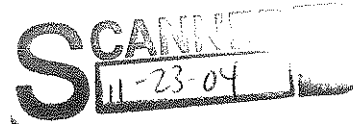


1 IN THE COURT OF COMMON PLEAS
2 OF CUYAHOGA COUNTY, OHIO
3 - - - - -

4 KATHY EVERETT,
5 Administratrix of the
6 Estate of ELSIE MARIE
7 PARSONS, deceased,
8 Plaintiff,



9 vs.

Case No. 432317

10 METROHEALTH MEDICAL
11 CENTER, et al.,
12 Defendants.
13 - - - - -

14 DEPOSITION OF ANTHONY DiMARCO, M.D.

15 THURSDAY, MAY 29, 2003

16 VOLUME III
17 - - - - -

18 Continued deposition of ANTHONY
19 DiMARCO, M.D., a Witness herein, called by the
20 Plaintiff for examination under the statute,
21 taken before me, Cynthia A. Sullivan, a
22 Registered Professional Reporter and Notary
23 Public in and for the State of Ohio, pursuant to
24 notice and stipulations of counsel, at the
25 offices of MetroHealth Medical Center 2500
MetroHealth Drive, Cleveland, Ohio, on the day
and date set forth above, at 5:37 p.m.
- - - - -

1 APPEARANCES:

2 On behalf of the Plaintiff:

3 Becker & Mishkind, by
4 HOWARD D. MISHKIND, ESQ.
5 660 Skylight Office Tower
6 1660 West Second Street
7 Cleveland, Ohio 44113
8 (216) 241-2600
9

10 On behalf of the Defendants:

11 Weston, Hurd, Fallon, Paisley & Howley, by
12 STEPHEN D. WALTERS, ESQ.
13 2500 Terminal Tower
14 50 Public Square
15 Cleveland, Ohio 44113
16 (216) 687-3321
17

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1 - - - - -
2 (Thereupon, Plaintiff's Deposition
3 Exhibit 1 was marked for purposes
4 of identification.)

5 - - - - -
6 ANTHONY DiMARCO, M.D., of lawful age,
7 called for examination, as provided by the Ohio
8 Rules of Civil Procedure, being by me first duly
9 sworn, as hereinafter certified, deposed and
10 said as follows:

11 EXAMINATION OF ANTHONY DiMARCO, M.D.
12 BY MR. MISHKIND:

13 Q. Even though we have met before,
14 would you officially state your name for the
15 record?

16 A. Anthony DiMarco.

17 MR. WALTERS: On the subject we were
18 talking about just before we got started, I
19 would hope that to the degree humanly possible
20 that we can avoid going over stuff. This is his
21 third session, and I know you didn't receive his
22 one-page expert report until the day after the
23 second session ended, so you have every right in
24 the world to take the deposition; but as we look
25 through that, he did express all of his

1 opinions, I think, in his deposition.

2 MR. MISHKIND: And he may have, but
3 just for the record, the reason that there was a
4 second session was obviously Dr. DiMarco's
5 father was ill, and so the deposition ended, and
6 then we had to complete it, and he was not
7 identified as an expert.

8 MR. WALTERS: I'm not debating your
9 right to take the deposition, but much of that
10 you've gone over.

11 MR. MISHKIND: Okay.

12 Q. Doctor, Plaintiff's Exhibit 1 is a
13 copy of the report which you wrote to Deirdre
14 Henry following the completion of your
15 deposition; is that true?

16 A. Yes.

17 Q. Is that the only letter that you
18 have written expressing opinions other than
19 those which you provided in your discovery
20 deposition?

21 A. Yes.

22 Q. Do you stand by what you have stated
23 in this letter?

24 A. Yes.

25 Q. Briefly, tell me where you are

1 currently working.

2 A. I'm working at University Hospitals
3 of Cleveland. I have an office at University
4 Suburban Health Center, and I also have offices
5 near Geauga Hospital.

6 Q. It sounds like your employment
7 status is basically the same --

8 A. Exactly the same.

9 Q. -- as when we met last year?

10 A. Exactly the same.

11 Q. Have you reviewed any testimony in
12 this case?

13 A. I just was provided with the
14 depositions of two nurses and one of the doctors
15 just briefly.

16 Q. Which nurses?

17 A. I have to check the depositions. I
18 don't have them. One was a Maggie something or
19 other. I don't recall her last name.

20 MR. WALTERS: Janesch and Mason.

21 Q. When were you provided with those?

22 A. Yesterday.

23 Q. In fairness to you, have you read
24 those depositions at this point?

25 A. Not entirely, no.

1 Q. Before yesterday being provided with
2 those, had you been provided with any deposition
3 testimony in this case?

4 A. No.

5 Q. Which doctor's deposition is it that
6 was provided to you yesterday?

7 A. I have to check the name.

8 Q. The name doesn't come to mind right
9 now?

10 A. It slips my mind because I looked at
11 it earlier. I can't recall. It was one of the
12 emergency room residents who was rotating
13 through the MICU.

14 Q. Was it Dr. Eisenberg?

15 A. Eisenberg, yes.

16 Q. Have you read Dr. Eisenberg's
17 testimony?

18 A. I went through that briefly, also.

19 Q. But not reading it from front to
20 back?

21 A. From front to back, no.

22 Q. Were you provided any type of a
23 summary?

24 A. No.

25 Q. Do you have copies of those, or were

1 you loaned counsel's copies?

2 A. I was just provided a copy which I
3 brought here and I gave back to Mr. Walters.

4 Q. Other than those three depositions
5 which you indicate you've not read entirely, is
6 there any other information that you have
7 reviewed since we were last together?

8 A. No.

9 Q. To your knowledge, do you anticipate
10 being provided with any additional information
11 to review prior to testifying at trial in this
12 matter?

13 A. No.

14 MR. WALTERS: I'll interject that I
15 may well provide him with copies of the expert
16 depositions when they're done and available.

17 Q. Obviously, Doctor, I'm here to find
18 out what your opinions are to the extent that
19 they haven't already been expressed. As you sit
20 here right now, hopefully you are in a position
21 to provide me those opinions, and to the extent
22 that you arrive at any new or additional
23 opinions based upon anything that you may review
24 or Mr. Walters provides you before trial, I
25 would ask that I be given reasonable advance

1 notice of that before you walk into the
2 courtroom, okay?

3 A. Sure.

4 Q. Your charge for an expert's
5 deposition such as this is how much?

6 A. I'd have to check the records. I do
7 have some charges written out, but I don't
8 recall what they are exactly.

9 Q. You don't know how much you charge
10 per hour for a deposition?

11 A. No. It has been a long time since
12 I've given one, so I don't recall exactly what
13 the numbers are.

14 Q. Are you serving as an expert witness
15 in any medical negligence cases currently
16 besides this matter?

17 A. Yes.

18 Q. How many others?

19 A. One, and it was just recently. I
20 haven't actually reviewed it yet or expressed an
21 opinion about that case.

22 Q. Is it concerning Metro?

23 A. No.

24 Q. Is it for the plaintiff or for the
25 defendant?

1 A. It's for the plaintiff.

2 Q. Is it a local case or outside of the
3 state?

4 A. Out of state.

5 Q. When is the last time you testified
6 in court in a medical negligence case?

7 A. It has been several years.

8 Q. For the plaintiff or for the
9 defendant?

10 A. For the defendant.

11 Q. Who was the doctor?

12 A. I don't recall his name. It was a
13 physician at I believe Heather Hill Nursing
14 Home, and it was an internist.

15 Q. Have you ever testified in court in
16 a medical malpractice case on behalf of a
17 patient?

18 A. Yes.

19 Q. When?

20 A. It was probably 15 years ago, also
21 out of state.

22 Q. Would that be one time that you've
23 testified in court on behalf of a patient?

24 A. Yes.

25 Q. How many times have you testified in

1 court in total in medical negligence cases?

