AL-ZAHRANI v. DONALD RUMSFELD, et al Doc. 245 Att. 4

EXHIBIT 14

Dockets.Justia.com

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

LAKEISHA ELLIS,	)	
Plaintiff,	)	Civil Action No.
	)	08-1174 (JDB)
v.	)	
	)	
GEORGETOWN UNIVERSITY	)	
HOSPITAL,	)	
Defendant.	)	
	)	

COPY

WASHINGTON, D.C.

MONDAY, DECEMBER 8, 2008

Deposition of:

RENIE ANGELLA McKENZIE,

called for oral examination by counsel for Plaintiff, pursuant to notice, at the law offices of Denise M. Clark, 1250 Connectic Avenue, NW, Suite 200, Washington, D.C. 20036, before Leslie A. Todd, RPR/CSR, of Capital Reporting, a Notary Public in and for the Commonwealth of Virginia, beginning at 9:20 a.m., when were present on behalf of the respective parties:

©2008

1 Q. Do you recall if you ever had to register
2 a patient in the ER?
3 A. Yes.
4 Q. Do you recall if you ever had to register
5 a patient at Leavey?
6 A. There is no Leavey registration.
7 Q. There is no Leavey registration?
8 A. No.
9 Q. Did you ever have to register a patient at
10 Lombardi?
11 A. Yes.
12 Q. When you started your day as a
13 registration PFA, you would report to main?
14 A. Yes.
15 Q. When would you be -- when would you have
16 to register a patient in ER? Would somebody call
17 you to tell you to report there?
18 A. I would register a patient in ER and any
19 other place if I'm assigned there, or if they are
20 short staffed, or if they need help, then we would
21 go down and help out.
22 Q. So your assignment, who would make that

1 assignment?
2 A. Our supervisor.
3 Q. Was your assignment for a day, a week, a
4 month?
5 A. It's hard to say. It could be that you
6 are assigned to main on that month or that schedule.
7 I can't tell you how the schedule was then, but if
8 you are scheduled to work in main on your shift, on
9 your schedule, and the emergency room needed help,
10 then we would go and help out in main, or if they
11 said, can you go and work in the ER today, then we
12 would go to the ER or Lombardi, wherever. Wherever
13 the need is, and your supervisor asks you to go, you
14 go.
15 Q. But when you started your day, you would
16 report at main?
17 A. Yes.
18 MS. FAIRLEY: Objection. Asked and
19 answered.
20 BY MS. CLARK:
21 Q. So then you became a team leader of
22 patient access?

1 A. Yes.
2 Q. What is patient access?
3 A. Oh, patient access is a department that
4 does mostly registration, and the department is
5 comprised of different areas in the hospital where
6 we have different setup areas for patients to come
7 in wherever they are seeing their doctors, the
8 closest place where we can find in that department
9 where we have a booth where our people would
10 register those patients that are coming in for those
11 doctors. So we are all over the hospital. We are
12 in different areas of the hospital. And it's mostly
13 registration. That's what we do all day.
14 Q. Okay. You mentioned that you've been an
15 employee at Georgetown Hospital for 17 years. Did
16 you ever work at another hospital?
17 A. Not since that time, no, ma'am.
18 Q. What about before --
19 A. Before, no.
20 Q. -- working at Georgetown?
21 A. No.
22 Q. So the only hospital setting you've ever

1 Q. Do you know what she became ill of?
2 MS. FAIRLEY: Objection. Vague.
3 You can answer if you can.
4 THE WITNESS: She told me that her stomach
5 was hurting and she felt like throwing up.
6 BY MS. CLARK:
7 Q. What happened next?
8 A. She came back from lunch, and she told me
9 that her stomach was hurting and that she felt like
10 throwing up.
11 She went to the washroom, and she got a
12 towel, one of those paper towels from the washroom,
13 and she came back to my area. And I asked her if
14 she would like to go to the emergency room to be
15 checked out, and she was hesitant for a moment, and
16 I said, you know, let's walk down to the ER; I will
17 walk with you.
18 So I walked with her to the emergency
19 room, and we walked up to the front desk where the
20 nurse was, where the triage nurse was, and I
21 explained to the triage nurse what was going on, and
22 she sat in the chair.

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1 And at that point, my supervisor came down
2 because -- I can't remember whether I called Fannice
3 then when I got to the ER with her, or called her
4 before I left Gorman with her. But my supervisor
5 came down, and I left and went back to Gorman.
6 Q. Do you recall if Ms. Ellis was assigned to
7 the ER that day?
8 A. I can't recall.
9 Q. Had you heard whether or not she had had
10 an asthma attack?
11 A. I hadn't heard that.
12 Q. So you called Ms. Beckett while waiting
13 with Ms. Ellis at the ER for treatment?
14 MS. FAIRLEY: Objection. Mischaracterizes
15 her testimony.
16 You may answer if you can.
17 THE WITNESS: I can't recall whether I
18 called her then in the emergency room while I was
19 there with Lakeisha, or whether I called her before I
20 left Gorman.
21 BY MS. CLARK:
22 Q. But you recall calling her?

1 A. Yes.
2 Q. And did she arrive at the ER?
3 A. Yes.
4 Q. And did you stay during that -- did you
5 stay with Ms. Beckett and Ms. Ellis?
6 A. No.
7 Q. You left after Ms. Beckett came in?
8 A. Yes, ma'am.
9 Q. Did you hear anything about Ms. Ellis's
10 condition afterwards?
11 A. No.
12 Q. Do you recall if she came back to work
13 that day?
14 A. I don't recall.
15 Q. Do you recall whether she was -- whether
16 she reported to work the next day?
17 A. I don't remember whether she came back the
18 next day. I can't recall.
19 Q. Do you remember at all that she was on
20 leave for any period of time?
21 A. No. I cannot recall.
22 Q. Did anyone ever advise you that she was on

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EXHIBIT 15

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

LAKEISHA ELLIS Plaintiff, v. GEORGETOWN UNIVERSITY HOSPITAL Defendant.	Case No. 1:08-cv-01174-JDB Judge John D. Bates

DECLARATION OF CYNTHIA G. HECKER IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

I, Cynthia G. Hecker, under penalty of perjury, declare pursuant to 28 U.S.C. § 1746 that the following is true and correct to the best of my knowledge. I am providing this declaration in support of the above-referenced motion for summary judgment. I have personal knowledge of the matters set forth herein, and, if called upon, can and would testify concerning the same:

1. I am the current Director of the Patient Access Department at Georgetown University Hospital ("Georgetown" or the "Hospital"). I have held this title since 2005.

2. In my role as Director of the Patient Access Department, I supervise approximately 40 Patient Financial Associates ("PFAs") that work in the Patient Access Department ("Patient Access"). PFAs in the Patient Access Department are required to register patients in several departments of the Hospital. The PFAs work daily in the particular departments the Patient Access Department services. For example, PFAs regularly register patients in the Lombardi Cancer Center, the Emergency Department ("ED"), the Gorman Building, and in Main Admissions, among others. PFA workstations are physically located in these various departments.

3. It is imperative that our PFAs are able to rotate among the various departments we serve everyday. The reason underlying this requirement is that we often cannot predict when and where patients will arrive to access the Hospital's services. Because the registration process is often the first step in patients receiving care, if there are not enough Patient Access PFAs working in a particular department when that department has a surge of patients, that lack of resources can become a significant bottleneck and negatively impact patient care. Thus, we must have the flexibility to rotate our Patient Access PFAs to all departments we service at any time.

