician.)
Low back pain
Feeling of uneasiness
Chest pain
Headache, nausea or vomiting
Weakness or fainting
Blood in the urine or dark urine
Decreased urine output
Any other abnormality or unusual discomfort

(These symptoms may also occur within 24 to 48 hours after transfusion. If so, notify your physician immediately). Yellowing of the skin can occur from 1-6 months after receiving blood. If so, notify your physician immediately.

I have received and understand the above instructions.

NURSE: [Signature] PATIENT: [Signature] DATE: 4/10/01 09:20

CHART COPY

- S - HBCO # 5032

STAC 42
OPERATIVE REPORT

OPERATION: Esophagogastroduodenoscopy, no biopsies.

PROCEDURE IN DETAIL: Oropharynx sprayed with cetacaine. Demerol 30, Versed 1.5. Conscious sedation used on patient. Oxygen per nasal cannula, pulse oximetry, cardiac monitoring, blood pressure every five minutes.

Scope passed under direct vision. Larynx normal. UES normal. Esophageal body normal. She has a Z line that is intact. She has a lower esophageal ring which is thickened, but it is wide opened. Hiatal hernia is of moderate size. There is some retained food in it. In the stomach she has a moderate amount of retained food. It is all green colored. We could not suck it all up, although we tried irrigating it repeatedly. I cannot rule out a lesion high in the stomach, especially on greater curve. In the distal body in the proximal antrum there are some erosions which have signs of recent bleeding. They do not appear to be the chronic type we usually see. They appear to be relatively fresh, raising the possibility of esophagogastric tube trauma. The rest of the antrum appears normal. Pylorus open and nonfriable. The bulb is normal as well as fornix of bulb. In the C-loop she has some pale red spots which are not typical of angiodysplasias, but they are present. No biopsies taken.

DIAGNOSES:
1. Retained food.
2. Erosions.
3. Shallow ulcerations in distal body, proximal antrum. See photos three and four.
4. Moderate size hiatal hernia with retained food.
5. Open lower esophageal ring.

RECOMMENDATIONS: Could recommend the use of a ProTime pump inhibitor. We might want to use a motility drug if symptoms would demand that. If she has symptoms of dysphagia we can offer dilatation.

...continued...
Thanks for letting me help out.

Job#14990/MT680
dd: 11/10/01
dt: 11/12/01
TO THE PATIENT: You have been told that you should consider medical treatment/surgery. The Medical Disclosure Panel Law requires us to tell you (1) the nature of your condition, (2) the general nature of the procedure/treatment/surgery, (3) the risks of the proposed treatment/surgery, as defined by the Medical Disclosure Panel, and (4) reasonable therapeutic alternatives and risks associated with such alternatives.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

In keeping with the State Law of Informed Consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. We wish to inform you as completely as possible. Please read the form carefully. Ask about anything you do not understand, and we will be pleased to explain it.

1. Patient Name: Evelyn Roosevelt

2. Treatment/Procedure:
   - Description, nature of the treatment/procedure: Esophagostroduodenoscopy, obtain specimens, polypectomies, dilation of strictures, control bleeding.
   - Purpose: Use a lighted, flexible tube to examine the esophagus, stomach and duodenum, take tissue samples, enlarge narrow openings, remove polyps and control bleeding.

3. Patient Condition:
   Patient's diagnosis, description of the nature of the condition or ailment for which the medical treatment, surgical procedure or other therapy described in item number 2 is indicated and recommended:

4. Material Risks of treatment procedure:
   - The material risks associated with the medical treatment, surgical procedure, or other therapy described in item number 2 of this consent form, as required by the Medical Disclosure Panel Law, are:
     _X_ See attachment GI 2 Not yet determined; risks as determined by your doctor are:
     Drug reaction
     Respiratory arrest
   - Additional risks (if any) particular to the patient because of a complicating medical condition are:

HBOC #00114
PATIENT CONSENT FOR MEDICAL TREATMENT/SURGICAL PROCEDURE AND ACKNOWLEDGMENT, AUTHORIZATION AND CONSENT

Dx: R/O MI

Iso: Smk: UNK
Sgy: Type: OVP

3207-3 000243562 0131000439
Adm: 11/06/01 Dob: 09/25/26 75Y
Phys: Thomas, C. Level: Roosevelt, Evelyn

(c) Risks generally associated with any surgical treatment/procedure, including anesthesia are: death, brain damage, disfiguring scars, paralysis, the loss of or loss of function of body organs, the loss of or loss of function of any arm or leg, infection, bleeding, and pain.

5. Therapeutic alternatives and risks associated therewith:
Reasonable therapeutic alternatives and the risks associated with such alternatives are: X-ray evaluation or surgery

ACKNOWLEDGEMENT AUTHORIZATION AND CONSENT

6. (a) No Guarantees: All information given me and, in particular, all estimates made as to the likelihood of occurrence of risks of this or alternate procedures or as to the prospects of success, are made in the best professional judgment of my physician. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there are and can be no guarantees, either express or implied, as to the success or other results of the medical treatment or surgical procedure.

(b) Additional Information: Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.

(c) Particular Concerns: I have had an opportunity to disclose to and discuss with the physician providing such information, those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.

(d) Questions: I have had an opportunity to ask, and I have asked, any questions I may have about the information in this document and any other questions I have about the proposed treatment or procedure, and all such questions were answered in a satisfactory manner.

(e) Authorized Physician: The physician (or physician group) authorized to administer or perform the medical treatment, surgical procedures or other therapy described in item 2 is:

Full name of authorized physician/group: Drs. Moolah, Gensler, Richard or Roberts

(f) Physician Certification: I hereby certify that I have provided and explained the information set forth herein and answered all questions of the patient, or the patient's representative, concerning the medical treatment or surgical procedure, to the best of my knowledge and ability.

HBOC #00114

- 2 -

STAC 46
CONSENT

Consent: I hereby authorize and direct the designated authorized physician/group, together with associates and assistants of his choice, to administer or perform the medical treatment or surgical procedure described in item number 2 of this consent form, including any additional procedures or services as they may deem necessary or reasonable, including the administration of any general or regional anesthetic agent, X-ray or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure, and I hereby consent thereto.

I have read and understand all information set forth in this document, and all applicable blanks were filled in prior to my signing. This authorization for and consent to medical treatment or surgical procedure is and shall remain valid until revoked by me in writing.

I acknowledge that I have had the opportunity to ask any questions about the contemplated medical procedure or surgical procedure described in item number 2 of this consent form, including risks or alternatives, and acknowledge that my questions have been answered to my satisfaction.

HBOC #00114
PATIENT CONSENT FOR MEDICAL TREATMENT/SURGICAL PROCEDURE AND ACKNOWLEDGMENT, AUTHORIZATION AND CONSENT ATTACHMENT GI 2

PATIENT CONSENT TO TREATMENT DISCLOSURE OF RISKS

The Justice Medical Disclosure Panel has identified that the following material risks are associated with the medical treatments and surgical procedures listed below. Please review closely those risks associated with the procedure(s) for which you are scheduled as listed in item No. 2 of the consent form.

ESOPHAGEAL DILATION/ESOPHAGOGASTRODUODENOSCOPY
1. Infection.
2. Bleeding which may require transfusion and/or surgery.
3. Perforation of esophagus, stomach, intestinal wall which may require surgery.
4. Respiratory arrest.
5. Cardiac arrhythmias (irregular heartbeats).

Physician Certification: I hereby certify that I have provided and explained the information set forth herein and answered all questions of the patient, or the patient's representative, concerning the medical treatment or surgical procedure, to the best of my knowledge and ability.

[Signature of Physician] Date/Time

Consent: I have read and understand all information set forth in this document and all applicable blanks were filled in prior to my signing. I acknowledge that I have had the opportunity to discuss with my doctor and to ask any questions about the risks associated with this procedure, including those listed above, and that all my questions have been answered to my satisfaction.

[Signature of Patient] Date/Time

[Signature of Patient Representative (if required)] Date/Time

[Signature of Witness] Date/Time Relationship to Patient

[Print Representative's Name]

[Patient Representative's Address] HBCO #00114

Dx: R/O MI

Iso: Smk: UNK

Sgy: Type: OVP

3207-B 000243562 013100439

Adm: 11/06/01 Dob: 09/25/26 75Y

Phys: Thomas, C. Level: Roosevelt, EVELYN Sex: F
CONSCIOUS SEDATION/LOCAL ANESTHESIA

I, [Signature], acknowledge that my doctor has explained to me that I will have an operation, diagnostic or treatment procedure. My doctor has explained the risks of the procedure, advised me of alternative treatments and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia conscious sedation services are needed so that my doctor can perform the operation or procedure. Anesthesia conscious sedation services do not normally involve Anesthesia Department personnel (Anesthesiologists and CRNA's).

It has been explained to me that all forms of anesthesia involve some risks, and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected severe complications with anesthesia conscious sedation can occur and include the remote possibility of infection, bleeding, drug allergy reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. Some patients may experience nausea, vomiting, hypotension or hypertension. I understand that the type(s) of anesthesia conscious sedation service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthesia conscious sedation technique which involves the use of local anesthetics, with or without sedation, may not succeed completely and, therefore, another technique may have to be used including general anesthesia.

Monitored Conscious Sedation
Expected Result: Reduced anxiety and pain, partial or total amnesia.

   Technique: Drug injected into the bloodstream, intravenously, given by mouth or intramuscularly, producing a semi-conscious state.

   Risks: An unconscious state, depressed breathing, injury to blood vessels and/or tissue.

Local Anesthesia
Expected Result: Temporary loss of feeling and/or movement of a specific limb or area.

   Technique: Drug injected near nerves providing loss of sensation to the area of the operation.

   Risks: Infection, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels.

Pregnancy: The fetus could be affected by injected agents in the pregnant patient.
I hereby consent to receive the conscious sedation service checked above. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by my physician, which may be provided by Anesthesia Department personnel.

I certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia conscious sedation service and that I had ample time to ask questions and to consider my decision.

[Signature]
Date/Time

Substitute's Signature  Relationship to Patient

[Signature]
Date/Time

<table>
<thead>
<tr>
<th>PHYSICAL STATUS CLASSIFICATION (Circle One.)</th>
<th>American Society of Anesthesia</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA 1 A normal, healthy patient</td>
<td></td>
</tr>
<tr>
<td>ASA 2 A patient with a mild systemic disease (mild diabetes, controlled hypertension, anemia, chronic bronchitis, morbid obesity)</td>
<td></td>
</tr>
<tr>
<td>ASA 3 A patient with a severe systemic disease that limits activity (angina, obstructive pulmonary disease, prior myocardial infarction)</td>
<td></td>
</tr>
<tr>
<td>ASA 4 A patient with an incapacitating disease that is a constant threat to life (heart failure, renal failure)</td>
<td></td>
</tr>
<tr>
<td>ASA 5 A moribund patient not expected to survive 24 hours (ruptured aneurysm, head trauma with increasing intracranial pressure)</td>
<td></td>
</tr>
</tbody>
</table>

Physician's Signature

HBOC #00114/00023
rev 1/2000

- 6 -
OPERATIVE/PROCEDURE REPORT

NAME OF OPERATION: Laparoscopic exploration.

PREOPERATIVE DIAGNOSIS: Chronic cholecystitis and cholelithiasis.

POSTOPERATIVE DIAGNOSIS: Evidence of previous cholecystectomy.

HISTORY OF PRESENT ILLNESS: This is a 75-year-old white female with a history of chest pain in the mid anterior area. The patient has undergone a cardiac workup which was negative. The patient underwent an abdominal ultrasound which revealed the presence of a contracted gallbladder with stones. Preoperative lab work revealed a total bilirubin of 1.3. The patient gave a history of previous "kidney stone surgery" but no history of previous gallbladder surgery.

DESCRIPTION OF PROCEDURE: The patient was placed on the operating table in the supine position and after adequate general endotracheal anesthesia had been obtained, the patient’s abdomen was prepped and draped in the usual sterile fashion. The anterior abdominal wall was then elevated and a 1-cm incision was made in the superior umbilicus. The Veress needle was then inserted and the pneumoperitoneum was obtained with carbon dioxide. Under direct vision, 5-mm trocars were placed in the right mid and right lateral subcostal areas, and another 10-mm trocar was placed into the epigastrum just to the right of the midline.

Attention was turned to the right upper quadrant where there was noted to be intense adherence of omentum and colon onto the undersurface of the right lobe of the liver. Blunt dissection of a careful nature was then carried out and the adherent omentum and colon were dissected off of the undersurface of the liver. No obvious gallbladder was seen during this dissection. The dissection was carried down into the mid gallbladder fossa area and at this point, multiple surgical clips were encountered. Photographs were obtained. At least 7-8 surgical clips were counted.

Further careful dissection was performed in an attempt to delineate the anatomy, but because of the intense and chronic scarring, it was not possible to delineate further the anatomy. Visualization gave the impression that there was a gallbladder remnant present, but this could not be definitely confirmed. The common bile duct structures could not be identified visually.

At this point, it was felt that the best approach would be to end the operation and perform ERCP in the near future. Also attempts will be made to obtain any previous operative reports on this patient.
At this point, the entire right upper quadrant area was copiously irrigated with sterile saline solution. Hemostasis was noted to be intact. The pneumoperitoneum was then released and the umbilical fascia was closed with simple sutures of 0 Vicryl. The skin wounds were then closed with subcuticular sutures of 5-0 PDS. Sterile Band-Aids were applied and the patient retrieved from anesthesia and taken to the recovery room in satisfactory condition.

Signed: Sydney Sotomayor, M.D.

V# 14217/ D# 5512
D: FJL/ T: osia1
CONSENT FORM ATTACHMENT FOR
CHOLECYSTECTOMY WITH OR WITHOUT
COMMON BILE DUCT EXPLORATION

Dx : R/O MI
Iso: 
Smk: UNK
Sgy: 11/08/01 GASTROSCOPY
Type: OVP
3207-B 000243562 0131080439
Adm : 11/06/01 Dob: 09/25/26 75 Y
Phvs: Thomas, Clarence
Level: 
Roeveln: EVELYN

Sex: F

The JUICE Medical Disclosure Panel has identified the following risks associated with Cholecystectomy (Removal of the Gallbladder) With or Without Common Bile Duct Exploration:

1. Pancreatitis (inflammation of the gland that produces insulin).
2. Injury to the tube (common bile duct) between the liver and the bowel.
3. Retained stones in the tube (common bile duct) between the liver and the bowel.
4. Narrowing or obstruction of the tube (common bile duct) between the liver and the bowel.
5. Injury to the bowel and/or intestinal obstruction.

Other risks, if any, associated with this procedure are:

I acknowledge that I have received and read the above list of risks associated with Cholecystectomy (Removal of the Gallbladder) With or Without Common Bile Duct Exploration.

Signature of Patient

Evelyn Roosevelt Date 11/01/01

Signature of Representative (where required)

Relationship to Patient

Witness

HBOC CD #5031
PROCEDURE FOR THE COMPLETION AND USE OF
MEDICAL AND SURGICAL CONSENT FORM AND ATTACHMENTS

1. DUTY TO INFORM: A physician has a duty to inform his or her patient about proposed medical or surgical treatment. Since Justice law requires that a patient be given an opportunity to ask questions and that these questions be answered in a satisfactory manner, the risks and hazards of a proposed medical or surgical procedure should be disclosed to and discussed with the patient by the physician who will actually perform the contemplated procedure.

2. CONSENT FORM: A patient's consent to treatment should be documented by the use of the written form entitled "Consent for Medical or Surgical Treatment and Acknowledgment of Receipt of Information". A consent form should be completed for each specific medical or surgical procedure recommended.

3. ATTACHMENTS FOR RISKS IDENTIFIED BY MEDICAL DISCLOSURE PANEL: The Consent Form requires the attachment of the list of risks associated with the proposed medical or surgical treatment identified by the Justice Medical Disclosure Panel. The Attachment(s) should also include any additional risks identified by the physician. The Attachment(s) must be annexed to the Consent Form.

4. ATTACHMENTS FOR OTHER RISKS: The Medical Disclosure Panel has not yet identified risks for certain medical or surgical procedures. Accordingly, the physician must identify the risks for these medical or surgical procedures on the attachment numbered 5001. This Attachment must be annexed to the Consent Form.

5. OUTLINE FOR DISCUSSION WITH PATIENT: The Consent Form, with its Attachment(s), provides a useful outline for the physician's discussion of the purpose of the proposed treatment and its risks and hazards. The Consent Form and Attachment(s) should be completed by the physician prior to the discussion of the proposed medical or surgical procedure with the patient.

6. PATIENT SIGNATURES: The patient's signature (or his/her representative) must be obtained on the Attachment(s) of specific risks and on the Consent Form itself. The patient's signature (or his/her representative) on both the Attachment(s) and the Consent Form must be dated and witnessed.

7. PHYSICIAN CERTIFICATION: The physician Certification should be signed by the physician after the informed consent discussion with the patient.

8. WITNESS: The most medically sophisticated person available should be present when the patient signs the Consent Form, with its Attachments, and legibly sign the forms as a witness.

9. FILE CONSENT FORM IN HOSPITAL CHART: The original Consent Form and Attachment(s) should be placed in the patient's hospital chart. If the patient requests a copy of the Consent Form and/or Attachment(s), give the patient a copy of the Consent Form and all Attachments.

HBOC #5031

- 2 -
PATIENT CONSENT TO MEDICAL TREATMENT

Dx: R/O MI

OR SURGICAL PROCEDURE AND

ACKNOWLEDGMENT OF RECEIPT OF MEDICAL

INFORMATION PAGE 1

READ CAREFULLY BEFORE SIGNING

TO THE PATIENT: You have been told that you should consider medical
treatment/surgery. Justice law requires us to tell you (1) the nature of
your condition, (2) the general nature of the medical treatment/surgery,
(3) the risks of the proposed treatment/surgery, as defined by the
Justice Medical Disclosure Panel or as determined by your doctor,
(4) reasonable therapeutic alternatives and material risks associated with
such alternatives, and (5) risks of no treatment.

You have the right, as a patient, to be informed about your condition and
the recommended surgical, medical or diagnostic procedure to be used so
that you may make the decision whether or not to undergo the procedure
after knowing the risks and hazards involved.

In keeping with the Justice law of informed consent, you are being asked
to sign a confirmation that we have discussed all these matters. We have
already discussed with you the common problems and risks. We wish to
inform you as completely as possible. Please read the form carefully. Ask
about anything you do not understand, and we will be pleased to explain.

1. PATIENT NAME: Evelyn Roosevelt

2) TREATMENT/PROCEDURE: Laparoscopic cholecystectomy
(a) Description, nature of the treatment/procedure: make small cuts in the abdomen

(b) Purpose: to remove the gallbladder

3. PATIENT CONDITION:
Patient's diagnosis, description of the nature of the condition or ailment
for which the medical treatment, surgical procedure or other therapy
described in item number 2 is indicated and recommended:

4. MATERIAL RISKS OF TREATMENT PROCEDURE:
(a) All medical or surgical treatment involves risks. Listed below are
those risks associated with this procedure that we believe a reasonable
person in your (the patient's) position would likely consider significant
when deciding whether to have or forego the proposed therapy. Please ask
your physician if you would like additional information regarding the
nature or consequences of these risks, their likelihood of occurrence, or
other associated risks that you might consider significant but may not be
listed below.

_x See attachment for risks identified by the Justice Medical
- Disclosure Panel
____ See attachment for risks determined by your doctor

- 3 -

HBOC #5031

STAC 55
PATIENT CONSENT TO MEDICAL TREATMENT

OR SURGICAL PROCEDURE AND

ACKNOWLEDGMENT OF RECEIPT OF MEDICAL
INFORMATION PAGE 2

Dx: R/O MI

Iso: Smk: UNK
Sgy: 11/08/01 GASTROSCOPY
Type: OVP
3207-B 000243562 0131000439
Adm: 11/06/01 Dob: 09/25/26 75V
Phys: Thomas, C. Level: ROOSEVELT, EVELYN
Sex: F

(b) Additional risks (if any) particular to the patient because of a complicating medical condition are:

(c) Risks generally associated with any surgical treatment/procedure, including anesthesia are: death, brain damage, disfiguring scars, quadriplegia (paralysis from neck down), paraplegia (paralysis from waist down), loss or loss of function of any organ or limb, infection, bleeding, and pain.

5. REASONABLE THERAPEUTIC ALTERNATIVES AND RISKS ASSOCIATED THEREWITH, RISKS OF NO TREATMENT:

6. ACKNOWLEDGMENT AUTHORIZATION AND CONSENT

(a) NO GUARANTEES: All information given me and, in particular, all estimates made as to the prospects of success, are made in the best professional judgment of my physician. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is and can be no guarantee, either express or implied, as to the success or other results of the medical treatment or surgical procedure.

(b) ADDITIONAL INFORMATION: Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.

(c) PARTICULAR CONCERNS: I have had an opportunity to disclose to and discuss with the physician providing such information, those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.

(d) QUESTIONS: I have had an opportunity to ask, and I have asked, any questions I may have about the information in this document and any other questions I have about the proposed treatment or procedure, and all such questions were answered in a satisfactory manner.

(e) AUTHORIZED PHYSICIAN: The physician (or physician group) authorized to administer or perform the medical treatment, surgical procedures or other therapy described in item 2 is:

(Name of authorized physician or group)

(f) PHYSICIAN CERTIFICATION: I hereby certify that I have provided and explained the information set forth herein, including any attachment, and answered all questions of the patient, or the patient's representative, concerning the medical treatment or surgical procedure, to the best of my knowledge and ability.

Physician signature: [Signature] Date/Time

RBCG #5031
Dx: R/O MI
Iso: Smk: UNK
Sgy: 11/08/01 GASTROSCOPY Type: CVP
3207-B 000243562 0131000439
Adm: 11/06/01 Dob: 09/25/26 75Y
Phys: Thomas, C.
Roosevelt, Evelyn
Level: Sex: F

CONSENT: I hereby authorize and direct the designated authorized physician/group, together with associates and assistants of his choice, to administer or perform the medical treatment or surgical procedure described in item 2 of this Consent Form, including any additional procedures or services as they may deem necessary or reasonable, including the administration of any general or regional anesthetic agent, x-ray or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure, and I hereby consent thereto.

I have read and understand all information set forth in this document, including any attachment, and all blanks were filled in prior to my signing. This authorization for and consent to medical treatment or surgical procedure is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask any questions about the contemplated medical procedure or surgical procedure described in item 2 of this consent form, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

Witness

11/8/01 1215
Date/Time

Patient or person Authorized to Consent

11/8/01 1215
Date/Time

If consent is signed by someone other than the patient, state the reason and relationship

HBOC CD #5031
All Saints Hospital

Roosevelt, EVELYN

DATE: 11/06/2001

TN Thomas, CLarence, M.D.

MR#: 243562

CC:

THE RELEVANT COMPONENTS TO THIS PATIENT'S HISTORY AND PHYSICAL ARE AS FOLLOWS:

HISTORY AND PHYSICAL

CHIEF COMPLAINT: “I had chest pain.”

HISTORY OF PRESENT ILLNESS: This is a history of a 75-year-old female who presented with a history of having chest pain which began yesterday while sitting down. She reports that it was sharp and in the middle of her chest and it was altered by movement and by pressing on her chest. She does have a history of having had chest pain back in May and had an angiogram which showed normal coronary arteries. She also had a normal left ventricular hypertrophy. She did not have any shortness of breath, nausea or vomiting, left arm or neck pain or diaphoresis. The patient is on Voltaren for musculoskeletal pains. She has not had a gastrointestinal workup. She does have hypertension and is on medications for this. She denies any recent paroxysmal nocturnal dyspnea or orthopnea and has not had dyspnea on exertion. Her chest pain lasted about 2-1/2 hours and resolved prior to coming to the emergency room.

PAST MEDICAL HISTORY: Hypertension and arthritis, hyperlipidemia, borderline diabetes, and she had a remote diagnosis of coronary artery disease, although as noted above her recent angiogram was negative. SURGICAL – Kidney stone removal. She has also had a left shoulder repair due to dislocation.

MEDICATIONS: Current medications include Norvasc 5 mg p.o. q.d., Plavix 75 p.o. q.d., Voltaren 75 p.o. b.i.d., Altace 10 p.o. b.i.d., Lipitor 10 p.o. q.d.

ALLERGIES: Keflex causes a rash.

SOCIAL HISTORY: She lives alone, never smoke, never used alcohol and never used drugs. She is a retired nurse.

FAMILY HISTORY: The patient’s sister had a cerebrovascular accident. Her aunt had diabetes and her mother and father had hypertension. No family history of angina. Her sister had some type of heart trouble.

REVIEW OF SYSTEMS: Head – She has not had any headaches, nasal drainage, throat pain or ear pain. NECK – No neck pain or stiffness. LUNGS – No cough or sputum production. HEART – See History of Present Illness. ABDOMEN – No nausea or vomiting, melena, hematochezia, diarrhea, constipation. GENITOUREINARY – No dysuria or hematuria. EXTREMITIES – No joint pain or swelling.

PHYSICAL EXAMINATION:

VITAL SIGNS: Blood pressure 156/70 by me, respiration 20, pulse 80, afebrile.
GENERAL: Alert and oriented x 4, in no apparent distress.


NECK: Supple, without thyromegaly, jugular venous distention or bruits.

HEART: Regular rate and rhythm without murmur, rub or gallop.

LUNGS: Clear to auscultation.

ABDOMEN: Positive bowel sounds, no hepatosplenomegaly. No distention, rebound or guarding.

GENITOURINARY AND RECTAL: Not pertinent to this illness.

NEUROLOGICAL: Cranial nerves II-XII intact. Sensorimotor function intact. Cerebellar function intact.

SKIN: No skin lesions.

LABORATORY FINDINGS: She has negative enzymes thus far and nonfasting glucose was high, however, her other labs were normal. She does have a monitor strip showing a 1.6 second pause. EKG shows a normal sinus rhythm with a rate of 64 with right bundle branch block. Premature ventricular contraction was noted. She also has a left axis deviation. Chest x-ray reportedly was normal in emergency room.

IMPRESSION:
1. Atypical chest pain.
2. Hypertension.
3. Cardiac pause, 1.6 second.

PLAN:
1. I will consult cardiology for review of her catheterization films and her chest pain with the combined 1.6 second pause.
2. Consult Dr. Mula to consider an esophagastroduodenoscopy to rule out gastrointestinal causes of her pain.
3. Will increase her blood pressure medication at this time and monitor on telemetry. Will rule out myocardial infarction.

Signature: Thomas, Clarence, M.D.

V#13399/ D# 5012
D: 11/07/2001 / T: ms
DD: 11/07/2001 / TD: 11/07/2001 23:00:24
EVELYN ROOSEVELT (D) ET AL.                          MEDICAL REVIEW PANEL
VERSUS                                         PCF NO:
DR. SYDNEY SOTOMAYOR ET AL.

OPINIONS AND REASONS

The Medical Review Panel, composed of the undersigned, having reviewed the evidence submitted by the parties, given notice to the parties with reference to their right to convene the panel for questioning, having made the evidence available to the parties, and having met in consideration of same, the panel renders the following expert opinion.

1.

The evidence does not support the conclusion that the defendants, ALL SAINTS HOSPITAL, DR. CLARENCE THOMAS, DR. ANTHONY KENNEDY, AND DR. SYDNEY SOTOMAYOR, failed to meet the applicable standard of care as charged in the Complaint.

REASONS

AS TO ALL SAINTS HOSPITAL:

1. There is nothing in the records presented to the panel to review to indicate that the hospital and/or its employees deviated from the standard of care.

AS TO DR. CLARENCE THOMAS:

1. Dr. Thomas did an appropriate work-up for the patient's hospitalization. He ordered appropriate tests and consulted the appropriate physicians to help direct her treatment.

AS TO DR. ANTHONY KENNEDY:

1. Dr. Kennedy read and reported the films correctly and appropriately.
AS TO DR. SYDNEY SOTOMAYOR:

1. The clinical impression of cholecystitis was bolstered by the ultrasound report and resulted in an appropriate recommendation for surgery.

2. The decision to proceed with surgery at the time, while the patient was receiving Lovenox and Plavix, was an acceptable risk given the patient’s cardiac history.

3. The patient’s post-operative hemorrhage was clinically unapparent in the first 24 hours. By the second day, when it became apparent that she had suffered a post-operative hemorrhage, she was already in acute renal failure.

OPINION AND REASONS RENDERED THIS 16TH DAY OF MAY, 2006.

BADER GINSBURG, M.D. (Gen. Surgeon)

STEPHEN BREYER, M.D. (Radiologist)

SAMUEL ALITO, M.D. (Radiologist)

SANDRA DAY O’CONNOR
ATTORNEY CHAIRPERSON
Deposition of DOCTOR BADAR GINSBURG, taken on Tuesday, September 7, 2010, commencing at 4:07 p.m.

DOCTOR BADAR GINSBURG, 4224 Maine Boulevard, in Justice, after being duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION BY PLAINTIFFS’ COUNSEL:

Nice to see you again, Doctor Ginsburg.

THE WITNESS:

Same here.

EXAMINATION BY COUNSEL FOR DEFENDANT:

Q. Could you please state your name and address for the Record.

A. Badar Ginsburg, 4224 Maine Boulevard, Justice.

Q. And we're deposing you today because you were a panel member in the case we're here for today, correct?

A. Evelyn Roosevelt versus Doctor Sotomayor, et al, yes, ma'am.

Q. Okay. I want to attach your CV as Exhibit 1.

BY PLAINTIFF ATTORNEY:

Q. It's current and up to date, as of, I guess, June '09?

A. Yeah, I don't think much has changed since then.

Q. Okay. Just briefly, could you tell me what your area of expertise is?

A. General surgery would be my area of specialization certification. I do a fair bit of general family medicine, as well.

Q. Okay.

A. Routine doctor stuff, but I'm primarily a surgeon - general surgeon.

Q. Are you in private practice or -

A. Private practice, yes.

Q. Okay. Do you work at all as on-call for emergency rooms?

A. At the hospital that I'm currently working at
St. Jefferson since 2005, I am on the ER call-schedule there.

Q. Okay.

A. So on rotation with the other doctors, I do take call.

Q. For the emergency room?

A. Yes, ma'am.

Q. Any other hospitals?

A. I'm on staff at Marsh Regional. I used to take ER call there but no longer do.

Q. Okay, and why not?

A. It just got to be a headache, so I traded off with the doctor at St. Jefferson. I do his call here, and he does mine over there.

Q. Do you feel like you are - you had enough information to prepare for this depo - deposition or do you - you need more -

A. I - I think so, yeah.

Q. Okay.

A. I mean I can answer questions. And if there's anything I need, I'm sure you - you guys have both brought parts of the chart that I could -

PLAINTIFF ATTORNEY:

I didn't. Did you bring the record?

MR. STEVENS:

(Nodding head affirmatively.)