2 A. Maybe three times total.

3 Q. How many times have you given
4 depositions as an expert witness in medical
5 malpractice cases?

6 A. Probably maybe seven or eight times.

7 Q. Of those seven or eight times, how
8 many have been for the plaintiff?

9 A. I would say probably two for the
10 plaintiff and the remainder for the defendant.

11 Q. Other than this case that you were
12 recently retained on, you are not serving as an
13 expert in any other cases besides the Metro
14 case?

15 A. That's true.

16 Q. Have you ever provided your services
17 as an expert through any of the expert services?

18 A. No -- well, actually I have in the
19 past. That was more than ten years ago, though.

20 Q. Which service was that?

21 A. It was a national forensic
22 organization where I provided my name.

23 Q. Have you ever advertised your
24 services?

25 A. No.

1 Q. The case that you're involved in
2 now, do you know how your name was obtained?

3 A. I was actually contacted by a man
4 names Sapanaro, I think his name was. I guess
5 somebody contacted him, and he contacted me.

6 Q. Sapanaro is a gentleman that
7 operates an expert search firm. Mr. Sapanaro
8 contacted you to see whether you'd be willing to
9 review?

10 A. Right.

11 Q. So the case that you are currently
12 looking at, you were, for lack of better
13 terminology, solicited by Mr. Sapanaro to see
14 whether you would be willing --

15 A. That's right.

16 Q. What are the arrangements between
17 you and Mr. Sapanaro?

18 A. There's no arrangement really.

19 Q. The lawyer that has retained you
20 pays Mr. Sapanaro, and then he pays you,
21 correct?

22 A. No. The lawyer paid me directly.

23 Q. Do you know what the lawyer had to
24 pay Mr. Sapanaro to get you?

25 A. I have no idea.

1 Q. Is this the first case you have ever
2 gotten through Mr. Sapanaro?

3 A. I think there was one other in the
4 past. It may have been two others. I don't
5 recall exactly, but not very many.

6 Q. At the time that Elsie Parsons was a
7 patient at Metro, you were an employee of Metro,
8 correct?

9 A. Yes.

10 Q. To the extent that there were any
11 departures from the standard of care in the
12 afternoon or the evening of September 14th,
13 1999, who in your opinion would be responsible
14 as the attending for those departures?

15 A. Well --

16 MR. WALTERS: I'm going to object to
17 the form, but go ahead.

18 A. If you're asking who the attending
19 physician was, I was the attending physician
20 during that month. In terms of being
21 responsible, to the extent that an attending can
22 be responsible, I mean, I don't have direct
23 control over every action of the several
24 residents who are also managing patients while
25 I'm the attending.

1 We're also licensed physicians in
2 the state of Ohio, and only to the extent which
3 I can supervise them can I be responsible for
4 their actions.

5 Q. But you would have been the
6 attending in the afternoon, true?

7 A. Yes.

8 Q. And the attending in the evening as
9 well, true?

10 A. I was on call as the attending, yes.

11 Q. There wasn't any other on-call
12 attending besides yourself?

13 A. Not that evening, no.

14 Q. Have you reviewed your deposition
15 transcript at any time since we last met?

16 A. No, I haven't.

17 Q. Do you have a copy of your
18 deposition transcript?

19 A. Yes. It's here.

20 Q. I think you read through it after it
21 was submitted to you, and I believe you provided
22 a correction page at the time that you read the
23 deposition. Do you remember doing that?

24 A. No, I don't.

25 Q. As you sit here right now, do you

1 have any reason to change or to alter any of the
2 statements or opinions that you gave in your
3 deposition?

4 A. No.

5 Q. So may I assume that you stand by
6 the answers that you gave in your deposition
7 previously?

8 A. Yes.

9 MR. WALTERS: If he submitted an
10 errata sheet.

11 MR. MISHKIND: Right.

12 Q. Subject to any errata sheet that you
13 may have submitted, but you're comfortable with
14 stating that subject to having submitted an
15 errata sheet, you stand by the opinions and
16 statements that you made in your deposition,
17 true?

18 A. Yes.

19 Q. The note that you wrote on
20 September 14th as the MICU attending, would you
21 mind getting that handy? When we met last, I
22 think we established that you didn't time that.
23 You didn't put a time on it, but it was clearly
24 written on the 14th, true?

25 A. Yes.

1 Q. You reference in your note a history
2 of nosebleed as well as the ecchymosis on the
3 right side of her neck, correct?

4 A. Yes.

5 Q. Is it fair to say that this note
6 would have been written at some point after
7 those events had been charted or brought to your
8 attention?

9 A. Yes.

10 Q. Are you able to tell me to any
11 greater certainty whether this note was written
12 late in the day or the middle part of the day?
13 Do you have any way of telling me?

14 A. Well, I generally make -- I write my
15 notes after I make rounds which usually are
16 completed by 1:00 in the afternoon or so. This
17 note was written sometime that afternoon.

18 Q. Do you know of any reason in this
19 case, Doctor, that the first transfusion could
20 not have been started earlier than 5:30 p.m.?

21 A. Well, the transfusion was started --
22 I mean, it had to be related to the time it was
23 ordered to be transfused, so that was probably
24 the limiting factor -- one of the limiting
25 factors, anyway.

1 Q. It was apparent, was it not, by
2 midday that Elsie Parsons had a bleed? When I
3 say midday, I mean 12:00, 1:00.

4 A. I'm not certain about that. I think
5 that one of the first indications was that there
6 was a falling hematocrit. I think that lab
7 returned around 1:00. There was a suspicion
8 that something was going on. I think it was
9 subsequently repeated.

10 Q. There was a stat H&H that was
11 ordered around 12:00 noon, correct?

12 A. I believe so.

13 Q. That was reported back about 12:59?

14 A. I don't remember the times, to be
15 honest with you.

16 Q. Do you know from reviewing
17 Dr. Eisenberg's deposition why it is that he
18 ordered a repeat stat H&H at about 1:00?

19 A. I believe it was to confirm the
20 previous value.

21 Q. Do you recall what his testimony was
22 as to whether he suspected based upon the
23 previous value that the patient to a probability
24 had a bleed?

25 A. I don't remember that, no.

1 Q. I think we talked about when I met
2 with you last time that you have no explanation
3 for why the stat repeat H&H that was ordered at
4 1:00, why that was not reported back until
5 2:40 p.m., true?

