

1                    IN THE COURT OF COMMON PLEAS

2                    CUYAHOGA COUNTY, OHIO

3                    LINDA LOCKETTE, etc.,

4                                    Plaintiff,

5                    -vs-

JUDGE McCAFFERTY  
CASE NO. 500191

6                    GRACE HOSPITAL, et al.,

7                                    Defendants.

8                    - - - -

9  
10                    Videoconference deposition of

11                    AARON CHEVINSKY, M.D., taken as if upon

12                    cross-examination before Juliana M. Lawson, a

13                    Notary Public within and for the State of Ohio,

14                    at the offices of Reminger & Reminger, 1400

15                    Midland Building, 101 Prospect Avenue, West,

16                    Cleveland, Ohio, at 3:45 p.m. on Thursday,

17                    February 12, 2004, pursuant to notice and/or

18                    stipulations of counsel, on behalf of the

19                    Defendants in this cause.

20                    - - - -

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APPEARANCES:

Ronald A. Margolis, Esq.  
Daniel M. Finelli, Esq. (Via Telephone)  
Finelli & Margolis  
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On behalf of the Plaintiff;

David Krause, Esq.  
Reminger & Reminger  
1400 Midland Building  
101 Prospect Avenue, West  
Cleveland, Ohio 44115  
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On behalf of the Defendants.

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

7                    CROSS-EXAMINATION OF AARON CHEVINSKY, M.D.

8                    BY MR. KRAUSE:

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

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

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

15                    A.    That's correct.

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

18                    A.    That is correct

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

21                    A.    I charge \$200 per hour for review of documents.  
22                    \$400 an hour for deposition testimony.

23                    Q.    How about trial testimony?

24                    A.    \$5,000 per day.

25                    Q.    Are you scheduled to testify at trial next week

1 in this case?

2 A. That's what I've been told.

3 Q. Have you received your \$5,000 payment?

4 A. I have.

5 Q. Are you just coming in for one day or two?

6 A. I'm coming in the night before and then staying  
7 over until the next day.

8 Q. How does that work out? Do you just take the  
9 \$5,000 or do you charge extra for the overnight?

10 A. Well, I charge for my time. So if there is any  
11 conferences or anything that is happening the  
12 night before, I usually charge a fee for that as  
13 well.

14 Q. What is the fee? Is that an hourly fee?

15 A. It's either an hourly fee or out of town it's  
16 usually half a day.

17 Q. Half a day?

18 A. That would be 3,500.

19 Q. 3,500 is half a day?

20 A. Yes.

21 Q. So for your testimony, not including the review,  
22 just the trial testimony, the cost will be about  
23 \$8,500?

24 A. That's correct.

25 MR. MARGOLIS: Objection. That's

1 not what he testified to.

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

7 A. The fee for the day of trial is \$5,000. For the  
8 trip out of town and the pretrial preparation is  
9 3,500.

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

11 A. No, sir.

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

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

17 A. No, I have not.

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

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

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

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

1 Q. Did you serve as an expert on the behalf of a  
2 defendant in any state in a medical malpractice  
3 case last year?

4 A. Yes, sir.

5 Q. And what state?

6 A. New Jersey.

7 Q. When is the last time you've come to Cleveland to  
8 testify in a trial on behalf of a plaintiff?

9 A. I was out sometime late in 2003. I'm not  
10 absolutely sure. October, November, something  
11 like that.

12 Q. And you had two trials out here in Cleveland in  
13 November 2003, right?

14 A. If it's November, yeah. I was there twice.

15 Q. I understand. You were out here twice at the end  
16 of the fall in 2003?

17 A. That's correct.

18 Q. And in both of those cases you testified against  
19 both the doctor or hospital?

20 A. That's correct.

21 Q. When were you first contacted in this case?

22 A. My first letter of transmittal is November the  
23 24th of 2003.

24 Q. Do you know how long this case has been pending?

25 A. I do not.

1 Q. That letter of November 24, 2003, you said it was  
2 a transmittal letter?

3 A. That's correct.

4 Q. Did it enclose materials for you to review?

5 A. Yes, it did.

6 Q. Are those the materials, just to sort of speed  
7 this along, referenced in your report of December  
8 5th?

9 A. That's correct.

10 Q. How many patients do you see, Doctor?

11 A. I think you are going to have to be more specific  
12 than that.

13 Q. That's fine. In a week, how many patients do you  
14 see typically?

15 A. I see probably 80 patients in the office and I  
16 probably operate on about 15 to 20.

17 Q. When is the last time you performed a  
18 cholecystectomy?

19 A. What is today?

20 Q. Today is February 12th.

21 A. Tuesday.

22 Q. How many have you performed in your career,  
23 knowing that you are not going to give me a  
24 precise number, but a ballpark?

