IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

LINDA LOCKETTE, etc.,

Plaintiff,

-vs-

JUDGE McCAFFERTY
CASE NO. 500191

GRACE HOSPITAL, et al.,

Defendants.

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Videoconference deposition of AARON CHEVINSKY, M.D., taken as if upon cross-examination before Juliana M. Lawson, a Notary Public within and for the State of Ohio, at the offices of Reminger & Reminger, 1400 Midland Building, 101 Prospect Avenue, West, Cleveland, Ohio, at 3:45 p.m. on Thursday, February 12, 2004, pursuant to notice and/or stipulations of counsel, on behalf of the Defendants in this cause.

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MEHLER & HAGESTROM
Court Reporters

CLEVELAND
1750 Midland Building
Cleveland, Ohio 44115
216.621.4984
FAX 621.0050
800.822.0650

AKRON
1015 Key Building
Akron, Ohio 44308
330.535.7300
FAX 535.0050
800.562.7100

APPEARANCES:

Ronald A. Margolis, Esq.
Daniel M. Finelli, Esq. (Via Telephone)
Finelli & Margolis
730 Leader Building
526 Superior Avenue
Cleveland, Ohio 44114
(216) 621-2222,

On behalf of the Plaintiff;

David Krause, Esq.
Reminger & Reminger
1400 Midland Building
101 Prospect Avenue, West
Cleveland, Ohio 44115
(216) 687-1311,

On behalf of the Defendants.

AARON CHEVINSKY, M.D., of lawful age, called by the Defendants for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF AARON CHEVINSKY, M.D.

BY MR. KRAUSE:

Q. Doctor, my name is David Krause. Could you please just for the record state and spell your last name.

A. Aaron H. Chevinsky. C-H-E-V-I-N-S-K-Y.

Q. And, Doctor, you are located at a teleconference site in New Jersey?

A. That's correct.

Q. And is that where you practice medicine, in New Jersey?

A. That is correct

Q. How much do you charge to review the case as an expert, Doctor?

A. I charge $200 per hour for review of documents. $400 an hour for deposition testimony.

Q. How about trial testimony?

A. $5,000 per day.

Q. Are you scheduled to testify at trial next week

in this case?
A. That's what I've been told.
Q. Have you received your $5,000 payment?
A. I have.
Q. Are you just coming in for one day or two?
A. I'm coming in the night before and then staying over until the next day.
Q. How does that work out? Do you just take the $5,000 or do you charge extra for the overnight?
A. Well, I charge for my time. So if there is any conferences or anything that is happening the night before, I usually charge a fee for that as well.
Q. What is the fee? Is that an hourly fee?
A. It's either an hourly fee or out of town it's usually half a day.
Q. Half a day?
A. That would be 3,500.
Q. 3,500 is half a day?
A. Yes.
Q. So for your testimony, not including the review, just the trial testimony, the cost will be about $8,500?
A. That's correct.
MR. MARGOLIS: Objection. That's

not what he testified to.

Q. Well, Doctor, Mr. Margolis has objected and said that is not what you testified to. Am I correct that the fees that you charge for your trial testimony will be $8,500? You tell me. I don't know.

A. The fee for the day of trial is $5,000. For the trip out of town and the pretrial preparation is 3,500.

Q. Okay. Have you been paid the 3,500 as well?

A. No, sir.

Q. Have you ever been identified by -- as an expert -- let me start over.

Have you ever been identified as an expert on behalf of a defendant in a medical malpractice case in the State of Ohio?

A. No, I have not.

Q. How long have you been doing review of medical malpractice cases, Doctor?

A. I've reviewed cases for the past 14 years.

Q. And let's say in the last five, what is the breakdown of cases that you serve as an expert for defendant versus plaintiff?

A. It's approximately 80 percent plaintiff, 20 percent defendant.

Q. Did you serve as an expert on the behalf of a defendant in any state in a medical malpractice case last year?
A. Yes, sir.
Q. And what state?
A. New Jersey.
Q. When is the last time you've come to Cleveland to testify in a trial on behalf of a plaintiff?
A. I was out sometime late in 2003. I'm not absolutely sure. October, November, something like that.
Q. And you had two trials out here in Cleveland in November 2003, right?
A. If it's November, yeah. I was there twice.
Q. I understand. You were out here twice at the end of the fall in 2003?
A. That's correct.
Q. And in both of those cases you testified against both the doctor or hospital?
A. That's correct.
Q. When were you first contacted in this case?
A. My first letter of transmittal is November the 24th of 2003.
Q. Do you know how long this case has been pending?
A. I do not.

Q. That letter of November 24, 2003, you said it was a transmittal letter?
A. That's correct.
Q. Did it enclose materials for you to review?
A. Yes, it did.
Q. Are those the materials, just to sort of speed this along, referenced in your report of December 5th?
A. That's correct.
Q. How many patients do you see, Doctor?
A. I think you are going to have to be more specific than that.
Q. That's fine. In a week, how many patients do you see typically?
A. I see probably 80 patients in the office and I probably operate on about 15 to 20.
Q. When is the last time you performed a cholecystectomy?
A. What is today?
Q. Today is February 12th.
A. Tuesday.
Q. How many have you performed in your career, knowing that you are not going to give me a precise number, but a ballpark?
A. Hundreds.

Q. Have you ever ordered prophylactic antibiotics following a cholecystectomy?
A. That's a misnomer. You don't order prophylactic antibiotics after a procedure.
Q. Well, have you ever ordered them before a procedure?
A. Yes, sir.
Q. I misspoke. I'm sorry, Doctor.
A. Yes, I have.
Q. Were they ordered in this case?
A. I don't recall.
Q. Would you be critical of the surgeon if they were not?
A. No, I would not.
Q. Between November 24th, when you received the transmittal letter, and December 5th, when you authored your reports, did you receive any additional material?
A. According to letters that I have, and I will read them to you, on November the 24th, I received the medical records. On November the 25th, I received the deposition of Dr. Tamaskar. And those are the only things I received prior to authoring the report.
Q. When you say you received the medical records,

did you receive the autopsy report on November 24th?

A. I believe that was included as part of those records, yes.

Q. So you were aware when you reviewed the case of the findings of the autopsy and, of course, of the fact that Mrs. Arrington had died?

A. Yes, sir.

Q. Since authoring your report, have you reviewed any additional materials?

A. Yes, sir.

Q. And why don't we do it this way, Doctor, because you kind of sped it along by going through. Why don't you tell me after -- I take it you have identified for me all of the correspondence up to December 5th, when you authored your report?

