

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

3

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



9 Plaintiff,

10 vs

Case No. 432317
Judge Burnside

11 METROHEALTH MEDICAL CENTER,
12 et al.,

13

Defendants.

14

15

16 TELEPHONE DEPOSITION OF MARK EISENBERG, M.D.

17 FRIDAY, MAY 17, 2002

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19 Deposition of MARK EISENBERG, M.D., a
20 Witness herein, called by counsel on behalf of
21 the Plaintiff for examination under the statute,
22 taken before me, Vivian L. Gordon, a Registered
23 Diplomate Reporter and Notary Public in and for
24 the State of Ohio, pursuant to agreement of
25 counsel, at the offices of Becker & Mishkind,
Skylight Office Tower, Cleveland, Ohio,
commencing at 2:30 o'clock p.m. on the day and
date above set forth.

1 APPEARANCES:

2 On behalf of the Plaintiff

3 Becker & Mishkind

4 HOWARD D. MISHKIND, ESQ.

5 Skylight Office Tower Suite 660

6 Cleveland, Ohio 44113

7 216-241-2100

8

9 On behalf of the Defendants

10 Weston, Hurd, Fallon, Paisley & Howley

11 DEIRDRE HENRY, ESQ.

12 2500 Terminal Tower

13 Cleveland, Ohio 44113

14 216-241-6602

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1 MR. MISHKIND: Let me indicate on the
2 record that the plaintiffs are taking the
3 deposition of Dr. Eisenberg who was an employee
4 of MetroHealth Medical Center back in September
5 of 1999 at the time that Elsie Parsons was a
6 patient at Metro; that Dr. Eisenberg, I
7 understand, is no longer employed at Metro and
8 is, in fact, no longer residing in the State of
9 Ohio. We are doing the deposition with the
10 doctor at his residence.

11 Ms. Henry, counsel for the hospital,
12 is present with me in my office and we are doing
13 the deposition by speaker phone. Vivian Gordon
14 is the court reporter and she is here in
15 Cleveland and she is going to administer the
16 oath to the doctor.

17 To the extent that there are any
18 defects in notice or technicalities with regard
19 to locations, all of those are waived for
20 purposes of this discovery deposition?

21 MS. HENRY: Correct.

22 - - - - -

23 MARK EISENBERG, M.D., a witness herein,
24 called for examination, as provided by the Ohio
25 Rules of Civil Procedure, being by me first duly

1 sworn, as hereinafter certified, was deposed and
2 said as follows:

3 EXAMINATION OF MARK EISENBERG, M.D.

4 BY MR. MISHKIND:

5 Q. Would you please state your name for
6 the record.

7 A. Mark Howard Eisenberg.

8 Q. Where do you live, Dr. Eisenberg?

9 A. I live in Poulsbo, Washington.

10 Q. How do you spell that?

11 A. P-O-U-L-S-B-O.

12 Q. What is your residence address,
13 please?

14 A. 839 Northwest, Petar Lane P-E-T-A-R.

15 Q. How long have you lived in
16 Washington, the State of Washington?

17 A. This time around, 11 months.

18 Q. Where were you living before 11
19 months ago?

20 A. I was living in Cleveland Heights,
21 Ohio.

22 Q. What were you doing when you were
23 living in Cleveland Heights, Ohio?

24 A. I was an emergency medicine resident
25 at MetroHealth Medical Center.

1 Q. How long were you in emergency
2 medicine as a resident?

3 A. Three years.

4 Q. What are you doing currently?

5 A. I am an attending physician in an
6 emergency department.

7 Q. What hospital?

8 A. Harrison Memorial Hospital.

9 Q. Harrison, doctor?

10 A. Yes.

11 Q. Harrison Memorial?

12 A. Yes.

13 Q. What city is that?

14 A. Bremerton, Washington.

15 Q. How long have you been an emergency
16 doctor at Harrison Memorial Hospital?

17 A. Since July of last year.

18 Q. Did you leave Cleveland and start
19 your position with Harrison Memorial within a
20 close proximity of time?

21 A. Yes.

22 Q. Where did you go to medical school?

23 A. Case Western Reserve University
24 School of Medicine.

25 Q. And you graduated in what year?

1 A. 1998.

2 Q. What year were you in your residency
3 at the time that you were involved in Elsie
4 Parsons' care?

5 A. It was my second year of residency.

6 Q. You mentioned a moment ago, doctor,
7 that you were in emergency medicine in a
8 residency program.

9 A. Correct.

10 Q. Was that the program that you were in
11 at the time that you were involved in Elsie's
12 care?

13 A. Yes, sir.

14 Q. Can you explain to me how you were
15 involved in Elsie's care in the medical
16 intensive care unit?

17 A. One of the rotations that we do as
18 emergency medicine residents is to rotate
19 through the intensive care unit, and I was on my
20 rotation through the intensive care unit at that
21 time.

22 Q. How long did that rotation last?

23 A. One month.

24 Q. Starting when?

25 A. I don't have the dates in front of

1 me. We were on calendar months at that time,
2 so, I presume, though I can't guarantee it, it
3 was from the beginning of September until the
4 end of September.

5 Q. What do you have in your possession
6 as we talk right now concerning Elsie Parsons?

7 A. I have a copy of the medical record.

8 Q. Anything else?

9 A. No, sir.

10 Q. Have you ever had your deposition
11 taken before, sir?

12 A. No, sir.

13 Q. Have you ever been named as a party
14 to any lawsuits?

15 A. No, sir.

16 Q. I take it you satisfactorily
17 completed your residency?

18 A. That's correct.

19 Q. Are you board certified?

20 A. I'm board pending at this time, sir.

21 Q. What does that mean?

22 A. I have taken half of the exam and I
23 am eligible for the second half of the exam
24 which is scheduled for later this year.

25 Q. What part was the first half that you

1 took?

2 A. The written exam.

3 Q. Were you successful?

4 A. Yes, sir.

5 Q. The oral exams are later this year?

6 A. Correct.

7 Q. And assuming you are equally

8 successful, you will then become board

9 certified?

10 A. In emergency medicine; correct.

11 Q. Have you sat for any board

12 certification in any other disciplines other

13 than -- or have you applied for board

14 certification in any other disciplines aside

15 from emergency medicine?

16 A. No to both questions.

17 Q. Have you written anything, doctor?

18 A. As in? You mean --

19 Q. Good question. Have you published

20 any articles in the medical literature?

21 A. I have not published any original

22 works. I have done some limited editing work.

23 Q. Can you explain that to me?

24 A. There is a software called

25 Micromedics that has emergency medicine topics,

1 and I did some editing and updating of that, but
2 it was not original.

3 Q. I'm familiar with E-Medicine. Is
4 that similar to?

5 A. I'm not familiar with E-Medicine.

6 Q. Tell me the name again.

7 A. Micromedics.

8 Q. Is this something on the Internet?

9 A. No. It's a subscription sent out by
10 CD rom to hospitals and subscribers.

11 Q. Other than that editing?

12 A. I have not done any other published
13 work.

14 Q. Have you co-authored anything?

15 A. No.

16 Q. Do you have anything in the works
17 currently?

18 A. No.

19 Q. Do you have an independent
20 recollection of Elsie Parsons?

21 A. No, I do not.

22 Q. In looking at the hospital record,
23 did it cause you to remember any aspect of your
24 treatment of Elsie?

25 A. No.

1 Q. So for purposes of the questions that
2 I'm going to have for you this afternoon, you
3 are relying on the hospital record as it relates
4 to the various events that occurred?

5 A. That is correct.

6 Q. After reviewing the records, when did
7 you determine that you were first involved in
8 Elsie's care during the admission in September
9 of '99?

