CUYAHOGA COUNTY
COURT OF COMMON PLEAS
CASE NO. 397309

BESSIE M. BROOKS, Individually, and as Administratrix of the Estate of Lee Thomas Brooks,

Plaintiff,

-vs-

THE CLEVELAND CLINIC FOUNDATION,

Defendant.

ÄÄ

DEPOSITION OF TODD D. EISNER, M.D.

Thursday, November 16, 2000

2499 Glades Road, Suite 205
Boca Raton, Florida 3341
6:50 p.m. - 9:05 p.m.

APPEARANCES:

On behalf of the Plaintiff:
HOWARD D. MISHKIND, ESQUIRE
BECKER & MISHKIND CO., L.P.A.

On behalf of the Defendant:
JAMES M. KELLEY, 111, ESQUIRE
REMINGER & REMINGER CO., L.P.A.

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Deposition taken before Denise T. Medina, Registered Professional Reporter and Notary Public in and for the State of Florida at Large, in the above cause.

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Thereupon,

(TODD D. EISNER, M.D.)

having been first duly sworn or affirmed, was examined and testified as follows:

DIRECT (TODD D. EISNER, M.D.0

BY MR. KELLEY:

Q. Could you state your name, please?

A. Todd David Eisner.

Q. And it is my understanding you are a physician, Dr. Eisner?

A. That's correct.

Q. Okay. What area of specialty do you practice in?

A. Gastroenterology and internal medicine.

Q. And are you double boarded, then?

A. Yes.

Q. And when did you get your internal

medicine boards?

A. 1993.

Q. And what about your GI boards?

A. 1995.

Q. Have you ever had your depo taken before?

A. Yes.

Q. And on how many occasions, if you know?

A. Approximately 13, 12, 12 to 15 say.

Q. Okay. In the capacity as a Defendant at any point?

A. No.

Q. In the capacity as medical expert in a medical negligence case?

A. In all except for one.

Q. Okay. What was the other one?

A. The other one was as a treating physician.

Q. Okay. So approximately a dozen times you have been an expert witness to date?

A. Correct.

MR. MISHKIND: I think he said 12 to 15.

THE WITNESS: 12 to 15.

BY MR. KELLEY:

Q. And that's over the course of the last, is that in the last five years?

A. It would probably be since 1997. So the last three and a half years.

Q. Why did you start doing expert work?

A. Initially one of the partners in my group had been doing work for a couple of the companies locally here. And at one point in time, they came looking, calling the office looking for him to look at a case. He wasn't around. I ended up reviewing the case, and I just took an interest to it.

Q. When you say local companies, you mean law firms?

A. Law firm, law firm.

Q. Do you belong to any referral services?

A. No.

Q. Have you ever advertised your services for expert work?

A. I have never advertised, no.

Q. Okay. The rules of a deposition you're familiar with. But I want to make sure we have them set tonight in the transcript.

I'm going to ask you a series of questions. The rules are pretty simple. Don't answer my question if it doesn't make any sense to you. If you want me to clarify a question, I will or you can always have the court reporter read it back. Okay?
A. Okay.
Q. Our exchange has to be verbal. Ah-has, ah-ahs, nods and points won't show up in the transcript. All right?
A. Okay.
Q. Have you ever worked with Mr. Mishkind before?
A. Yes.
Q. Howmanytimes?
A. Two other issues.
Q. Okay. And when was the first time you worked with Mr. Mishkind?
A. Some time I believe either the end of '98, the beginning of '99.
Q. So is this the third case you have done with Mr. Mishkind?
A. Correct.
Q. Any idea how he got your name?
A. I'm not sure.

Q. Have you worked with anyone else in his law firm?
A. No.
Q. Have you done any other cases involving care and treatment out of Cleveland, Ohio?
A. Not that I can recall.
Q. Okay. Let me go through -- we don't have your CV here. So let me go through it pretty quickly. Where did you go to medical school?
A. Medical school at State University of New York at Stonybrook.
Q. Okay. And when did you finish up?
A. I finished up there in 1989.
Q. Okay. And then I assume you did a four-year program with an internship and a residency?
A. Right. It was actually a three-year internship residency at North Shore University Hospital, Cornel1 Medical Center.
Q. Okay. New York City?
A. Long Island and New York City.
Q. Okay. And after that, you went into some training I assume for **GI?**

A. Right. First I did an extra year as a chief resident and then did gastroenterology training for two years after that.
Q. Where did you do your GI training?
A. It was all done at the same institution.
Q. Same institution. Did you have as far as GI training any sort of proctors or mentors within that program?
A. Well, there were four full-time attendings basically that their primary job was to instruct the fellows.
Q. Have you ever heard of Aaron Brzyzenski before this case?
A. Not before this case.
Q. Okay. You're familiar with The Cleveland Clinic Foundation, though?
A. Yes.
Q. Before this case?
A. Yes.
Q. Have you ever visited The Cleveland Clinic Foundation to give or receive any sort of lectures?
A. No.
Q. Have you ever referred any patients

to The Cleveland Clinic Foundation either in Cleveland or down here in Florida?
A. In Florida.
Q. And who do you refer patients to at the Cleveland Clinic down here in Florida?
A. Just the department. Nobody in particular.
Q. Which department?
A. Gastroenterology.
Q. Okay. How frequently do you refer patients to the Cleveland Clinic?
A. I would say over the five years, five-and-a-halfyears I've been here, I've referred two or three patients.
Q. Any particular reason that you would refer those patients instead of caring for them yourself?
A. Basically every once in a while you are going to have a patient that is going to want a second opinion but they don't want to go just to another doctor in town and they will ask you, you know, about going to another institution. And that's the closest to us. So we would recommend that or University of Miami.
Q. Okay. And you have never been to any

lectures at the Cleveland Clinic down here in Florida?
A. No.
Q. Have you ever had any privileges suspended?
A. No.
Q. Have you ever had your license suspended?
A. No.
Q. Have you ever been the subject of any disciplinary action?
A. No.
Q. I think you have already answered this. I know you haven't given a deposition. But have you ever been sued for malpractice?
MR. MISHKIND: Objection.
THE WITNESS: Yes.
BY MR. KELLEY:
Q. Okay. How many times?
A. Once.
Q. Is that lawsuit pending?
A. Yes, it is.
Q. Okay. In a very broad general sense, do you know what the subject of that lawsuit is?

A. Yes.
MR. MISHKIND: Before you answer the question, let me do two things. One, let me pose an objection and, secondly, not knowing what stage it's at and whether or not you are, whether it is in litigation or your deposition has been taken, and Mr. Kelley would know as well, that you may or may not want to discuss the details ofthat.
BY MR. KELLEY:
Q. That is why I said in a broad sense I just want to know what. Did it involve a Peg tube by any chance?
A. I guess in a broad. It involves an uncommon drug interaction of two medications that myself or my partners did not prescribe. However, we were one of many physicians that were seeing the patient in the hospital and essentially the lawsuit was against basically all, it was all treating physicians failing to recognize this unusual drug interaction.
MR. MISHKIND: Let's go off the record for one second.
(Discussion held off the record.)

BY MR. KELLEY:
Q. Without delving into that lawsuit too much, if I understand what you just said, the allegations against a lot of physicians from different specialties for failing to diagnose something in a timely manner? Is that the allegation?
A. I don't know about a timely manner. But --
Q. I know that's not your position. But is that what the Plaintiffs are saying?
A. I don't believe that their claim said timely manner. I just think they said failure to recognize the drug interaction.
Q. Okay. You completed your two-year GI training. Did you do any additional fellowships or things of that sort afterwards?
A. No.
Q. Okay. And you sat for your GI boards and passed them in 1995?
A. Correct.
Q. Was that your first attempt?
A. Yes.
Q. Have you stayed current with your CMEs?

A. Yes.
Q. It is my understanding that in this lawsuit you do not have opinions regarding polymyositis as it pertains to life expectancy and quality of life for Mr. Brooks. Is that fair?
A. That's correct.
Q. Okay. It is my understanding you have opinions, though, where you believe the physicians at the Cleveland Clinic deviated from the standard of care, correct?
A. Correct.
Q. What is your definition of standard of care that you're using in your report?
A. I basically use the standard of care as the appropriate medical care to be given to a patient based on the physician providing the care's education, experiences, training and basically what would be the normal treatment for a patient presenting with those symptoms and condition.
Q. And then do you have any opinions regarding causation? And by that, I mean whether or not timely intervention by a surgeon or earlier intervention by **a** surgeon would have

affected the outcome in this case.
A. Yes.
Q. Okay. You are not a surgeon, though, correct?
A. Correct.
Q. Have you consulted with any other physicians to formulate your opinions?
A. No, I have not.
Q. What have you reviewed as it pertains to this case?
A. I've reviewed the medical records of Mr. Brooks, two volumes basically, and multiple depositions.
Q. Do you have any notes?
MR. MISHKIND: And also you have reports from --
THE WITNESS: Correct. Correct.
MR. MISHKIND: Depositions. And he has got reports too.
THE WITNESS: A couple of reports from experts.
BY MR. KELLEY:
Q. Okay. Do you have any notes?
A. The only notes I have, I just made myself a little list here of all the

depositions that I have reviewed and just some of the issues on standard of care.
Q. Okay. Can I take a look at them?
A. Sure.
(Pause)
Q. Were these notes made before you came here tonight or while you were here tonight?
A. While I was here.
Q. Okay. Were they made during your meeting with Mr. Mishkind?
A. Yes.
Q. Okay.
MR. KELLEY: Let me mark this as Defendant's Exhibit 1.
(The document was marked Exb. No. 1.)
BY MR. KELLEY:
Q. These notes that you made during your meeting before the deposition, why is it that you chose to make notes at that time?
A. Just in discussion with Dr. Mishkind I just -- with Mr. Mishkind just some of these things that I brought up that I was going to say. I just wanted to organize some things, that I didn't leave anything out, tell you all

my opinions and then go home and say, "Ahh. I didn't tell him about that."
Q. Were these your opinions or Mr. Mishkind's opinions?
A. Yes. These were my opinions.
Q. Okay. But are all of those opinions -- and I think they are noted as 1 through 7 -- contained --
A. There is a little overlap in there.
Q. I'm just saying because they are numbered 1 through 7.
A. Correct.
Q. Are those opinions contained in your report of March 22nd, 2000?
A. Not, the details of these opinions are not contained in that report.
Q. Okay. The first time you ever wrote down these opinions was tonight during a meeting with Mr. Mishkind?
A. Correct.
MR. MISHKIND: Let me object. The details -- his report was written back in March. I'm not sure that he is is telling you that these are not new opinions. They are covered in that but they are more

specific as delineated.
THE WITNESS: Specific details.
MR. MISHKIND: You're not hearing new opinions.
BY MR. KELLEY:
Q. Let's go through them. Do you have any opinions -- do you have a copy of your report?
A. Yes. 1 will add that at the time that the report was written the only thing I had reviewed was the records. The details of the, of that short, little list there come out after reading the multiple I guess nine or ten -- the list on there -- depositions and I was able to better understand exactly what had gone on after reading the depositions.
Q. Having read the depositions, are you changing any of the opinions you have in your March 22nd letter?
A. The general opinion has not changed. Again, there are so many minor details. We can go over it however you want to. This is just times and whatnot may have changed from what I've seen in the depositions.
Q. Okay. Is there a single reference in

your report of March 22nd to any criticisms that you have of nursing personnel or any personnel prior to 2 a.m. on June 5th?