A. That's correct.

Q. Were you given any time lines or any summaries of the medical records?

A. I was given charts that had the relative hemoglobin and hematocrit levels after the hospitalization.

Q. And did you compare that against the medical record to ensure that it was accurate?

A. I didn't directly compare it, but I did go

through the medical records and I did not use the chart in the preparation of my report.

Q. Did you just cast it aside?

A. I looked at it initially and then I reviewed the record and I prepared my report directly from the record.

Q. Do you know if the time line contains all of the hematocrit and hemoglobins for Mrs. Arrington from the date of her surgery -- well, from her admission for surgery until the date of her death?

A. I can't tell, because I didn't directly compare every value.

Q. And, Doctor, part of the reason you didn't consult that time line is because you, as an expert, want to remain objective as you review records?

A. Yes.

Q. Following your report of December 5th, what is the next item of correspondence you received?

A. December 22nd.

Q. December 22nd?

A. Correct.

Q. And what is -- can you read that letter for me.

A. It's a transmittal letter transmitting the

deposition of Dr. Chari or Chari.

Q. Did you review Dr. Chari's deposition?

A. Yes, I did.

Q. The letter of November 25th that we talked about where you got Dr. Tamaskar's deposition, was that simply a transmittal letter?

A. That is correct.

Q. Something to the effect enclosed please find --

A. Yes, sir.

Q. After the transmittal letter of December 22nd, what is the next -- what are the next items you received?

A. Would you like me to just run through all of them?

Q. Yes. That's what I'm doing, Doctor.

A. January the 7th, 2004, I received the deposition of Nurse Catherine Thompson. January the 13th, I received the letter informing me that the trial was going to go forward and asking me to reserve time during the second, third week in February. January the 14th, I received the deposition of Arlene Williams and Linda Lockette and also a letter confirming the discovery deposition today.

On January the 16th, I received deposition transcripts of Mary Daniels and Kathleen

Reynolds. On January the 26th, I obtained additional medical records of Dr. Perryman. On January the 27th, I received deposition transcript of Dr. Beth Braver. On January the 29th, I received deposition transcript of Dr. Joseph Tomashefski. On February the 6th, I received deposition transcript of Dr. Michael Yaffe and, also, the instructions regarding today's deposition.

Q. Have you fairly and accurately characterized the entire amount of correspondence you have received from the Finelli & Margolis firm with respect to this case today?

A. Yes, I think I have.

MR. KRAUSE: What I'm going to ask, Ron, is if you will, because we're kind of working in an awkward manner, either have Dan or you produce a copy of those letters so that we can have them and obviously I won't be able to attach them as an exhibit today.

MR. MARGOLIS: I will fax all correspondence that we sent to Dr. Chevinsky to you tomorrow.

MR. KRAUSE: Thank you.

Q. Doctor, I think I might have asked you this. How many surgeries do you perform in a week?
A. Well, I do probably between six and ten major procedures a week and probably between five and ten minor procedures.
Q. And cholecystectomy, does that fall in the realm of a minor or major procedure?
A. Major.
Q. And at what hospitals do you have privileges?
A. Morristown Memorial Hospital.
Q. Are you still with Allied Surgical Group?
A. Yes, sir.
Q. Can you tell me if -- you have had privileges at other hospitals throughout your career, correct?
A. Only one.
Q. Well, at any of the hospitals where you have had privileges, have any of the lab criteria for those facilities defined a 7.9 hemoglobin as a criteria value?
A. I can't tell you because I don't know.
Q. Have you reviewed the blood transfusion criteria from Grace Hospital?
A. I don't believe that I have, no.
Q. Have you reviewed the deposition of Clifford Arrington?

A. I have not because I've read you all the depositions I've received.
Q. Fair enough. I'm just checking. I didn't know if I heard you.

Do you have a copy of your report handy, Doctor?

A. Yes, sir.
Q. Is your December 5th report the one and only record you have authored in this case?
A. Yes, sir.
Q. You have not issued any supplements to the report?
A. That is correct.
Q. And did this report go out in draft before it went out signed or how does that work?
A. Well, generally, I speak with the attorneys after I've reviewed the documents that they've sent me, discuss with them my findings. And if I feel that there is reason to proceed and I agree that there has been malpractice or negligence, I then author a report and send it to them.

If they have any major problems or criticisms, they'll usually call me and I'll issue a supplemental report. But I always author my own reports without input from the attorneys

other than the discussion that I had with them.
Q. Doctor, what percentage of your professional time is involved with medicolegal expert review?
A. Probably five to ten percent.
Q. And have the rates that we talked about earlier, have they been the same for how long?
A. At least the last two years.
Q. Do you have any changes or amendments to your report of December 5th?
A. It was just pointed out to me today that I have the date of the Huron Hospital admission incorrect. I listed it as being admitted on 4/12, but I was told it was 4/19. So I needed to amend that as being just probably a typo.
Q. Any other changes to your report?
A. No.
Q. Would you agree with me that it is important for you to be objective and reasonable in reviewing the medical records to determine whether a physician met the standard of care?
A. Yes, I would agree with that.
Q. Would you agree with me that the standard of care and an objective review of the standard of care would require you to view the patient and view the care in the -- under the -- as close as we

can come to the same circumstances as the physician whom you've been retained to review against?

A. Yes.

Q. Why did Mrs. Arrington have a cholecystectomy?

A. She had symptomatic cholecystitis.

Q. Can you explain to me what that means?

A. She had inflammation of her gallbladder, gallstones and symptoms referable to that.

Q. What was causing the inflammation of her gallbladder? The gallstones?

A. Correct.

Q. Is cholecystitis a form of infection?

A. It can be.

Q. Can infection cause necrosis of the vasculature of the gallbladder?

A. Not that I'm aware of.

Q. Is staph aureus an infection that can kill a person?

A. Yes.

Q. Why did Mrs. Arrington's hemoglobin drop from 14.26 to 12.9 prior to surgery?

A. I believe that was secondary to dehydration.

Q. Have you reviewed the deposition testimony of Dr. Beth Braver?

A. I have.
Q. Do you recall her discussion of that issue and dehydration?
A. I don't recall it specifically, no.
Q. As you sit here right now, do you disagree with any of the testimony you reviewed of Dr. Braver?
A. I can't specifically recount every part of her testimony. If there is a specific question that you have related to it, I'll be happy to answer it.
Q. Are you critical of Dr. Tamaskar's use of anticoagulants?
A. The answer to that is yes and no.
Q. Tell me why.
A. Well, in a patient who has had a history of recurrent deep-veined thrombosis, some degree of anticoagulation is appropriate. However, I am critical of the fact that he continued the Lovenox and in addition to the Coumadin while at the great -- I guess it's Grace Hospital. The rehab hospital or long-term care facility. Because I believe that that put Mrs. Arrington in undue risk for bleeding, which subsequently did occur.
Q. Do you agree with Dr. Tomashefski that it is