10 A. I was the one that wrote the
11 admission note, so from the time she arrived in
12 the intensive care unit.

13 Q. And you were involved on various
14 dates thereafter, up to and including September
15 14, 1999; true?

16 A. Correct.

17 Q. Were you involved in each day from
18 September 8th through September 14th, or do you
19 recall a day or two that you were not involved?

20 A. I believe there were a couple of days
21 presumably over a weekend where I was not
22 involved.

23 Q. As you look at the record, does the
24 10th and the 11th of September, does that sound
25 like the dates that you were not involved?

1 A. On the 10th there is a cross-cover
2 note, which means I was not there. On the 11th
3 there is a cross-cover note, as well. So again,
4 I was not there those days, correct.

5 Q. Thank you. Doctor, do you have any
6 deposition transcripts of any of the doctors or
7 nurses that have testified in this case?

8 A. No, I do not.

9 Q. Have you been provided with any
10 summaries, written summaries of any deposition
11 testimony?

12 A. No, I have not.

13 Q. Do you have any type of a time line
14 or anything that would summarize the medical
15 records for you, other than the copy of the
16 records that you have in your possession?

17 A. No. I have exclusively the copy of
18 the medical record.

19 Q. In going through the medical records,
20 have you made any notes?

21 A. Not written. I made mental notes,
22 but not written notes.

23 Q. Are those mental notes just stored in
24 your head, or have you stored them on some
25 computer?

1 A. No, they are just in my head.

2 Q. Presumably, you will be able to share
3 them with me during the deposition.

4 A. Presumably.

5 Q. Aside from your mental notes and the
6 copy of the chart, is that the extent of any
7 documentation that you have either produced or
8 been provided?

9 A. Correct.

10 Q. Who is your attending on September
11 8th through September 14th?

12 A. I believe that the attending was
13 Dr. DiMarco; however, there may have been
14 individual days when another attending was
15 covering. I don't know for sure. But
16 Dr. DiMarco was on service during that time
17 period as the ICU attending.

18 Q. When is the last time you had any
19 contact with Dr. DiMarco?

20 A. Any direct contact would be the last
21 day of my rotation in the intensive care unit.
22 I may have had contact with him the subsequent
23 year, while I was doing other services, but the
24 last time I remember dealing with him directly
25 was when I was on service with him.

1 Q. And as best as you can recall, your
2 service in the intensive care unit would have
3 ended the end of September of 1999?

4 A. Correct.

5 Q. You have never discussed any aspect
6 of this case with Dr. DiMarco, is that your
7 testimony?

8 A. Other than at the time of the
9 verification, that's correct.

10 Q. Did you have any discussion with
11 Dr. DiMarco at any time after Elsie Parsons
12 died, but while you were still working in the
13 intensive care unit?

14 A. Not to my knowledge.

15 Q. Do you have any recollection of
16 having any discussion with any doctors or nurses
17 concerning Elsie Parsons after her death and
18 while you were still working in the intensive
19 care unit?

20 A. Not to my knowledge.

21 Q. Were you ever asked to appear at any
22 conferences to talk about what occurred with
23 Elsie Parsons? And before you answer that, I
24 don't want you to tell me the substance of any
25 discussions, just whether or not you were asked

1 by someone at the hospital to appear at a
2 meeting where the subject of Elsie Parsons was
3 discussed.

4 A. Not that I recall.

5 Q. Did you ever have any notes, either
6 written or computer generated, concerning any
7 aspect of this patient's care that you no longer
8 have?

9 A. Not that I recall.

10 Q. Briefly, with the benefit of the
11 record, tell me what your admission note
12 reflects as to the patient's condition upon
13 admission to the hospital in September of 1999.

14 A. According to my note, she had three
15 days of some vomiting and diarrhea and
16 complained of some leg pain, for which she was
17 given some Percocet. She had a decrease in her
18 alertness. She was given a dose of Narcan, with
19 slight improvement in her mental status.

20 According to my note, she was either
21 unable or unwilling at the time that I was
22 taking my history to give details of her
23 condition, and the family was unavailable by
24 telephone at that time.

25 She had several items in her past

1 medical history. Her only current medication
2 was Albuterol. She denied any allergies.

3 Her vital signs at the time of
4 admission were she was afebrile, she had very
5 minimal hypertension, upper limits, normal heart
6 rate, normal respiratory rate, oxygen saturation
7 could be consistent with her asthma. I
8 described her as a well developed, elderly
9 female appearing confused, but in acute
10 distress, slightly pale.

11 Q. Does that cover the basic history?

12 A. I'm just looking through the rest of
13 it. I am looking through the rest of the
14 physical exam, which looks unremarkable. I
15 described her neurological exam as increasing
16 alertness.

17 Q. Increasing alertness?

18 A. Yes.

19 Q. Does that fairly describe the
20 admitting history that you obtained?

21 A. Yes. She had lab work, as well. Her
22 EKG revealed an atrial fibrillation with a heart
23 rate of 110, which was new from 1995, when she
24 was in sinus rhythm.

25 So assessment at the time was

1 73-year-old female with history of nausea and
2 vomiting with question of dehydration,
3 hyponatremia, or low sodium, with some evidence
4 of a respiratory acidosis and atrial
5 fibrillation.

6 So, do you want me to go through
7 exactly what I wrote in the assessment and plan?

8 Q. No, that's okay. I wanted to get an
9 overview of the history and I'm intentionally
10 being silent because I don't want to interrupt
11 you. We don't need you to read all of what is
12 in the record. I have the records, as well.

13 I wanted to get sort of a global
14 statement, if you would, in terms of the
15 admitting history and understanding that you had
16 at the time on September 8th.

17 A. Okay.

18 Q. Is what you just told me adequate?

19 A. Yes. I mean, the overall assessment
20 was she had several issues that brought her to
21 the intensive care unit, including decreased
22 level of consciousness, that may or may not have
23 been related to several factors that were going
24 on at the time.

25 She had atrial fibrillation that we

1 weren't sure if it was new or old. It was
2 different than her previous visit in 1995 that
3 we had records of.

4 She had an underlying history of
5 asthma. She had a mild hyponatremia. She was
6 slightly cold. Her temperature was just
7 slightly below normal, but not significantly,
8 and she had a baseline slight anemia. These
9 were all things that we were going to evaluate
10 through her stay in the intensive care unit.
11 That was the plan to look into each of those
12 things.

13 Q. Doctor, you mentioned the '95
14 admission. Do you have the actual records for
15 the '95 admission?

16 A. No. All I have is my note says
17 comparison 1995, normal sinus rhythm under EKG,
18 which means at the time I must've had an EKG
19 from 1995 to compare with.

20 Q. Do you know what her admission in
21 1995 pertained to?

22 A. I have no idea.

23 Q. Or how long she was admitted to the
24 hospital?

25 A. The only information I have about

1 that visit is that I must have seen an EKG from
2 then.

3 Q. Do you have any knowledge as to any
4 other admissions to Metro other than in 1995?

5 A. No.

6 MR. MISHKIND: Deirdre, do you have
7 the '95 records?

8 MS. HENRY: I don't. I can get them.

9 MR. MISHKIND: I would request you
10 get those for me.

11 Q. You mentioned, doctor, at the very
12 beginning of the history that the family was
13 unavailable at that time; that the family was
14 unavailable to you in the intensive care unit?

15 A. They were unreachable by telephone
16 and they were not present, apparently. My note
17 says family unreachable by telephone, message
18 left, so they must not have been in the
19 hospital, nor at home.

20 Q. Do you know which family member or
21 members you were attempting to reach?

22 A. I do not.

23 Q. Does the record reflect which family
24 you were attempting to reach?

25 A. The record reflects the statement I

1 just read. I have no other information.

2 Q. From your notes and from your review
3 of your notes, do you have any record of having
4 discussions with any family members throughout
5 Elsie's stay in the hospital up through the
6 14th?

