IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

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KATHY EVERETT,
Administratrix of the
Estate of
ELSIE MARIE PARSONS,
deceased.

Plaintiff,

vs

Case No. 432317
Judge Burnside

METROHEALTH MEDICAL CENTER,
et al.,

Defendants.

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CONTINUED DEPOSITION OF ANTHONY DiMARCO, M.D.

TUESDAY, APRIL 30, 2002

VOLUME II

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Continued deposition of ANTHONY DiMARCO, M.D., a Witness herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at the offices of MetroHealth Medical Center, 2500 MetroHealth Drive, Cleveland, Ohio, commencing at 3:30 o'clock p.m. on the day and date above set forth.

APPEARANCES:

On behalf of the Plaintiff

Becker & Mishkind

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On behalf of the Defendants

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DEIRDRE HENRY, ESQ.

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ANTHONY DiMARCO, M.D., a witness herein, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was deposed and said as follows:

EXAMINATION OF ANTHONY DiMARCO, M.D.

BY MR. MISHKIND:

Q. Doctor, we met back in November and I started your deposition at that time. We were interrupted by a tragedy to you personally and we are here to finish the deposition today.

I'm not going to repeat the questions that had been previously asked of you. I hope to just pick up from where we left off and continue.

I do want to ask you, first, whether you had a chance to review the transcript, the 30 some pages of transcript from your November deposition?

A. I did.

Q. When you read it over, did you note any significant errors or mistakes in what was taken down in the transcript?

A. No, I didn't.

Q. Since the deposition, have you had an

opportunity to review any additional records or information concerning this case?

A. No.

Q. Have you been provided with any of the depositions of any of the nurses that have been taken in this case?

A. No, I haven't.

Q. Have you been provided any of the expert reports that have been authored on behalf of the plaintiff in this case?

A. No, I haven't.

Q. Any research?

A. No.

Q. The information that you had back in November in terms of what you had reviewed, that being the chart, is the extent of the information that you have reviewed again for purposes of today's deposition; true?

A. That's true.

Q. I do see a copy of the CV, which we had mentioned and you had talked about various abstracts and articles. Is this a current copy of your CV?

A. I believe so, yes.

Q. In terms of your position, doing the

research at UH and the pulmonary aspect and your position in Geauga, has any of that changed at all?

A. No.

Q. I believe I had asked you whether any of your articles pertained to or were relevant to any of the issues in this case, and my recollection from reviewing the transcript was that you said there wasn't anything that you have written that would be relative or pertinent to this case. Does that still stand?

A. Yes.

Q. I'm not going to mark this as an exhibit, other than to acknowledge it's a 29 page document, with the last entry being under current grants, November of 2000 to October of 2003, and a revision as of October 2000.

A. Right.

Q. That would be the most recent edition that you produced?

A. Yes.

Q. Thank you.

When we left off, you had referenced or indicated to me that there were certain aspects of the afternoon of September 14th that

you remembered independently from the record. Do you remember that?

A. Yes.

Q. I think you indicated that your normal practice was to round in the morning and then in the late afternoon or early evening; true?

A. Yes.

Q. And I think you also referenced that you had a recollection of talking with the resident as to the change in the afternoon in terms of the patient's hematocrit?

A. Yes.

Q. I think you also told me that you remember having a discussion about getting a CT scan done to evaluate the patient?

A. Yes.

Q. In terms of anything independent of the record -- and we are going to talk about the record and what went on during that hospitalization -- primarily with regard to September 14th, leading up to the time of her death, but on the 14th, is there anything that you remember independent of the record, other than what you have already told me about in the

beginning of your deposition?

A. Nothing I recall at this time.

Q. When you refer to the resident, I want to try to determine which resident it likely would have been, because there appeared to be two different residents, a Dr. Sarkar and a Dr. Eisenberg.

Do you know which of the residents it would have been that you would have communicated with that afternoon?

A. I don't remember.

Q. By looking at the chart, in terms of the progress notes or the orders that were written, would that help at all in terms of being able to determine which of the two it was, or possibly both?

A. Well, I would have spoken to the resident taking care of this patient, but short of that, I don't remember a specific name that I spoke with.

Q. When I say Dr. Eisenberg's name, are you able to picture him or remember him as a resident that was working?

A. I know he was a resident working in the unit at that time, but I don't remember

specifically talking to him.

Q. There were a number of orders written by Dr. Sarkar at 5:30, including the order, I believe, for the CT scan. Can you tell me whether you would have talked with Dr. Sarkar before the CT scan would have been ordered or would he likely have ordered that on his own?