4. More so than any other department we service, it is vital that all Patient Access PFAs are able to work in the ED as needed. This is so because the Hospital needs to be able to respond to any mass emergency situations that may arise and possess the capacity to handle a flood of patients entering the ED in a short amount of time. As such, the Hospital must be able to rely on its Patient Access PFAs to be able to respond to these emergencies and assist in registering the mass of patients entering the ED.

5. Our Patient Access PFAs also need to be capable of being in close proximity to the patients we assist on a daily basis. It almost goes without saying that the vast majority of the patients we assist are sick in some form or another based on the fact that they are seeking the services of the Hospital. Further, Patient Access PFAs register patients who are physically present in the Hospital. In so doing, they need to be able to close enough to the patients to be able to pass documents back and forth such as insurance cards and drivers' licenses. Thus, close physical proximity to patients is at the heart of a Patient Access PFA's job duties.

6. I declare under penalty of perjury that the foregoing is true and correct.

Executed on October 9, 2009

Cynthia G Hecker
Cynthia G. Hecker

CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury that on this 13 day of October 2009, I caused a copy of the foregoing to be delivered via electronic mail in accordance with the U.S. District Court for the District of Columbia's Rules of Civil Procedure to the following individual:

Denise Clark
The Law Offices of Denise M. Clark
1250 Connecticut Ave., Suite 200
Washington, DC 20036
(202) 293-0015
dmclark@benefitcounsel.com

Counsel for Plaintiff

/s/ Trina L. Fairley
Trina L. Fairley

EXHIBIT 16

MEMO TO FILE

Re: Lakeisha Ellis

On July 25, 2006 approx 3p I rec'd a call from Renie the team leader in Gorman. She stated that Lakeisha had gotten sick and she was escorting her to the ER. I was concerned because not less than an hour before I had a conversation with Deborah Felton when I saw Lakeisha leaving from her office. Deborah said she had several complaints about her first time working in the ER. She had also stated she (Lakeisha) had an asthma attack.

I went to the ER to check on Lakeisha when I arrived she was being triaged and Renie filled me in on what transpired as to why Lakeisha was being seen in the ER. Renie stated that Lakeisha had been vomiting in the restroom and was complaining of stomach pains and lightheadedness. At this point Lakeisha was coming out of triage and Freddie told her as soon as they had available place for her she would go back to the treatment area.

We sat in the ER waiting area Renie told us she had to get back to her area. I inquired to Lakeisha how she was feeling and what happen. She stated what Renie had told me and that she started feeling sick when she returned from lunch. I inquired again by asking about the asthma attack and did that bring this on and Lakeisha stated no. I then asked could the first time working in the ER cause her to have this from possible stress, she again stated no. She said she was fine until she returned from lunch. After that brief conversation she was called back and placed in a hallway bed. I told her if she needed something to call and to the staff in the ER keep me apprised of what's happening with her.

When she was released from the ER I was called and she (Lakeisha) came to my office. I asked how she was feeling. She said no better that she had some type of stomach virus, and would be seeing her primary physician. I knew she would be leaving for the rest of the day and out the following day (Wednesday). I informed her if she was unable to report to duty to follow the policy and call in using the on-call pager and gave her the number to make sure she had it.

I was paged on Wednesday evening I responded three different times no answer. On the third time on hanging up my cell phone rang back from the number I was calling. It was Lakeisha stating she didn't know it was I calling. She went on to explain her medical condition, I interrupted asking and informing I didn't need to know her personal info but was she calling out for the next work day. She said she was and that her doctor had placed her out until the 31st of July. She also stated that she had documentation from her doctor saying she couldn't work in the ER because of health reasons. I then inquired was she relinquishing her position because she was hired to work the ER. There was a long pause and she started rambling about the scheduling and that she went to church on Sundays and that she told me this and she was unable to work evenings and I was aware of this from our interview. At this point in the conversation I informed her I was not

going to have this conversation over the phone. I told her to bring her documentation from her doctor and all this would be discussed when she returned.

I have spoken to HR (Lorna McFarland) and reviewed the notes I placed on her (Lakeisha) employment application during the interview and I'm certain these issues weren't discussed or agreed on.

EXHIBIT 17

Georgetown University Hospital

MedStar Health

EMERGENCY DEPT. MEDICAL RECORD

CLINICAL I

Ellis, Lakeisha 29F
BN: 7706896177 MRN: 002136082
Date: 07/25/2006 DOB: 12/28/1976
Time: 15:51

INITIAL ASSESSMENT

Date	Time	Previous Patient	Family Present	EMS	LMP	Td	M F	Educational Barriers	EMERGENT 1 / URGENT 2
7/25/06	1550	☐ Yes ☒ No	☐ Yes ☒ No	N/A	6/27/06		F (circled)	☒ No ☐ Yes	URGENT 2 (circled)

GR / Para — Pain 0 1 2 3 4 5 6 7 8 9 10 (7 circled) — NON URGENT 3

Temp	HR	RR	BP	O2 Sat	Mental Status	UTD Ped Immun	Room
36.9	104	18	119/67		☒ nl ☐ abnl	☐ No ☐ Yes Wgt ___ kg	Hall E

PMD Ellen Finkleman — Time Back 1558

CC c/o nausea c diarrhea x 1 hour Also c/o dizziness Denies SOB Also c/o abd. pain (no vomiting)

Meds Albuterol, ~~Advair~~ Advair

PMH (Circle if positive)

Asthma (circled) CAD ~~CHF~~ BOTH COPD CVA DM ESRD Last Dialysis ______
HIV HTN PE/DVT (circled) Pneumonia Psych PUD Sz Sickle Cell
☐ None Surgery: ______ Cancer: ______ Other: ______

PMH

FH:

☐ NKDA ☒ Allergy Band ☒ Allergies: Compazine

Triage RN: [signature] RN

HPI MD Time: 16:50 Initial nsg notes reviewed ☒ Yes ☐ No

Source: ☒ Patient ☐ Family / Friend ☐ EMS ☐ PMD ☐ Records

Unable to obtain data due to:

~~29 yo AAF c 2hrs ago developed nausea, loose stool, lightheadedness 15-20 min after eating. (+) floaters x 1 when walking. (-) vomiting. Didn't look at stool. Ate tuna sandwich from Leavey Center c strawberries. Light-headedness + stomach cramping, nausea continue. HA → frontal, throbbing & more floaters, numbness / tingling of vision. Unknown BRBPR or melena~~

☐ Case d/w resident. Patient interviewed and examined.
☒ Case d/w student. Patient interviewed and examined.

29 yo AA F c Nausea, pt treated c one episode of diarrhea. continues to be nauseous → abd cramping

Severity / Quality / Location / Context / Duration / Timing / Associated Symptoms / Modifying Factors

(margin:) (+) F/C, (-) SOB, (-) CP

Habits: ☒ None ☐ ETOH ☐ Tobacco ☐ Substance SH: ☐ Home/alone ☒ Home/others ☐ Institution ☐ NFA

ROS: Constitutional Eyes ENT CV Resp GI (circled) N GU
All others neg MS Skin Neuro Psych Heme / Lymph Endo All / Imm

House Staff / Student Signature: Rebecca [signature] MS4 — Attending MD Signature: [signature]

TMR 240.010 (3/1/06) (F3F)

Georgetown University Hospital
MedStar Health

EMERGENCY DEPT. MEDICAL RECORD
CLINICAL II

Ellis, Lakeisha
DOB: 12/28/1976 A/S: 29F
MRN: 2136082 ACCT: 7706896177
Reg Date/Time: 07/25/2006 15:51

☐ PE Check if normal, circle if abnormal and specify abnormality.