unusual to see a bleed post cholecystectomy?
A. Well, again, I think you are taking what he said out of context. It's unusual to see a bleed after cholecystectomy so far remote from the surgery.
Q. Do you believe that that was an unexpected outcome?
A. Well, I would hope so.
Q. When do you believe Dr. Tamaskar should have stopped the Lovenox and Coumadin?
A. I believe the Lovenox and Coumadin as a combination were very dangerous for this person. And I believe that once the Coumadin had been started, within 48 hours the Lovenox should have been stopped.
Q. I'm sorry. Once the Coumadin was started, within 48 hours the Lovenox should have been stopped?
A. 48 hours of Coumadin.
Q. Based upon your review of the records, was that while the patient was here at Huron Hospital or transferred to Grace Hospital?
A. I'm sorry. Can you repeat the question.
Q. Based upon your review of the records, did that occur prior to discharge to Grace Hospital?
A. Did that happen or did not happen?

Q. Based on your review of the records, were they running Coumadin and Lovenox while the patient was at Huron Road?
A. Yes.
Q. To the extent any of the other physicians were involved in the determination of anticoagulation, would you be critical of them as well?
MR. FINELLI: Are we talking pre-op, postop or in totality?
Q. Postoperative.
A. Let me back up for a moment. I think that I misspoke and I confused Grace Hospital with Huron Hospital. The patient was on both Coumadin and Lovenox on the tail end of the admission to Huron Road Hospital and then was transferred to Grace Hospital on both of those medications. And I believe that the use of those medications while in Grace Hospital was appropriate, but upon transfer to Huron Road, was inappropriate after the first -- transfer to Grace Hospital --
Q. Doctor, let's start over. We've mixed up the names of the hospitals. I want to be clear because I want to be fair to you and everybody else.
A. Let me start again. I believe that the care

rendered and the medications given in the Huron Road Hospital admission were appropriate. And I believe that when the patient was transferred to Grace Hospital, that the continuation of both the Lovenox and Coumadin was not appropriate. Does that clarify it?

Q. I think we have it. Are you critical of Dr. Tamaskar in the postoperative management of this patient prior to transfer to Grace Hospital?

A. No, I am not. With one exception. And that is that the patient had a diminution of the hemoglobin and hematocrit at the last time it was checked at Huron Road Hospital on May the 2nd the hemoglobin was down to 10.7. Although it was not inappropriate -- although it was appropriate to transfer her to the rehab facility, to Grace Hospital, I certainly would have been much more diligent in both management of the anticoagulation on transfer and in following up the drop in hemoglobin and hematocrit.

Q. In essence, what you are telling me is after the patient was transferred or during transfer you would have done the anticoagulation differently?

A. Yes. After transfer.

Q. After transfer. So prior to transfer, while the

patient was in Huron Road Hospital, postoperatively, is it safe to say you have no criticisms of Dr. Tamaskar's care?

A. Yes, that is correct.

Q. You are not critical of the decision to discharge?

A. Not of that decision specifically. Considering the fact that the patient was still in an inpatient facility and could still be available for the needed tests and evaluations that were required. I would have been more critical if he had discharged her to home.

I think she was going from one facility to another facility that still allowed for -- that if she was -- this was still part of an inpatient setting in the same building essentially just down the hall. So I think that the patient was stable for transfer to the long-term care facility because it was a long-term care facility still under the management of a physician.

Q. But if he had discharged her to home, then you would be critical?

A. I would.

Q. But that is not the case here, so you are not critical, right?

A. That is correct.
Q. For a patient that has a drop in hemoglobin or hematocrit such as Mrs. Arrington, what would be in your differential diagnosis?
A. Well, just in a vacuum, drop in hemoglobin and hematocrit is either due to one of three factors. The loss of blood, hemolysis or failure to produce new blood cells.
Q. Maybe I'm unclear. It might be my own inexperience. Doctor, I've never seen failure to produce new blood cells on a differential. Can you give me some why as to the scope of your differential diagnosis for a patient such as Mrs. Arrington relative to her hemoglobin and hematocrit?
A. If you are talking specifically to this patient in this situation, that's different than the question about what can cause a decrease in hemoglobin and hematocrit. Do you want me to limit it to this clinical situation and give you the most likely scenarios? I would be happy to do that.
Q. I want your differential diagnosis. Not just one likely scenario.
MR. FINELLI: Relative to Mrs.

Arrington's condition or in general or an increase in H and H?

Q. Let me try again. In general, Doctor, what is your differential diagnosis for a patient such as Mrs. Arrington relative to a drop in hemoglobin and hematocrit?

MR. FINELLI: Just for clarity, Dave, you are saying in general, then you are saying relative to someone like Mrs. Arrington.

A. Do you mean someone postop on cholecystectomy? I can give you a differential diagnosis from these that cause hemoglobin and hematocrit.

Q. You walk in a room, you see a patient and the nurse comes and tells you the hemoglobin and hematocrit has been dropping with the values that we see or the hemoglobin and hematocrit has the values that we see for Mrs. Arrington both preoperatively and postoperatively.

MR. FINELLI: Objection. What kind of patient are we talking about?

Let's stop right there, David. They just knocked and we can transfer over to video. Do you want him to answer first?

MR. KRAUSE: I don't care. Go

ahead. Transfer over.

- - - -

(Off the record.)

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(Whereupon, the videoconferencing of the deposition commenced.)

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Q. What were the potential causes for changes in the hemoglobin and hematocrit?

A. Any patient any time?

Q. Yeah. When we last left off, you had been a little confused because of the nature of my question. So I'm asking generally speaking, what is the potential causes in any patient?

A. There are three major categories of causes of drop in H and H. Blood loss, failure of production or premature destruction of the red cells.