A. Basically I think at the end here that the care, the patient was clearly below accepted standards of care -- sorry -- care by the medical team, essentially meaning, medical team meaning physicians, nurses. It's basically I think everybody is kind of covered under medical team.

Q. Okay. Any criticisms that you state in that report prior to 2 a.m. on June 5th?

MR. MISHKIND: Let me just object because that sentence says during the early morning hours. I'm not -- but he can go ahead and answer.

THE WITNESS: Correct. Care provided during the early morning hours. In this report, it was saying early morning hours.

BY MR. KELLEY:

Q. So nothing before midnight, though?

A. Correct. In this report, correct.

Q. Okay. Now, it looks like you have some criticisms before midnight in your note sheet.

A. Correct.

Q. The fact that the dressings were changed at 9:45, you didn't require the depositions to notice that, did you? That is contained in the chart, right?

A. That is contained in the chart. However, it was also more obviously brought out in the deposition.

Q. The fact that vital signs were not taken from 4 p.m. until 12 a.m., that is clearly demonstrated in the chart, isn't it?

A. That's correct.

Q. And when you reviewed this chart before writing this report on March 22nd of 2000, you reviewed it I assume with a critical eye?

A. Correct.

Q. And at the time that you initially reviewed it, you never wrote anything about any criticisms that you had prior to midnight on June 5th?

A. That iscorrect.

Q. And do you have any notes in the margins of the depos or anything like that that would --

A. No.

Q. -- demonstrate that you were critical of those things other than this page which we have marked as Exhibit 1?

A. No.

Q. Why don't you list for me as best you can the ways in which you believe the physicians at The Cleveland Clinic Foundation and nurses deviated from the standard of care?

MR. MISHKIND: You want him to just give you a global statement? It is kind of a broad --

BY MR. KELLEY:

Q. I want a list of what you think they did which amounted to a deviation from the standard of care.

A. Okay. I think that essentially the medical team including nurses and physicians that were, deviated from the standard of care in their delay in recognizing the intra-abdominal bleed that Mr. Brooks had as a result of the gastrostomy, say peg tube placement from June 4th of 1998.

Q. Did they administer any medications or do anything for the patient that they should

not have done?

A. Well --

Q. Do you understand -- let me rephrase it. It sounds to me like you're alleging that they weren't quick enough or timely in recognizing the bleed and initiating treatment. And from your report, I assume that to be a surgical consult, correct?

A. Well, correct. A surgical consult, administering of blood products, intubation of the patient, basically multiple different steps along the course were delayed.

Q. Were any of the tests that they performed or procedures that they performed harmful to this patient in any way?

MR. MISHKIND: Let me just object because I'm not sure what you mean by harmful. If the doctor does, he can answer the question.

THE WITNESS: I guess we're saying as opposed to like any active thing as opposed to passive?

BY MR. KELLEY:

Q. Yeah. As opposed to a failure to do something, which is what you allege that they

were a little slow, I'm asking if the things they did before the surgical consult taking time away, were those things appropriate, each of those tests.

MR. MISHKIND: Before you answer, let me just object to your phrase a little slow because I'm not sure that is what he said. But go ahead and answer the question.

THE WITNESS: All right. I have to just think about it for a second because I want to separate the different things. So let me just continue to look at this and gather some thoughts here.

BY MR. KELLEY:

Q. Sure.

A. I would say that the answer would be no.

Q. Okay. Just so I make sure because there were some objections, I want to make sure Howard understands what you said and I understand. There wasn't anything that they actively did wrong but you just don't believe they got to the surgical consult quickly enough?

A. Correct. And once the surgical consult was gotten, the surgeons did not act quick enough as well.

Q. Okay. Do you feel qualified to render opinions regarding surgical actions as a nonsurgeon?

A. Yes. Because we are frequently dealing with a patient's -- as a gastroenterologist, as an internist, we are dealing with the patient before the surgeons get there and then making decisions with the surgeons to send the patient to surgery.

Q. Okay. When did this patient start bleeding?

A. I think the patient started bleeding shortly after -- at the time, after that the gastrostomy tube was inserted. I believe the note was written 9:10 in the morning.

Q. And did he continue bleeding all day or--

A. Yes. I believe that he continued to bleed through the day and then somewhere around midnight became volume depleted, began developing shock and then developed a rapid downward course thereafter.

Q. You believe he was in shock by midnight?

A. I believe that he had early signs of shock around midnight.

Q. And what were those early signs of shock around midnight?

A. At that point, he had had agitation. He had had a relative decrease in his blood pressure, a relative elevation in his heart rate, he had been pulling at the gastrostomy tube which may or may not have been representative of pain in the abdomen which would have been a sign of bleeding as well.

Q. The patient had agitation before the Peg tube was placed, didn't he?

A. He did have agitation before the Peg tube was placed. I'm just putting all the symptoms together, the pain, with the agitation and the change in the vital signs.

Q. But this was a patient who had been agitated for 48 hours at least before the Peg tube was ever placed, correct?

A. That's correct.

Q. He refused to speak to the physicians who tried to give him informed consent. You

saw that, correct?

A. Right.

Q. Agitation isn't something new, is it?

A. There are varying degrees of agitation. At that point, it is unclear why he did not speak to the physicians. I don't know if we can consider that as agitation, being uncooperative.

Q. Did you see multiple references to the patient being anxious and agitated before the Peg tube was placed?

A. Yes.

Q. Okay. Do you see references to the patient being agitated between the time the Peg tube was placed and midnight in the chart?

A. There was evidence shortly I think after 9:45 and up until midnight where he had been pulling at the tube, where he had pulled the dressing off, were some of the things that would suggest that he was agitated. In one of the nursing notes in depositions, there is mention of agitation before the midnight area.

Q. Is there, around the midnight area, though, is the first time anyone charts any agitation, isn't it?

A. Well, again, we are -- a dressing change at 9:45. There is a whole issue there as to why the dressing was changed. He had most likely pulled the dressing off which was evidence of some type of agitation as well.
Q. Don't a lot of patients pull on their Peg tube?
A. People, patients pull on their Peg tube.
Q. They don't pull on their Peg tube because they are bleeding. They pull on their Peg tube because they have a tube sticking out of their abdominal wall, correct?
A. Some patients do. Also some patients that are having pain at the site hold the site, pull the tube as well.
Q. Don't most patients tend to push in the area where there is pain instead of pull?
A. No. I think that is very non-specific. If somebody is having pain and they look down and they see a tube, they might think that is what is causing the pain and pull it out, try to pull it.
Q. Could that have caused the bleeding?
A. It could have. But very unlikely.

Q. Why?
A. Because the tube being on the inside of the stomach has already gone through the, the tube has gone through the skin into the stomach. It is a relatively soft tube. And the sheer force of pulling the tube would be unlikely to cause bleeding from the blood vessel that was felt to be pierced and bleeding. It was, more likely would have been a direct stick of the needle used to insert the tube.
Q. Was there any evidence of where the bleeding originated from at the time of surgery?
A. There was just hypothesized in the note by the surgeon that the gastro epiploic artery. And it would be more likely that that occurred at the time of the piercing of the needle through the skin to help place the tube.
Q. When you pierce an artery during the placement of a Peg tube, aren't there typically findings that are visible such as a hematoma?
A. Not always because it is underneath the skin. So you would not see that in many. In most cases, you would not see that.

Q. Okay. Would, if the Peg tube pierced an artery going in, the needle and then the tube going over that needle, wouldn't there typically be bleeding into the stomach as well?
A. Not always. Again, not even a lot of the time. We can commonly, we commonly see instances where you are going to pierce through organs and not recognize that fact when the tube is placed. You don't always see bleeding in the stomach. The bleeding is usually outside of the stomach in the abdomen.
Q. Just so we are clear while we are on this point, you don't have any criticisms of the placement of this tube even if it caused the bleed?
A. That's correct.
Q. Okay. That's an accepted risk of this procedure?
A. That's correct.
Q. The signs and symptoms that you are relying on to form the opinion that the patient had a slow, ongoing bleed are the nature of a Peg tube insertion first?
A. Correct.
Q. I guess as a foundation, agitation,

heart rate and the fact the patient was pulling on his tube?
A. Right. Heart rate increased, blood pressure decreased and the fact that he was pulling on his tube, pulling on the dressing.
Q. What was his baseline for his heart rate and blood pressure prior to the placement of the Peg tube?
A. Baseline he had a hypertensive, he was generally hypertensive previous to the Peg tube.
Q. And what were his vital signs during the course of the day? We'll say since you put it on the note from up until 12 p.m., from the time of the Peg tube placement, until 12:12 a.m?
A. His blood pressure was in the morning, right after the Peg tube placement was it looks like 158 over 82.
Q. Is that hypotensive?
A. No, it is not.
Q. Is that blood pressure in any way, shape or form indicative of a bleed or volume loss?
A. No.

Q. Okay. What is his heart rate?
A. His heart rate is 100 which is an upper end of normal.
Q. Okay. For him, that is, does he seem to have a baseline that would be in a normal person tachycardic?
A. Close to that. He had a mild tachycardia.
Q. When you say a mild tachycardia, this is an individual who runs around it looks like around 100 normally?
A. Correct.
Q. Okay. So can we really take anything from that heart rate that would indicate that the patient was losing fluid?
A. No.
Q. Okay. Let's go to the next time. If we go to I think the next one is about approximately 12 o'clock?
A. Correct.
Q. His blood pressure, 172 or 177 -- it is difficult to read -- over 77.
A. It's the same, the same range as previous.
Q. The pulse is 90?