6 A. I don't recall that, no.

7 Q. You don't recall testifying to that,
8 or you don't recall?

9 A. Well, the usual time course when
10 something is ordered stat is usually around an
11 hour, an hour-and-a-half, something like that.
12 So the time course you are giving me now fits
13 into approximately that time period.

14 Q. But you don't recall when I asked
15 you that question at the time of your original
16 deposition what you said to me?

17 A. I don't recall exactly, no.

18 Q. Do you know why the first stat H&H
19 was ordered at 12:00 and was reported back
20 within the hour whereas the second stat H&H took
21 an hour and 40 minutes?

22 A. I don't know why that is.

23 Q. Would you agree that it's preferable
24 to start transfusions as early as possible once
25 there's a high index of concern that a patient

1 has a bleed?

2 A. Yes.

3 Q. In this patient can we agree that
4 she could least afford to have a low H&H if in
5 fact she had a bleed given her history of her
6 age as well as her prior history of an MI?

7 MR. WALTERS: Objection to form.

8 A. Yeah. The question, I'm not sure
9 exactly what you're asking.

10 Q. Sure. I'll rephrase it for you.
11 With a prior history of an MI, is it reasonable
12 to conclude that Elsie Parsons probably had some
13 degree of coronary artery disease?

14 A. Yes.

15 Q. In a patient that has coronary
16 artery disease, would you agree that they are at
17 increased risk of complications if their
18 hemoglobin and hematocrit are allowed to drop
19 into unsafe ranges?

20 A. Yes.

21 Q. If they become hypovolemic, they are
22 at greater risk of suffering infarcts as well as
23 suffering fatal arrhythmias, true?

24 A. Yes.

25 Q. The idea is that if you have a

1 patient that is at least at increased risk of
2 coronary artery disease, you want to start
3 transfusions as early as possible to avoid
4 potential complications such as the ones that
5 I've just mentioned?

6 A. When you say as early as possible, I
7 mean, I think as long as someone is
8 hemodynamically stable, you start it within some
9 reasonable amount of time. You wouldn't wait
10 days, but you certainly would want to start it
11 within hours.

12 Q. Do you have any reason to believe
13 that her hematocrit and hemoglobin would not
14 have stabilized if she had received transfusions
15 earlier in the day and either continuous
16 transfusions as well as closer in time?

17 A. Could you rephrase that? You said
18 two negatives in there, and I lost you.

19 Q. Sure. We can agree that her death
20 was caused to a reasonable degree of medical
21 probability by complications secondary to her
22 bleed, true?

23 A. I think that the bleed contributed
24 to this, her demise, yes.

25 Q. In fact, it was the bleed

1 superimposed on her underlying health condition
2 that was the straw that broke the camel's back,
3 true?

4 A. Most likely.

5 Q. Most likely had her hemoglobin and
6 hematocrit not gotten to dangerous levels at
7 that time, she probably would not have suffered
8 a fatal arrhythmia, true?

9 MR. WALTERS: Objection.

10 A. That's hard to answer. I don't know
11 exactly what her hematocrit was at the time of
12 her demise exactly. Also, regardless of what
13 the actual value was at that time, it's hard to
14 know exactly what value of hematocrit would be,
15 -- you know, what levels are critical for her in
16 terms of maintaining adequate cardiac perfusion,
17 assuming that it was a cardiac event that
18 resulted in her demise.

19 Q. Well, your opinion to a probability
20 is that it was a cardiac event, true?

21 A. I'd say that's most likely.

22 Q. And a cardiac event which most
23 likely was caused by a hypovolemic state which
24 precipitated a fatal arrhythmia, true?

25 A. No. That's not necessarily the

1 case. She had been transfused. She had
2 received fresh frozen plasma, and I'm not
3 certain that she actually was hypovolemic at the
4 time of her demise.

5 Q. When was the last time that her H&H
6 was checked prior to her demise?

7 A. I'd have to check the records.

8 Q. Go ahead.

9 A. The last thing I see here was on
10 September 15th at 2:50 a.m., and this hematocrit
11 was 17.3. But this may have been drawn during
12 the resuscitation, and those values tend not to
13 be accurate. The one before that was 20.1 at
14 1:15 a.m. which is probably the more accurate
15 one.

16 Q. With the hemoglobin of what?

17 A. 6.6.

18 Q. Is that value in your opinion, the
19 level of her hemoglobin and her hematocrit, a
20 contributing factor to the cardiac event?

21 A. I'd say it's probable, yes.

22 Q. If you had been notified by nursing
23 or by residents that the CT scan that had been
24 ordered at 5:30 had not been performed by
25 11:00 p.m., at or around that time period, and I

1 pick 11:00 p.m. just because of shift changes,
2 knowing that this patient had an order at 5:30
3 for a CT scan, knowing that there was a concern
4 about a retroperitoneal bleed or intraabdominal
5 bleed, what as the attending would you have
6 done?

7 A. I would have asked if the patient
8 was -- I would have asked several questions of
9 the parties involved. The first would have been
10 why wasn't it done. The second is, you know,
11 what the condition of the patient was and
12 whether or not it was warranted that we have
13 this done on an emergent basis or not.

14 Q. I think when we last spoke you
15 agreed that as the attending you expected that
16 that CAT scan was going to be performed that
17 evening and not the next day?

18 A. That's true.

19 Q. And that in fact it should have been
20 performed that evening, true?

21 A. Yes.

22 Q. In terms of how a patient
23 compensates for a drop in their hematocrit and
24 hemoglobin, you look to certain clinical
25 parameters; do you not?

1 A. Yes.

2 Q. If a patient is complaining of pain
3 in the abdominal area, would that be one factor
4 that you would be concerned about as the patient
5 is experiencing a bleed?

6 A. Not in terms of -- not in terms of
7 their stability, but in terms of the potential
8 source of bleeding, it would be useful.

9 Q. What about if the patient appears
10 faint or their color is not as good as it was
11 earlier in the day, is that a clinical marker
12 that you would be concerned about in a patient
13 that has a bleed?

14 A. No. Color is a very poor indication
15 of hemodynamic status.

16 Q. What would you be looking for?

17 A. I'd be looking for blood pressure
18 and pulse, postural changes in vital signs.
19 Those are a much better indication of
20 hemodynamic status.

21 Q. What about a drop in urine output?

22 A. If it's a sustained significant
23 drop, that would be also useful information.

24 Q. A drop in blood pressure?

25 A. If it was a significant change in

1 blood pressure, yes.

2 Q. Confusion?

3 A. Confusion, again, by itself is a
4 poor indication, particularly in elderly
5 patients. It's just so common for patients in
6 that age group to have a change in mental
7 status, particularly in the evening hours.

8 Q. But if you were informed during the
9 day, not during the evening, that in addition to
10 the drop in her H&H there had been a drop in her
11 blood pressure, a drop in her urine output, and
12 confusion which was charted on the 7:00 to 3:00
13 shift, not the evening shift, of what
14 significance would that be to you in a patient
15 that at least one has reason to be concerned
16 that they have some type of a bleed going on?

17 A. Well, that symptom would be used in
18 the context of everything else that was
19 presented. In isolation, I don't think it has a
20 lot of value. But in the context of everything
21 else, it might be useful.