Q. Can infection cause a drop in H and H?

A. Certain infections can cause hemolysis. And long-term chronic infections can suppress the bone marrow.

Q. Is that a yes or a no or a maybe?

A. Well, in certain circumstances, certain infections can cause a drop in H and H.

Q. Can staph aureus cause a drop in H and H, generally speaking?
A. Generally speaking, no.
Q. Is a drop in H and H associated with blood loss usually accompanied with hypotension?
A. Depends on the repetitivity of the drop.
Q. Well, the circulatory system is a closed system, correct, when it's functioning properly?
A. Not specifically. Not specifically. Everything is interconnected.
Q. Well, blood just doesn't fall out of your body and it doesn't just fall out of vessels. So in that sense, it is a closed system, correct?
A. Correct.
Q. And I take it you believe that Mrs. Arrington was suffering from a postoperative bleed?
A. I believe Mrs. Arrington bled in the postoperative period. That's different than what I would consider a postoperative bleed.
Q. What do you consider a postoperative bleed?
A. Well, in the vernacular that I usually use, postoperative bleed is a bleed that is due to the surgery directly related to or very soon after an operation.
Q. Let's take that one at a time. Do you believe

that Mrs. Arrington's bleed was directly due to her surgery?

A. No. I believe it was indirectly due to her surgery.

Q. Do you have an opinion to a reasonable degree of medical probability as to whether if Mrs. Arrington had not been on anticoagulants, whether she would have any postoperative bleeding?

A. Yes.

Q. What is that opinion?

A. My opinion is that she would not have.

Q. In this ten-day span postoperatively, when did Mrs. Arrington start to bleed in your opinion?

A. Well, according to the hemoglobin and hematocrit records that I have, she started to bleed slowly between the May 2nd, May 3rd area -- I can't give you an exact time. But that accelerated on May 7th.

Q. So she was not bleeding on -- I'm sorry, Doctor. I'll wait for you.

You believe the bleed started on May 2nd?

MR. MARGOLIS objection.

A. I believe it started somewhere in that time frame. May 2nd, May 3rd.

Q. Where was she bleeding from on May 2nd or May

3rd?

A. I believe she was bleeding from or oozing from the liver bed where the gallbladder had been removed.

Q. Do you believe she had any other sites of bleeding?

A. Not that I know of or not that I've seen.

Q. Do you believe Mrs. Arrington demonstrated any clinical signs of infection either while she was at Huron Road Hospital or Grace Hospital?

A. Well, she was admitted to Huron Road Hospital with the questionable pneumonia so, therefore, I do believe that preoperatively she did manifest at least some symptoms of a possible infection. I do not believe that she manifested any signs of infection during the Grace admission.

Q. Are you critical of Dr. Tamaskar for not diagnosing infection?

A. No, I am not.

Q. Are you critical of Dr. Tamaskar for not treating her for infection?

A. No, I am not.

Q. What do you believe the standard of care required of Dr. Tamaskar on May 2nd, 2002 that was not done in this case?

A. On May 2nd, 2002, the hemoglobin was 10.7, the hematocrit was 33 and the standard of care required him to reevaluate the anticoagulation that she was on and look for signs of where the blood had gone.

Q. So Dr. Tamaskar at that point in time should just have known that she was bleeding and that was the nature -- let me finish my question -- and that that was the nature of the 10.7, 33 H and H?

A. No. What he should have done is been alert to the fact that the hemoglobin was dropping consistently from 4/29, 4/30, 5/1, 5/2, 5/3. And although one level in a vacuum can't mean very much of anything, the trend is important.

Q. Is it your testimony that the H and H for Mrs. Arrington consistently dropped from 4/29 up to and including 5/3?

A. I'm sorry. I missed the last word that you said.

Q. Is it your testimony that the H and H for Mrs. Arrington consistently dropped from 4/29 down to 5/3?

A. No. She had a slight bump from 5/4 to 5/6. Between May 3 and May 6. Those are relatively the same in my opinion. And the degree of laboratory variability, she showed an overall

trend that diminished from 4/29 through 5/8. And it stabilized a bit between May 3rd and May 6th and dropped again on May 7th.

Q. Did Mr. Finelli just speak to you?

A. No, sir.

MR. KRAUSE: Dan, if you talk, I'd ask that you speak up so we can all hear you. Okay?

MR. FINELLI: That's fine.

Q. Do you believe infection played any role in Mrs. Arrington's demise?

A. No.

Q. On autopsy, they found I believe it was 450 milliliters of flesh blood?

A. According to my recollection of the autopsy, they found blood in three different places.

Q. But as for the fresh blood, 450 milliliters?

A. They found 450 cc's or milliliters of unclotted blood.

Q. When did that 450 milliliters leave the circulatory system and enter the abdominal cavity?

A. Sometime between May 6th and May 8th.

Q. Did Mrs. Arrington exhibit any clinical signs of bleeding during her ten-day postoperative course?

A. Well, she manifested abdominal pain, which was likely a representation of the blood in her abdomen.

Q. And from what -- is that something you have formed an opinion on because you've reviewed the autopsy or do you believe there is evidence in the medical records simultaneous with the care and treatment that Mrs. Arrington's complaints of abdominal pain were due to a bleed?

A. Well, again, nothing can be interpreted in a vacuum. In a patient whose hemoglobin and hematocrit is dropping and who is complaining of abdominal pain in an area where a previous surgery had been done, you know, the signs point to a bleeding in that area and it needs to be evaluated. They're not conclusively definitive for bleeding. But bleeding in the abdomen does cause pain.

Patients who have pain need to be suspected of multiple problems. And the drop of hemoglobin and hematocrit and pain in the area near where a surgery was recently done, one has to be very suspicious there is bleeding going on in that area.

Q. Do you believe that Dr. Tamaskar didn't at all

consider the possibility of a bleed?

MR. KRAUSE: Objection.

A. I don't know what his considerations were.

Q. Based on your review of the medical records, do you see any evidence that he was concerned about Mrs. Arrington's condition during her postoperative course?

A. Well, I'm not sure I can answer a vague question like that. I'm sure he was concerned about her postoperative course. He was her doctor.

Q. Maybe you have answered my question.

A. Okay.

Q. I'm sorry. I didn't want to interrupt you. If you continue to answer, go ahead. I'm sorry.

A. No. That's all.

MR. MARGOLIS: Just for purposes of the record, so that I don't need to interrupt, David, I would be very appreciative if you could give time parameters when you are talking about postop care. Are we talking about just from when she is admitted to Grace 5/2 forward or not? Because it's not a fair question unless you are asking from the date of surgery forward. I would just ask

you to specify times.

MR. KRAUSE: Okay. I'm sure you will when you ask the questions.

MR. MARGOLIS: Yes. My questions will be precise.

Q. When Mrs. Arrington presented to Huron Road Hospital, what diagnoses or comorbid conditions did she bring with her?

A. The same ones that she brought with her when she was admitted to -- I'm sorry. Huron Road. I'm getting hung up on the hospitals again. Her comorbidities included hypertension, congestive heart failure, diabetes, chronic obstructive pulmonary disease, recurrent deep vein thromboses.