PLAINTIFF ATTORNEY:

Okay.

EXAMINATION BY PLAINTIFF ATTORNEY:

Q. Do you know Doctor Sotomayor?

A. I trained with Doctor Sotomayor for - I mean off and on during my training at University Hospital. We never worked together on a team. We were on separate teams, but I knew who he was, and - and, you know, - and, you know, we were - we were training about the same time, so we were in the same program.

Q. Were you training side by side with him, or under him, -

A. No. He was -

Q. - or over him?
A. He was more - I guess more side by side. He actually was - is probably a year or two old - further along than I am. I was a year or two behind him.

Q. Okay, and what about Doctor Thomas?

A. I don't - I don't know him.

Q. Okay. Did you see - Was there anything in Doctor Scalia's depositions that maybe you want to point out that you either agreed with or disagreed with -

A. I don't think -

Q. - more than -

A. I don't remember it well enough to - to - to go point by point. I mean I'd - I'd be happy to address if there's any one point, but I couldn't specifically say X, Y or Z.

Q. Okay.

A. I believe it's - I mean I think it's fair to say he found evidence of malpractice on a couple of issues, and we - and I did not, so I would disagree with him on a couple of issues, but, you know, I couldn't quote him verbatim or anything.

Q. Okay. It was his opinion that it was below the standard of care to get a consent on a patient who is in the holding area. Do you have an opinion on that?

A. In - in - in that, I disagree with him. I mean that's - that's geography. If you give me permission to do surgery on you, does it really matter whether you're in a chair, in bed, in the room, or here or there. I - I think that's - that's kind of silly. It's not a question of geography. The question is: Does the patient understand what I'm telling her, and does she agree to the surgery? So as a question of geography, I entirely disagree with that.

Q. Okay. Would it make a difference if the patient had been given some type of pre-op medication?

A. It - it - That's always a - a difficult thing in - in - in surgery, and the answer obviously is "yes." You don't have, I guess, true
informed consent if someone's not in their right mind. On the other hand, to be honest, many hospital patients that are going for surgery many times have pain as a part of their symptom complex. And part of the vast majority of ones that signed their consent, have gotten a pain shot in the last few hours, and they're - they still appear to be perfectly alert and awake, just like if you drink a glass of wine or two, you - you still may be in - in - in full control of your faculties. So I think - I think very often we get consents, there's some pharmacology on board; but if - if the patient appears to understand and be alert and awake, you know, I think that's probably standard.

Q. Okay. In this case, I think everyone's in agreement that there was - or there's some testimony and you've had - you had some of that given to you in the Medical Review Panel stage, some of the other depositions and the medical records, that she did have a supraumbilical scar without hernia, as described by Doctor Roberts (phonetic) in his consult report, that was not noted by Doctor Sotomayor in his physical exam and his report. Do you have an opinion about that?

MR. STEVENS:

I'm going to object to the form of the question, as far the characterization of Doctor Sotomayor's physical. You can answer, Doctor.

BY PLAINTIFF ATTORNEY:

A. Assuming - You know, and again, I'm assuming what you're telling me is true, you know, because at any point, I may be fuzzy on all the - all the details of the chart, but I believe my recollection is that Doctor Sotomayor did not mention that scar, and one of the other doctors did. I - I do not know if Doctor Sotomayor missed it, he didn't see it, or if he saw it and assumed it was a small umbilical hernia scar in the absence of any other physical scars. So I - I don't - I think you have to ask him where - where his thinking was or - in that sense.

Q. Okay. Assume that he says he didn't see it -
Well, strike that. You have - If you had a patient
that was in this situation and told you - or didn't
tell you that she had her gallbladder removed and you
do your - your physical exam and you see the type of
scars that you know are left after having your
gallbladder removed, would you question the patient
further?

MR. STEVENS:

Object to the form of the question. You can
answer, Doctor.

BY PLAINTIFF ATTORNEY:

A. Yeah, I mean obviously if - if - if you've
got a - say, a hysterectomy scar or - or - or
something and - and you say, no, you've never had
surgery or you - you had a - your tonsils out, I'm
saying, "Well, what - what the heck is this?" I mean
obviously, yes, you would further ask the patient.
And if Doctor Sotomayor in this particular case saw
typical gallbladder scars, then obviously, yes, it
would be, "Well, what is this then?" Now, if the
patient said, "Oh, I had a liver biopsy," or some
other procedure that is consistent with those scars,
"Okay, that's fine." But, yes, of course you would
ask them further if you noticed something that was
inconsistent with what the patient said or what your
physical exam was.

Q. Okay, and what would be typical gallbladder
removal scars, assuming her gallbladder was - was
removed in -

A. How do we do it or - or a typical scar?

Q. '01, I think - 2001?

A. Again, it's - knowing where all this is
going, I think it's important to say that not
everybody heals the same or scars the same. Some
people have quite visible scars depending on your skin
color, texture, and the way they heal, and others are
nearly invisible. And I, myself, have had patients
that I've examined, and - and after doing so, said,
"Okay, I'm going to get a gallbladder ultrasound, and
go, "Oh, I've had it out." "You had it out?" I had
to go back and look to find the scar. So I mean it's happened to me personally, so I know some of them can be difficult to - to actually see. But the typical gallbladder surgery involves a scar somewhere around the umbilicus. Most of us put it either in the umbilicus, slightly below. Some doctors put it slightly above. So it's - There's an individual variation and preference. Secondarily, there are smaller scars, kind of the size maybe the diameter of a pencil or a little bit less, and those are placed just below the xiphoid in the upper abdomen. And then in the right upper quadrant, I use two. Some - Most doctors use three. There are even surgeries where you can do it all through the belly button. Some newer techniques now with thin patients, you can actually do it through the belly button and not have any scars other than the belly button.

Q. Okay. That's a newer technique though?
A. That's fairly new, yeah. And it's just for relatively thin people.

Q. Would you agree that Mrs. Roosevelt was not in an urgent or emergent situation when Doctor Sotomayor made the decision to remove - quote/unquote remove her gallbladder?
A. I don't think we saw anything on the chart that would say it was emergency surgery, no. It wasn't life threatening or anything like that.

Q. All right, and let me go through - I know you have it, the Medical Review Panel opinion.
A. Mm-hm (acknowledging). I have it here.

Q. Yeah. Your reasons as to Doctor Sotomayor:
A. Mm-hm (acknowledging).

Q. - was bolstered by the ultrasound report and resulted in an appropriate recommendation for surgery.
A. Correct.

Q. Can you explain for me what you meant by "bolstered by the ultrasound report"?
A. The - the clinical impression was cholecystitis and that was his diagnosis as to the
cause of abdominal pain. The ultrasound supported that by suggesting cholecystitis, so it supported his clinical diagnosis. I do have the ultrasound report now.

Q. Okay.

A. And it says, "Abnormal gallbladder region suspicious for contracted gallbladder; possibly containing shadowing stones; consider general surgery consultation."

Q. Okay. Well, what part of that report bolstered the impression of cholecystitis?

A. Well, just - just - what I just read, "abnormal gallbladder region suspicious for contracted gallbladder," which by definition is an abnormal gallbladder; "possibly containing shadowing stones," again, an abnormality, presence of stones in the gallbladder; consider general surgery consultation.

Q. And is that just in the impression?

A. Yes.

Q. And is that generally what you would only look at when you would look at an ultrasound report of a gallbladder -

A. Pretty - pretty much -

Q. - or do you read the whole report?

A. - pretty much you go by the impression, unless there was a reason to go further. For instance, if the impression is normal, well, I don't have to read a whole paragraph, "Normal this, normal that. Okay, it's normal." If the impression is "Funny looking thing in the left kidney, not sure what it is," well, then I might go back and read, "Okay, what do you mean by 'Funny looking thing'? It's calcified? It's round? It's 3 centimeters?" You know, then I would be more interested in looking up. So -

Q. What about the way that impression reads, would you - would you go and - ahead and look up and read the rest of the report?

A. I don't - I don't know. I mean it's - it's - it's relatively - it's relatively standardized wording
indicating bad gallbladder with stones. Now, he does qualify it by saying" suspicious for" and "possibly containing stones," so there's some - some qualification language in there that might or might not make read up a little bit or talk to him in person. You know, I mean there's a little bit of qualifying language, but it's subtle. I mean to be fair to all parties, it's a little subtle. I mean if - a quick read of this would be "abnormal gallbladder, suspicious for gallbladder trouble, possibly stones. Okay, yeah, that's what she's got." You know, I think a quick read of this would not strike any major - major bells and make super suspicious. Obviously, now, sitting here in deposition and being aware of what transpired and so forth and reading it, there's some qualifying language in there a little bit that might - might make me. But I - You know, what I would do now today presented with this thing, it may not be what I would have done at that time at that spot, you know.

Q. Okay.

A. Does that -

Q. Not -

A. - does that make sense?

Q. It does, but not - not - Just because you don't - you can't say what you would do, not because anything has changed with this - with regards to standards of care or -

A. Oh, no, no, no. Just -

Q. Okay.

A. - just - just because, you know, catching it cold, this might not - that might not have been equivocation enough to arouse my suspicion.

Q. Right.

A. Just a quick read doesn't really bring out the equivocation that I - I now might read into it knowing that she didn't have the gallbladder, you know.

Q. Right, right. If you had read the entire report, would you have ordered further study - any
further studies?

MR. STEVENS:

Object to the form. You can answer, Doctor.

BY PLAINTIFF ATTORNEY:

A. Prob - Again, poss - possibly because -
because the - You know, you're not treating - We're
not treating paper when you're treating a patient.
I'm treating the patient, her - who's a - you know, a
biologic organism, and it would depend a lot on the
history, what I got from her, the feel that I got from
the physical exam, you know, how comfortable I was
with everything. So, you know, if - if - if I had
talked to her and I was confident, number one, she had
her gallbladder, and two, her pain was in the right
spot, and she said, "Oh, yeah, I've been having" - you
know, "her symptoms were fitting gallbladder. Well,
assuming she still has a gallbladder," you say, "Yeah"
- well, you know, the radiologist doesn't know, "of
course she has her gallbladder," and so, "Yes, that's
what this is." You know, so that wouldn't have
necessarily thrown me off course to make me order any
further testing. If I was uncertain of the diagnosis,
and, you know, I said, "Gee, I don't know. Maybe this
is really gastritis, maybe it's not gallbladder," and
then I read this report where there's a couple of
qualifying languages, and then that might have
prompted me to call the radiologist, "Are you saying
you're not sure" or whatever, and then that might have
prompted further testing. So -

Q. Like, for example, assuming the gallbladder
was still present, is that in the report somewhere?

A. Yes.

Q. That might make you call him and say, "What
are you talking about?"

A. If - if - Again, if - if I was not confident
in my diagnosis -

Q. With your physical -

A. - and - and I read that, I'd say, "Okay, what
are you trying to tell me here?" It might have - it
might have been just enough to - to giggle a little
bit of uncertainty and say, "Are you trying to tell me something? You're not really sure these are stones?"

Q. Okay.

A. And - and I think part of this is the radiologist's poor use of - of language, you know, because he's obviously - I mean retrospect. I'm looking at this as - as kind of an - an equivocation. I think he should have been more powerful in his equivocation if he really wasn't sure, because it's - you know, the way - the way his impression is probably doesn't display what his real equivocation, I guess, it was.

Q. Right. But not in any way that fell below the standard of care that you found when you were -

A. I - I - I wouldn't say -

Q. - when y'all were looking at it?

A. - "standard of care." I think it's just maybe his - his - you know, his wording because a little bit - I mean reading back up in the body where it says "assuming she still has a gallbladder," now says, "Well, now, okay what do you mean? You don't think she has a gallbladder? Well, then why did you say 'suspicious for contracted gallbladder'? I mean it sounds like you're saying two different things."

So, again, you know, had - had - had my clinical suspicions been aroused that something more was amiss, and then I read that, you know, that might have - might have prompted more. I can't say. It's hard to go back and say what you would have done, because I wasn't there.

Q. Okay.

A. But, you know, it might have prompted more discussion.

Q. Okay, and what are the clinical symptoms of a bad gallbladder or -

A. It can vary quite a bit, but classic textbook systems - symptoms, excuse me, would be right-upper quadrant pain primarily, usually after eating; some nausea; occasionally vomiting; bloating, sense of,
know, ate too much, Thanksgiving dinner; those kinds of symptoms; unsettled stomach. And it can be any combination of those. Some patients come to the hospital with absolutely none of those symptoms with a red hot infected gallbladder, you know, and they quote never had a problem before. Usually if you sit them down and really pick at them, you'll fair it out a few little indigestions in the past, but then, you know, that's so common, it's hard to say. But sometimes these things can present with actually no symptoms.

Q. Okay. Well, I don't know if the record is in front of you, but do you recall what symptoms that -

A. No.

Q. - Ms. Roosevelt -

A. No, I -

Q. - presented with?

A. - I - I do not recall her exact symptoms.

Q. All right. Assume for me you had that report - that ultrasound report.

A. Mm-hm (acknowledging).

Q. And the only symptoms you found upon physical exam were the scars - the supraumbilical scar, the gout, hernia, and chest pain that was relieved since she - since she's been at the hospital?

MR. STEVENS:

I'm going to object to the form of the question.

BY PLAINTIFF ATTORNEY:

Q. Would you -

MR. STEVENS:

You can go ahead.

BY PLAINTIFF ATTORNEY:

Q. Would you then - What would you do? Would you order more tests with that scenario?

MR. STEVENS:

If you have enough information to answer the question, Doctor.

BY PLAINTIFF ATTORNEY:

A. If - if I understand the question, well, number one, if I had noticed the umbilical scar, I - I
would think I would ask her, "What was this surgery?"
So right off the bat, you know, she would have said,
"Well, I had my gallbladder out," that would have ended the gallbladder discussion at that point. If she said something else that threw me off or something, I'm - I'm still thinking the gallbladder. Or if for some reason she couldn't ask or if I didn't notice it or whatever and I'm still thinking
"gallbladder." The fact that her pain resolved wouldn't necessarily throw me off to gallbladder because gallbladder pain usually does come and go; it's more episodic. Unless you have an infected gallbladder, then it sort of festers for a day or two or three until you do something about it. So if I thought she had an infected gallbladder and her physical exam was totally benign, no tenderness whatsoever, I would have to question my diagnosis, and say, "Well, wait a minute," you know, "how come she's not tender of the gallbladder, if - if I'm thinking that's what she has?" On the other hand, if she has some slight tenderness there and says, "But I'm feeling better," that would in and of itself throw me off the gallbladder chase.
Q. Okay. Do you believe it's the standard of care or it would have been the standard of care had you seen the scar to ask her what surg - what was that surgery, what was that scar from?
MR. STEVENS:
Object to the form.
BY PLAINTIFF ATTORNEY:
A. Yeah. I - I - I think you have to ask to know what's going on with the patient, and I - I don't - may not document it, you know. But, you know, sometimes somebody's got several scars, a hysterectomy, this or that, and it's not germane to what I'm doing, I may not in my consultation write, "Patient had a hyster - had a hysterectomy, if I'm seeing them for stomach or reflux -
Q. Right.
A. - or something like that.
Q. But a situation like this where you're looking at a supraumbilical scar without hernia, and you're thinking "gallbladder," and you see that, you - but you're - you did say it was the standard of care to ask the patient what that scar - what surgery the scar was from?

A. Well, I - I think as part of a - a good physical exam, you'd have to ask them what - you know, what was done. I mean you have to know what was done.

Q. That's part of the standard of care of doing your exam?

A. Yeah, I think so. I mean I think you have to - you have to know what the patient had done, you know, if you're - if you're treating the patient.

Q. If you are questing it's the gallbladder, what other type of studies or tests could you do to help confirm or rule out gallbladder?

A. You could do a HIDA scan, which is a nuclear medicine scan that can show you the biliary tree and gallbladder. You could do a CAT scan, but actually the ultrasound which was done is the gold standard for gallbladder.

Q. Okay, all right. Is there any secondary golden standard scan or test if the ultrasound is not conclusive enough for your satisfaction.

A. Yeah. X-rays, no, I think probably a HIDA scan would - you'd probably go to that. In the old days when I first started training, we would do dye studies called "oral cholecystograms," and nobody even knows how to do that anymore. It's -

Q. What would a - In this situation where we now know there was no gallbladder, -

A. Mm-hm (acknowledging).

Q. - what would a HIDA scan have shown?

A. It may - it may not have helped at all.

Q. Okay. What about abdominal x-rays?

A. Abdominal x-rays probably would not have helped. A CAT scan maybe might have shown some clips in the gallbladder region. But the - the gold standard is the ultrasound; that's the one we would
do. Often times, if I'm uncertain, I might wait a
week or two and redo the ultrasound, because it – it
really is the best study for it.

Q. Okay. The medications that she was taking at
the time of the surgery, the LOVENOX and the Plavix
specifically, –

A. Mm-hm (acknowledging).

Q. – why was – being that it wasn't an urgent or
emergent situation, why was it acceptable to go
forward with the surgery then and not wait to have her
off of those medications for whatever period of time?

MR. STEVENS:

I'm going to object to the form of the question as
far as the classification that it was "not urgent or
emergent." But you can answer the question.

BY PLAINTIFF ATTORNEY:

A. I – I think Doctor Sotomayor felt that she
had acute cholecystitis which is a gallbladder
infection, so that's a – it's not emergency in the
sense of life

threatening, "I got to do it right now or she's going
to die." It's not that emergency, but it is more of
an urgency in the sense that the patient's in pain, or
hurting, there's an infect - infection, an older lady,
and – and those can get worse. And so most of us
would operate fairly quickly. You know, that day, or
the next morning. So it's an – it is an urgent sort
of a surgery, if you make that clinical diagnosis. We
talked at - at the Panel a lot about the
anticoagulants and all because there was some
evidence, I think, of bleeding down the line. A lot
of it depends on the patient's medical situation and
whether you think they're better off with the
anticoagulants and - and - and accepting an increased
risk of bleeding or whether you think the risk of
bleeding is high enough to accept the risk of heart
attack or whatever you're treating with anticoagulants
for. So it's hard to give a definitive answer to
this. Back in 2001, Plavix was just gaining popular
use. I'm not sure when it hit the market, to be
honest with you. But certainly in the early 2000s is when the cardiologists discovered and starting putting everybody and their brother and dog on Plavix, so we started seeing it a lot, and when it first came out, it hadn't yet hit the surgery field as a major problem. It - it still is not a major major problem, but it - it's definitely for some people increases a risk of bleeding quite a bit. I, myself, operated on many patients on Plavix, did vascular surgery on them, which you'd think you wouldn't even want to touch a blood vessel, and so -

Q.   Right.
A.   - and they did fine. I never had a single problem on Plavix.

Q.   Right.
A.   But subsequently during the 2000s, we started hearing stories of our, you know, associates, other general surgeons of having all these, you know, problems with bleeding from Plavix. And - and since then, in - in later times, I've had some patients that have bruised a bit with Plavix, interoperably one or two, "Why won't they stop? Oh, it's Plavix," and so forth. So we did learn fairly quickly that if at all possible, stop the Plavix, and - and the - the - the standard now, I think, is to stop the Plavix, if possible, on patients prior to surgery. In the early 2000s, that wasn't really recognized. Just from personal experience, I'll tell you I did the same - I operated on them the same way. LOVENOX was not in as high of use back then, but it's - it's - it is certainly now. And LOVENOX, again, does increase the risk of bleeding, but there are many doctors who have used heparin and LOVENOX, as a form of heparin, in conjunction with surgery to prevent blood clots, and there are - there are many studies that have come out recommending you give a little dose before surgery to try to prevent blood clots which potentially would save more lives than a little bit of bleeding. This - this lady had, of course, a double whammy; she had the Plavix and the LOVENOX too. So while I think nowadays
in 2010, we would probably question whether the surgery should be delayed to get her off one or both of those drugs, I think we'd probably say, "Yes, if at all possible, it would be better to wait a day or so and get her off of some of that." Back then, it was less of a press because the problem with Plavix wasn't broadly recognized as a major bleeding event for surgery. And LOVENOX has been sold as having fairly low risk of bleeding, you know, with surgical procedures, so much so that St. Jefferson now just about mandates everybody that gets admitted gets put on LOVENOX, and if you don't, you - you get a demerit for not fighting against blood clots. And we've seen some bleeding in surgery because of all that stuff too.

Q. When you - When a patient comes to you and you're considering whether to stop these types of medications, do you have discussions with any other physicians that are involved in the patient's care?

MR. STEVENS:

Today or in 2001?

PLAINTIFF ATTORNEY:

In 2001.

BY PLAINTIFF ATTORNEY:

A. Not really. I mean even today, I - I - I can handle the problem myself.

Q. It's your - it's your call?

A. Well, the only thing - The discussion I would have would be if I wanted to stop the Plavix and the patient says, "Oh, my heart doctor says 'Don't stop it,'" I would say, "Okay, let - let - let me talk to the heart doctor," because -

Q. Okay.

A. - and most of the time, it's, "Yeah, you can stop it. Sure." I mean, you know, and so forth.

Again, back in 2001, I probably wouldn't have even noticed the Plavix, you know, and said, "Yeah, fine."

Q. But in 2001, if you wanted to stop the Plavix, that would have been your call, you could have done that?
A. Sure. True, the surgeon, you know, can - can do anything. Now, again, you take responsibility. If I stop -

Q. Right.

A. - your heart medicine and you get a heart attack, you're going to be mad at me and so will a heart doctor, but, yes, I can do it. Any doctor treating the patient can alter any medicine at any time.

Q. Okay. Have you ever heard of or seen remnants of a gallbladder left behind after gallbladder removal?

A. I've never seen a gallbladder remnant left behind, you know, on purpose or even by accident. I guess it could happen. I mean it really shouldn't because, you know, when you're taking the gallbladder out, anatomically you have to get down the bile ducts to see it, you know, you can't just cut it in half, I mean.

Q. Postoperatively in a case like this or - and in 2001, we're talking standards of care in 2001, whose responsibility is the patient postoperatively?

A. Again, it would - it depends on what you're actually asking -

Q. In a situation when you've got a patient admitted through the emergency room through her primary care, has a - an attempted gallbladder removal procedure by a surgeon, by Doctor Sotomayor, postoperatively who is in charge of, you know, monitor - monitoring her and watching her?

A. Basically the - the team has shared responsibility. If - if Doctor X is the - is the family doctor and admits the patient or is participating in her care, then he also assumes some responsibility for participating in that care. The surgeon, I - I would think in - in the op - certainly in the operative period, and in the immediate postoperative period is probably primarily responsible because we're following our surgery and this and that, but - but there's shared
responsibility. You know, if she has a heart condition, there's a heart doctor on the case, I would expect he's paying more attention to the heart than maybe the surgeon would, you know, and so on. So it and and practices - professional practices, be it medicine, law, or anything else can vary a bit. In some hospitals, you'll find there's - there's team medicine where every patient has three or four doctors. And then in other hospitals, no, you just - you have one doctor and he treats everything, so - so different practices can have different personalities, if you will.

PLAINTIFF ATTORNEY:

Okay, off the Record. (At this time, there was a discussion held off the Record. Back on the Record:)

BY PLAINTIFF ATTORNEY:

Q. How about the cardiologist, Doctor Gremillion (phonetic), do you know him?

A. No, I do not.

Q. Okay.
I'm not sure if my definition would - would be accurate. What I understand it to be is the accepted practice in the community which one practices, such that the standard of care for gallbladder might be different in Montana, than it would be here, although in our, you know, connected developed westernized country, there shouldn't be much difference in the way - in treatment. But there are - there are differences in treatment in different areas so that the standard could vary a bit in - in minor areas.

Q. Okay. How many gallbladder removal surgeries have you done - performed?
A. I don't have an exact number, but the last time I tried estimating, I think it was in the 2500 range, give or take.

Q. Okay. Would your deposition hourly rate of $500 an hour sound correct?
A. Probably.

Q. Okay, and you think it's the same if you go to court?
A. Probably.

Q. Okay.
A. You know, I'd - I'd probably charge you for travel time too, you know, or something like that, but I - you know, I don't think it's any more than that.

THE WITNESS:
Should I up my rates? Is that what she's telling me?

MR. STEVENS:
No comment.

THE WITNESS:
A lot of "no comments" here.

BY PLAINTIFF ATTORNEY:
Q. Explain this to me. I really don't know the answer. How does Doctor Sotomayor do this procedure? She's already had the procedure. I'm assuming he's making the same incision - is going in the same area where the other incisions were. Is that how it works, you would make an incision in the same place as the previous incisions or is he making -
A. I'm - I'm sure they were similarly placed, yeah. Like - It - Like I said, the - I don't know where he put his bellybutton incision where he went through - she had another incision at the belly button that was - we weren't sure what he understood that to be. Whether he went in that same incision or a different one, I - I don't know.

Q. Okay.

A. The other incisions are traditionally placed reasonably in a standard fashion along the right rib margin, a few couple of inches below the rib, you know, again, placing two or three depending on - on how you practice and how you technically do it.

Q. Okay.

A. I don't think he noticed any other incisions. I - I - I don't know about the belly button incision; we've talked about that. Certainly the other ones, he didn't notice is my understanding.

MR. STEVENS:

No questions. Thank you, Doctor. I appreciate your time.

(The deposition was concluded at 4:58 p.m.)
At the request of the plaintiffs’ attorneys in this case, I have carefully reviewed the above
deposition transcript to determine whether it was true and complete and whether I had any
additional information relevant to the matters discussed therein. I did so, and hereby certify,
under penalty of perjury, that the deposition transcript is true and complete and that I have no
information relevant to the matters discussed in the deposition, that is not contained in the
same.

Dr. Ginsberg 3/13/14

Signature Date
Deposition of Anthony Kennedy, M.D., taken on Monday, February 21, 2005, in the office of All Saints Hospital, Radiology Department, State of Justice.

EXAMINATION BY MR. EEYOR:

Q. Doctor, would you please give us your full name and address?
A. My full name is Anthony Kennedy. I live here in Justice.

Q. What is your practice area, Doctor?
A. I’m a board certified diagnostic radiologist.

Q. Briefly, take me through your educational history starting with college.

MR. GREEN:

We have a copy of his C.V.

THE WITNESS:

I’ll be glad to briefly review it, but what I did was—well, let’s see here. You want to start with undergraduate school?

EXAMINATION BY MR. EEYOR:

Q. Sure.
A. I went to LSU undergraduate school in Baton Rouge, LA. I received a bachelor of science degree cum laude, then I went to LSU in New Orleans for medical school, received my M.D. degree there, graduated with honors. After I finished there, I did an internship at All Angels Hospital, then did a radiology residency in radiology, and the last year I was the chief resident in radiology at All Angels. When I finished there in 1978, I moved here to Las Vegas and practiced here 26 and one half years.

During my residency, I passed my boards on my first attempt, board certified radiologist by the American College of Radiology. I have licenses to practice in Nevada and Arizona.

Q. Doctor, you’ve given me a copy of your CV here.
A. I have included at the end, let see, I’ve included organizations that I’m a member of in the State of Justice and national organizations, academic awards, my education, board certification. And then the third page is I’ve given CME 2001 through 2004. And since I’ve had this CV typed and updated, I attended another
conference in Dallas, which I added to the end of the CME listings.

MR. EEYOR:
Let’s go ahead and attach a copy of the CV to the deposition as Kennedy 1.

MR. GREEN:
No objection.

EXAMINATION BY MR. EEYOR:
Q. Doctor, you currently have privileges here at All Saints Hospital; is that correct?
A. That’s correct.

Q. Have you ever had any action taken by any hospital with regard to your privileges, either suspended or revoked?
A. Never.

Q. Is your practice limited to diagnostic radiology?
A. Yes.

Q. That’s been the case since 1981?
A. That’s correct.

Q. Doctor, do you ever do any work as an expert witness?
A. No, I don’t.

Q. Medical review panels, how many have you served on in the past year?
A. None.

Q. Have you ever had any lawsuits filed against you?
A. No.

Q. Doctor, what have you reviewed in preparation for your deposition today?
A. I guess the only things I reviewed is notes my attorney and I would have reviewed, whether it was -- certainly I reviewed the report that I dictated. Thirty minutes ago I reviewed the ultrasound case that you just gave me, which I’ve never seen since the day I dictated it. My attorney or insurance company would send the hospital records. I reviewed some of those documents, anything else that my attorney would have forwarded me.

Q. Let me show you what’s been marked as All Saints, ASH, Page 272.

Q. Dr. Kennedy, do you recognize this document?
A. Yes, I do

Q. Tell us what it is, please.
A. This is a copy of my dictated report on the abdominal ultrasound on Ms. Roosevelt dictated on 11/7/01.

Q. At 2:56 in the afternoon? 1456, is that what that dictates?
A. That would have been the time that the dictation was completed.

Q. You did not see Ms. Roosevelt this day or any day thereafter?
A. No.

Q. You’ve had no contact with Dr. Thomas concerning this patient at any time?
A. No.

Q. Is there anything on this document which we’re going to attach as Exhibit 2 indicating the clinical history of a 75 year-old female with abdominal pain?
A. 75 year-old female. It says 75-year old female.

Q. All right. What about abdominal pain?
A. Now, all the technologists in the hospital, and this is standard procedure, the patient has an abdominal ultrasound ordered, but the history is rule out MI, myocardial infarction. So what they would -- what the technologist would try to do: Well, can I get some more information? MI is in the heart, the chest. This is an abdominal ultrasound, so they’re instructed: Can you get any more information from the patient? The information they got was abdominal pain. I have -- you know, I don’t know how that was done.

Q. You’re assuming that’s the case? You can’t recall any discussion with Ms. Crystal --
A. No, I didn’t have any discussion with her.

Q. And you certainly didn’t have any discussion with any of the physicians who gave you a history of abdominal pain?
A. No, I did not talk with any physicians during this case.

Q. And you certainly didn’t have any discussions with any of the physicians who gave you a history of abdominal pain?
A. No, I did not talk with any physicians during this case.

Q. Doctor, in reviewing the ultrasound, did you find it to be a technically adequate study?
Q. When performing an abdominal ultrasound, what are the things generally that you as a radiologist are looking for?

MR. GREEN: Objection to the form of the question. The doctor doesn’t perform the study.

EXAMINATION BY MR. EEYOR:

Q. With that exception, in reviewing an ultrasound study, what are the things you’re looking for?

A. I’m looking for the major anatomic structures that are visible either most of the time or all of the time, the major organs, the liver, the spleen, the gallbladder, the bile ducts, aorta and pancreas. Those are the major structures, the major organs we’re looking for, and anything else that might show up which might be abnormal. If you see a mass or a cyst or a collection of fluid, that would not be normal things, but anything else that might show up, but basically the major anatomical structures within the abdomen.

Q. In this particular case where the request asked to rule out an MI, is there anything in particular that you would be looking for or paying attention to in reviewing the ultrasound?