A. I think it's likely that I saw the patient and evaluated the patient that afternoon, had discussions with the residents, probably all the residents that were present there, and we discussed what the situation was, what the differential diagnosis was, and what the plan would be. And these orders probably followed that.

Q. Dr. Sarkar, is that a name that you remember?

A. I remember the name.

Q. Do you remember him being a resident?

A. I don't remember.

Q. Again, I understand it's been a long time. This was back in '99.

A. Right.

Q. I think you told me that you remember assessing the patient?

A. Yes.
Q. But you weren't certain what time that assessment was made; is that true?
A. That's true.
Q. Are you able to give me a better sense as to whether their assessment would have been late in the afternoon or early in the afternoon?
A. Well, my general practice is to make rounds in the morning and those rounds usually extend until at least noon or 1:00 o'clock. And then I leave the unit and I usually come back in the afternoon between, say, 3:00 or 4:00 o'clock and 6:00 o'clock. So my best recollection, that return would have been in the late afternoon.
Q. Independent of what may be noted in the progress notes by you concerning the patient's condition, do you have an independent recollection of what your assessment revealed when you saw her on September 14th sometime later that afternoon?
A. Yeah, based upon my progress notes.
Q. And we will talk about that. But is there anything without that progress note that you remember independently about Mrs. Parsons in

terms of how she appeared?

A. I do remember that. I remember she appeared comfortable and able to give me a history. And there was nothing strikingly different about her compared to when I had seen her that morning. She appeared very stable.

Q. Now, the change in the hemoglobin and the hematocrit that became evident when the labs were drawn early that afternoon -- and there were several sets of labs that were drawn. There was a set of labs at about 12:15 and another set of labs at 1:05 or 1:00 o'clock.

A. I think I know which one you are referring to.

Q. Those were the ones eventually brought to your attention; correct?

A. Yes.

Q. Would that likely have been later that afternoon when you came back or would you likely have been made aware of those at or around the 12:00 to 1:00 o'clock time frame?

A. I would have most likely been made aware of those later in the afternoon.

Q. Is this a progress note that you wrote?

A. Yes, it is.
Q. On the 14th, did you write any additional progress notes besides the one I just handed to you?
A. I would have to check the record.
Q. Please.
A. This is the only progress note on that day.
Q. This progress note is not timed; correct?
A. That's correct.
Q. Is this a progress note that would have been written in the afternoon or in the morning?
A. In the afternoon.
Q. Can you slowly read what you have written there so that I can understand it and also so that we can get it into the record.
A. Certainly. It's dated September 14th, 1999. Labeled MICU attending. Patient seen/examined. Feeling better. Less short of breath. At rest - hoarse. Generalized weakness.
Next line, examination. Elderly female in distress. Afebrile. Blood pressure

160 over 78. HEENT. Post pharynx erythematous. Nasal bleeding.

Neck, ecchymosis, right neck area. Chest, few wheezes bilaterally. Heart, irregular rhythm. Norm at S1/S2. Abdomen soft. Positive bowel sounds. Extremities positive edema.

Normal sodium, potassium. Calcium 8.2. Hematocrit 29 arrow 22. PO2 68. PCO2 39. Chest x-ray right infiltrate.

Assessment, pneumonia, hypoxemia. Respiratory failure improved. Anemia. Recent fallen hematocrit. Atrial fibrillation.

Plan, continue antibiotics. Workup for blood loss. Question related to ENT procedure. Follow hematocrit closely. Check stool quiac. Transfusion.

And then critical care time is 35 minutes and then my signature.

Q. What does critical care times 35 minutes mean?

A. That's the minimum amount of time I spent either discussing or examining that patient during that day.

Q. And then that's your signature after

that?

A. Yes.

Q. And to your knowledge, in reviewing the chart, is this the only progress note that you wrote on the 14th?

A. Yes.

Q. What caused the patient's nasal bleeding that you noted toward the top?

A. My assessment was it was possibly related to, she had an ears, nose and throat evaluation. She had a procedure where they place a tube through the nose to evaluate her upper airway.

Q. That was done on the 13th?

A. The day before.

Q. A flexible endoscopy?

A. Yes.

Q. She didn't have any bleeding on the 13th, though?

A. During the procedure, it's not uncommon to have some slight bleeding.

They oftentimes don't document that because it's a common occurrence with a procedure like this.

Q. Did the nurses bring to your

attention when you assessed her in the afternoon that she had had bleeding that was documented around noon on the 14th, the day after this procedure?

A. I don't recall.

Q. At that time, she was on heparin; true?

A. Yes.

Q. And can heparin cause a patient to have epistaxis?

A. Yes.

Q. Are you able to say to any degree of certainty based upon the history that you obtained at that point what the cause of the nasal bleeding was?