7 A. I don't remember where I saw it, but
8 I believe I did see a note that I had written
9 somewhere where I had spoken with the family. I
10 don't remember where in the record I saw it.

11 Q. Are you looking for that, doctor?

12 A. I am flipping through. I am trying
13 to see if I can find anything.

14 I have, spoken with the family.
15 Presuming your chart is the same way as mine
16 under hospital admission, flowsheets and
17 consents, the second tag, look through the
18 consent sheets, there is a consent for swan
19 catheter, about three or four pages back. Phone
20 consent by Kathy Everett, daughter. I must've
21 spoken to her at the very least at that time,
22 and there is also verbal consent previous for a
23 transesophageal echocardiogram that says from
24 Frances Mihalek.

25 Q. Any other notes that you recall

1 seeing where you would have had some contact
2 with the family, either by phone or in person?

3 A. I don't know if there are any other
4 notes to that effect or not.

5 Q. As we go through what we are going to
6 be talking about, if you detect or if you
7 discover any such notes, will you let me know?

8 A. Yes.

9 Q. On September 8th, Elsie had a lumbar
10 puncture done; correct?

11 A. Correct.

12 Q. Were you the one that did the lumbar
13 puncture?

14 A. Yes, sir.

15 Q. What was the reason for the lumbar
16 puncture?

17 A. The reason for the lumbar puncture
18 was because of her change in mental status, to
19 evaluate for any central nervous system causes
20 of her apparent decreased level of
21 consciousness.

22 Q. Was the lumbar puncture negative?

23 A. I will look at the lab results.

24 (Pause.)

25 A. The cell count in the chemistries

1 were negative according to the microbiology and
2 the micro values were also negative.

3 Q. Thank you. Doctor, I want to back up
4 for one second. Your current position at the
5 hospital at Harrison Memorial, is this a
6 full-time position?

7 A. Yes, sir.

8 Q. You are an attending in the emergency
9 room?

10 A. Correct. I'm a staff emergency
11 physician.

12 Q. Do you hold any other positions other
13 than at Harrison Memorial?

14 A. No, sir.

15 Q. Since coming to Washington after
16 leaving Cleveland, have you held any other
17 positions?

18 A. No, sir.

19 Q. You mentioned at the very beginning
20 that this time around you have been in
21 Washington, I think you said, 11 months, if I am
22 not mistaken?

23 A. I came here in July. Is that 11
24 months?

25 Q. Close to it.

1 A. I may have misspoken.

2 Q. That's okay, we are pretty close to
3 11 months.

4 I take it you had been to Washington
5 previously?

6 A. Correct. I lived in Washington
7 before I moved to Cleveland.

8 Q. Are you originally from Washington?

9 A. Born in California, grew up in
10 Washington.

11 Q. Did you do your undergraduate in
12 Washington?

13 A. Yes, sir.

14 Q. Where did you go to college?

15 A. University of Washington, Seattle.

16 Q. And then all of your medical school
17 was at Case Western Reserve?

18 A. Correct.

19 Q. On September 8th, doctor, I noted
20 that the lumbar puncture informed consent was
21 obtained from the patient's daughter. So that
22 would be another contact that you would have had
23 with the family; correct?

24 A. Correct.

25 Q. Do you recall which daughter that

1 was?

2 A. It's written on the consent note,
3 which is what we were looking at before.

4 Q. Was that the informed consent
5 document you were referring to or was that
6 different?

7 A. Actually it was a different one. It
8 appears that Frances --

9 Q. Mihalek?

10 A. -- apparently signed this one in
11 person, so presumably she was present at that
12 time.

13 Q. Any recollection of discussing the
14 results of the lumbar puncture with Frances or
15 any other family member?

16 A. I do not know. I do not have a
17 recollection.

18 Q. Every once and awhile, even though
19 you told me you don't remember this patient, and
20 not to be obnoxious about it, but I will test
21 your memory just to see whether something does
22 come back to you.

23 A. All right.

24 Q. I'm going to jump ahead, doctor, to
25 September 12. You placed an arterial line on

1 September 12th, according to my notes. Does
2 that correspond with what you know to be the
3 case?

4 A. Yes, sir.

5 Q. Why was an A-line placed on September
6 12th?

7 A. The purpose, according to the note,
8 is for frequent arterial blood gas measurements
9 and ventilating weaning.

10 Q. She was still on the ventilator or
11 had she been extubated?

12 A. According to the notes of that day,
13 it appears she was still intubated.

14 MS. HENRY: The 13th she was
15 extubated, or 12th.

16 Q. According to the records, doctor,
17 tell me when was she extubated?

18 A. Apparently she was extubated some
19 time on the 12th. At the time of the A-line
20 placement it is not clear whether she is still
21 intubated at that time or not. If it was for
22 vent weaning, I presume she was still intubated.
23 But some time she appears to be extubated as the
24 note on the 13th says, she was extubated
25 yesterday.

1 Q. What is a Corpak?

2 A. A small feeding tube.

3 Q. Do you know why Elsie at some time
4 had a Corpak?

5 A. In order to provide nutrition to
6 patients on ventilators, tube feedings are
7 usually given and Corpak is the instrument
8 through which they are given.

9 They are usually placed through the
10 nose or mouth down into the stomach to allow
11 feeding for patients that are unable to swallow
12 or eat otherwise for various reasons, including
13 intubation.

14 Q. After she was extubated, was the
15 Corpak on the 12th or on the 13th, was it kept
16 out? In other words, was she on oral intake?

17 A. The note of the 13th says she was NPO
18 still for evaluation by the ear, nose and throat
19 doctors and with a plan to start a diet soon. I
20 don't see not written explicit where the Corpak
21 was replaced or not.

22 (Pause.)

23 A. There is an x-ray on 9-13 at 6:42
24 a.m. saying the feeding tubes have been removed,
25 so they were no longer present at that time.

1 MS. HENRY: What time was that at,
2 doctor?

3 THE WITNESS: There is an x-ray
4 report under the radiology section 9-13-1999,
5 6:42 a.m., that says the ET tube and feeding
6 tubes have been removed. So they weren't seen
7 on the x-ray and no more radiology reports. And
8 x-rays are routinely obtained after feeding tube
9 placement to confirm where they are.

10 Q. Doctor, I'm looking --

11 A. No evidence that a feeding tube was
12 replaced.

13 Q. Okay, thank you. I'm looking at the
14 progress note that you wrote in the MICU on
15 September 13th.

16 A. Yes.

17 Q. Do you have that handy?

18 A. Yes. In front of me.

19 Q. Can you tell me what time that note
20 was written? Because it doesn't appear to be
21 timed. Other than the date, there is no time
22 referenced.

23 A. I cannot tell you the exact time that
24 it was written. My routine in the intensive care
25 unit was to write the notes early in the

1 morning, try to have them written before rounds,
2 which were usually somewhere between 7:00 and
3 9:00 in the morning, but I don't know exactly
4 what time it was written.

5 Q. And then when would your shift, if
6 you will, end on the 13th?

7 A. Nights when I was not on call would
8 usually end somewhere between 4:30 and 5:30-ish.
9 Nights when I was on call would continue through
10 the next day. I don't know what my call
11 schedule was.

12 Q. Do you have any reason to believe
13 that you saw Elsie at any time on the 13th of
14 September after that 4:00 or 4:30 time period?

15 A. If I look at the order forms, the
16 last order I gave on the chart on 9-13 was at
17 1450 hours. The subsequent orders on that day
18 are by a different physician.