A. There’s no way I can rule in or rule out an MI on an abdominal ultrasound for sure. Now possibly a patient might have referred pain to the chest from something going on in the abdomen. That’s what I would – that would be my thought if someone – if that’s the only history I ever got and they said: Rule out MI, well, I’m assuming that patient has chest pain. Could there be something going on in the abdomen, referred pain to the chest? So I would be looking for any abnormality that I could see in the chest, in the abdomen.

Q. Doctor, could you take a minute and look through those and tell us which images actually show the gallbladder?

A. No images show the gallbladder.

Q. Let me rephrase my question. Doctor, could you identify for us the images that show the gallbladder region?

A. Okay. That would be Images 23, 24, 25, 26, 27,
and basically that’s it.

Q. Five stills, five images?
A. Right.

Q. Let’s go back to the report, Doctor. The gallbladder region displays high level echoes.
What are high level echoes?
A. Bright spots, white spots that you would see here (indicating).

Q. What are the possible causes for that type of bright echo?
A. Well, in the area of the gallbladder, if the gallbladder is still present, the most common thing would be gallstones.

Q. Would a staple also, a surgical staple in that area, give off high level echoes?
A. It might, but normally we don’t see – we don’t see staples that we can say: Oh, those are staples. There’s no way for me to look at that and say: That’s a staple. Staples you can see on a routine x-ray or a CT scan. You can say: Oh, those are metallic staples. They have a classic appearance on an x-ray or CT scan, but not on ultrasound.

Q. On ultrasound, though, isn’t it an item of density, a very dense item that gives off a higher level echo?
A. Potentially. I’ve never made a diagnosis of staples on ultrasound, ever, in 26 years of practice. I’ve never said, you know, these are staples.

Q. What are the possibilities, in your experience?
A. Well, the most common thing we see are gallstones. Bowel gas can do it. If you have a loop of bowel with some gas in it, that will commonly reflect it. It doesn’t tell you – there’s no way to know exactly what it is by looking at that. There’s nothing diagnostic that tells me what that is it’s hitting. All I can tell you is that it’s in the area where the gallbladder normally resides, the gallbladder region.

Q. Doctor, can you describe these white areas as more or less like gallstones, like what you would expect to see form a gallstone or typical or atypical?
A. Gallstones come in all sizes and shapes. I’ve seen gallstones that size. They can be so small you can’t see them and they can be very big.

Q. Is that fairly large, what we’re seeing there?
A. No. Those are fairly small.

Q. What makes what we’ve seen there suspicious for a contracted gallbladder containing stones?
A. The only thing that’s suspicious is, first of all, I don’t have a history that the gallbladder has been removed, so I cannot rule out that it’s still there, okay. I don’t know if the gallbladder is there or not. I started my report saying I do not see a normal fluid filled distended gallbladder. Never in my report do I say I see the gallbladder. All I’m saying is I see a level of echoes with shadowing behind it and it’s in the gallbladder region. It’s where the gallbladder should be.

I’ve seen many, many times patients who still have their gallbladder and there was no fluid or bile in the gallbladder, but the gallbladder was contracted and contained stones and looked just like that.

Q. Overall, your impression was what?
A. My impression is that the gallbladder region was abnormal because I don’t see a normal gallbladder. If you don’t see a normal gallbladder, then the region is abnormal, and it would be suspicious for contracted gallbladder, possibly containing stones.

Q. And the bile ducts are within normal limits?
A. Right. They’re not dilated.

Q. Having reviewed these ultrasounds today, is that still your impression on reviewing those?
A. Yes. Yes, it is.

Q. Finally, there it says: Consider general surgery consultation?
A. Right.

Q. What is the purpose of that recommendation?
A. Well, I have here a patient with abdominal pain.

Q. Again, that’s the clinical history, but we’re uncertain as to where that –
A. Right.

Q. -- description comes from.
A. Right. But I don’t see a normal gallbladder.
I see some abnormal echoes in that area, so I think the patient, you know – I said consider general surgery consultation, and I don’t know how much you want me to go into about what do I mean by that or whatever.

Q. What did you mean by that?

A. Well, what I mean by that is any consultation, whether it be a surgical consultation or not, always starts with a history. I mean, that’s standard medicine.

Q. Okay.

A. It always starts with a history. A surgical consultation starts with a surgical history. To me, if the patient’s able to give an accurate history and says: Oh, I’ve had my gallbladder removed, well, then you can forgot about suspicious gallbladder contracting stones because I’ve had my gallbladder removed. If the patient says: I’ve never had my gallbladder removed, I’ve never had any surgery, well, we’ve got something abnormal here that we need to explain; but that’s -- in other words, because it’s an area that surgeons are involved in, gallbladder disease, but that’s their decision, whether they take it from there.

Q. Doctor, are there other diagnostic studies that could have been performed to further study this area?

A. Well, there are many other ways to evaluate the gallbladder. The simplest thing is an abdominal x-ray.

Q. Do you know if that was done before surgery in this case?

A. No, I don’t believe it was done.

Q. Is there any reason why you didn’t recommend that also be done?

A. Well, again, that’s the decision of the patient’s physician. You know, they can determine whether or not they want to do additional studies based on the history. If I start recommending things, then people say: You’re just recommending because you’re trying to jack up your billing.

Q. Your radiology?

A. My point is when I say consider a consultation, hopefully the consult will say: Okay, well -- and my feeling -- as I’ve said,
there’s no way for me to know if the gallbladder is there. My report states that and I’m saying that in my deposition. I’m looking at the films. I cannot see a gallbladder. I don’t know if it’s there or not.

What I’m saying is you asked me what other things you could do. One way is to do an abdominal x-ray, okay, and I’ll say this since you’ve talked about abdominal x-ray. If you definitely see some metallic clips in the region of the gallbladder, that’s -- nothing in medicine is 100. That’s probably 99 percent sure, positive, that the patient has had their gallbladder removed. Now I’ve practiced 26-and-a-half years. I’ve seen patients where people say: I’ve got my gallbladder removed, and I can’t see clips. So it’s not 100 percent. If you want to evaluate the abdomen, you can do a CT scan of the abdomen. I’ve seen metallic clips on a CT scan. I’ve had cases where I’ve looked at thousands of CT scans and I can’t see the gallbladder and I don’t see any clips. Nothing is 100 percent. The only other -- so one option is a routine x-ray of the abdomen. We call it a KUB or a flat and erect abdomen. Another thing is a CT scan of the abdomen. The other thing is a HIDA scan. So that’s another way of evaluating the bile ducts in the gallbladder region. Those are the three ways of doing it.

Q. CT scan, would that have given you or any other radiologist, for that matter, a better view of the possible contracted gallbladder in this case? Would it have given you a cleaner view, a better angle, any of those things on a possibly contracted gallbladder?

A. In this particular case, based on the way it looks, I don’t think a CT scan would have given me any more information about whether -- because, actually, you normally see the gallbladder better on ultrasound than you do on a CT scan.

Q. What about the surgical clips, knowing in hindsight that they’re there, do you think a CT would -- were you made aware of that?

A. What’s that?

Q. Were you ever made aware that there was, in fact, a prior cholecystectomy?
MR. LOWRY:

I’m going to object to the form of the question, because I don’t think we know that there were any clips there.

MR. EEYOR:

I believe it was mentioned in the surgery report from Dr. Sotomayor.

EXAMINATION BY MR. EEYOR:

Q. Assuming there are surgical clips in the site.
A. If there are surgical clips, usually you can see them either on an abdominal x-ray or a CT scan. But I’m telling you in my experience it’s not 100 percent.

Q. Doctor, I’m looking at Dr. Sotomayor’s consultation report identified, for the record, as All Saints Hospital pages 36 and 37. It’s dated 11/8/2001. I’m going to read right in here. He states in his consultation and history of present illness: Ultrasound revealed the presence of an abnormal gallbladder with contraction and stones. Does your ultrasound report indicate any such findings?
A. Well, it’s semantics, but I do not believe it reveals the presence. That’s too definitive a term. I described suspicious findings, not definite presence. And it says presence of an abnormal gallbladder. As I’ve said, I never saw the gallbladder. I can’t say the gallbladder is abnormal if I don’t see it.

Q. Doctor, could you have been any more equivocal on your ultrasound report there?
A. Well, normally, you know, radiologist don’t like to be equivocal. We like to be black and white, but some cases are not black and white. They fall in the gray zone like this case does.

Q. Would you agree with me that that is an equivocal report?
A. Yes, this is an equivocal report.

Q. For both the gallbladder and the presence of stones?
A. That’s correct.

Q. Would such a report require further correlation with physical findings perhaps?

MR. GREEN:

Object to the form of the question.

THE WITNESS:
All tests require clinical correlation. Whether they’re -- whether they’re described as definitive or equivocal, it needs to be correlated with the history and physical findings and the doctor’s experience. That’s the doctor’s function, not mine.

EXAMINATION BY MR. STEVENS:

Q. Dr. Kennedy, just a couple of questions.

A. No, it would not have been shown. As I previously stated, I’ve seen many patients in which patients came in, good historians, said: I’ve had my gallbladder removed in the past, and I couldn’t see clips.

Q. Again, regarding the abdominal x-ray, I believe you previously testified that it was the decision of the patient’s physician whether or not to order that abdominal x-ray; is that correct?

A. Right. Other physicians order x-rays. I don’t.

Q. If the general surgeon were to order an abdominal x-ray, what indication would he need in order to make that order for an abdominal x-ray?

A. Well, there’s any number of reasons you could do it, one of which might be, I mean, it’s always easier in hindsight, but I’m trying to answer your question the best I can. One reason you might order it is to say: I’m not sure whether or not this patient has had their gallbladder removed.
Let me get a KUB film and see if I can see metal clips. The other thing is: What else is going on in the abdomen that I do not see?

Q. The Ultrasound revealed the presence of an abnormal gallbladder with contraction and stones.

A. Right.

Q. I believe it was your previous testimony that that is not what your report read; is that correct?

A. That's correct.

Q. Did your report indicate possibility of contraction and stones?

A. It revealed the possibility, yes.

Q. I don’t have any further questions.

[End of deposition]
Deposition of JESSE ROOSEVELT, 12345
Highway 10 South, State of Justice, taken on
Tuesday, the 13th day of July, 2004, after
having first been duly sworn by a certified
Court Reporter, did testify as follows:

EXAMINATION BY MR. STEVENS:

Q. Good morning, Miss Roosevelt.
A. Good morning.

Q. My name is John Paul Stevens, I represent
Dr. Sydney Sotomayor in the medical
malpractice action filed against Dr.
Sotomayor.

So if you could, please state your name,
address and telephone number for the record,
please.
A. My name is Jesse Roosevelt. My address
is 12345 Highway 10, State of Justice.

Q. Miss Roosevelt, you are the daughter of
Evelyn Roosevelt; is that correct?
A. Correct.

Q. Have you recently been employed in the
past five years?
A. No. The past five years? No. I am
disabled.

Q. What is your disability?
A. I have had a heart transplant.

Q. And when did that occur?

Q. Have you ever been arrested or convicted
of any crimes?
A. No, sir.

Q. Are you presently taking any medications?
A. Yes, sir.

Q. And what are those medications?
A. I will have to get a list.

Q. Yeah, that would help, but specifically,
any medications that would impair your
ability to testify here today or hinder your
recollection?
A. I don’t think so.

Q. Miss Roosevelt, I’m going to ask you a
few questions today regarding your mother’s
admission to All Saints --
A. Yes, sir.

Q. November 6th of 2001 and thereafter. And
particularly, my questions will be regarding
the care and treatment provided by Dr.
Sotomayor, her surgeon.
It is my understanding that your mother was admitted to the emergency room on November 6 of 2001; is that correct?

A. Yes.

Q. And what were her chief complaints, if you recall?

A. Chest pains.

Q. Did you give a medical history to anyone in the emergency room?

A. She did. I parked the car.

Q. So your mother gave a medical history?

A. Right, she was alert.

Q. You weren’t present at that time?

A. No, sir.

Q. When you did enter the emergency room did any nurse or doctor give you an evaluation of your mother’s condition?

A. No, sir.

Q. What was the first thing you were told?

A. That possibly she had arthritis in her chest.

Q. And who told you this?

A. Dr. Smith.

Q. Did Dr. Smith mention to you what his recommended treatment was?

A. He said they were going to do some x-rays and they did that.

Q. Were you present with your mother when the x-rays were taken?

A. Not in the x-ray room. I waited in her room in the emergency room —

Q. I believe you said your mother was alert and oriented, correct?

A. Oh, yes.

Q. So did you leave the hospital at that time?

A. No.

Q. It is my understanding that your mother was scheduled for surgery when Dr. Sotomayor; is that correct?

A. At that time?

Q. At some time —

A. Oh, at some time.

Q. -- in this period.

Where you with your mother when she first met with Dr. Sotomayor?

A. Yes.
Q. Am I correct in understanding that that date was November 8th of 2001, two days later?
A. Yes.
Q. And were you in Dr. Sotomayor’s office or were you in the hospital?
A. No, I was in the hospital.
Q. Dr. Sotomayor came and met with you and your mother?
A. I met with Dr. Sotomayor in the room where they do the procedure. They were getting ready to do a – – I don’t know the name of the procedure where they go in and look around (indicating)
MR. ROOSEVELT:
   Endoscopy.
THE WITNESS:
   And – –
MR. EEYOR:
   Hang on one second. Just for the record, she was indicating going down through the throat, as well, going down through the mouth.
THE WITNESS:

Yeah, I don’t know what it was, bronchoscopy, endoscopy, whatever.
EXAMINATION BY MR. STEVENS:
Q. And this is all on November 8th; correct?
A. Correct.
Q. Was there anyone else in the room with you and your mother?
A. No.
Q. And Dr. Sotomayor?
A. No.
Q. Your mother, again, was she alert and oriented on this date?
A. I don’t recall if she was oriented, but they had given her something for this procedure that they thought they were going to do – – I thought they were going to do. I was sitting out in the waiting room.
Q. Do you recall Dr. Sotomayor discussing with you and your mother the possibility of a gallbladder removal?
A. Yes, when he told me that my mother and he had decided – – I was in the room where they do – – she was on th stretcher – – to go ahead with the gallbladder surgery. And I
thought to myself, that is strange, that is awful fast, he doesn’t have her records, you know, I thought. And then I thought, well, with computers and faxes, it is possible he got them, I don’t know. But he talked to Dr. Thomas, I don’t know.

Q. So you weren’t in the room with your mother when this was decided between her and Dr. Sotomayor to have the gallbladder — —
A. Not when it was decided, no. I was out in the waiting room. He came and got me and told me they decided.

Q. Was this surgical procedure, gallbladder removal, did you ever discuss this with Dr. Roberts and Dr. Sotomayor?
A. I don’t even know who Dr. Roberts is.

Q. Do you recall discussing this, yourself, your mother, Dr. Sotomayor and another doctor at any time on November 8th?
A. No, no.

Q. Did Dr. Sotomayor explain the gallbladder removal procedure, which is laparoscopic cholecystectomy? Was this procedure ever described to you and your mother by Dr. Sotomayor?
A. He may have described it to my mother, he didn’t describe it to me.

Q. So you weren’t in the room with Dr. Sotomayor when he was describing this to your mother?
A. No.

Q. Do you recall Dr. Sotomayor ever asking either your mother or yourself if your mother had ever had any previous surgeries?
A. No.

Q. Do you know, sitting here today, whether or not Dr. Sotomayor discussed with your mother whether or not she had any previous surgeries?
A. I don’t know.

Q. Now, you previously stated that Dr. Sotomayor and your mother had agreed to this procedure, this surgery, while you weren’t present. Where were you at this time that Dr. Sotomayor was discussing this with your mother?
A. Sitting outside the waiting room where the procedure room takes place. There is a waiting area on the second floor. I was sitting out there in one of the chairs. He came outside, asked me if I was with Miss Roosevelt. I said, “Yes.” He asked me to come in. And he told me, he said, “Miss Roosevelt and I have decided to go on with the surgery.”

Q. And you were the only family member there at that time?
A. Correct.

Q. Now, when you came back in the room, was there any mention of previous surgeries while you were there with your mother and Dr. Sotomayor?
A. No, sir.

Q. Miss Roosevelt, I’m going to show you a three-page form, it is entitled, “Patient Consent to Medical Treatment or Surgical Procedure and Acknowledgment of Receipt of Medical Information.” It is a three-page document taken from the medical records from All Saints Hospital.

A. “To remove the gallbladder,”

Q. And, Miss Roosevelt, on the last page, is that your mother’s signature?
A. Yes, it is.

Q. Were you in the room with her when she signed this document?
A. I don’t remember.

Q. Have you ever seen this document before, to your recollection?
A. No, sir.

Unless your counsel has any objection, I would like you to look at that very briefly. And, if I may, if you look about the middle of the first page when there is the description of the procedure, can you read that for me?

A. “To remove the gallbladder,”

Q. And, Miss Roosevelt, on the last page, is that your mother’s signature?
A. Yes, it is.

Q. Were you in the room with her when she signed this document?
A. I don’t remember.

Q. Have you ever seen this document before, to your recollection?
A. No, sir.

MR. STEVENS:

Unless you have any objection, I’m going to attach the three-page consent form as Exhibit A.

MR. EYOR:

That’s fine.

EXAMINATION BY MR. STEVENS:
Q. Now, I believe you testified previously that your mother was alert, correct?

MR. EEYOR:
Object to the form of the question.

EXAMINATION BY MR. STEVENS:
Q. Was your mother alert on November 8th, 2001?

MR. EEYOR:
At that time?

EXAMINATION BY MR. STEVENS:
Q. At the time she was meeting with Dr. Sotomayor prior to the surgical procedure -

A. I don’t remember.

Q. I do, however, believe it was your testimony previously that, at least on November 6th of 2001, your mother was alert and oriented, correct?

A. November 6?

Q. When she went into the emergency room.

A. Correct.

Q. Had her condition deteriorated in those intervening two days between November 6 and November 8 to where you believe she may not have been alert or oriented?

MR. EEYOR:
Object to the form of the question.

EXAMINATION BY MR. STEVENS:
Q. You can answer.

A. I don’t remember. I don’t understand what you are talking about.

Q. Do you believe that your mother was alert and capable of discussing this with Dr. Sotomayor, this surgical procedure, this gallbladder removal, or that she could have validly given her consent to the procedure?

MR. EEYOR:
Object to the form of the question.

THE WITNESS:
I can’t answer that right now.

EXAMINATION BY MR. STEVENS:
Q. Now, Miss Roosevelt, from what I understand, Dr. Sotomayor attempted to perform the laparoscopic cholecystectomy on November 8th, 2001; is that correct?

A. Correct.
Q. Were you at the hospital while the procedure was taking place?
A. Yes.
Q. And did Dr. Sotomayor discuss the surgery with you afterwards?
A. Afterwards?
Q. Yes.
A. Yes.
Q. Were there any other family members present?
A. Kerry; my sister, Janice; and there may have been another sibling, I don’t remember.
Q. And what did Dr. Sotomayor tell you?
A. He told us the surgery went fine except there was one problem, her gallbladder had been removed before.
Q. Did this surprise you?
A. Yes, it did.
Q. And why is that?
A. Because I told Dr. Thomas that she had - - may have had her gallbladder removed already, that he would have to check her records - -
Q. Did you ever tell Dr. Sotomayor that her gallbladder may have been removed?
A. No.
Q. Reviewing the medical records, it appears your mother’s gallbladder was removed back in 1991; is that correct?
A. It may have been.
Q. You weren’t present with her at All Angels?
A. No. I lived in another state.
Q. So at the time - and I say at the time meaning November 8th of 2001, did you know for certain whether or not your mother’s gallbladder had previously been removed?
A. No, sir.
Q. Do you know whether or not your mother told Dr. Sotomayor that she had had her gallbladder removed previously?
A. No, sir, I don’t know whether or not.
Q. Do you know whether any of your other siblings ever spoke to Dr. Sotomayor?
A. I don’t know.
Q. Were you with your mother when she went back into All Saints - - I say went back in
— when Dr. Sotomayor performed an additional procedure on November 11th, 2001?

A. I never left the hospital.

Q. I now you said previously you had not spoken to Dr. Sotomayor again, I didn’t know if he possibly had spoken to you or any of your brothers or sisters after the exploratory laparotomy performed on November 11.

A. Yes, sir. He came out and spoke to all of us.

Q. And what did he tell you at this time?

A. He said he may have nicked something.

Q. Was he any more specific?

A. He was specific, but I don’t know — — I don’t recall what it was that he said. Everyone was in shock. I know I was.

Q. Do you have any particular criticisms regarding the treatment provided to your mother by Dr. Sydney Sotomayor?

MR. EEYOR:

Object to the form.

EXAMINATION BY MR. STEVENS:

Q. You can answer the question.
Q. Was there ever any discussion about having the procedure done on a separate day?
A. No. Actually, she was supposed to just have the bronchoscopy done that day and then all of a sudden, it was changed.

Q. Did Dr. Sotomayor or any other physician tell you that it was emergent or urgent that your mother have this procedure on November 8th?
A. No.

MR. STEVENS: No further questions.

EXAMINATION BY MS. SUMMERS:
Q. Hi, my name is Amy Summer and I represent Dr. Thomas and I have a few questions in follow-up for you.
Was your mother relatively independent before she went into the hospital?
A. Oh, yes, very much.
Q. She could take care of herself; is that correct?
A. She was taking care of me, too.
Q. So she cooked and cleaned for herself?
A. Yes, ma’am.

Q. Did she have any hobbies or was she affiliated with any groups where she undertook assignments?
A. She volunteered with our church, is all I know. They did fundraisers and helped an orphanage, Masonic orphanage. They helped members of the community when they got burnt out and stuff like that.

Q. And what did she do for the church?
A. She was a treasurer.

Q. And she held those positions — —
A. Ever since the church started back in 19 — — I don’t recall.

Q. Was she doing that immediately prior to her admission to the hospital in November 2001?
A. Oh, yeah.

Q. What was our understanding of the reason that your mother was staying in the hospital on the 7th?
A. Chest pains.

Q. Did you understand that she was going to have any particular procedures?
A. The next day they were supposed to be doing the bronchoscopy or endoscopy or whatever.

Q. When you saw Dr. Thomas on the 8th, you were there in the morning on the 8th?
A. Yes.

Q. And you remember a discussion with Dr. Thomas about gallbladder surgery?
A. Correct.

Q. Was your mother present in the room?
A. Yes.

Q. Was your mother awake?
A. Not quite.

Q. What did Dr. Thomas and you talk about on that morning?
A. He asked my mother first had she ever had her gallbladder removed

Q. And what was her response?
A. My mother was rubbing her eyes, and she couldn’t think clearly, you could tell. And she said, “No.” and I said, “Mom, I think you have.” And I looked towards Dr. Thomas and I said, “I think she has.”

A. And he says, “If so, where would she have had it done?” I said, “At All Angel’s Hospital.” He said, “Is that in Justice?” I said, “Yes, sir.” I said, “You will have to check her records.”

Q. You said your mother was kind of sleepy and a little confused; is that how you described her in the morning?
A. She was not fully awake.

Q. When did you find out that she was not going to have the bronchoscopy or endoscopy?
A. When Dr. Sotomayor came and got me. That’s when I was kind of leery, but I didn’t say anything because, like I said, with computers and faxes, I thought maybe they already obtained the records and he has already talked to Dr. Thomas.

Q. When did Dr. Thomas tell you that he had reviewed medical records and saw that she had surgery in 1991?
A. It was after she was in intensive care when he came out and spoke to the family.

Q. Do you know why your mother had to have exploratory surgery?
A. Supposedly because she was bleeding and they didn’t know where it was coming from.

Q. Was your mother able to sign the consent for the exploratory surgery?
A. No.

Q. At what point in your mother’s hospitalization was she unable to make her own decisions?
A. After her gallbladder surgery.

Q. Who made the determination that she was not capable of making those decisions?
A. All of us got together and talked about it.

Q. And that being all of your brothers and sisters?
A. Yes.

Q. It is my understanding that at some point during your mother’s hospitalization you signed several consents for your mother. Do you recall that?
A. Yes.

Q. In your complaint to the Medical Review Panel you indicate that your mother advised Dr. Thomas in her daughter’s presence that she thought she had a gallbladder removed years earlier. That would have been you?
A. Yes.

Q. And this is the conversation that we talked about where your mother was not fully awake?
A. That statement is incorrect.

Q. Can you correct it for me?
A. Miss Roosevelt said she thought she had not had her gallbladder removed. I was the one stated, “Mother, I think you have.” It was early in the morning, and she really didn’t know.

Q. And that was the conversation you described earlier?
A. Right, with Dr. Thomas.

Q. And then the complaint to the Medical Review Panel goes on to state, “Miss Roosevelt’s daughter suggested review of Mrs. Roosevelt’s past medical records to confirm her past medical history.”
A. Yes.

Q. And the daughter referred to is you?
A. Yes.
MS. SUMMERS:
No further questions.

EXAMINATION BY MR. GREEN:
Q. Miss Roosevelt, my name is MR. Green and I represent Dr. Anthony Kennedy and Dr. John Roberts in this matter.
Q. In answer to one of Ms. Summer’s questions earlier I believe you testified that the first discussion you had with any anyone in particular about gallbladder issues was on the morning of November 8th with Dr. Thomas; is that correct?
A. That’s correct.
Q. So that, on the 7th, there would have been no discussions by you with anyone, including physicians, of any sort of gallbladder issues?
A. That’s correct.
Q. And I know you testified earlier that Dr. Thomas evaluated your mother on the morning of November 7 at approximately 5:30; is that correct?
A. That’s correct.
Q. And how did the monitor problem come up afterwards?
A. One of my sibling — which was, I guess it was on a Saturday when I called everyone in.
Q. Which sibling?
A. Kerry. Kerry was watching my mother breathe. And Kerry looked at the monitor and said, “It is not right.” So Kerry asked one of my sister-in-laws to check her, for her to look at mother and look at the monitor. And they discussed what they got, which wasn’t what the machine had.
Then they got my third — my other sister-in-law to come in and she checked. And that’s when they went immediately to get the nurse.
Q. And, as far as you understand, what was the effect of this problem with the monitors?
A. Her heart rate or her pulse, whatever, was lower than what the monitor had read,
Q. And, according to your understanding, did that hurt her in some way?
A. Yes.
Q. And how did it hurt her?
A. Well, the reason why she was so weak -- well, when her blood pressure would drop or whatever it was that was dropping, immediately that should have alarmed the nurses, you know, that there was a problem, and it didn’t.

So she laid there for two days with the same -- the same numbers on her monitor, you know. So how -- the nurse didn’t know, I don’t guess, but still, those two days was time that she could have got help.

Q. I understand.
A. And there was another time when I was there, and she got up to use the bathroom and it was early in the morning, I mean, like 1, 2:00. And then she got up, I ran over to help her, and she passed out and she had used the bathroom on herself.

And I called for a nurse and I couldn’t get a nurse, I pushed the button, I called for a nurse. Finally -- my mother is a retired nurse, and I heard her always speak medical terms. So I hollered, “I need a nurse stat.” That time the doors flew open.

And I said, “I need you to help me with my mother, she has fallen.” And -- well, she had fell up against the bed. And when she stood up, she kind of just went straight back and she was kind of a big women for me.

And we got her back in the bed and she had used the bathroom on herself. And they were just going to cover her up. I said, “Oh, no, no, we can’t do that, you have to clean her.” So we cleaned her up, and it wasn’t long after that, that’s whenever Dr. Thomas had came in later that morning.

Q. And when you say she fell or whatever when you called for the nurse, with the button or whatever or --
A. No, I called the nurse with the button first --
Q. That’s what I am asking.
A. Right.
Q. And you didn’t get any response?
A. Did not get a response.
Q. Then you yelled?
A. I yelled and pushed the button again.
Q. So the first time that you heard of any issue with a monitor is when Kerry said something to you?
A. He said it to all of us.
Q. And what did Kerry say?
A. Yes, I don’t know if it was her pulse or blood pressure or respiration or whatever, it wasn’t matching the monitor.
Q. Earlier you indicated that your understanding was that the failure of the monitor made some type of difference in the treatment of your mother.
A. Correct.
Q. What do you base that understanding on?
A. Well, if her respiration -- which I don’t know anything about medicine, but I have looked it up. Supposedly, she had been bleeding internally, and they didn’t know where it was coming from. Well, with her respiration dropping, a nurse or a doctor would have immediately seen that and started doing some type of medical assistance, I don’t know what.
Q. Did somebody tell you this or did you think this up in your mind?
A. I thought it up in my mind.
Q. Did anybody tell you that any problems that were encountered by your mother were caused by a monitor?
A. No one told me that.
Q. The understanding you were talking about is what your own mind thought about?
A. I have been in a hospital a long time and I have seen things and, quite naturally, if the machine is not working well, that’s what we rely on.
Q. Have you ever heard an opinion given to you by a physician that the cause of any of your mother’s problems was due to a monitor?
A. No, sir.
MR. GREEN:
I have no further questions.
MR. STEVENS:
I have a couple of very brief follow up questions.
EXAMINATION BY MR. STEVENS:
1 Q. You have mentioned on a couple of occasions that you don’t have any medical background, correct?
A. Correct.
Q. But your mother did?
A. Yes.
Q. She was a registered nurse?
A. No, she was an LPN nurse.
Q. She was an LPN. Was she retired — —
A. Yes.
Q. — — or was she still working?
A. She was retired.
Q. How long had she been retired; do you recall?
A. I don’t recall, a long time.
Q. Do you know where she worked as an LPN, where was she employed when she was working?
A. Charity Hosp. in Labor & Delivery. After she retired, she worked up at Manor Nursing Home.
Q. Manor Nursing Home?
A. I think that is the name of it.
Q. When Miss Summer was asking you some questions earlier, I believe you stated that whenever the physicians came to examine your mother, you were right by her bedside; is that correct?
A. Which physicians, any of them?
Q. You didn’t really clarify, you just said whenever any of the physicians came by — —
A. Whenever Dr. Thomas came, I was there.
Q. Just Dr. Thomas?
A. I don’t recall the other ones, but I was there.
Q. I am just trying to clarify because when I was asking you some questions earlier, you said you weren’t in the room when her and Dr. Sotomayor were discussing the gallbladder surgery.
A. Dr. Sotomayor never came in her room that I remember.
Q. So Dr. Sotomayor saw her in the prep room or the operating room?
A. Right.
Q. So when you were answering the questions earlier regarding bedside, you only meant her bedside in the room?
A. Right, her bedside in her room. I don’t recall seeing Dr. Sotomayor.
Q. In her room?
A. In her room.

MR. STEVENS:
That’s all the questions I have.