A. At this point my impression was that it was related to the procedure, because she had trauma to her upper airway and it was probably a combination of the fact that she was on heparin and the fact that she had trauma to her upper airway.

Q. Now, you also noted the ecchymosis on the neck area; correct?

A. Yes.

Q. And there had been a note made at

about 1:15 that afternoon on the 14th by a senior medical student who also noted a three by three centimeter ecchymotic area on the neck. It wasn't noted by any of the nurses. It just seemed that you and the senior medical student noted it.

I guess my first question to you, with that background in mind, do you recall seeing the ecchymotic area on the neck, independent of the note?

A. No.

Q. I presume the answer is no, but I will ask it anyway. Do you recall having any discussion with the nurses about how long the ecchymosis existed or when it first became evident to any of the medical team?

A. No.

Q. Is ecchymosis also a potential sign of a bleed?

A. It is bleeding. It represents blood underneath the skin.

Q. With the ecchymosis in the neck and the bleeding from the nose, can both of those events be secondary to the patient's heparin?

A. They can be.

Q. Did you have an opinion at the time that you saw the patient as to what was causing the ecchymosis in the neck area?

A. My impression was, in reviewing this, that likely she had an attempt at an intravenous placement in the neck area, because that's our common practice, and that the ecchymosis was a consequence of that.

Q. There is no evidence in the record, though, that there was any attempt to place a line in the neck area, is there?

A. Not that I'm aware of.

Q. In fact, she had a central line in place, didn't she, at that time?

A. She had. At the time of this note you mean?

Q. Yes.

A. At the time of the note she did, yes.

Q. So that is supposition, that's speculation on your part as to that someone tried to place an IV into the neck area; true?

A. Yes.

Q. Short of some instrumentation or attempted insertion of an IV line, what else would explain an acute onset of ecchymosis in a

patient such as Elsie Parsons?

A. Trauma to the neck.

Q. Any evidence that she had sustained any type of trauma?

A. Not that I know of, no.

Q. Of what significance was the drop in the hematocrit that you noted from 29 to 22 in your note there?

A. I'm sorry, I don't understand the question.

Q. Were you concerned about the drop in her hematocrit?

A. Yes, I was.

Q. What was within your differential as to potential causes for her drop in her hematocrit at that time?

A. Well, the common causes would be blood loss. We were concerned about blood loss from some source, and common sources would be GI bleeding. So some internal bleeding from either the stomach or the small bowel or large bowel would be a major concern.

It was thought that it was probably some bleeding from the nose that may have been attributing to a certain extent, although it did

not seem enough to explain this fallen hematocrit.

Q. In fact, the note, I think you would probably agree, showed an oozing of blood from the nose?

A. Right.

Q. And that certainly would explain a significant drop in hematocrit in and of itself; true?

A. Right, true.

Q. So possible causes would include intraabdominal bleed, as well as a GI bleed?

A. There is other causes as well. There is intraalveolar bleeding that could also explain the fallen hematocrit. Those are the major things to be concerned about.

Q. Right next to anemia -- I'm sorry, I was listening -- what does that say?

A. Recent fallen hematocrit.

Q. And you questioned whether it was related to the ENT procedure with a little question mark there; right?

A. Yes.

Q. You weren't certain when you made that note; correct?

A. That's correct.
Q. When you marked down transfusion, had the patient -- strike that.
I take it that when you marked down transfusion, the patient had already been typed and crossmatched?
A. I don't know that.
Q. The records would reflect that she was actually typed and crossmatched some time around 12:15, I believe.
MS. HENRY: Objection.
Q. I'm sorry, 1:05 p.m.
MS. HENRY: Still objection.
Q. If she had been typed and screened at 1:05, do you know what the normal period of time is at Metro or what it was back in '99 to type and screen a patient for a transfusion?
A. The duration it would take to type and screen somebody?
Q. Right.
A. I would think it would take several hours is my guess.
Q. Are there circumstances where a type and screen is done on a stat basis?
A. Yes.

Q. And what are those circumstances?
A. Well, somebody is hypotensive, in shock, we would do it much more promptly. I don't know exactly the amount of time that's required to type the blood and then screen the blood for the antibiotics, I don't know how long that process is.
Q. When a stat H&H is ordered, what is the normal time period when a patient is in the medical intensive care unit?
A. My recollection would be within an hour or so.
MS. HENRY: Off the record.
(Discussion off the record.)
Q. On the MICU attending note that we have just gone through, you don't reference the CT scan, do you?
A. No.
Q. Was the discussion concerning the CT scan likely after this note or before?
A. Most likely it was after, because at the time I wrote this note, we had not evaluated her for internal GI bleeding, and if that would have been positive, there would have been no need for the CAT scan. And since that workup

was negative, that prompted the additional search for blood.