22 Q. If you add slurred speech to those
23 symptoms, of what significance would that be?

24 A. Well, if someone had slurred speech,
25 I'd be concerned about a stroke.

1 Q. When you documented in your note on
2 September 14th that she had had a nasal bleed or
3 a nosebleed and the ecchymotic area on the neck,
4 was this of concern to you because the patient
5 was on anticoagulants?

6 A. Yes, it was.

7 Q. I think under your plan which you
8 wrote, and correct me if I'm wrong, but this
9 plan probably would have been written at 1:00 or
10 thereabouts after?

11 A. I think it was probably written
12 somewhat later than that, but I'm not exactly
13 sure what time.

14 Q. It wouldn't have been written at
15 4:00 or 5:00 in the afternoon, correct?

16 A. I can't tell you for certain.

17 Q. In any event, under the plan you
18 mark down to work up the patient for blood loss
19 and to follow the hematocrit, correct?

20 A. Yes.

21 Q. Isn't it likely that the hematocrit
22 that was ordered, the second stat hematocrit
23 that was ordered that didn't come back until
24 2:40, is it likely that this note was written
25 before you were aware of that 2:40 --

1 A. It was likely written before I was
2 aware of that value because I most likely would
3 have written that value down.

4 Q. At 12:15 Elsie's hemoglobin was 7.7
5 and her hematocrit was 23.9, her PTT was 98 and
6 her urine output was only 18 cc's for that hour?

7 MR. WALTERS: What hour?

8 MR. MISHKIND: 12:15.

9 MR. WALTERS: Thanks.

10 MR. MISHKIND: Sure.

11 Q. Her BP was 110 over 62. Of what
12 significance are those parameters in a patient
13 who is on anticoagulation and who is suspected
14 of having a bleed?

15 A. Of what significance are they?

16 Q. Right.

17 A. Well, I'm assuming all the numbers
18 that you gave me are accurate. I haven't
19 verified all of them. But in somebody who is on
20 anticoagulants, and just looking at the two
21 points, that somebody is being anticoagulated
22 that you suspect is having a bleed, just those
23 two factors by themselves would make one
24 concerned and want to monitor the situation
25 closely.

1 Q. The PTT of 98 at 12:15, that's
2 basically two times what her morning PTT had
3 been, correct?

4 A. I'd have to check the records to
5 know if that was accurate exactly.

6 MR. WALTERS: Where are you looking
7 because he can look at the same thing.

8 MR. MISHKIND: I'm looking at my
9 notes.

10 MR. WALTERS: I'm sorry. I thought
11 you had a page.

12 MR. MISHKIND: No. It's my notes,
13 but my notes are derived from the chart.

14 MR. WALTERS: If you look right
15 there (indicating).

16 A. Yes. I actually have them here. So
17 at 12:15 it was 98 seconds and at 4:00 a.m. that
18 morning it was 43.2 seconds, so that's correct.

19 Q. Would you agree that the heparin
20 drip should have been discontinued or at least
21 held while awaiting the lab results at 12:15
22 given the PTT of 98 versus the morning PTT with
23 her dropping hematocrit that was recorded at
24 12:15?

25 A. That's a judgment call. It really

1 depends on how much faith you have in that
2 hematocrit and believe that it actually is a
3 significant reduction. I think it would have
4 been prudent to hold the heparin at that point.

5 Q. I recognize that you didn't see the
6 patient at that point.

7 A. Right.

8 Q. It was either Dr. Eisenberg or
9 Dr. Sarkar?

10 A. It was one of the residents.

11 Q. If you had seen the patient, I take
12 it acting as a reasonable and prudent attending,
13 you would have held the heparin, correct?

14 A. Yes.

15 Q. We know the heparin was not
16 discontinued until approximately 2:40 or
17 thereabouts?

18 A. I believe it was about an hour later
19 or thereabouts, something like that, or
20 half-an-hour later. I don't remember the exact
21 times. I know it was held at some point. I
22 believe it was within an hour of that time
23 period or something like that. I don't have the
24 exact time.

25 Q. That's all right, and the records

1 will reflect that. But I think we had agreed
2 last time that we talked that pending the
3 results on the H&H, the heparin in your opinion
4 should not have been restarted, correct?

5 A. I would have held the heparin.

6 Q. That in your opinion would have been
7 a reasonable and prudent thing to have done,
8 correct?

9 A. Yes.

10 Q. Actually, the records show that the
11 heparin was restarted at 2:10 p.m. and was not
12 discontinued until 2:40 p.m. while the stat labs
13 were still pending, and that's something that in
14 your opinion should not have taken place,
15 correct?

16 A. No. I would have stopped the
17 heparin at that point.

18 Q. So you agree with me?

19 A. Yes.

20 Q. If a transfusion is being
21 considered, Doctor, whose responsibility is it
22 to make sure that the stat H&H that has been
23 drawn, that the results are returned promptly to
24 the responsible doctor so that decision-making
25 can take place?

1 A. Whose responsibility is it that it
2 be performed?

3 Q. Whose responsibility is it to follow
4 up and make sure that stat H&H results in the
5 intensive care unit are obtained in a timely
6 manner and reported to the attending or to the
7 resident?

8 A. Well, it's the ordering physician's
9 responsibility to initiate that. Following that
10 it goes through several channels. It goes to
11 the nurse who takes it off the chart to the
12 secretary who calls it down to the laboratory to
13 the technician who comes and makes the blood
14 draw, and then once that's performed, it has to
15 be run in the laboratory and then called back up
16 to the secretary who reports it then directly to
17 the doctor or to the nurse.

18 And after some time passes, if that
19 value has not returned to the ordering
20 physician, then it's his responsibility to
21 question what the delay might be.

22 Q. If the CAT scan had been performed
23 sometime between 5:30 and 11:00 p.m., what would
24 the CAT scan have shown?

25 A. No one can say that for certain.

1 We're assuming.

2 Q. More likely than not what would it
3 have shown?

4 A. We're assuming it would have shown
5 some evidence of what was found at the autopsy
6 which was this intraabdominal bleeding.

7 Q. What type of image does that show up
8 as on the CAT scan? Is it like a darkened area?

9 A. It would have shown as a different
10 density from the surrounding tissue in the
11 abdominal wall.

12 Q. The CAT scans are typically used
13 when one is looking to isolate or determine the
14 source of an intraabdominal bleed, correct?

15 MR. WALTERS: The source does?

16 MR. MISHKIND: Yes.

17 A. I wouldn't say the source. The
18 presence of, I would say.

19 Q. If transfusions had been started at
20 3:00 and Elsie had been given not only packed
21 red blood cells, but fresh frozen plasma at the
22 same time and continued throughout the evening,
23 do you have an opinion as to what impact that
24 would have had on her hematocrit and her
25 hemoglobin prior to the time that she arrested?

1 A. Well, if the total amount of packed
2 red cells and fresh frozen plasma, the total
3 amount was the same, then it would have had no
4 impact.

5 Q. If it had been increased, though, in
6 other words, if it had started at 3:00,
7 obviously you would have wanted to have checked
8 the hematocrit and hemoglobin after the blood
9 had been infusing and the packed red blood cells
10 as well as the fresh frozen plasma had infused,
11 correct?