Pulse Ox on ______ O2 ☐ normal ☐ abnormal
Cardiac Monitor ______

Const	☐ VS	☑ appearance
Eyes	☑ conj / lids	☑ pupils
ENT	☑ ext ear / nose	☑ oropharynx
Resp	☑ resp effort	☑ auscultation
CV	☑ auscultation	☑ leg edema
Abd	☐ mass / tender	☐ liver / spleen
GU - female	☐ external genitalia	☐ cervix / adnexa
male	☐ scrotum	☐ penis / testes
Lymph	☑ neck	☐ other
Neuro	☑ cranial nerves	☑ sensation
Skin	☑ color	☑ temperature
MS	☑ strength	☐ tenderness
Psych	☐ orientation	☐ judgment
	☑ memory	☐ mood
	☑ affect	☐ thought

(handwritten notes, largely illegible: "[illegible] – [illegible] / pt is comfortable –" ; "abd soft non-tender – [illegible] organomegaly [illegible]")

Reviewed procedure risks / benefits / alternatives. Patient consents: ☐ Yes ☐ No

☐ Correct Patient
☐ Correct Procedure
☐ Correct Site
☐ Second Party Verified

TIME	SERIAL NOTES / PROCEDURES / CASE ANALYSIS
	A/P Gastroenteritis

Care Assumed by Dr. ______ at ______ AM / PM

TIME	ORDERS				RN	TIME
	CBC	Chem 7	PT	PTT		
	Cardiac Enzymes		LFT's	Lipase		
	UA-dip	UA-lab	(UHCG)	(–)	[illegible]	[illegible]
	UCx	BldCx	ABG	Type & Screen		
	ECG: ☐ Chest Pain ☐ Palpitations					
	☐ Other:					
	Xray: ______					
	☐ Pain ☐ SOB ☐ Trauma ☐ Vomiting					
	☐ Other:					
5[illegible]	phenergan 25 mg [illegible]				[illegible]	[illegible]
	discharge home				[illegible]	174[illegible]

TIME	ORDERS	RN	TIME

Observation Dr.: ☐ MED TELE
Admit. Dr.: ☐ CARD TELE
Service: ☐ ICU
Diagnosis: ☐ ISOL

House Staff / Student Signature:
Attending MD Signature: [signature]

TMR 240.011D (8/05) (F3F)

ELLIS000063

07/25/2006 1
Reg Date/Time: 07/25/2006 15:51 MRN: 2136082 Acct: 7706896177 **Ellis, Lakeisha**

Georgetown University Hospital
MedStar Health

EMERGENCY DEPT. MEDICAL RECORD
CLINICAL III

Ellis, Lakeisha
DOB: 12/28/1976 A/S: 29F
MRN: 2136082 ACCT: 7706896177
Reg Date/Time: 07/25/2006 15:51

DIAGNOSTIC STUDIES

WBC ____ Na | Cl GLU ____
HCT ____ K | HCO3 BUN ____
PLT ____ CR ____
TN-1 ____ CK-MB ____ UHCG ____
UA

Radiology ☐ EMD Reading

ECG reading by EMD

DATA REVIEWED

- ☐ Old Records:
- ☐ Hx from other:
- ☐ Test d/w performing MD:
- ☐ Reviewed image: XRAY CT US
- ☐ Case d/w: @
- ☐ Case d/w: @
- ☐ Case d/w: @
- ☐ Consults: @
- ☐ Critical care time=30-74 minutes (circle if performed)

DISCHARGE INSTRUCTIONS

Diagnosis: Gastroenteritis

You were seen by Dr. [signature] 202-444-2119
Work related? ☐ Yes ☐ No
____ Days full disability ____ Days light duty

Co-Morbidity:

Follow-up w/ [illegible] your regular MD

- ☐ You should be re-examined in ____ days, call as soon as possible for an appointment.
- ☐ If not improving after ____ days, call for the next available appointment.
- ☐ Additional follow-up ____
- ☐ For a referral to a GUH affiliate physician call Georgetown MD 202-342-2400

GUH Clinics

Clinic	Phone
Internal Medicine Clinic	202-444-8168
Surgical Clinic	202-444-4954
Orthopaedics Clinic	202-444-8766
OB / Gyn Clinic	202-444-8232
Pediatrics Clinic	202-444-5437
Neurology Clinic	202-444-8525

Return to Emergency Department if: vomiting, unable to keep anything down, ↑ fever.

Additional Instructions: you may get imodium AD for diarrhea without a prescription

Prescriptions

		# RX:	# To Go:
1			
2			
3			

Instruction Sheets:

Pending Labs:

I have read, understood and received a copy of my disposition record and discharge instructions: Patient's signature X [signature]

DISPOSITION

Time Out 17[illegible] ☒ Home ☐ Expired ☐ AMA ☐ AWOL ☐ LWBS
☐ Mode of Transportation
☐ Car ☐ Taxi ☐ Bus ☐ Walk ☐ Ambulance
☐ Accompanied ☐ Unaccompanied
☐ Admit Rm ____ Service ____
Dr. ____
☐ Transfer To ____

INITIALS **SIGNATURES**

Condition on Discharge: ☐ Improved / stable ☒ Unchanged / stable

RN Signature [signature] | House Staff / Student Signature | Attending Physician Signature [signature]

Print Date/Time: MR 240.012 (2006) 07/25/2006 15:51

Reg Date/Time: 07/25/2006 15:51 MRN: 2136082 Acct: 7706896177 Ellis, Lakeisha

ELLIS000064

Georgetown University Hospital
MedStar Health

EMERGENCY DEPT. MEDICAL RECORD
CLINICAL IV

Ellis, Lakeisha
DOB: 12/28/1976 A/S: 29F
MRN: 2136082 ACCT: 7706896177
Reg Date/Time: 07/25/2006 15:51

NEUROLOGICAL
Oriented: ☐ No ☐ Yes ☐ Time ☐ Place ☐ Person
Pupil Response:
Size (R) ______ Size (L) ______
Brisk .... ☐ R ______ ☐ L ______
Sluggish .... ☐ R ______ ☐ L ______
No Reaction .... ☐ R ______ ☐ L ______
1 2 3 4 5 6 7 8

RESPIRATORY
Breath Sounds: Other:
☐ Clear .... ☐ R ☐ L ______
☐ Crackles ..... ☐ R ☐ L ______
☐ Decreased .. ☐ R ☐ L ______
☐ Wheezes .... ☐ R ☐ L ______
☐ Absent ...... ☐ R ☐ L ______

CARDIOVASCULAR
Pulse: ☐ Regular ☐ Irregular ☐ Absent ☐ Strong ☐ Weak
Peripheral Pulses: ☐ + ☐ – ☐ N/A
Skin Temp / Moisture / Color:
☐ WNL ☐ Warm ☐ Hot ☐ Cool ☐ Diaphoretic ☐ Dry
Edema: ☐ No ☐ Yes
☐ N/A or ______

GASTROINTESTINAL
Bowel Sounds: ☐ Present ☐ Absent
Voiding Patterns:
☐ Normal ☐ Retention ☐ Incontinent
Abdomen: ☐ Soft ☐ Rigid ☐ Tender ☐ Distended
Other: ______

