IN THE COURT OF COMMON PLEAS

OF CUYAHOGA COUNTY, OHIO

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

Plaintiff,

vs

Case No. 432317
Judge Burnside

METROHEALTH MEDICAL CENTER,
et al.,

Defendants.

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TELEPHONE DEPOSITION OF MARK EISENBERG, M.D.

FRIDAY, MAY 17, 2002

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

APPEARANCES:

On behalf of the Plaintiff

Becker & Mishkind

HOWARD D. MISHKIND, ESQ.

Skylight Office Tower Suite 660

Cleveland, Ohio 44113

216-241-2100

On behalf of the Defendants

Weston, Hurd, Fallon, Paisley & Howley

DEIRDRE HENRY, ESQ.

2500 Terminal Tower

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

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

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

MS. HENRY: Correct.

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

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

EXAMINATION OF MARK EISENBERG, M.D.

BY MR. MISHKIND:

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

A. Mark Howard Eisenberg.

Q. Where do you live, Dr. Eisenberg?

A. I live in Poulsbo, Washington.

Q. How do you spell that?

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

Q. What is your residence address, please?

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

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

A. This time around, 11 months.

Q. Where were you living before 11 months ago?

A. I was living in Cleveland Heights, Ohio.

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

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

Q. How long were you in emergency medicine as a resident?
A. Three years.
Q. What are you doing currently?
A. I am an attending physician in an emergency department.
Q. What hospital?
A. Harrison Memorial Hospital.
Q. Harrison, doctor?
A. Yes.
Q. Harrison Memorial?
A. Yes.
Q. What city is that?
A. Bremerton, Washington.
Q. How long have you been an emergency doctor at Harrison Memorial Hospital?
A. Since July of last year.
Q. Did you leave Cleveland and start your position with Harrison Memorial within a close proximity of time?
A. Yes.
Q. Where did you go to medical school?
A. Case Western Reserve University School of Medicine.
Q. And you graduated in what year?

A. 1998.
Q. What year were you in your residency at the time that you were involved in Elsie Parsons' care?
A. It was my second year of residency.
Q. You mentioned a moment ago, doctor, that you were in emergency medicine in a residency program.
A. Correct.
Q. Was that the program that you were in at the time that you were involved in Elsie's care?
A. Yes, sir.
Q. Can you explain to me how you were involved in Elsie's care in the medical intensive care unit?
A. One of the rotations that we do as emergency medicine residents is to rotate through the intensive care unit, and I was on my rotation through the intensive care unit at that time.
Q. How long did that rotation last?
A. One month.
Q. Starting when?
A. I don't have the dates in front of

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

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

A. I have a copy of the medical record.

Q. Anything else?

A. No, sir.

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

A. No, sir.

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

A. No, sir.

Q. I take it you satisfactorily completed your residency?

A. That's correct.

Q. Are you board certified?

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

Q. What does that mean?

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

Q. What part was the first half that you

took?

A. The written exam.

Q. Were you successful?

A. Yes, sir.

Q. The oral exams are later this year?

A. Correct.

Q. And assuming you are equally successful, you will then become board certified?

A. In emergency medicine; correct.

Q. Have you sat for any board certification in any other disciplines other than -- or have you applied for board certification in any other disciplines aside from emergency medicine?

A. No to both questions.

Q. Have you written anything, doctor?

A. As in? You mean --

Q. Good question. Have you published any articles in the medical literature?

A. I have not published any original works. I have done some limited editing work.

Q. Can you explain that to me?

A. There is a software called Micromedics that has emergency medicine topics,

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

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

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

Q. Tell me the name again.

A. Micromedics.

Q. Is this something on the Internet?

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

Q. Other than that editing?

A. I have not done any other published work.

Q. Have you co-authored anything?

A. No.

Q. Do you have anything in the works currently?

A. No.

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

A. No, I do not.

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

A. No.

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

A. That is correct.

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

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

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

A. Correct.

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

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

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

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

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

A. No, I do not.

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

A. No, I have not.

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

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

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

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

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

A. No, they are just in my head.
Q. Presumably, you will be able to share them with me during the deposition.
A. Presumably.
Q. Aside from your mental notes and the copy of the chart, is that the extent of any documentation that you have either produced or been provided?
A. Correct.
Q. Who is your attending on September 8th through September 14th?
A. I believe that the attending was Dr. DiMarco; however, there may have been individual days when another attending was covering. I don't know for sure. But Dr. DiMarco was on service during that time period as the ICU attending.
Q. When is the last time you had any contact with Dr. DiMarco?
A. Any direct contact would be the last day of my rotation in the intensive care unit. I may have had contact with him the subsequent year, while I was doing other services, but the last time I remember dealing with him directly was when I was on service with him.