25 A. Hundreds.

1 Q. Have you ever ordered prophylactic antibiotics  
2 following a cholecystectomy?

3 A. That's a misnomer. You don't order prophylactic  
4 antibiotics after a procedure.

5 Q. Well, have you ever ordered them before a  
6 procedure?

7 A. Yes, sir.

8 Q. I misspoke. I'm sorry, Doctor.

9 A. Yes, I have.

10 Q. Were they ordered in this case?

11 A. I don't recall.

12 Q. Would you be critical of the surgeon if they were  
13 not?

14 A. No, I would not.

15 Q. Between November 24th, when you received the  
16 transmittal letter, and December 5th, when you  
17 authored your reports, did you receive any  
18 additional material?

19 A. According to letters that I have, and I will read  
20 them to you, on November the 24th, I received the  
21 medical records. On November the 25th, I  
22 received the deposition of Dr. Tamaskar. And  
23 those are the only things I received prior to  
24 authoring the report.

25 Q. When you say you received the medical records,



1           did you receive the autopsy report on November  
2           24th?

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

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

8   A.   Yes, sir.

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

11  A.   Yes, sir.

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

17  A.   That's correct.

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

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

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

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

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

3 Q. Did you just cast it aside?

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

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

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

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

18 A. Yes.

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

21 A. December 22nd.

22 Q. December 22nd?

23 A. Correct.

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

25 A. It's a transmittal letter transmitting the

1 deposition of Dr. Chari or Chari.

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

3 A. Yes, I did.

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

7 A. That is correct.

8 Q. Something to the effect enclosed please find --

9 A. Yes, sir.

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

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

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

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

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

1 Reynolds. On January the 26th, I obtained  
2 additional medical records of Dr. Perryman. On  
3 January the 27th, I received deposition  
4 transcript of Dr. Beth Braver. On January the  
5 29th, I received deposition transcript of Dr.  
6 Joseph Tomashefski. On February the 6th, I  
7 received deposition transcript of Dr. Michael  
8 Yaffe and, also, the instructions regarding  
9 today's deposition.

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

14 A. Yes, I think I have.

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

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

25 MR. KRAUSE: Thank you.

1 Q. Doctor, I think I might have asked you this. How  
2 many surgeries do you perform in a week?

3 A. Well, I do probably between six and ten major  
4 procedures a week and probably between five and  
5 ten minor procedures.

6 Q. And cholecystectomy, does that fall in the realm  
7 of a minor or major procedure?

8 A. Major.

9 Q. And at what hospitals do you have privileges?

10 A. Morristown Memorial Hospital.

11 Q. Are you still with Allied Surgical Group?

12 A. Yes, sir.

13 Q. Can you tell me if -- you have had privileges at  
14 other hospitals throughout your career, correct?

15 A. Only one.

16 Q. Well, at any of the hospitals where you have had  
17 privileges, have any of the lab criteria for  
18 those facilities defined a 7.9 hemoglobin as a  
19 criteria value?

20 A. I can't tell you because I don't know.

21 Q. Have you reviewed the blood transfusion criteria  
22 from Grace Hospital?

23 A. I don't believe that I have, no.

24 Q. Have you reviewed the deposition of Clifford  
25 Arrington?

1 A. I have not because I've read you all the  
2 depositions I've received.

3 Q. Fair enough. I'm just checking. I didn't know  
4 if I heard you.

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

7 A. Yes, sir.

8 Q. Is your December 5th report the one and only  
9 record you have authored in this case?

10 A. Yes, sir.

11 Q. You have not issued any supplements to the  
12 report?

13 A. That is correct.

14 Q. And did this report go out in draft before it  
15 went out signed or how does that work?

16 A. Well, generally, I speak with the attorneys after  
17 I've reviewed the documents that they've sent me,  
18 discuss with them my findings. And if I feel  
19 that there is reason to proceed and I agree that  
20 there has been malpractice or negligence, I then  
21 author a report and send it to them.

