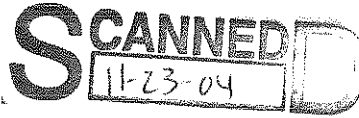


1 IN THE COURT OF COMMON PLEAS  
2 OF CUYAHOGA COUNTY, OHIO  
- - - - -

3 KATHY EVERETT,  
4 Administratrix of the  
5 Estate of  
6 ELSIE MARIE PARSONS,  
7 deceased.



8 Plaintiff,

9 vs

Case No. 432317  
Judge Burnside

10 METROHEALTH MEDICAL CENTER,  
11 et al.,

12 Defendants.  
- - - - -

13 CONTINUED DEPOSITION OF ANTHONY DiMARCO, M.D.

14 TUESDAY, APRIL 30, 2002

15 VOLUME II  
- - - - -

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

1 APPEARANCES:

2 On behalf of the Plaintiff

3 Becker & Mishkind

4 HOWARD D. MISHKIND, ESQ.

5 Skylight Office Tower Suite 660

6 Cleveland, Ohio 44113

7 216-241-2100

8

9 On behalf of the Defendants

10 Weston, Hurd, Fallon, Paisley & Howley

11 DEIRDRE HENRY, ESQ.

12 2500 Terminal Tower

13 Cleveland, Ohio 44113

14 216-241-6602

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

6           EXAMINATION OF ANTHONY DiMARCO, M.D.

7   BY MR. MISHKIND:

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

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

16                I do want to ask you, first, whether  
17   you had a chance to review the transcript, the  
18   30 some pages of transcript from your November  
19   deposition?

20           A.     I did.

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

24           A.     No, I didn't.

25           Q.     Since the deposition, have you had an

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

3 A. No.

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

7 A. No, I haven't.

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

11 A. No, I haven't.

12 Q. Any research?

13 A. No.

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

19 A. That's true.

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

24 A. I believe so, yes.

25 Q. In terms of your position, doing the

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

4 A. No.

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

12 A. Yes.

13 Q. I'm not going to mark this as an  
14 exhibit, other than to acknowledge it's a 29  
15 page document, with the last entry being under  
16 current grants, November of 2000 to October of  
17 2003, and a revision as of October 2000.

18 A. Right.

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

21 A. Yes.

22 Q. Thank you.

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

1     you remembered independently from the record.

2     Do you remember that?

3             A.     Yes.

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

8             A.     Yes.

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

13            A.     Yes.

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

17            A.     Yes.

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

1 beginning of your deposition?

2 A. Nothing I recall at this time.

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

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

11 A. I don't remember.

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

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

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

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

1 specifically talking to him.

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

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

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

18 A. I remember the name.

19 Q. Do you remember him being a resident?

20 A. I don't remember.

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

23 A. Right.

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



1 A. Yes.

2 Q. But you weren't certain what time  
3 that assessment was made; is that true?

4 A. That's true.

5 Q. Are you able to give me a better  
6 sense as to whether their assessment would have  
7 been late in the afternoon or early in the  
8 afternoon?

9 A. Well, my general practice is to make  
10 rounds in the morning and those rounds usually  
11 extend until at least noon or 1:00 o'clock. And  
12 then I leave the unit and I usually come back in  
13 the afternoon between, say, 3:00 or 4:00 o'clock  
14 and 6:00 o'clock. So my best recollection, that  
15 return would have been in the late afternoon.

16 Q. Independent of what may be noted in  
17 the progress notes by you concerning the  
18 patient's condition, do you have an independent  
19 recollection of what your assessment revealed  
20 when you saw her on September 14th sometime  
21 later that afternoon?

22 A. Yeah, based upon my progress notes.

23 Q. And we will talk about that. But is  
24 there anything without that progress note that  
25 you remember independently about Mrs. Parsons in

1 terms of how she appeared?

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

7 Q. Now, the change in the hemoglobin and  
8 the hematocrit that became evident when the labs  
9 were drawn early that afternoon -- and there  
10 were several sets of labs that were drawn.

11 There was a set of labs at about 12:15 and  
12 another set of labs at 1:05 or 1:00 o'clock.

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

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

17 A. Yes.

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

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

24 Q. Is this a progress note that you  
25 wrote?

1           A.     Yes, it is.

2           Q.     On the 14th, did you write any  
3 additional progress notes besides the one I just  
4 handed to you?

5           A.     I would have to check the record.

6           Q.     Please.

7           A.     This is the only progress note on  
8 that day.

9           Q.     This progress note is not timed;  
10 correct?

11          A.     That's correct.

12          Q.     Is this a progress note that would  
13 have been written in the afternoon or in the  
14 morning?

15          A.     In the afternoon.

16          Q.     Can you slowly read what you have  
17 written there so that I can understand it and  
18 also so that we can get it into the record.