A. Correct.
Q. Nothing indicative of a bleed there?
A. Correct.
Q. Okay. Next 88 and then 190 over 60. Nothing indicative of a bleed there, correct?
A. Correct.
Q. And then midnight, 136 over 77 and 111. Do you believe those are indicative of a bleed?
MR. MISHKIND: You are talking about in the absence of the clinical symptoms?
THE WITNESS: That is what I was going to say.
MR. KELLEY: The vitals in and of themselves.
THE WITNESS: We never like to look at one thing in and of itself. But I think in combination with the fact that he appeared to be agitated, pulling at the tube. He did from 4 p.m. until midnight. It would be eight hours between when the vital signs had been taken. His heart rate did elevate 25 percent or even more than 25 percent. His blood pressure, at least his systolic blood pressure at that

time did drop again by 33 percent or so over that eight-hour period. And then the next reading which it looks like is --
MR. KELLEY: 2:25.
MR. MISHKIND: That is 2:25.
THE WITNESS: 2:25. The next reading he shows even more of decrease in blood pressure and a rise in heart rate as well as a significant elevated respiratory rate.
BY MR. KELLEY:
Q. Prior to the findings at midnight, was there anything that you saw that mandated a physician's intervention?
MR. MISHKIND: Vital signs --
MR. KELLEY: Vital signs, clinical picture, anything prior to midnight.
THE WITNESS: I think at least in patients that I put gastrostomy tubes in we are always asked to be notified if the patient appears to be uncomfortable, appears to be pulling at the tube, at least so we can assess the situation and restrain them because you don't want someone pulling out the tube initially.

That could be dangerous and cause significant sepsis and infection if they pull the tube before a tract can mature. So in combination with the patient pulling the dressing when it was specifically ordered that the dressing not be touched for 24 hours, that the patient was agitated. Whether the patient had been continuously agitated or intermittently agitated, there appeared to be some degree of agitation going on around from 9 o'clock at night, 10 o'clock at night, 11 o'clock where he is pulling at the tube, pulling at the dressing, that in combination with a mild change in vital signs, I would expect that the physicians at least be called to say the patient is pulling at the tube. If they are agitated and you can't really get a history, we don't know if it is because they are having pain or not and I would think that a physician should have been notified to come up and evaluate the patient some time around the midnight area at the latest.

BY MR. KELLEY:
Q. Prior to the midnight hour, should a physician have been called to see this patient?
A. I would say yes. I would say 100 percent at the midnight hour. But I would say even before when the dressing was changed, I would think that once the patient had pulled the dressing off and the nurse has an order not to change the dressing and something is being done that is not ordered, it is their obligation to call the physician and say, "This is what happened. What should we do?"
Q. Regardless of whether it is the fact that the patient pulled his own dressing off?
A. Because I think you have to be considerate to the fact that is there a reason why the patient pulled their dressing off.
Q. Regardless if it is just serosanguineous fluids?
A. Yes. Regardless of anything that is external.
Q. I would like you to look at the nursing narrative at 4:30.
A. 4:30 p.m.?
Q. Yeah.

A. Okay. See where it says the patient denies pain? He is claiming that no one there knows what they are doing.
A. I see it says patient hard to understand at times.
MR. MISHKIND: General weakness.
THE WITNESS: General weakness. Something not assessed -- okay. I see. Denies pain.
BY MR. KELLEY:
Q. Moderate anxiety?
A. Moderate anxiety. States no one knows what they are doing around here.
Q. So his anxiety appears to be rather focused?
A. Correct.
Q. It is that he is not satisfied with the quality of medical care he is receiving, correct?
MR. MISHKIND: Objection. You're asking him to interpret what the nurse --
MR. KELLEY: He is interpreting the chart. That is his role as an expert.
THE WITNESS: I think from this I think it's hard to say what the patient

exactly, why was he not happy about his medical care.
BY MR. KELLEY:
Q. Okay. Let me phrase it this way. Do you believe that his anxiety at that point was related to pain or because he was dissatisfied with his medical care?
MR. MISHKIND: Objection. Go ahead.
THE WITNESS: From looking at this note, he denies pain. So he was not having pain apparently at that point at 4:30.
BY MR. KELLEY:
Q. Okay. If he is having a slow bleed that had started around between 9 and 10 a.m. when the tube was placed and we are now several hours out -- we are at 4:30 p.m. -- why is the patient pain free?
A. Well, you don't have to have pain from the bleed. A lot of the pain can come from after there is enough blood in the abdomen causing decreased blood flow to different organs. If you have collection of blood, like a hematoma or blood clots, that can cause pain as well. Just the bleeding itself may not

cause pain.
Q. Okay. And you see if you read on that the last line of that note is the patient is comfortable and lying on back?
A. Correct.
Q. Okay. At 2145, then, the 9:45 is when the dressing is changed to the Peg tube, correct?
A. Correct.
Q. Do you see any notation that it was because the patient was in pain?
A. No.
Q. Do you see any notation that it was because there was bleeding?
A. No.
Q. Do you see any evidence that when the nurse changed the dressing that there was anything abnormal or unusual that she found?
A. No.
Q. Do you see in her data charts which are the graphs with kind of the boxes to check any evidence that they found any bleeding or abnormalities in the area of the Peg tube?
A. I don't believe so.
Q. Do you see that they charted that the

abdomen was soft and nontender?
MR. MISHKIND: At what time are you talking about now?
MR. KELLEY: During that shift. During the shift between -- the shift runs between 1500 and 2300.
MR. MISHKIND: But does it indicate what time that note of soft and --
MR. KELLEY: It is for the shift.
MR. MISHKIND: Okay. I'm just asking you--
MR. KELLEY: That is all I'm asking.
BY MR. KELLEY:
Q. Any evidence of that during that shift?
THE WITNESS: Do you have that there?
MR. MISHKIND: Yeah. Hold on one second.
THE WITNESS: I don't believe so.
(Pause)
THE WITNESS: Soft, non-tender up until I guess through the 11 p.m. shift, soft non-tender with bowel sounds present.
BY MR. KELLEY:
Q. And do you see that there was no

nausea or vomiting either?
A. Correct.
Q. Okay. Assuming that the Peg tube was changed for, dressing was changed for an innocuous reason, whether it be the patient pulled it off, whether it was coming off a little bit or because there was a little bit of serosanguineous fluid, do you believe the standard of care required the GI physician to be called at 9:45, or is that something that is optional?
A. If it was not because the patient appeared to be confused and in pain, then I would say no.
Q. Okay. The next note that we have after that goes to in essence the midnight hour and the nursing progress note is written at 2455. Do you see that note?
A. Yes.
Q. Okay. I assume from some of your discussions and some of the things you have written you have criticisms of the nursing care at midnight or between 12 and 1 a.m. in essence?
A. Correct.

Q. Okay. What are those criticisms?
A. There was similar criticisms that the patient was again pulling at the tube, pulling the dressing off and appeared to be in a somewhat agitated state and not being reasonable, basically talking about eating food, and seemed to be confused in that he was not understanding of the situation. Because if he was coherent and understanding, he would not have felt that he wanted to eat food. He would have understood that the reason why he had the feeding tube in was because it was not safe for him to eat food. So it didn't sound like he had all his wits about him again during that time period.
Q. Okay. Obviously this is a patient who had mumbled speech?
A. Right.
Q. During the whole hospitalization?
A. Correct.
Q. Okay. Do you believe it was good medicine for the nurse to sit with him for that extended period of time to try and calm the patient down and reorient the patient?
MR. MISHKIND: Let me object to the

term extended period of time. I'm not sure what you mean by that. But go ahead.
BY MR. KELLEY:
Q. If the nurse testifies that she sat with the patient for between a half hour and an hour after she found him pulling his Peg tube off or trying to pull on his Peg tube, would that be good medicine for her to spend that time with the patient to try to reorient the patient?
MR. MISHKIND: Let me just object because I'm not certain that that is what her testimony was. But he can go ahead and answer the question.
THE WITNESS: From what I remember from the testimony, she apparently did spend a lot of time with the patient. I don't remember the exact amount of time. I think it was very nice. But I think that she also should have picked up on some of these other things that why, why all of a sudden did he need someone to be there for that amount of time.
BY MR. KELLEY:
Q. Well, you see she described that he

has a moderate amount of anxiety, correct?
A. Correct.
Q. That he was trying to pull on the Peg tube?
A. Correct.
Q. Patient at this point denies any pain or discomfort?
A. Correct.
Q. And that she was able to reorient the patient?
A. Again, there, you know, there are parts in there also about him wanting to eat food and things like that which just to me makes it seem like he really wasn't oriented and understanding of the situation. So you kind of almost have to take, go more on his actions than on what he is telling you because he doesn't really appear to understand at least definitely 100 percent of what is going on.
Q. Now, there is, there's not a sentence in your report that directly -- and I know that you and Mr. Mishkind said earlier that there is a sentence that can be inferred -- what I want to know is is there a direct sentence in your report that is critical of the nursing care at

12a.m.
MR. MISHKIND: Before you -- let me just make an objection. And then you can go ahead and answer the question. And I'm not -- my objection is not going to in any way impact his testimony. I just want the record to reflect that the doctor has just received recently, like within the last two weeks, the deposition testimony and has not, therefore, written any supplemental report based upon that.
MR. KELLEY: That's not a problem.
MR. MISHKIND: But he can go ahead and answer the question.
MR. KELLEY: I'm going to clarify that.
THE WITNESS: That **is** exactly what I was going to say. Basically that the depositions specifically of the nurses and the residents were basically just read over the past week or 10 days.
BY MR. KELLEY:
Q. So the note in and of itself without the depositions didn't warrant a sentence in your report where you would specifically

describe a deviation from the standard of care? It was only with the testimony?
A. Correct.
Q. So reading the note on its face without the deposition testimony, you felt that the care and treatment at 2455 was okay?
A. I just did not address that at all.
Q. And you didn't address it at all at a time that you were being paid to review the chart with a critical eye?
MR. MISHKIND: Objection. It is argumentative.
MR. KELLEY: No.
BY MR. KELLEY:
Q. I'm saying you were reviewing this chart with a critical eye to find favorable and not so favorable things for both sides, correct?
A. Correct.
Q. I'm not saying it was a biased review.
A. Correct. Correct.
Q. And you didn't find based on your review of the chart that note which is approximately 10 lines long, you didn't find

any reason to add that to your report?
MR. MISHKIND: Let me object because he has already testified that the care provided during the early morning hours -- and I'm not sure whether that is what he is referencing or not.
MR. KELLEY: Well, he can tell us what he is referencing.
MR. MISHKIND: Sure. I just don't want the record to inaccurately reflect what he has testified.
MR. KELLEY: No. You objected and stated that twice so far tonight.
MR. MISHKIND: Okay. I might even do it a third time.
MR. KELLEY: A third time. And I welcome it.
MR. MISHKIND: I appreciate that.
THE WITNESS: I did not specifically in this note concentrate on putting details of every single criticism and the exact times and dates, time in the note. Basically instead of -- actually, if I remember correctly, I think I had not written a report after initially reviewing

the records and then Mr. Mishkind called and said we needed a report and basically kept it not intentionally but broad saying the medical care and by the medical team in the early morning hours instead of sitting and going through, going through all the details again.