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

1 other than the discussion that I had with them.

2 Q. Doctor, what percentage of your professional time  
3 is involved with medicolegal expert review?

4 A. Probably five to ten percent.

5 Q. And have the rates that we talked about earlier,  
6 have they been the same for how long?

7 A. At least the last two years.

8 Q. Do you have any changes or amendments to your  
9 report of December 5th?

10 A. It was just pointed out to me today that I have  
11 the date of the Huron Hospital admission  
12 incorrect. I listed it as being admitted on  
13 4/12, but I was told it was 4/19. So I needed to  
14 amend that as being just probably a typo.

15 Q. Any other changes to your report?

16 A. No.

17 Q. Would you agree with me that it is important for  
18 you to be objective and reasonable in reviewing  
19 the medical records to determine whether a  
20 physician met the standard of care?

21 A. Yes, I would agree with that.

22 Q. Would you agree with me that the standard of care  
23 and an objective review of the standard of care  
24 would require you to view the patient and view  
25 the care in the -- under the -- as close as we

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

4   A.   Yes.

5   Q.   Why did Mrs. Arrington have a cholecystectomy?

6   A.   She had symptomatic cholecystitis.

7   Q.   Can you explain to me what that means?

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

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

12   A.   Correct.

13   Q.   Is cholecystitis a form of infection?

14   A.   It can be.

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

17   A.   Not that I'm aware of.

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

20   A.   Yes.

21   Q.   Why did Mrs. Arrington's hemoglobin drop from  
22           14.26 to 12.9 prior to surgery?

23   A.   I believe that was secondary to dehydration.

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



1 A. I have.

2 Q. Do you recall her discussion of that issue and  
3 dehydration?

4 A. I don't recall it specifically, no.

5 Q. As you sit here right now, do you disagree with  
6 any of the testimony you reviewed of Dr. Braver?

7 A. I can't specifically recount every part of her  
8 testimony. If there is a specific question that  
9 you have related to it, I'll be happy to answer  
10 it.

11 Q. Are you critical of Dr. Tamaskar's use of  
12 anticoagulants?

13 A. The answer to that is yes and no.

14 Q. Tell me why.

15 A. Well, in a patient who has had a history of  
16 recurrent deep-veined thrombosis, some degree of  
17 anticoagulation is appropriate. However, I am  
18 critical of the fact that he continued the  
19 Lovenox and in addition to the Coumadin while at  
20 the great -- I guess it's Grace Hospital. The  
21 rehab hospital or long-term care facility.  
22 Because I believe that that put Mrs. Arrington in  
23 undue risk for bleeding, which subsequently did  
24 occur.

25 Q. Do you agree with Dr. Tomashefski that it is

1 unusual to see a bleed post cholecystectomy?

2 A. Well, again, I think you are taking what he said  
3 out of context. It's unusual to see a bleed  
4 after cholecystectomy so far remote from the  
5 surgery.

6 Q. Do you believe that that was an unexpected  
7 outcome?

8 A. Well, I would hope so.

9 Q. When do you believe Dr. Tamaskar should have  
10 stopped the Lovenox and Coumadin?

11 A. I believe the Lovenox and Coumadin as a  
12 combination were very dangerous for this person.  
13 And I believe that once the Coumadin had been  
14 started, within 48 hours the Lovenox should have  
15 been stopped.

16 Q. I'm sorry. Once the Coumadin was started, within  
17 48 hours the Lovenox should have been stopped?

18 A. 48 hours of Coumadin.

19 Q. Based upon your review of the records, was that  
20 while the patient was here at Huron Hospital or  
21 transferred to Grace Hospital?

22 A. I'm sorry. Can you repeat the question.

23 Q. Based upon your review of the records, did that  
24 occur prior to discharge to Grace Hospital?

25 A. Did that happen or did not happen?

1 Q. Based on your review of the records, were they  
2 running Coumadin and Lovenox while the patient  
3 was at Huron Road?