MUSCULOSKELETAL
Symptoms: ☐ Swelling ☐ Pain ☐ Deformity ☐ Limited ROM
Location: ______
Limb Movement:
Normal Power .... ☐ No ☐ Yes
Weakness .... ☐ No ☐ Yes
No Response .... ☐ No ☐ Yes

INTEGUMENTARY
Integrity:
☐ Intact ☐ Burn ☐ Rash ☐ Decub ☐ Laceration ☐ Abrasion
Location: ______

PSYCHOSOCIAL
☐ Delusions ☐ Hallucinations
☐ Depressed ☐ Agitated
☐ Age Appropriate ☐ Other ______

GLASCOW COMA SCORE

	Score
Eye Openings:	
4 Spontaneous	
3 To Voices	
2 To Pain	
1 None	
Verbal Response:	
5 Oriented	
4 Confused	
3 Inappropriate Words	
2 Inappropriate Sounds	
1 None	
Motor Response:	
6 Obeys Command	
5 Localizes Pain	
4 Withdrawal Pain	
3 Flexion	
2 Extension	
1 None	
TOTAL:	

DISCHARGE NEEDS / EDUCATIONAL NEEDS
Assistance Needed on Discharge .... ☐ No ☐ Yes
Social Worker Needed .... ☐ No ☐ Yes
Family Involved .... ☐ No ☐ Yes
Learns Best By:
☐ Reading ☐ Listening ☐ Demonstration
☐ Other ______

Time	BP	T	P	R	Pain	Pulse Ox	NURSING PROGRESS REPORT
1600	Adm. ED [illegible]						[illegible] following
	[illegible]						
1700	Seen [illegible]. By ED M.D.						
1730	D/C from ED.						[signature]

Georgetown University Hospital

MedStar Health

EMERGENCY DEPT. MEDICAL RECORD

CLINICAL V - B

Ellis, Lakeisha

DOB: 12/28/1976 A/S: 29F

MRN: 2136082 ACCT: 7706896177

Reg Date/Time: 07/25/2006 15:51

MEDICATIONS

TIME	MEDICATION	DOSE	RT	SITE	INIT.	TIME	RESPONSE / EVALUATION	INIT.

INTRAVENOUS SOLUTIONS

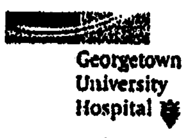
TIME	BAG #	SITE / GAUGE	SOLUTION	ADDITIVES	RATE	AMOUNT UP	AMOUNT IN	TOTAL IN	INIT.
							TOTAL IV ⇨		

INTAKE				OUTPUT				SIGNATURES	
TIME	PO	TUBE		TIME	URINE	NGT		SIGNATURES	INIT.
								[signature]	[initials]
TOTALS				TOTALS					
		TOTAL INPUT ⇨				TOTAL OUTPUT ⇨			

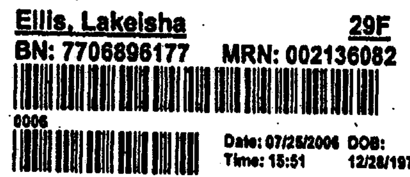
TMR 240.015 07/25/2006 15:52

Reg Date/Time: 07/25/2006 15:51 MRN: 2136082 Acct: 7706896177 Ellis, Lakeisha

ELLIS000066



Consent to Emergency Treatment



I am presenting myself for diagnosis and treatment in the Emergency Department of Georgetown University Hospital and voluntarily consent to such care, including but not limited to:

1. Diagnostic procedures, physical and mental examination, surgical and medical procedures, medication, blood transfusions, laboratory testing including the drawing and testing for HIV (the virus that causes AIDS) and other blood born diseases, and hospitalization (collectively, "Treatments"), by authorized members of the hospital staff or their designees, as may in their professional judgement be necessary.

2. I understand that I have the right to make informed decisions regarding all care and Treatments, and that it's my responsibility to ask my health care professionals to further clarify or explain anything I do not understand. This right includes the right to refuse any Treatments that I do not want.

3. I release the Hospital from any responsibility for valuables, money, personal or other posessions which are properly deposited by me with the Hospital depository and that in any event, the Hospital's maximum liability shall be $500.00

4. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarentees have been made to me regarding the results of any examination or Treatment.

5. I acknowledge that this form has been explained to me, and I certify that I understand it's contents.

X ____________________
Signature of Patient or Responsible Party (and relationship to patient)

____________________ 7/25/06
Witness Date

Revised August 2005

Ellis, Lakeisha

DOB: 12/28/1976 A/S: 29F
MRN: 2136082 ACCT: 7706896177
Att. MD: Morrell, Todd Room:
Reg Date/Time: 07/25/2006 15:51

Georgetown University Hospital Emergency Department
Patient Chargeables Sheet

LEVEL OF NURSING CARE

	Code	Item
____	41000233	FOLLOW-UP VISIT LVL1
____	41000241	MINOR EM VISIT LVL2
✓	41000258	MINOR EM VISIT LVL3
____	41000266	REG EM VISIT LVL 4
____	41000274	EXT EM VISIT LVL 5
____	41000282	CRIT EM VISIT LVL 6
____	41001110	LEFT; NOT SEEN
____	41001111	TRIAGED; NOT SEEN BY PHYSICIAN

PROCEDURES AND SUPPLIES

EENT

	Code	Item
____	41000829	CHEMICAL CAUTERY TISSUE
____	41000597	EAR IRRIGATION
____	41000720	NASAL PKG ANTERIOR
____	41000738	NASAL PKG POSTERIOR
____	41000183	MORGAN LENS

GU/GYN

	Code	Item
____	41000944	CATH INSERTION, FOLEY
____	41000563	DELIVERY CHARGE
____	41000332	FEMALE CATH KIT
____	41000340	INFANT CATH KIT

INJECTIONS

	Code	Item
____	41001009	INJ SUB Q/IM
____	41001017	IV PUSH NON CHEMO,PRIMARY/1ST
____	41001112	IV PUSH NON CHEMO,NON-PRI/ADDL

IV

	Code	Item
____	41000506	A-LINE INSERTION
____	41000530	CUT DOWN
____	41000548	CVP LINE INSERTION
____	41000290	LEVEL ONE TUBING
____	41000423	PIC LINE

ORTHOPEDIC

	Code	Item
____	41000639	ARTHROCENTESIS
____	41000571	DISLOCATION REDUCT SIMPLE
____	41000589	DISLOCATION REDUCT COMPL
____	41000852	FRACTURE SIMPLE
____	41000860	FRACTURE INTERMEDIATE
____	41000878	FRACTURE COMPLEX
____	41000886	SPRAIN SIMPLE
____	41000894	SPRAIN INTERMEDIATE
____	41000902	SPRAIN COMPLEX
____	41000175	AIR CAST-PNEU ANKLE

PROCEDURES AND SUPPLIES CONT

TRAUMA

	Code	Item
____	41000522	CHEST TUBE INSERTION
____	41000779	PARACENTESIS/LAVAGE
____	41000795	THORACENTESIS
____	41000993	VENTRICULOSTOMY

WOUND

	Code	Item
____	41000514	BURN CARE
____	41000837	DEBRIDEMENT SKIN
____	41000845	DEBRIDEMENT SKIN & MUSCLE
____	41000803	I&D HEMATOMA
____	41000670	INCISION & DRAINAGE
____	41000704	LACERATION REPAIR SIMPLE
____	41000696	LACERATION REPAIR INTERM
____	41000688	LACERATION REPAIR COMP
____	41000811	REPAIR/REMOVE NAILPLATE
____	41000985	WOUND CLOSURE BY ADHESIVE
____	41000464	DERMABOND