19          A.     Certainly. It's dated September  
20 14th, 1999. Labeled MICU attending. Patient  
21 seen/examined. Feeling better. Less short of  
22 breath. At rest - hoarse. Generalized  
23 weakness.

24                 Next line, examination. Elderly  
25 female in distress. Afebrile. Blood pressure

1 160 over 78. HEENT. Post pharynx erythematous.  
2 Nasal bleeding.  
3 Neck, ecchymosis, right neck area.  
4 Chest, few wheezes bilaterally. Heart,  
5 irregular rhythm. Norm at S1/S2. Abdomen soft.  
6 Positive bowel sounds. Extremities positive  
7 edema.

8 Normal sodium, potassium. Calcium  
9 8.2. Hematocrit 29 arrow 22. PO2 68. PCO2 39.  
10 Chest x-ray right infiltrate.

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

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

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

20 Q. What does critical care times 35  
21 minutes mean?

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

25 Q. And then that's your signature after

1 that?

2 A. Yes.

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

6 A. Yes.

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

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

14 Q. That was done on the 13th?

15 A. The day before.

16 Q. A flexible endoscopy?

17 A. Yes.

18 Q. She didn't have any bleeding on the  
19 13th, though?

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

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

25 Q. Did the nurses bring to your

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

5 A. I don't recall.

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

8 A. Yes.

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

11 A. Yes.

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

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

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

24 A. Yes.

25 Q. And there had been a note made at

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

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

11            A.     No.

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

17            A.     No.

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

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

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

25            A.     They can be.

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

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

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

12 A. Not that I'm aware of.

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

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

17 Q. Yes.

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

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

22 A. Yes.

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



1 patient such as Elsie Parsons?

2 A. Trauma to the neck.

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

5 A. Not that I know of, no.

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

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

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

13 A. Yes, I was.

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

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

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

1 not seem enough to explain this fallen  
2 hematocrit.

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

6 A. Right.

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

10 A. Right, true.

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

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

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

19 A. Recent fallen hematocrit.

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

23 A. Yes.

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

1 A. That's correct.

2 Q. When you marked down transfusion, had  
3 the patient -- strike that.

4 I take it that when you marked down  
5 transfusion, the patient had already been typed  
6 and crossmatched?

7 A. I don't know that.

8 Q. The records would reflect that she  
9 was actually typed and crossmatched some time  
10 around 12:15, I believe.

11 MS. HENRY: Objection.

12 Q. I'm sorry, 1:05 p.m.

13 MS. HENRY: Still objection.

14 Q. If she had been typed and screened at  
15 1:05, do you know what the normal period of time  
16 is at Metro or what it was back in '99 to type  
17 and screen a patient for a transfusion?

18 A. The duration it would take to type  
19 and screen somebody?

20 Q. Right.

21 A. I would think it would take several  
22 hours is my guess.

23 Q. Are there circumstances where a type  
24 and screen is done on a stat basis?

25 A. Yes.

1 Q. And what are those circumstances?

2 A. Well, somebody is hypotensive, in  
3 shock, we would do it much more promptly. I  
4 don't know exactly the amount of time that's  
5 required to type the blood and then screen the  
6 blood for the antibiotics, I don't know how long  
7 that process is.

8 Q. When a stat H&H is ordered, what is  
9 the normal time period when a patient is in the  
10 medical intensive care unit?

11 A. My recollection would be within an  
12 hour or so.

13 MS. HENRY: Off the record.

14 (Discussion off the record.)

15 Q. On the MICU attending note that we  
16 have just gone through, you don't reference the  
17 CT scan, do you?

18 A. No.

19 Q. Was the discussion concerning the CT  
20 scan likely after this note or before?

21 A. Most likely it was after, because at  
22 the time I wrote this note, we had not evaluated  
23 her for internal GI bleeding, and if that would  
24 have been positive, there would have been no  
25 need for the CAT scan. And since that workup

1 was negative, that prompted the additional  
2 search for blood.

3 Q. What workup was negative?

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

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

10 A. For blood.

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

14 A. Yes.

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

17 A. Correct.

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

21 A. Yes.

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

1 A. No.

2 Q. On September 14th, who would have  
3 been responsible for supervising the senior  
4 medical student?

5 A. The attending cardiologist.

6 Q. Who would that have been?

7 A. There is a note September 13th,  
8 signed by Dr. Bahler, who is a cardiologist.

9 Q. Give me the last name again, please.

10 A. Bahler.

11 Q. B-A-Y?

12 A. B-A-H-L-E-R.

13 Q. Even though you don't work at Metro  
14 any longer, I think at the time that I took your  
15 deposition, I think you said that because of  
16 some of your research activities that you do  
17 have some contact with Metro?