12 A. Yes.

13 Q. If the patient's hemoglobin and
14 hematocrit had not gotten to a stable level, it
15 would have been reasonable and prudent to order
16 additional blood, correct?

17 A. That's true.

18 Q. That's assuming that there aren't
19 any signs that the patient is going into
20 congestive heart failure, true?

21 A. That's correct.

22 Q. You have to sort of balance things
23 out?

24 A. Right.

25 Q. Can we agree that if Elsie had

1 started with transfusions earlier in the day,
2 there would have been an opportunity to have
3 checked her blood prior to her arrest to
4 determine whether or not her hemoglobin and
5 hematocrit were responding or whether or not she
6 needed additional transfusions?

7 MR. WALTERS: Objection.

8 A. Well, it would have been optimal to
9 check it certainly, just as there was had she
10 not received the blood.

11 Q. Sure. But obviously, you check it
12 and you administer the blood because you want to
13 get the hemoglobin and hematocrit up to a
14 certain level to avoid potential problems; is
15 that correct?

16 A. That's true.

17 Q. What was the level that they wanted
18 to try to get her up to?

19 A. I don't think that's stated anywhere
20 in here.

21 Q. Hydrating fluids were also started
22 on Elsie, correct?

23 A. Yes.

24 Q. They are used in conjunction with
25 the blood products, correct?

1 A. Yes.

2 Q. Again, to try to reverse the
3 hypovolemic state?

4 A. Well, I'm not certain that she was
5 hypovolemic. But in general when someone has
6 suspected bleeding, it's presumed that there is
7 going to be a loss of intravascular volume, so
8 this is automatically replaced.

9 Q. At 1:00 p.m. Elsie's urine output
10 remained less than 20 cc's per hour, and it had
11 been that way for two hours. Of what
12 significance is that in this patient?

13 A. That in and of itself doesn't
14 concern me particularly. There's fluctuations
15 in urine output throughout the day, and the fact
16 that she was still making urine and seemed
17 hemodynamically stable, that didn't concern me
18 particularly.

19 Q. What does reduced urine output
20 potentially indicate to you in a patient that is
21 at least being suspected of having a bleed?

22 A. Well, we watch the urine output
23 because it's possible that a decrease in urine
24 output reflects poor perfusion to the kidney,
25 and that might be an indication that there is a

1 hypovolemic state.

2 Q. Hydrating fluids will help reverse a
3 hypovolemic state?

4 A. Yes.

5 Q. It will help with profusion?

6 A. Yes.

7 Q. Do you know why the hydrating fluids
8 were not started until 6:00 p.m. in this case?

9 A. I believe because she was -- she was
10 hemodynamically stable prior to that time, and
11 also, you know, they were also planning on -- I
12 mean, there were plans in place to transfuse her
13 and give her fresh frozen plasma as well.

14 Q. Well, there was talk about
15 transfusion as early as 1:00 in the afternoon,
16 correct?

17 A. There may have been talk about it,
18 but I don't think it was strongly considered
19 until there was more evidence that there was in
20 fact acute blood loss.

21 Q. Would it have been of any harm to
22 the patient to have started hydrating fluids on
23 this patient earlier than 6:00 p.m. even in the
24 face of decision-making that the transfusions
25 weren't going to start until 5:30?

1 MR. WALTERS: Objection. Are you
2 saying with hindsight?

3 MR. MISHKIND: No. I'm saying
4 prospectively.

5 A. Prospectively, I would not have
6 started fluids in someone like this who had a
7 history of heart disease, just in terms of the
8 amount of information that we had at that point,
9 the fact that her hemodynamic status was stable.
10 I don't think there was an indication of that,
11 particularly in view of the fact that this was a
12 lady who was going to be transfused, and blood
13 products themselves are volume sources, and
14 given in excess, these things have side effects
15 and complications.

16 Q. Sure. Obviously, you'd have to
17 monitor a patient and decide whether or not the
18 patient is going into congestive heart failure
19 by giving those fluids, correct?

20 A. Right.

21 Q. There are things one can do if blood
22 products and hydration are necessary to treat or
23 minimize a patient going into congestive heart
24 failure, correct?

25 A. There are things that you can do,

1 but the best treatment is to avoid that from
2 happening in the first place.

3 Q. Just like there are advantages and
4 disadvantages to having a patient on
5 anticoagulation therapy, correct?

6 A. Absolutely. There are risks and
7 benefits to everything we do.

8 Q. Obviously, the decision was made
9 that the risk of continuing the anticoagulation
10 or the benefit of anticoagulation was outweighed
11 by the risk of continuing it because of the
12 patient's bleed, correct?

13 A. Correct.

14 Q. The only question is whether or not
15 that decision should have been made sooner in
16 this case, correct?

17 A. I don't think that one hour of
18 additional heparin had any effect on the
19 outcome.

20 Q. Elsie had a type and screen drawn at
21 1:00 p.m., true?

22 A. Again, I'd have to check the times,
23 but I think that's approximately correct.

24 Q. She was then ordered --

25 A. It was ordered at that time

1 actually, but when it was actually done or
2 performed --

3 Q. I think it was at 1:00 p.m.

4 A. Was it ordered at 1:00 p.m. or
5 performed at 1:00 p.m.?

6 Q. She had the type and screen at
7 1:00 p.m., and then there was an order given for
8 two units of blood to be transfused at 3:00 p.m.
9 However, the first unit was not hung until
10 5:30 p.m.

11 I'm making a statement. I just want
12 to make sure that that is consistent with your
13 recollection.

14 MR. WALTERS: Well, let's take the
15 time to look at it then. Can you flag what
16 you're referring to?

17 MR. MISHKIND: I could.

18 Q. Doctor, you know that Dr. Eisenberg
19 ordered a type and screen at 1:00 p.m.?

20 A. I know he ordered it. I don't know
21 the exact time that he ordered it.

22 Q. I'll represent to you that he did
23 that, and at 3:00 p.m., an order was written at
24 that time for two units of blood to be
25 transfused.

1 A. Okay. Type and screen at 1:05 p.m.
2 by Dr. -- I can't read the writing, but one of
3 the physicians, it looks like.

4 Q. Then at 3:00 p.m.?

5 A. At 3:00 p.m., transfuse two units of
6 packed cells each and every two hours. After
7 3:00 p.m. that order was written.

8 Q. We know that the first unit of blood
9 was not started until 5:30 p.m.

10 A. That's correct.

11 Q. Two-and-a-half hours later?

12 A. That's correct.

13 Q. Dr. Sarkar, I believe, at 5:30
14 ordered two units of fresh frozen plasma to be
15 given as well. Does that appear to be accurate?

16 A. He ordered type and cross for four
17 units of packed cells, and fresh frozen plasma,
18 two units, yes.

19 Q. How long would you expect it to take
20 for the fresh frozen plasma to be hung in a
21 patient that's in the intensive care unit that
22 there is a very high index of suspicion that she
23 has a bleed, that a transfusion order has been
24 given, and fresh frozen plasma is being added to
25 that order? How long would you expect for it to

1 take for the first unit to be hung?