CARDIAC

	Code	Item
____	41000753	PACING EXTERNAL
____	41000761	PACING INTERNAL

GI/ENDO

	Code	Item
____	41000936	ANOSCOPY DIAGNOSTIC
____	41000910	DIAGNOSTIC LARYNGOSCOPY
____	41000928	GI ENDOSCOPY PROCEDURES
____	41000654	GTUBE CHANGE
____	41000746	NG TUBE PLACEMENT
____	41000662	TRACH TUBE CHANGE

RESPIRATORY

	Code	Item
____	41000969	CRICOTHYROIDOTOMY
____	41000605	ENDOTRACHEAL INTUBATION
____	41000324	END TIDAL CO2 FILTER
____	41000316	END TIDAL CO2 NAS. C
____	41000373	SPACER, MDJ
____	41000415	NEUBULIZER
____	41000431	OXIMETER SET UP
____	41000449	PEAK FLOW METER

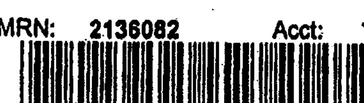
MISCELLANEOUS

	Code	Item
____	41000498	BLOOD TRANSFUSION
____	41000647	FOREIGN BODY REMOVAL
____	41000712	LUMBAR PUNCTURE
____	41000308	BEAR HUGGER BLANKETS
____	41001082	PERITONEAL DIALYSIS SUPPLY
____	41000951	CATH INSERTION, STRAIGHT

Hospital Encounter Form 2-06

Print Date/Time: 07/25/2006 15:52
Reg Date/Time: 07/25/2006 15:51 MRN: 2136082 Acct: 7706896177 **Ellis, Lakeisha**

ELLIS000068



Ellis, Lakeisha

Georgetown University Hospital
MedStar Health

ED Out-Processing Patient Information Form

DOB: 12/28/1976 A/S: 29F
MRN: 2136082 ACCT: 7706896177
Att. MD: Morrell, Todd Room:
Reg Date/Time: 07/25/2006 15:51

[ ] ED Co-payment Required [ ] $ Amount Due

The ED Unit Secretary will add the appropriate data to this form when a patient is discharged and place it in the pick up box at the Unit Secretary workstation counter.

	Date	Time			
Arrival:	7/25/06	1550	AM/PM	Triage Code:	2
Triage:		1551	AM/PM	Mode of Arrival:	3
Patient in Room:		1558	AM/PM	Ambulance Run Number:	
Doctor in Room:		1650	AM/PM	Discharge Disposition:	AHR
Admission Order:			AM/PM	Transferred to OR?	Y N (circle one)
Discharge Order:		1740	AM/PM	ER Doctor Number:	235283
Departure to Floor/Home		1740	AM/PM	ER Doctor Name:	Sauter

NOTE TO UNIT SECRETARY: When placing the Admissions Reservation Request please include the "Mode of Arrival".

Chart Completion:

___ Physician chart and billing sheet *complete*, OK to process
initial here

___ Physician chart and billing sheet *incomplete*, OK to process
initial here

[x] RN chart completed ______________
RN's Signature

Patient Access PFA will check the Unit Secretary workstation every 30 minutes and retrieve the ED Out-processing form. This is the responsibility of the PFA, not the Unit Secretary.

UB92 Screen: Prior hospital stay information entered into SMS (Inpatient Only) YES or NO

Out-processed by: ______________ (PFA Name) Time: ________ Date: ________

Patient Access, Emergency Department
Revised: 4/12/06

Print Date/Time: 07/25/2006 15:51
Reg Date/Time: 07/25/2006 15:51 MRN: 2136082 Acct: 7706896177

Ellis, Lakeisha

EXHIBIT 18

0001
1 UNITED STATES DISTRICT COURT
2 FOR THE DISTRICT OF COLUMBIA
3 ---------------------------:
4 LAKEISHA ELLIS, : Case No:
5 Plaintiff : 1:08-cv-01174-JDB
6 v. : Judge John D. Bates
7 GEORGETOWN UNIVERSITY :
8 HOSPITAL, :
9 Defendant :
10 ---------------------------:
11 Hyattsville, Maryland
12 Tuesday, February 3rd, 2009
13 Deposition of:
14 ELLEN FINKELMAN, M.D.
15 called for oral examination by counsel for Plaintiff,
16 pursuant to notice at 6525 Belcrest Road, Hyattsville,
17 Maryland 20782 before Dawn M. Hyde of Capital Reporting
18 Company, a Notary Public in and for Howard County,
19 beginning at 9:15 a.m., when were present on behalf of
20 the respective parties:
21
22
0002
1 A P P E A R A N C E S
2 On behalf of Plaintiff:
DENISE M. CLARK, ESQ.
3 COURTNEY L. LEYES, ESQ.
Law Office of Denise M. Clark
4 1250 Connecticut Avenue, NW
Suite 200
5 Washington, DC 20036
(202) 293 0015
6 dmclark@benefitcounsel.com
7
8 On behalf of Defendant:
TRINA L. FAIRLEY, ESQ.
9 CHRISTOPHER CALSYN, ESQ.
Crowell Moring
10 1001 Pennsylvania Avenue NW
Washington DC 20004-2595
11 (202) 624 2830
tfairley@crowell.com
12
13
14
15
16
17
18
19
20
21
22
0003
1 C O N T E N T S

2 EXAMINATION BY: PAGE
3 Counsel for Plaintiff 4, 37
4 Counsel for Defendant 29, 41
5 EXHIBIT DESCRIPTION
6 1 Office visit 7/26/06 28
7 2 Progress Notes 7/26/06 28
8 3 Medication, documentation 7/26/06 28

20 Q Do you know Lakeisha Ellis?
21 A I did when I was treating her.
22 Q And when did you begin treating Ms. Ellis?
0009
1 A I only saw her for a few times. Let me just
2 see if I can find my first encounter that I ever saw
3 her. 2/15/2005 was I think the first time I met her.
4 She had been cared for by my colleagues up until then.
5 Q Your colleagues, meaning?
6 A Meaning other physicians in Kaiser Permanente
7 including primary care physicians, pulmonary
8 specialists, and at one point I think she was in the
9 hospital and was cared for by hospitalists. But my
10 first encounter with her is 2/15/2005.
11 Q And you just mentioned that she was
12 hospitalized.
13 A Yes.
14 Q What year was that?
15 A 2003.
16 Q And was that in any way related to her
17 asthma?
18 A No.
19 Q So your first encounter with Ms. Ellis was
20 2/15/2005.
21 A Right.
22 Q And why did she see you on that particular
0010
1 date?
2 A Cough, congestion and a history of asthma.
3 Q So you were not the first person to diagnose
4 her asthma?
5 A No.
6 Q Do your records in any way reflect who was?
7 A She came to Kaiser stating that she had a
8 history of asthma. The first record I have is
9 9/11/2002. It's a referral to pulmonary medicine for
10 pulmonary function testing and it says it's a
11 community-based PCP, that means a community-based
12 doctor wants testing of her pulmonary function because
13 the diagnosis is stated as asthma.
14 Q Is the physician's name referenced at all in
15 the referral that you see?
16 A Dr. El Bayoume, who is a doctor at GW. She's
17 a -- I know her. She's a primary care physician at GW.
18 And that's in 2002.
19 Q Regarding your treatment of Ms. Ellis, when
20 you saw her she was referred for a cough, congestion
21 and asthma?
22 A Right.
0011
1 Q And can you tell us on that particular date
2 what her ailments were?
3 A She basically had flu symptoms with an
4 overlay of asthma is what I wrote though her chest was
5 clear. So she wasn't actively wheezing and I did
6 either add her medicine or just renew her medicine.
7 It's not clear to me from this note.
8 Q And what was she taking at that time?
9 A It looks like she was taking Advair, which is
10 a bronchodilator medicine that you puff in and out to
11 help open up your airways.
12 I added Robitussin with codeine, that's a
13 mucolytic, something to loosen up your secretions.