18 A. Yes.

19 Q. Have you had occasion to talk to any  
20 of the nurses that were involved in the aspect  
21 of Elsie Parsons' care at any time since we met  
22 back in November?

23 A. No.

24 Q. Or at any time prior to November,  
25 since Elsie Parsons died?

1 A. No.

2 Q. Do you know why a flexible endoscopy  
3 was done on September 13th?

4 A. This is by the ENT physicians?

5 Q. Yes.

6 A. Yes, I do.

7 Q. What is the reason?

8 A. After she was extubated, she was  
9 complaining of shortness of breath and had signs  
10 of upper airway obstruction. The evaluation was  
11 to determine whether she had any vocal cord  
12 inflammation or stricture that would cause her  
13 to have further difficulty breathing.

14 Q. Any type of subglottic stenosis or  
15 anything of that nature?

16 A. Any type of stenosis or vocal cord  
17 inflammation or stricture that would cause  
18 obstruction.

19 Q. Would the flexible endoscopy,  
20 endoscope, identify any source of bleeding --

21 A. Yes, it would.

22 Q. -- if there was an acute bleed in the  
23 area of the upper airway?

24 A. Yes.

25 Q. If it wasn't in the upper airway, a

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

4 A. No.

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

7 A. Yes, I was.

8 Q. I'm sorry, September 14th.

9 A. Yes.

10 Q. I jumped a couple months ahead.

11 A. All right.

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

19 A. Can you repeat that again?

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



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

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

9 A. No.

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

13 A. Yes.

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

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

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

25 A. No, I can't tell.

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

5           A.     Yes.

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

9           A.     Yes.

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

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

25          Q.     The record would suggest that the H&H

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

6 A. Somewhat long, yes.

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

10 A. Not that I know of.

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

13 A. Yes. It was 1:40?

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

15 A. I thought you said 1:40.

16 MS. HENRY: One hour and 40 minutes.

17 I'm sorry, Howard, you said it was  
18 not communicated to Dr. Sarkar until 2:40. Can  
19 you tell me -- at the moment I can't find it.

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

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

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

3 A. Yes.

4 Q. And the T&S would stand for?

5 A. Type and screen.

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

9 A. Yes.

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

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

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

18 A. Yes.

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

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

25 Q. And then continuing?

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

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

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

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

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

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

1           A.     Yes.

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

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

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

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

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

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

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

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

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

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

12          A.     I don't know why.

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

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

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

1 A. Yes.

2 Q. Doctor, looking at the labs, again it  
3 looks like the next H&H that was done was at  
4 1650?

5 A. Yes.

6 Q. Or 4:50 p.m.?

7 A. Yes.

8 Q. And at that time, that hemoglobin of  
9 6.8 is in the critical range; true?

10 A. Just below the critical range, yes.

11 Q. But nonetheless, that little C next  
12 to it means that the lab is to be doing certain  
13 things in terms of reporting it back to the  
14 individual that requested it; true?

15 A. They are to call the requesting nurse  
16 or physician.

17 Q. And again, at this point, at 4:50  
18 p.m., Mrs. Parsons was not being transfused;  
19 true?

20 A. True.

21 Q. Should Dr. Sarkar have been notified  
22 within minutes of the results being available of  
23 that 4:50 critical hemoglobin?

24 A. Yes, he should have been notified.

25 Q. Do you know, or do you have any



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

4 A. I don't know why.

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

9 MS. HENRY: Objection.

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

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

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

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

1 would be roughly a 50 minute --

2 A. The lab was drawn at 1640 and the  
3 note says below critical value, call to Laura at  
4 1713, which is 5:13, and he was notified at  
5 5:30, which is only 15 minutes later. So that  
6 sounds like a pretty fairly prompt notification.

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

9 A. Yes.

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

14 A. Yes.

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

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

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

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

4 A. I don't understand that.

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

8 A. True.

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

11 A. I don't remember.

12 Q. Or whether they were at the same  
13 level?

14 A. I don't remember.

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

18 A. Yes.

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

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

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

5 MS. HENRY: Objection.

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

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

16 A. Not that I recollect, no.

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

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

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

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

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

9           Q.     You weren't notified, were you?

10          A.     No, I wasn't.

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

16          A.     True.

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

20          A.     That's true.

21          Q.     And explain to me why you say that.

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

1 so she was managed as if she was bleeding.