Q. What workup was negative?

A. They looked at her stomach contents to see if there was blood there. And they looked at a sample of her rectal excretions and that was also negative.

Q. So they did a lavage to look for blood?

A. For blood.

Q. So from the standpoint of there being a GI bleed, that was fairly helpful in terms of ruling that out?

A. Yes.

Q. That didn't necessarily rule out any type of a retroperitoneal bleed, though?

A. Correct.

Q. And would a CT scan be of any assistance in terms of evaluating a patient for a retroperitoneal bleed?

A. Yes.

Q. The senior medical student that made the note at 1:15 p.m. on September 14th is referenced under cardiology. Would he have been under your jurisdiction?

A. No.
Q. On September 14th, who would have been responsible for supervising the senior medical student?
A. The attending cardiologist.
Q. Who would that have been?
A. There is a note September 13th, signed by Dr. Bahler, who is a cardiologist.
Q. Give me the last name again, please.
A. Bahler.
Q. B-A-Y?
A. B-A-H-L-E-R.
Q. Even though you don't work at Metro any longer, I think at the time that I took your deposition, I think you said that because of some of your research activities that you do have some contact with Metro?
A. Yes.
Q. Have you had occasion to talk to any of the nurses that were involved in the aspect of Elsie Parsons' care at any time since we met back in November?
A. No.
Q. Or at any time prior to November, since Elsie Parsons died?

A. No.
Q. Do you know why a flexible endoscopy was done on September 13th?
A. This is by the ENT physicians?
Q. Yes.
A. Yes, I do.
Q. What is the reason?
A. After she was extubated, she was complaining of shortness of breath and had signs of upper airway obstruction. The evaluation was to determine whether she had any vocal cord inflammation or stricture that would cause her to have further difficulty breathing.
Q. Any type of subglottic stenosis or anything of that nature?
A. Any type of stenosis or vocal cord inflammation or stricture that would cause obstruction.
Q. Would the flexible endoscopy, endoscope, identify any source of bleeding --
A. Yes, it would.
Q. -- if there was an acute bleed in the area of the upper airway?
A. Yes.
Q. If it wasn't in the upper airway, a

flexible endoscopy would not be your first line of diagnostic tool to identify, for example, a retroperitoneal bleed?

A. No.

Q. You were the attending in the afternoon of December 14th?

A. Yes, I was.

Q. I'm sorry, September 14th.

A. Yes.

Q. I jumped a couple months ahead.

A. All right.

Q. In terms of hierarchy, if you will, if there needed to be a change in the heparin administration, or stat transfusion, or anything to treat this patient once there was a significant change in her hematocrit, were you to be notified or was it acceptable to notify one of the residents?

A. Can you repeat that again?

Q. I guess there is no question that at or around 1:00 o'clock, even a little bit earlier than that, Dr. Eisenberg and others recognized that this patient's hematocrit had dropped from what it had been on the 13th and then was noted to be even lower at 1:00 o'clock.

And I think you told me in your deposition that there had been a change in the hematocrit in the afternoon.

If there was a need to change the heparin administration or to provide the patient with transfusion or other diagnostic studies, was it required that you be contacted to authorize any of that?

A. No.

Q. So contacting Dr. Eisenberg or Dr. Sarkar, assuming he was a resident, as well, was acceptable?

A. Yes.

Q. It doesn't appear as if you were contacted in any way during the afternoon until you came back to make your late afternoon rounds; would that be a fair statement?

A. I'm not certain of that, because I'm usually in the ICU until 1:00 or 2:00 o'clock in the afternoon before I finish making rounds, and so it's quite possible that I was informed at that point.

Q. Can you tell from the record whether or not you were informed?

A. No, I can't tell.

Q. According to the labs, the hematocrit that was drawn at 12:15 on September 14th was, hematocrit and hemoglobin was 23.9 and 7.7 respectively. Does that appear to be accurate?

A. Yes.

Q. And then there was a stat H&H drawn and that was at 12:59 which was reported at 22.1 and 7.4 respectively; true?

A. Yes.

Q. Now, in looking at the record, it does not appear that the heparin drip was turned off until approximately 1:40 on September 14th. Do you know why the heparin was continued?

A. Well, this lab was drawn at 1:00 o'clock. I think the physician wasn't informed about this until sometime later. Below you can see that they notify the physician when critical values are obtained and these are not in the critical range. So it took some time, I would imagine, between the time it was drawn, taken down to the lab, run, and then reported back up to the intensive care unit. And that could have been as long as 45 minutes, an hour, something like that.