4 A. Yes.

5 Q. To the extent any of the other physicians were  
6 involved in the determination of anticoagulation,  
7 would you be critical of them as well?

8 MR. FINELLI: Are we talking  
9 pre-op, postop or in totality?

10 Q. Postoperative.

11 A. Let me back up for a moment. I think that I  
12 misspoke and I confused Grace Hospital with Huron  
13 Hospital. The patient was on both Coumadin and  
14 Lovenox on the tail end of the admission to Huron  
15 Road Hospital and then was transferred to Grace  
16 Hospital on both of those medications. And I  
17 believe that the use of those medications while  
18 in Grace Hospital was appropriate, but upon  
19 transfer to Huron Road, was inappropriate after  
20 the first -- transfer to Grace Hospital --

21 Q. Doctor, let's start over. We've mixed up the  
22 names of the hospitals. I want to be clear  
23 because I want to be fair to you and everybody  
24 else.

25 A. Let me start again. I believe that the care

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

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

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

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

24 A. Yes. After transfer.

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

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

4 A. Yes, that is correct.

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

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

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

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

23 A. I would.

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

1 A. That is correct.

2 Q. For a patient that has a drop in hemoglobin or  
3 hematocrit such as Mrs. Arrington, what would be  
4 in your differential diagnosis?

5 A. Well, just in a vacuum, drop in hemoglobin and  
6 hematocrit is either due to one of three factors.  
7 The loss of blood, hemolysis or failure to  
8 produce new blood cells.

9 Q. Maybe I'm unclear. It might be my own  
10 inexperience. Doctor, I've never seen failure to  
11 produce new blood cells on a differential. Can  
12 you give me some why as to the scope of your  
13 differential diagnosis for a patient such as Mrs.  
14 Arrington relative to her hemoglobin and  
15 hematocrit?

16 A. If you are talking specifically to this patient  
17 in this situation, that's different than the  
18 question about what can cause a decrease in  
19 hemoglobin and hematocrit. Do you want me to  
20 limit it to this clinical situation and give you  
21 the most likely scenarios? I would be happy to  
22 do that.

23 Q. I want your differential diagnosis. Not just one  
24 likely scenario.

25 MR. FINELLI: Relative to Mrs.

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

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

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

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

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

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

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

25                   MR. KRAUSE:   I don't care.   Go

1                   ahead. Transfer over.

2                               - - - -

3                               (Off the record.)

4                               - - - -

5                               (Whereupon, the videoconferencing  
6                               of the deposition commenced.)

7                               - - - -

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

10      A. Any patient any time?

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

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

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

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

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

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



1 Q. Can staph aureus cause a drop in H and H,  
2 generally speaking?

3 A. Generally speaking, no.

4 Q. Is a drop in H and H associated with blood loss  
5 usually accompanied with hypotension?

6 A. Depends on the repetitiveness of the drop.

7 Q. Well, the circulatory system is a closed system,  
8 correct, when it's functioning properly?

9 A. Not specifically. Not specifically. Everything  
10 is interconnected.

11 Q. Well, blood just doesn't fall out of your body  
12 and it doesn't just fall out of vessels. So in  
13 that sense, it is a closed system, correct?

14 A. Correct.

15 Q. And I take it you believe that Mrs. Arrington was  
16 suffering from a postoperative bleed?

17 A. I believe Mrs. Arrington bled in the  
18 postoperative period. That's different than what  
19 I would consider a postoperative bleed.

20 Q. What do you consider a postoperative bleed?

21 A. Well, in the vernacular that I usually use,  
22 postoperative bleed is a bleed that is due to the  
23 surgery directly related to or very soon after an  
24 operation.

25 Q. Let's take that one at a time. Do you believe

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

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

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

9   A.   Yes.

10   Q.   What is that opinion?

11   A.   My opinion is that she would not have.

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

14   A.   Well, according to the hemoglobin and hematocrit  
15           records that I have, she started to bleed slowly  
16           between the May 2nd, May 3rd area -- I can't give  
17           you an exact time. But that accelerated on May  
18           7th.

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

21           You believe the bleed started on May 2nd?

22                   MR. MARGOLIS objection.

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

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

1 3rd?