2 A. It would take probably a couple
3 hours or so.

4 Q. Certainly less than three hours,
5 correct?

6 A. It can take -- it really depends
7 upon, too, the availability of fresh frozen
8 plasma in the blood bank, and assuming there's
9 no problems with compatibility in this
10 transfusion, it would be hours. I can't give
11 you an exact because I don't know exactly what
12 they had to do to obtain this.

13 Q. In the medical intensive care unit,
14 assuming there aren't any incompatibility issues
15 or any other factors that would cause a delay,
16 would you agree that under normal circumstances
17 fresh frozen plasma that's being hung along with
18 a patient that's receiving packed red blood
19 cells should be started in less than two hours?

20 A. No, I don't think so. I don't think
21 that. In somebody that's hemodynamically stable
22 to expect it to happen within two hours, I don't
23 think that is necessarily true.

24 Q. Would you agree in a patient who is
25 becoming hemodynamically unstable you can

1 transfuse blood faster than over a two- to
2 three-hour period of time?

3 A. That, again, depends on the
4 individual patient. Transfusing a unit of blood
5 over two hours is very fast, very fast; and for
6 me to transfuse blood that quickly, someone
7 would have to be very hemodynamically unstable,
8 particularly an elderly patient because someone
9 who is volume depleted can be thrown into
10 pulmonary edema by giving blood products that
11 quickly. So it would be very rare that I would
12 transfuse blood that quickly.

13 Q. If you had the results of the CT
14 scan early in the evening, from the standpoint
15 of treatment to this patient, would that have
16 altered the mode of treatment?

17 A. No, it wouldn't have.

18 Q. What about the administration of
19 blood products?

20 A. It would not have changed that,
21 either.

22 Q. Why?

23 A. Because I already knew that this
24 lady was bleeding. The only thing the CAT scan
25 would have told me was where the bleeding was

1 actually occurring. But in terms of the fact
2 that this was an event, that's now which is
3 already known.

4 Q. Are there circumstances where you
5 will alter the rate of blood transfusion in a
6 patient who is becoming hypovolemic and shocky,
7 in other words, increase the infusion rate?

8 A. Certainly.

9 Q. And while forcing blood into the
10 patient can cause congestive heart failure, if
11 the patient is becoming hypovolemic and shocky,
12 you can certainly give Lasix between the
13 transfusions to minimize the risk of congestive
14 heart failure, correct?

15 A. You can do those things, but again,
16 that's easier said than done. I mean, these
17 things happen rapidly, in minutes. Effective
18 drugs like Lasix to counteract those effects
19 don't happen as rapidly. So you want to avoid
20 those complications prior to them happening
21 because they are not treated that readily, and
22 throwing somebody, particularly of this age with
23 underlying heart disease, there's a big risk of
24 causing substantial problems which could have
25 led to hypoxemia and further complicate her

1 cardiac status.

2 So they are not that easily treated.

3 They are not treated that readily. These
4 treatments usually take hours to work, and the
5 effect of the blood or volume can happen in
6 minutes.

7 Q. Decreased urine output, decreased
8 blood pressure, change in mental status,
9 decrease in hemoglobin and hematocrit, would you
10 agree that all of those are signs and symptoms
11 of bleeding and that hypovolemia is apparent?

12 A. Those are -- all those descriptions
13 that you are giving me really depend upon the
14 magnitude and degree of those events.

15 Q. Sure.

16 A. So there are parameters that we
17 follow in terms of what level of blood pressure
18 is considered adequate, what level of urine
19 output is considered adequate. Change in mental
20 status, to what degree are we seeing changes in
21 mental status? So all those things can't be
22 lumped together as generalities. They really
23 need to be looked at, you know, really each
24 individually and within certain parameters.

25 Q. But when you look at a patient, an

1 elderly patient such as Elsie who was admitted
2 and was being treated for atrial fibrillation,
3 if in fact she developed decreased urine output,
4 decreased blood pressure, change in mental
5 status, had a decrease in her hemoglobin and
6 hematocrit, certainly those clinical parameters
7 in this patient would at least suggest that some
8 intervention is necessary on the patient's
9 behalf, true?

10 A. Yes.

11 Q. It's reasonable and foreseeable that
12 without some intervention on this patient's
13 behalf, with decreased urine output, decreased
14 blood pressure, change in mental status,
15 continued decrease in her H&H, that a serious
16 outcome is inevitable?

17 A. Well, I would look at those in terms
18 of each individually. The urine output by
19 itself, the relative change in urine output was
20 not a particular concern to me. Her blood
21 pressure change, also. Her blood pressure
22 remained in a good range throughout the day.
23 That by itself didn't concern me.

24 The fact that her hematocrit had
25 fallen substantially, that definitely needed to

1 be addressed. That was what in fact all the
2 attention was paid to. The fact that the
3 hematocrit was falling and needed to be --- that
4 parameter needed to be addressed, and it was.

5 Q. And your opinion is it was addressed
6 timely and with an appropriate dose?

7 A. Yes.

8 Q. But you certainly recognize that had
9 it been addressed sooner with more blood
10 products being given, that Elsie would have had
11 a greater likelihood of her hematocrit and her
12 hemoglobin stabilizing, correct?

13 A. I don't think that's true because we
14 don't know the time course of this bleeding.
15 For example, had she have gotten blood earlier
16 and the hematocrit was checked earlier than it
17 had been, the blood count would likely have been
18 higher. So the urgency of continued volume
19 replacement and continued blood may not have
20 been given at that point until there were
21 further indications of a greater drop in her
22 hematocrit, which may have been drawn later in
23 the night.

24 What I'm taking from your question
25 is that we're assuming that there was a constant

1 rate of bleeding throughout, which there may not
2 have been.

3 Q. You don't know, though?

4 A. We don't know that.

5 Q. Do you know in this case whether
6 there was any contraindication to hanging the
7 packed red blood cells and the fresh frozen
8 plasma at the same time?

9 A. There was a relative
10 contraindication to the fact that you are giving
11 two agents who have a large osmotic load. Both
12 of these factors tend to pull fluid into the
13 intravascular space and increases the propensity
14 to cause congestive heart failure or a fluid
15 overload state. So in general, we don't give
16 them together.

17 The second reason we don't give them
18 together is because there's possible transfusion
19 reactions. If both of these were hung together,
20 we wouldn't know if it were one agent or another
21 and which to stop. So generally we try to give
22 these things not together, but separately.

23 THE WITNESS: Can we take a quick
24 break?

25 (Brief recess.)

1 Q. You have, I take it, never seen the
2 reports from plaintiff's experts in this case;
3 is that correct?

4 A. I did see a report -- two reports, I
5 think.

6 Q. When did you see those?

7 A. I actually looked at them again
8 today. I think I saw one of them around the
9 time of my prior deposition.

10 Q. Do you remember which report it was?

11 A. One was by a surgeon, Dineen, I
12 think was the name, and the other one I don't
13 remember the name. It was an intern, I believe.

