IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

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

vs. Case No. 432317

METROHEALTH MEDICAL
CENTER, et al.,
Defendants.

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DEPOSITION OF ANTHONY DiMARCO, M.D.

THURSDAY, MAY 29, 2003

VOLUME III

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

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APPEARANCES:

On behalf of the Plaintiff:

Becker & Mishkind, by
HOWARD D. MISHKIND, ESQ.
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Cleveland, Ohio 44113
(216) 241-2600

On behalf of the Defendants:

Weston, Hurd, Fallon, Paisley & Howley, by
STEPHEN D. WALTERS, ESQ.
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(Thereupon, Plaintiff's Deposition Exhibit 1 was marked for purposes of identification.)

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

EXAMINATION OF ANTHONY DiMARCO, M.D.

BY MR. MISHKIND:

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

A. Anthony DiMarco.

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

opinions, I think, in his deposition.

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

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

MR. MISHKIND: Okay.

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

A. Yes.

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

A. Yes.

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

A. Yes.

Q. Briefly, tell me where you are

currently working.

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

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

A. Exactly the same.

Q. -- as when we met last year?

A. Exactly the same.

Q. Have you reviewed any testimony in this case?

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

Q. Which nurses?

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

MR. WALTERS: Janesch and Mason.

Q. When were you provided with those?

A. Yesterday.

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

A. Not entirely, no.

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

A. No.

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

A. I have to check the name.

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

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

Q. Was it Dr. Eisenberg?

A. Eisenberg, yes.

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

A. I went through that briefly, also.

Q. But not reading it from front to back?

A. From front to back, no.

Q. Were you provided any type of a summary?

A. No.

Q. Do you have copies of those, or were

you loaned counsel's copies?

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

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

A. No.

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

A. No.

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

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

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

A. Sure.

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

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

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

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

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

A. Yes.

Q. How many others?

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

Q. Is it concerning Metro?

A. No.

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

A. It's for the plaintiff.
Q. Is it a local case or outside of the state?
A. Out of state.
Q. When is the last time you testified in court in a medical negligence case?
A. It has been several years.
Q. For the plaintiff or for the defendant?
A. For the defendant.
Q. Who was the doctor?
A. I don't recall his name. It was a physician at I believe Heather Hill Nursing Home, and it was an internist.
Q. Have you ever testified in court in a medical malpractice case on behalf of a patient?
A. Yes.
Q. When?
A. It was probably 15 years ago, also out of state.
Q. Would that be one time that you've testified in court on behalf of a patient?
A. Yes.
Q. How many times have you testified in

court in total in medical negligence cases?
A. Maybe three times total.
Q. How many times have you given depositions as an expert witness in medical malpractice cases?
A. Probably maybe seven or eight times.
Q. Of those seven or eight times, how many have been for the plaintiff?
A. I would say probably two for the plaintiff and the remainder for the defendant.
Q. Other than this case that you were recently retained on, you are not serving as an expert in any other cases besides the Metro case?
A. That's true.
Q. Have you ever provided your services as an expert through any of the expert services?
A. No -- well, actually I have in the past. That was more than ten years ago, though.
Q. Which service was that?
A. It was a national forensic organization where I provided my name.
Q. Have you ever advertised your services?
A. No.

Q. The case that you're involved in now, do you know how your name was obtained?
A. I was actually contacted by a man names Sapanaro, I think his name was. I guess somebody contacted him, and he contacted me.
Q. Sapanaro is a gentleman that operates an expert search firm. Mr. Sapanaro contacted you to see whether you'd be willing to review?
A. Right.
Q. So the case that you are currently looking at, you were, for lack of better terminology, solicited by Mr. Sapanaro to see whether you would be willing --
A. That's right.
Q. What are the arrangements between you and Mr. Sapanaro?
A. There's no arrangement really.
Q. The lawyer that has retained you pays Mr. Sapanaro, and then he pays you, correct?
A. No. The lawyer paid me directly.
Q. Do you know what the lawyer had to pay Mr. Sapanaro to get you?
A. I have no idea.

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

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

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

A. Yes.

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

A. Well --

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

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

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

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

A. Yes.

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

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

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

A. Not that evening, no.

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

A. No, I haven't.

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

A. Yes. It's here.

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

A. No, I don't.

Q. As you sit here right now, do you

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

A. No.

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

A. Yes.

MR. WALTERS: If he submitted an errata sheet.

MR. MISHKIND: Right.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

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

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

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

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

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

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

A. I believe so.

Q. That was reported back about 12:59?

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

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

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

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

A. I don't remember that, no.

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

A. I don't recall that, no.

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

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

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

A. I don't recall exactly, no.

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

A. I don't know why that is.

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

has a bleed?

A. Yes.

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

MR. WALTERS: Objection to form.

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

Q. The idea is that if you have a

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

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

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

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

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

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

Q. In fact, it was the bleed

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

A. Most likely.

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

MR. WALTERS: Objection.

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

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

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

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

A. No. That's not necessarily the

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

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

A. I'd have to check the records.

Q. Go ahead.

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

Q. With the hemoglobin of what?

A. 6.6.

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

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

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

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

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

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

A. That's true.

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

A. Yes.

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

A. Yes.

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

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

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

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

Q. What would you be looking for?

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

Q. What about a drop in urine output?

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

Q. A drop in blood pressure?

A. If it was a significant change in

blood pressure, yes.

Q. Confusion?

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

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

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

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

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

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

A. Yes, it was.

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

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

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

A. I can't tell you for certain.

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

A. Yes.

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

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

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

MR. WALTERS: What hour?

MR. MISHKIND: 12:15.

MR. WALTERS: Thanks.