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

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

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

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

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

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

19 A. No, I am not.

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

22 A. No, I am not.

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

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

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

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

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

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

19 Q. Is it your testimony that the H and H for Mrs.  
20 Arrington consistently dropped from 4/29 down to  
21 5/3?

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

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

4 Q. Did Mr. Finelli just speak to you?

5 A. No, sir.

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

9 MR. FINELLI: That's fine.

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

12 A. No.

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

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

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

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

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

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

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

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

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

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

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

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

1 consider the possibility of a bleed?

2 MR. KRAUSE: Objection.

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

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

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

11 Q. Maybe you have answered my question.

12 A. Okay.

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

15 A. No. That's all.

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

1                   you to specify times.

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

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

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

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

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

20                   MR. KRAUSE:   Objection.

21   A.   Yes.

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

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



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

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

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

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

15                   MR. FINELLI: Objection.

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

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

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

3 MR. KRAUSE: Correct.

4 A. Yes.

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

8 MR. MARGOLIS: Objection. What  
9 date?

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

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

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

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

25 Q. Have you been involved in your career with

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

3 A. Yes.

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

7 A. Yes.

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

17 A. That's correct.

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

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

1 I think we've talked about that earlier.

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

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

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

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

17 A. That's correct.

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

22 A. That is correct.

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

25 A. Yes.

1 Q. Do you have them there with you?

2 A. I have them in my bag.

3 MR. FINELLI: Dave, you're asking  
4 about May 7th?

5 MR. KRAUSE: Yes.

6 Q. Specifically, I wish I could give you a page, but  
7 they were signed off, I believe, at 2120.

8 MR. FINELLI: The ones he wrote at  
9 6:00 p.m. himself?

10 MR. MARGOLIS: At the risk of Dave  
11 coming over the table hitting me, if you  
12 look at page 148.

13 A. I believe I have it. It's Bates stamped 29. 29  
14 in our book.

15 MR. MARGOLIS: Right.

16 MR. KRAUSE: Just for the record,  
17 Ron, I would never come across the table  
18 and hit you.

19 Q. Doctor, why did Dr. Tamaskar order a KUB now?

20 A. Well, according to this, it says nausea.

21 Q. What do you attribute the patient's nausea to?

22 A. Bleeding.

23 Q. Did the patient have any other clinical signs and  
24 symptoms of bleeding? Well, let me give you a  
25 time. In fairness, let me give you a time. From

1           5/2 up until the time of her death.

2       A.    She had signs of complaining of abdominal pain.

3           And let me go to the nurse's notes.

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

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

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

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

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

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

22      Q.    What date was that, Doctor?

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

1 abdominal cramps.

2 Q. Cramping pain?

3 A. And then at -- pardon me.

4 Q. Cramping abdominal pain?

5 A. Complaining of abdominal cramps.

6 Q. And that is due to a bleed?

7 A. That is due to the distension of the bowel caused  
8 by the bleeding in the peritoneal cavity.

9 Q. That's on -- I'm sorry. That's on 5/7?

10 A. I believe that's 5/7 at 6:30 in the morning.

11 Q. So you have an opinion that she bled -- she had  
12 enough blood in her abdomen on 5/7 to have  
13 distension which led to abdominal cramps?

14 A. I believe that she at 6:20 on 5/7, there is a  
15 sufficient blood in the abdomen to cause both  
16 abdominal cramps or pain, which is likely  
17 secondary to the peritoneal. Then she was  
18 medicated with Percocet for that at 6:30.

19 Then at 8:00 p.m. she was complaining of  
20 abdominal discomfort in the right quadrant with  
21 nausea. And then at 2200 she had emesis. At  
22 1:30, it states that Dr. Tamaskar notified  
23 earlier of H and H. And I believe those are all  
24 signs of bleeding.

25 Then at 0800 it says patient hard to arouse.

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

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

6   A.   I have no clue.

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

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

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

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

19  A.   No, sir.

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

22  A.   No.

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



1 a bleed comes into your differential?