14 Q. Dr. Selwyn perhaps?

15 A. It could be, yes.

16 Q. Are you in a position to comment at
17 all on the opinion that Dr. Selwyn has expressed
18 in his report?

19 A. Yes. If I could just see it to
20 review it again?

21 MR. WALTERS: I'm handing him a
22 copy.

23 MR. MISHKIND: Sure. That's fine.

24 A. Yes. I disagreed with his
25 impression.

1 Q. Which impression is that? Which
2 page are you looking at?

3 MR. WALTERS: We don't have numbers.

4 A. This is the third page, the first
5 paragraph, the left arm ecchymosis and enlarging
6 abdomen should have been enough evidence to
7 arouse a high suspicion of potential
8 complications. I disagree with that.

9 Q. Why?

10 A. By my exam and several other
11 physicians, there was not an enlarging abdomen,
12 and certainly not one that would be suspicious
13 for bleeding.

14 Q. What would you expect to see if the
15 abdomen was getting larger and is suspicious of
16 a bleed?

17 A. I don't understand your question.

18 Q. What type of an appearance if in
19 fact the abdomen was enlarging would cause you
20 to be suspicious that it may be enlarging
21 secondary to a bleed?

22 A. I still don't understand that.

23 Q. Would there be some type of
24 appearance of the abdomen? Would the size of
25 the abdomen have to be a certain dimension or

1 size?

2 A. What type of bleed are you talking
3 about?

4 Q. Either a retroperitoneal or an
5 intraabdominal wall.

6 A. A retroperitoneal bleed would not
7 change it at all.

8 Q. What about an intraabdominal bleed?

9 A. An intraabdominal wall bleed, there
10 may be some enlargement, but it would be
11 difficult to detect unless there was a huge
12 amount of blood there.

13 But by the examination of myself and
14 other physicians, that wasn't present. My
15 disagreement with this is the fact that the
16 description of an enlarging abdomen wasn't
17 present.

18 Q. Obviously, the nurses are in seeing
19 the patient on a daily basis, probably more than
20 the doctors are, right?

21 A. No. The doctors are seeing the
22 patient every day as well.

23 Q. The nurses make more notes in terms
24 of whether it be every hour or every couple
25 hours in terms of their observations?

1 A. In terms of vital signs they do,
2 yes.

3 Q. Have you studied the nurse's notes
4 in terms of what they have written about the
5 abdomen?

6 A. I read them about the time of my
7 prior deposition. I do recall that there were
8 one or two nurses who did mention abdominal
9 size.

10 Q. But you don't believe that
11 Dr. Selwyn's statement about enlarging abdomen
12 should have been evidence?

13 A. No, because I examined this patient
14 myself.

15 Q. You have an independent memory of
16 examining this patient?

17 A. This would have been reflected in my
18 progress notes or the progress notes of the
19 other physicians who saw the patient.

20 Q. What else do you disagree with?

21 A. He described a right neck hematoma.
22 There was no hematoma present.

23 Q. What was it that was on the
24 patient's neck?

25 A. The patient had ecchymosis which is

1 just a discoloration of the skin.

2 Q. What caused that?

3 A. That was probably subcutaneous
4 bleeding from an attempted line placement.

5 Q. But why would there have been an
6 attempted line placement when she had lines
7 already in place?

8 A. Well, these lines may have been
9 placed after this attempt.

10 Q. Was there any indication that they
11 tried to put in a line when they already had?

12 A. Well, you're assuming they already
13 had one. This line attempt could have been made
14 prior to the lines that they had.

15 Q. How long would it take for that
16 ecchymotic area to be apparent?

17 A. It takes probably -- well, actually
18 it can happen quite rapidly. It can happen
19 within minutes. But generally speaking, if it
20 was a dark discoloration, it would take hours.

21 Q. What else do you disagree with?

22 A. He states that such interventions
23 were not timely. I think they were extremely
24 timely. The significant timely initiation of
25 effective medical management existed, that's not

1 true. All the response of this medical team was
2 extremely prompt. This was recognized early.
3 Repeat measurements were made promptly to
4 confirm there in fact was a change in this
5 patient's status, and medical therapy was
6 initiated rapidly within hours in a patient who
7 was hemodynamically stable and monitored very
8 closely from the time this was first suspected,
9 and appropriate tests were ordered and
10 appropriate therapy was ordered promptly.

11 Again, it reiterates here, hours
12 past the initial recognition of neck hematoma.
13 Again, there was no neck hematoma. He again
14 reiterates, enlarging abdomen. If the abdomen
15 was so enlarged, why is it that the attending
16 physician and none of the physicians note it who
17 were attending this patient and monitoring this
18 patient for signs of bleeding, including the
19 placement of an NG tube and looking for gastric
20 bleeding which is much, much more common in
21 addressing these issues.

22 At least two-and-a-half hours
23 occurred between the time an order was placed
24 and initial transfusion of packed cells was
25 first administered, that's true and is an

1 appropriate time period in a patient that is
2 hemodynamically stable. These are not delays.
3 These are appropriate time periods to take place
4 in a patient who has this set of parameters.

5 Q. How long would you expect, Doctor,
6 in a patient that is showing signs of
7 hemodynamic decompensation, if you will, or is
8 no longer hemodynamically stable that the
9 transfusion from the time of the order to the
10 time that it starts should be given?

11 A. Well, in a patient that is extremely
12 hemodynamically unstable, what we do is we kind
13 of skip our routine. By routine I mean in terms
14 of screening a patient extremely carefully to
15 make sure there is not going to be any
16 transfusion reactions or side effects to that
17 bleed. We skip a step or two because we realize
18 that the urgency of the situation mandates that
19 the patient gets blood immediately.

20 So if a patient, for example, comes
21 in in a trauma situation or a patient is, quote,
22 bleeding out, we won't screen the patient.
23 We'll just use what we call universal donor
24 blood, so the patient will be transfused with
25 blood types that are most of the time

1 compatible. So we can get blood transfused
2 usually probably within an hour or so, about an
3 hour.

4 But again, we haven't taken the
5 proper precautions to determine that that blood
6 type is absolutely not going to have any
7 reaction to that patient.

8 Q. Forgetting about situations where
9 you would use unmatched blood, but in a patient
10 that is hemodynamically unstable where you still
11 go ahead and type and screen and crossmatch, how
12 long would you expect to be reasonable to get
13 the transfusion under way?

14 A. You know, that's -- I'm guessing
15 because it really depends upon how quick that
16 person in the laboratory performs that test. I
17 would still think it's probably a few hours, and
18 I can't give you any more accurate assessment
19 than that.

20 Q. Is that what you believe takes place
21 at MetroHealth Medical Center?

22 A. Yes.

23 Q. By the way, do you still have
24 privileges here?

25 A. No.

1 Q. When is the last time you practiced
2 here at Metro?

3 A. In 2000.

4 Q. Do you do any consulting on
5 patients, Metro patients?

6 A. Well, I study research patients, so
7 I do have -- I'm granted temporary privileges
8 for those patients.

9 Q. This is an ongoing process?

10 A. Yes.

11 Q. What type of research is this?

12 A. Respiratory muscle rehabilitation.

13 Q. So do you see the patients here at
14 Metro?

15 A. Yes.

16 Q. How frequently do you do that?

17 A. Well, we have -- we study probably a
18 few patients per year. When a patient I am
19 studying, that patient, though, they are usually
20 admitted to the one part of the hospital where
21 we do research subjects, and I'll see the
22 patient every day during that time period.