Q. The record would suggest that the H&H

from 12:59 was not reported back to Dr. Sarkar until approximately 2:40 p.m. or an hour and 40 minutes. If that is in fact accurate, would you find that to be an unusually long period of time in a patient that has had a stat H&H ordered?

A. Somewhat long, yes.

Q. Do you know of any reason in this case that a stat H&H would take an hour and 40 minutes to report back up to a resident?

A. Not that I know of.

Q. Would you expect it to be reported back sooner?

A. Yes. It was 1:40?

Q. It was reported back up at 2:40.

A. I thought you said 1:40.

MS. HENRY: One hour and 40 minutes. I'm sorry, Howard, you said it was not communicated to Dr. Sarkar until 2:40. Can you tell me -- at the moment I can't find it.

MR. MISHKIND: It's actually on the flowsheet, 2:40 p.m., repeat H&H.

Q. In the physician's order sheet, doctor, at 1:05, I think we have pretty well established that this is Dr. Eisenberg's note. There is three things that he has ordered, a

stat H&H, repeat coags and then T&S. Do you see that?

A. Yes.

Q. And the T&S would stand for?

A. Type and screen.

Q. And again, this was not your order, but you know what is being planned by this order; correct?

A. Yes.

Q. And when one types and screens someone, what is that being done for? What's the reason?

A. Well, it's in preparation for possible transfusion.

Q. There is an order right below that also, I believe, by Dr. Eisenberg and it appears to be 3:00 p.m. or 1500. Do you see that?

A. Yes.

Q. And there is an order to transfuse. If you could perhaps help me out with deciphering that, although I am pretty sure I know what it means.

A. Transfusion, two units of packed red blood cells.

Q. And then continuing?

A. Check hemoglobin/hematocrit four hours post. Each unit over two to three hours.

Q. It does not appear that the transfusion was started on this patient until, I believe, the earliest was 5:30, according to the records. Do you have any explanation for why that period of time would go by where the patient was typed and screened at 1:05, an order for transfusion was given at 3:00 o'clock, and yet transfusion was not started until 5:30?

A. Well, it doesn't strike me as an unusually long period of time. The blood still has to be crossmatched between the donor and the recipient's blood. That takes some time.

Q. Isn't that what the 1:05 order is all about?

A. To my knowledge, screening is just a screening of the recipient's blood for possible antibiotics. A crossmatch is where they actually look at the donor blood and see if there will be any transfusion reaction between the donor and recipient.

Q. Is it fair to say at 1:05 at least a possibility of transfusion was under consideration?

A. Yes.

Q. Is there any reason why a type and screen and a type and crossmatch can't be done at the same time?

A. It could be, but there wasn't any order to transfuse at 1:05, so they may be in preparation, but they may not have gotten donor blood prepared as yet.

Q. If you anticipate doing a transfusion, though, isn't it standard of care to type and crossmatch a patient at the time the consideration for transfusion is given?

A. Not necessarily, because they may not -- at that point in time, it appears that at a definite decision hadn't been made to transfuse.

Q. And do you know, even assuming that is an accurate account, do you know why there wasn't a crossmatch done at 3:00 p.m.?

A. Well, at 3:00 p.m. with the order to transfuse, I'm sure the blood bank is going to be doing the crossmatch at that point.

Q. Do you have any explanation in this case why in a patient who has a dropping hematocrit and hemoglobin, why it would take

until 5:30 to start the administration of the packed red blood cells?

A. Again, with the order at 3:00 o'clock, two and a half hours doesn't see like an inordinately long period of time in terms of what our standard is in terms of giving patients blood when the patient was as stable as she was.

Q. Do you have any explanation for why the heparin drip in this case was restarted at 2:10 p.m. while the results from the 1:05 stat H&H were still pending?

A. I don't know why.

Q. Would that seem a little bit unusual if you have a stat H&H on a patient that has a drop in their hematocrit and hemoglobin to restart a heparin drip pending the results of the hemoglobin and hematocrit?

A. I'm trying to think of the thought process that went through the residents at that time, and if there were certainly a fallen hematocrit, and that fallen hematocrit was attributable to bleeding, then in that case, it should have been stopped.