Q. Do you believe the standard of care required Dr. Tamaskar to prescribe anticoagulants for a patient such as Mrs. Arrington with a history of recurrent DVT?

MR. KRAUSE: Objection.

A. Yes.

Q. In your opinion, if he wouldn't have done it, he would be negligent, correct?

A. Again it depends on the timing and the time frame of it. If she were not undergoing a surgical

procedure, then somebody who has long-term or recurrent deep vein thrombosis needs to be anticoagulated. Certainly during the time of surgery anticoagulation is contraindicated and the postoperative period has to be viewed circumspect.

Q. He already went through up until May 2nd. If you are changing or I misheard you, my understanding is you had no criticism of the anticoagulation up to May 2nd; is that correct?

A. That's correct. That's correct.

Q. Are you critical of any of the physicians who diagnosed Mrs. Arrington with congestive heart failure, COPD, hypertension or diabetes?

MR. FINELLI: Objection.

A. I don't believe I have any information that can corroborate or not. I basically looked at the medical record when she was admitted to the hospital and those are the conditions that were listed as her preceding medical conditions.

Q. And if you were her treating physician in the hospital and your patient reported to you with those comorbidities, you would assume that those diagnoses, to the extent that they can be accurate, would be, correct?

MR. FINELLI: At that time, the time of admission?

MR. KRAUSE: Correct.

A. Yes.

Q. Other than stopping the Coumadin on May 2nd, do you believe Dr. Tamaskar needed to do anything else to comply with the standard of care?

MR. MARGOLIS: Objection. What date?

MR. KRAUSE: May 2nd. I just said May 2nd. I'm not going to deal with both of you.

Q. Doctor, I'll repeat my question for clarity in case you misunderstood it, because apparently Mr. Margolis did.

On May 2nd, did Dr. Tamaskar need to do anything other than stop the Coumadin to meet the standard of care?

A. He could have stopped the Coumadin or stopped the Lovenox. One or the other. I would have stated that the proper thing would have been to stop the Lovenox and continue the Coumadin. But no, he would not have needed to do anything else as of May 2nd.

Q. Have you been involved in your career with

patients who are on Coumadin and Lovenox at the same time?

A. Yes.

Q. At the dosages Mrs. Arrington received on May 1st and May 2nd and throughout her admission through Grace Hospital?

A. Yes.

Q. And I guess, Doctor, if you want to reference your report, just for ease of where I'm going, what we just talked about is the criticism on the fourth paragraph of the second page where you say first Dr. Tamaskar discharged Mr., you meant Mrs. Arrington from Huron Hospital with a hemoglobin and hematocrit which was below normal. Despite having a normal 48 hours before. I'm trying to give you a frame of reference, Doctor.

A. That's correct.

Q. Do you have any other criticisms of Dr. Tamaskar on May 2nd other than the issue with the anticoagulants?

A. As I mentioned earlier, on May 2nd, with the trending down of the hemoglobin and hematocrit and the fact she was on two anticoagulants, one had to be cautious about further bleeding and at least evaluating her for the source of bleeding.

I think we've talked about that earlier.

I don't think that on May 2nd specifically anything else needed to be done, but it certainly needed to be watched.

Q. Do you believe Dr. Tamaskar did not evaluate Mrs. Arrington on her date of discharge from Huron Road Hospital to Grace rehabilitation hospital?

A. Do I believe that he did not? No, I believe he did.

Q. Your next criticism referenced in your report you say, "Second, upon admission to Grace rehabilitation facility, Dr. Tamaskar continued anticoagulation at full dose with both Lovenox and Coumadin despite a blood count that continued to drop." Which is also what we've already talked about, correct?

A. That's correct.

Q. "Third, at no time during the hospitalization at Grace did Dr. Tamaskar perform any diagnostic evaluation to identify the source of bleeding." That's your third criticism, right?

A. That is correct.

Q. Did you have an opportunity to review the records of Dr. Tamaskar on May -- of May 7th?

A. Yes.

Q. Do you have them there with you?
A. I have them in my bag.
MR. FINELLI: Dave, you're asking about May 7th?
MR. KRAUSE: Yes.
Q. Specifically, I wish I could give you a page, but they were signed off, I believe, at 2120.
MR. FINELLI: The ones he wrote at 6:00 p.m. himself?
MR. MARGOLIS: At the risk of Dave coming over the table hitting me, if you look at page 148.
A. I believe I have it. It's Bates stamped 29. 29 in our book.
MR. MARGOLIS: Right.
MR. KRAUSE: Just for the record, Ron, I would never come across the table and hit you.
Q. Doctor, why did Dr. Tamaskar order a KUB now?
A. Well, according to this, it says nausea.
Q. What do you attribute the patient's nausea to?
A. Bleeding.
Q. Did the patient have any other clinical signs and symptoms of bleeding? Well, let me give you a time. In fairness, let me give you a time. From

5/2 up until the time of her death.

A. She had signs of complaining of abdominal pain. And let me go to the nurse's notes.

Q. While you are going there, Doctor, would you agree that you would expect abdominal pain in a patient ten days following a cholecystectomy?

A. I wouldn't expect increasing abdominal pain, no. And I wouldn't expect hardly any pain ten days after a laparoscopic cholecystectomy and I would be very suspect of a complication.

Q. I didn't want to cut you off, Doctor. I know you are going through the nurses notes.

MR. FINELLI: The question on the table is signs of bleeding besides H and H --

MR. KRAUSE: Clinical signs. And I don't know that I brought up the H and H. But if you want to volunteer that, Dan, it meets my expectations of you.

A. Well, according to the nurse's notes, May the 7th at 2:30 a.m.

Q. What date was that, Doctor?

A. I have a page of nurse's notes that I believe to be May the 7th at 2:30 a.m. where it complains -- I'm sorry. It's 6:20 a.m., complaining of

abdominal cramps.
Q. Cramping pain?
A. And then at -- pardon me.
Q. Cramping abdominal pain?
A. Complaining of abdominal cramps.
Q. And that is due to a bleed?
A. That is due to the distension of the bowel caused by the bleeding in the peritoneal cavity.
Q. That's on -- I'm sorry. That's on 5/7?
A. I believe that's 5/7 at 6:30 in the morning.
Q. So you have an opinion that she bled -- she had enough blood in her abdomen on 5/7 to have distension which led to abdominal cramps?
A. I believe that she at 6:20 on 5/7, there is a sufficient blood in the abdomen to cause both abdominal cramps or pain, which is likely secondary to the peritoneal. Then she was medicated with Percocet for that at 6:30.