EXAMINATION BY MR. EEYOR:
Q. What did Dr. Sotomayor tell you when you asked him about the medical records?
A. Dr. Sotomayor stated, “we don’t go by medical records, we go by what patient says.”
Q. When Dr. Sotomayor explained why he did the surgery, what did he say?
A. Dr. Sotomayor stated, he personally cancelled the test that was to be done and decided to take her in and do gallbladder removal. “After all, she’s the last patient of the day and that means I would have had to come back.” He further stated, “She is the last patient of the day and I couldn’t see any point in having to come back later.”
Q. Did he say anything else?
A. He argued with us over going by patient rather than records.
Q. Did you ask Dr. Sotomayor any other questions and what was his response?
A. We asked him, “Why would you start a procedure like this on your own without checking with someone else?” And he said,
“It wasn’t necessary. I just saw that something needed to be done.”

Q. After the second surgery, the exploratory Surgery, what were you told and by whom?
A. Drs. Sotomayor and Thomas came out to the waiting room and said they were truly sorry.

Q. Was anything else said?
A. He said that my mom had complications due to an unnecessary surgery. – that she suffered due to complications of an unnecessary surgery.

Q. Who stated this was an unnecessary surgery?
A. Dr. Sotomayor.

END OF DEPOSITION
<table>
<thead>
<tr>
<th>Q.</th>
<th>A.</th>
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</thead>
<tbody>
<tr>
<td>And what is your telephone number?</td>
<td>59707 Highway 10 in Justice</td>
</tr>
<tr>
<td>What is your date of birth, sir?</td>
<td>9/13/53</td>
</tr>
<tr>
<td>The last four digits of your Social?</td>
<td>1321</td>
</tr>
<tr>
<td>Are you currently married?</td>
<td>No</td>
</tr>
<tr>
<td>When were you divorced?</td>
<td>'94</td>
</tr>
<tr>
<td>Is your ex-wife's name?</td>
<td>Lisa Smith</td>
</tr>
<tr>
<td>How long have you been at Northeast?</td>
<td>Twelve years</td>
</tr>
<tr>
<td>What type of business is that?</td>
<td>Working with the mentally disabled, you know, with developmental disabilities.</td>
</tr>
<tr>
<td>Where did you attend high school?</td>
<td>Hott High school in Hope, Justice.</td>
</tr>
<tr>
<td>What year did you obtain your degree?</td>
<td>1971</td>
</tr>
<tr>
<td>Any college after high school?</td>
<td>Yes. Let me see where I can start. Southeastern.</td>
</tr>
<tr>
<td>Were you working at Manor at the same time?</td>
<td>No.</td>
</tr>
<tr>
<td>So you worked at Manor briefly and then went to</td>
<td>Southwest, Mississippi.</td>
</tr>
</tbody>
</table>
Q. Okay.
A. And then I came back to Southeastern.
Q. Okay.
A. And that's it.
Q. And did you obtain your degree from Southeastern?
A. No, I think I was a junior.
Q. All right. You did obtain your certification as an LPN?
A. Yes.
Q. And you have maintained that certification for the last 12 years?
A. Yes.
Q. And has your certification ever been suspended, revoked, or restricted in any way?
A. No.
Q. And where did you obtain that certification from?
A. Southwest Mississippi in Summit.
Q. Mr. Doolittle, are you on any medication today that would prevent you from answering my questions fully and completely to the best of your knowledge?
A. No.
Q. Have you ever been arrested or convicted of any crimes?
A. No.
Q. Have you ever filed any lawsuit other than the one we are here for today?
A. No.
Q. Have you ever been sued by anyone?
A. No.
Q. Prior to November of 2001, had you ever met Dr. Sotomayor?
A. No.
Q. Had you ever been treated by Dr. Sotomayor?
A. No.
Q. Other than at the hospital admission in question, November 6th through November 15th, 2001, have you ever spoken to Dr. Sotomayor?
A. No.
Q. So neither before or after this admission?
A. You said from the admission?
Q. Have you ever spoken to Dr. Sotomayor either before or after your mother's hospital admission?
I am aware that she might have been in there for was when she had — she tried to pass kidney stones, and, you know, I think that's about the only time I recall her ever being in the hospital besides having given birth. Q. And were you aware of whether or not your mother had any cardiac or heart conditions? A. Yes.

Q. were you familiar with the medication she was on? A. Nitroglycerin.

Q. Anything else? A. She had been taking Lasix, and she was taking high blood pressure pills for hypertension.

Q. You were working at Northeast Support Services back in 2001, correct? A. Yes, but it was under a different name.

Q. Were you at home on November 6th, 2001 when your mother, I assume, took herself to the hospital? A. Yes, I was at home that evening.

Q. She called and said that she had pains earlier that evening because this was later through the night, and she to told him that she had chest pains or confusion? A. No, she had none whatsoever. She remembered my number, and I can’t do that. Q. All right. So after your mother went in with the intake nurse she took the information, what happened next? A. She came out, and then we left from there and walked directly to the emergency room. when we got to the emergency room, the nurse directed us where to go. We walked into the emergency room. My sister Jesse and I stood there while my mother stepped up and got on the emergency room table. Q. Okay.

A. And then it was shortly thereafter the doctor appeared. Then the doctor asked my mother about what seemed to be her problem tonight, and she told him that she had chest pains earlier that evening, that they were so close together that she wanted to have it — she was concerned. She wanted to have it checked out. Q. This was the ER doctor?
I

1. A. Uh-huh. (Affirmative response.)
2. Q. Do you remember his name?
3. A. Dr. Smith. When Dr. Smith was there, he began to palpate around the area she was complaining that was sore. I think it was on the left side or this region here (indicating), and he pressed a certain area and she sighed. When she sighed, he said, "is that painful?" She said, "yes, it's very tender."

10. So then he sent for the guy to do the EKG. When he arrived to do the EKG, he took the readings and left. By then it was getting close to shift change, and I don't know if the other shift — if it was 11:00 or if it was 12:00, but in the meantime, she was getting irritable sitting on that stretcher, and the hours were going by and minutes, so she was --

18. I told her -- I said, "Are you ready to go home?" I said, "there's no telling how long you are going to be sitting here because it seems like it's been an hour," She told me -- she said, "Find out what they are going to do." So then I just stayed with her the next morning, so I did not have to see her the next morning, so I did not go until the next morning.

21. "Yes. He had begun to ask her questions on her history, medical history, and I informed her that they were going to do this diagnostic test, a diagnostic test, so I knew it was a diagnostic test. I said, "Well, let me know how it comes out." Then later that evening, I believe -- it's been -- time has gone by, so I'm going to go ahead and admit her.

20. Q. Did you go back to the hospital the next day?
21. A. No, sir. I didn't because she was there overnight, and I knew they were going to have to see her the next morning, so I did not go until the next morning.

22. Q. When were you first notified that your mother was going to surgery?
23. A. I had received a call because I had to go to work the next day.

24. Q. Did the first Dr. Smith.
25. A. Yes.

MR. LOWRY:
26. Excuse me, John. She told the first Dr. Smith or the second Dr. Smith?
27. THE WITNESS:
28. I believe it was the first one.
I know that she is going to have gallbladder surgery?

Q. Who asked you this?

A. My sister Janice.

Q. All right. What was your response?

A. I said, "No, I didn't know that."

Q. Okay. Did you make it to the hospital, and your mother was already

A. Well, I am at work now, but I will see if I could take off. I have to find somebody to cover for me before I can leave."

Q. Okay. Before I was able to leave.

A. Yes, sir, I did.

Q. Okay. Then you eventually did make it to the hospital?

A. Yes, sir, I did.

Q. So you did not have the opportunity to speak to Dr. Solomon prior to the surgery?

A. Prior to surgery, no, sir.

Q. Did you have an opportunity to speak to your mother prior to surgery?

A. No, sir.

Q. Did you have an opportunity to speak to Jesse prior to surgery?

A. We were waiting for her during the surgery and after the surgery.

Q. Before the surgery, did you speak to Jesse?

A. Yes.

Q. Okay. Did you tell Jesse that your mother had already had gallbladder surgery?

A. No.

Q. All right. So you were up at the hospital, and your mother was already in surgery; is that correct, or was she already out?

A. Until the surgery was being performed, and I was there waiting for her to recover from the surgery.

Q. And who else was there?

A. Janice, our sister, and Jesse.

Q. So Janice and Jesse were there?

A. Correct.

Q. When you got to the hospital, did you have any discussions with your sisters about your mother's prior gallbladder surgery?

A. No.

Q. Was this an issue at all for you, that your mother was being taken to surgery to remove her gallbladder that you knew had already been removed?

A. It just did not ring a bell.

Q. When your mother got out of surgery, did you have the opportunity to speak to someone?

A. I sure did.

Q. And what did he tell you?

A. He asked to speak to the family that was there with Evelyn, so my two sisters and I went into the room to wait for him to come in there. When he came in, he told us about the gallbladder surgery, and then he said that he was shocked because she did not have a gallbladder. When he said that, that's when it clicked that, well, I knew that, that she didn't have a gallbladder, but I still didn't -- I didn't think about saying it at the time, but my two sisters -- their remarks were: "what?" They were astonished over the fact that they went to remove it and it wasn't there.

Q. Did you tell Dr. Solomon, I remember now that 10 years ago she had a gallbladder surgery?

A. Yes. If he would have asked, we could have told him because we knew it, but I didn't think about saying anything.

Q. You say "we knew it," but you just testified that your sisters were surprised, so
2 A. In other words, I knew it, but at the time they said, "what," and I said, "Yeah, I knew that she had it 10 years ago."
3 Q. But your sisters didn't know it?
4 A. I think they knew it, too, but I am not sure.
5 Q. I am just trying to make sure we are clear because you said -- your testimony was that they were shocked that she didn't have her gallbladder removed, so my question to you is: Did they indicate to you prior to that surgery that they knew?
6 A. I am not sure.

<table>
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<tr>
<th>EXAMINATION BY MR. STEVENS:</th>
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<tr>
<td>1 Q. In your opinion, were your sisters, Janice and Jesse, surprised when Dr. Sotomayor said she already had her gallbladder removed?</td>
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<tr>
<td>2 A. No, they weren't surprised.</td>
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<td>3 Q. Janice was there with your mother prior to surgery, correct?</td>
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<td>4 A. Yes, sir.</td>
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<td>5 Q. Did Jesse know that your mother had her gallbladder removed?</td>
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<td>6 A. I don't believe Jesse was around when she had her gallbladder removed.</td>
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<td>7 Q. I guess, then, my question comes back again to: To your knowledge, did Jesse know about it or was she surprised?</td>
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<td>8 A. No, because I remember now that Jesse wasn't living around the area during the time that she had her gallbladder removed, and she might have not. I just can't remember it because I was spacey during that time, too.</td>
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<td>9 Q. I am not asking you to testify as to what they knew. I am asking you for what your understanding was. Did you think when you got -- you are there after surgery and Sotomayor comes out and says, Your mother didn't have a gallbladder. Now, you testified you said, &quot;yeah, I know that.&quot;</td>
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<tr>
<td>10 A. Okay.</td>
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<td>11 Q. Did Janice and Jesse?</td>
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<td>12 A. I don't know. I can't speak for them. All I knew was that I knew it.</td>
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<td>13 Q. Did they appear surprised that she had her gallbladder removed?</td>
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<td>14 A. I wasn't even looking at them. I just can't remember it.</td>
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<td>15 Q. I am just trying to make sure we have it clear for the record.</td>
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<tr>
<td>16 A. Yeah, I knew that. That's what I said.</td>
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<td>17 Q. And what was your response to that?</td>
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<td>18 A. &quot;Ooh.&quot;</td>
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<td>19 Q. Did they appear surprised?</td>
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<tr>
<td>20 A. No. His remark was -- when I said, &quot;I knew that,&quot; he said, &quot;Well, it would have been nice if somebody would have told me,&quot; or something to that effect.</td>
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<td>21 Q. Did you have any other discussions with Dr. Sotomayor that day?</td>
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<td>22 A. Well, I did when I had a question.</td>
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<td>23 Q. I don't recall the exact question because we are talking about seven or eight years ago. I don't recall the exact question, but, I mean, he explained it to us, and he sketched it out.</td>
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<td>24 A. I asked him a question about complications arising from this, but I don't recall the exact words or what complications I was referring to. I do remember saying something about complications arising from this.</td>
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<td>25 Q. Okay. And what did he tell you?</td>
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<td>26 A. I don't recall the answer either, but I remember I asked him -- I had a question for him, and that was the question. I just can't remember what it was.</td>
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<td>27 Q. Is it your understanding that certainly there are complications that could arise from any type of surgery?</td>
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<tr>
<td>28 A. Oh, yes.</td>
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<td>29 Q. So there are complications that could arise from a gallbladder procedure?</td>
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<td>Q.</td>
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<tr>
<td>You are aware of that?</td>
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<td>You have to say yes or no.</td>
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<tr>
<td>Is that what you were asking Dr. Solomayor?</td>
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<td>what type of complications could arise from this surgery?</td>
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| Q. | Did you or any one of your family members, at this point in time, have any -- let's start with you. Did you have any opinions as to whether or not Dr. Solomayor did.
something wrong in performing the gallbladder surgery?

A. I do.

Q. what is that opinion?

A. I feel like records should have been observed, and due to the fact that if a person was elderly, handicapped, sometimes they are not verbal to be able to express themselves, so records is what you look at.

The other thing is lab work prior to.

Q. Prior to the first surgery?

A. Right. Lab values should be assessed and looked at in comparison to post-surgeries, you know, to see how things are, if the values are still the same.

Q. Now, you said records should have been observed for someone who is elderly or incapacitated, but it is your testimony that your mother was fully capable; correct?

A. Yes, sir, she was.

Q. Do you have any reason to believe that she could not communicate correctly or properly with the doctor?

A. The only way that I would know of that she would not be able to verbally and orally express herself is if she is under sedation. Which you'd confuse a person.

Q. okay.

A. -- which would confuse a person.

Q. Do you know whether or not she was under sedation prior to surgery?

A. I don't know because I don't -- I didn't look at her medication sheet to see what medications were given to her for sleep or for the next day prior to the surgery. I really don't know.

Q. Okay. So you said the records should have been observed and lab work should have been compared. Anything else just in your opinion?

A. I just feel like there was some negligence in healthcare, you know, the standard procedures, and I felt like it was overlooked, but other than that -- well, the main thing is that a lot of the results would never have happened if prevention was there to keep things from escalating like it had been.

Q. other than your attorneys, have you spoken to anyone who has given you an opinion regarding your mother’s care of your mother?

A. I am not easily influenced.

Q. I guess my question really is: Did any other doctor tell you, Salomayor messed up?

A. No.

Q. were you present when your mother was transferred to ICU?

A. Yes, sir.

Q. who else was there with you?

A. All of us because during this time, you know, was when her condition was deteriorating, and it seems like each system was going, from one system to another, and each time we were dealing with a different problem. At that time, the flag was raised, so everyone was there.

Q. It's my understanding that your mother then went through her second surgery; is that correct, exploratory surgery?

A. I think they wanted to do an exploratory surgery, but I don't remember if it was ever done or not.

Q. Did anyone ever tell you what actually caused your mother's deteriorating condition, any doctor?

A. Not that recall. I don't know.

Q. Do you have any opinion about what happened that then caused her condition to deteriorate?

A. Unnecessary surgery.

Q. The surgery itself I understand was performed. Was there anything done during that surgery? what condition -- you know, surgery itself normally doesn't kill someone or --

A. Well, the surgery itself doesn't.

Q. That's what I am asking you. Do you know what that was?

A. No. I am not a surgeon.

Q. Okay. Eventually they called a code; is that correct?

A. Right. I was with her then.

Q. You were present?

A. Yes.

Q. Who else was present when they called a code?

A. I have a sister-in-law named Sherry. We were both standing there.
Q. What doctors were there; do you know?
A. I didn't see a doctor. It was a nurse, a male nurse.
Q. Do you know who that male nurse was?
A. No, sir, I don't.
Q. And was your mother eventually resuscitated?
A. Yes, she was, but we left out of the room.
Q. And I assume you were present, as your siblings have testified, when you had this family meeting to discuss whether or not to take your mother off of life support?
A. Say what?
Q. There's been some prior testimony that there was a family meeting to discuss whether or not to take your mother off of life support. Were you present for that meeting?
A. Yes.
Q. Was it your decision to remove your mother from life support at that time?
A. Yes.
Q. By 2001, you had moved -- it would be to your current home; is that correct?
A. Yes. As a matter of fact, I bought my home in September, and she came up there just about every day up to that time.
Q. What I am saying is: I guess you weren't living with your mother on her property in 2001, November of 2001?
A. No, not in November.
Q. Did your mother provide you with any other financial support? Is that a trick question?
A. Let's see. I lived with her for forty something years.
Q. In November of 2001 -- all of our parents provide us with support at some point or another. In November of 2001, did she provide you with any support?
A. No.
Q. Did you have any discussions with Dr. Sotomayor --
A. No.
Q. -- just prior to your mother passing away?
A. Just that one time when he wanted to meet up with the family.
Q. Came in where?
A. Her room.
Q. A room on the floor?
A. Apparently, that must have been before the surgeries.
Q. Okay. Have you been told or do you have any information that indicates that any employee of All States, nurses, etcetera, not the doctors, did anything wrong that caused or contributed to your mother's death?
A. Personally? Is that what you are asking?
Q. Right.
A. Personally, I feel the surgery, the gallbladder surgery, and I also feel like the blood pressure machines -- you know, I feel like if they were operating accurately or close to being accurate, with them being faulty towards the end of her declining health, I felt like it would have prevented a lot of that because it would have been caught it and her health wouldn't have deteriorated as fast as it did. They would have caught that her blood pressure was lower than what the machines were showing.

Q. And earlier you made the statement -- I don't remember exactly how you worded it, but you basically said that prevention was not there. Is that what you were talking about?
A. Right.
Q. okay.
A. Because the machines were not operating like they should have been, it caused a delay in her treatment.
Q. Okay. Are you attributing the surgery to All States' employees or were you just listing the things it caused?
A. Listing the things it caused.
Q. Okay. Anything else?
A. No.

MR. LOWRY:
That's all I have. Thank you.

(End of Deposition.)

***
WITNESS CERTIFICATION

At the request of the defense attorneys in this case, I have carefully reviewed the above deposition transcript to determine whether it was true and complete and whether I had any additional information relevant to the matters discussed therein. I did so, and hereby certify, under penalty of perjury, that the deposition transcript is true and complete and that I have no information relevant to the matters discussed in the deposition that is not contained in the same.

Kerry Roosevelt    3/17/13

Signature    Date
Andy Scalia, M.D.

having been first duly sworn, testified as follows:

EXAMINATION

BY MR. OWENS:

Q. Doctor, my name is Chris Owens. How are you?
A. Good.

Q. And I'm just going to ask you some questions about this, if I could. Could you provide us your educational background, let's say, starting with college, sir?
A. Yes. I went to college at Harvard.
Q. Uh-huh. What year?
A. I would actually have to look at that.
Q. Sure. No problem.
A. Let's see. So, that finished in 1981.
Q. So, you started in '78, '77?
A. I actually started in '74. I took some time off.
Q. Okay. What did you do in your time off?
A. I went to -- Well, I did about a year-and-a-half of research at Harvard.
Q. Uh-huh.
A. I went to motorcycle mechanic school.
Q. Okay. Did you get a degree there?
A. Yeah, I did pass it.
Q. Did you?
A. So, -- Okay.
Q. Okay. So, you graduated from Harvard in 1981?
A. Yes.
Q. And what was your major?
A. That was biology.
Q. Okay. And from there?
A. Then, I went to Harvard Medical School, and I finished in '86. And then I went to University of California, San Francisco, did my general surgery internship.
Q. Uh-huh.
A. And then, I went to the University of Arizona, where I did my residency.
Q. When did you finish your internship, doctor?
A. Oh, that was finished in '87.
Q. And then, the University--I'm sorry--of
Arizona?

A. University of Arizona in Tucson from '87 to '91 for my residency.

Q. Uh-huh.

A. And then, I did a fellowship training in thoracic surgery and oncology from '91 to '92.

Q. Any honors that I should be aware of, let's say, residency?

A. Well, No. I was Magna Cum Laude at Harvard, --

Q. Uh-huh.

A. -- and I guess that's it.

Q. Okay. So, the fellowship in '91 to '92 in thoracic and --

A. Thoracic surgery and oncology.

Q. Oncology. And what is that? Tell me what that is.

A. Oh, it's basically working on lung cancer and esophageal cancer.

Q. Okay.

A. Everything in the chest, except the heart.

Q. So, you finished that in '92?

A. Yes.

Q. And what did you do from there?

A. Then, I went on to -- to the VA in Temple, Texas.

Q. How did you get to the VA in Temple, Texas?

A. Well, they needed a general surgeon and a thoracic surgeon, which is exactly what I wanted.

Q. And had you ever lived in that -- in Texas before?

A. No.

Q. What attracted you? The job attracted you, or the location, or what?

A. No, just the job.

Q. Okay.

A. I also liked the VA.

Q. So, you took that position in '92?

A. Yeah.

Q. Okay. With the VA. How long did you stay there with the VA?

A. That was for 13 years.

Q. Okay. And what are you? -- a GS, Government Service, employee when you were at the VA? How does that work?

A. Yes.

Q. What position did you hold there at the VA for the 13 years you were there, sir?

A. Well, I was, you know, staff surgeon in general thoracic and -- general and thoracic surgery. I
was the Director of the Intensive Care Unit -- surgical
Intensive Care Unit.

Q. Uh-huh.
A. I was the VA Residency Coordinator for awhile.

Q. Uh-huh. And did you see all types of surgical
patients, or was it limited to any particular
subspeciality?
A. Well, -- No. I -- I did basically general
surgery, thoracic surgery, and head and neck surgery.

Q. Okay. What did you do after you left the VA?
A. Then, I came up here to Henderson Memorial
Hospital.

Q. What attracted you to Henderson Memorial
Hospital?
A. I had done a -- Well, I was kind of burnt out
on the VA, and I did a locum's, and they just offered me
a nice deal.

Q. Okay. So, you came on a locum tenens deal
here, or did you do a locum tenens, and then came here
after that?
A. No, I did a locum tenens here, and then became
full time from that.

Q. And then became full time. And what was your
position here?
A. Staff Surgeon.

Q. Okay. Were you employed by the hospital, or
is that -- Is that still your position?
A. No.

Q. Okay. So, when you came here, what -- were
you employed by the hospital?
A. I was employed by some type of entity of the
hospital.

Q. Okay. So, you didn't set up your own private
practice?
A. No.

Q. You were employed by some entity of the
hospital?
A. Yes.

Q. Okay. How long did that last?
A. Three years.

Q. What did you do after that?
A. And then I decided to do my mission work, you
know, more -- well, not full time, but more time.

Q. Uh-huh.
A. So, I've been working in the emergency room
and doing my mission trips.

Q. Okay. So, when did you stop working as an
employee of the hospital?
A. Last November.

Q. Okay. And tell me, in those three years that
you worked -- when you worked at the hospital, what were your duties and responsibilities?
A. Well, I was the only surgeon in town.
Q. Okay.
A. So, I handled all of the surgical problems that showed up.
Q. And I read something about your mission work. Tell me, when did that first start, Doctor?
Q. All right.
A. Somebody took me on a mission trip to Nigeria.
Q. Uh-huh.
A. And then -- then, I went again in '86, and '91, and then every year since '96, sometimes more than once a year.
Q. Do you belong to an organization, or do you have an organization that finances and organizes these mission trips?
A. It's both. I'm -- I am on the Board of Directors of the Health Care Foundation, which has a hospital called the Christian Hospital.
Q. Uh-huh.
A. And then, I have my own foundation, which is worldwide Surgical Foundation. And then, I've worked
for other foundations, other groups.
Q. Uh-huh.
A. And so, some of the trips will be with my foundation, or their foundation, or -- It doesn't really matter.
Q. Uh-huh. I understand. When did you start your foundation?
A. I think that was in 2004.
Q. And the name of that foundation, again? I'm sorry. I missed it.
A. worldwide Surgical Foundation.
Q. Okay.
A. And that's a 503C.
Q. Okay. Are you the only member, or do you have other members of the foundation?
A. No. I have -- There's a nurse --
Q. Uh-huh.
A. -- on it. And my sister, who is a lawyer. She helped me form it.
Q. Uh-huh.
A. And actually, there is another nurse. So, there's two nurses, my sister, and me.
Q. And so, you've been -- Since you left the hospital, which is what year, again, --
A. That was last year.
Q. Last year?
A. No. It would have been 2008.
Q. 2008.
Q. Since 2008, you've been working the emergency room?
A. Yeah. At Houghton.
Q. Where is Houghton at?
A. Houghton is about 25 miles up the road from here.
Q. How often do you work in the emergency room?
A. Well, it just depends when I'm taking my trip. I probably average seven shifts a month.
Q. Okay. I assume that doesn't include any surgical practice?
A. No.
Q. Strictly an ER practice? Do you have any certifications in emergency room practice?
A. No. I've just done it for a long time.
Q. Uh-huh. So, at the present time, you're not doing any surgical procedures?
A. Not here, no.
Q. When you go on your mission trips, do you do surgery there?
A. Yeah. That's all surgery.
Q. Okay. And in the last couple of years, tell me where you have gone on your mission trips.
A. Well, I'm going to Nigeria four times a year.
Q. Uh-huh.
A. And I've been to -- also been to Kenya --
Q. Uh-huh.
A. -- a couple of times. And I think I've --
Q. What time frame did you say?
A. The last two years.
Q. The last two years.
A. Uh. I think I've also been to Guatemala during that time.
Q. And how did you pick out Nigeria and Kenya as compared to other parts of the world?
A. Well, the Nigeria one is the same one I've been going to since '85.
Q. That's the trip that you were taken on by someone else?
A. Yes. And I've been to the same place about 20 or 30 times.
Q. Uh-huh.
A. The Kenya trip, someone just called me and they needed a surgeon. --
Q. Uh-huh.
A. -- so I went. And the Guatemala one I've also been also doing for quite some time. I think since '98.
1 actually, I've gone to Guatemala.
2 Q. Okay. Doctor, are you Board Certified?
3 A. Yes.
4 Q. In what field?
5 A. General surgery.
6 Q. When did you take your -- first take your
7 boards?
8 A. '94.
9 Q. Did you pass them the first time?
10 A. I passed the written. I didn't pass the oral
11 ones the first time.
12 Q. When did you retake the oral exam?
13 A. Whenever I could the next time.
14 Q. Okay.
15 A. I think within six months or a year. I'm not
16 sure.
17 Q. I understand. So, you first sat for them some
18 time before '94, and you passed them completely in 1994;
19 is that correct?
20 A. That's correct.
21 Q. Have you had to be recertified?
23 Q. And have you had any other participation in
24 your Board? Have you ever sat as a Board Examiner, or
done anything else with the Boards, other than take the
25 Boards?
2 A. No.
3 Q. When you took them in 2003, did you pass them
4 the first time?
5 A. Yes.
6 Q. Okay. Any other Board certifications in any
7 other fields?
8 A. No.
9 Q. Any other subspecialties that you consider --
10 Are there any fields that you consider yourself a
11 subspecialist in?
12 A. Well, I consider myself kind of an expert in
13 thoracic surgery.
14 Q. Okay. Other than your practice as an
15 emergency room physician and your mission work, do you
16 do any other type of medical practice?
17 A. No.
18 Q. Have you ever been sued for medical
19 malpractice?
20 A. Yes.
21 Q. Can you tell me how many times?
22 A. Let's see. I was sued in '94.
23 Q. Uh-huh. What was that case about?
24 A. That was a case of -- It was a misdiagnosis of
25 lung cancer.
Q. Uh-huh. Tell me the circumstances and the outcome, if you could.
A. Oh. The patient came in with an abscess on their buttack, and it was at the VA, and they needed to have an x-ray in order to get into the operating room. So, that was done.

Q. Uh-huh.
A. That showed an abnormality, which was present before, but an abnormality --
Q. Uh-huh.
A. -- and that was not followed up on until a later date. And I believe the VA settled that.

Q. Okay. Were you deposed in that case?
A. No.
Q. Was a payment made on your behalf?
A. Mine, and others.
Q. Okay. Did an expert give expert testimony adverse to you in that case?
A. I don't think it works like that in the VA.
Q. Okay.
A. I don't think there was -- I think it was just settled.
Q. Okay. Before it even got to that point?
A. Exactly.
Q. Okay. Did you have anything to say about whether it should be settled, or not?
A. No. Actually, I found out about it after.
Q. Ah. Do you know how much it was settled for?
A. I think it was 80,000, but I'm not 100 percent sure.
Q. Okay. Did you have counsel?
A. Mine, and others.
Q. Okay. Did an expert give expert testimony adverse to you in that case?
A. Yeah. I have a current one.
Q. And to the extent you can speak about it, could you tell me generally what the case is about?
A. I didn't hear you. I'm sorry.
Q. To the extent that you can speak about it, could you tell me what the case is about, generally?
A. The case is a -- an OB/GYN at Anderson was doing a procedure, he called me to the O.R. for a consultation, and this patient subsequently had multiple complications.
Q. Uh-huh.
A. I think that's about the gist of what I can tell you about it.
Q. Okay. And where is that case pending? What court?
A. Well, I would imagine it's Polk County, but
I'm not sure.

Q. Okay. And who is your insurance carrier?
A. I don't know.

Q. Are you insured for the claim?
A. Yes.

Q. Okay. Do you have counsel?
A. Yes, sir.

Q. Who is your counsel?
A. Dave Sweeney.

Q. And the reason I ask that is I believe that you're insured by Medical Protective Insurance Company.

A. Yes, the -- the word "Protective" does sound familiar.

Q. And the reason I ask that question is because the -- Dr. Solomon, who is my client, is also insured by Medical Protective Insurance Company. And I wanted to ask you at this juncture whether you feel that you have any conflict of interest in being insured by Medical Protective for the claim and testifying, I presume, adversely against Dr. Solomon in this case.

A. I -- I don't see any --

Q. That's fine.

A. -- conflict of interest, and nobody has said anything to me about it.
didn't -- I haven't studied it much.

Q. Okay. As far as you know, it was a report adverse to you, though? Or was it about the other doctor in the case? I presume they sued the OBGYN, as well?

A. Yeah. Yeah, they -- they had some criticisms of me, yes.

Q. Okay. But you don't know what those are at the present time?

A. Well, one criticism -- I can tell you one, the only one that stands out. They had one criticism that when the patient came back, that I hadn't seen the patient expeditiously. But in fact, I had seen the patient and operated on the patient within one hour of seeing them. So, I didn't really pay much attention to it.

Q. I understand. You don't feel there's any merit to the claim?

A. No.

Q. Okay. Any other malpractice claims other than those two?

A. No.

Q. Have you had any other claims that have not been filed but have been just settled before they ever became a claim?

A. Well, no. There was one they just -- they -- I don't know what they did, but whatever they did, they withdrew it, and it just never became anything.