19 Q. Tell me, who was the doctor that
20 wrote the next set of orders on the 13th?

21 A. I can't tell you. I don't know whose
22 handwriting that is.

23 Q. There is reference in the chart to a
24 Dr. Inkster, or something close to that. Does
25 that appear to be --

1 A. That looks like it could be.

2 Q. Do you remember such a doctor?

3 A. Yes.

4 Q. Am I pronouncing his name correctly?

5 A. Dr. Michelle Inkster.

6 Q. So I am pronouncing her name
7 correctly?

8 A. Correct.

9 Q. Do you know where Dr. Inkster works
10 now?

11 A. I have no idea.

12 MR. MISHKIND: Is she at Metro?

13 MS. HENRY: No.

14 Q. On the 14th, just so I can get a time
15 frame reference for the remainder of my
16 questions, later in the afternoon on the 14th,
17 there are orders written by Dr. Sankar or
18 Dr. Sarkar, either S-A-N-K-A-R or S-A-R-K-A-R.
19 Tell me whether your involvement in Elsie's care
20 would have ended sometime in the late afternoon
21 on the 14th?

22 A. I'm sorry, whose care would have
23 ended?

24 Q. Your involvement, or were you
25 involved in any aspect of her care after the

1 late afternoon of the 14th?

2 A. No, I was not. Again, I was not on
3 call that night.

4 Q. Can you help me whether it's Sankar
5 or Sarkar?

6 A. I believe it's Sarkar, S-A-R-K-A-R.

7 Q. Was Dr. Sarkar a resident, as well?

8 A. Correct.

9 Q. Is Dr. Sarkar a male or female?

10 A. A female.

11 Q. What is Dr. Sarkar's first name?

12 A. I can't remember.

13 Q. That's a very weird first name.

14 A. I don't recall her first name. I
15 think it may have been Loxmi, but I'm not sure.

16 Q. That would have been my first guess.

17 A. With an L, but I'm not positive that
18 that's her first name.

19 Q. I won't hold you to it.

20 Was Dr. Sarkar and Dr. Eisenberg at
21 the same level of residency?

22 A. You mean Dr. Eisenberg, being me?

23 Q. Yes.

24 A. I believe so. I believe she was a
25 second-year internal medicine resident however.

1 Q. And how about Dr. Inkster?

2 A. She was a second-year internal
3 medicine resident.

4 Q. So you were the only emergency
5 resident that was involved apparently on the
6 13th or the 14th?

7 A. Correct. I was the only emergency
8 resident rotating through the intensive care
9 unit at that time.

10 Q. Got it. Doctor, in the progress
11 notes, there is a progress note written at 1:15
12 p.m. It's written under cardiology.

13 A. On which date, sir?

14 Q. September 14th, '99.

15 A. Yes, 1:15 a.m. Is that the note we
16 are talking about?

17 Q. Right. You read that as 1:15 a.m.? I
18 think it is 1:15 p.m., but in any event, we are
19 talking about the same note?

20 A. Yes.

21 Q. And it's signed by an individual with
22 SMS. Is that senior medical student?

23 A. Yes, sir.

24 Q. Any recollection as to who that
25 senior medical student was?

1 A. No, sir.

2 Q. Do you know who the attending
3 cardiologist was?

4 A. Not at that time, no.

5 Q. Does Dr. Bahler, B-A-H-L-E-R --

6 A. Dr. Bahler was a cardiologist at
7 Metro. Whether he was the consulting
8 cardiologist or not, I do not know.

9 Q. Do your notes reflect any
10 communication or consultation with Dr. Bahler,
11 either on the 13th or the 14th?

12 A. There are no notes from me. I don't
13 see any documented evidence of that. The note
14 would have been reviewed at some point after it
15 was written; however, direct discussion, I don't
16 see any written evidence of that.

17 Q. And as I understand it, when a
18 medical student writes a note, either a resident
19 or an attending countersigns that note; correct?

20 A. That is correct.

21 Q. That's the normal procedure?

22 A. That's correct.

23 Q. Is there any such counter signature
24 on this senior medical student's note that you
25 have?

1 A. I do not see one, but the senior
2 medical student's signature is also partially
3 not there on the photocopy.

4 Q. But on the photocopy that you have,
5 you don't see any type of counter signature by a
6 resident or an attending; true?

7 A. I do not. Correct, I do not see
8 that.

9 Q. On the 14th, you would have attempted
10 to create your progress note early in the
11 morning like you did on the 13th, as well; is
12 that correct?

13 A. Yes, sir.

14 Q. And before you round with the
15 attending?

16 A. Yes, sir.

17 Q. And then you would have been in the
18 medical intensive care unit throughout the day
19 up to 4:00 or 4:30-ish?

20 A. Yes.

21 MS. HENRY: 4:30 to 5:30-ish.

22 Q. Tell me your best recollection as to
23 when you would said sayo-nara for the day?

24 A. I believe sign out rounds were
25 somewhere between 4:30 and 5:30.

1 Q. So when we look at the MICU note for
2 September 14th that you wrote, again, that is
3 not timed, but your best recollection would be
4 sometime in the 7:00 to 8:00 a.m. time period?

5 A. Correct.

6 Q. And in your note on September 14,
7 '99, I take it you would have examined the
8 patient before writing this note; is that
9 correct?

10 A. Correct.

11 Q. So under GI -- I'm sorry, under the
12 assessment and plan, and then the subcategory
13 under GI, you have some slight abdominal pain?

14 A. Correct.

15 Q. And then at the very end of that
16 sentence, you write down, will follow?

17 A. Correct.

18 Q. What does that mean?

19 A. Generally it means we will pay
20 attention to what is going on with the patient
21 and at some point reexamine them and see if it
22 gets better or gets worse.

23 Q. When you made this note on September
24 14th, before rounds, were you aware of the
25 results of the 4:00 a.m. CBC?

1 A. Yes, because those are the results
2 that are written on the note.

3 Q. Her hemoglobin had dropped to 9.6 and
4 her hematocrit had dropped 29.2; correct?

5 A. Correct. However, the previous day's
6 results were 30.9 and 10.2, which is not a
7 significant drop.

8 Q. This was certainly the lowest that it
9 had been since she had been in the hospital;
10 true?

11 A. True. However, on her admission,
12 hematocrit -- she was 10.6 and 30.3, which is
13 not a significant difference from 9.6 and 29.2.

14 Q. Nonetheless, though, the results the
15 early morning of the 14th were the lowest that
16 they had been?

17 A. That is a correct statement.

18 Q. And below the GI, two lines down, why
19 don't you read me what that --

20 A. Hem, stable anemia, will watch.

21 Q. Tell me again in terms of stable
22 anemia and will watch, what are you saying at
23 that point?

24 A. Again, 29.2 and 30.3, which was her
25 admission, and 30.9, which was the previous day,

1 there is not a significant change in hematocrit.
2 Will watch means we will continue to check CBC's
3 periodically and make sure that it does not
4 change in any significant manner.

5 Q. She was on aspirin therapy as of the
6 14th; correct?

7 A. Correct.

8 Q. Was she on heparin or Coumadin at
9 this point?

10 A. She was on both.

11 Q. For the atrial fib; correct?

12 A. Correct.

13 Q. Did you have any concern as of this
14 7:00 or 8:00 o'clock in the morning as it
15 relates to the anticoagulation and her H&H?

16 A. Not at that time.

17 Q. Or her platelet count?

18 A. It does not appear that I did at that
19 time.

20 Q. Her platelets were low; correct?

21 A. Correct. However, they were higher
22 than they were two days ago at admission.

23 Q. They were lower than what they had
24 been the day before; correct?

25 A. Correct.

1 Q. The other note that I have on the
2 14th by you in the progress notes is a MICU
3 addendum?

4 A. Correct.

5 Q. Other than the MICU addendum, and the
6 MICU note that you did not time on the 14th, did
7 you write any other progress notes on the 14th?

8 A. I do not see any; therefore, I don't
9 think so.

10 Q. The MICU addendum, you did time that
11 on the 14th; correct?

12 A. Correct.

13 Q. Is there a reason you wrote an
14 addendum note?

15 A. Addendum notes are generally written
16 when there is a change in condition or a
17 significant event that should be recorded in the
18 medical record.