Then at 8:00 p.m. she was complaining of abdominal discomfort in the right quadrant with nausea. And then at 2200 she had emesis. At 1:30, it states that Dr. Tamaskar notified earlier of H and H. And I believe those are all signs of bleeding.

Then at 0800 it says patient hard to arouse.

And then at 11:00, it says speech slurred, slightly lethargic. And I believe those are all signs of incipient bleeding.

Q. To what do you attribute the ethanol found on the autopsy?

A. I have no clue.

Q. Well, let's be scientists and tell me what your differential diagnosis would be.

MR. MARGOLIS: Objection. How does one diagnosis that?

A. Well, imagine that, if it wasn't a contaminant, then it must have been in her system. It must have been ingested. It must have been ingested.

Q. Do you see anything in the record -- I take it you have already told us you have no clue. You don't see anything in the record which would provide an adequate explanation to you for that level of ethanol?

A. No, sir.

Q. Have you ever seen evidence of an abdominal bleed on KUB in your career?

A. No.

Q. Have you ever seen evidence of organs which are -- strike that. Have you ever seen evidence on KUB of organs, some don't look as they should and

a bleed comes into your differential?
A. That's an obtuse question and I'm not sure I understand what you are driving at.
Q. Have you ever had a case where you looked at KUB? Well, first of all, do you review KUBs as a surgeon?
A. Yes, sir.
Q. You order them?
A. Yes, sir.
Q. And can you see free air on KUB?
A. Yes, sir. On KUB, if it's flat, usually not.
Q. What if it changes the shape and location of the organs in the abdomen?
A. Free air?
Q. Free air.
A. Well, free air migrates anteriorly on KUB, which is a flat abdominal x-ray. Unless you had massive amounts of free air, you would not be able to see it because it was layered anteriorly.
Q. What about a liter of blood?
A. Again, KUB is a very insensitive test for picking up the bleeding. I'm not sure you can reliably pick up bleeding, even up to a liter, on KUB.
Q. Would you characterize Mrs. Arrington's bleed, which you believe started I think you said on 5/2

or 5/3, up until the time of her demise as acute, subacute or chronic?

A. I would say acute and subacute.

Q. You agree with Dr. Tomashefski in that respect?

A. If that's what he said.

Q. If a physician described this as a chronic bleed, I take it you would take issue with that?

A. Again, those are not scientific terms. Those are relative terms depending upon what the person who is saying them means. I would characterize this is an acute and subacute. To my way of thinking, acute bleed is something that happens within 24 hours and subacute is within a few days and a chronic bleed is longer than that. That's my definition.

Q. You when say within 24 hours, within 24 hours of what? 24 hours prior to death?

A. 24 hours of identification of the bleed. We are talking about an acute bleed. We're referencing it to the time it's diagnosed. So, therefore, I would define an acute bleed as 24 hours from the time of its bleeding until the time you recognize it. You know, it's within that 24-hour period.

Q. What about subacute?

A. Within a few days, three, four, five days.

Q. Do you have any criticisms of Dr. Tamaskar's preoperative care of Mrs. Arrington?
A. I do not.
MR. MARGOLIS: Excuse me. He was just editorializing. We've been over this three times.
MR. KRAUSE: No, no. Actually, I didn't ask him preoperative.
Q. When Dr. Tamaskar received the phone call from the nurse at Grace Hospital on 5/7, you've addressed a criticism in your report during that time frame. I wanted to know what Dr. Tamaskar needed to do to meet the standard of care.
A. During which time frame? I'm sorry.
Q. 5/7/2002 after getting the call from the nurse about the 7.9.
A. Well, he needed to do everything. He needed to -- shall I continue?
Q. Yes. Please.
A. He needed to make sure there was blood available to transfuse her. He needed to move her to the hospital so that she could be better evaluated. He needed to obtain an imaging study to identify where the bleeding was.
Q. A CT scan?

A. Correct.
Q. Anything else?
A. I believe those are the major ones. And establish IV access, if she didn't have it. Running fluids for resuscitation.
Q. So let me go through these to make sure I have them all. Need to make sure there was blood available for transfusion. Transfer to the hospital. Obtain a CT scan. And if she didn't already have it, establish IV access. Is there anything I missed?
A. And check her coagulation parameters.
Q. Do you have an opinion as to what her coagulation parameters would have been on 5/7/02 and up to the early morning hours -- not early morning hours. Let's say early 5/8?
A. Well, according to the chart that I have, the INR was 1. -- 1.18 when it was initially drawn. And the next one on May 8th, the 2.2 with a PT of 57. Of course, you can't gauge the effect of the Lovenox because that's not measured either by the PT or PTT. My impression would be her clotting parameters would be closer to the 2.2 and 57 than to the 1.18.
Q. Do you have an opinion as to what would need to

be done to reverse the anticoagulation?
A. Yeah. She would need to get fresh frozen plasma and/or cryoprecipitate.
Q. Do you have an opinion as to how much fresh frozen plasma?
A. Enough.
Q. Explain to me how that works. Are you telling me that you continue to monitor the patient and see how she does or what are you telling me?
A. Well, it's a continuum with many things being done at once. You need to establish where her pro time and PTT are and correct them back down towards normal at the same time that you give blood to transfuse the hemoglobin and hematocrit back towards normal at the same time that you are resuscitating with IV fluids and obtaining the needed imaging studies to see where the bleeding is from and whether it's ongoing.
Q. Well, let's do it this way. Do you have an opinion as to how long it would take to get her on fresh frozen plasma?
A. Well, fresh frozen plasma takes approximately 20 minutes to thaw.
Q. So do I understand your opinion to be that within 20 minutes or so of receiving the phone call from

the nurse, Dr. Tamaskar should have had Mrs. Arrington on fresh frozen plasma?

A. No.

Q. Why not?

A. What you understood me to say is that within 20 or 30 minutes of the phone call, the patient needed to be evaluated, transferred to the hospital, IV lines started and resuscitation begun, clotting parameters checked, blood made available and a CT scan ordered. And if the clotting factors came back elevated or abnormal, then the fresh frozen plasma should be transfused. Rough ballpark, within two hours of that phone call.

Q. All of those things, all of those things, the CT scan should be ordered, the patient transferred and fresh frozen plasma available based on PTT and INR?