Q. All right. When was that -- that one?

A. That was in the last couple of years.

Q. Have you ever had any actions taken against your license? Revoked? Suspended? Limited in any way?

A. No.

Q. Have you ever had your privileges limited, suspended, revoked at any of the hospitals that you've practiced at?

A. No.

Q. Have you ever been called before the state licensing board for any reason?

A. No.

Q. I presume you have given expert testimony in a medical malpractice case before this one?

A. Yes.

Q. Okay. Could you tell me approximately how many times?

A. 37
Q. All right. And of these depositions, the 37 depositions, how many of these have you testified for the doctor versus the claimant?
A. I think the deposition -- I think the depositions and the trials are all for the plaintiff.
Q. All for the plaintiff. So, you've never testified for the defendant doctor in a medical malpractice claim; is that correct?
A. That's correct.
Q. Okay.
A. As far as I can remember.
Q. Uh-huh.
A. But if I have, it's not a lot of them.
Q. Uh-huh. When did you first start acting as an expert witness in medical malpractice cases?
A. I think it was 2003.
Q. How did that occur?
A. I think it started because I had written an article and somebody saw it, and it was pertinent to their case, and they called me about it.
Q. Okay. And I saw somewhere that you had written some articles about, I guess, litigation and medical malpractice. Is that correct? Is --
A. Yeah. I used to actually have a little editorial page in one of the journals about medical malpractice.
Q. When did you start -- Well, what publications did you have your editorial page in? I assume that's on your Curriculum Vitae?
A. Yes. It was called Scalpel and Gavel.
Q. Was that the name of the publication, or was that your --
A. No, that was my --
Q. -- editorial piece?
A. That was my little -- Excuse me for one second.
Q. Take your time.
A. Oh, that was in Contemporary Today. I'm sorry.
Q. Contemporary Today?
A. That was the journal.
Q. Is that a national journal?
I'm sorry.

A. So, then, at some point after that, the Editor had asked me if I would like to start this new section.

Q. What prompted you to write the article, in the first place?

A. We have a case of it at the VA that I did not injure it, but I actually diagnosed. And so, I decided to write an article about it.

Q. Uh-huh. And then, you were approached by the Editor of the journal to start writing a regular column?

A. Right.

Q. Okay. And you agreed to do so?

A. Yes.

Q. And did you have a particular interest in the medical legal field?

A. I had a particular interest in surgical complications and avoiding them and, you know, quality control.

Q. Uh-huh.

A. -- and teaching.

Q. What did that stem from? I'm just curious.

A. Well, the -- you know, I taught people.

Q. Uh-huh.

A. I taught residents at the VA.

Q. Uh-huh.

A. I enjoyed teaching people when I was a Chief Resident. And part of the work in the Third World involved teaching. You know, when I became an attending involved, you know, kind of doing the same thing that somebody had done for me, --

Q. Uh-huh.

A. -- which was take people on trips and teach them.

Q. Uh-huh.

A. And then, to teach the local people, as well.

Q. Uh-huh. So, the Scalpel and Gavel editorial column, how often was that published?

A. I think that was -- Yes know, I don't remember. I think that was every couple of months.

Q. Okay. Did you pick the topics, or were you asked by the Editor to write about certain things?

A. I picked the topics but, you know, we would talk about things, and sometimes he would make suggestions.

Q. Uh-huh. Okay. How long did you write -- Or, are you still writing for them?

A. No. I think I did that for about a year.

Q. Okay. So, you wrote perhaps six or seven editorials?

A. I wrote five.
Q. Five. Are they listed? The editorials are listed on your CV?
A. Yes.
Q. Okay. Are any of them pertinent to this case, in your opinion?
A. No.
Q. Okay. And you believe because of the articles being published that you were contacted by someone to review a case, a malpractice case?
A. Not because of the editorials. Because of the original article that I wrote.
Q. The original article that you wrote. Okay. And we'll get back to the expert witness stuff in just a minute. While I'm thinking about articles, have you published any articles, other than the editorials which you talked about? The articles that you have published are listed in your CV?
A. Yeah. There's a bunch of them.
Q. Okay. And are any of the articles, in your opinion, have any bearing on this case—the Wallace case?
A. No.
Q. Generally speaking, or directly.
A. No.
Q. And I don't have it in front of me. When was the last time you published an article, Doctor?
Q. Where was that published at?
A. The American Academy of Otolaryngology, Head and Neck Surgery.
Q. Are you a member of any professional organizations?
A. No.
Q. Back to the malpractice—
A. Well, I'm sorry. Texas Medical Association, --
Q. Uh-huh.
A. -- And Texas Medical Foundation. That's it.
Q. Any national organizations?
A. No.
Q. Have you ever advertised for your services as an expert witness?
A. Semi. I mean, I have been listed with some agencies that connect lawyers and experts.

Q. Which agencies?
A. MedQuest.

Q. Say that, again?
A. MedQuest.

Q. Uh-huh.

A. TASA, T-A-S-A.

Q. Uh-huh.

A. TAB, T-A-B.

Q. Uh-huh. What is TAB? I haven't heard of that one. Is that a -- initials for something?

A. It is, but I don't remember what.

Q. Okay. Any others?
A. Not that I can remember offhand.

Q. How long have you been with MedQuest?
A. I don't know that -- the time period for any of them.

Q. Uh-huh.

A. But I didn't start with them, and I haven't really had anything to do with any of them -- any of those for a little while.

Q. Uh-huh.

A. So, three or four years.

Q. How did you come in contact with those

A. I don't remember.

Q. Can you recall the arrangements that you had with any or all of them, as far as how the cases came to you, and then how the payments were arranged?
A. The arrangements are basically the same.

Q. Okay.

A. Someone will contact them, and they'll call me and say "hey, we have so and so a case, it's about so and so", and you know, I'll basically say "Well, you know, let me talk to the attorney about it". So, they'll put me in contact with the attorney, and based on what I hear. I'll say "I can handle it", or "I can't".

Q. Okay. And then from there, do you deal directly with the lawyers as far as payment of fees, or --

A. No.

Q. -- is this TASA, or whoever, whichever one of these agencies, take care of that?
A. No, the -- they all handle the fees.

Q. Uh-huh. So, you quote them a rate per hour to review and a rate to give deposition testimony, and then from there, they take care of that with the lawyer?
A. Exactly.
Q. Okay. Did you get this case from a referral from any of these agencies?
A. I don't think so.
Q. Okay. In addition to these 37 depositions that you've given, have you reviewed other cases that you haven't given depositions in?
A. Yeah.
Q. Uh-huh.
A. You know, many cases don't get to the -- Well, two-thirds of my cases don't get to the deposition level, or something like that.
Q. Okay. And that's what I was leading to. So, how many cases would you say -- since you've started in 2003, how many cases would you say that you've reviewed overall, regardless of whether you've given depositions, or testified at trial?
A. I am not sure, but probably 150.
Q. Okay.
A. Well, that would make sense. Yeah.
Q. Okay. Do you recall who the judge was that you testified in front of?
A. No.
Q. Do you recall if it was the jury or a judge trial?
A. I don't.
Q. But you testified in?
A. Yes.
Q. And you were qualified as an expert?
A. Yes. Yes.
Q. Do you remember anything about that case?
A. No. I think it was a hand injury. But that's all I remember.
Q. Have you ever worked with plaintiff at any before?
A. I -- I'm not sure. I think I may have worked with her once before, but I don't remember the case.
Q. Do you have any other cases with her, other than this one?
A. No. Not that I remember.
Q. Have you ever attempted to give testimony but were not qualified to do so? Or, the court ruled that you weren't qualified to do so?
A. No.
Q. Okay. You've been doing this since 2003. Can you give me an estimate of what percentage of your income comes from expert review and testimony?
A. It just depends upon the year. I would say the most it's ever been is maybe 25 percent.
Q. Uh-huh.
A. Obviously, in 2003 it was just a small percentage.
Q. Sure. When would you say it was 25 percent?
A. I think a couple of years ago.
Q. Okay. And let's say in 2009, what would you estimate it would be, as far as percentage?
A. Well, I haven't done my taxes, so I can't -- Anything I tell you will be an estimate.
Q. That's all I'm asking for.
A. I would say 15 to 20.
Q. Okay. And do you actively cultivate this practice?
A. Well, when I do a case, I try to be prompt about it.
Q. Uh-huh.
A. I try to do -- give good service.
Q. Uh-huh.
A. So, I would say that, you know, to that extent, I certainly cultivate it.

Q. Okay.
A. I don't -- but I don't -- you know, I don't, like, have a big advertisement about it. I have listed with those companies, but if they call me and say, you know, "do you want to contact a lawyer, or should he contact you", you know, I say "well, let him contact me", and I use that as kind of a screening mechanism to see if they have some interest in it.

Q. Uh-huh.
A. So, I'd say that I try to do a good job, but I'm not overly gun-ho about it.

Q. Uh-huh. Is there any reason that you have not given expert testimony in defense of a doctor in a malpractice case, that you're aware of?
A. I don't know why I haven't gotten more cases.

Q. Uh-huh.
A. I certainly would be glad to. I have reviewed some. It's a small percentage. I think -- I don't like to -- what I would say -- I don't like to do spin work. So, the nice thing about plaintiff is if -- there's -- it's just -- there's just two bifurcation when you get a --

Q. Meaning what?
A. -- when you get a case. It's either you believe there's malpractice, or there's not.

Q. Uh-huh.
A. And if you believe there is, then you can go ahead and move on. And if you believe there's not, then it goes in the garbage.

Q. Uh-huh.
A. But it's different with defense work, because if you -- you know, if you believe there's malpractice, then you have to -- you still have to -- you know, you do get asked to "well, you know, how can we explain this", to a certain extent.
Q. Uh-huh.
A. And I don't like to do that.
Q. Okay.
A. So, I would say that the people that I have worked for, if there was malpractice, I can remember at least one case where there was malpractice, and you know, they said "well, we probably won't be needing you anymore".
Q. Sure. I understand. And I'm sure that's happened on the plaintiff's side, too; when you've told them there's no malpractice, they probably don't want to use you, either?
A. That has happened. Sometimes they'll say things, like, "don't write a report". That, like, code for they are going to go somewhere else.
Q. All right.
A. But I think the people that I've worked with who know me will usually respect what I say.
Q. Okay. And speaking of malpractice, how do you define 'medical malpractice'?
A. I would say, you know, malpractice is what a -- you know, a -- the breach of what a normal -- if it's a surgical case, what a normal surgeon would do under similar conditions.
Q. How do you go about determining what a normal

surgeon would do under similar situations?
A. Well, it's not necessarily what I would do. So, that's one thing.
Q. Okay. And that's a good point. So, how do you distinguish what you would do versus what this normal surgeon would do, --
A. Well, it's --
Q. -- just generally speaking? Not talking about this case.
A. Well, you know, it's like that -- to a certain extent, it's like what that judge said "I can't define pornography, but I know it when I see it".
Q. Uh-huh.
A. So, there are some things that you can -- you can say you just know it. There are some things that are so outrageous that, you know, nobody would do it.
Q. Uh-huh.
A. And then, there's some that -- you know, that are a little bit cloudier about it. And I think, you know, I know a lot of surgeons who work under different conditions in different parts of the country. I've been in many different parts of the country. I think I'm very aware of what -- what residents are taught, so what they should know, --
Q. Uh-huh.
A. -- and I think I'm cued in to what I think a
surgeon should know, even if he's not the best surgeon
in the world.

Q. Uh-huh.

A. If that makes sense.

Q. It does. Do you feel that you have any
particular bias as you review these cases? And we all
have biases of some type. Do you feel that you have any
bias, that you can identify, about the way you review
cases?

A. Well, I'm sure every expert says this, but I
think I try to be objective about it.

Q. Okay.

A. I try to review a chart, and the actual
outcome, to me, is -- is -- I try to make it irrelevant.

Q. Uh-huh.

A. In other words, just because someone has the
worst outcome, for instance, it -- it shouldn't change
your view of whether there's malpractice.

Q. Uh-huh.

A. Just because someone died a terrible death, it
should just be was there malpractice.

Q. Uh-huh.

A. And the actual consequence whether they
recovered or didn't recover, I try not to use that as

Q. Uh-huh.
A. So, I just try to find out whether it's in my area of expertise, because I don't want to get a chart and then say -- have to say after "well, this isn't my area of expertise", or -- So, that's one thing I want to get. Another thing is I try to -- with people I've worked with before, I try to -- you know, I may try to avoid getting just a dumb case sent to me.

Q. Uh-huh. And to determine that, you have to at least know something about the case from the lawyer, huh?

A. So, I need to know something, but I try not to use any information that they have sent me --

Q. Uh-huh.

A. -- as a basis for making any decision.

Q. And when you get materials to review, are you aware of the allegations against the defendant doctor before you review the chart, typically?

A. I would say I'm probably -- Yeah, I would say typically I do know what the allegations are. Even if I didn't, you know, I would know them within a second of opening the chart.

Q. Uh-huh. How so?

A. Well, you know, you get a case of someone who had a lap-coli, and you see -- you know, their post op bilirubin is 4, you know it's going to be a case about a common duct injury.

Q. Okay.

A. Or if you see one op report and then you know -- and then you see the second op report, once you see the second op report, you immediately know -- have a general idea of what the case is about, --

Q. Uh-huh.

A. -- unless it's, you know, a very complex particular issue. Then, you may not know it right away.

Q. You agree that -- that complications aren't always indicative of malpractice or substandard care?

A. I agree with that.

Q. Okay. And do you think that the standard of care is subjective, or objective?

A. I think in most cases, it's objective.

Q. Uh-huh.

A. And in the cases where it's subjective, then you know you're -- well, then is -- in a lot of those, you may be -- there should be a pursuit of malpractice.

Q. And the reason I ask that, in most of these cases we find different opinions about the same exact case from different doctors, and -- and I'm trying to find out from your perspective is there a standard of care, a standard of care, or is it something that you have ten doctors in a room, you could have ten different
I stand standards of care? Again, generally speaking; not about this case. Your thoughts on that.

A. Well, I will be honest with you. I -- I've often wondered how a relatively intelligent person can have an opinion that's different than mine. So, --

Q. That's fair.

A. You know. And, you know. I joke about that, but it's -- it's correct. How can you have two experts who have completely opposite opinions? I think the problem is not the -- in the objectivity of the -- of the situation, --

Q. Uh-huh.

A. -- it's in the experts.

Q. Right. And in most cases, you would think that they are probably incorrect if they disagree with you?

A. Well, I would -- I'm -- I'm flexible, but I would think that that's probably the case, most of the time.

Q. Okay. Doctor, when were you first contacted about this case?

A. Some time around August 3rd, 2006.

Q. Okay. And I see you looking at a stack of documents there.

A. Yeah.

Q. Okay. Did you have any conversation with counsel before you received this letter on August 3rd, 2006?

A. Well, I'm sure I had something to the effect that "I have a case I want you to review". But I don't remember any specifics about it.

Q. Okay. And did you receive -- other than the records, which I'll ask you to identify in a minute, anything else other than this transmittal letter and the
records that you didn't tell me about?
A. No. But I subsequently got other records, I think.
Q. Okay. So, why don't we start off with the records that --

Owens: You want to see that? Oh, I'm sorry. Sure.
Q. What records did you initially receive from plaintiffs counsel?
A. I initially received all of the medical records concerning the case from North Oaks.
Q. Uh-huh. Okay. And then, you received additional records thereafter?
A. Right. And then, I received some depositions.
Q. Uh-huh. Okay. And then, I received Dr. Thomas' deposition.
A. Uh-huh.
Q. Uh-huh.
A. And there's some information here from All Angels, which may have been attached to his deposition, but I'm not sure.
Q. Uh-huh.
A. And then, I received Dr. Solomonayor's --
Q. Okay.
Plaintiff Atty.: Do you have a copy of that?

A. I --

Owens: Do you want to make a copy?

It's up to you.

THE WITNESS: We'd better make a copy, because I don't --

Plaintiff Atty.: Yeah, let's not mark these. We'll make copies when we're done.

Owens: Okay. That's fine. We'll have to do the same thing with the letter.

Plaintiff Atty.: Yeah.

Q. (By Owens) All right. So, we have the summary, we have the depositions you've identified, the medical records. Is there any other materials that you've reviewed in preparation for today?

A. No.

Q. Okay. Are there any textbooks or articles which you feel are authoritative on topics in this case?

A. No.

Q. And I assume you didn't review any textbooks or articles, other than what might have been reviewed to -- to write Document Number 4, the HIT document?

A. Yes.

Q. Other than that, have you reviewed any other
articles or textbooks?

A. No.

Q. Okay. The notes that are on Exhibit 3 in your handwriting, when were these prepared?--the notes.

A. These must have been done when I read the chart, --

Q. Okay.

A. -- which was, you know, within a week or two of August 3rd, 2006.

Plaintiff Atyy: And you -- you're looking at Exhibit 3.

Owens: 3.

Plaintiff Atyy: -- 3.

Owens: Correct.

Q. (By Owens.) And following your review of the chart and making those notes on Exhibit Number 3, did you prepare any type of report?

A. No.

Q. Okay. Did you report your findings to Plaintiff's counsel?

A. Well, this wasn't a report, but instead of just having it scribbled there, whatever was written there, I have written here.

Q. And can I see that?

A. Yeah.
Plaintiff: You've prepared? I see there's some things over there that you've prepared in connection with this deposition.

A. That's my fee schedule.

Q. Okay.

A. And that's it.

Q. Okay.

Owens: And we'll make that Number 6 -- Exhibit Number 6, which will be his fee schedule.

(Exhibit No. 6 was marked)

Q. And is this the fee schedule that are you using in this case and have used in this case?

A. Well, it's -- it's more or less. Well, there's a typo here. This should be 12; 1200. The chart review, the deposition testimony are the same. Some of -- there may be some little changes on some of the other things.

Q. Meaning the amounts that you charge to do some of these other things have changed?

A. I don't know if some of these were exactly the same as the fee schedule that I gave to Plaintiff.

Q. Okay. So, that's your current fee schedule that you've given me?

A. Yes.

Q. You may not have charged those exact fees to

Plaintiff: at the time?

A. Mostly, there may have -- the only major changes would have been the cancellation fees, because after working in the emergency room, I'm scheduling days. So, if there's cancellations, there's a bigger penalty.

Q. You charge for that. I understand. I'm aware of that.

Plaintiff: That's why we're here.

Q. (By Owens) Which is why we're here. So, it worked. Any other documents you've reviewed that I haven't asked you about --

A. No.

Q. -- in preparation for today's testimony?

Okay. Could you just give me an overview of what you understand the facts of the case to be?

A. The overview is Ms. -- came in with some symptoms; chest type symptoms. She was seen by multiple consultants, including Dr. Sokolow. He decided to do a laparoscopic cholecystectomy on her. He performed the surgery, and found out that she had already had a laparoscopic cholecystectomy.

Q. Uh-huh.

A. She bled post op, and had all the complications that would go along with that, and then
Q. Okay.

Owens: What was the list of --

Lowry: I think 5.

Owens: Is that 5?

Lowry: Deviations?

Owens: Yeah, the list of deviations, Exhibit 5.

Q. (By Owens) The document you've given me, which is -- we've called the "list of deviations", is that still the list of deviations, as far as you're concerned, as of today?

Plaintiff's Atty: You want to take a quick break while he's looking at that?

Owens: That's fine.

(Recess from 12:42 to 12:45.)

A. Yes, this is -- yeah, nothing has changed.

Q. (By Owens) Okay. Great. Can I see the list? We can go through it, if you need it. I would like to just take you through these. These are your opinions with respect to the treatment provided by Dr. Scherzer; is that correct?

A. Yes.

Q. All right. The first particular here is the -- performing the H & P in the holding area. What is your understanding of that? What is that about?

A. Well, I think one of the key points about this case is that if it was known ahead of time that there was no gall bladder, then nothing -- then we wouldn't have -- we wouldn't even be here.

Q. Right.

A. So, you know, it -- I think the standard of care certainly requires the surgeon to know if there's a gall bladder present before he goes in to remove one.

Q. Uh-huh.

A. And doing a H & P in the holding area while the patient is getting ready to have another procedure is -- is -- I would say that's a breach of the standard of care. You want to be able to get as much information from the patient, you want them to be able to think clearly, and -- and that's not the place for it.

Q. Okay. From looking at the records, does it appear that he took an H & P?

A. Well, that's what he says in his deposition, that he interviewed her and examined her in the holding area.

Q. Uh-huh. And from the records you reviewed, does it appear that he has listed information about her previous surgeries?

A. Yes.
Q. Okay. And does it appear from those documents that she did not tell him that she had a gall bladder surgery?

A. It appears that, yes.

Q. Okay.

A. That appears to be correct.

Q. All right. And as a physician, do you rely on a history that a patient has given you?

A. Well, we want to rely on the history under, you know, good conditions. So, yes, I do rely on it, but I don't exclusively rely on it, especially in older people.

Q. All right. And was there something about her condition in the holding room that made her unable to give an accurate history?

A. Well, this is -- Yes. I mean, patients are anxious when they are in the holding area. Now, I don't specifically know if she was anxious, but in general, patients are -- In fact, in some hospitals, you can't get a consent in the holding area.

Q. Okay.

A. So, anxiety, being nervous about the upcoming procedure, those would impair someone's ability to give a correct history.

Q. All right. You're aware that she also did not give Dr. Thomas, her admitting physician, a history of the gall bladder being removed?

A. That's -- Yes, I'm aware of that.

Q. Okay. And do you believe the patient has an obligation to provide an accurate history to the physician?

A. To the extent that they can.

Q. Okay. It's your understanding that this lady was an RN; correct?

A. Yes.

Q. Okay. And back to discussion in the waiting room. I mean, in the holding room. You are aware that there was a family member present at that time?

A. I can't --

Q. Based on his deposition testimony, assume that to be the case.

A. I don't remember that. But I'm assuming you're not trying to trick me, so I would believe it if you told me that.

Q. Yeah. And we can make it hypothetical so we don't have to dispute it. But would that be another source of information if you're concerned that the patient's, because of their age or anxiety, might be hindered in giving a history, that you would go to a
family member to make sure that that's correct?
A. That would be another source, yes.
Q. You don't believe the standard of care requires him to obtain all previous medical records before doing a surgical procedure, do you?
A. No. No. But I do believe that the standard of care would require him to explain all scars.
Q. Okay. We'll get to that in a minute.

Plaintiff Atty: Okay, let me ask. Are we doing general questions in general -- situations in general, or specific to this case in and this surgeon?
Owens: Well, we can do both. Actually, I just meant generally.
Q. That question was a general question, --
A. Okay.
Q. -- and I'll ask you specifically in a minute.
But generally speaking, I think -- I think you've answered that you don't -- that standard of care doesn't require him generally for a surgeon to obtain all previous records from previous physicians.
A. Then I better qualify that.
Q. That's fine.
A. It just depends upon the type of surgery.
Q. Okay.
A. If someone is -- if a surgeon is about to operate on a particular organ that has been operated on before, let's say -- I'll just give you a hypothetical. We're going in to operate on a pancreas where there's been a problem before.
Q. Uh-huh.
A. I would say that the standard of care requires that all operative reports be known, if someone is going to operate on someone's liver. But in the case where someone is going to operate on someone's gall bladder, I don't think they would necessarily need to know -- necessarily need to read the Operative Report of a hemorrhoid surgery.
Q. Okay. And in this case, assuming that he was told that there was no gall bladder surgery done before, would he be required -- in this case -- to obtain previous medical records from Ms. Roosevelt?
A. No, I don't think so.
Q. Okay. Do you have any reason to believe that if Ms. Roosevelt had been interviewed by Dr. Solomon in some other location, that her history that she gave would have been different than the one that she gave Dr. Thomas prior to the time she even was considered for surgery?
A. Yes.
Q. Why?
A. Well, because under a different condition when she came to the emergency room, she told two different people that she had her gall bladder removed.

Q. Uh-huh. Okay. But she told Dr. Thomas that she didn't, that the gall bladder had not been removed. Is that your understanding of the facts?

A. Well, we don't know. We don't know what he asked, and -- Well, what I'm trying to say is I don't know whether he said "has your gall bladder been removed", but he has a list of some things that have been done to her, and that's not on it.

Q. Okay. And have you reviewed Dr. Thomas' records from outside of the hospital?

A. I think -- I think this stack has his records from outside the hospital.

Q. Did you review those records, Doctor?

A. Yes. Or, maybe these are All Angles. No, I'm not sure whether I did, or not.

Q. Okay.

A. I have some -- Yes, these are -- I believe these are -- Excuse me for one second.

Q. Take your time.

A. I think some of these are Dr. Thomas', and I don't see anything about a gall bladder surgery in there.

Q. And would you agree, Doctor, that in office setting, you would expect the patient to accurately give you a history of previous surgeries rather than, say, the angst (inaudible) situation of the holding room?

A. I don't know if they would give you an accurate one, but it certainly would be a better place to get an accurate one than the holding area.

Q. It would certainly be one in that you could rely on typically as a physician?

A. Yes.

Q. Okay. So, from the records you reviewed, the history that she gave to Dr. Thomas outside of the hospital didn't indicate that she had her gall bladder out, either; isn't that correct?

A. I don't have all of his, I don't think, but I think that's -- as far as I know, that's correct.

Q. Okay. Is it your opinion that the physician who treats a patient in the hospital is required to review the emergency room Nurses Notes before treating a patient?

A. Not necessarily.

Q. That's not what you do?

A. I might do that.

Q. Okay. But the standard of care wouldn't
require it, unless there was some specific reason to?
A. That's correct.
Q. Okay. In other words, if -- for example in
this case, if Dr. Solman had questions about whether or
not the history was accurate, he might look at some
other documentation?
A. Correct.
Q. Okay. But typically, a physician isn't
required to review all the other records in the chart to
treat the patient?
A. That's not what you asked me. You asked me
the --
Q. I'm sorry. Let's restate the question.
A. -- the emergency room.
Q. The emergency room records.
A. Yeah. Now, I would -- I do think it would be
the standard of care to review the physician notes.
Q. Okay. And is -- from your review of this
chart, where are the two notations that you refer to
about her giving a history of her gall bladder being
out?
A. One is the triage note, which is a nursing
note.
Q. Is that in the emergency room?
A. Yes.

Q. Okay.
A. And then, the other one is the emergency room
doctor's note.
Q. Okay.
A. -- Well, yes.
Q. Okay. So, both -- both locations of the
history of a gall bladder being removed are in the
emergency room portion of the chart; is that correct?
A. Yes.
Q. All right. Is there any indication from the
physicians notes, which you have testified should be
reviewed, from the physicians notes after she's admitted
to indicate that she's had her gall bladder removed?
A. No.
Q. Okay.
A. You mean, the consults?
Q. Yes.
A. No.
Q. Okay. And do you have any information to
indicate that Dr. Solman was -- was told that she didn't
have her gall bladder out prior to doing surgery by --
from anyone?
A. No. We -- there's no evidence that he was
told that she had her gall bladder out.
Q. And you've reviewed the Consent Forms in this
1. A. Yes.
2. Q. Does it appear that the Consent Form that Ms. Roosen signed indicates that he was going to remove the gall bladder?
3. A. Yes.
4. Q. Okay. Does it appear that's an appropriate Consent Form?
5. A. Yes.
6. Q. Okay. So, as far as you know, she consented to having her gall bladder removed?
7. A. Yes.
8. Q. Would you agree that based on the consent form alone, she would have been aware of the fact that he intended to remove her gall bladder?
9. A. Yes.
10. Q. Okay. And so, I want to ask you a little bit more about number 2, which is "failure to obtain history previous lap chole". I'm not sure how you feel he was supposed to obtain that.
11. A. Well, I guess two ways. Number one, by reviewing the emergency room doctor notes, he could have gotten information about it. But even more importantly, we're -- we're breaking the history into history and -- but it's really History & Physical.
as we can about the patient. And that is just one source.

Q. Uh-huh.
A. Did that answer your question?
Q. Yes, it did. In other words, that's your practice, that's your personal practice, that you look at the emergency room physician's records on every patient that you see in the hospital before you do a surgical procedure; is that correct? To confirm whatever history you're given to make sure it matches up with the history that was given to the emergency room record doctor?

A. I don't --
Q. Go ahead.
A. I don't specifically do it for that reason. I do it -- Well, in the first place, most patients -- You know, I would say 75 percent of the patients you see are not coming in through the emergency room.
Q. Uh-huh.
A. So, they are coming in through their primary care doctor.
Q. Uh-huh.
A. So -- And I certainly feel that it's the standard of care to review the primary care doctors. So, in the case of the emergency room, the emergency doctor becomes their primary care doctor. He is their -- the first person who has seen them with the problem.
Q. Uh-huh.
A. And things may well change from the time that the emergency room doctors saw them till the time you do. So, it is another source of information, and I think, yes, that is the standard of care to review those records.
Q. In this case, though, she had a Primary Care Physician, didn't she?
A. She did.
Q. Dr. Thomas; correct?
A. Yes.
Q. And indeed, Dr. Thomas had seen the patient after she was admitted from the emergency room to the hospital; is that correct?
A. That's correct.
Q. And from what you could tell, Dr. Thomas was unaware of the fact that she had her gall bladder removed; correct?
A. That's correct.
Q. Would it have been appropriate for Dr. Solomayor to -- after consulting with Dr. Thomas -- have any reason to then look at the emergency room physician's records.
pertinent to history?

A. To be -- to be thorough and see if you can
gather any other information.

Q. But would the standard of care require that if
he had a conversation with the Primary Care Physician,
who had been treating this lady since 1993, or earlier.
to, in addition to that, review the emergency room
records?

A. I think -- I think yes.

Q. You think that's the standard of care?

A. Yes.

Q. So, if Dr. Solomon and Dr. Thomas had a conversation with Dr.
Thomas and said "I'm going to take your patient's gall
bladder out" and Dr. Thomas said "That's fine, if it's
indicated", you don't believe that Dr. Solomon could rely
on the fact that Dr. Thomas would have -- or, should
have known that the gall bladder had been removed
previously?

A. There's more information to be obtained from
going through the emergency room notes than just about
the gall bladder.

Q. Okay.

A. In other words, when Dr. -- You see, when Dr.
Solomon came to see the patient, he wasn't coming to see
the patient to remove her gall bladder.
believe it?

A. No. No.

Q. Do you have any indication with this particular lady, Ms. Roosevelt, was there anything that Dr. Solomon should have been aware of that would have made him suspicious of the history that she gave? I'm talking just about history, not about the physical.

A. Yeah. Excuse me for one second.

Q. Take your time.

(Pausing)

A. No.

Q. So, as I understand it, the reason you believe that Dr. Solomon should have been aware of her previous history was not because he should have been suspicious that she wasn't accurate, but because he would have looked at the emergency room physician's notes for other information, and then happened to see that there. Is that the basis?