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

A. Correct.

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

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

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

A. Not to my knowledge.

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

A. Not to my knowledge.

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

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

A. Not that I recall.

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

A. Not that I recall.

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

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

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

She had several items in her past

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

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

Q. Does that cover the basic history?

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

Q. Increasing alertness?

A. Yes.

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

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

So assessment at the time was

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

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

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

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

A. Okay.

Q. Is what you just told me adequate?

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

She had atrial fibrillation that we

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

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

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

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

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

A. I have no idea.

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

A. The only information I have about

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

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

A. No.

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

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

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

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

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

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

A. I do not.

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

A. The record reflects the statement I

just read. I have no other information.

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

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

Q. Are you looking for that, doctor?

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

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

Q. Any other notes that you recall

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

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

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

A. Yes.

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

A. Correct.

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

A. Yes, sir.

Q. What was the reason for the lumbar puncture?

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

Q. Was the lumbar puncture negative?

A. I will look at the lab results.

(Pause.)

A. The cell count in the chemistries

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

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

A. Yes, sir.

Q. You are an attending in the emergency room?

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

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

A. No, sir.

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

A. No, sir.

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

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

Q. Close to it.

A. I may have misspoken.
Q. That's okay, we are pretty close to 11 months.
I take it you had been to Washington previously?
A. Correct. I lived in Washington before I moved to Cleveland.
Q. Are you originally from Washington?
A. Born in California, grew up in Washington.
Q. Did you do your undergraduate in Washington?
A. Yes, sir.
Q. Where did you go to college?
A. University of Washington, Seattle.
Q. And then all of your medical school was at Case Western Reserve?
A. Correct.
Q. On September 8th, doctor, I noted that the lumbar puncture informed consent was obtained from the patient's daughter. So that would be another contact that you would have had with the family; correct?
A. Correct.
Q. Do you recall which daughter that

was?

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

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

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

Q. Mihalek?

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

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

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

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

A. All right.

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

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

A. Yes, sir.

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

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

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

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

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

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

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

Q. What is a Corpak?
A. A small feeding tube.
Q. Do you know why Elsie at some time had a Corpak?
A. In order to provide nutrition to patients on ventilators, tube feedings are usually given and Corpak is the instrument through which they are given.

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

Q. After she was extubated, was the Corpak on the 12th or on the 13th, was it kept out? In other words, was she on oral intake?
A. The note of the 13th says she was NPO still for evaluation by the ear, nose and throat doctors and with a plan to start a diet soon. I don't see not written explicit where the Corpak was replaced or not.

(Pause.)

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

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

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

Q. Doctor, I'm looking --

A. No evidence that a feeding tube was replaced.

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

A. Yes.

Q. Do you have that handy?

A. Yes. In front of me.

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

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

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

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

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

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

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

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

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

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

A. That looks like it could be.
Q. Do you remember such a doctor?
A. Yes.
Q. Am I pronouncing his name correctly?
A. Dr. Michelle Inkster.
Q. So I am pronouncing her name correctly?
A. Correct.
Q. Do you know where Dr. Inkster works now?
A. I have no idea.
MR. MISHKIND: Is she at Metro?
MS. HENRY: No.
Q. On the 14th, just so I can get a time frame reference for the remainder of my questions, later in the afternoon on the 14th, there are orders written by Dr. Sankar or Dr. Sarkar, either S-A-N-K-A-R or S-A-R-K-A-R. Tell me whether your involvement in Elsie's care would have ended sometime in the late afternoon on the 14th?
A. I'm sorry, whose care would have ended?
Q. Your involvement, or were you involved in any aspect of her care after the

late afternoon of the 14th?