19 I presume this was written due to the
20 epistaxis and the new lab results.

21 Q. And the time of your note, an
22 addendum note, was what time?

23 A. 1530.

24 Q. So 3:30 in the afternoon?

25 A. Correct.

1 Q. And when you wrote
2 indicated the patient comp]
3 abdominal pain; correct?

4 A. Correct.

5 Q. The note that you had made
6 the morning under GI, you had marked down
7 slight abdominal pain; true?

8 A. Correct.

9 Q. When you made the note at 1530, or
10 3:30 p.m., was your reference to some abdominal
11 pain a current reference or were you reflecting
12 upon events that had transpired hours before
13 this 1530 note?

14 A. I don't know the answer to that. It
15 is likely that I was referring to the current
16 time period.

17 Q. I take it you are not at the hospital
18 right now?

19 A. No, I'm at home.

20 Q. Doctor, I have had the benefit of
21 taking some nurses' depositions, including a
22 Nurse Mason. I don't know if you happen to have
23 any recollection of that name as one of the
24 nurses that was working in the MICU?

25 A. I do not.

1 Q. M-I-G-D-A-L-I-A, she went by Maggie,
2 does that help you at all?

3 A. The name sounds vaguely familiar.

4 Q. According to the nurse's notes,
5 Maggie or Nurse Mason notified you of the nose
6 bleed that Elsie had. Do you know what time,
7 according to the records, you were notified of
8 the nose bleed?

9 A. 12 P, Dr. Eisenberg aware of oozing
10 nose bleed. CBC and repeat PTT order. CBC and
11 PTT sent per nursing notes.

12 Q. That was according to the nursing
13 notes?

14 A. Correct.

15 Q. According to the notes or according
16 to anything that you have noted, how long had
17 her nose been bleeding before you were notified?

18 A. That's the first note I see, I
19 believe.

20 Q. The first note I see is the nursing
21 note that says 12:00 p.m., Dr. Eisenberg aware.
22 Would you agree that prior to 12:00 p.m., there
23 are no nurse's notes in this flowsheet between
24 6:30 a.m. and the 12 P note that you were
25 advised of the oozing of blood from the nose?

1 A. I will agree that there are no
2 significant events listed; however, there are
3 nursing notes charting vital signs.

4 Q. In terms of any reference to the time
5 that there was oozing of blood from the nose,
6 there is no reference to any of that prior to
7 12 P; correct?

8 A. I don't see any.

9 Q. And is it fair to say that based upon
10 what's in the record, you don't know for a fact
11 from anything, either this note or anywhere else
12 in the chart, how long she had had any bleeding
13 from the nose before 12 P?

14 A. I would agree that I do not see any
15 reference to it prior to 12:00 p.m.

16 Q. And when she had a nose bleed two
17 minutes before or an hour before, there is no
18 way to confirm or to refute the length of time
19 prior to 12 P; correct?

20 A. I do not see any. There is an 11:00
21 a.m. vital signs documented and no note that
22 there was bleeding at that time.

23 Q. In fact, it's totally blank; right?

24 A. Correct. But the area that's blank
25 is for significant events, and if there are

1 none, they don't chart any.

2 Q. Got it. And then according to the
3 notes at 12:00 p.m., you ordered a stat CBC and
4 PTT; correct?

5 A. Correct.

6 Q. Now, why did you order a stat CBC and
7 PTT at that time?

8 A. I presume based on -- I don't know
9 what I was thinking at that time, to be honest
10 with you, but I'm presuming I was thinking
11 similar to what I am right now, because a
12 patient on anticoagulation with a nose bleed,
13 anemia, at baseline, is at risk for blood loss,
14 and to evaluate for how much blood she had lost
15 and the need for transfusion.

16 Q. So when you gave the order at 12:00
17 o'clock, you wanted to attempt to determine
18 whether or not the patient had some type of
19 acute bleed; correct?

20 A. To determine whether there had been a
21 change in her hematocrit, whether it had been a
22 significant bleed or not, yes.

23 Q. What would have been within your
24 differential at this point when you ordered the
25 stat CBC and the PTT, aside from a bleed?

1 A. Differential in terms of what?

2 Q. Potential causes for the epistaxis.

3 A. Positive epistaxis including
4 mechanical irritation from anticoagulation in
5 this patient are the two most likely. Although
6 it's been a day or two at this point and she has
7 had recent instrumentation in her nose. She has
8 been on oxygen, which has a drying effect.

9 Q. The labs that you ordered stat at 12
10 appear to have been collected at 12:15,
11 according to the hematology labs, and were
12 reported at 7.7 and 23.9 respectively, the
13 hemoglobin and hematocrit.

14 A. Yes.

15 Q. What time were you made aware of the
16 12:15 labs?

17 A. It appears there is a nursing note
18 which states 1300 Dr. Eisenberg aware of 12:00
19 p.m. CBC, repeat order as well as hyphen screen,
20 hyphen labs sent.

21 Q. I'm sorry?

22 A. Hyphen screen, hyphen labs sent.

23 Q. What does that mean?

24 A. It means at 1300 hours, I was advised
25 that the results of the blood from the new draw

1 and I instructed the nurses to order a type and
2 screen.

3 Q. Why did you --

4 A. A repeat CBC.

5 Q. Why did you order that a type and
6 screen be done?

7 A. The patient had evidence of a drop in
8 hematocrit and hemoglobin; however, these
9 patients in the ICU often are not poked with
10 needles for blood draw, they are done from their
11 central line catheters or arterial catheters, in
12 which case you can get dilution of the blood --
13 whatever fluid you are obtaining -- if enough
14 waste was not discarded during the draw.

15 So at that time, I felt that
16 repeating the test one more time would confirm
17 that had really dropped versus a laboratory or
18 drawing error had caused it. And to be on the
19 safe side, not to waste time, order a type and
20 screen to obtain the type of blood that the
21 patient has in case a transfusion would be
22 needed in the future.

23 Q. What does the screen part of that
24 type and screen mean?

25 A. The screen is an antibody screen to

1 look for common antibodies in the blood.

2 Q. At that time, in terms of typing and
3 screening the patient, were you considering that
4 the patient might need a transfusion?

5 A. It was a consideration in the future
6 the patient may need a transfusion.

7 Q. You weren't ordering a transfusion at
8 1:00 o'clock, though; correct?

9 A. The possibility of a future
10 transfusion was entertained. The need for a
11 current transfusion was not.

12 Q. And that's why you wanted to type and
13 screen the patient so if an order were to be
14 given for transfusion, you would be underway
15 with regard to steps that needed to be taken;
16 correct?

17 A. Correct.

18 Q. If, in fact, the results of the 12:15
19 CBC that you had ordered stat were accurate as
20 opposed to dilutional, or due to a dilutional
21 effect, would you consider the hematocrit and
22 hemoglobin to have significantly dropped from
23 the 4:00 a.m. results that you were aware of?

24 A. Yes.

25 Q. And if, in fact, that was a true drop

1 as opposed to some dilution having caused the
2 drop, would you agree that the patient more
3 likely than not would need a transfusion?

4 A. It is more likely than not that the
5 patient would need a transfusion.

6 Q. Was the time response with your stat
7 order of 12:00 and then the blood being drawn at
8 12:15, was that a reasonable turnaround, in your
9 opinion?

10 A. Yes.

11 Q. Was the response to you of the
12 results of that stat CBC at 12:59 or 1:00 p.m.,
13 was that a reasonable turnaround on a stat CBC?

14 A. Yes.

15 Q. When you got the results at 12:59 or
16 1:00 o'clock, you wanted to make sure that they
17 were true readings and that's why you ordered a
18 repeat CBC and the type and screen; correct?