14 Codeine is a cough suppressant, and I gave her a Z-Pak,
15 which is antibiotics, for ten days.
16 Q What was her dosage of Advair?
17 A From all the notes I can see, it's 250.
18 Q 250 milligrams?
19 A It's probably milligrams.
20 Q Do your notes reflect whether that was an
21 increase or just a continuation?
22 A I think it was just a continuation.
0012
1 Q When did you next see Ms. Ellis?
2 A I didn't see her but she was seen 5/25/05 for
3 knee pain and her -- if you want to know, her active
4 medicines at that time were both albuterol and an
5 Advair discus which says 550 but I don't -- without my
6 records I can't tell you if that was her normal dosage
7 or whether it had been increased by someone. I don't
8 know.
9 Q So it was 500 milligrams she was taking
10 orally?
11 A No, no, no. It's an inhaler.
12 Q Inhaler, I'm sorry. And the albuterol?
13 A It says two sprays four times daily as
14 needed. Okay. It says Advair -- member requests a
15 refill of Naprosyn and Advair but it was decreased to
16 250. States she was told that here PCP would decrease
17 Advair back to usual 250 after previous asthma attack.
18 Q Do the records reflect when the asthma attack
19 took place?
20 A No. I have the 2/15 visit and the 5/24 visit
21 and I don't have anything in between.
22 Q That is May 24th, not May 25th?
0013
1 A May 24th, 2005.
2 Q In your opinion, the addition of albuterol,
3 is that reflective of any additional problems
4 concerning asthma?
5 A No. We usually give it as a rescue medicine.
6 Meaning that the Advair is her baseline medicine in the
7 hopes that it will control and prevent asthma attacks,
8 and the albuterol is used for rescue if you feel that
9 you are getting more short of breath.
10 Q And you said that the Advair reflected 500
11 milligrams but there were notes that her --
12 A That her usual maintenance dose is 250.
13 Q And did I hear you correctly, the notes may
14 have reflected some anticipation that she would go back
15 to the 250?
16 A Yes. Actually, here she has both 250 and 500
17 on her record. I don't have -- I didn't see her then
18 so I can't tell you what exactly she was told. But I
19 would assume that she's supposed to be on the 250 at
20 that time as a maintenance dose.
21 Q Does your record reflect the physician who
22 may have prescribed the 500?
0014
1 A I would have to go back -- I couldn't copy
2 that out. Our system doesn't allow us to copy the
3 medications. It's available for me to see but I can't
4 print it. That's the one problem with this system. I
5 can't print the meds.
6 Q Is that a difficult task? Is that something
7 that you could do --

8 A I can't do it.
9 Q For you to see, not to print.
10 A I can see it. I just can't print it.
11 Q Is that something you could see here?
12 A I'd have to go back to my office and go into
13 her records and I could handwrite, you know, when she
14 got a prescription and what the dose was. I literally
15 can't print them out.
16 Q Okay.
17 A And our records do indicate when something
18 was prescribed, whether the patient picked it up or
19 not, how many refills they managed to pick up, you
20 know, so we do have all that data. I just can't -- the
21 system doesn't permit me to print it out. So it's -- I
22 don't know how to get it except to look at it and
0015
1 hand-do it. There's no printing function on that page.
2 MS. CLARK: Can we go off the record for a
3 second.
4 (Discussion off the record.)
5 BY MS. CLARK:
6 Q So in your records, when did you next see
7 Ms. Ellis?
8 A 7/26/2006.
9 Q And can you tell me about that treatment.
10 A She had 24 hours of stomachache, diarrhea,
11 nausea. She was seen at the Georgetown University
12 emergency room and diagnosed with gastroenteritis. No
13 history of problems in the past. Was not in severe
14 pain.
15 She had a history of asthma and I wrote down
16 it is not flaring. She told me she worked in the
17 emergency room at Georgetown. She blamed the food in
18 their cafeteria. I tell people you can never blame the
19 last meal for your illness.
20 And she had very mild tenderness in her upper
21 abdomen. And when I reviewed her labs the next -- that
22 evening, I told her they showed mild pancreatitis,
0016
1 which is an inflammation of the pancreas.
2 I told her to stay off work for five days,
3 clear fluids until her bowels became back to normal and
4 I rewrote her Advair for 250 and gave her albuterol.
5 Her chest was clear at the time. There were no wheezes
6 or rales which would indicate any flare of her asthma.
7 Q Now, did you make a recommendation regarding
8 her return to work in the ER?
9 A Yes, I have -- I said -- I have a copy of her
10 letter and I said, "Lakeisha Ellis should not work in
11 the emergency department as this is too high an
12 exposure to many sick patients and puts her at risk for
13 her own health."
14 Q And you reached this conclusion based on your
15 treatment of her on July 26th, 2006?
16 A Yes. And I would not have written this kind
17 of letter if she had not requested it of me. And we
18 discussed the fact that she was exposed to a lot of
19 people coming in who were sick.
20 Q Did you discuss with her whether these
21 illnesses that she was exposed to could possibly flare
22 up her asthma?
0017
1 MS. FAIRLEY: Objection; calls for

2 speculation.
3 A Okay. I know I would not write a letter like
4 that unless I was requested to do so.
5 BY MS. CLARK:
6 Q So you wrote this based on a request, not
7 because of any conclusions that you reached about --
8 A Right. I think I forgot to redo the first
9 line which says, "The above-named patient has asthma."
10 Q What does that mean?
11 A Which means that I was associating the two.
12 Okay. That I didn't want to say specifically that
13 being exposed to people is going to flare her asthma
14 but I had to put down what health issue we were talking
15 about. So that would mean, you know, that she has
16 asthma and she was telling me, as far as I recall,
17 that, you know, she felt her asthma would flare every
18 time she got ill.
19 "The above-named patient has asthma." And
20 this is too high an exposure, puts her at risk to her
21 own health. I try to make my letters as very vague and
22 as general as I can so that -- and she told me there
0018
1 were other -- I remember she told me there were over
2 opportunities in the hospital. I mean, I wasn't trying
3 to put her out of work at all. We were just
4 discussing, you know, what situation in the hospital
5 would be appropriate.
6 I wrote her two other letters the same day
7 right on top of one another. This one you see is at
8 4:55, then I have one at 4:57 and 4:59. Same day. So
9 these are much more vague. "The above-named patient
10 has received medical treatment on 7/26 and may return
11 to work." That didn't make sense.
12 Then I think I wrote -- this one didn't make
13 sense. If you read this letter, she can return to work
14 before she even got sick. So then two minutes later I
15 wrote, "The above-named patient has received medical
16 treatment on 7/26 and 7/25 and she can return to work
17 7/31."
18 So she had a choice. She could give this
19 letter in or she could give this letter in. They were
20 all written on the same day.
21 MS. FAIRLEY: So that the record is clear,
22 you have referred to several documents. I would like
0019
1 to mark them so that when we're reading the deposition
2 transcript, we'll know.
3 A They have -- thank goodness they have time
4 stamps on them.
5 BY MS. CLARK:
6 Q These were not part of the records that were
7 turned over to us by Kaiser, so why would that be?
8 A I don't know. I am not the one who copies
9 records.
10 Q Well, where would those be copied?
11 A They're in the letter section of our record.
12 MS. CLARK: Okay. I would object to these
13 being attached unless they come per the custodian and I
14 understand it's in her possession, I understand she
15 brought them here.
16 MS. FAIRLEY: And she's also testifying
17 directly from them.
18 MS. CLARK: I understand that.