Q. It would be below the standard of care to restart it; true?

A. Yes.
Q. Doctor, looking at the labs, again it looks like the next H&H that was done was at 1650?
A. Yes.
Q. Or 4:50 p.m.?
A. Yes.
Q. And at that time, that hemoglobin of 6.8 is in the critical range; true?
A. Just below the critical range, yes.
Q. But nonetheless, that little C next to it means that the lab is to be doing certain things in terms of reporting it back to the individual that requested it; true?
A. They are to call the requesting nurse or physician.
Q. And again, at this point, at 4:50 p.m., Mrs. Parsons was not being transfused; true?
A. True.
Q. Should Dr. Sarkar have been notified within minutes of the results being available of that 4:50 critical hemoglobin?
A. Yes, he should have been notified.
Q. Do you know, or do you have any

explanation in this case as to why Dr. Sarkar was not notified until 5:30 or almost 40 minutes after this critical hemoglobin was reported?

A. I don't know why.

Q. Would you expect that a critical hemoglobin should be reported to the resident in a more timely manner than what took place in this case?

MS. HENRY: Objection.

A. Well, under ordinary circumstances, I don't know what he was doing, if he was with another patient or down in the emergency department. I don't know all the circumstances. Ordinarily, the physician is notified promptly about critical values.

Q. In this case, being the attending, you know of no reason why Dr. Sarkar or some other resident couldn't have been notified of the critical hemoglobin from the 4:50 time period; true?

A. Well, I don't even know that they were not notified.

Q. The nurse's notes show that at 5:30 Dr. Sarkar was notified of the drop in the H&H. If that record accurately reflects things, that

would be roughly a 50 minute --

A. The lab was drawn at 1640 and the note says below critical value, call to Laura at 1713, which is 5:13, and he was notified at 5:30, which is only 15 minutes later. So that sounds like a pretty fairly prompt notification.

Q. You believe that's a reasonable period of time?

A. Yes.

Q. Dr. Sarkar's order at 5:30 p.m. includes 15 various things, including the CT of the abdomen, to rule out a retroperitoneal bleed, and that was a reasonable order; correct?

A. Yes.

Q. And that's something that should have been done that evening as opposed to the next day; true?

A. Well, it was ordered for that day. And we expected it to be done that day.

Q. I'm curious. The order immediately above the 5:30 p.m. note on September 14th, which is written by Dr. Eisenberg, shows the patient being moved to a stepdown bed. Do you know whether this patient, with what was going on that afternoon, was transferred from the

medical intensive care unit to a stepdown bed or does that appear to be a somewhat peculiar order?

A. I don't understand that.

Q. You wouldn't expect that the patient should be transferred given the drop in her hematocrit and hemoglobin that afternoon; true?

A. True.

Q. Do you know who was at what level in terms of the residency, Eisenberg and Sarkar?

A. I don't remember.

Q. Or whether they were at the same level?

A. I don't remember.

Q. A suspected retroperitoneal bleed or ruling out a retroperitoneal bleed you would agree is a medical emergency; true?

A. Yes.

Q. In this case, the CT scan was not done during the evening and obviously prior to Elsie Parsons' death. Do you find it acceptable that the CT scan was postponed and never performed prior to the patient's death?

A. Well, in this case, it didn't influence how we managed the patient.

Q. Do you find it acceptable, though, that the CT scan was postponed and never performed, regardless of whether it did or did not impact the management of the patient?

MS. HENRY: Objection.

A. Well, that's hard for me to answer that. In general we expect tests to be performed within some reasonable amount of time. I would expect this test to have been performed that evening.

Q. Did anyone, either nurses or residents, contact you that evening to, perhaps, help out with getting the powers to be in radiology to do the CT scan that had been ordered?

A. Not that I recollect, no.

Q. The testimony in this case has been from the nurses that there were several calls made and the patient was apparently prepped for the CT, and the CT scan was continually put off because of apparently other emergencies.

MS. HENRY: Traumas. That's a little different.

Q. If the CT scan is something that needed to be done on an emergent basis, and

there are traumas that are going on that are preventing it, what steps are the residents or the nurses to take in terms of notifying you as the attending concerning this problem?

A. Well, at some point I would expect to be notified if we thought that was going to make a particularly -- if it was going to make a big impact on how we are managing the patient.

Q. You weren't notified, were you?

A. No, I wasn't.

Q. There wasn't even apparently an attempt to consult with you as to whether or not the postponement of the CT scan was or was not a significant factor in the management of the patient; true?

A. True.

Q. Now, you said a moment ago that you don't believe that the failure to do the CT scan affected the management of the patient?

A. That's true.

Q. And explain to me why you say that.

A. Because we assume that she was bleeding and we managed her with that in mind. So she was being transfused blood and her anticoagulation was stopped and corrected, and

so she was managed as if she was bleeding.

Q. And the first packed red blood cell that was hung was not until 5:30 p.m.; true?

A. True.

Q. Do you hold an opinion in this case, doctor, as to whether earlier transfusion of blood in this case would have altered the outcome?