19 A. Correct.

20 Q. Did you go and see the patient at
21 12:00 o'clock?

22 A. I don't know.

23 Q. Can you tell me based upon the notes
24 and based upon your custom and practice whether
25 you likely went to examine the patient?

1 A. I don't know.

2 Q. After getting the results from the
3 12:15 blood draw at 1:00 o'clock, did you go to
4 see the patient?

5 A. I can tell you I was in the intensive
6 care unit at 1:00 p.m., based on the order
7 actually signed by Dr. Sarkar at 1:00 p.m.
8 The line on number two is actually my
9 handwriting, where it says chest x-ray in a.m.,
10 following pneumonia. So I was in the unit. So
11 presumably if I was in the unit, I did see the
12 patient.

13 Q. The order that you are referring to,
14 doctor, is dated September 14 and timed 1:00
15 p.m.?

16 A. Correct.

17 Q. Chest x-ray in a.m., following
18 pneumonia?

19 A. Correct, that's my handwriting.

20 Q. You wanted a chest x-ray done the
21 following morning on the 15th?

22 A. Correct. All of those orders were
23 for the morning.

24 Q. Now, you mentioned Dr. Sarkar's
25 signature?

1 A. I believe that's her signature.

2 Q. So the number two in the order was
3 your handwriting?

4 A. Correct.

5 Q. Was number one her handwriting?

6 A. I'm not a handwriting expert, so I
7 don't know.

8 Q. Was number one someone other than
9 your handwriting?

10 A. It appears similar, to my
11 nonprofessional eye, similar to her other
12 handwriting.

13 Q. I guess what I am asking you is --

14 A. She started the order, she signed the
15 order, and I wrote in the chest x-ray part.

16 Q. Why didn't you write a separate order
17 and sign it for the chest x-ray? I just find
18 that a little curious, or a little unusual that
19 you would add to another doctor's order
20 something and not sign it.

21 A. I don't know why.

22 Q. In any event, is that what you are
23 basing on your belief that you would have seen
24 the patient, the note of chest x-ray in a.m.?

25 A. I am basing the fact that I was in

1 the intensive care unit at 1:00 p.m. in order to
2 write that, and so my usual practice if I would
3 have been in the unit and there would have been
4 some issue with the patient of mine, I would
5 have seen them.

6 Q. The next note right below that is an
7 order at 1:05 p.m.; true?

8 A. Correct.

9 Q. And that is the stat H&H that you
10 wanted done to make sure that the results were
11 accurate from the 12:15 draw; correct?

12 A. Correct.

13 Q. I'm sorry, doctor, I cut you off.

14 A. So, yes, I was there at 1:00 o'clock
15 or 1:05.

16 Q. Why did you want repeat coags, also?

17 A. Because she was on two forms of
18 anticoagulation, and to evaluate whether her
19 anticoagulation was too high.

20 Q. Of what concern with a patient that
21 is showing a significant drop in their
22 hematocrit and hemoglobin would you have as it
23 relates to a patient that's on anticoagulation?

24 A. In terms of what?

25 Q. What impact would Coumadin or heparin

1 have on a patient that has a significant drop in
2 their hematocrit and hemoglobin?

3 A. If a patient has a source of bleeding
4 and is on anticoagulation, they are likely to
5 bleed more than someone not on anticoagulation.

6 Q. So certainly, if the patient is
7 bleeding, you want to stop the heparin as soon
8 as possible?

9 MS. HENRY: Objection.

10 Q. Is that correct?

11 You can answer the question, doctor.

12 MS. HENRY: Go ahead and answer,
13 doctor.

14 A. If a patient is having bleeding and
15 is on anticoagulation, it depends on the
16 location and type of bleeding they have. You
17 would want to be cautious with your
18 anticoagulation; however, you have to weigh the
19 benefits and risks stopping the anticoagulation
20 for whatever reason it was given versus the
21 risks of continued bleeding.

22 Q. Are GI bleeds in elderly patients
23 that are on heparin or Coumadin of more concern
24 than a GI bleed in a younger patient?

25 A. More of a concern meaning what?

1 Q. In terms of diagnosing the cause of
2 the bleed and taking appropriate steps to treat
3 the drop in the hematocrit and hemoglobin.

4 (Record read.)

5 MS. HENRY: Go ahead and answer.

6 Objection, but go ahead and answer.

7 Q. Is a drop in hematocrit and
8 hemoglobin to the levels that we have in this
9 case in an elderly patient that's on heparin and
10 Coumadin of more concern to you as a physician
11 than a drop in the hemoglobin and the hematocrit
12 in a younger patient?

13 A. Any drop in hemoglobin and hematocrit
14 is significant, whether it's in an older person
15 or a younger person.

16 Q. What concerns, whether it's an older
17 person or a younger person, do you have when you
18 are facing a patient that has a significant drop
19 in their hematocrit and hemoglobin that is on
20 heparin and Coumadin in terms of potential
21 complications?

22 A. Are you asking for a differential
23 diagnosis as the cause or the effect?

24 Q. The effect.

25 A. The effects of the drop in hematocrit

1 and hemoglobin leading to anemia can cause
2 increased strains on the cardiovascular system,
3 can cause increased strains on all body systems
4 through a decrease in the availability of
5 nutrients and oxygen delivery. Those concerns
6 don't have to do with age so much as the
7 functional reserve in any given patient. So an
8 ill person may show more signs of those effects
9 than an otherwise healthy person, if that
10 answers the question.

11 Q. It does, thank you.

12 Now, we have the 12:59 draw on the
13 CBC showing a hemoglobin of 7.4 and the
14 hematocrit of 22.1. What time were you made
15 aware of the H&H from the 1:00 o'clock or 12:59
16 draw?

17 A. I don't know that I see any
18 documentation of that. I don't have a
19 recollection. I don't see any documentation as
20 to effect of time.

21 Q. At 12:59, when the labs were drawn,
22 there was an order for heparin to be held for
23 one hour. Why was that?

24 A. Where do you see the order?

25 MS. HENRY: There wasn't an order.

1 Q. The heparin was held for one hour.
2 Would that be an appropriate thing to do pending
3 the lab results?

4 A. It depends why was it held. Was it
5 held by protocol?

6 Q. Let's assume it was held by protocol.

7 A. If the nurse was following the
8 anticoagulation protocol, then, yes, it would
9 have been appropriate if it was by protocol.

10 Q. Would it be appropriate to hold the
11 heparin pending the results of the repeat
12 hematocrit and hemoglobin in this case, as well?

13 A. It would, depending on what the PT,
14 PTT were.

15 Q. According to the nursing flowsheet,
16 doctor, the repeat H&H was reported or at least
17 documented at 2:40 p.m. Do you see that?

18 MS. HENRY: Where is that, Howard?
19 It's on the hemodynamic parameters?

20 MR. MISHKIND: Right.

21 Q. Do you see that, doctor?

22 A. I also see in reading on the nursing
23 notes under significant events 2:40 p.m. repeat
24 H&H with a down arrow hyphen heparin. I don't
25 know if that's the same place you are looking at

1 or someplace else.

2 Q. No, that's exactly the same thing.

3 MS. HENRY: He is looking here on the
4 significant events. Is that what you have? Oh,
5 you have it on a different format, okay.

6 Q. Do you know why the heparin was
7 started back at 2:10 p.m. while the results of
8 the H&H were still pending?

9 A. Again, if the nurse was acting off
10 the heparin protocol, then if she had held it
11 for an hour, based on the protocol, and the
12 partial thromboplastin time, if the protocol
13 said to start it again, and she started it
14 again, the nurse would have been acting under
15 the orders of the protocol and not under a
16 specific order from a physician, I guess not a
17 direct order from a one of the caring physicians
18 at that time, but under the orders from the
19 protocol.