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

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

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

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

A. Correct.

Q. Is Dr. Sarkar a male or female?

A. A female.

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

A. I can't remember.

Q. That's a very weird first name.

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

Q. That would have been my first guess.

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

Q. I won't hold you to it.

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

A. You mean Dr. Eisenberg, being me?

Q. Yes.

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

Q. And how about Dr. Inkster?
A. She was a second-year internal medicine resident.
Q. So you were the only emergency resident that was involved apparently on the 13th or the 14th?
A. Correct. I was the only emergency resident rotating through the intensive care unit at that time.
Q. Got it. Doctor, in the progress notes, there is a progress note written at 1:15 p.m. It's written under cardiology.
A. On which date, sir?
Q. September 14th, '99.
A. Yes, 1:15 a.m. Is that the note we are talking about?
Q. Right. You read that as 1:15 a.m.? I think it is 1:15 p.m., but in any event, we are talking about the same note?
A. Yes.
Q. And it's signed by an individual with SMS. Is that senior medical student?
A. Yes, sir.
Q. Any recollection as to who that senior medical student was?

A. No, sir.
Q. Do you know who the attending cardiologist was?
A. Not at that time, no.
Q. Does Dr. Bahler, B-A-H-L-E-R --
A. Dr. Bahler was a cardiologist at Metro. Whether he was the consulting cardiologist or not, I do not know.
Q. Do your notes reflect any communication or consultation with Dr. Bahler, either on the 13th or the 14th?
A. There are no notes from me. I don't see any documented evidence of that. The note would have been reviewed at some point after it was written; however, direct discussion, I don't see any written evidence of that.
Q. And as I understand it, when a medical student writes a note, either a resident or an attending countersigns that note; correct?
A. That is correct.
Q. That's the normal procedure?
A. That's correct.
Q. Is there any such counter signature on this senior medical student's note that you have?

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

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

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

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

A. Yes, sir.

Q. And before you round with the attending?

A. Yes, sir.

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

A. Yes.

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

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

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

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

A. Correct.

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

A. Correct.

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

A. Correct.

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

A. Correct.

Q. What does that mean?

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

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

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

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

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

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

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

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

A. That is a correct statement.

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

A. Hem, stable anemia, will watch.

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

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

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

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

A. Correct.

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

A. She was on both.

Q. For the atrial fib; correct?

A. Correct.

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

A. Not at that time.

Q. Or her platelet count?

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

Q. Her platelets were low; correct?

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

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

A. Correct.

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

A. Correct.

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

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

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

A. Correct.

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

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

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

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

A. 1530.

Q. So 3:30 in the afternoon?

A. Correct.

Q. And when you wrote
indicated the patient compl
abdominal pain; correct?
A. Correct.
Q. The note that you had made
the morning under GI, you had marked down
slight abdominal pain; true?
A. Correct.
Q. When you made the note at 1530, or
3:30 p.m., was your reference to some abdominal
pain a current reference or were you reflecting
upon events that had transpired hours before
this 1530 note?
A. I don't know the answer to that. It
is likely that I was referring to the current
time period.
Q. I take it you are not at the hospital
right now?
A. No, I'm at home.
Q. Doctor, I have had the benefit of
taking some nurses' depositions, including a
Nurse Mason. I don't know if you happen to have
any recollection of that name as one of the
nurses that was working in the MICU?
A. I do not.

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

A. The name sounds vaguely familiar.

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

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

Q. That was according to the nursing notes?

A. Correct.

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

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

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

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

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

A. I don't see any.

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

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

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

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

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

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

none, they don't chart any.

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

A. Correct.

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

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

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

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

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

A. Differential in terms of what?
Q. Potential causes for the epistaxis.
A. Positive epistaxis including mechanical irritation from anticoagulation in this patient are the two most likely. Although it's been a day or two at this point and she has had recent instrumentation in her nose. She has been on oxygen, which has a drying effect.
Q. The labs that you ordered stat at 12 appear to have been collected at 12:15, according to the hematology labs, and were reported at 7.7 and 23.9 respectively, the hemoglobin and hematocrit.
A. Yes.
Q. What time were you made aware of the 12:15 labs?
A. It appears there is a nursing note which states 1300 Dr. Eisenberg aware of 12:00 p.m. CBC, repeat order as well as hyphen screen, hyphen labs sent.
Q. I'm sorry?
A. Hyphen screen, hyphen labs sent.
Q. What does that mean?
A. It means at 1300 hours, I was advised that the results of the blood from the new draw

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

Q. Why did you --

A. A repeat CBC.

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

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

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

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

A. The screen is an antibody screen to

look for common antibodies in the blood.