A. Correct.

Q. Within two hours?

A. And, of course, the Coumadin and Lovenox had to be stopped.

Q. Yeah. Frankly, I had assumed that, Doctor.

A. Yeah.

Q. Do you have an opinion as to what a CT scan would

have shown had it been done at 2:00 in the morning or so on May 8th?

A. Yes.

Q. And what would it have shown?

A. It would have shown fluid in the abdomen and a hematoma in the area of the liver bed.

Q. And the fluid in the abdomen would have been blood, in your opinion?

A. Correct.

Q. And the hematoma in the liver bed, to what do you attribute that?

A. Bleeding from the liver bed as a result of overanticoagulation with both Lovenox and Coumadin.

Q. When did the bleeding that led to the hematoma occur?

A. Well, I think it was an ongoing phenomenon, as I mentioned earlier. But I think the major part of the bleeding occurred sometime at the time that the patient started to become symptomatic of nausea and cramps. So sometime around 6:00 or 7:00 a.m. on May 7th.

Q. Can the level of ethyl alcohol found on autopsy cause lethargy in a person?

A. I don't recall what the absolute level was. Do

you have it there?

Q. 52, Doctor.

A. Blood alcohol of 52.

MR. FINELLI: .052.

A. Should not.

Q. What is the legal limit for ethanol intoxication in New Jersey?

A. Well, I believe it's .08. It used to be .1.

MR. FINELLI: .3 for Margolis.

Q. And she was a .052 under your .08 standard?

A. Correct. Correct.

Q. Do you have any opinion as to how much ethyl alcohol one would have to ingest to have a .052 alcohol level?

A. Well, I'm not a toxicologist. And we don't know on what point of the spectrum we're picking this up. But typically speaking, two drinks of hard liquor, which means two shots, would raise your blood alcohol to .8.

Q. Right. And after you pass away, do you agree that the level of ethyl alcohol actually decreases?

A. That is a bit out of my area of expertise. I really couldn't comment one way or the other. I don't know.

Q. So you won't be commenting at trial about that, fair enough?
A. That's correct. Just to let you know, we have about another ten minutes. I have 20 after, but.
Q. Do you believe that surgical intervention would have been necessary to save Mrs. Arrington's life?
A. No.
Q. You believe that a transfer to Huron Road Hospital and CAT scan and transfusion and reversal of her anticoagulants would have stopped the bleed in time to save her life?
A. Yes, I do.
Q. Do you have an opinion as to what the PTT and INR would have been had Dr. Tamaskar taken the steps that you say he was required to take by around 2:00 or 3:00 in the morning on May 8th?
A. Well, as I mentioned before, I believe that it would be closer to the level of 2.2 for the INR and the 57 for the PTT. I would imagine that they would be very close to those numbers.

MR. FINELLI: Just for clarification, I don't think he said around 2:00 or 3:00 in the morning.

Q. I don't want to rehash it, Doctor. Didn't you

say two hours -- you would expect the CT scan and the transfer and the fresh frozen plasma and all those things to be beginning within a time span of two hours or so?

MR. FINELLI: I think he said the fresh frozen plasma within two hours.

MR. KRAUSE: I thought he said it all together.

A. Actually, I said I would expect all of those things to be done within two hours.

Q. So if a doctor didn't get all those things done in two hours, he would be negligent; is that what you are saying?

A. That's correct.

Q. Do you believe the standards of care required a surgical consult on May 8th?

A. I don't believe that it was a standard of care that required a surgical consult because I don't believe it was a surgical issue. I think it would have been prudent to get a surgical consult, but it would have been more important to deal with the problem.

Q. So you don't fault Dr. Tamaskar at least in that respect, correct?

A. Well, I think -- I think that getting a surgical

consult would have been part of the things that I would have recommended as of the dropping H and H at 2:00 a.m., as you said. Is it the standard of care, did he violate the standard of care by not getting a surgical consult at that point; I don't think so. I think he had other things that needed to be done though.

Q. I understand. And I don't think I've -- I think we've delved into that.

A. But a surgical consult in and of itself, no, I don't believe that not doing it at that moment of time violated the standard of care.

Q. Well, then, now you just changed it a little bit and I want to make sure I'm clear.

Do you believe Dr. Tamaskar breached the standard of care by failing to order a surgical consult or requesting a surgical consult at any time on 5/7/02 or 5/8/02?

A. Let me answer you in this way: A physician needed to evaluate this patient when the hemoglobin and hematocrit were low and she was complaining of abdominal pain. The nature of that physician could have been a surgeon or Dr. Tamaskar or any one of a number of people. But the fact that nobody saw that patient at that

time is a violation of the standard of care. I don't necessarily think it had to be a surgeon.

Q. Could it have been a resident?

A. Could have been a resident.

Q. Do you fault the nurses for not calling a resident with this extremely low, problematic hemoglobin according to you?

MR. FINELLI: Objection.

Q. On May 7th, 2002?

MR. FINELLI: Objection.

A. I believe that's the responsibility of the surgeon -- not the surgeon. I'm sorry. I believe that's the responsibility of the attending physician.

Q. What were the patient's vital signs when the nurse contacted Dr. Tamaskar on 5/7/02?

A. Well, it's unclear to me exactly what time Dr. Tamaskar was contacted because the note at 1:30 says Dr. Tamaskar notified earlier of H and H. And according to the deposition transcript of the nurses, he was notified sometime in the evening, but she didn't say specifically when. The vital signs that are listed on the chart as of the last set that I see, and I'm not sure I have the correct ones here, because it doesn't say

completely -- I don't have a specific vital sign for the time when he was notified.

Q. Do you believe that the patient was hypotensive and the nurses failed to document it?

MR. FINELLI: Objection.

A. The patient may or may not have been hypotensive. I don't know.

Q. Do you have an opinion as to whether or not the patient was or is it you don't know?

MR. FINELLI: At what time, Dave?

Q. 11:30 or 11:45 when Dr. Tamaskar -- I think that's around the time when he was called?

A. Well, the last set of vital signs that I have I believe were at 11:00 p.m. with a blood pressure of 122 over 55 and a pulse of 84.

Q. Do you have an opinion as to whether the patient was hypotensive around 11:30 or 11:45 when Dr. Tamaskar was called on 5/7/02?

A. I don't know a way of knowing for sure. My suspicion is the blood pressure would have been lower than it is, 122 over 55, but that's just a speculation.