BY MR. KELLEY:

Q. Okay. You did specifically state that at 2 a.m. the patient developed chest pain, abdominal pain, hypotension and tachycardia, correct?

A. Correct.

Q. So you did put 2 a.m. specifically in there but chose not to write anything specific about the 12 p.m. note?

A. 12 a.m., correct.

Q. Okay. Isn't it more realistic that you just didn't have a criticism when you reviewed the chart of the nursing care --

MR. MISHKIND: Objection. Go ahead.

BY MR. KELLEY:

Q. -- before 2 a.m.?

A. I would say no. Because, again, I don't remember exactly when all the criticisms

came. But I specifically remember conversations with Mr. Mishkind before having the deposition speaking about the nurse's failure to recognize.

Q. And what was it about Nurse Grewel's deposition testimony that helped you formulate your opinion that she was negligent?

A. Looking at basically talking about the dressing changes and what was done and it got me thinking and looking at why was the reason the dressing was off in the first place. That was when I went back and looked at things a little more carefully.

Q. I'm sorry. I didn't want to interrupt.

A. Okay.

Q. That was all in this chart, though? Both dressing changes are clearly reflected in this chart, correct?

A. Correct.

Q. Was there anything new in her testimony, Nurse Grewel's testimony that made you say, "Now I have a more clear or a more defined criticism of the nursing care?"

A. Again, just reading through the

deposition was just something that triggered my attention.

Q. What did you think the purpose of writing a report was for?

A. To give my broad opinions at the time of when I initially reviewed the records to I guess Mr. Mishkind who was identifying me as an expert and needed some type of statement as to my opinion.

Q. Okay. Would you agree with me that in reading your report it would be a fair conclusion for a reasonable person to believe that it wasn't until 2 a.m. when the patient developed chest pain, abdominal pain, hypotension and tachycardia that you felt there was a problem with the care and treatment?

MR. MISHKIND: Let me object. Just one second. You have asked the question now two or three times.

MR. KELLEY: I never asked that question.

MR. MISHKIND: Yes, you have. You are reading the report. You have said reading the report isn't it fair to say what you have just said, and we have

already gone over the fact that you have got two paragraphs to his report. The second one talks about the early morning hours, and a reasonable person can read the report, the second paragraph and the first paragraph and arrive at conclusions. You have enough notice, Jay -- and I understand where you are going with this -- you have enough notice --

MR. KELLEY: I'm not looking to file a motion. That is not what I'm doing.

MR. MISHKIND: By all means, I would almost encourage you to do it because of the lateness of the deposition.

MR. KELLEY: That's not what I'm doing here.

MR. MISHKIND: I don't see the point behind it.

MR. KELLEY: I'm asking questions. If you object, please go ahead and object.

MR. MISHKIND: I will.

MR. KELLEY: You objected on this. I have never asked him that question before.

BY MR. KELLEY:

Q. Do you agree with me that a

reasonable person reading your report would come to the conclusion that your first criticism occurred at or about 2 a.m.?

MR. MISHKIND: Objection for several reasons. And also I'm not sure who the reasonable person is.

MR. KELLEY: Him, Dr. Eisner.

THE WITNESS: Again, as he stated too, the second paragraph of the report states the early morning hours by the medical team and, again, at the end of the report basically saying, you know, I look forward to reviewing additional information as it becomes available. I mean, I don't make myself out to be a writer. But that was meant to say that as I review other parts including depositions that this report is not set in stone, that opinions can be added to and changed based on other things that I read.

BY MR. KELLEY:

Q. So you believe this report does clearly include that criticism?

MR. MISHKIND: Objection.

THE WITNESS: It includes a general

criticism. Again, a broad, broad criticism. It does not specifically reading it, especially if you read the first paragraph, you cannot, it does not mention criticism of the nurses, but, again --

BY MR. KELLEY:

Q. What should the nurse have done?

A. I think that the nurse should have called the physicians by around midnight because of the reasons that I stated.

Q. The patient's vital signs at midnight, the 111 and the 136 over 77, if we take them from the baseline incorporating the vitals for the entire day, they aren't that significantly different, are they?

A. No. But compared to the previous reading there is a, as I mentioned the numbers before, there is a difference.

Q. But vitals can go up and down. And when you look at vitals, you tend to look at baselines, correct?

A. You look at a general trend up and down.

Q. Okay. And looking at the general

baseline for this patient, these are not significantly altered vital signs at midnight, are they?

MR. MISHKIND: Objection.

THE WITNESS: Again, I think I just said looking at the general trend of which it was an eight-hour gap in obtaining vital signs and we weren't able to see the trend from 4 o'clock to midnight, just in taking the two points in time, there is a difference.

BY MR. KELLEY:

Q. So the one thing that the nurse should have done at that 2455 note is bring a physician in?

A. Correct. I believe that that was 24 -- I don't know what 2455 meant.

MR. MISHKIND: I think her testimony was actually at 12:55 which is when she made her note, but she says she was in around --

THE WITNESS: Somewhere between midnight and 1 a.m.

BY MR. KELLEY:

Q. 1 a.m.

A. Correct.

Q. You as the phyician get called in. You have a patient with the vital signs as recorded by Nurse Grewel. You know that the patient is not in pain, specifically denies pain or discomfort. He is no longer suffering from anxiety because she spent that time with him and the dressing has been reapplied. What are you going to do?

A. At that point, you are able to get the history from the nurse of the anxiety and that he did pull the dressing and whatnot and ask what the vital signs were, what they were before. There was a general change. You want to get her to put a pulse ox on to see what his oxygen level is.

And if I was concerned, if she was concerned about his anxiety and whatnot, I would draw some blood work to see why the patient is anxious and having a change in mental status and not acting reasonable.

Q. Looking at the chart -- and I know you are familiar with it having reviewed it -- does the patient truly have a change in mental status?

A. Well, apparently he is not -- he is speaking out of the norm. He is talking about -- first of all, he is anxious. Second of all, he is talking about eating food. You would not expect somebody that was with it and had a feeding tube placed to give him nutrition because it wasn't safe for them to eat to be asking for food to the degree that she would put it in the note there.

Q. So you do believe that his anxiety has progressed at this point?

A. Correct.

Q. And are we using anxiety and agitation interchangeably?

A. Yes. I'm more using agitation than anxiety.

Q. So had you come at between 12 a.m. and 1 a.m. to see this patient, you would have put a pulse ox on. What else?

A. And gotten some blood work and probably an EKG as well.

Q. Okay. The pulse ox, if the pulse ox, what sort of pulse ox reading would be concerning to you?

A. Well, if there was evidence of

hypoxia or if he was less than 90 percent oxygen saturation.

Q. Okay. If it was over 90 percent, would you stop your inquiry there or would you do additional tests?

A. I would also wait and see what the electrolytes showed too. If it showed there was any evidence of acidosis, then I might get a blood gas done.

Q. Why would do you an EKG?

A. Well, again, if the blood work didn't reveal any reason why he might be agitated, a patient that has had heart disease in the past does have heart disease and has developed more agitation, one of the things you want to consider is is he having a silent ischemia. **A** little tachycardic. His blood pressure was relatively a little bit low is something happening. You want not a surgical procedure. But he had an invasive procedure that day. Is there any heart damage going on?

Q. So one of your considerations at least at that time would have been could this be cardiac?

A. Correct.

Q. Okay. You also said you would want to know if the patient was acidotic. Could that be from a septic picture?

A. That could be from a septic picture. It could be from medication. Looking for some reason as to why the change in his mental status.

Q. Okay. If the patient's change in mental status was caused at that time by volume loss, would you be able to reorient that patient without giving volume resuscitation?

A. No. But it's unclear -- you know, again, the note is not 100 percent clear as to documenting reorientation which is that he wasn't complaining anymore. He wasn't speaking anymore. She just says she gave him emotional support.

Q. If the patient was able to be, through that emotional support able to be reoriented to time -- see up at the top where it says patient alert oriented times two, reorient time with success?

A. Yes.

Q. Okay. It also states at the end that the patient denies pain or discomfort, correct?

A. Yes.

Q. She was able to get the patient to stop pulling on his Peg tube, correct?

A. Apparently, yes.

Q. She was able to position the patient with his legs up on pillows, correct?

A. Correct.

Q. And she obviously we know, whether successful or not, sat with the patient to try to provide emotional support, correct?

A. Correct. Basically she could have just gotten him to sleep, you know, which doesn't -- in other words, we don't know the exact details of what was happening, whether he was just out or whether he was sitting. It doesn't appear that he was sitting having a conversation with her. It's not 100 percent clear from the note.

Q. Well, they oriented him to time. He voices a desire to eat food, denies pain and she got his legs up on pillows. It sounds like he is awake for at least a portion of that time, doesn't it?

A. Correct.

Q. Now, you wouldn't be able to calm a

patient down or reorient a patient if their dementia or disorientation was secondary to a bleed, would you?
A. Well, if they are just not saying anything and they are kind of just out of it, you could.
Q. Does that chart give you that picture, though, in fairness?
A. No. But it doesn't really give you a great picture at all.
Q. There should be more information you believe in that note?
A. No. I'm just saying I don't think you can tell 100 percent that, you know, I think you're also doing a lot of inferring into what she is writing down.
Q. Well, my, I'm just trying to get an understanding of -- and we will call it a hypothetical so we're fair to both sides -- if she was able to calm this patient down, reorient this patient, that's not something that she would be able to do if the symptoms were caused by the bleed, correct, typically?
A. I would say no.
Q. Okay. If we assume that she was able

to reorient the patient, knowing the patient's history of having agitation for 24 to 48 hours at least beforehand, knowing the fact that the patient has been somewhat for lack of a better term angry with his medical providers -- you saw from the note earlier he is dissatisfied --
A. Correct.
Q. -- do you agree that it is reasonable that these signs and symptoms that you see here or that the Peg tube, pulling on the Peg tube may have in fact caused this bleed?
MR. MISHKIND: Objection.
BY MR. KELLEY:
Q. Has that become a reasonable possibility?
MR. MISHKIND: Objection.
THE WITNESS: I think it's possible, but I think it is unlikely. And I think that if it did it would probably even be, they would have a big fault because one of the faults is also someone if they were concerned that he was agitated and whatnot, is this somebody who should have been restrained so as not to pull on the tube?