A. That's -- that's one of them.

Q. Okay.

A. And then --

Q. Just history wise, not physical.

A. Yes.

Q. Okay. But as far as the history alone, that's -- that's the basis of your position; is that correct?

A. Yes.

Q. Okay. I understand. Now, let's talk about the scars. Okay. So, tell me your opinion with respect to what he should have seen on this lady's body before he did the surgery.

A. Well, if he did a careful physical, and he wouldn't have had to be the most careful. I mean, the source -- the chief complaint was pain, you know, epigastric chest type pain, --

Q. Uh-huh.

A. -- you know, he should have seen the scars.

And the scars were, in fact, noticed by other people.

Q. Okay.

A. So, that should have then led to "Well, you know, what are these scars? They look like a laparoscopic procedure".

Q. Uh-huh. Let me stop you there. What other people noticed the scars?

A. It will take me just a second to find them.

Q. Take your time.

(Pausing)

A. Dr. Roberts.

Q. Dr. Roberts. And when did Dr. -- What document are you looking at, specifically?
A. I'm looking at his consult that I think was on November 7th, 2001.
Q. Okay.
A. Under "Abdomen", he says "There's a small super umbilical scar without hernia".
Q. Okay. Does he mention any other scars?
A. He doesn't.
Q. Okay. And what do you think that's indicative of?
A. Well, you know, the first thing -- Two things would come to mind. Either laparoscopy, or an umbilical hernia.
Q. Okay. And do you believe that Dr. Roberts did a careful physical examination of the patient?
A. I'm sorry. I shouldn't have closed that. Well, I don't know. It was -- it was -- he was careful enough to pick up that she had a scar there.
Q. Okay. Did he note any other scars?
A. No.
Q. Okay. Are you aware of the fact that Dr. Roberts was in the holding room when Dr. Solomon examined the patient?
A. Not -- not offhand. I wasn't, no.
Q. Are you aware of the fact that Dr. Solomon spoke with Dr. Roberts about the decision to do the gall bladder removal, rather than the procedure Dr. Roberts had favored in the holding room to do?
A. Yes.
Q. Could you presume from that that Dr. Roberts, too, was unaware of the fact that she had her gall bladder removed?
A. Excuse me for one second, if you don't mind.
Q. Sure.
A. Okay?
Q. Uh-huh.
(Pausing)
A. Okay. I'm sorry. Could you -- would you --
Owens: Do you want to read it back, please?
THE REPORTER: "Could you presume from that that Dr. Roberts, too, was unaware of the fact that she had her gall bladder removed?"
Q. (By Owens.) Do you think Dr. Roberts, who had done the physical examination, as well, breached the standard of care for not telling Dr. Solomon, 'There's scars here, you might want to check this out'?
A. Well, it's -- No, I don't. And the reason I don't is because, you know, different things -- First of all, I don't want to say the standard of care for a GI guy, which I believe Dr. Roberts is. But different things..."
are going to raise different flags based upon your specialty. So, if you're a GI person, you -- you know, and you see a little scar over someone's belly button, that may not raise a flag like it should to a surgeon.

Q. Uh-huh. Okay. Did Dr. Roberts note -- I think I've asked you that question. He didn't note any other scars; is that correct?
A. That's correct.
Q. And how many scars would you expect to see if there was a gall bladder surgery done?
A. There had to be at least two others, and maybe three others.
Q. Three others. And so, Dr. Roberts, with his examination, didn't see those scars? At least he didn't note it, did he?
A. That's correct.
Q. Okay. And can you explain that?
A. Well, not to be -- not to be gross, but I think she was fat. So, they could have been buried in one of her -- her rolls.
Q. Okay. And that would be true for Dr. Solomon, as well. Isn't that true?
A. That's correct.
Q. Okay. So, simply the presence of a super umbilical scar doesn't automatically mean that she had her gall bladder removed, does it?
A. No.
Q. Okay. Does it automatically mean that have you to then question the history that she's given you because she has this one scar?
A. Well, I would certainly -- if -- I mean, that has actually happened to me where you don't get a full history, and you see the scar, and you say "what is this?". Yes, I think you would -- you would have to.
Q. But -- I hear you. But why would he think he's not getting a full history?
A. Well, it's not that you wouldn't necessarily think you're getting the full history. You have to explain facts that -- that worry you. For instance, if she -- if he goes through his History & Physical, and she doesn't say she had her gall bladder out, but she also doesn't say that she had an umbilical hernia, then you've got to explain -- you know, that -- then -- then something is not correlating, and it has to be -- it should be explained.
Q. Okay. Do you believe that Dr. Solomon should have on his physical exam been able to see any other scars than the one that Dr. Roberts saw?
A. Yeah, I believe he should have been able to.
Q. And how can you say that without seeing his
A. Well, because even if there are -- you know, even if she's overweight and there are rolls, you can -- you can manipulate the skin and -- and look. And, you know, presumably, -- I've never seen anybody that healed so well that the scar was completely -- it -- it's all a package. You know, you see one, "hey, there's a super umbilical. You know, I've got no history of a hernia". You know, then you would -- then your eye would naturally go into the right upper quadrant.

Q. And you believe that that scar would have been evident had he looked for it. That's your belief?

A. Yes.

Q. And when was this surgery performed? The gall bladder removal, when was it done?

A. I don't know the answer to that.

Owens : I think it's 1991. Is that correct?

Plaintiff Atty : I think so.

Owens : I think that's --

Q. So, you would expect -- Let's assume, hypothetically, that it's 1991.

A. That seems a little bit unlikely.

Q. That it was done in 1991?

A. Yeah.

Q. Okay. Why is that?

A. Because that's when just -- then she would have been one of the first ones that had it done.

Q. Okay.

A. It's not impossible.

Q. Uh-huh.

A. But if it was 1991, then I would expect that the scars would have been even more likely, because back then they didn't have the best equipment. The trocars were bigger than -- They didn't even have 5 millimeter trocars back in '91, I don't think.

Q. Okay.

A. They had 10 millimeter ones.

Q. All right. So, you believe his physical examination should have revealed scars that should have been suspicious to then ask more questions about her history?

A. Yes.

Q. Which would have led him then to finding out that she had had her gall bladder removed. Is that your theory?

A. Yes.

Q. Okay. Do you believe -- Let's assume for purposes of my question that he was unaware and had no idea that the gall bladder had been removed previously.
Did you believe that there was an indication to do the gall bladder surgery, absent the fact that she was on Plavix, Lovenox and Voltaren, which we'll talk about separately?

A. So, you're saying if there was no scars, or --

Q. Yes.

A. I believe there was indications to do it.

Q. Okay.

A. I don't find fault with that necessarily, but the timing, I find fault with.

Q. Okay. And tell me about that.

A. Well, that relates to the drugs that she was taking.

Q. So, in other words -- But -- but based on the ultrasound report that he had and her symptoms, let's assume that there's nothing else about the case, with just those two pieces of information, you felt it was an indication to do the surgery, absent all the other things that we've talked about, the history and the fact she's on the drugs, that -- Do you understand my question?

A. Yeah, yeah, but I'll -- let me rephrase it so --

Q. Please.

A. -- I understand.
drugs that would have been paralyzed her platelets. So, her platelet function is -- would have been significantly impaired. And of those three, you know, Plavix is the worst.

Q. Uh-huh.

A. Now, I'm not saying that you can't operate on someone who is on Plavix, or Voltaren, or aspirin, or even the combination of the three, and I've operated on a zillion patients who have been on aspirin, but I would never operate on someone who's -- I would never do an elective case, which I'm sure we are going to talk about, on someone who is on Plavix, because they bleed.

Q. Uh-huh.

A. Now, in this particular case, she did need to be on the Voltaren. That's -- that was for her arthritis. And she didn't need to be on Plavix, because we had good evidence that she did not have coronary artery disease.

Q. Uh-huh.

So, the surgery could have been done at a different time with those two things stopped. I wouldn't necessarily have stopped the aspirin. I believe there was some indications for that.

Q. The decision to have her on these medications would have nothing to do with Dr. Solomon, though, would it? In terms of just her being on the medications, not doing the surgery while on the medications, that would be whoever prescribed those medications; correct?

A. That's correct.

Q. And that would be either Dr. Thomas, or -- I presume it was Dr. Thomas, because that was her Primary Care Physician; correct?

A. That's correct.

Q. All right. And as far as you know, Dr. Thomas was aware of the fact that he was going to perform surgery; is that correct?

A. That Dr. Solomon was?

Q. Yes.

A. I -- Yes, he knew they was -- Yeah.

Q. And do you believe that Dr. Thomas had any obligation as the Primary Care Physician to be aware of -- or, concerns about the surgery with the patient on these medications in combination?

A. Well, again, I don't want to talk about the standard of care for -- for an internist, but the ramifications of platelet -- platelets -- I'm sorry. The ramifications of Plavix are different to a surgeon than they are to an internist. So, I -- I don't even know if he knew that, you know, this is something that, you know, is a big deal.
Q. Okay. And I'm not sure I understood your previous answer as to -- You've said a couple of things. You said that you've operated on patients with Plavix, and you've operated on patients that have been on aspirin, and I'm trying to understand. Was it a breach to operate on a patient because she was on these medications? Is it -- is it -- in general, is that a breach, to operate on a patient with these medications?
A. No, I -- I think it's a breach to do an elective case with someone on multiple platelet inhibitors when the drugs can be stopped.
Q. Okay. And -- and the decision about whether the drugs could be stopped would not be Dr. Schornayor decision, would it? Because he's not treating her for -- for the conditions that they were prescribed.
A. It would be him and the other doctors in conjunction.
Q. He would refer her back and ask whether or not we can take her off these drugs, because they are treating -- whoever they are, assuming it's Thomas, "can we take her off these drugs so I can do this surgery". Isn't that how it would work?
A. Yes.
Q. Okay. And he would then determine whether or not she could, or could not come off these medications?
A. Yes.

A. Yes.
Q. And let's say hypothetically, that Thomas said "no, I really think she should be on these medications", would it have been appropriate then for him to do surgery on her, assuming that he didn't know about the gall bladder removed, -- all of that being assumed. Do you understand my question?
A. Yes. Well, then, the -- I'm sorry, I forgot -- Now, I've forgot the question.
Q. Well, my question is, and again this is a hypothetical, --
A. Yeah.
Q. -- let's assume that none of the underlying problems, about knowing about the gall bladder being removed, let's take that out of the equation.
A. Yeah.
Q. Just simply she has a gall bladder problem, she's on all of these medications. he asked Thomas "can we take her off these medications", and Thomas says "no, I think we need to keep her on there". Would it have been acceptable to do surgery on her with these medications? Is it a contraindication to do the surgery, period, because she's on these medications? Do you understand that question?
A. Yes.
Q. Okay.
A. Well, it's a hypothetical situation, --
Q. It is.
A. -- and it's a -- I would say it's a relative contraindication, and why do it if you -- if you didn't have to.
Q. I understand.
A. Especially since there may be a time in the future where she could come off the drugs. Yeah.
Q. Okay. Now, when you say "elective", what do you mean by that?
A. Well, what I mean is, you know, surgeries are either elective, which means they can be done any time; they are, you know, urgent, which means they need to be done in the near future; or they are emergencies. And she didn't fall into either of those categories -- either of the last two categories. She had some pain, but that can be controlled with pain medicine. So, it wasn't an emergency, and it wasn't even an urgency.
Q. So, you think the fact that she had come into the hospital, she had been admitted with this pain, and there was a positive ultrasound, or so we thought, that would not put her in the category of it being at least urgent?
A. No. All the ultrasound said was that if she -- if she has a gall bladder, that it's contracted, and there may be stones. But just the presence of stones is not -- you know, is not necessarily an indication for -- for doing -- it doesn't make it an urgency.
Q. Okay. So, you believe the standard of care required him to attempt to get her off these medications before doing this procedure?
A. Yes.
Q. Okay. Because of the risk of bleeding?
A. Yes.
Q. And do you believe that her bleeding that ultimately occurred was because she was on those medications, or do you know?
A. Well, the bleeding, there's two possibilities.
Q. Okay.
A. That there was a technical error that left a blood vessel unattended to, --
Q. Uh-huh.
A. -- or that this was just generalized bleeding from the surgery.
Q. Okay.
A. Now, when they went back -- before I answer that, let me just take a look at something here.
Q. Sure.
A. So, when they went back, they did not find a bleeding blood vessel, which would again -- which would lean towards the drugs being the cause. --

Q. Uh-huh.

A. -- but not 100 percent.

Q. Would what would the other percent be, other than --

A. Well, it's still possible that there was a technical error, --

Q. Uh-huh.

A. -- which would not be malpractice, by the way. --

Q. Okay.

A. -- that left a blood vessel unclipped, which subsequently stopped bleeding, and therefore, they didn't find it.

Q. Okay. But you didn't see any evidence of that, based on their second surgery? The technical error.

A. No, we don't, but in all fairness, it -- it still could be the issue.

Q. It could have stopped by the time they --

A. Yes.

Q. -- (inaudible)? While we're at it, why do you think she died? What do you think the cause of death was?

A. Well, you know, I like to think of this as --

Q. You know, I call it the domino effect. You know, the domino -- once you've knocked one down, you know, multiple -- multiple dominos fall. And this is a typical case of that. She has a -- she's an older lady, she has a post-operative bleed, she gets hypotensive at some point, this leads to injury to the organs, she has a bleed, which leads to a low hematocrit, so she gets blood and blood products. All of these are detrimental to the body. Many studies have shown these things. They cause injury to the kidneys and the lungs, and basically, you end up with, you know, multiple systems that are injured.

Q. So, not one specific thing, but a multiple --

A. Combination of events, is what you're saying?

Q. Okay. (By Owens) Okay.

A. Let me put it this way. I think the proximate cause is that she had a bleed, --

Q. Uh-huh.
A. -- but the actual -- but -- but the -- then, she developed, essentially, you know, multi system organ failure.

Q. Okay. And a bleed unto itself is not necessarily a breach of the standard of care. That is a complication of having your gall bladder removed, is it not?

A. That's correct.

Q. Okay. Even if she had been taken off aspirin, Plavix, Lovenox and Voltaren, and had her gall bladder surgery, she could have had a bleed?

Plaintiff: Object to the form.

A. That's correct.

Q. (By Owens) Which could have caused the same things?

Plaintiff: Object to the form.

A. Yes.

Q. (By Owens) Okay. Number 5, "Repeat -- Failure to repeat H/H on post-op day number one". Tell me about that.

A. Can I look at that for a second?

Q. Sure.

A. That's not exactly what I meant, but it is -- "Failure to repeat it..." -- Yeah. No, I'm sorry. That is correct.
A. So, I think it behooves a surgeon in that case to find out whether there's a bleed.

Q. Yeah. From looking at the records, does it appear that the assumption was that she was bleeding from somewhere?

A. I have to look at that. I don't know if the assumption at that time was that she was. I'll be with you in just a second.

Q. Take your time.  

Plaintiff Attty: Take your time.  

(Pausing)  

A. Well, I'm not sure. I'm not sure if they were thinking that on the 9th. But on the 9th, there's an order for a CVC in the a.m. Now, if you're concerned that someone is bleeding, you don't recheck their blood vessels 24 hours after.

Q. (By Owens) You think that should have been done stat?

A. I think there should have been one stat, and then there should have been one, you know, within four to six hours after that.

Q. Okay. And you also believe that just based on the drop in hematocrit from 36 to 27, that a CT scan or ultrasound, which one, should have been done that day?

A. A CAT scan.  

Q. A CAT scan?

A. A CAT scan would have delineated things better.

Q. And what do you believe, if a CAT scan had been done, what do you believe it would have shown?

A. I think it would have shown that she had post-op bleeding.

Q. Do patients have post-op bleeds that -- I mean, the fact that a patient's hematocrit drops, is that an indication, is that an unusual occurrence in a post-op patient that's just had a surgery?

A. Well, no, it would be somewhat unusual after a lap chole.

Q. Okay.

A. Now, not impossible, but somewhat unusual.

Q. Okay. In -- in all cases, do those patients who have bleeds after a lap chole require additional surgery, additional treatment, or does it sometimes that's -- the bleeding stops on its own?

A. Sometimes it stops on its own.

Q. Okay. So, if a CT scan had been done and it showed some type of bleeding, would that have required immediate surgical intervention?

A. It would -- I guess it would depend upon the
extent of the bleed.

Q. Okay.

A. If it showed, you know, sometimes -- And I've gotten -- You know, if it showed some bleeding in the gall bladder passa, you know, then, you know, no.

Q. Uh-huh.

A. But if you have blood, you know, over to the splenic flexure, for instance, or down into the pelvis, then you would certainly be worried about it. Especially in someone who is 75.

Q. "Failure to diagnose a possible HIT". Why don't you tell me what "HIT" is?

A. "HIT" is called Heparin Induced Thrombocytopenia. And a certain number of people who get Heparin, or -- which Lovenox is, as well, will develop antibodies to platelets. If you want me to get very technical, I can read you some of this stuff from that.

Q. You can just explain it to me in layman's terms.

A. Okay. And so, these antibodies then attack the platelets, and your platelets get consumed, and these complexes can form clots. So, despite the fact that you're using up your platelets and you have a tendency to bleed, you're also at the same time forming clots that can embolize to different areas.

Q. Okay.

A. And the treatment is to immediately stop Heparin -- all Heparin products.

Q. Uh-huh. And how do you make that diagnosis?

A. You make the diagnosis with -- Well, one way you can make it is if you stop all the Heparin products and the platelets rebound, you can be pretty sure you had hit.

Q. Uh-huh.

A. But you can also do some assays -- Could I take a look at --

Q. Oh, yeah, sure. There it is.

A. The -- Well, you make the diagnosis by someone who's developing a thrombocytopenia, low platelets after being exposed to Heparin, and then you can confirm it with H-I-T, HIT antibodies.

Q. Now, were her platelets tested, and the -- the platelet count, was it ever tested in the hospital?

A. It was tested on multiple times.

Q. Okay. And do you think the platelet counts, the tests that were done, evidenced, or were confirmatory of the diagnosis of HIT, or just a possible diagnosis?

A. The platelet counts won't tell you for sure.
Q. Okay.
A. The platelets is -- will do -- I guess you would call it presumptive evidence of of HIT.
Q. Okay. And did -- did the physicians at some point in time stop the Lovenox and Plavix?
A. They did eventually.
Q. What date was that?
A. It looks like they stopped it on -- Hang on just one second. Looks like they stopped it on the 10th.
Q. Okay. And you believe they should have been stopped sooner?
A. Can I see that?
Q. Sure.
A. I believe it should have been sooner, should have been --
Q. When?
A. I'm sorry. Can I see that, again?
Q. Sure.
A. I withdraw that complaint.
Q. Okay. Fair enough. I appreciate your honesty.
A. No. I think -- I don't know why I was confused about that, but it appears that -- that the Lovenox was stopped on the 10th. They may not have made the diagnosis of HIT, but they did stop the Lovenox in a reasonable time frame.
Q. Okay. So, I guess that leads us to the next issue of when she should have been given platelets. I mean, I presume -- I guess I'm trying to understand. If your response to HIT is to stop Lovenox, that's the first thing one does; correct?
A. Yes.
Q. Is there anything else one does other than stopping Lovenox?
A. The -- the giving of platelets doesn't have anything to do with -- with HIT.
Q. Okay.
A. Okay? The giving of platelets is we have a lady who has bled and whose platelets are nonfunctional.
Q. Uh-huh.
A. Even if the numbers -- even if it looked like she had the correct number of platelets, --
Q. Uh-huh.
A. -- the number of functioning ones was almost certainly low.
Q. Okay. And so, you believe that she should have been given platelets when?
A. Well, I believe that she should have gotten platelets as -- you know, when theoretically they should
have diagnosed her, which I think was on the 9th. We had evidence of a bleed, hematocrit dropped from 36 to 27, and that's when they -- and in a lady who is elderly, can't afford to have a bleed, and whose platelets are paralyzed. They should -- I believe they should have made the diagnosis then, and that's when they should have given the platelets.

Q. And when did they give the platelets?
A. I'm not sure. Do I have it written down there?

Q. Let's see, --

Plaintiff's Attorney: Can he see -- can he look at it?

Owens: Oh, sure.
A. The platelets were given on the 11th.

Q. (By Owens) Okay. And you think they should have been given on the 9th, --
A. Right.

Q. -- based, -- based on the hematocrit alone?

The drop in the hematocrit from 36 to 27?
A. Well, even -- even if we assume that, hypothetically, they shouldn't have found out about the bleed on the 9th, the -- on the 10th, the hematocrit was down to 19. That was that CBC --

Q. Uh-huh.

A. -- which I said shouldn't have been ordered at 24 hours, but they did get it then. So, yes. I mean, it -- whatever -- Even if you happen to miss that there was a bleed when the hematocrit went to 26, you can't -- nobody could miss a bleed when the hematocrit was 19.

Q. Okay.

A. So, it wasn't enough to give platelets on the 10th, because -- I'm sorry. It wasn't enough to just give blood on the 10th, you had to give platelets, because you had -- in the face of the drugs that she had been on.

Q. Uh-huh. So, blood alone would not do it; you had to give her platelets, as well as blood --

A. Yes.

Q. -- on the 10th, based on the second hematocrit, which now goes to 19, and the presence of the drugs that she was on at the time?

A. Right. Now, I'm not saying that she should have gotten the platelets on the 10th.

Q. Uh-huh.

A. I believe it should have been before that.

Q. Okay.

A. But certainly, she should have gotten them on the 10th.

Q. All right. You believe they should have been
... on the 9th, based on the first hematocrit?

A. Based on acting on the first hematocrit.

Q. Uh-huh.

A. And what I mean by that is getting a scan, repeating the CBC. Obviously, I mean, it is obvious. Obviously, if they had repeated the H/H on the -- on the 9th, the first one, when it was 27, was at 6 o'clock in the morning. So, I'm sure if they repeated that within six hours, it would have been lower.

Q. Uh-huh.

A. At some point, it had to go lower, because the next day it was lower.

Q. Uh-huh. It would have been picked up sooner, and then you believe that would have caused them to act on it sooner?

A. Exactly.

Q. Okay. And you believe that is Dr. Solomon's responsibility, not Dr. Thomas' responsibility to follow that?

A. I do. He -- he's the surgeon, he operated on her. Yes.

Q. Okay.

A. Do I -- I'm not saying that, you know, it has to be a group effort, but there has to be one person who's at that particular time, you know, taking care of the patient, the major person.

Q. Okay.

A. The patient, the major person.

Q. Uh-huh.

A. And in the early post-operative period, that should be the surgeon.

Q. And I think we've covered everything but number 10, "Failure to collect coagulopathy more aggressive". Is that similar to what you've been saying, or is that a different point?

A. It is similar, but it's not the whole picture.

Q. Okay.

A. Excuse me for one second.

Q. Sure.

A. And so, the platelets are just one part of the coagulopathy.

Q. Okay.

A. She also had another component of it. And what I'm talking about there is that her PT, which is her pro time, on the 7th was -- which was pre-op, was 14.4. Now that in itself is a little high, and --

Q. What's the significance of the PT?

A. The PT is -- is -- is a measure of one of the coagulation cascades.

Q. Uh-huh.

A. There's -- they basically have two of them.

Q. Uh-huh.
Okay? And Heparin works on one, and Coumadin, for instance, works on another. But when you get a coagulopathy, they both can be affected. But we have a PT that was slightly elevated even before surgery, and then -- Of course, I believe that they should have measured it on the 9th when -- You know, when someone bleeds, you typically measure their hematocrit, their platelets, and their PT/PTT.

Q. Okay.

A. So, they didn't check that on the 9th, so they didn't know to correct it. Then on the 10th, we see that it's elevated. Now, it's 16.6, and it's not -- it's not terribly elevated, but you have a lady who is bleeding. So, you can't -- you can't leave any stone unturned.

Q. Okay.

A. You have to fix everything you can. You have to fix the platelets, you have to fix the PT. So, I believe that it should have been fixed on the 10th. And then, by the time the 11th comes around, at -- at 6 o'clock that day, you basically have a person who is, you know, almost fully anticoagulated. Her PT is 20.

Q. And how should they have fixed it?

A. They should have given FFP, which --

Q. What is "FFP"?

A. Fresh frozen plasma.

Q. Okay.

A. Now, -- Excuse me for one second.

Q. Uh-huh.

A. And we don't -- she didn't get any of that until the 10th.

Q. Okay. Do you believe that should have been given on the 9th? Had they tested her correctly, had the things they worked her up been done at the right time, they would have given it on the 9th?

A. Well, you know, in the cosmic picture of Ms. Wallace's care, I think this is a small deviation.

Q. Uh-huh.

A. Okay? Because they gave it on the 10th, and at that time her PT was 16, which is not terrible, but -- Excuse me for one more second.

(Pausing)

A. Now, I don't see any more FFP given. So, I think my comment was a criticism of being more aggressive in -- in fixing it.

Q. Uh-huh.

A. I don't think the timing -- I don't think I said so much as timing, as being aggressive.

Q. Correct.

A. Failure to correct it more aggressively. So,
I think it should have started earlier, but that is a little bit -- it's -- it's not the biggest deal, --

Q. Uh-huh.

A. -- because her PT wasn't that terribly elevated. But by the time we got to 20, it needed to really be aggressively done --

Q. Uh-huh.

A. -- with vitamin K and FFP, and I don't think that was done. She did get four units of FFP, but I don't think there was more. Well, on the 11th, she got another two. But she needed a lot more than that.

Q. Okay. Any other criticisms of Dr. Soto's that either I haven't asked you about, or are not on that list?

A. No.

Q. Okay. And you would agree with me, Doctor, that if Ms. Roosevelt had told Dr. Soto that she had had her gall bladder out, none of this would have happened?

A. That's correct.

Owens : That's all the questions I have.

EXAMINATION

BY Lowry :

Q. I think I just have a few. Mr. Owens started his questioning with -- I believe that this was the list of deviations as far as Dr. Soto goes.

A. Yes.

Q. Do you have a separate list with regard to All Saints Hospital?

A. With regard to --

Q. Any deviations by All Saints.

A. No.

Q. Do you believe that there were any deviations by All Saints?

A. Nothing comes to mind.

Lowry : I have no further questions.

EXAMINATION

BY Owens :

Q. Doctor, just to make sure I -- just to cover everything, is there any questions that I haven't asked, and this is a broad question, but that -- that -- other issues that I haven't asked specifically about that you would want to tell me about about this case? And it's an open-ended question. I understand it's overly broad, but it's done so purposely because sometimes I simply don't ask all the questions I need to ask, and you may have another opinion in there that's -- that you are wondering why I haven't asked you.

A. I want to read this over before I answer that.

Q. Sure. I just want to be complete.
plaque to form antigens. In turn, an antibody is formed in response to these antigens. The immune reaction process results. Platelets are then consumed in the immune reaction process, and the platelet count falls. Thus, there is heparin-induced thrombocytopenia (HIT). Simultaneously, there is stimulation of clot formation, or thrombosis. Thrombocytopenia plus thrombosis is known as Heparin-induced Thrombocytopenia and Thrombotic Syndrome (HITTS).

Close can cause poor blood flow to various tissues, including poor blood flow through the peripheral vessels of the arms and legs. HIT is associated with a 30-50% risk of severe thrombosis or extension of an existing thrombus. The thrombosis can be venous or arterial. Typical areas of thrombotic events include the deep veins, pulmonary emboli, limb arterial and venous thrombi, venous limb gangrene, thrombotic stroke, and microvascular infarction.

The diagnosis process results from the HIT antibodies combining with an antigen complex made up of platelet factor 4 (PF4) and heparin. The antibody-antigen complex then initiates a chain reaction which causes the platelets to begin the formation of small clots. The result is a decrease in the platelet count and formation of multiple thrombi.

The usual presentation of HIT begins with a drop in the platelet count. Initially there may or may not be thrombosis. This drop is usually 50% or more from the admission platelet count, or evidence of an absolute thrombocytopenia beginning 5-10 days after exposure to heparin. If this occurs in the absence of other causes of thrombocytopenia, then it should be considered HIT until proven otherwise. The fall in the platelet count can occur quicker than the 5-10 day window in a patient who has had recent exposure to heparin, usually in the prior 100 days.

HIT occurs in up to 5% of patients exposed to unfractionated heparin. The diagnosis of HIT is made in a patient who is on or was recently exposed to heparin and has thrombocytopenia. HIT should be in the differential diagnosis of any patient with new or recurrent venous or arterial thromboembolism which develops during or shortly after exposure to heparin.

The diagnosis can be confirmed by lab evidence of HIT antibodies. Serum should be sent for testing for HIT antibody or for the PF4-heparin antigen, but therapeutic decisions should not be delayed if the clinical suspicion of HIT is strong.

Management consists of stopping all exposure of heparin, both unfractionated and low molecular weight heparin. Anticoagulation must be achieved with a non-heparin anticoagulant. Lepirudin is a direct thrombin inhibitor that can be used for this purpose. Monitoring is done by following the aPTT (activated Partial Thromboplastin Time). Warfarin should be avoided until therapeutic anticoagulation with a non-heparin anticoagulant has been achieved and the platelet count has recovered. Unfractionated and low molecular weight heparin must be avoided in patients with a history of HIT.
Re: Evelyn Roosevelt

11/24/06

Attempted lap chole on patient who had previous lap chole. Patient on ASA, Plavix, Lovenox, Voltaren. Postop bleed then complications and death.

Errors:

1. Performing H&P in holding
2. Failure to obtain hx previous lap chole (noted in ER chart)
3. Failure to note scars of previous surgery on physical
4. Operating on elective case while on ASA, Plavix, Lovenox, Voltaren
5. Failure to repeat low H/H on POD 1 (11/9) (Hct dropped 36-27)
6. Failure to diagnose possible HIT 11/10-certainly by 11/11 (Pt dropped from 208-140)
7. Failure to do US or CT on 11/9-certainly by 11/10
8. Failure to give Pts 11/9-certainly by 11/10 (ultimately given 11/11)
9. Failure to check PT 11/9
10. Failure to correct coagulopathy more aggressively

FEE SCHEDULE

1. Initial chart review/research - $1200 non-refundable retainer
2. Followup chart review/research - $300/hr
3. Deposition testimony - $400/hr. A $1200 retainer must be received 5 weeks prior to testimony.
4. Trial testimony - $5000/day. Fees must be received 5 weeks prior to testimony
5. Telephone consultation - $300/hr
6. Expedited reviews (7 days or less) - $500 additional
7. Expenses for travel/miles, food, lodging and parking are billed separately
8. A fee of $1200 will be charged for cancellation of deposition testimony with less than 5 weeks notice.
9. A fee of $5000 will be charged for cancellation of trial testimony with less than 5 weeks notice.

Any additional time or charges will be authorized prior to my proceeding. If there are any questions about my fee schedule, feel free to discuss them with me at any time.
WITNESS
CERTIFICATION

At the request of the defense attorneys in this case, I have carefully reviewed the above
deposition transcript to determine whether it was true and complete and whether I had any
additional information relevant to the matters discussed therein. I did so, and hereby certify,
under penalty of perjury, that the deposition transcript is true and complete and that I have no
information relevant to the matters discussed in the deposition that is not contained in the same.