23 Q. Do you have patients under study
24 right now?

25 A. Yes, but they are not in the

1 hospital right now.

2 Q. Is there an end date to this
3 research?

4 A. It's ongoing projects. It's based
5 upon our grant support, but there's no -- the
6 grant, the current grant, ends in October. We
7 have a renewal pending, so it's really ongoing
8 research.

9 Q. Is the research in terms of these
10 patients, is it just at this hospital?

11 A. It's also University Hospitals.

12 Q. So between University and
13 MetroHealth Medical Center, these are the two
14 institutions that afford you the opportunity to
15 do this research pursuant to the grant?

16 A. This type of research, yes.

17 Q. Do you have any other ongoing
18 relationship with Metro currently other than
19 associated with your grant research?

20 A. No.

21 Q. Is there anything else on
22 Dr. Selwyn's report before we finish with that?

23 MR. WALTERS: Now, he hasn't made a
24 study of this report. I don't want him to be
25 bound. He's going through here at your request.

1 MR. MISHKIND: Steve, I'm asking him
2 to take as much time as he wants to go through
3 it. That's what the purpose of a discovery
4 deposition is, to find out any other areas.

5 A. He says he feels the CT scan should
6 have been done on an emergent basis, and I
7 disagree with that. A suspected retroperitoneal
8 bleed is a medical emergency, and had a CT scan
9 been performed in a timely manner, it would have
10 demonstrated that.

11 MR. WALTERS: He's quoting from the
12 letter.

13 A. Well, in fact, there was no
14 retroperitoneal bleed, so that is inaccurate.
15 He has this bleed wrong because it wasn't a
16 retroperitoneal bleed. It was an intraabdominal
17 bleed.

18 Q. You didn't know it was an
19 intraabdominal bleed until --

20 A. Well, he states it. He said, had
21 this been performed, prompt recognition of such
22 a bleed would have been made. That's not true
23 because it wasn't made.

24 And this being the case, initiation
25 of appropriate medical therapy and necessary

1 consultation would have been done immediately.
2 Well, that's not true, because she was already
3 receiving appropriate medical therapy. It would
4 not have been different had we seen what we
5 believe we would have seen based upon the
6 autopsy results.

7 Q. So you think that Elsie Parsons was
8 going to die no matter what you as the attending
9 and any of your residents under your direction
10 did for her on the 14th of September?

11 A. That's true.

12 Q. Is there anything else in
13 Dr. Selwyn's report?

14 A. He states, I feel the outcome of
15 this case would have been more than likely quite
16 different, and I disagree with that.

17 Q. Okay.

18 A. And the subsequent paragraph as
19 well, the administration of blood and blood
20 products, she was getting that. Reversal of
21 systemic anticoagulation, intensive hemodynamic
22 support would have been life saving, I disagree
23 with that. Initiation of proper management, she
24 received proper management.

25 Q. Are there any other areas that you

1 disagree with on that report?

2 A. No, that's it.

3 Q. Let me see your report. In your
4 report you indicate that the treatment provided
5 to her including the transfusions and the
6 cessation of heparin were all within accepted
7 standards of medical care. You see that, don't
8 you?

9 A. Yes.

10 Q. We can agree that the heparin should
11 have been stopped in the afternoon while you
12 were waiting for the results of the second stat
13 H&H, correct?

14 A. Yeah. What I said before, that was
15 a judgment call. My opinion was that I would
16 have stopped that, but I don't think it was
17 beyond the standards of medical care to continue
18 it for an additional hour until they had
19 additional results back. This was, again, a
20 judgment call by a different physician.

21 Q. But you were the attending, and as
22 the attending you would not have had heparin
23 continuing while you had a stat H&H pending,
24 true?

25 A. I personally would have stopped it

1 earlier.

2 Q. Can you cite me to any literature,
3 Doctor, that would support the proposition that
4 continued heparin on a patient that has a
5 suspected bleed where a second stat H&H is being
6 ordered, where a continuation of heparin is
7 appropriate?

8 A. No, and I don't think I could find a
9 study that would say it was inappropriate.

10 Q. So you would be surprised to see
11 literature --

12 A. Either way, looking at that
13 particular point.

14 Q. You'd be surprised to see literature
15 or guidelines that indicate that a
16 discontinuation of heparin in a patient with a
17 suspected bleed while lab results are pending to
18 confirm the bleed is the standard of care?

19 MR. WALTERS: Objection. It's been
20 asked, and he answered. He said he would not
21 find it either way. Within the last two minutes
22 he just answered it.

23 MR. MISHKIND: Go ahead.

24 MR. WALTERS: He's trying to get a
25 discrete question and answer that he's going to

1 blow up.

2 MR. MISHKIND: Steve, stop.

3 MR. WALTERS: You're asking the same
4 question three times in a row.

5 MR. MISHKIND: Stop talking and let
6 him answer the question.

7 A. I think you could probably find
8 guidelines. Again, they are guidelines, because
9 it really depends upon the clinical context of a
10 specific patient, and guidelines are
11 generalities that are made assuming a lot of
12 other issues are not playing a role. So I
13 suspect you could find guidelines that would
14 make that recommendation.

15 Q. You don't believe that there is any
16 literature that would indicate that the standard
17 of care is to stop heparin under those
18 circumstances?

19 A. I believe you can't find guidelines
20 to support that.

21 Q. I didn't say guidelines. I said
22 literature that indicates the standard of care
23 is to stop.

24 MR. WALTERS: You mean medical or
25 legal literature?

1 MR. MISHKIND: Medical.

2 A. Standard of care, I don't think you
3 would find that saying standard of care, no.

4 Q. Are there any other opinions that
5 you hold in this case that we haven't already
6 covered, Doctor?

7 A. I don't know.

8 Q. Well, we have now met for the third
9 time.

10 A. Right.

11 Q. I've asked you --

12 A. That was almost a year ago that we
13 met or eight months ago.

14 Q. Do you believe that you have
15 adequately indicated to me why you believe that
16 the standard of care was met by you and by those
17 people that were working either under your
18 supervision or along with you and why you
19 believe that the outcome in this case would not
20 have been altered if things had been done
21 differently?

22 A. Yes. I believe I have.

23 Q. Do you believe, as you sit here
24 right now and as you look at your own report,
25 that you hold any other opinions that you

1 anticipate providing at the time of trial in
2 this matter?

3 A. I don't believe there are any other
4 opinions, no.

5 MR. MISHKIND: I have nothing
6 further for you.

7 MR. WALTERS: He'll want to read it.

8 - - - - -

9 (Deposition concluded at 7:00 p.m.)

10 (Signature not waived.)

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1 AFFIDAVIT

2 I have read the foregoing transcript from
3 page 1 through 63 and note the following
4 corrections:

5 PAGE LINE REQUESTED CHANGE

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20 Subscribed and sworn to before me this

21 _____ day of _____, 2002.

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Notary Public

25 My commission expires _____.

CERTIFICATE

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

I, Cynthia A. Sullivan, 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 4th day of June 2003.

Cynthia A. Sullivan

Cynthia A. Sullivan, Notary Public
Within and for the State of Ohio

My commission expires October 6, 2006.

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