MR. MISHKIND: Sure.

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

A. Of what significance are they?

Q. Right.

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

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

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

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

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

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

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

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

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

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

A. That's a judgment call. It really

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

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

A. Right.

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

A. It was one of the residents.

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

A. Yes.

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

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

Q. That's all right, and the records

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

A. I would have held the heparin.

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

A. Yes.

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

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

Q. So you agree with me?

A. Yes.

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

A. Whose responsibility is it that it be performed?

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

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

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

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

A. No one can say that for certain.

We're assuming.

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

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

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

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

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

MR. WALTERS: The source does?

MR. MISHKIND: Yes.

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

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

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

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

A. Yes.

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

A. That's true.

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

A. That's correct.

Q. You have to sort of balance things out?

A. Right.

Q. Can we agree that if Elsie had

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

MR. WALTERS: Objection.

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

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

A. That's true.

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

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

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

A. Yes.

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

A. Yes.
Q. Again, to try to reverse the hypovolemic state?
A. Well, I'm not certain that she was hypovolemic. But in general when someone has suspected bleeding, it's presumed that there is going to be a loss of intravascular volume, so this is automatically replaced.
Q. At 1:00 p.m. Elsie's urine output remained less than 20 cc's per hour, and it had been that way for two hours. Of what significance is that in this patient?
A. That in and of itself doesn't concern me particularly. There's fluctuations in urine output throughout the day, and the fact that she was still making urine and seemed hemodynamically stable, that didn't concern me particularly.
Q. What does reduced urine output potentially indicate to you in a patient that is at least being suspected of having a bleed?
A. Well, we watch the urine output because it's possible that a decrease in urine output reflects poor profusion to the kidney, and that might be an indication that there is a

hypovolemic state.

Q. Hydrating fluids will help reverse a hypovolemic state?

A. Yes.

Q. It will help with profusion?

A. Yes.

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

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

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

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

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

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

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

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

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

A. Right.

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

A. There are things that you can do,

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

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

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

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

A. Correct.

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

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

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

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

Q. She was then ordered --

A. It was ordered at that time

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

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

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

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

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

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

MR. MISHKIND: I could.

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

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

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

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

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

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

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

A. That's correct.

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

A. That's correct.

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

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

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

take for the first unit to be hung?

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

Q. Certainly less than three hours, correct?

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

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

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

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

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

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

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

A. No, it wouldn't have.

Q. What about the administration of blood products?

A. It would not have changed that, either.

Q. Why?

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

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

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

A. Certainly.

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

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

cardiac status.

So they are not that easily treated. They are not treated that readily. These treatments usually take hours to work, and the effect of the blood or volume can happen in minutes.

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

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

Q. Sure.

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

Q. But when you look at a patient, an

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

A. Yes.

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

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

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

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

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

A. Yes.

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

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

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

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

Q. You don't know, though?

A. We don't know that.

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

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

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

THE WITNESS: Can we take a quick break?

(Brief recess.)

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

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

Q. When did you see those?

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

Q. Do you remember which report it was?

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

Q. Dr. Selwyn perhaps?

A. It could be, yes.

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

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

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

MR. MISHKIND: Sure. That's fine.

A. Yes. I disagreed with his impression.

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

MR. WALTERS: We don't have numbers.

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

Q. Why?

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

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

A. I don't understand your question.

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

A. I still don't understand that.

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

size?

A. What type of bleed are you talking about?

Q. Either a retroperitoneal or an intraabdominal wall.

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

Q. What about an intraabdominal bleed?

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

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

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

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

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

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

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

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

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

A. No, because I examined this patient myself.

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

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

Q. What else do you disagree with?

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

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

A. The patient had ecchymosis which is

just a discoloration of the skin.

Q. What caused that?

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

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

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

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

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

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

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

Q. What else do you disagree with?

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. No.

Q. When is the last time you practiced here at Metro?
A. In 2000.
Q. Do you do any consulting on patients, Metro patients?
A. Well, I study research patients, so I do have -- I'm granted temporary privileges for those patients.
Q. This is an ongoing process?
A. Yes.
Q. What type of research is this?
A. Respiratory muscle rehabilitation.
Q. So do you see the patients here at Metro?
A. Yes.
Q. How frequently do you do that?
A. Well, we have -- we study probably a few patients per year. When a patient I am studying, that patient, though, they are usually admitted to the one part of the hospital where we do research subjects, and I'll see the patient every day during that time period.
Q. Do you have patients under study right now?
A. Yes, but they are not in the

hospital right now.

Q. Is there an end date to this research?

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

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

A. It's also University Hospitals.

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

A. This type of research, yes.

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

A. No.

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

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

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

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

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

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

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

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

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

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

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

A. That's true.

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

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

Q. Okay.

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

Q. Are there any other areas that you

disagree with on that report?

A. No, that's it.

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

A. Yes.

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

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

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

A. I personally would have stopped it

earlier.

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

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

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

A. Either way, looking at that particular point.

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

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

MR. MISHKIND: Go ahead.

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

blow up.

MR. MISHKIND: Steve, stop.

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

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

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

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

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

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

MR. WALTERS: You mean medical or legal literature?

MR. MISHKIND: Medical.

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

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

A. I don't know.

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

A. Right.

Q. I've asked you --

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

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

A. Yes. I believe I have.

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

anticipate providing at the time of trial in this matter?

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

MR. MISHKIND: I have nothing further for you.

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

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

(Signature not waived.)

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AFFIDAVIT

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

PAGE	LINE	REQUESTED CHANGE

_____

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

_____
Notary Public

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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DEPOSITION OF ANTHONY DiMARCO, M.D.

VOLUME III