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

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

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

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

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

A. Correct.

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

A. Yes.

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

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

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

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

A. Yes.

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

A. Yes.

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

A. Correct.

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

A. I don't know.

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

A. I don't know.
Q. After getting the results from the 12:15 blood draw at 1:00 o'clock, did you go to see the patient?
A. I can tell you I was in the intensive care unit at 1:00 p.m., based on the order actually signed by Dr. Sarkar at 1:00 p.m. The line on number two is actually my handwriting, where it says chest x-ray in a.m., following pneumonia. So I was in the unit. So presumably if I was in the unit, I did see the patient.
Q. The order that you are referring to, doctor, is dated September 14 and timed 1:00 p.m.?
A. Correct.
Q. Chest x-ray in a.m., following pneumonia?
A. Correct, that's my handwriting.
Q. You wanted a chest x-ray done the following morning on the 15th?
A. Correct. All of those orders were for the morning.
Q. Now, you mentioned Dr. Sarkar's signature?

A. I believe that's her signature.
Q. So the number two in the order was your handwriting?
A. Correct.
Q. Was number one her handwriting?
A. I'm not a handwriting expert, so I don't know.
Q. Was number one someone other than your handwriting?
A. It appears similar, to my nonprofessional eye, similar to her other handwriting.
Q. I guess what I am asking you is --
A. She started the order, she signed the order, and I wrote in the chest x-ray part.
Q. Why didn't you write a separate order and sign it for the chest x-ray? I just find that a little curious, or a little unusual that you would add to another doctor's order something and not sign it.
A. I don't know why.
Q. In any event, is that what you are basing on your belief that you would have seen the patient, the note of chest x-ray in a.m.?
A. I am basing the fact that I was in

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

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

A. Correct.

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

A. Correct.

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

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

Q. Why did you want repeat coags, also?

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

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

A. In terms of what?

Q. What impact would Coumadin or heparin

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

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

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

MS. HENRY: Objection.

Q. Is that correct?

You can answer the question, doctor.

MS. HENRY: Go ahead and answer, doctor.

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

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

A. More of a concern meaning what?

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

(Record read.)

MS. HENRY: Go ahead and answer. Objection, but go ahead and answer.

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

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

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

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

Q. The effect.

A. The effects of the drop in hematocrit

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

Q. It does, thank you.

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

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

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

A. Where do you see the order?

MS. HENRY: There wasn't an order.

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

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

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

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

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

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

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

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

MR. MISHKIND: Right.

Q. Do you see that, doctor?

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

or someplace else.

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

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

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

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

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

A. Right.

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

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

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

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

MS. HENRY: Objection.

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

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

MS. HENRY: Objection.

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

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

A. I do not.
Q. Dr. DiMarco was your attending; correct?
A. That is correct.
Q. The reporting back of the stat H&H at 12:15 took 45 minutes; correct?
A. I'm sorry, which results?
Q. The ones that you ordered at 12:00 o'clock that were drawn at 12:15, those were reported back at 12:59 or 1:00 p.m.; true?
A. Correct.
Q. Why the repeat stat H&H took from 12:59 to at least 2:40 p.m. to be reported back, can we agree that you have no explanation for that?
MS. HENRY: Objection.
A. We agree.
Q. The orders, doctor, are those your orders, 1500?
A. Yes, sir.
Q. And part of your orders included transfusing two units of packed red blood cells; correct?
A. Correct.
Q. You wanted each unit of the packed

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

A. Correct.

Q. Why did you want the heparin held?

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

Q. Why did you stop the Coumadin?

A. The same reason.

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

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

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

A. Correct.

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

MS. HENRY: Objection.

A. My orders were written at a time when

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

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

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

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

A. Are you talking about the orders or notes?

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

A. Yes.

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

A. Correct.

Q. What was the reason for the NG tube?

A. To evaluate the gastric bleeding.

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

gastric lavage?

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

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

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

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

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

Q. Who told you to write that order?

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

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

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

the same monitoring capabilities.