2 A. That's an obtuse question and I'm not sure I  
3 understand what you are driving at.

4 Q. Have you ever had a case where you looked at KUB?  
5 Well, first of all, do you review KUBs as a  
6 surgeon?

7 A. Yes, sir.

8 Q. You order them?

9 A. Yes, sir.

10 Q. And can you see free air on KUB?

11 A. Yes, sir. On KUB, if it's flat, usually not.

12 Q. What if it changes the shape and location of the  
13 organs in the abdomen?

14 A. Free air?

15 Q. Free air.

16 A. Well, free air migrates anteriorly on KUB, which  
17 is a flat abdominal x-ray. Unless you had  
18 massive amounts of free air, you would not be  
19 able to see it because it was layered anteriorly.

20 Q. What about a liter of blood?

21 A. Again, KUB is a very insensitive test for picking  
22 up the bleeding. I'm not sure you can reliably  
23 pick up bleeding, even up to a liter, on KUB.

24 Q. Would you characterize Mrs. Arrington's bleed,  
25 which you believe started I think you said on 5/2

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

3   A.   I would say acute and subacute.

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

5   A.   If that's what he said.

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

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

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

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

24   Q.   What about subacute?

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

1 Q. Do you have any criticisms of Dr. Tamaskar's  
2 preoperative care of Mrs. Arrington?

3 A. I do not.

4 MR. MARGOLIS: Excuse me. He was  
5 just editorializing. We've been over this  
6 three times.

7 MR. KRAUSE: No, no. Actually, I  
8 didn't ask him preoperative.

9 Q. When Dr. Tamaskar received the phone call from  
10 the nurse at Grace Hospital on 5/7, you've  
11 addressed a criticism in your report during that  
12 time frame. I wanted to know what Dr. Tamaskar  
13 needed to do to meet the standard of care.

14 A. During which time frame? I'm sorry.

15 Q. 5/7/2002 after getting the call from the nurse  
16 about the 7.9.

17 A. Well, he needed to do everything. He needed to  
18 -- shall I continue?

19 Q. Yes. Please.

20 A. He needed to make sure there was blood available  
21 to transfuse her. He needed to move her to the  
22 hospital so that she could be better evaluated.  
23 He needed to obtain an imaging study to identify  
24 where the bleeding was.

25 Q. A CT scan?

1 A. Correct.

2 Q. Anything else?

3 A. I believe those are the major ones. And  
4 establish IV access, if she didn't have it.  
5 Running fluids for resuscitation.

6 Q. So let me go through these to make sure I have  
7 them all. Need to make sure there was blood  
8 available for transfusion. Transfer to the  
9 hospital. Obtain a CT scan. And if she didn't  
10 already have it, establish IV access. Is there  
11 anything I missed?

12 A. And check her coagulation parameters.

13 Q. Do you have an opinion as to what her coagulation  
14 parameters would have been on 5/7/02 and up to  
15 the early morning hours -- not early morning  
16 hours. Let's say early 5/8?

17 A. Well, according to the chart that I have, the INR  
18 was 1. -- 1.18 when it was initially drawn. And  
19 the next one on May 8th, the 2.2 with a PT of 57.  
20 Of course, you can't gauge the effect of the  
21 Lovenox because that's not measured either by the  
22 PT or PTT. My impression would be her clotting  
23 parameters would be closer to the 2.2 and 57 than  
24 to the 1.18.

25 Q. Do you have an opinion as to what would need to

1 be done to reverse the anticoagulation?

2 A. Yeah. She would need to get fresh frozen plasma  
3 and/or cryoprecipitate.

4 Q. Do you have an opinion as to how much fresh  
5 frozen plasma?

6 A. Enough.

7 Q. Explain to me how that works. Are you telling me  
8 that you continue to monitor the patient and see  
9 how she does or what are you telling me?

10 A. Well, it's a continuum with many things being  
11 done at once. You need to establish where her  
12 pro time and PTT are and correct them back down  
13 towards normal at the same time that you give  
14 blood to transfuse the hemoglobin and hematocrit  
15 back towards normal at the same time that you are  
16 resuscitating with IV fluids and obtaining the  
17 needed imaging studies to see where the bleeding  
18 is from and whether it's ongoing.

19 Q. Well, let's do it this way. Do you have an  
20 opinion as to how long it would take to get her  
21 on fresh frozen plasma?