Q. Well you have done this before. You don't speculate when you testify in cases, right?

A. Well, I try not to.

Q. You want to express opinions to a probability when you have them, right?
A. That's correct.
Q. If the patient were hypotensive, would you expect the nurses to write that down?
MR. FINELLI: Objection.
A. If they monitored the vital signs, I would expect them to write that down, yes.
Q. Have you been given any of the blood transfusion criteria from Huron Road Hospital?
A. I don't believe I've seen those, no.
Q. Do you believe Mrs. Arrington was a chronic anemic?
A. The only information I have is based on the admitting labs and labs prior to her surgery which showed she was not anemic.
Q. Did you review the records of Dr. Perryman?
A. I did. But I don't recall them specifically as we sit here.
Q. Well, when did you get those?
A. I got those January 26th.
Q. The CT that you say should have been ordered, would that be a CT with or without contrast?
A. A CT with contrast.
Q. And what would need to be done to the patient to

prepare her for a CT with contrast?
A. Put an IV in.
Q. What about her digestive system?
A. Well, if you are talking about oral contrast versus intravenous contrast, when you are looking for bleeding, particularly in a patient with a low hemoglobin and hematocrit like this, then you can forgo the oral contrast or use an abbreviated prep which can be done within an hour and still give the intravenous contrast.
Q. So you still, despite the fact that you believe a CT with contrast was warranted, you still believe that all of that should have been completed within two hours of Dr. Tamaskar receiving the phone call on May 7th in order for him to comply with the standard of care?
A. That's correct.

MR. FINELLI: David, is this a good point to stop?

MR. KRAUSE: I might wrap up if you hang on here for a minute.

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(Thereupon, a discussion was had off the record.)

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Q. Have I covered all of your criticisms of Dr. Tamaskar?
A. Yes, you have.
Q. If you form any new opinions -- strike that. Have we covered all of your opinions with respect to cause of death?
A. Whatever we had in this deposition, whatever is in my written report are my sum total of my opinions.
Q. Let me ask you this: You have reviewed the autopsy report from Dr. Tomashefski?
A. Yes, sir.
Q. And you have reviewed Dr. Tomashefski's deposition?
A. Yes.
Q. Do you agree with the findings on autopsy?
A. Well, the findings on autopsy speak for themselves. The bleeding and the blood in the abdomen speak for itself.
Q. Is that a yes or no or maybe or I can't answer?
A. Well, very specific. The findings on the autopsy, I agree with the findings of the autopsy that the patient exsanguinated.
Q. Doctor, do you have any criticism of any other care providers?

A. Do I? I do not.
Q. You believe the nurses met the standard of care?
A. Yes, I do.
Q. Is it safe to say you do not believe the hemoglobin and hematocrit of May 7th, 2002 were critical values such that after the nurse advised Dr. Tamaskar and Dr. Tamaskar didn't come in the nurse should have gone up the chain of command and gotten another doctor to look at this patient?

MR. FINELLI: Objection.

A. I believe as it is stated in the nurse's note that the nurse spoke with the doctor, that the doctor told her that he was not -- that he gave some orders and that she was to monitor the patient. I believe that was her responsibility. I don't believe her responsibility included anything more than that.
Q. As a general concept, if a nurse -- you would agree that if a nurse receives an order from a physician or believes a patient needs to be seen by a physician and the physician is not there, the nurse has a responsibility to go up the chain of command? That's not a new concept?
A. It depends on the protocol of the hospital that

you happen to be at. There are different ways of handling that situation. And in some cases a more senior nurse is brought into the picture in order to evaluate the patient, then a decision is made. Sometimes another phone call is placed to the physician to reaffirm that information. Other times if it's a teaching hospital, then a more senior resident is called. There's no blanket answer to that.

Q. Since a surgical consult wouldn't have been required by the standard of care, Doctor -- since a surgical consult would not have been required by the standard of care, can we agree that a surgeon like yourself would not have been involved in this patient's care and the decisions in her care once she was at Grace Hospital?

MR. FINELLI: Objection.

A. No. I'm actually both a surgeon and a specialist in critical care medicine. I'm board in surgical and critical care. Therefore, I believe I'm fully qualified to evaluate this situation and would have clearly been involved when the patient had been transferred over to the intensive care unit.

Q. Well, then, you just added something. We didn't

talk about intensive care unit. Do you believe that is where the patient needed to be for the transfusion?

A. I believe that the patient needed to be there for evaluation and monitoring. Not necessarily for the transfusion.

Q. So you believe the standard of care required an admission to the ICU at Huron Road Hospital, CT scan and the transfusions that we talked about earlier?

A. That's correct.

Q. All within two hours?

A. That's correct.

Q. If it would have been three hours, would it be negligence?

A. I think you are splitting hairs. I think that you need to make preparations for doing that and a two-hour time frame is certainly enough time to do the CAT scan, cross match the blood, start the IV and move the patient.

Now, remember, we talked about the fresh frozen plasma being transfused once the coagulation profile is back. That doesn't necessarily have to be within two hours. And if the CAT scan is done in two hours and five

minutes, I'm not going to parse hairs. You have a reasonable period of time in order to evaluate a patient who is clearly changing in the clinical status.

Q. Did the nurses document changes in clinical status and their concern that the doctor wouldn't come in?

MR. FINELLI: Objection.

A. They documented the status, the clinical status. That the patient was complaining of new symptoms.

Q. Is it the nurse's job to communicate changes in clinical conditions and new symptoms to the physician?

A. Yes.

Q. So if the patient as you perceived it had -- if there is documentation in the nurse's notes from 1:00 in the morning on 5/8 up until the time of death on 5/8 of changing clinical conditions or onset of new symptoms or changing symptoms, you would agree with me it's the responsibility of the nurses to communicate those to the doctor, correct?

A. Yes. As well as the responsibility of the doctor to inquire about them when he speaks to the nurses.

Q. Sure.
A. Or to make plans to see a patient who is clearly changing in condition with a new finding of a decreased hemoglobin and hematocrit before the next morning.
Q. Understood. Doctor, have we discussed all your opinions that you intend to testify to at trial with respect to this case?
A. Yes, sir.
Q. And if you form any new ones, I would ask you to let Mr. Margolis and Mr. Finelli know and they will get in touch with me and we can do this again perhaps by phone. Fair enough?
A. That's fine.

MR. FINELLI: We didn't hear you, Dave.

Q. Does that sound fair to you, Doctor?
A. That's fair.

MR. KRAUSE: And I think that's it. Off the record.

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AARON CHEVINSKY, M.D.

C E R T I F I C A T E

The State of Ohio,) SS:
County of Cuyahoga.)

I, Juliana M. Lawson, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named witness was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action; that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this 16th day of February A.D. 2007.

Juliana M. Lawson, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires October 3, 2007

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