Dr. Scalia       3/17/13

Signature       Date
Deposition of Sydney Sotomayor, M.D., taken on Monday, December 20, 2004 in offices of Dr. Sydney Sotomayor, 120 Wall Street, State of Justice.

EXAMINATION BY MR. EYOR:

Q. Good evening, Dr. Sotomayor. My name is Michael Eeyor, and I represent the Roosevelt family in this matter. You understand you’re here for the deposition concerning Ms. Roosevelt?

A. I sure do.

Q. Doctor, go ahead and give me your name and your address for the record.

A. My name is Sydney Sotomayor, address is 120 Wall Street, State of Justice.

Q. Okay. Doctor, if you’d like a question repeated during the course of the deposition or I misstate something, would you simply ask me to do that, please?

A. I certainly will.

Q. Also, are you on any medications or feeling ill, that you might not understand my questions?

A. The answer is no. I feel fine. I’m very happy to be here right now.

Q. I’m sure you are. Doctor, you have the right to read and sign your deposition. I don’t know if you discussed that with your attorney?

MR. OWENS:

Yes. He wants to read and sign.

EXAMINATION BY MR. EYOR:

Q. Okay. Doctor, how did you come to consult on this particular patient?

A. Dr. Clarence Thomas consulted me to see the patient.

Q. Okay, and what morning would that be?

A. That would be November the 6th, 2001.

Q. Do you have an independent recollection of Ms. Roosevelt?

A. Yes, I do.

Q. And what were you advised by Dr. Thomas during that call?

A. He told me that she had come into the hospital with chest pain, and the workup had progressed to evidence of gallbladder disease. I was called on the night of the 7th by the nurses’ station.

Q. Okay.

A. That there was a consult on Ms. Evelyn Roosevelt and then I saw her the next morning, but I do
remember talking to Dr. Thomas. I think that probably was after I had seen her.

Q. Okay, and the first time you would have seen her would have been what?
A. That would have been on the 8th.

Q. Any idea what time of day that would have been?
A. It was around nine or 10:00 in the morning. I think it was about nine, and I’ll go ahead and start with, I’ll tell you where I saw her. She was in the endoscopy area of the hospital. Dr. Roberts was preparing to do a gastroscopy on her. I had gone to the floor where she was located, and the nurses there told me that she was down in endoscopy, and that’s why I went down and saw her there.

Q. What particular documents did you review before seeing Ms. Roosevelt, if any?
A. Before seeing her?
Q. Yes, sir.
A. None.
Q. Okay. Tell me what you did when you went down to endoscopy.
A. Well, I introduced myself to her and told her, you know, who I was and what I do and why I was there to see her, and told her that the reason I was there to see her was because Dr. Thomas had asked me to see her.
Q. Okay. You’re a general surgeon; is that correct?
A. That’s correct.
Q. Okay, and did you explain to her specifically what the request for your consult was, what Dr. Thomas wanted you to examine her for?
A. Well, he wanted my general surgical opinion about her case.
Q. Okay. Was he more specific than that?
A. No. When you’re consulted you’re asked to give your opinion, and in my case I’m a general surgeon so I’m asked to give my opinion with regards to the case, based on a general surgical approach.
Q. Okay. So he didn’t call you and say, “Listen, I think she may need a cholecystectomy,” or “I think she may have gallbladder problems.” He simply asked you to come in and take a look at this patient?
A. That’s correct.
Q. And after you introduced yourself to Ms. Roosevelt and explained what you were doing there,
what did you review then?
A. Well, I talked -- I had looked at her chart also at that time, and I don’t remember if I had looked at the chart before I started talking to her or looked at the chart after talking to her. Probably I looked at the chart first, and then I did my standard consultation work that I do on every patient. I took a history and did a physical exam on her.

Q. Okay. Specifically what parts of the chart would you be looking at, Doctor?
A. I would have looked at the lab and x-ray data, and her history and physical. That’s usually what I look at.

Q. Okay. What labs in particular?
A. All the labs.

Q. In terms of looking through the chart, would you have looked at other physicians’ entries in the chart?
A. What do you mean by entries?

Q. Any history and physical that they might have had in the chart?
A. No.

Q. All right. What about the emergency room, when she was admitted to that? Would you have looked at that?
A. I would not have looked at that record.

Q. Would you have looked at the admit to the hospital?

MR. OWENS:
Meaning what?

MR. EEYOR:
The admit sheet? Anything?

THE WITNESS:
Absolutely not.

EXAMINATION BY MR. EEYOR:
Q. Okay. Could you specifically tell me what particular records, other than the labs and x-rays you would have reviewed in the chart?

MR. OWENS:
I think he said the history and physical

THE WITNESS:
That’s correct.

EXAMINATION BY MR. EEYOR:
Q. Would that have been by physicians or nurses as
Q. Do you recall whose HNP's you reviewed?
A. Well, only a physician does the history and physical.
Q. Do you recall if there were other consults done before you saw this particular patient?
A. Well, it's only one, and that's Dr. Thomas.
Q. Do you recall if there were other consults done before you saw this particular patient?
A. Well, Dr. Roberts had obviously seen the patient or had been consulted, because he was planning to do a gastroscopy on her. Now, at the time I saw the patient I think he had just seen her that day also, or maybe the day before. I'm not sure about that exact detail, but doubt if his consult had even been typed up and was on the chart.
Q. Did you have a discussion with him about what his findings were?
A. I had a brief discussion with Dr. Roberts when I told him why I was there, and we discussed the fact that her x-ray data had indicated gallbladder disease, and I asked him if he wanted to proceed with the gastroscopy and he said no, he didn't think that was necessary.
Q. Did you review the consult section of the chart to see if there were other consults in there?
MR. OWENS: At that time?
EXAMINATION BY MR. EEYOR:
Q. At that time, yes.
A. I'm sure I did not. Let me change that. I recall seeing the cardiology consult from Dr. Gremillion on the chart, because I was interested in her cardiac situation.
Q. And this is, again, during that initial visit with Ms. Roosevelt?
A. Yes, sir.
Q. And what do you recall the cardiology consult -
A. Dr. Gremillion opinion was that she had had cardiac arrhythmias, and he also had mentioned that she had had a coronary angiogram during an admission back in May of 2001, that was normal.
Q. Did you perform a physical assessment of Ms. Roosevelt?
A. Yes, sir.
Q. Was that done in the lab or wherever the endoscopy -
A. Well, there’s what’s called the holding area, where the patients are brought on a stretcher before they’re rolled into the rooms where the endoscopy is done, and that’s where I did my assessment on her.

Q. Okay. Tell me what that assessment entailed.

A. Well, it involved a physical examination.

Q. Okay. Tell me specifically what you did.

A. I examined her physically.

Q. What did you do to her, sir?

A. I didn’t do anything to her. I examined her physically.

Q. Okay. How do you do that? What did you look at? What did you touch? What did you listen to?

A. Okay. Well, I didn’t understand your question. I examined first her scalp, then I examined her eyes, all the structures in the head and neck. I examined her chest. I did a breast exam. I listened to her lungs. I listened to her heart. I examined her upper extremities, examined her axilla. I examined her abdomen. I examined her lower extremities. I did a rectal exam. I did not do a pelvic exam. I did an examination of her lower extremities and feet.

Q. And in particular, the examination of the abdomen; what did you do to conduct that examination?

A. I did a visual and manual examination.

Q. Okay. What did the manual examination entail?

A. Palpation of her abdomen and also an auscultation examination. That’s listening to the abdomen with a stethoscope.

Q. And the purpose of the rectal exam?

A. That’s part of a complete physical exam.

Q. Okay, and did you record your findings of that physical exam anywhere?

A. Yes, on my dictated consultation.

Q. Okay. Doctor, let me give you that document. And again, that’s a consultation with your name in the upper left-hand side, dated 11/8/2001; is that correct?

A. Correct.

Q. Doctor, on here you have medications she was taking. For the record, would you list those, please?

A. Norvasc, Plavix, Voltaren, Altace, and Lipitor.

Q. And briefly, what are those medications and what are they for?

A. Well, Norvasc is an antihypertensive. Plavix is a platelet aggravation inhibitor, Voltaren is a
nonsteroidal anti-inflammatory agent. Altace is also an antihypertensive, and Lipitor is a elevated cholesterol medication.

Q. And just above that there’s previous surgery, and what’s listed there, sir?
A. Kidney stone removal and left shoulder surgery.

Q. Now, where did you come about that particular information?
A. Kidney stone?

Q. Both of those.
A. The kidney stone removal, the patient told me she had had kidney stone surgery, and also Dr. Thomas’ history and physical said that. The left shoulder surgery, the patient told me she had had that, and also Dr. Thomas’ history and physical said that.

Q. Okay. In your experience, have you performed kidney stone removal before?
A. No, that’s not what I do.

Q. Okay. Past medical history, positive for hypertension, arthritis, and hyperlipidemia; is that correct?
A. That’s right.
and the date. I know that’s what we’re instructed to
do but I obviously didn’t, but I made that correction
I’m sure at the time, or when the dictated form came
back onto the chart, but I didn’t -- we’re also
instructed just to draw a single line through it and
not show that you’re trying to hide anything, which
is what I did. Not instructed but advised.

Q. And your impression listed here?
A. Page 47, chronic cholecystitis with
cholelithiasis and recent biliary cholic.

Q. And which of the findings, Doctor, led you to
that particular conclusion or impression?
A. Well, a combination of her history and her x-
ray, her ultrasound report.

Q. Okay. Specifically what - -
A. And also her physical exam too.

Q. Okay. Specifically what portions of her history?
A. She had had, she told me that she had had the
anterior chest pain, which is quite common in
gallbladder disease. Usually pain is in the right
upper quadrant and what’s called the epigastric area,
but anterior chest pain is also very common. She
also gave me a history of heartburn and indigestion,
situation, in the gallbladder could be what we call acute cholecystitis, which means it’s probably blocked off with a stone or blocked off for another reason, or there could be gallstones that have migrated out of the gallbladder into the bile ducts.

Q. Did Ms. Roosevelt have nausea or vomiting?
A. Not that I indicated in my consultation.

Q. Did she have severe cramping?
A. Severe cramping?
Q. Yes, sir.
A. I didn’t mention that.

Q. Did she have cramping?
A. I guess not. I’m rereading it right now. I don’t recall that.

Q. Okay. Did she indicate to you how long, or do you record how long she had had the tenderness in the upper right quadrant?
A. Well, that’s a physical finding, so that’s not a history finding.

Q. Okay. Is that physical finding, the duration of that physical complaint important in assessing a patient for possible gallbladder.
A. Well, tenderness is important because it indicates a urgent process, or it can indicate that.

Q. And again, how was that expressed to you? Was it during your physical exam when you’re palpating the abdomen?
A. When you palpate and the patient indicates that it hurts.

Q. Was anyone else present while you were conducting your physical exam?
A. One of her daughters. I don’t recall her name.

Q. Do you recall physically what she looked like?
A. If I saw her, I could tell you that was her.

Q. Did you have any discussion with the daughter at this time you were conducting this exam?
A. The daughter was sitting beside her in the endoscopy holding area, and was present while I was doing the history and physical exam, and then I discussed with her and the patient my findings and my recommendations.

Q. And what was your recommendation following your --
A. My recommendation was to her that she needed to
1. have surgery, to have her gallbladder removed.

Q. Okay. Did you discuss that or inform her other physician, Dr. Thomas?

A. I called Dr. Thomas. I distinctly remember calling him after I had seen her, and explaining to him my finding and what I recommended, and I also discussed it with Dr. Roberts, who was still in the area.

Q. Okay, and again, this whole thing took place on the 9th; is that correct?

A. I think it is the 8th.

Q. The 8th. I’m sorry; and your recollection as to the time of this examination?

A. It was in the morning, around nine, 9:30, 10, somewhere in that area.

Q. And she was scheduled for surgery then?

A. I went ahead and scheduled her for surgery later that day.

Q. Did you make any handwritten notes concerning the particular patient?

A. Handwritten?

Q. Yes, sir.

A. Do you mean on the progress note sheet? I certainly remember writing in the post-op note. I don’t recall if I wrote anything on the pre-op, on the progress notes before surgery. I wrote some orders, you know, to schedule her for surgery and obtain the consent.

Q. Did you actually get the informed consent, or is that something that was done by someone else?

A. The nurse did that, but I documented on my -- I always document on my history and physical or consultation form that I discussed it with the patient.

Q. Okay, and the 1.2 bilirubin, that’s an elevated level?

A. No, that’s at the upper limits of normal at the time. I think the upper limit of normal for the lab at that time was either 1.2 or 1.3.

Q. What are they currently?

A. The upper limits of normal now is 2.0. The lab changed the technique of running the study.

Q. What does the bilirubin reflect?

A. Well, the bilirubin reflects a lot of things, but in this situation it reflects the presence or absence of inflammation in the liver or gallbladder.
Q. Are there any other lab values you took into consideration in assessing Ms. Roosevelt’s possibility of a gallbladder issue?

A. Well, you look at all the lab values, and that one and the ultrasound report were the two that were pertinent in her situation. Her other lab values were, as I recall, relatively normal.

Q. In assessing a patient for a possible gallbladder issue, enzymes are important, correct?

A. Well, they’re one of the studies that we get, yes.

Q. Which enzymes?

A. SGOT, SGPT, alpha, and phosphatase are the standard ones that we - -

Q. And do you have a recollection as to where Ms. Roosevelt’s were?

A. I think hers were normal. I’ll tell you in just a second. Let me see what I said in my consult; SGPT, SGOT were within normal limits.

Q. How about her white blood count?

A. White blood count was normal at 6,900; also her amylase and lipase were normal. Those are functions of the pancreas, which is an organ in that area.

Q. And Doctor, just for the record, sake of the record, what page are you referencing there?

A. Forty-seven.

Q. Doctor, is there any particular reason the surgery was scheduled for that same day? Was this an emergency situation?

A. Well, I considered it an urgent situation. It was not emergency, but it was an urgent situation in that she had some mild tenderness, and her total bilirubin was at the upper limits of normal.

Q. Okay. Did you order any tests or further studies before surgery?

A. No.

Q. Did you order any additional medications or order certain medications be stopped prior to surgery?

A. No.

Q. Were there any abdominal x-rays available to you?

A. No, sir.

Q. Do you agree with me that abdominal x-rays would have likely showed the clips?
A. They would have showed the clips in the right upper quadrant.

Q. Have you had any discussion with the radiologist in this particular case?

A. Before surgery?

Q. At any time.

MR. OWENS:

About this case?

EXAMINATION BY MR. EEYOR:

Q. Yes.

A. I might have told the radiologist about the findings at the time of the surgery, and that would have been that day or the day, you know, within the area. I have not had any discussions since that time.

Q. Have you had discussions about this particular case with any of the doctors involved?

A. No, I have not.

MR. OWENS:

Off the record.

(off the record discussion)

EXAMINATION BY MR. EEYOR:

Q. Doctor, did you note a scar on Ms. Roosevelt’s abdomen at some point?

A. I did not.

Q. Are you aware that there was a scar in fact below her naval?

A. Yeah, I’m aware now of Dr. Roberts’ impression that he saw a scar there.

Q. Okay. Doctor, performing laparoscopic cholecystectomies, do surgeons generally go in in the same general area?

A. A laparoscopic cholecystectomy is four scars, one at the umbilicus, and then three in the right upper quadrant.

Q. And where would one expect a scar from a kidney stone operation?

A. Well, I don’t do kidney stone surgery, so I really couldn’t answer that.

Q. Again, just so I’m clear, you don’t have a recollection of any scar on Ms. Roosevelt?

A. No, sir, I do not.

Q. Doctor, what is an ERCP?

A. Stands for endoscopic retrograde cholangiopancreatography.

Q. And what exactly is that, Doctor?
A. That's, gastroenterology physicians do this procedure, and it involves passing a lighted tube with a camera on the end of it through the mouth and down the esophagus into the stomach, through the area called the pylorus, which is the outlet to the stomach, down into the duodenum. The duodenum is the first portion of the small intestine. In the second portion of the duodenum there is an ampulla. There's an outlet. It's called the ampulla of Vater, and that is the area where the bile duct, the common bile duct enters into the small intestine, into the duodenum. The common bile duct drains the liver, and the test involves putting a little thin catheter through that ampulla into the lower portion of the bile duct and injecting dye, and visualating the bile duct anatomy. Also the pancreatic duct is part of that procedure, where you inject dye into that to visualize the pancreatic duct.

Q. And this is not a procedure you perform?

A. It's not a procedure I do.

Q. Okay. Doctor, did you at any point consider requesting a cholecystography?

A. No. Wait; you mean before or after?

Q. Before, before surgery.

A. Before, no.

Q. What about after?

A. After, I wanted to get an ERCP exam --

Q. Is that the same thing?

A. Endoscopic retrograde cholangiopancreatography. I wanted to get that test done post-op, so that we could visualize her biliary tract anatomy.

Q. Okay. What were your suspicions of?

A. I thought, based on the findings at the time of surgery, I was -- and in conjunction with the ultrasound report, I thought it was likely that the patient had a remnant of her gallbladder still present that was causing her symptoms, and that's what I was interested in finding out about.

Q. Doctor, following the surgery, did you undertake to follow up and obtain her earlier records?

A. I wrote an order to try to obtain those records from All Angels Hospital.

Q. Did you ever see them?

A. I have never seen them, that I can recall.

Q. Doctor, are there three tests you run to
1 diagnose gallbladder disease, typically?
2 A. Are there three?
3 Q. Yes, sir.
4 A. Well, there’s a number of tests that you can do.
5 The standard and most proficient test is an
6 ultrasound, and the most reliable.
7 Q. In most cases?
8 A. In most cases.
9 Q. Do you have any recollection of informing Ms.
10 Roosevelt’s family that there were three tests to
11 detect gallbladder disease, and that two of the three
12 had been run, there was no need for a third?
13 A. I don’t’ have any recollection of that.
14 Q. During the surgery a tape was made, correct?
15 A. Right.
16 Q. Was that made during both surgeries?
17 MR. LOWRY:
18 Video, audio, or what?
19 MR. EEYOR:
20 Video.
21 THE WITNESS:
22 The videotape, just made during the
23 first procedure.
24 1 EXAMINATION BY MR. EEYOR:
25 2 Q. And have you reviewed that?
26 3 A. Yes, sir.
27 4 Q. When did you review that?
28 A. I reviewed it right before I reoperated on her
29 the second time, and then I reviewed it again when I
30 had communications from you, and those are the two
31 times I’ve reviewed it.
32 Q. What was the purpose of the review before your
33 second surgery?
34 A. I wanted just to familiarize myself. It was only
35 three days later, but I just wanted to make sure that
36 I had familiarized myself completely with the
37 findings that I had found at the time of surgery.
38 Q. There’s also reference in the record to
39 photographs taken during the procedure. Do you have
40 those photographs?
41 A. I do not. Those would be part of the hospital
42 record.
43 MR. EEYOR:
44 Does anyone have those?
45 THE WITNESS:
46 They should be on the patient’s
MR. LOWRY:
They're just stills.

THE WITNESS:
Yeah, just still photographs.

MR. OWENS:
Would those be stills from the videotape?

THE WITNESS:
Yeah. The equipment used, you can take photographs, but they don’t come out when you -- yeah. That’s not legible.

MR. LOWRY:
Off the record.
(discussion off the record)

EXAMINATION BY MR. EEYOR:
Q. Just so we’re clear, Doctor, the photographs referenced in the chart, those are simply stills or video captures from the tape?
A. Yes, sir.

Q. Okay. Doctor, would you look at Page 152 in the record, and that’s a copy of the report on the abdominal ultrasound, dated November 7th 2001?

A. I got it.

Q. And the impression states “Abnormal gallbladder region suspicious for contracted gallbladder, possibly containing shadowy stones. No dilated bile ducts, consider general surgery consultation.” Would you agree with me, Doctor, that that’s a fairly equivocal impression there?
A. No, I would agree that that’s a pretty definite impression.

Q. And was it based largely on this particular report that you elected to perform or recommend performing surgery on Ms. Roosevelt?
A. Based on this report, her history, and her physical exam.

Q. Doctor, do you have any recollection of being told by Ms. Roosevelt or her family members that she may have had a prior gallbladder surgery --
A. No, sir.

Q. -- before your surgery?
A. No, sir.

MR. OWENS:
Let him finish, so it’s on the record.

EXAMINATION BY MR. EEYOR:
Q. Before you performed surgery?
A. No, sir.
Q. All right. After you performed surgery and came out, I suppose you spoke to the family at that point?
A. Yes, sir.
Q. And advised them that in fact there was no gallbladder?
A. I advised them it looked like she had had previous gallbladder surgery. At the time, remember I told you that it was my suspicion that she may have had a remnant of her gallbladder still there, but in answer, yes. I advised them that there was evidence that she had had previous surgery done on her gallbladder, and at least a portion of her gallbladder had already been removed.
Q. And did the family tell you anything at that point?
A. One of the family members said now, I can’t quote directly, but I’ll paraphrase it “You know, I thought she might have had previous gallbladder surgery.”
Q. Okay. I’ll ask you, if Dr. Thomas had been informed of that fact by Ms. Roosevelt or a family member, is that something that should have been in his history and physical?
A. I would prefer not to answer that. I think I would let you ask him that.
Q. Let me ask you, if you had been advised of that by the family of the patient that you were seeing, is that something you would have put in your history and physical?
A. If a family member told me that I would ask that patient about it, and whatever the patient told me is what I would put.
Q. Doctor, are there or were there in 2001 any further diagnostic studies that could have been done prior to surgery to have determined whether or not there was a gallbladder present?
A. Well, let me answer that by saying first that there was no reason to do any other studies at that time. The studies that we had were adequate for what diagnosis was. If -- and you had mentioned this earlier. If she had a previous abdominal x-ray or just a plain film of her abdomen, it undoubtedly would have shown clips in the right upper quadrant, because they’re stainless steel and they are visible
on x-ray. So if she had had that, then that would have indicated prior surgery in that area.

Q. And what would you have done in the face of such an x-ray?

A. I would have quizzed her even harder about her previous surgical history.

Q. Doctor, was there a gallbladder remnant? Did you ever find one?

A. I found what I felt was likely a gallbladder remnant, but I stopped the surgical procedure at that point to try to do an ERCP afterwards to identify that.

Q. Why? Why did you elect that course?

A. I felt that it was the proper prudent thing to do at that point. That's my answer.

Q. Did you follow Ms. Roosevelt after the first surgery?

A. Yes, I did.

Q. Okay. What did that entail?

A. Seeing her on rounds?

Q. Okay, and when would you make those?

A. Well, you had asked me earlier. Normally I make rounds in the mornings. I can't give you time,

because it really does vary. If I have cases starting at 7:30, then I'll usually try to make rounds in between cases, and it just varies; just varies in time.

Q. Do you chart those particular follow up visits?

A. I write a progress note.

Q. Okay. Are those in this chart? Could you look for those?

A. Yes, sir, they are. The progress notes start on Page 56.

Q. Okay, and I'm looking on Page 56, and there appear to be two entries, one dated 11/7 and one dated 11/8; is that correct?

A. Correct.

Q. And which of those two is in your handwriting, Doctor?

A. Neither one.

Q. Okay. Are either of them written at your request?

A. No.

Q. Written for you?

A. No.

Q. Okay. Where is your first — —
A. On the next page, Page 57.
Q. Okay, and which one of those notes would be yours?
A. The one, the top, the one with my signature.
Q. Dated 11/8/01?
A. Correct.
Q. Operative note?
A. Correct.
Q. Read that into the record for us, please.
Q. Okay. Who did you speak to about that recommendation for an ERCP?
A. I called Dr. Thomas immediately after the procedure and told him my findings.
Q. Okay, and would it be Dr. Thomas then who would ask for the consult for the ERCP?
A. I don’t recall which one of us did, but I’m sure it was him. Take it back, I’m not sure. I don’t recall which one of us did.
Q. Do you recall any discussion with Dr. Thomas following this particular surgery about your findings from the surgery?
A. Right.
Q. Tell me about those conversations.
A. I told him basically what I said in the note here, that I found evidence that she’d had previous gallbladder surgery, and I was concerned that she had a remnant of her gallbladder still present which would be giving her her symptoms, and that I thought that we need an ERCP to try to identify that situation.
Q. Did either of you question why the prior gallbladder surgery wasn’t picked up through the history and physical?
A. I don’t know what he did, but I know that - - you know, I know that I had asked her if she had, specifically. I had asked her what other surgeries she had had. She said kidney stone surgery only. I asked her specifically if she’d ever had any gallbladder problems, and her answer was no.
Q. When did you ask her that question?
A. At the time that I examined her.

Q. Prior to surgery?

A. Prior to surgery.

Q. And you don’t recall any discussion with Dr. Thomas kind of like, “How did this get missed? How did we miss this, or how did they not tell us anything,” along those lines?

A. You know, something like that is obvious, okay, and it’s certainly obvious that it’s -- if we had known, obviously she wouldn’t have had surgery.

Q. Have you ever had this happen before?

A. No.

Q. Has it happened since?

A. No. I will tell you about a case that I have since operated on, that the woman swore she had had her gallbladder removed. She had a big scar, but all of her studies said that her gallbladder was there, and I ended up operating on her and it was there. I took it out.

Q. And this was after Ms. Roosevelt?

A. This was after Ms. Roosevelt.

Q. Did she have two gallbladders?

A. It’s pretty detailed.

Q. Doctor, back on Page 57 of the chart here, any of the handwriting yours on there?

A. No.

Q. Okay. How about on Page 58?

A. No.

Q. Page 29?

A. Yeah, that’s mine.

Q. Go ahead and read that entry into the record for me.

A. Okay. “Post-op day number one, patient confused regarding place and time. Vital signs stable, except pulse remains slow. Lungs clear bilaterally, abdomen soft, trocar sites okay. Active bowel sounds. Lab hematocrit 27 percent, white blood cell count 12,900. Rest of labs pending. Discussed operative findings yesterday with Dr. Roberts and today with Dr. Moolah. ERCP indicated. Patient refused ERCP today, discussed with daughter. Impression, stable post-op. Number two, mild disorientation, probably related to surgery, should be transient. “Recommendations, number one, ERCP should be done, but not imperative that it be done immediately. Could certainly be done in near future as an
outpatient if the patient and family desires. Number two, await review of operative report from All Angels. Number three, continue medical care per Dr. Thomas.”

Q. Who’s primarily responsible for the patient at this point postoperatively, you or Dr. Thomas?
A. Well, she’s on Dr. Thomas’ service so, you know, I mean – – I don’t know the answer primarily responsible.

Q. Are you both making rounds on her at this time?
A. Right.

Q. Are you talking about what’s going on with her during the day to each other?
A. You know, you talk to other doctors on the case as indicated or as needed, but that’s why you write detailed notes.

Q. Okay. The hematocrit and the elevated white blood cell count, does that give you any cause for concern?
A. The white blood cell count was only slightly elevated, and it’s very frequent after an operative procedure on anyone for it to slightly elevate, just in inflammatory response to the surgical procedure.

The hematocrit of 27 percent is a little low. I think hers starting off was around 35 percent, if I recall correctly, and so that hematocrit of 27 is a little bit low and it was concerning, although we do frequently see the hematocrit drop after a surgical procedure just in response to the little bit of blood lost from the time of the surgery, and also it’s volume related in response to the IV fluids that the patient gets while they’re under anesthesia and in the recovery room.

Q. Okay. You have referenced here that the vital signs were stable. Did you take a blood pressure?
A. Not myself, but I read on the chart where the nurse on the graphic sheet, where the graphic sheet where the nurses record temperature, blood pressure, pulse, respirations.

Q. What else would you review on the nurses’ graphics?

MR. OWENS:
At that time?

EXAMINATION BY MR. EEYOR:
Q. At that time for this particular patient.
A. Really, that would be about it at that time.
Q. Are you following I&Os at this point?
A. Well, that’s on the graphic sheet also.
Q. That’s something you would follow, though?
A. Yes.
Q. And your explanation for the low pulse, is that pulse rate, I assume?
A. Pulse rate, yeah.
Q. And what was your thinking with regard to that?
A. I really couldn’t. That’s not my you know, I felt at that point that it was more likely her cardiac situation that was causing her pulse to be low. Generally post-op I’m interested in whether or not the heart rate is rapid, or higher than normal. Let me say it like that.
Q. Did Ms. Roosevelt offer an explanation as to why she was refusing the ERCP?
A. I can’t recall her exact reasons.
Q. The daughter you discussed this with, was this the same daughter or perhaps a different daughter from the initial visit?
A. I can’t recall that exactly. I think it was the same daughter, but I do not remember.
Q. Okay. Let’s go to Page 60. An of the handwriting on there yours?
A. No.
Q. Okay. How about 61?
A. That’s mine.
Q. Okay. Why don’t you read that into the record, please.
A. “Surgery note, post-op day number two. Lab today, hematocrit 19.3 percent, hemoglobin 6.6. Bowel movement earlier today, no obvious blood. Abdomen soft. Trocar site tenderness. No appreciable distension. Impression, post-op anemia, likely secondary to continued bleeding,” and in parentheses I wrote “ooze,” “from operative dissection, as patient has been on Lovenox, etcetera. Recommendation, agree with discontinuing Lovenox, etcetera. Number two, agree with need for EGD to rule out gastric bleed. Number three, fresh frozen plasma indicated, as well as transfusion. Number four, patient does still eventually need ERCP, but agree with postponement now.”
Q. And the reference to agree, agree with these several findings, those were recommendations made by another physician?
1 A. Those were recommendations already made by Dr.
2 Thomas.
3 Q. Okay. Had you had discussions with him
4 concerning this, or is that something you just picked
5 up in the record, the progress notes?
6 A. I don’t recall if I discussed it with him that
7 morning or not.
8 Q. The hematocrit down to the 19.3, does that give
9 you some concern?
10 A. That was very concerning.
11 Q. Okay. Is that a critical value?
12 A. That’s a critical value.
13 Q. All right. Is that an indication that the
14 patient is hypovolemic?
15 A. That’s correct.
16 Q. How were her vital signs during this particular
17 visit?
18 A. I didn’t record vital signs on my progress note,
19 but looking back at her in reviewing the chart,
20 looking back at her graphic sheet, I seem to recall
21 that her blood pressure and pulse were okay. I can’t
22 tell you the exact figures.
23 Q. So you want to take a minute to look at those
24 back in this section? Doctor, do you ever time your
25 progress notes?
26 A. Not usually. This particular sheet that you
27 provided me with does not have the vital signs listed
28 on the 10th.
29 Q. And what page are you looking at, Doctor?
30 A. It’s 248.
31 Q. In fact, it has them for the 6th, 7th, 8th, 9th,
32 then the 10th is absent, correct?
33 A. The 10th is absent, as is the 11th, and the 12th,
34 and the 13th.
35 Q. Do you have a recollection of actually reviewing
36 vital signs?
37 A. I’m sure I did, and I’m not sure why it doesn’t
38 show up on your sheet, but I distinctly remember
39 reviewing her vital signs.
40 Q. At the time of this particular visit?
41 A. Yes, sir.
42 Q. Okay, have you seen any record of those since
43 this day?
44 A. I have reviewed them. I cannot recall the exact
45 figures for you.
46 Q. Okay. Back to the progress record, Doctor, when
A. My next entry is on the 11th. My partner, Dr. Oscar Meyer next entry is later that day on the 10th.