22 A. Well, fresh frozen plasma takes approximately 20  
23 minutes to thaw.

24 Q. So do I understand your opinion to be that within  
25 20 minutes or so of receiving the phone call from

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

3 A. No.

4 Q. Why not?

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

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

19 A. Correct.

20 Q. Within two hours?

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

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

24 A. Yeah.

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

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

3   A.   Yes.

4   Q.   And what would it have shown?

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

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

9   A.   Correct.

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

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

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

17   A.   Well, I think it was an ongoing phenomenon, as I  
18           mentioned earlier. But I think the major part of  
19           the bleeding occurred sometime at the time that  
20           the patient started to become symptomatic of  
21           nausea and cramps. So sometime around 6:00 or  
22           7:00 a.m. on May 7th.

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

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

1           you have it there?

2       Q.    52, Doctor.

3       A.    Blood alcohol of 52.

4                           MR. FINELLI:   .052.

5       A.    Should not.

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

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

9                           MR. FINELLI:   .3 for Margolis.

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

11      A.    Correct.  Correct.

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

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

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

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



1 Q. So you won't be commenting at trial about that,  
2 fair enough?

3 A. That's correct. Just to let you know, we have  
4 about another ten minutes. I have 20 after, but.

5 Q. Do you believe that surgical intervention would  
6 have been necessary to save Mrs. Arrington's  
7 life?

8 A. No.

9 Q. You believe that a transfer to Huron Road  
10 Hospital and CAT scan and transfusion and  
11 reversal of her anticoagulants would have stopped  
12 the bleed in time to save her life?

13 A. Yes, I do.

14 Q. Do you have an opinion as to what the PTT and INR  
15 would have been had Dr. Tamaskar taken the steps  
16 that you say he was required to take by around  
17 2:00 or 3:00 in the morning on May 8th?

18 A. Well, as I mentioned before, I believe that it  
19 would be closer to the level of 2.2 for the INR  
20 and the 57 for the PTT. I would imagine that  
21 they would be very close to those numbers.

22 MR. FINELLI: Just for  
23 clarification, I don't think he said around  
24 2:00 or 3:00 in the morning.

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

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

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

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

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

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

14 A. That's correct.

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

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

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

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

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

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

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

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

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

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

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

3   Q.    Could it have been a resident?

4   A.    Could have been a resident.

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

8                   MR. FINELLI:  Objection.

9   Q.    On May 7th, 2002?

10                   MR. FINELLI:  Objection.

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

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

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

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

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

5                   MR. FINELLI:  Objection.

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

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

10                   MR. FINELLI:  At what time, Dave?

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

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

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

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

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

25   A.   Well, I try not to.

1 Q. You want to express opinions to a probability  
2 when you have them, right?

3 A. That's correct.

4 Q. If the patient were hypotensive, would you expect  
5 the nurses to write that down?

6 MR. FINELLI: Objection.

7 A. If they monitored the vital signs, I would expect  
8 them to write that down, yes.

9 Q. Have you been given any of the blood transfusion  
10 criteria from Huron Road Hospital?

11 A. I don't believe I've seen those, no.

12 Q. Do you believe Mrs. Arrington was a chronic  
13 anemic?

14 A. The only information I have is based on the  
15 admitting labs and labs prior to her surgery  
16 which showed she was not anemic.

17 Q. Did you review the records of Dr. Perryman?

18 A. I did. But I don't recall them specifically as  
19 we sit here.

20 Q. Well, when did you get those?

21 A. I got those January 26th.

22 Q. The CT that you say should have been ordered,  
23 would that be a CT with or without contrast?

24 A. A CT with contrast.

25 Q. And what would need to be done to the patient to

1           prepare her for a CT with contrast?

2       A.   Put an IV in.

3       Q.   What about her digestive system?

4       A.   Well, if you are talking about oral contrast  
5           versus intravenous contrast, when you are looking  
6           for bleeding, particularly in a patient with a  
7           low hemoglobin and hematocrit like this, then you  
8           can forgo the oral contrast or use an abbreviated  
9           prep which can be done within an hour and still  
10          give the intravenous contrast.