20 Q. Your progress note at 3:30 p.m.
21 reflects the repeat H&H?

22 A. Right.

23 Q. Can we agree that you would have
24 expected with the stat H&H ordered at 12:59 and
25 actually collected at 12:59 that those results

1 of 7.4 and 22.1 should have been brought to your
2 attention or to a doctor's attention sooner than
3 2:40 p.m.?

4 A. The results should have been brought
5 to the attention of a physician when they became
6 available. I don't know when they became
7 available.

8 Q. You would expect stat H&H to be
9 available quicker than an hour and 40 minutes
10 later; correct?

11 MS. HENRY: Objection.

12 A. Stat labs usually take between 45
13 minutes and just over an hour from the intensive
14 care unit.

15 Q. So certainly an hour and 40 minutes
16 would be beyond what you would expect stat labs
17 to take; true?

18 MS. HENRY: Objection.

19 A. Notified of the lab results take the
20 labs to be returned and the labs to be read and
21 then the doctor to be contacted, and that is not
22 unusual or unreasonable time.

23 Q. You are not aware of what Dr. DiMarco
24 has testified when I asked him that same
25 question, are you?

1 A. I do not.

2 Q. Dr. DiMarco was your attending;
3 correct?

4 A. That is correct.

5 Q. The reporting back of the stat H&H at
6 12:15 took 45 minutes; correct?

7 A. I'm sorry, which results?

8 Q. The ones that you ordered at 12:00
9 o'clock that were drawn at 12:15, those were
10 reported back at 12:59 or 1:00 p.m.; true?

11 A. Correct.

12 Q. Why the repeat stat H&H took from
13 12:59 to at least 2:40 p.m. to be reported back,
14 can we agree that you have no explanation for
15 that?

16 MS. HENRY: Objection.

17 A. We agree.

18 Q. The orders, doctor, are those your
19 orders, 1500?

20 A. Yes, sir.

21 Q. And part of your orders included
22 transfusing two units of packed red blood cells;
23 correct?

24 A. Correct.

25 Q. You wanted each unit of the packed

1 red blood cells to be given over a two to three
2 hour period; correct?

3 A. Correct.

4 Q. Why did you want the heparin held?

5 A. Because the previous PTT had been
6 elevated and the patient had evidence of loss of
7 blood. It was felt at that time that the risks
8 of continued or increased bleeding at that time
9 outweighed the risks of any complications from
10 not keeping her anticoagulated.

11 Q. Why did you stop the Coumadin?

12 A. The same reason.

13 Q. You didn't stop the aspirin, though,
14 did you?

15 A. Aspirin I believe was a once a day
16 medicine and she probably already received it
17 that day, but no, it was not.

18 Q. Subsequent order by Dr. Sarkar was to
19 DC the aspirin; correct?

20 A. Correct.

21 Q. Can we agree that that was an
22 oversight on your part at 3:00 p.m. in terms of
23 not DC'ing the aspirin?

24 MS. HENRY: Objection.

25 A. My orders were written at a time when

1 I was trying to stop things that would cause her
2 to bleed at this time. Coumadin is dosed at
3 p.m. and heparin is dosed continuously and
4 aspirin is -- I don't know when the patient's
5 aspirin was dosing. It was an oversight not to
6 stop it by order at that time, perhaps; however,
7 it had no impact on the patient's case.

8 Q. When did you expect that the patient
9 would be transfused?

10 A. I expected the patient would be
11 transfused over the next several hours.

12 Q. Doctor, you wrote a note at 1540 on
13 September 14th, 3:40 p.m.

14 A. Are you talking about the orders or
15 notes?

16 Q. I'm sorry, the orders, excuse me.

17 A. Yes.

18 Q. Actually, I want to back up for one
19 second. The 3:00 p.m. note, under the
20 physician's order, you had NG tube.

21 A. Correct.

22 Q. What was the reason for the NG tube?

23 A. To evaluate the gastric bleeding.

24 Q. The NG tube, was it maintained or was
25 it just used to evaluate the gastric -- to do a

1 gastric lavage?

2 A. I don't know. I presume it was
3 removed. My usual practice is to place an NG
4 tube to lavage, and if it's negative for blood,
5 to remove the tube, but I don't know.

6 Q. When you wrote the order then to
7 transfuse the patient two units of packed red
8 blood cells, you obviously felt that her anemia
9 was getting worse; correct?

10 A. We had documented that she had a drop
11 in her H&H to a level that would benefit from
12 her transfusion.

13 Q. Why did you write an order at 1340 to
14 move her to the stepdown bed?

15 A. I'm sure it was because I was told to
16 write such an order.

17 Q. Who told you to write that order?

18 A. I don't know. It would have either
19 been the fellow or the attending.

20 Q. Was she in a condition at that time
21 with a transfusion ordered and her H&H dropping
22 to be transferred from the MICU to a stepdown
23 bed?

24 A. A stepdown bed is within the MICU.
25 It's within the same unit, the same nurses, with

1 the same monitoring capabilities.

2 The patient was hemodynamically
3 stable at that time and transfusion has been
4 ordered on a nonurgent basis, and presumably in
5 consultation with my supervising physicians, it
6 was determined that she would be safe to go to a
7 stepdown bed at that time.

8 Q. You are assuming that you consulted
9 with someone or do you know for a fact that you
10 consulted with someone before putting down move
11 to stepdown bed?

12 A. As a junior resident in the intensive
13 care unit I was not in a position to make
14 decisions as to who goes to stepdown beds. My
15 usual practice would have been to consult with
16 one of my supervisors.

17 Q. Was this patient actually transferred
18 to a stepdown bed?

19 A. I don't know.

20 Q. What time was Elsie typed and crossed
21 for the transfusion?

22 A. The blood to do that was already in
23 the lab with the previous screening and
24 presumably the order was given at 1500 to
25 transfuse, which means the crossmatch would have

1 been ordered at that time. Secretarial orders
2 have a time of 3:20. It appears that the order
3 to put in the computer was somewhere between
4 3:00 o'clock and 3:20.

5 Q. Do you have any explanation for why
6 the first transfusion of fresh frozen plasma was
7 not started until 5:30?

8 A. Because it wasn't ordered until then.

9 Q. You ordered a transfusion at 3:00
10 p.m.; right?

11 A. You asked me about the fresh frozen
12 plasma. Fresh frozen plasma is at 5:30 p.m.

13 Q. What transfusion did you want?
14 Packed red blood cells?

15 Doctor, are you with me? Did you
16 hear my question?

17 A. No.

18 Q. You wanted packed red blood cells to
19 be transfused; correct?

20 A. That's what I ordered at 3:00
21 o'clock.

22 Q. And you told me that you expected the
23 packed red blood cells to be transfused starting
24 within what period of time after that order was
25 given?

1 A. Starting within a few hours.

2 Q. And, in fact, the packed red blood
3 cells were not started until 8:00 p.m.; correct?

4 A. The first unit was completed at 8:00
5 p.m., the first unit of packed red blood cells,
6 which would be a completion time.

7 Q. Your order called for two units of
8 packed red blood cells?

9 MS. HENRY: The packed red blood
10 cells are started at 5:30. Are we confused on
11 this?

12 MR. MISHKIND: No.

13 Q. Your order was to transfuse two units
14 of packed red blood cells; correct?

15 A. Correct.

16 Q. Each unit over a two or three hour
17 period; correct?

18 A. Correct.

19 Q. Do you know whether the packed red
20 blood cells were, in fact, transfused over a two
21 to three hour period?

22 A. I do not know. I presume they were
23 based on my order.

24 Q. Why didn't you order a CT scan?

25 A. Of what?

1 Q. Where did you think the bleed -- you
2 suspected a bleed, did you not?

3 A. I had evidence of a nose bleed.

4 Q. Well, what did you --

5 A. I had no evidence of an intra-luminal
6 GI bleed. The patient was hemodynamically
7 stable.

8 Q. Do you know why a CT scan was ordered
9 at 5:30 by Dr. Sarkar?

10 A. Because the patient had resolved her
11 nose bleed and had a drop in her hematocrit and
12 hemoglobin.

13 Q. Hadn't the patient resolved her nose
14 bleed during your watch?

15 A. I believe so.

16 Q. Why didn't you order a CT of the
17 abdomen during your watch?

18 A. Because an acute blood loss does not
19 cause an immediate drop in your hematocrit and
20 hemoglobin and so the decline may have been of
21 the previous bleeding rather than an ongoing
22 bleed.