Q. Okay, and what page is his entry on?

A. Page 64.

Q. Okay, and why would your partner have seen Ms. Roosevelt?

A. As I recall, he was on call that weekend for our group, and normally would be taking over the care of all of our patients for the weekend.

Q. Okay. And why did he see her?

A. I had called him and told him about her. I had come in and seen her that morning. Normally he would have been the patients, but I was obviously concerned about his particular patient and came in and saw her, and then called him and told him the status and asked him to please keep a close watch on her.

Q. And presumably that’s what he was doing, in response to your request?

A. Yes, sir.

Q. All right. In reviewing his note on Page 64, is there anything in there that gives you concern, looking at it today?

A. I don’t understand what you mean by that. I’m concerned throughout this period about this patient.

Q. Do you see a further decline in Ms. Roosevelt’s condition, as evidence in this particular chart entry?

A. Her blood pressure is okay, 102 over 40. She has no tachycardia, so her pulse rate is normal. She’s pale, which would indicate the low hematocrit but she was being transfused at that time, and the follow up, she’d only had tow units at that time. The follow-up hematocrit according to his note was pending at that time.

Q. Okay, and the recommendation is if the H and H continues to fall, consider follow-up laparoscope?

A. Consider laparoscopy and repeat surgery.

Q. Just going in to see what’s happening in there, correct?

A. Putting a little small incision, and putting the camera and seeing if you find out what’s going on, if anything is going on, in the abdomen.

Q. Do you agree with that assessment?

A. Yes.

Q. And what’s going on with the patient at this
A. I agree with his assessment, yes.
Q. What’s your next entry?
A. My next entry is –– his next entry is on 11/11, 12:30. My next entry is 11/11/01, probably about 3:00 in the afternoon.
Q. Okay.
A. And the way –– I had called him that morning or late morning to inquire about the status of this patient, and that’s when I found out the things that had gone on about the patient.
Q. What were you advised of?
A. What did I advise him?
Q. No. What did he advise you of?
A. Oh, he advised me, told me about all the things that had happened since I had seen her the morning before.
Q. Which were?
A. She had had a cardiac arrest, cardiorespiratory arrest, and she was successfully resuscitated.
Q. Did you ever come to learn why she went into cardiac arrest, the cause of that?
A. Well, I know the event. I know what was ongoing when that occurred.
Q. Okay. What was that?
A. She had just been placed on dialysis?
Q. Why was she placed on dialysis?
A. She had developed acute renal failure.
Q. Is that a result of the hypovolemia?
A. I’m not qualified to answer that. Dr. Thomas had consulted nephrologist.
Q. Is kidney failure a result from hypovolemia, or kidney shut down?
A. That’s a broad question. In her case her renal failure was, her hypovolemia and subsequent renal failure were certainly linked.
Q. Okay, and your next entry is on Page 74; is that correct?
A. Seventy-three.
Q. I’m sorry; and which of the two is that?
A. The one on the bottom.
Q. Okay. Why don’t you go ahead and read that one?
A. “Surgery note, discussed surgical exploration with entire family. Plan to proceed with exploratory laparotomy this p.m. Patient’s family explained procedure and extreme risk. They state they...
understand, and consent signed.”

Q. And that’s dated 11/11/01?
A. Yes, sir.
Q. With your signature at the bottom?
A. Right.
Q. Okay. Do you recall how many family members were there?
A. A lot.
Q. Okay. All right. Your next entry?
A. 11/11/01.
Q. Page 74?
A. Page 74.
Q. Okay.
A. Do you want me to read it?
Q. Please.
A. “Op note,” parentheses, “procedure dictated,” end parentheses. “Findings, large amount of nonclotted blood within the peritoneal cavity, no obvious source identified, no active bleeding. Patient tolerated procedure, and brought back to the intensive care unit.”
Q. Doctor, do you have an opinion as to the source of the blood that you found in the stomach there?

A. We could not find an obvious source.
Q. Do you believe it was related to the surgery that you had performed earlier?
A. I would think so.
Q. When you say no active bleeding, how do you determine that?
A. No active bleeding. There was no ongoing bleeding.
Q. And how do you determine that?
A. You look.
Q. Okay. You evacuate the contents?
A. You take all of that out and you look. In my op note I discuss every place that we looked. First place I looked obviously was in the area where I had done some dissection, and there was no active bleeding there. Then we looked at other areas throughout the entire peritoneal cavity, and there was no active bleeding. We looked at the actual site where the trocars had gone through the muscle into the abdominal Roosevelt, and there was no active bleeding there.
Q. Again, are you using a sponge to kind of clean up, and saline, and rinse and watch and see if blood
Q. Other than continue on with the fresh frozen plasma and Vitamin K and whatever else you may have been giving, that’s what you looked to do? You looked to improve clotting, correct?
A. After this procedure?
Q. Yes, sir.
A. Yes.
Q. I mean, she was on that before this procedure as well?
A. Right.
Q. Because you had suspected with the drop in H and H that there was bleeding going on?
A. That was a possibility.
Q. Okay. All right. Do you have another entry, Doctor, you or your partner?
A. 11/12, “Surgery note, see Dr. Thomas’ extensive notes,” and then I have an arrow that I agree. I wrote “agree.” “Plan number one, proceed as per Dr. Thomas. Number two, dialysis likely today. Number three, fresh frozen plasma today,” parentheses, “see elevated PT, PTT,” end parentheses. “Number four, neurology evaluation”.
Q. And for the sake of the record, this is Page 78?
A. Seventy-eight.
Q. Okay. Fresh frozen plasma, again is to try to increase clotting?
A. To try to correct the abnormalities in her clotting mechanism.
Q. And that’s what the PT and PTT measure, clotting time?
A. Right.
Q. And the neurological evaluation was the result of the earlier code incident?
A. Yes, sir.
Q. To determine her status?
A. Right.
Q. Did you have any discussions with the family following the second surgical procedure?
A. Yes, sir, I did.
Q. Tell me what you can recall of those discussions.
A. Well, I came out and told them exactly what we had found; a lot of blood in the abdominal cavity,
and no obvious source, and no ongoing bleeding.

Q. Do you recall questions being put to you at that
time by any of the family members?
A. Oh, I’m sure they had questions. I don’t recall
the specifics.

Q. Okay, and no video was taken of that second
procedure; is that correct?
A. No. The second procedure was an open procedure,
a midline incision. It wasn’t done laparoscopically.

Q. Okay, and Dr. Oscar Meyer assisted you during
that surgery?
A. Yes, he did.

Q. Did anyone assist you during the first
procedure?
A. No.

Q. Is there a need for someone to assist you with
an open procedure versus laparoscopic?
A. Well, a lot of times with laparoscopic we rarely
have a physician assistant. An open procedure we
quite frequently do, depending on what the procedure
is. In this case he was there and, you know, we were
together and we operated together.

Q. You wanted a second set of eyes in there?
A. Sure.

Q. Okay. Any entries after 11/12?
A. Dr. Oscar Meyer has an entry on the 13th.

Q. What page is that?
A. Eighty-five.

Q. All right. Any idea why he saw the patient on
this particular day?
A. It might have been a day that he was making
rounds on all our patients.

Q. Do you recall discussion the patient with Dr.
Oscar Meyer following this November 13th visit?
A. I don’t recall.

Q. And Dr. Oscar Meyer’s entry from the 13th, does
that reflect a further decline in Ms. Roosevelt’s
condition?
A. Yes.

Q. When is the next time --
A. I continued to see this patient every day,
extcept obviously that day maybe I was -- we go to
another hospital and I might have been up there that
day. I continued to see her every day. I didn’t
write a note. It just wasn’t -- I had nothing to
add to the case at that point, and what was your next
1 question? I’m sorry.
2 Q. Were you having discussions with family members
3 during the subsequent - -
4 A. Whoever happened to be in the room, I would
discuss.
5 Q. Just in general follow-up?
6 A. Yeah.
7 Q. Doctor, you said something earlier in the
8 deposition, that the x-ray data, or I assume you
9 meant the ultrasound data indicated gallbladder
disease. What specifically in that radiology report
10 indicates to you gallbladder disease? Page 152, I
11 believe.
12 A. Well, they called it an abnormal gallbladder.
13 Q. I believe it says abnormal gallbladder region;
14 is that correct?
15 A. Okay, and then “suspicious”. That would
16 indicate something wrong. Then “contracted
gallbladder, possibly containing shadowy stones”.
17 “Shadowing stones”.
18 Q. Doctor, let me ask you to take a look at Pages
19 29 through 33, which are the consent forms.
20 A. All right. I’m on 29.
21 Q. Any of that handwriting your handwriting?
22 A. No.
23 Q. Go through the next pages and see if you find
24 any of your handwriting.
25 A. Thirty-one.
26 Q. Okay. What on that particular page is in your
27 handwriting?
28 A. “Laparoscopic,” in the area where it says
29 “treatment, procedure,” “laparoscopic
30 cholecystectomy”. Then I wrote on there “make small
31 cuts on the abdomen,” and its purpose, to remove the
32 gallbladder. Patient’s condition, I wrote
33 “cholelithiasis and cholecystitis”.
34 Q. Okay. What about at the top of the page, the
35 next page, 31, where gastroscopy is crossed out and
36 lap cholecystectomy is written. Is that your
37 handwriting?
38 A. That’s mine.
39 Q. And what about the patient’s name, Evelyn
40 Roosevelt? Is that your handwriting?
41 A. No, that’s not mine.
42 Q. So of all the handwritten things, the only one
43 on this sheet that isn’t yours is the patient name,
correct?
A. That’s right.
Q. What about the next page, 32? Is that your signature?
A. Yes.
Q. Do you have any idea when you signed that, Doctor?
A. Well, it either would have been at that time or it would have been when the chart came back to the - - when we do our medical records, when the patient has left the hospital. When we do our medical records the chart comes back, and the medical records people flag things that you need to sign or fix or whatever.
Q. Would you have gone over this with the patient, or is this something - -
A. I would not have gone over this one with the patient. I explained it to the patient, documented it in my note that I had, and then the nurse gets the consent form signed.

MR. LOWRY:
One moment. The page where you have it marked at the top, I’m looking for that.

MR. OWENS:
What Bates stamp number?

MR. EYOR:
Page 31, and again, gastroscopy is lined out with lap cholecystectomy handwritten in there.

THE WITNESS:
Over on Page 29, it’s got gastroscopy written up at the top of that but it’s clearly about the gallbladder surgery, so it’s a clerical error there.

MR. EYOR:
Let’s go off the record for a minute.
(discussion off the record)

EXAMINATION BY MR. EYOR:
Q. Doctor, if you would, take a look at Bates stamped Pages 7, 9, 10, 11, and 12. I think Page Number 8 probably is put in there incorrectly. It looks to me like 7 through 12 are the five pages of another consent with a number, and I don’t know what this number references but they all include the HBOC Number 5032, with the exception, as I said, of Page 8, okay. Do you see those pages?
Q. Pages 7 through 12.
A. Okay.

Q. I think Page 8 probably is just out of place and doesn’t belong in this group.
A. Okay.

Q. If you could, look through 7 through 12 and see if any of the handwriting on those pages is yours.
A. Yes, that’s mine.

Q. On Page 9?
A. Page 9.

Q. Okay. Is all of the handwriting on Page 9 yours?
A. That’s correct.

Q. Okay, and what about on Page 10?
A. Page 10 is mine.

Q. Okay, and then there’s a line that says “Sotomayor” in your handwriting?
A. Correct.

Q. And the signature in your handwriting?
A. That’s right.

Q. And a date/time listed, 11/8/01?
A. Correct.

Q. Okay, and what about Page 11? Anything there in your handwriting?
A. No.

Q. What about Page 12?
A. No.

Q. Okay. Doctor, you’ll agree with me that the dates on 11 and 12 and 7 are all 11/10/01?
A. Right

Q. Do you have an explanation as to why your —
A. Well, the one on Page 12 is for, looks like it’s for blood transfusion.

Q. Okay.
A. The one on Page 11 is dated, it’s signed by the daughter. I assume that’s the daughter, Jesse Roosevelt, and that’s dated 11/10, so obviously that goes with something else.

Q. Would you agree with me that there’s a number down there, HBOC Number 5032, on all these pages we’re talking about?
A. Right. Yeah, I agree.

Q. Doctor, do you have any explanation as to why yours is dated 11/8/01, but the rest of these, which appear to be in a group, are dated —
A. I don’t know.
1
Q. Okay. Let’s go to Page 13, Doctor, Bates stamped copy, and this appears to be another consent form, again with an HBOC number down there, 00114.
2
Do you see that?
3
A. Uh-huh (affirmative response).
4
Q. Go through those. Any of the handwriting on those yours?
5
A. No.
6
Q. Okay, and you go to Page 19. This is four pages, with again an HBOC number of 00114, and at the top of Page 19 it lists a laparoscopic exploration, 11/8/01. Any of the handwriting on those four pages yours.
7
A. Not that I see, no.
8
Q. Okay. Doctor, what would you have done differently in this particularly case, in the face of the findings following your physical examination and assuming you’d been given a past medical history of possible cholecystectomy?
9
A. From the patient, if she had told me she had a previous gallbladder surgery?
10
Q. Believed or suspected that she had had a prior gallbladder surgery.
11
A. I would not have operated on her.
12
Q. Okay. Would you have ordered any further diagnostic tests?
13
A. Yeah, probably would have ordered an ERCP at that point, or would have consulted a gastroenterologist to see if they felt that an ERCP was indicated. That’s not a test I can order. I have to consult, you know, a gastroenterologist and ask them, tell them that’s why I’m consulting them and see if they would agree to do that.
14
Q. Because that’s the specialty that performs that procedure?
15
A. Correct.
16
Q. Okay. Doctor, briefly where did you go to undergraduate?
17
A. LSU.
18
Q. When did you get out?
19
A. Undergrad school, 1972.
20
Q. And what about med school? Where did you go to med school?
21
A. LSU in New Orleans, LSU School of Medicine
in New Orleans, as opposed to the one in Shreveport, and I graduated from there in 1976.

Q. Go through and take me through your residency and whatever training you had after med school.

A. Residency was in the LSU Department of Surgery system. We were based at University Hospital in City of Hope, and that’s where I did most of my training and work. The LSU Department of Surgery at that time staffed the University hospitals in the State of Justice, City of Hope, so I did work at those areas throughout that time.

Q. And was that in general surgery?

A. General Surgery.

Q. How long is that program?

A. At that time, it was a four-year program. It’s a five year program now.

Q. And upon completion, did you sit for your boards?

A. I passed my boards in 1983, American Board of Surgery.

Q. And you are board certified?

A. I am board certified.

Q. In general surgery?

A. In general surgery.

Q. Any other specialties?

A. No.

Q. Did you ever fail any part of your board certifications, Doctor?

A. No.

Q. Is there a recertification process?

A. Yes.

Q. How often does that occur?

A. Every ten years.

Q. And you’ve done that once?

A. Twice.

Q. Twice now; I’m sorry. All right.

A. The most recent was 2003.

Q. Okay. Doctor, where do you hold a medical license? What states?

A. Louisiana.

Q. Have you ever had any action taken against your medical license?

A. Against my license?

Q. Yes, sir.
A. No.

Q. Upon completing your residency, where did you go?

A. I came to Justice.

Q. Okay, and did you open your own practice?

A. I came in with Dr. Oscar Meyer.

Q. And the two of you have been practicing together since that time?

A. He’s retired since, but we practiced together. He retired in 2002.

Q. Okay. In November of 2001, by whom were you employed?

A. Self-employed.

Q. Okay. Is there some legal entity set up?

A. Yeah, we’re a partnership called Surgical Associates, and at the time it was Dr. Oscar Meyer, myself and Dr. Lewis.

Q. Dr. Lewis? Is she a doctor?

A. She’s a general surgeon.

Q. Surgical Associates, LLC?

A. It’s a partnership. She’s a general surgeon when she’s not pregnant.

Q. And is Surgical Associates still in good standing? Is it still the entity that you operate under?

A. Yes, sir. It’s just the two of us now. We had another partner, Dr. Haynes, who also retired in 2001, somewhere along in there.

Q. What hospitals do you have privileges at?

A. All Saints, University. Those are the two hospitals where I have admitting privileges. I also have consulting privileges at Hood Hospital.

Q. And was that the case in November of 2001?

A. Yes.

Q. Did you ever have any action, privileges suspended or denied by any institution?

A. No.

Q. Did you ever have any action, privileges suspended or denied by any institution?

A. No.

Q. Other than your attorney and Dr. Thomas and Dr. Roberts I believe, have you discussed this particular case with anyone else?

A. Well, Dr. Oscar Meyer.

Q. Dr. Oscar Meyer as well? I’m sorry. Other than those person, anyone else?
A. I can’t - - well, probably the neurologist, the cardiologist, the - -

Q. Let me rephrase. Let me stop you. Other than at the time you were treating Ms. Roosevelt back then, since this matter’s gone on to litigation - -

A. No. The answer is no.

Q. You’ve had no discussions?

A. With anybody.

Q. Okay. Ever been reprimanded by any organization or hospital?

A. No.

Q. What’s your relationship with Dr. Thomas?

A. Medical staff colleague.

Q. Okay. That would be the same of Dr. Roberts and the other treating physicians of Ms. Roosevelt?

A. Yes.

Q. What professional organizations do you belong to, Doctor?

A. I’m a Fellow of the American College of Surgeons, the Surgical Association of the State of Justice, Southwest Surgical Congress. That’s all I can recall right now.

Q. Did you ever hold any offices with any of those entities, or are you simply a member of them?

A. I have held office before, but none right now.

Q. Doctor, have you ever testified in a medical malpractice case before?

A. Testified?

Q. Yes, sir.

A. No.

Q. Have you ever given depositions in medical malpractice cases before?

A. No. The answer is no.

Q. Do you recall about how many times you’ve served on a medical review panel?

A. Five or six.

Q. Do you recall what the opinions in any of those cases were?

A. In all the cases of the ones that I’ve serve on, we held in favor of the physician.

Q. Do you recall if you were deposed following any of those panels?
A. I was not.

Q. Do you ever review medical malpractice cases for attorneys?

A. No.

Q. Have you yourself been sued before for medical malpractice?

A. I have had actions --

Q. Let me rephrase. Have you ever had complaints of medical malpractice brought against you before a medical review panel?

A. Correct.

Q. How many occasions has that occurred?

A. Two, if I recall.

Q. Okay. Why don’t you tell me a little about those two cases?

A. One was, the most recent one was -- I can’t use patient’s names, but was a patient that had had extensive bleeding diverticulosis, which is a disorder of the colon, and she had had multiple previous surgical procedures, and ended up having to operate on her because she continued bleeding. All the things that we did to try to stop it didn’t work; had to do a total abdominal colectomy on her. It was a very, very difficult procedure because of her previous surgical history of adhesions and scar tissue, and she had some postoperative complications primarily involving an anastomotic leakage, and that was that case.

Q. Has that case gone to panel yet?

A. It’s over.

Q. Okay. What happened?

A. IT was unanimous in my favor.

Q. Okay, and no suit was filed after the medical review panel?

A. No, sir.

Q. Who represented you during that case?

A. Mr. Owens.

Q. And in the other case?

A. The other case that I can recall and I guess it went to the panel. Is it all right if I and Mr. Owens --

MR. OWENS:

Just tell him what you remember.

THE WITNESS:

Was a patient that had had an
inguinal hernia repair done and had post-op pain
and he had filed, and that was unanimously held
in my favor.

EXAMINATION BY MR. EEYOR:

Q. Okay, and did that go to suit following the
panel?
A. No.

Q. Okay. You’ve never had a lawsuit filed
against you?
A. No.

Q. You’ve given depositions before?
A. Yes.

Q. As a treating physician, I presume?
A. No, not as a treating physician.

Q. Tell me about those depositions. Why were
you giving depositions?
A. Primarily trauma. I guess, well, maybe --
let me amend. Yeah, as a treating physician, one
that I recall, a gunshot wound, a murder case.
I’ve testified in court.

Q. Okay.
A. That’s really all that I can recall.

Q. Just the one?
Q. Are there any texts or publications that you consider authoritative concerning general surgery, dealing specifically with cholecystectomies and laparoscopic procedures and treatments?

A. Well, there’s a lot of textbooks, obviously. I don’t know what you would say is authoritative.

Q. Are there any on which you refer in your practice?

A. Well, I try to read a lot, obviously, and there’s two standard textbooks, Sabiston’s textbook on surgery, and Schwartz.

Q. Those are the two textbooks?

A. Well, there’s a lot of textbooks, but those are two very, very popular and common ones.

Q. Okay. In terms of publications articles, and again dealing with laparoscopic procedures for cholecystectomy, what texts or magazines do you refer to?

A. Well, “American Journal of Surgery,” “The American Surgeon,” and “Archives of Surgery,” and then we get a lot of what we call throw-away journals, “Contemporary Surgery,” “Surgical Rounds,” that sort of stuff that occasionally has some useful stuff.

Q. We’ve got them on this side too. Have you reviewed any publications in preparation of your review of this particular case?

A. Publications?

Q. Yes. Articles, treatises, textbooks?

A. No.

Q. Doctor, the persons who assist you during the laparoscopic procedure, are those hospital staff?

A. Hospital employees.

Q. Okay. What is your relationship with the hospital? What was it in November 2001?

A. What do you mean by relationship?

Q. You weren’t an employee of the hospital, were you?

A. No.

Q. Have you been asked to give any opinions in this matter concerning any of the care rendered to Ms. Roosevelt by the other defendants or doctors or health care providers?
A. No.

Q. Do you plan on giving any opinion testimony, should this matter progress, on the actions of anyone other than yourself?
A. Just whatever Mr. Owens says I’m supposed to do.

Q. You weren’t asked to evaluate the care rendered by any of the other health care providers in this case?
A. No.

Q. Did you prepare any kind of report following Ms. Roosevelt’s case, other than what’s in the medical record?
A. No.

Q. To your knowledge, was there any review by the hospital of this particular incident?
A. Not to my knowledge.

Q. Have you ever gone back and reviewed the actual ultrasound in this case?
A. The actual ultrasound?
Q. Yes, sir.
A. No.

Q. Doctor, do you believe your actions in treating Ms. Roosevelt were within the standard of care?
A. Yes, I do.

Q. Do you have an opinion as to what caused Ms. Roosevelt’s death?
A. That’s -- can you be more specific?

Q. Do you believe that anything you did in this particular case caused or contributed to Ms. Roosevelt’s death?
A. Do I believe that anything I did?
Q. Or failed to do.
MR. OWENS: Objection; compound. You can answer. He’s asked you two questions, what you did or what you failed to do. That’s two different things.

THE WITNESS: Okay. You know, that’s just too hard for me to answer.

EXAMINATION BY MR. EYOR:
Q. Okay. If I separate it, is it going to make it any easier, or is it just the nature of the question?
A. Well, you know, I don’t think I will be able to answer that.

Q. Okay. Do you believe that complications Ms. Roosevelt suffered following the surgery that you performed caused or contributed to her death?
A. I can answer, the complications that occurred after her initial operation set in motion a series of events that resulted in her demise.

Q. Okay. Would you agree with me that had she not had the surgery, the laparoscopic procedure, that she more likely than not would not have had those complication leading to her demise?
A. I’ll agree with that.

Q. Doctor, when a physician becomes aware of a harmful error made by another physician, should that doctor encourage the other doctor making the mistake to tell the patient about the error?

MR. OWENS:
Objection; overly broad, calls for speculation. You can answer if you can, Doctor.

THE WITNESS:
Could you ask me that question again?

EXAMINATION BY MR. EEYOR:
Q. If a doctor discovers a harmful error made by another physician, should the doctor who discovers the error of the other physician encourage the physician committing the error to advise the patient?

MR. OWENS:
Same objection. Answer it if you can.

THE WITNESS:
In that board context, yes.

EXAMINATION BY MR. EEYOR:
Q. Did you review the complaint that was filed with the Division of Administration before your deposition today?
A. Not recently.

MR. EEYOR:
I think I’m done.

Does anyone else any questions?
No? Okay. That concludes the depositions (end of deposition)
WITNESS CERTIFICATION

At the request of the plaintiffs’ attorneys in this case, I have carefully reviewed the above deposition transcript to determine whether it was true and complete and whether I had any additional information relevant to the matters discussed therein. I did so, and hereby certify, under penalty of perjury, that the deposition transcript is true and complete and that I have no information relevant to the matters discussed in the deposition that is not contained in the same.

Dr. Sotomayor  3/13/14

Signature Date
IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF JUSTICE

NO.  123-456

DAVID ROOSEVELT, WARREN ROOSEVELT, RANDALL ROOSEVELT, SR., LANA JOY
ROOSEVELT, JESSE ROOSEVELT, KERRY ROOSEVELT, MARK ROOSEVELT,
MARSHALL ROOSEVELT AND JANICE ROOSEVELT, INDIVIDUALLY AND ON
BEHALF OF THEIR DECEASED MOTHER, EVELYN ROOSEVELT

VERSUS

SYDNEY SOTOMAYOR, M.D., CLARENCE THOMAS, M.D., ANTHONY KENNEDY,
M.D. AND ALL SAINTS HOSPITAL

FILED: ___________________________ ______________________________

DEPUTY CLERK

CERTIFICATION OF COMPLIANCE BY COUNSEL

The Court has Ordered that before trial commences the parties re-interview their witnesses
and certify to the Court that they have made a diligent effort to determine whether any witness had
any material information not contained in the statements on file with the Court. The
Court defined material information as information that changed the merits of the case or which
changes the credibility of any witness or litigant, including any background information.

I hereby certify to the Court that I personally conducted a thorough and searching interview
of each witness for the ________, including ___________________ and ___________________,
and have determined that neither witness has any material information not contained in the
statements filed with the Court.

__________________________________________
Signature                      Date
JURY INSTRUCTIONS

General

1. The sole issue in this case is whether the plaintiff was injured or damaged by the negligence of the defendant. On this issue, the burden of proof is on the plaintiff. This means that the plaintiff must prove, by the greater weight of the evidence, that the defendant was negligent and that such negligence was a proximate cause of the plaintiff’s injury.

2. The greater weight of the evidence does not refer to the quantity of the evidence but to the convincing force of the evidence. It means that you must be persuaded, considering all the evidence, that the necessary facts are more likely to exist than not. If you are so persuaded, it would be your duty to answer the issue in favor of the party with the burden of proof. If you are not so persuaded, it would be your duty to answer the issue against the party with the burden of proof.

3. You are the sole judges of the credibility of the witnesses. You must decide for yourselves whether to believe the testimony of any witness. You may believe all, or any part, or none of that testimony. In determining whether to believe any witness you should use the same tests of truthfulness which you apply in your everyday lives including the opportunity of the witness to see, hear, know, or remember the facts or occurrences about which the witness testifies; the manner and appearance of the witness; any interest, bias, or partiality the witness may have; the apparent understanding and fairness of the witness; whether the testimony of the witness is sensible and reasonable; and whether the testimony of the witness is consistent with other believable evidence in the case.

4. Expert witnesses have testified in this case. You are the sole judges of the credibility of expert witnesses and the weight to be given the testimony of expert witnesses. Consider the testimony of any expert witnesses using the same tests you are to use with any other witness. In addition to those tests, consider any evidence about the witness’ training, qualifications, and experience or the lack thereof; the reasons, if any, given for the opinion; whether or not the opinion is supported by the facts that you find from the evidence; whether or not the opinion is reasonable; and whether or not it is consistent with the other believable evidence. You should consider the opinion of an expert witness, but you are not bound by it.

5. You are also the sole judges of the weight to be given to any evidence. If you believe that certain evidence is believable, you must determine the importance of the evidence in the light of all other believable evidence in the case.

Medical Negligence

In diagnosing (plaintiff)’s condition, (doctor) was required to use the degree of care, skill, and judgment which a reasonable doctor practicing medicine would exercise in
the same or similar circumstances, having due regard for the state of medical science at the time. A doctor who fails to conform to this standard is negligent. The burden is on (plaintiff) to prove that (doctor) was negligent.

You have heard testimony during this trial from doctors who have testified as expert witnesses. The reason for this is because the degree of care, skill, and judgment which a reasonable doctor would exercise is not a matter within the common knowledge of laypersons. This standard is within the special knowledge of experts in the field of medicine and can only be established by the testimony of experts. You, therefore, may not speculate or guess what the standard of care, skill, and judgment is in deciding this case, but rather must attempt to determine it from the expert testimony that you heard during this trial.

A person’s negligence is a cause of the plaintiff’s death if the negligence was a substantial factor in producing the death. This question does not ask about “the cause” but rather “a cause.” If you conclude from the evidence that the death was caused jointly by (doctor)’s negligence and also the natural progression of (plaintiff)’s condition, then you should find that the (doctor)’s negligence was a cause of the (plaintiff)’s death.

**Medical Review Panel**

Justice law requires a plaintiff in this kind of case to present the claim first to a panel of physicians called a “Medical Review Panel.” The panel hears from both sides in a case and renders an opinion. The opinion of the panel has been admitted into evidence in this case, but is not conclusive as to your opinion about any lack of care on the part of the defendant. The Medical Review Panel opinion is to be weighed and considered like any other expert opinion. It does not carry any special weight over any other expert opinion in the case, and may be accepted or rejected by the jury.

**Informed Consent**

A doctor has the duty to provide his or her patient with information necessary to enable the patient to make an informed decision about treatment options. If the doctor fails to perform this duty, he or she is negligent.

To meet this duty to inform his or her patient, the doctor must provide the patient with the information a reasonable person in the patient’s position would regard as significant when deciding to accept or reject a medical treatment. In answering this question, you should determine what a reasonable person in the patient’s position would want to know in consenting to or rejecting a medical treatment.

If (doctor) offers to you an explanation as to why he or she did not provide information to (plaintiff), and if this explanation satisfies you that a reasonable person in (plaintiff)’s position would not have wanted to know that information, then (doctor) was not negligent.
**Contributory Negligence**

Every person in all situations has a duty to exercise ordinary care for his or her own safety. This does not mean that a person is required at all hazards to avoid injury; a person must, however, exercise ordinary care to take precautions to avoid injury to himself or herself.