11      Q.   So you still, despite the fact that you believe a  
12          CT with contrast was warranted, you still believe  
13          that all of that should have been completed  
14          within two hours of Dr. Tamaskar receiving the  
15          phone call on May 7th in order for him to comply  
16          with the standard of care?

17      A.   That's correct.

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

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

22                   -   -   -   -

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

25                   -   -   -   -

1 Q. Have I covered all of your criticisms of Dr.  
2 Tamaskar?

3 A. Yes, you have.

4 Q. If you form any new opinions -- strike that.  
5 Have we covered all of your opinions with respect  
6 to cause of death?

7 A. Whatever we had in this deposition, whatever is  
8 in my written report are my sum total of my  
9 opinions.

10 Q. Let me ask you this: You have reviewed the  
11 autopsy report from Dr. Tomashefski?

12 A. Yes, sir.

13 Q. And you have reviewed Dr. Tomashefski's  
14 deposition?

15 A. Yes.

16 Q. Do you agree with the findings on autopsy?

17 A. Well, the findings on autopsy speak for  
18 themselves. The bleeding and the blood in the  
19 abdomen speak for itself.

20 Q. Is that a yes or no or maybe or I can't answer?

21 A. Well, very specific. The findings on the  
22 autopsy, I agree with the findings of the autopsy  
23 that the patient exsanguinated.

24 Q. Doctor, do you have any criticism of any other  
25 care providers?



1 A. Do I? I do not.

2 Q. You believe the nurses met the standard of care?

3 A. Yes, I do.

4 Q. Is it safe to say you do not believe the  
5 hemoglobin and hematocrit of May 7th, 2002 were  
6 critical values such that after the nurse advised  
7 Dr. Tamaskar and Dr. Tamaskar didn't come in the  
8 nurse should have gone up the chain of command  
9 and gotten another doctor to look at this  
10 patient?

11 MR. FINELLI: Objection.

12 A. I believe as it is stated in the nurse's note  
13 that the nurse spoke with the doctor, that the  
14 doctor told her that he was not -- that he gave  
15 some orders and that she was to monitor the  
16 patient. I believe that was her responsibility.  
17 I don't believe her responsibility included  
18 anything more than that.

19 Q. As a general concept, if a nurse -- you would  
20 agree that if a nurse receives an order from a  
21 physician or believes a patient needs to be seen  
22 by a physician and the physician is not there,  
23 the nurse has a responsibility to go up the chain  
24 of command? That's not a new concept?

25 A. It depends on the protocol of the hospital that

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

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

17                   MR. FINELLI: Objection.

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

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

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

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

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

11   A. That's correct.

12   Q. All within two hours?

13   A. That's correct.

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

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

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

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

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

8                           MR. FINELLI: Objection.

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

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

14   A. Yes.

15   Q. So if the patient as you perceived it had -- if  
16           there is documentation in the nurse's notes from  
17           1:00 in the morning on 5/8 up until the time of  
18           death on 5/8 of changing clinical conditions or  
19           onset of new symptoms or changing symptoms, you  
20           would agree with me it's the responsibility of  
21           the nurses to communicate those to the doctor,  
22           correct?

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

1 Q. Sure.

2 A. Or to make plans to see a patient who is clearly  
3 changing in condition with a new finding of a  
4 decreased hemoglobin and hematocrit before the  
5 next morning.

6 Q. Understood. Doctor, have we discussed all your  
7 opinions that you intend to testify to at trial  
8 with respect to this case?

9 A. Yes, sir.

10 Q. And if you form any new ones, I would ask you to  
11 let Mr. Margolis and Mr. Finelli know and they  
12 will get in touch with me and we can do this  
13 again perhaps by phone. Fair enough?

14 A. That's fine.

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

17 Q. Does that sound fair to you, Doctor?

18 A. That's fair.

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

21

22

23

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AARON CHEVINSKY, M.D.

24

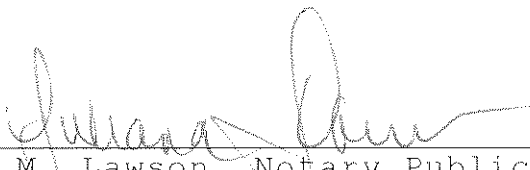
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C E R T I F I C A T E

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 16<sup>th</sup> 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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