BY MR. KELLEY:
Q. Well, you don't restrain a patient who pulls on a Peg tube once, do you?
A. No. But you do restrain patients who have pulled out IVs and have showed agitation. Because if they pull on it once, they can pull it out and cause the tract to close.
Q. Is that restraining a patient a last resort, especially a patient with a cardiac history?
A. Well, it's -- I wouldn't say it is a last resort. But in someone that has a fresh Peg tube in, it's, the standard of care is to try to do everything you can to prevent them from pulling out the tube, and soft wrist restraints is really not contraindicated to someone just because they have a cardiac history.
Q. Anxiety, though, can be a problem for a patient who has a cardiac history, correct?
A. Correct.
Q. And restraining someone's ability to move even with soft restraints because the theory is it prevents him from getting access to his abdomen, right? --

A. Right.
Q. -- that can cause anxiety, right?
MR. MISHKIND: Objection.
THE WITNESS: It can.
BY MR. KELLEY:
Q. It wouldn't be your first step if a patient pulled on a Peg tube one time, would it?
MR. MISHKIND: Objection. I think he has already said --
THE WITNESS: If he had shown evidence of pulling on other things, I would say yes.
BY MR. KELLEY:
Q. What else has he pulled on?
A. I believe it was the morning of or the night before he had pulled out his IV, and if he is showing evidence of agitation, then that is something you want to pay attention to and you don't want them to pull it out. I don't think that in my opinion that with him pulling the tube caused the bleed, but if it did, then I think that that is something that should have been prevented.
Q. When he pulled on his IV, did he pull

it out because he was bleeding or in pain?
A. I'm not sure why he exactly pulled it out.
Q. You are really not sure why he pulled on his Peg tube either, are you?
A. No.
Q. Now, the next note is at 2:20. And it is the patient complains of overall pain, pain medication Percocet given.
A. Correct.
Q. Do you see that?
A. Yes.
Q. And then 2:25 patient complains of pain, holding chest, anxious, short of breath, taking clothes off.
A. Correct.
Q. Now, in your note, your letter, you had the time at 2 a.m. In looking at the chart with me, you will agree that it was actually between 2:20 and 2:25 that these symptoms started, correct?
MR. MISHKIND: Let me object that I think the reference is, Dr. Stanisic's reference is at 2 o'clock.
THE WITNESS: The resident's note was

written when he arrived at 3:15 the patient was having chest pain at 2 o'clock. And this is the nursing note. She wrote here 2:20. I don't know if she wrote the note at 2:20. But, yeah, from looking at this sheet, 2:20 was when she wrote this down, patient complained of pain. Pain --
BY MR. KELLEY:
Q. We know he wasn't holding his chest, anxious, short of breath prior to 2:20 because she has a separate note for 2:20, correct?
A. That's correct.
Q. So really that's at least we will say between 2:20 and 2:25 that he develops this chest pain?
A. Correct.
Q. Now, do you see that she paged the resident, Dr. Goldman?
A. At that point, just looking at this, I wasn't sure if he was the intern or resident or whatnot. Correct.
Q. Okay. And Dr. Goldman was there it looks like at least within the same note?
A. Correct.

Q. And you have had a chance to see Dr. Lisgaris' deposition?
A. Saying that she was there.
Q. That she came some time thereafter, correct?
A. Correct.
Q. And you can see, can you not, from several of the things that were ordered including blood work -- I think at 2:45 it was drawn --
A. Correct.
Q. -- the typing and crossing which was ordered at 3 a.m.?
MR. MISHKIND: Let me object because I'm not -- I'm not sure that they typed and cross matched.
THE WITNESS: I saw it typed.
MR. MISHKIND: I don't think that there was a cross match.
BY MR. KELLEY:
Q. The typing at 3 a.m.
A. Correct.
Q. That there were physicians present doing things prior to 3 a.m.?
A. That's correct.

Q. Okay. So you agree now, do you not, that there at least was a resident present before 3:15 a.m.? Correct?
A. Correct.
Q. You realized that it was the MICU resident who didn't get there until 3:15?
A. That's correct.
Q. Okay. Do you have any criticisms of the timeliness of the nurse contacting Dr. Goldman or Dr. Goldman getting in touch with Dr. Lisgaris?
MR. MISHKIND: Let me just object. Assuming that there shouldn't have been contact before that time?
MR. KELLEY: Yeah. Assuming no contact before 2:25.
THE WITNESS: Okay. That was an appropriate thing to do.
BY MR. KELLEY:
Q. Okay. And you have seen Dr. Lisgaris' deposition where she attempted to contact surgery but they weren't able to get the x-ray films because of other patient needs within the hospital?
MR. MISHKIND: Let me object.

THE WITNESS: Right. That is what she says; she contacted them.
MR. KELLEY: Let me just finish before you object.
MR. MISHKIND: Sure. Too late. I already objected.
MR. KELLEY: I know.
BY MR. KELLEY:
Q. And that she then went and sought assistance from the MICU? You saw that in her depo, correct?
A. Yes.
Q. Do you believe that that was a reasonable course for her to take to contact surgery, realized that they couldn't get the radiology tests and then contacted the MICU?
MR. MISHKIND: Let me object because the record -- I'm not sure that her testimony is supported by the evidence in this case. You are asking hypothetically if one believes that Dr. Lisgaris contacted --
MR. KELLEY: I'm just saying her testimony --
THE WITNESS: If she contacted the

surgeon at 3:15 or around there, then I think that that was appropriate what she did. But from reading some of the other depositions, I have a question as to whether a surgeon wasn't contacted until I think 5:30.
BY MR. KELLEY:
Q. We know surgery never got there until 5:30?
A. Correct.
Q. But you saw where Dr. Lisgaris described that she called back to say that, assuming she is being truthful, that they couldn't get the KUB or the CT scan?
A. Correct.
THE STENOGRAPHER: Excuse me. I need to change paper.
(Thereupon, a recess was held.)
BY MR. KELLEY:
Q. What I want to do now is talk about 2:25 going forward.
A. Okay.
Q. Okay. You obviously completed your residency, you completed two residencies in internal medicine, then also in GI?

A. Yes.
Q. Did you staff a hospital during the evening hours as a resident?
A. For residency, yes.
Q. And there is nothing abnormal about residents being the ones inhouse during the evening hours, correct?
A. No, correct.
Q. You don't have any criticisms of the fact that residents were involved in the care and treatment here, do you?
A. No.
Q. Have you had occasion during your residency or even since if you have been covering a hospital during the evening to be paged in the middle of the night for an emergency?
A. Yes.
Q. Okay. Is it more difficult to get things accomplished at 2 a.m. than 2 p.m. on average?
A. Certain things are more difficult. Certain things are not.
Q. Give me an idea of some of the things that are easier or the same versus more

difficult.
A. For example, routine things like blood work, x-rays can be done just as quick in the middle of the night as in the morning or during the day as opposed to when if the lab has a bunch of blood work that they have down there that they are doing their morning blood work on.
If patients are scheduled electively for x-rays in the middle of the night, you can just call, send the lab down to draw the blood and there is nothing else being ran. It gets ran quickly. The x-ray, the x-ray tech is always in the hospital, sits there, can come up and take an x-ray if he is not doing anything in the middle of the night.
Q. If he is not doing anything in the middle of the night, though, is a relatively important thing, correct?
A. Correct. Correct. And, again, there is going to be different degrees of emergencies and different degrees of priorities that things need to be taken care of. Most things, if there is two emergencies going on at once and there is only one person there to do it, it can

be more difficult during the night.
Q. Okay. At 2:25 a.m., were you the individual called, if you were the person there to evaluate this patient, what sort of things would have been on your differential diagnosis?
A. I think at that point when you see the patient hypotensive, having initially pain in, I think they said total body pain, even though he is holding his chest. But then they said he denied chest pain. Again, you are worried about a cardiac event. So you get an EKG first to see if the patient is having a heart attack. You are worried about volume depletion. So you are going to draw blood and see if there is any abnormalities in the blood count. Is the hemoglobin low?
You are worried about infection, sepsis. You are going to look at the white blood cell count. With hypotension, you are worried about bleeding. You are worried about initially is the blood pressure low because the patient got Percocet and is it from the Percocet being low.
That would give two things because it would give a reason for pain not causing the

blood pressure which we usually don't like to give two different diagnoses. But that would be another possibility to explain the significant drop in blood pressure at that time.
Q. Okay. So there would be -- I'm not putting these in any particular order. Just how I was trying to write them as you went in -- you would have in your mind could the vital signs be accounted for based on a pharmacologic reason, that being Percocet, could there be bleeding, could it be cardiac, could it be volume, which seems like it would overlap with bleeding, correct? --
A. Correct.
Q. --or sepsis?
A. Correct.
Q. Okay. Let's start with cardiac. The fact that the patient had a history, one would be relevant, correct?
A. Correct.
Q. The fact that he was clutching his chest even though he denied chest pain would be indicative of something perhaps cardiac, correct?

A. Correct.
Q. The fact that he was short of breath, correct?
A. Correct.
Q. I know some of these may go in multiple columnns because they are not pathopneumonic to one thing or another. But the fact that he was anxious could be consistent with a heart attack too, correct?
A. Correct.
Q. The description of all over body pain can be consistent with a heart attack, can't it?
A. Sure.
Q. The heart rate and blood pressure could be consistent with a cardiac event, correct?
A. Correct.
Q. It would be contraindicated to do an exploratory surgery on a patient who could be having an MI, correct?
A. Correct. Unless the reason why they were having the MI was because of the --
Q. Thebleed?
A. Correct. They were losing blood. It

is easy enough to rule out a cardiac event by getting a quick EKG and listening to the heart and lungs and whatnot.
Q. With volume -- shall we put a volume and bleeding together?
A. That's fine.
Q. Okay. Is chest pain or clutching one's chest consistent with bleeding into -- you're talking about blood in the abdomen, correct?
A. Correct.
Q. Would clutching one's chest be consistent with bleeding into the abdomen?
A. Well, again, if the hemoglobin has dropped low enough to cause a decreased cardiac output, then you can get chest pain as a result ofthat.
Q. How low would the hemoglobin have to be to create chest pain?
A. It really wouldn't be a specific number as opposed to a time factor. In other words, I believe his hemoglobin was 9 which can be a lot of people walking around with a hemoglobin of 9. If their hemoglobin has dropped from 14 to **9** over a year or even over a

month as opposed to somebody who just to make the comparison is out on the street with a hemoglobin of 14 and gets shot in the aorta and their blood count drops to 9 in a matter of minutes and then they are going to pass out right away and they can get chest pain like that. So really we look more at the change over time as opposed to the actual number.