18 as general as possible without violating any HIPAA
19 rules.
20 Q So then on 7/26/06 you wrote three letters
21 for Ms. Ellis, correct?
22 A Yes.
0031
1 Q And is it your recollection that you wrote
2 three letters so that she could choose from which
3 letters she'd like to present to her employer?
4 A More likely -- I looked at the date, the
5 times, so more likely -- usually I write a general
6 letter, the patient's been seen. Then they come back
7 to me and say, "Well, I need you to say more." And so
8 usually my second letter is more detailed. Because
9 they saw that my first letter was just the patient has
10 been seen and sometimes I write, you know, and she's
11 medically excused and can go back to work.
12 So she must have -- but I am really -- this
13 is supposition. She must have said, "I need a letter
14 that says I can't work in the emergency room." And
15 then she must have said, "Well, now I need a letter
16 saying how many days off I need." I'm supposing
17 because this is two years ago. And the middle letter
18 was a mistaken letter.
19 Q Well, let's look at --
20 A I am supposing. They were written two
21 minutes apart so, you know, she must have been -- I
22 must have handed it to them and she must have said,
0032
1 "No, that's not what I need." So I wrote a different
2 letter.
3 Q So then if we look at Exhibit Nos. 4, 5
4 and 6, are Exhibit Nos. 4, 5 and 6 the three letters
5 that you have just been referring to?
6 A Yes, but they're in opposite order from what
7 I wrote. First I wrote 6, then I wrote 5 and then I
8 wrote 4, from the time stamps on them.
9 Q I see. Let's focus on Exhibit No. 6 for a
10 minute, which is the letter that states that Ms. Ellis,
11 "Should not work in the emergency department as this is
12 too high an exposure to many sick patients and puts her
13 at risk for her own health."
14 A And it starts off with, "She has asthma,"
15 right?
16 Q Yes. Looking at that letter now, you
17 indicated that you wouldn't have written this letter
18 unless Ms. Ellis requested it, correct?
19 A Yes.
20 Q And so then would it be fair to say,
21 Dr. Finkelman, that you didn't reach a medical
22 conclusion that Ms. Ellis could not work in the
0033
1 emergency department; is that correct?
2 A Well, we probably, you know, knowing who I
3 am, I have been 30 years in the business, I am very
4 compliant with my patients. I don't like to argue with
5 them and I really like to make their lives easy.
6 So I probably agreed with her that she said I
7 have asthma, I am exposed to lots of sick patients and
8 I really don't want to keep working in the emergency
9 room. And I am pretty sure I wasn't trying to make her
10 quit work. I never make my patients quit work and I
11 always talk to them about their options.

12 And so as I recall -- and, granted, it's two
13 years ago -- we probably discussed the fact that the
14 emergency room had a high number of very sick patients
15 and that other places in the hospital would be better
16 situations for her.
17 And though I didn't write it, you know, that
18 she should be accommodated and placed in another area
19 of the hospital, I am pretty sure I had somewhat of
20 that discussion with her rather than -- because I would
21 never tell anybody quit your job, you know, even my
22 housekeeping patients who get terrible backaches and
0034
1 carpal tunnel, you know. I talk to them about this job
2 is not good for you, let's think about options.
3 I never write a letter saying stop working,
4 quit your job, it's bad for your health. So that's --
5 I'm sure my intent, even though it's written there, was
6 talk to them about getting out of the emergency room
7 and working somewhere else in the hospital where you're
8 not constantly, you know, exposed to hundreds of sick
9 people.
10 Q Sure. But you didn't -- you didn't run any
11 tests or reach any medical conclusion that Ms. Ellis
12 couldn't work in the emergency room; is that correct?
13 A Right. And that visit she wasn't seeing me
14 for asthma. She was seeing me for her pancreatitis.
15 Q Why did you conclude that Ms. Ellis needed to
16 be off work for five days?
17 A Because of her pancreatitis. She needed to
18 stay home, rest her stomach, drink clear liquids, go to
19 the bathroom a gazillion times a day. You can't work
20 when you're doing that.
21 Q So it wasn't related to the asthma?
22 A Not that I can see from my notes. And, you
0035
1 know, I see 20 patients a day. It's hard to remember
2 people that I saw two years ago and I only saw her one
3 more time so...
4 Q What causes pancreatitis?
5 A Gallstones, alcohol and idiosyncratic --
6 idiopathic. We don't know.
7 MS. FAIRLEY: If I could just take a moment
8 to confer with my colleague, I'll be very close to
9 being finished.
10 (Recess taken from 10:08 a.m. until
11 10:13 a.m.)
12 BY MS. FAIRLEY:
13 Q Just a couple more questions. We're really
14 almost finished.
15 Dr. Finkelman, you talked to us about the
16 various potential causes of pancreatitis. My question
17 is did you reach any conclusions in this case about the
18 cause of Ms. Ellis's pancreatitis?
19 A Let me just see. No, I didn't.
20 Q If we could have these documents marked as, I
21 guess, Exhibit Nos. 7 and 8.
22 (Finkelman Deposition Exhibit Nos. 7
0036
1 and 8 were marked for identification.)
2 BY MS. FAIRLEY:
3 Q If I may, I would like to show you what the
4 court reporter's just marked as Exhibit No. 7 which is
5 one of the three letters that you wrote. Can you

EXHIBIT 19

STEDMAN'S Medical Dictionary

26th Edition

ILLUSTRATED IN **COLOR**

Williams & Wilkins
Baltimore • Philadelphia • Hong Kong
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gas·tro·blen·nor·rhea (gas′trō-blen-ō-rē′ă). Excessive proliferation of mucus by the stomach. [gastro- + blennorrhea]

gas·tro·car·di·ac (gas′trō-kar′dē-ak). Relating to both the stomach and the heart.

gas·tro·cele (gas′trō-sēl). Hernia of a portion of the stomach. [gastro- + G. *kēlē,* hernia]

gas·tro·chron·or·rhea (gas′trō-kron-ō-rē′ă). Excessive continuous gastric secretion. [gastro- + G. *chronos,* time (chronic), + *rhoia,* a flow]

gas·troc·ne·mi·us (gas-trok-nē′mē-ŭs). SYN gastrocnemius *muscle.* [G. *gastroknēmia,* calf of the leg, fr. *gaster* (*gastr-*), belly, + *knēmē,* leg]

gas·tro·co·lic (gas′trō-kol′ik). Relating to the stomach and the colon.

gas·tro·co·li·tis (gas′trō-kō-lī′tis). Inflammation of both stomach and colon.

gas·tro·co·lop·to·sis (gas′trō-kō-lō-tō′sis). Displacement downward of stomach and colon. [gastro- + G. *kōlon,* colon, + *ptōsis,* a falling]

gas·tro·co·los·to·my (gas′trō-kō-los′tō-mē). Establishment of a communication between stomach and colon. [gastro- + G. *kōlon,* colon, + *stoma,* mouth]

gas·tro·cys·to·plas·ty (gas′trō-sis′tō-plas-tē). Augmentation of the bladder by a patch or piece of vascularized gastric tissue.

gas·tro·di·al·y·sis (gas′trō-dī-al′i-sis). Dialysis across the mucous membrane of the stomach.