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

4 A. True.

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

9 A. Yes.

10 Q. What is your opinion?

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

13 Q. Why?

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

1 Q. Have you seen the autopsy?

2 A. Yes.

3 Q. What caused the abdominal hematoma,  
4 in your opinion?

5 A. She was bleeding. No point source  
6 was ever identified.

7 Q. Do you have an opinion as to the  
8 cause of the abdominal bleed?

9 A. Well, I'm sure it was related to the  
10 anticoagulation that she received, but this is  
11 an extremely rare event. And I have been doing  
12 this for 20 years and I think I can remember one  
13 case in all that time where someone has had  
14 bleeding in that location.

15 Q. What is an epicrisis?

16 A. It's just an assessment by the  
17 pathologist after the fact to try to put  
18 together a clinical scenario on the patient in  
19 terms of what happened clinically and what they  
20 surmise might be the cause of death.

21 Q. Was there any type of a meeting that  
22 you had with the pathologist in terms of  
23 arriving at the anatomic or the clinical  
24 diagnosis?

25 A. Not that I recall.

1 Q. You did sign the death certificate,  
2 though; right?

3 A. Yes. That was also signed before I  
4 had the autopsy report.

5 Q. You have immediate cause being  
6 cardiac arrhythmia?

7 A. Yes.

8 Q. Secondary to retroperitoneal bleed?

9 A. Yes.

10 Q. Secondary to coagulopathy/lymphoma?

11 A. Yes.

12 Q. And other significant factors being  
13 the atrial fib, obesity and lymphoma?

14 A. Yes.

15 Q. Do you stand on those causes of death  
16 even after having reviewed the autopsy or would  
17 the cause of death be stated differently given  
18 the autopsy results?

19 A. It would be stated differently.

20 Q. And in what respect would you --  
21 strike that.

22 Did you ever file an appended death  
23 certificate?

24 A. No.

25 Q. Had you done so, how would the death



1 certificate read?

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

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

11 A. Yes, it would have.

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

14 A. Absolutely not.

15 Q. Why is that?

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

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

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

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

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

6 A. It's related to anticoagulation for  
7 certain.

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

10 A. Which endoscopic event?

11 Q. The flexible endoscopy.

12 A. I'm not sure exactly.

13 Q. September 13th.

14 A. You mean ENT physicians?

15 Q. Right.

16 A. No, it was not related to that.

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

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

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

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

6 A. Yes.

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

11 A. Yes.

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

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

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

25 A. No.

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

4           A.     I have not.

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

10          A.     That's true.

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

13                 (Pause.)

14          Q.     There is references to family  
15     visiting at various points in the records,  
16     including but not limited to the 14th, September  
17     14th. Any recollection of meeting daughters or  
18     any family members?

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

21          Q.     Tell me about that, please.

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

1 with her.

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

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

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

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

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

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

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

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

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

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

7 MS. HENRY: Objection.

8 Q. True?

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

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

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

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

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

1 contributed to her developing this arrhythmia.

2 And of course the major finding, the bleeding.

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

8 A. Yes.

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

13 MS. HENRY: Objection.

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

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

20 A. I think it was a contributing cause.

21 Q. Lymphoma we can rule out?

22 A. Yes, I think so.

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

1 A. Not that I can recall, no.

2 Q. -- telephone call or in person  
3 meetings?

4 A. I believe I met with them more than  
5 once shortly after this autopsy report was  
6 finalized, but after that, I did not talk or  
7 meet with them.

8 Q. Again, I think I asked you at the  
9 very beginning whether or not you had been shown  
10 any of the expert opinions authored by  
11 plaintiff's experts, nursing expert, internal  
12 medicine and surgical expert. I may not have  
13 identified them in that great degree, but I  
14 think you told me that you have not seen the  
15 expert opinions?

16 A. That's correct.

17 Q. Therefore, you have not been asked to  
18 comment on whether or not you agree or disagree  
19 with the opinions expressed by plaintiff's  
20 experts; correct?

21 A. That's correct.

22 Q. As you sit here right now, you have  
23 not been told that you are going to be called as  
24 an expert witness in this case; true?

25 A. True.



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

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

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

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

9 You asked the question, you got the  
10 answer.

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

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

18 MR. MISHKIND: Okay.

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

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

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

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- - - - -

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

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(Signature not waived.)

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Page 84

1 AFFIDAVIT

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

5 PAGE LINE REQUESTED CHANGE

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ANTHONY DiMARCO, M.D.

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19

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

22

23 Notary Public

24

25 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.

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