A. Yes.

Q. What is your opinion?

A. I don't believe it would have altered the outcome.

Q. Why?

A. Just looking at her progression in the course of the day, she remained very stable in terms of her hemodynamics. She was transfused at an appropriate rate based upon her clinical condition. I think to have forced blood into this patient more quickly, possibly could have had either other consequences and side effects, such as heart failure. And so I think things were done appropriately. We could not foresee based upon the knowledge we had during the course of the day what would happen later that night or the next morning.

Q. Have you seen the autopsy?
A. Yes.
Q. What caused the abdominal hematoma, in your opinion?
A. She was bleeding. No point source was ever identified.
Q. Do you have an opinion as to the cause of the abdominal bleed?
A. Well, I'm sure it was related to the anticoagulation that she received, but this is an extremely rare event. And I have been doing this for 20 years and I think I can remember one case in all that time where someone has had bleeding in that location.
Q. What is an epicrisis?
A. It's just an assessment by the pathologist after the fact to try to put together a clinical scenario on the patient in terms of what happened clinically and what they surmise might be the cause of death.
Q. Was there any type of a meeting that you had with the pathologist in terms of arriving at the anatomic or the clinical diagnosis?
A. Not that I recall.

Q. You did sign the death certificate, though; right?
A. Yes. That was also signed before I had the autopsy report.
Q. You have immediate cause being cardiac arrhythmia?
A. Yes.
Q. Secondary to retroperitoneal bleed?
A. Yes.
Q. Secondary to coagulopathy/lymphoma?
A. Yes.
Q. And other significant factors being the atrial fib, obesity and lymphoma?
A. Yes.
Q. Do you stand on those causes of death even after having reviewed the autopsy or would the cause of death be stated differently given the autopsy results?
A. It would be stated differently.
Q. And in what respect would you -- strike that.
Did you ever file an appended death certificate?
A. No.
Q. Had you done so, how would the death

certificate read?

A. The source of bleeding was not retroperitoneal. She had abdominal wall bleeding and there was some extension into the peritoneum. That would be the major change. And I also, in terms of consequences, I would have also added underlying cardiac disease.

Q. Now, in terms of the abdominal bleeding, had a CT scan been done, would the CT scan have revealed the abdominal wall bleed?

A. Yes, it would have.

Q. And would the patient in your opinion have been a surgical candidate?

A. Absolutely not.

Q. Why is that?

A. This type of bleeding is not managed surgically. In fact, that would have been contraindicated.

Q. The cause of the abdominal wall hematoma, you said was -- tell me again what you believe to be the most likely cause of the abdominal wall hematoma.

A. I think it was related to the fact that she was anticoagulated, but to pinpoint specific cause is impossible. Again, as I said

before, this is extremely rare to have bleeding in that location, so I don't think we know for certain why she had bleeding in that area.

Q. But is that the most likely explanation, that being a reaction to?

A. It's related to anticoagulation for certain.

Q. Was the endoscopic procedure a causative event of the abdominal wall bleeding?

A. Which endoscopic event?

Q. The flexible endoscopy.

A. I'm not sure exactly.

Q. September 13th.

A. You mean ENT physicians?

Q. Right.

A. No, it was not related to that.

Q. Can you think of anything that would be of a higher likelihood in terms of being causative of the abdominal wall bleed than a coagulopathy from the heparin?

A. I can't think of a specific cause unless she had some minor trauma to her abdominal wall from some source. I can't say.

Q. And you would agree that if one suspects a retroperitoneal bleed or an abdominal

wall hematoma in a patient that is on heparin, that it's important to stop the heparin as soon as one suspects either of those causes, either retroperitoneal bleed or abdominal wall hematoma?

A. Yes.

Q. And the treatment of that is cessation of the additional anticoagulation as well as transfusion of the patient as promptly as possible; true?

A. Yes.

Q. As you sit here right now, have you been asked to review or to provide opinions concerning the nursing care and whether or not the management of this patient from the morning into the afternoon prior to your coming back in the afternoon, whether or not the care met or fell below accepted standards of care?

A. I reviewed the nursing care just prior to this deposition.

Q. Have you been advised that you are going to be called as an expert witness in terms of providing opinions on standard of care in this case?

A. No.

Q. And you have not reviewed any of the depositions in terms of what was or was not done by the various nurses; correct?

A. I have not.

Q. And as you sit here right now, you have not written any opinion reports expressing any opinions on whether the care was or was not in compliance with accepted standards; is that true?

A. That's true.

MR. MISHKIND: Give me a few minutes and I may be done, doctor.

(Pause.)

Q. There is references to family visiting at various points in the records, including but not limited to the 14th, September 14th. Any recollection of meeting daughters or any family members?