Q. Wouldn't the pain first manifest itself in the area of the bleed typically, though?

A. Again, not always. You know, as people that have -- you can have leaks of blood. You can become anemic rather rapidly and get chest pain. That doesn't have to, it doesn't have to happen abdominal pain before the chest pain.

Q. Well, if in fact this patient had lost, had gone from we will use your numbers 14 to 9.1, that would be about a unit and a half of blood on average, correct, to drop six points or five points?

A. No. That would basically be like five units. I was talking hemoglobin.

Q. Hemoglobin.

A. From 14 to 9.

Q. So that would be five units of blood lost?

A. Correct.

Q. And how many are in the body?

A. Well, when you are talking hemoglobin, usually --

Q. We are talking about different things. I understand what we're doing now. Obviously it dropped five --

A. If you start at 14 and you drop by five, you are dropping a third of your blood volume.

Q. Okay. It doesn't correlate directly to a third of your blood volume, though, based on your hemoglobin drop, does it?

A. No. Those are calculated numbers.

Q. Isn't the typical rule of thumb that each unit of blood represents four numeric drops on a hemoglobin?

A. On a hematocrit.

Q. On a hematocrit. How does that correspond to hemoglobin?

A. A hemoglobin of **14** and a hematocrit of **say** 42. I don't think his was 14. I think

his was like 13. We can get the exact -- we probably should get the exact numbers instead of just...

(Pause)

A. His hematocrit at 1:52 p.m. was 39 with a hemoglobin of 13.3 and then at 3:08 a.m. -- so over 12, 13 hours -- his hemoglobin had dropped from 13.3 to 8.6. So that's the five -- the hemoglobin goes up one with each unit. The hematocrit goes up three with each unit. The hematocrit drops from 39 to 24 and a half. So, again, a third.

Q. At I, the time of the first blood draw, was that at 1:45?

A. Correct. 1:47.

Q. Okay. There is no -- those blood values aren't consistent with someone who is having a bleed, are they?

A. Correct.

Q. They are perfectly normal, the hemoglobin and hematocrits there, correct?

A. I would consider them normal. They actually do fall below the normal range for the lab. But just looking again at that blood value, it's a normal, we would consider that

I normal.

Q. Yeah. That is not something you would look at and say, "This guy has a bleed?"

A. Correct.

Q. Now, so we have the hemoglobin being low. Actually, we don't know that when we first -- let's talk about what we know when we first get there at 2:25.

A. The hemoglobin is drawn because of the low blood --

Q. Low blood pressure?

A. -- low blood pressure.

Q. That was obviously a reasonable thing to do, correct?

A. Correct.

Q. Other than the vital signs, the low blood pressure, the high heart rate and I believe the respiration rate was up to 50 at that point as charted --

A. Correct.

Q. -- is there anything else that would have been consistent with a bleed?

A. I believe in one of the notes there was abdominal distention as well. And the blood was drawn at **3** a.m. I guess it took

eight minutes to get a blood result back. So as soon as the hypotension was evident and the blood work ordered, you have your answer within minutes.

MR. MISHKIND: I think that may have been second blood, if I'm not mistaken. I think there was one even earlier than that. Lisgaris testified 2:45.

MR. KELLEY: 2:45. It comes back at 2:56.

THE WITNESS: I didn't see that in the lab section here. Here we go. 2:45 was when they drew the blood gas because of the respiratory rate which was also a reasonable thing to do. That is where the 9.1 was.

MR. MISHKIND: What is that?

MR. KELLEY: Those are pages that clearly demonstrate there was no negligence in the case. Those are also pages that clearly demonstrate there was no negligence in the case.

MR. MISHKIND: We had this conversation before.

(Laughter)

MR. KELLEY: Off the record.

(Discussion held off the record.)

BY MR. KELLEY:

Q. So we have the fact that the abdomen is distended?

A. Correct.

Q. Anythingelse?

A. Well, again, there is also, the main thing that the person caring for the patient should think of is, you know, what did the patient have that day. The patient had a surgical or an endoscopic procedure done that day. So, you know, why is this day different than other days?

You are thinking that, you know, a procedure was done. That's one of the considerations of is this a complication of the procedure, which, again, would be perforation, which would be a sign of infection, sepsis and bleeding.

Q. Obviously all of these things take time, correct?

A. Well, an assessment of the patient an and ordering blood work should occur fairly rapidly. The intern draws the blood and it

took as you saw anywhere from eight to ten minutes to get the results back. An EKG takes a couple of minutes. It takes, I would think that the standard of care someone getting called to see this patient, evaluating the patient takes two or three minutes. You decide what tests you want. The initial test would be blood work, EKG and x-ray, and the blood work and EKG are back within minutes of when it is thought about. So those things don't take time.

Q. Those three things were all done here, correct?

A. Correct.

Q. So they were absolutely fine with their initial assessment to send that blood off by 2:45?

MR. MISHKIND: Again, assuming not before. Just dealing with it from a 2:20 time period?

MR. KELLEY: Right.

THE WITNESS: Maybe we can save some time with this. I think before the break we kind of got to that. I think that from the time that Goldman and Lisgaris were

called, got there, did their quick evaluation, ordered what they ordered, and if in fact she did at 3:15 call the surgical team, I think what she did was appropriate there.

BY MR. KELLEY:

Q. Okay.

MR. MISHKIND: Actually, I think she testified she called --

MR. KELLEY: I think she said she called between 3 and 3:15.

MR. MISHKIND: 2:45 and **3.**

MR. KELLEY: And she said -- my recollection is she said she called twice.

THE WITNESS: Correct.

BY MR. KELLEY:

Q. Once. And they said, "Get the films," and then she called back to say, "We can't get the films. We will call the ICU?"

A. Right. I'm not really sure why she was getting the films. I think that her job was to call the surgeon. I think she -- I don't know if it was her or the other one that had in the note that when they saw the hemoglobin was low, they lavaged the Peg.

There was no evidence of any bleeding coming from inside the GI tract.

I think at that point the diagnosis was, everything else was ruled out. Whether he was having a heart attack, they did the EKG. Anything I think at that point, it was obvious it was secondary to a significant drop in his intravascular volume, blood, you know, from the morning or afternoon until that time of the morning.

I think at that point she doesn't need any x-rays, she doesn't need any CAT scans and she had the diagnosis and she called the surgeon. If she did call the surgeon, I think she did the appropriate thing.

If the surgeon didn't come, then I think the surgeon was negligent in his care. Putting the patient in the ICU temporarily before going to surgery is a good idea. She couldn't take the patient to surgery.

Q. How long do you think it would have taken had you been there to get this patient to surgery?

A. Well, it can take X amount of time -- again, when you have a surgical emergency,

which at that point the diagnosis was clear that the patient was having an intra-abdominal bleed, if the surgeon was contacted at that time, the surgical resident I would assume or intern would come up and evaluate the patient, agree with the diagnosis, call the surgical attending who I assume would be at home or maybe he is in the hospital, and I would think that the attending could be at the hospital. Different hospitals have different policies.

I would think a reasonable amount of time for the surgeon to get to the hospital would be a half hour. In the meantime, I would think that the surgeon would tell the surgical resident to start to call the OR and begin to, you know, get the OR ready for surgery. So I would think that from the time the surgical resident was called he should come up, he or she should come up and evaluate the patient based on what the medical team was telling the patient it sounds like it is an emergency.

It's not like someone has, you know, a fever and abdominal pain and maybe has appendicitis. Maybe he doesn't. They had a significant drop in the blood volume that we

talked about, the 14 to 8 or 9. The Peg tube lavage was negative. The patient was hypotensive. And they can begin to stabilize the patient medically as best as they can.

Giving blood should be the first thing to do in that situation because he clearly needed blood. And I think that there was a delay in getting the patient blood. They could have given him unmatched blood quicker than when they eventually did. They had the result at 2:45. He didn't get blood until I believe 4:40. But it should be done in preparation for surgery. But I think that surgery could have realistically been done relatively soon, much sooner than it was done.

Q. By 4:30?

MR. MISHKIND: Before you answer that, you are --

MR. KELLEY: We are starting at 2:25.

MR. MISHKIND: And you are assuming that they are giving him blood in the interim until the surgery team --

MR. KELLEY: I'm asking if he was there at 2:25, put all the wheels in motion, did the assessment, ordered the

tests, got the blood work back around 2:50, whatever, or the second set of blood, tried to call the surgeon, tried to get the things, heard things back so that we know ICU was called between 3 and 3:15.

THE WITNESS: Correct.

BY MR. KELLEY:

Q. When does this patient get to surgery?

MR. MISHKIND: I've got to object because I'm not sure your question is including him being given blood in the meantime or no blood being given.

MR. KELLEY: If he is there and giving absolutely the perfect care that this world has to offer --

MR. MISHKIND: That's not the standard of care. The standard of care is what a reasonable practitioner would do.

MR. KELLEY: I'm asking how fast does this patient get to the OR.

MR. MISHKIND: You are not answering my question. But go ahead and answer.

THE **WITNESS:** I would say that realistically the patient should have

gotten surgical evaluation, the blood, the vital signs stabilized as much as possible, which obviously what he needed the most was blood. His respiratory rate appeared to be increasing. He needed to be intubated at that time, which he eventually was, but probably a little later than he should have been. The surgeon should have come in and mobilized the room. I would say the reasonable thing to do would have been the first thing in the morning, 6 o'clock in the morning get the patient to the OR.

BY MR. KELLEY:

Q. Okay.

A. Again, assuming, again, starting from that 2:30, 2:25 standpoint.

Q. Starting from that point.

A. Three and a half hours I think is more than enough time to be able to stabilize the patient and get the wheels in motion and get the OR available.

Q. The first thing that you have to do in a situation like this is kind of go back to the ABCs, airway, breathing and circulation?

A. Correct.

Q. We clearly have a patient in shock, right?

A. Correct.

Q. And before we treat the cause of the shock, we want to try to stabilize the patient who is in shock, correct?

A. You are doing both at the same time. You want to give him blood. It was the major thing that he needs. And sometimes giving blood you are able to stabilize the patient and sometimes it's not only blood. You have to stop the bleeding.

We can kind of -- I mean ABCs is the textbook what you have to do. But in reality it doesn't take that long to do the ABCs. The AB takes seconds. You get an airway, intubate the patient and that is done. And the C part, blood X amount of time to get blood available. You pump as much blood in as you can as quick as you can and you want to do something to correct the problem.

The analogy would be someone that comes into the emergency room with a gunshot, a trauma patient. I mean, you do everything you

can to stabilize the patient, but sometimes you are going to take the patient to the OR to actually stop the bleeding.