23 The patient had no hemodynamic
24 changes in her blood pressure or heart rate and
25 had minimal abdominal findings.

1 Q. So you were waiting for the patient
2 to develop hemodynamic changes before you looked
3 for a source of the bleed?

4 A. No. We had been looking for the
5 source of the bleed. It's an ongoing process.

6 Q. Doctor, do you know whether you
7 discussed at any time during your shift in the
8 afternoon of September 14th Elsie's condition
9 with Dr. DiMarco?

10 A. I don't have a specific recollection;
11 however, it is very likely that I did advise him
12 of the change in her lab result status before.
13 I presume I discussed with someone, whether it
14 was Dr. DiMarco or the fellow. The result was
15 to come to a decision to transfuse the blood.

16 Q. Do you know who the fellow was?

17 A. I do not know recall who the fellow
18 was at that time.

19 Q. Would you agree that the heparin
20 should not have been restarted at 2:10 p.m.
21 while the results from the 1:00 p.m. H&H were
22 pending?

23 A. No, I do not agree with that.

24 Q. So then would you disagree with
25 Dr. DiMarco if he indicated that they shouldn't

1 have been restarted; is that correct?

2 A. I think if the nurse was following
3 the protocol, and it was restarted by the
4 protocol, then that was reasonable. It would
5 have been potentially nice for it not to be
6 restarted, but I don't think -- I think the
7 nurse followed the orders she had.

8 Q. At 2:00 p.m. you felt she needed a
9 transfusion to treat her anemia; true?

10 A. True.

11 Q. And you ordered the transfusion at
12 3:00 p.m., even though, as you testified, her
13 vital signs were stable; correct?

14 A. Yes.

15 Q. You wanted to treat her anemia before
16 she became hemodynamically unstable; correct?

17 A. Correct.

18 Q. Do you know why the patient was not
19 transfused sooner than 5:30?

20 A. No.

21 Q. Would you agree that it would have
22 been preferable to have transfused the patient
23 earlier than 5:30?

24 MS. HENRY: Objection.

25 A. I think a nonemergent transfusion

1 taking place over that time period is
2 reasonable.

3 Q. At 4:00 p.m. her H&H was no longer
4 nonemergent, was it?

5 A. I do not know what her -- are you
6 talking about the results at 1650?

7 Q. Right, 4:50 p.m., I'm sorry.

8 A. 6.8 and 20.6.

9 Q. Those are considered critical;
10 correct?

11 A. They are significantly low.
12 Critical, if you are talking about the
13 designation on the lab result form, it's
14 critical. A designation from the lab, it
15 doesn't necessarily mean a critical number in
16 any given patient.

17 Q. In this particular patient --

18 A. It is very low. Yes, it is
19 significantly low.

20 Q. And certainly, this would represent a
21 medical emergency, would it not?

22 MS. HENRY: Objection.

23 A. It depends on the patient's
24 hemodynamic condition. Laboratory values don't
25 define an emergency. A patient's condition

1 defines an emergency.

2 Q. Well, was this patient, in your
3 opinion, with a 6.8 hemoglobin and a 20.6
4 hematocrit with the labs that were drawn at 4:00
5 and the results at 4:50, was this patient still,
6 in your opinion, hemodynamically stable?

7 A. Based on the patient's flowsheet, the
8 patient was hemodynamically stable. The
9 patient's hematocrit and hemoglobin are not
10 stable; however, the patient's hemodynamics,
11 meaning blood pressure, heart rate, and
12 respiratory status are.

13 Q. In terms of infusion of blood
14 products in a patient who does not have any
15 history of congestive heart failure, how fast
16 can you infuse the blood products?

17 A. It depends on the patient's clinical
18 status.

19 Q. Would you agree that blood products
20 can be infused as fast as the patient tolerates
21 them?

22 A. Yes. By definition, you can do
23 anything as fast as somebody tolerates it. The
24 question is when do you cross that line.

25 Q. You weren't involved at all in any

1 aspect of the care after 4:30 or 5:00 o'clock;
2 correct?

3 A. That's correct.

4 Q. With regard to the rate of infusion
5 of the fresh frozen plasma or the packed red
6 blood cells, you weren't involved in any aspect
7 in terms of that management in the evening, were
8 you?

9 A. That's correct.

10 Q. Were you aware of any of the problems
11 that were being encountered that evening with
12 regard to getting the CT of the abdomen
13 performed?

14 A. The CT of the abdomen was ordered
15 after the time period when I would have been
16 caring for the patient. I was not around.

17 Q. Did you ever discuss anything with
18 Dr. Sarkar in terms of the difficulties that
19 were being encountered that evening?

20 A. Not to my recollection.

21 Q. Why didn't you order a transfusion at
22 1:00 p.m.? What was there different about the
23 patient at 3:00 p.m.?

24 A. We confirmed that the blood drop was
25 real.

1 Q. That took two hours?

2 A. Apparently.

3 Q. Would you agree that it should have
4 taken less time?

5 MS. HENRY: Objection.

6 A. No. Again, we are back to the fact
7 of labs being sent, drawn, and doctors being
8 notified. As I said before, I think it was done
9 in a reasonable amount of time.

10 Q. This patient was still in the
11 intensive care unit?

12 A. Throughout her stay.

13 Q. And these parameters, in your
14 opinion, in terms of -- strike that.

15 You don't have to answer my
16 incompleated question.

17 A. Okay.

18 MS. HENRY: Looks like he is coming
19 to a close, doctor.

20 MR. MISHKIND: Don't assume that.

21 MS. HENRY: He said it would be
22 short.

23 Q. Doctor, there is an indication that
24 the patient was typed and crossed at 5:30 p.m.?

25 A. Are you talking about the orders?

1 Q. Right.

2 A. Okay.

3 Q. Was there any need to type and cross
4 Elsie at 5:30 p.m.?

5 A. For additional units of packed red
6 blood cells, a type and cross for a given number
7 of units of blood, she had been typed and
8 crossed per two units previously by the previous
9 order that I had given at 1500. Speculation
10 would infer that they requested an additional --
11 the order is for an additional four units to be
12 typed and crossed.

13 Q. When she was typed and crossed at
14 5:30, she had not been given any transfusion at
15 that particular point, though; correct?

16 A. I don't know. I don't think we have
17 established a definitive time of the first unit
18 of blood being hung.

19 MR. MISHKIND: Doctor, I have no
20 further questions.

21 MS. HENRY: Doctor, I know he is
22 going to have this transcribed and we are going
23 to send this to you so you can read it.

24 Howard, can he have more than a week?

25 MR. MISHKIND: Twenty-eight days.

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(Deposition concluded at 4:30 p.m.)

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(Signature not waived.)

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1 AFFIDAVIT

2 I have read the foregoing transcript from
3 page 1 through 69 and note the following
4 corrections:

5 PAGE LINE REQUESTED CHANGE

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MARC EISENBERG, M.D.

18

19

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

22

23 Notary Public

24

25 My commission expires .

CERTIFICATE

State of Ohio,


SS:

County of Cuyahoga.

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named MARC EISENBERG, 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 22nd day of May, 2002.



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

My commission expires June 8, 2004.

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