Gas·tro·dis·coi·des hom·i·nis (gas′trō-dis-koy′dēz hom′i-nis). A species of trematode sometimes found in the intestinal canal of man in India, Southeast Asia, and China; its normal host is the pig. SYN *Gastrodiscus hominis.* [gastro- + G. *diskos,* disk; L. *homo,* gen. *hominis,* man]

Gas·tro·dis·cus hom·i·nis (gas-trō-dis′kŭs). SYN *Gastrodiscoides hominis.*

gas·tro·du·o·de·nal (gas′trō-dū′ō-dē′năl, -du-od′ĕ-nal). Relating to the stomach and duodenum.

gas·tro·du·o·de·ni·tis (gas′trō-dū-ō-dē-nī′tis). Inflammation of both stomach and duodenum.

gas·tro·du·o·de·nos·co·py (gas′trō-dū-ō-dĕ-nos′kŏ-pē). Visualization of the interior of the stomach and duodenum by a gastroscope. [gastro- + duodenum, + G. *skopeō,* to view]

gas·tro·du·o·de·nos·to·my (gas′trō-dū-ō-dĕ-nos′tō-mē). Establishment of a communication between the stomach and the duodenum. [gastro- + duodenum + G. *stoma,* mouth]

gas·tro·dyn·ia (gas-trō-din′ē-ă). SYN stomach *ache.* [gastro- + G. *odynē,* pain]

gas·tro·en·ter·ic (gas′trō-en-ter′ik). SYN gastrointestinal.

gas·tro·en·ter·i·tis (gas′trō-en-ter-ī′tis). Inflammation of the mucous membrane of both stomach and intestine. SYN enterogastritis. [gastro- + G. *enteron,* intestine, + *-itis,* inflammation]

acute infectious nonbacterial g., SYN epidemic nonbacterial g.

endemic nonbacterial infantile g., an endemic viral g. of young children (6 months to 12 years) that is especially widespread during winter, caused by strains of rotavirus; the incubation period is 2 to 4 days, with symptoms lasting 3 to 5 days, including abdominal pain, diarrhea, fever, and vomiting. SYN infantile g.

eosinophilic g., gastroenteritis with abdominal pain, malabsorption, often obstructive symptoms, associated with peripheral eosinophilia and areas of eosinophilic infiltration of the stomach, small intestine and/or colon with eosinophiles. May be an allergic etiology and responds to elimination diet in some patients; corticosteroid therapy is also effective. SYN eosinophilic gastritis.

epidemic nonbacterial g., an epidemic, highly communicable but rather mild disease of sudden onset, caused by the epidemic gastroenteritis virus (especially Norwalk agent), with an incubation period of 16 to 48 hours and a duration of 1 to 2 days, which affects all age groups; infection is associated with some fever, abdominal cramps, nausea, vomiting, diarrhea, and headache, one or another of which may be predominant. SYN acute infectious nonbacterial g.

infantile g., SYN endemic nonbacterial infantile g.

porcine transmissible g., SYN transmissible g. of swine.

transmissible g. of swine (TGE), a rapidly spreading dis[...] swine, caused by a coronavirus (of the family Coronavirid[...] characterized by severe diarrhea and vomiting; case fata[...] in pigs younger than 10 days is high; in older pigs it is [...] porcine transmissible g.

viral g., SEE endemic nonbacterial infantile g., epidemi[...]terial g.

gas·tro·en·ter·o·a·nas·to·mo·sis (gas′trō-en-ter-ō-an[...]sis). SYN gastroenterostomy.

gas·tro·en·ter·o·co·li·tis (gas′trō-en′ter-ō-kō-lī′tis). In[...]tory disease involving the stomach and intestines. [gas[...] *enteron,* intestine, + *kōlon,* colon, + *-itis,* inflammation[...]

gas·tro·en·ter·o·co·los·to·my (gas′trō-en-ter-ō-kō-lo[...]) Formation of direct communication between the stomach [...] large and small intestines. [gastro- + G. *enteron,* in[...] *kōlon,* colon + *stoma,* mouth]

gas·tro·en·ter·ol·o·gist (gas′trō-en-ter-ol′ō-jist). A sp[...] gastroenterology.

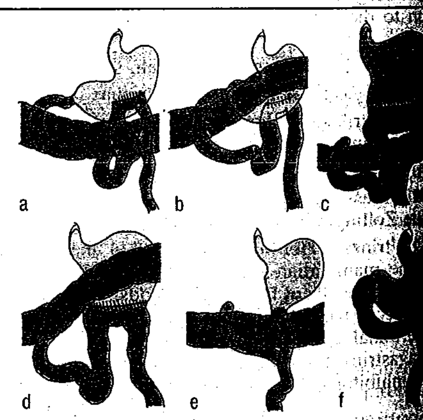
gas·tro·en·ter·ol·o·gy (gas′trō-en-ter-ol′ō-jē). The med[...]cialty concerned with the function and disorders of the [...]testinal tract, including stomach, intestines, and asso[...]gans. [gastro- + G. *enteron,* intestine, + *logos,* study]

gas·tro·en·ter·op·a·thy (gas′trō-en-ter-op′ă-thē). Any [...] of the alimentary canal. [gastro- + G. *enteron,* intestine [...]*thos,* suffering]

gas·tro·en·ter·o·plas·ty (gas′trō-en-ter-ō-plas′tē). O[...]pair of defects in the stomach and intestine. [gastro[...]*teron,* intestine, + *plassō,* to form]

gas·tro·en·ter·op·to·sis (gas′trō-en-ter-ō-tō′sis). [...] displacement of the stomach and a portion of the [...] [gastro- + G. *enteron,* intestine, + *ptōsis,* a falling]

gas·tro·en·ter·os·to·my (gas′trō-en-ter-os′tō-mē). [...]ment of a new opening between the stomach and the [...] either anterior or posterior to the transverse colon. SY[...]teroanastomosis. [gastro- + G. *enteron,* intestine [...] mouth]



gastroenterostomy

a: frontal gastroenterostomy (anterior to the colon) with [...]mosis; b: rear gastroenterostomy (posterior to the colon) [...] anastomosis (with Kroenlein's modification); d: Billroth II [...] (with Reichel-Polya modification: retrocolic gastrojejuno[...] e: Billroth II anastomosis (with Roux modification (Y)) [...] pyloroplasty (or gastroduodenostomy)

gas·tro·en·ter·ot·o·my (gas′trō-en-ter-ot′ō-mē)[...] both stomach and intestine. [gastro- + G. *entero*[...] *tomē,* incision]

gas·tro·ep·i·plo·ic (gas′trō-ep′i-plō′ik). Relating [...] and the greater omentum (epiploon).

gas·tro·e·soph·a·ge·al (gas′trō-ē-sof′ă-jē′ăl). R[...]