Q. It is pretty obvious, though, when you have a gunshot wound, right? You have a hole right in the middle of the --

A. Correct. But in this situation, you had something for the obvious. By 2:48 in the morning that a blood count had dropped from 14 to 8. And they had the diagnosis there. So we are not critical of them, of the medical team once they were were notified at 2:25. They basically had the diagnosis by 2:56 when they got the blood back with the hemoglobin that had dropped from 14 to 9 and the blood result came back at 2:56.

Q. Did you see in Dr. Stanisic's note where he talks about hypotensive shock as one of the things on his differential? He says "Due to a presumed intra-abdominal bleed, KUB was negative. Will check CT of the abdomen to rule out bleed. Once a hemodynamic improvement. Normal saline wide open. Begin NeoSynephrine to maintain maximum blood pressure" --

A. Let me just find that note so that we are on the same page here.

Q. It is his note from that morning of June 5th. It is a very neatly printed note.

A. Right. Where were you reading from?

Q. I think -- I'm on the second page of that note near the bottom. You will see it says number 2 and then it says CV, then across hypotension shock.

A. Okay. Let me just look at one thing for one second here.

(Pause)

A. I see where you are reading from. I think in reading the whole note, in other words, the next page too, where the **GI,** I think at that point when lavage for blood was negative of the Peg tube, the rectal examination was negative. There was no evidence on the stated physical examination written down here that there was any bleeding anywhere else on the skin from IV sites or whatnot, that at that point by the time he had this note written, which it looks like it was after -- it had to be after 3:15 because he wrote down at 3:15 patient was continued

hypotensive -- that the diagnosis was basically made. Dr. Lisgaris had already called the surgeons.

MR. MISHKIND: Supposedly.

THE WITNESS: Supposedly. They had done their job and made the diagnosis at that point. Whether, again, he mentions in here possible abdominal aortic aneurysm. But they basically made the diagnosis with the abdominal distention, the decrease in hemoglobin, and I think they did a good job in making the diagnosis. The problem was not rapidly correcting the problem.

BY MR. KELLEY:

Q. You see that he did order a type and cross in that same thing to transfuse four units of --

A. Right. I think with that degree of drop I think they could have just given uncrossed matched blood.

Q. There is risks with that, though, aren't there?

A. Yes.

Q. The risk is a hemolytic reaction?

A. That's correct. But in certain emergency situations, we give uncrossed matched blood, and the patient was hypotensive, volume depletion from blood depletion. These are the kinds of patients that you give uncrossed matched blood to.

Q. What is the threshold -- how do you determine what patients get uncrossed matched blood?

A. Somebody who is having a slow bleed you obviously wouldn't give it to. Somebody who is having, you know, maybe they are, you see they have black stools, their blood count has dropped from whatever, 10 to 9. You may have the leisure of time, but this is somebody who has had a significant drop in hemoglobin, enough to significantly change vital signs as well. This is somebody that should have in my opinion received unmatched blood.

Q. Now, did you see in his deposition where he said that this note was written around 5 a.m.?

A. Correct. I would -- like I said, I assume it was written much later because he was writing about 3:15. Usually I remember when

being a resident usually you can't get a chance to write the notes until all the dust is settled.

Q. You kind of provide your care and treatment and then write your note thereafter?

A. Correct.

Q. You never leave a patient's side to write a note?

A. No.

Q. So there is nothing unusual or unreasonable about the fact that this note was not written until approximately 5 a.m., correct?

^**A.** Correct.

Q. And is it typical as a resident that the resident who would be in charge would be the one who would write the note in a situation like this or would everybody write the same note?

A. I think everybody would write a note. I don't think, you know, usually what happens you got an intern on, a resident, the ICU resident.

Q. Is that required or is that just something that happens?

A. I guess different training programs would have different policies. Usually everybody is required to write a note as part of their education and training as well.

Q. The note by Dr. Stanisic, it clearly shows an understanding of the patient's condition, correct?

A. Correct.

Q. It clearly shows that he not only knew but ordered all the appropriate tests, correct?

A. The only thing I would fault in the note is that in looking at the impression part of the GI part, even though the surgeons were called, it doesn't seem to have the urgency of the surgeons. In other words, I don't think a CAT scan at that point was necessary. So it seems like the priorities were listed as suspect intraabdominal bleed. Will check CT scan at the abdomen. General surgery to evaluate suspect bleed post Peg.

Q. And you do see that they were trying to give an aggressive fluid resuscitation, correct?

A. Correct.

Q. And that the purpose of that is to increase the volume, to try to benefit the profusion, correct?
A. Correct. Although the standard is losing blood you really have to replace with blood better than with fluids. But that was --
Q. 8.6 and 9.1 for hemoglobin, that is not a critically low hemoglobin, correct?
A. I think we discussed that already.
MR. MISHKIND: I'm going to object. It has been asked and answered.
THE WITNESS: You don't look at an isolated value as the change.
BY MR. KELLEY:
Q. Is that number nonconducive with life?
A. Again, we discussed as well. I'll say no.
Q. Okay. The arrest which occurred first at 4:10 a.m., you saw the code sheet?
A. Yes.
Q. Okay. Do you believe that to be a cardiac, cardiorespiratory or simply a respiratory arrest?
A. Again, there is a lot of confusion

brought up in the depositions as well. But forgetting about the depositions and just looking at the note, Number 1, it clearly says cardiac arrest, no; respiratory arrest, yes, as opposed to the second code which is listed as a cardiac arrest and then looking just to see where they may put it on the first code, the second code is under significant events, they list CPR. There is no evidence under significant events in the first code that CPR was performed.
So if it was a cardiac arrest and CPR was not performed, then that would be below the standard of care. But there is nothing to suspect from the code sheet or the notes and from some of the physicians' depositions that that occurred. It seems that what occurred was that this was a respiratory arrest first code and second code of cardiac arrest.
Q. What was the patient's blood pressure from 4:10 a.m. to 4:22?
A. It is listed as unable.
Q. So they were unable to trace any sort of blood pressure during that time?
A. Correct.

Q. And how do you define a cardiac arrest?
A. A cardiac arrest basically is when the heart stops pumping. Now, you can have what we call a dissociation between the heart and the blood system or you can have a heart rate without any pumping of blood. That would be a cardiac arrest. But there are, it is very difficult in blood pressure listed usually during a code before more significant monitoring.
In other words, if a patient had an arterial line in the groin or wherever they are going to put it, monitoring the blood pressures, then you can say for sure what the blood pressure was. It is very difficult to auscultate a blood pressure sometimes if the blood pressure is very low. And just because it's unable doesn't mean that it's not there. And, again, the major thing in addition to that would be that there was no evidence that any CPR was performed.
Q. When it says in the nurse's note decreased mental status, unresponsive, triple initiated patient and then it shows that the

patient is transferred to the ICU, what does it mean when it says triple initiated?
A. I'm not sure what triple means.
Q. If triple included CPR, would that change your opinion as to --
A. 2:25 --
MR. MISHKIND: No. The testimony in the case was that was -- she did not time it. And I think this is at the time --
MR. KELLEY: That the patient was transferred to the ICU.
MR. MISHKIND: Right. Which would be in between the two codes. So I'm not sure, in fairness to the doctor, I'm not sure whether we can correlate that. In fact, if anything, it would correlate to the second.
MR. KELLEY: The timing issue is aside.
THE WITNESS: If triple means CPR, then at some point CPR was administered.
BY MR. KELLEY:
Q. Have you ever heard of a double or a triple in terms of codes?
A. No.

Q. Okay. What is epinephrine given for?
A. Usually to patients that do not have a heart rate to stimulate the heart.
Q. Any respiratory benefit?
A. No.
Q. What about Atropine?
A. Again, to speed up the heart if there is a heart rate present.
Q. And you see that this patient in the first code was given epinephrine --
A. Correct.
Q. -- and was given Atropine?
A. Correct.
Q. And the sole purpose of those are to pharmacologically stimulate heart function, correct?
A. Correct.
Q. Truly there is two ways you can, there is multiple ways you can get someone's heart back in rhythm. Pharmacologic, right?
A. Correct.
Q. You can use electrical paddles that we have all seen several times on TV. You have seen it in real life, correct?
A. Correct.

Q. Or chest compressions with someone's hands, correct?
A. Well, but a standard of a code is to continuously be giving chest compressions to facilitate, you know, circulation of the blood.
Q. And what is a CVP?
A. It's basically central venous pressure.
Q. And what is that for?
A. Like basically just to get access. It's a large bore -- CVP is basically a line. CVP stands for central venous pressure. But reading it in the context here, CVP inserted, it is basically a large bore IV to be able to give medications and fluids through more rapidly.
Q. Is that also a method that would allow you to measure blood pressure?
A. Well, that measures -- no. **A** CVP line would not measure blood. It measures venous pressures which are not ...
Q. And you see that throughout this the saline is wide open, correct?
A. Correct.
Q. Do you believe that the patient

following 4, the events of 4:10 to 4:25 we'll say -- let me just start over. Following that first code from 4:10, had this patient been taken to surgery and survived as you allege the patient should have been, would the patient have had any residual brain damage?
A. I think at this point in reviewing through the code sheet, the patient had a heart rate throughout the whole code. I think -- I don't think that I would be able to say if there would have been any residual brain damage.
Q. You can't say yes; you can't say no?
A. Correct. If I -- again, I think it would be more likely that he would not have. But at this point just from looking through this code sheet, I think it's not clear to me of the damage that was done to the patient during those, during those 20 minutes.
Q. Okay. Let me make sure because you added to that more likely than not. Do you have an opinion based on your training and your experience that the patient would not have been impaired neurologically or cognitively following the first code or is that outside

your specialty?
MR. MISHKIND: More likely than not.
MR. KELLEY: More likely than not.
THE WITNESS: I would say in my opinion but, again, as a caveat that that would be outside my specialty. So you are asking my opinion. I would say my opinion --
BY MR. KELLEY:
Q. I understand.
A. I don't make myself to be a neurologist in assessing brain function after codes.
Q. Okay. Just so I understand, you don't believe you're qualified to render that opinion in a courtroom?
A. Correct.
Q. Okay. And no disrespect meant by that. Just the fact that there is different specialties. What about the code at 4:50? Do you believe that the patient following that code, do you have an opinion based on your education, your training and experience as to whether or not that patient to a probability would have suffered brain damage or neurologic

deficits following that event or is that outside your specialty?

A. Well, again, I assume it would be outside my specialty. However, in looking at this code sheet, it's not very well documented. It appears that there were only two readings a minute apart where there was no blood pressure and then the next reading he had an excellent blood pressure. So looking at this code sheet, I'm not really sure how long the arrest was. If it in fact was only two minutes or so, I would not think that that would affect his neurologic status.