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

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

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

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

A. I don't know.

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

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

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

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

A. Because it wasn't ordered until then.

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

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

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

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

A. No.

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

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

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

A. Starting within a few hours.
Q. And, in fact, the packed red blood cells were not started until 8:00 p.m.; correct?
A. The first unit was completed at 8:00 p.m., the first unit of packed red blood cells, which would be a completion time.
Q. Your order called for two units of packed red blood cells?
MS. HENRY: The packed red blood cells are started at 5:30. Are we confused on this?
MR. MISHKIND: No.
Q. Your order was to transfuse two units of packed red blood cells; correct?
A. Correct.
Q. Each unit over a two or three hour period; correct?
A. Correct.
Q. Do you know whether the packed red blood cells were, in fact, transfused over a two to three hour period?
A. I do not know. I presume they were based on my order.
Q. Why didn't you order a CT scan?
A. Of what?

Q. Where did you think the bleed -- you suspected a bleed, did you not?
A. I had evidence of a nose bleed.
Q. Well, what did you --
A. I had no evidence of an intra-luminal GI bleed. The patient was hemodynamically stable.
Q. Do you know why a CT scan was ordered at 5:30 by Dr. Sarkar?
A. Because the patient had resolved her nose bleed and had a drop in her hematocrit and hemoglobin.
Q. Hadn't the patient resolved her nose bleed during your watch?
A. I believe so.
Q. Why didn't you order a CT of the abdomen during your watch?
A. Because an acute blood loss does not cause an immediate drop in your hematocrit and hemoglobin and so the decline may have been of the previous bleeding rather than an ongoing bleed.
The patient had no hemodynamic changes in her blood pressure or heart rate and had minimal abdominal findings.

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

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

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

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

Q. Do you know who the fellow was?

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

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

A. No, I do not agree with that.

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

have been restarted; is that correct?

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

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

A. True.

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

A. Yes.

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

A. Correct.

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

A. No.

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

MS. HENRY: Objection.

A. I think a nonemergent transfusion

taking place over that time period is reasonable.

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

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

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

A. 6.8 and 20.6.

Q. Those are considered critical; correct?

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

Q. In this particular patient --

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

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

MS. HENRY: Objection.

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

defines an emergency.

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

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

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

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

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

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

Q. You weren't involved at all in any

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

A. That's correct.

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

A. That's correct.

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

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

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

A. Not to my recollection.

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

A. We confirmed that the blood drop was real.

Q. That took two hours?
A. Apparently.
Q. Would you agree that it should have taken less time?
MS. HENRY: Objection.
A. No. Again, we are back to the fact of labs being sent, drawn, and doctors being notified. As I said before, I think it was done in a reasonable amount of time.
Q. This patient was still in the intensive care unit?
A. Throughout her stay.
Q. And these parameters, in your opinion, in terms of -- strike that.
You don't have to answer my incompleted question.
A. Okay.
MS. HENRY: Looks like he is coming to a close, doctor.
MR. MISHKIND: Don't assume that.
MS. HENRY: He said it would be short.
Q. Doctor, there is an indication that the patient was typed and crossed at 5:30 p.m.?
A. Are you talking about the orders?

Q. Right.
A. Okay.
Q. Was there any need to type and cross Elsie at 5:30 p.m.?
A. For additional units of packed red blood cells, a type and cross for a given number of units of blood, she had been typed and crossed per two units previously by the previous order that I had given at 1500. Speculation would infer that they requested an additional -- the order is for an additional four units to be typed and crossed.
Q. When she was typed and crossed at 5:30, she had not been given any transfusion at that particular point, though; correct?
A. I don't know. I don't think we have established a definitive time of the first unit of blood being hung.
MR. MISHKIND: Doctor, I have no further questions.
MS. HENRY: Doctor, I know he is going to have this transcribed and we are going to send this to you so you can read it.
Howard, can he have more than a week?
MR. MISHKIND: Twenty-eight days.

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

(Signature not waived.)

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AFFIDAVIT

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

PAGE	LINE	REQUESTED CHANGE

MARC EISENBERG, M.D.

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

Notary Public

My commission expires .

CERTIFICATE

State of Ohio,

SS:

County of Cuyahoga.

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named 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

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

My commission expires June 8, 2004.