A. I remember meeting with the family after the patient died.

Q. Tell me about that, please.

A. I believe it was a daughter, but I couldn't, I'm not absolutely certain, but I met with a woman who wanted to review the autopsy findings with me and I did review those findings

with her.

Q. Would that have been the amended or the original autopsy findings?

A. I believe it was the amended version, but I'm not absolutely certain.

Q. Tell me as best as you can recall in simple terminology what you would have explained to that family member.

A. I explained that she had a large amount of bleeding and that this is in part a complication of anticoagulation, and that she had a cardiac arrhythmia, which was addressed, but this was not reversible after CPR and she expired.

Q. Do you remember anything else that you most likely would have explained to the family member being that they were not medically trained, beyond what you just told me?

A. I believe that someone did ask about a CAT scan and I explained that it wasn't done, and that it did not affect our management.

Q. Were you able to get any explanation for why the CAT scan was not done?

A. Again, based on my recollection, this is a couple years ago, I just would explain the

exact circumstances that happened; that there were emergencies in other parts of the hospital and it was delayed.

Q. But you would agree with me that emergencies or no emergencies, a CAT scan should have been done sometime that evening?

MS. HENRY: Objection.

Q. True?

A. Well, again, I don't know. Under ordinary circumstances, yes.

Q. And other than what you may have been told in terms of traumas, you are not aware of anything specific to September 14th that would have prevented the CAT scan from having been done some time between 5:30 and prior to midnight?

A. I'm not aware of any specific circumstances, no.

Q. Anything else that you recall generally or specifically when you reviewed the autopsy with the family member?

A. I remember reviewing different aspects of her condition; the fact that there was no evidence of lymphoma, evidence of underlying heart disease that may have

contributed to her developing this arrhythmia. And of course the major finding, the bleeding.

Q. When a patient is experiencing a retroperitoneal bleed or an abdominal wall bleed and has an underlying cardiac abnormality, are they at greater risk of experiencing a fatal cardiac arrhythmia?

A. Yes.

Q. And is it fair to say that in this case, the fatal cardiac arrhythmia was in significant part caused by the underlying abdominal wall bleed that she sustained?

MS. HENRY: Objection.

A. That's hard to say exactly. I'm sure it was related. How much you can say was actual cause is difficult to say.

Q. Would you agree that the abdominal wall bleed was a cause of the fatal cardiac arrhythmia?

A. I think it was a contributing cause.

Q. Lymphoma we can rule out?

A. Yes, I think so.

Q. Did you ever have any contact with the family after this meeting concerning the autopsy by way of --

A. Not that I can recall, no.
Q. -- telephone call or in person meetings?
A. I believe I met with them more than once shortly after this autopsy report was finalized, but after that, I did not talk or meet with them.
Q. Again, I think I asked you at the very beginning whether or not you had been shown any of the expert opinions authored by plaintiff's experts, nursing expert, internal medicine and surgical expert. I may not have identified them in that great degree, but I think you told me that you have not seen the expert opinions?
A. That's correct.
Q. Therefore, you have not been asked to comment on whether or not you agree or disagree with the opinions expressed by plaintiff's experts; correct?
A. That's correct.
Q. As you sit here right now, you have not been told that you are going to be called as an expert witness in this case; true?
A. True.

MS. HENRY: He will be giving the opinions that you already elicited from him.

MR. MISHKIND: I think you have an obligation --

MS. HENRY: I will put that in writing to you by tomorrow.

Transcribe that part of it and we will put it in writing for him.

You asked the question, you got the answer.

MR. MISHKIND: It's a discovery deposition. It doesn't mean that you still don't have a requirement to produce expert reports.

MS. HENRY: I will have her transcribe that page of it and say this is his opinion.

MR. MISHKIND: Okay.

MS. HENRY: You have asked him basically the questions, but it will be in writing.

MR. MISHKIND: You can have it bronzed if you want to, I don't care.

MR. MISHKIND: Doctor, I have no further questions for you. Thanks.

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(Deposition concluded at 4:45 p.m.)

(Signature not waived.)

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AFFIDAVIT

I have read the foregoing transcript from page 1 through 83 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

ANTHONY DiMARCO, M.D.

Subscribed and sworn to before me this day of , 2002.

Notary Public

My commission expires .

CERTIFICATE

State of Ohio,

SS:

County of Cuyahoga.

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named ANTHONY DiMARCO, M.D. was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action. 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 affixed my seal of office at Cleveland, Ohio, on this 5th day of May, 2002.

Vivian L. Gordon, Notary Public
Within and for the State of Ohio

My commission expires June 8, 2004.