Q. If the first arrest, the 4:10 arrest was cardiac and the patient actually had no blood pressure from 4:10 to 4:22 as documented under the unable, if that actually meant none, did you have an opinion or would that be outside your specialty as to whether or not the patient would have been able to survive that event without brain damage?

A. Patients can survive codes of that duration even if it is cardiac arrest if CPR is being given and there is circulation. From here, it does not appear that CPR was given.

So, again, if this was a cardiac arrest, I would think that the management of the code was below, was definitely a deviation of the standard of care because CPR would not have been given.

If in fact the patient was at a cardiac arrest for that period of time and was not given CPR, I would think that he would have gotten brain damage and I would think that it would be, a large part would be attributed to why did he not get CPR during a cardiac arrest.

Q. Okay. Do you have any criticisms of Dr. Stanisic, the ICU resident in this case? I think you already stated that one was he didn't need to get the CT scan. I don't know -- does that amount to a deviation from the standard of care?

A. I think that more importantly I think he should have more aggressively gotten the surgeon there because that was the thing that needed to be done. And if a CT scan could have been done in the interim while they are waiting for the surgical attending to come in or whatnot, just to add more information.

But I don't think that a CT scan

should have been said, "All right. It is 3:15, 4 o'clock, 5 o'clock in the morning. We get a CT scan at 9 o'clock in the morning and see what that shows and then maybe take the patient to surgery."

I think that if a CT scan -- this would have been a noncontrast CT scan. It can be done in minutes, you know, again, depending on -- I'm not familiar with the situation at the hospital. But emergency CT scans of the abdomen can be done rather quickly even in the middle of the night.

If it did not affect the surgeon -- in other words, I would not take an answer from the surgeon get the CT scan and call me with the result. I think his obligation was to get the surgeon. And he did write in his note general surgery to evaluate. I would like to have him be a little more aggressive in getting the surgeon. There is a note right after his note. I'm not really sure who wrote that. It looks like MICU.

MR. MISHKIND: Doctor, I think Dr. Stanisic testified that he didn't request the surgical consult until 5:30.

THE WITNESS: And, again, I think that that was not appropriate.

BY MR. KELLEY:

Q. The CT scan going back to the ABCs and the fact that the patient was in shock, you can't put a patient in an elevator into a CT scanner who is in shock, can you?

A. Correct. And that's why I said I don't think a CT scan needed to be done or should have been done. That surgery was what needed to be done.

Q. When was this patient, if ever, between 2:25 and the end of the second code, which I think is 4:55, hemodynamically stable?

A. I think before the first code, except for -- let's look back at the vital signs. Hemodynamically stable for what? To go to surgery or to go --

Q. Let's take it this way. Was the patient in shock that entire time?

A. Yes. There were various degrees of shock. At one point, the blood pressure was 76. At one point, at 3 o'clock the blood pressure -- I don't know if it is 109. At 3:15, it was 120. *So* there are -- it's not

like the patient has no blood pressure at all; that the patient is I would think stable to go to the OR assuming that blood was getting ready to be on board and that the surgeon would then evaluate the patient, made the diagnosis and agreed with the diagnosis and said this has to be fixed surgically.

Q. At what time, considering the fact that the patient without receiving blood products is stable enough for surgery, at what point do you give blood without cross matching it to a patient that is stable enough for surgery?

A. I think at that point, you have the hypotension. You make the diagnosis. You have a significant decrease in blood pressure. That's when the blood has to be given right away. The patient has evidence that they have dropped their -- I mean, you don't know if they are going to be stable.

Looking at that point in time, you think seeing that, you know, this patient has chest pain, blood pressure at 90 over 60. Hemoglobin has dropped from 14 to 8. That is an emergency basically. He has to be given,

the blood should be given at that point right away.

You don't know what is going to happen. I said the blood pressure reading at 3:15 was 120. But you didn't know that. I think at 2:25, you have the decrease in hemoglobin, a marked decrease in hemoglobin, the low blood volume. That is when the patient should have been given typed blood.

Q. We don't even get the type back until 3.

A. Right. 3:08.

Q. Okay. So at 3:08 you believe we should have given the patient blood regardless of cross matching it?

A. Correct.

Q. Okay. And what we're doing in that situation, then, if we put ourselves in those physicians' shoes is we are weighing the risk of hemolysis against the patient's stability?

A. Correct.

Q. Okay. Even though this patient by your own testimony was stable enough to go to surgery without the blood product?

A. Correct -- I didn't say without the

blood product. I said if you can't get the blood -- in other words, the blood should be given immediately. That is part of the ABCs. The C is off the way it is because of the blood. You need blood.

Now, sometimes, you know, the blood isn't going to be good enough. You need surgery. At that point, nothing was done. They didn't give uncrossed matched blood and they didn't take surgery. I would never say that you should take him to surgery without giving him the uncrossed matched blood. You want to give him the blood and if need be take him *to* surgery.

Q. So the latest moment in time we could have given this patient blood was around 3:08 or immediately thereafter?

A. I don't understand the question.

MR. MISHKIND: Again, I'm going to -- let me -- hold on one second.

BY MR. KELLEY:

Q. Assuming 2:25 as the start point, the physicians had until they got the type back?

A. In looking at the vital signs here, I would say that at 3:25 the blood pressure was

80 over 50. At 3:30 it was 87 over 60. At 3:35 it was 85. At 3:50 it was 83. I think at that 3:25 when the blood pressure is 80, that's when I would have given the unmatched blood.

Q. That is when you would give the unmatched blood?

A. Yes.

Q. And you do agree with me that unmatched blood could potentially kill a patient?

MR. MISHKIND: Objection.

THE WITNESS: Correct.

BY MR. KELLEY:

Q. Especially a patient with low reserves?

A. Correct.

Q. And Mr. Brooks you will agree is a patient who had low reserves?

A. Correct.

Q. Once surgery arrives -- let me finish with Stanisic first. I'm sorry. Any other criticisms of Stanisic other than the issue regarding the CT which we touched on and failure to more aggressively push for a surgical consult? Any other criticisms?

MR. MISHKIND: And the blood.
THE WITNESS: And the blood.
BY MR. KELLEY:
Q. And the blood. Anything else?
A. No.
Q. Okay. What about once the surgeons were consulted and then got there? Any criticisms after that?
A. Yes. Because I believe -- they came at 5:30.
MR. MISHKIND: They were contacted at 5:30. I think the testimony was that the resident was there at about 6 o'clock.
MR. KELLEY: About 6 a.m.
THE WITNESS: I think that once they were there and evaluated the patient I think it was -- I forget his name, the resident, the surgical resident. It didn't appear to me that he was 100 percent on board as to the diagnosis and what needed to be done. He mentioned something about considering an endoscopy. I think that was an inappropriate decision on his part. He also wanted to get a CAT scan and whatnot, which I don't think was

necessary to do. And he wrote in his note probable exploratory lap this a.m. That should have been exploratory lap ASAP.
BY MR. KELLEY:
Q. So the surgical resident, even when he arrived, you can tell from the notes wasn't told that this was an immediate surgical situation?
MR. MISHKIND: Objection to the form of the question. But go ahead.
THE WITNESS: I think that he did not, I think he was very blase as to taking action. And then the surgical attending in the note, again, writes may need to repeat EGD which is not, which was inappropriate. There was something mentioned in one of the depositions about the surgical resident, surgical attending talking about not taking the patient to surgery until other cases were done. In other words, when you have an emergency, things have to be put off at times. And I just don't think that they took quick enough action. Even once the surgeons were consulted, I don't think the

surgeons -- and I will say that I will defer some of that decision to surgeons. However, as a gastroenterologist taking care of patients that I know -- in other words, if a patient is bleeding from within the stomach, we can do things. We can do an endoscopy, go through the scope and do things to stop the bleeding. If there is nothing I can do to stop the bleeding, I have to rely on the surgeons. I can't take the patient to surgery. So, you know, these are things that we encounter all the time, and I think at this point this was clearly not something that could be treated medically or even conservatively and the patient needed to go to surgery.
BY MR. KELLEY:
Q. When did the patient stop bleeding?
A. I don't think we know for sure when the patient did stop bleeding. I know by the time the patient was operated on about 11 o'clock that there was a lot of blood in there and blood had clotted off. I'm not exactly sure when the patient had stopped bleeding. I

would defer that to a surgeon.
Q. Okay. Do you agree that the patient was not actively bleeding at the time of surgery, though?
A. Correct.
Q. Any other criticisms that you have that we haven't talked about?
(Pause)
A. No.
Q. Okay. As it pertains to proximate causation, do you have an opinion as to what moment in time was the last period of time that surgery could have intervened or that blood could have been given and that Mr. Brooks' outcome would have been different?
MR. MISHKIND: To a reasonable degree of probability?
MR. KELLEY: To a probability.
THE WITNESS: I think that the blood which was initially given at 4:40 should have been given an hour earlier. That would have increased his chances of survivability if it would have been given earlier. However, if the major thing he needed was surgery -- I think surgery

ended up being done at 10:45 -- I would say, again, I would defer the details of that to a surgeon. But I would say looking at the numbers -- where do we have the vital signs for the next morning?

(Pause)

MR. KELLEY: You want the vitals for the next --

MR. MISHKIND: Yeah. I've got it.

(Pause)

MR. MISHKIND: Off the record.

(Discussion held off the record.)

BY MR. KELLEY:

Q. When was the last chance for intervention? You said the blood needed to be there an hour earlier.

A. Right.

Q. And surgery needed to be there to have altered the outcome?

A. When he actually should have been taken to surgery?

Q. Yeah.

A. As opposed to the surgeon coming?

Q. Yeah.

A. I would say somewhere by 8 and 9

o'clock.

Q. A.m.?

A. Yes.

Q. Do you know Moises Jacobs?

A. No.

Q. The other experts in this case, Dr. Dineen, do you know Dr. Dineen?

A. No.

Q. Dr. Nearman?

A. No. I know who they are from this.

Q. From this case. But that's the extent of your knowledge?

A. Yes.

Q. You haven't talked to any of the other experts in regards to this?

A. Correct.

Q. Is there anything else that you reviewed in preparation for today or of your report that we haven't talked about?

A. No.

MR. KELLEY: I don't have anything further. Thanks a lot.

MR. MISHKIND: Okay. We will read the deposition. And we can go off the record.

(Discussion held off the record.)

THE STENOGRAPHER: Are you ordering the transcript?

MR. KELLEY: Yes, I am ordering the transcript.

MR. MISHKIND: And I need a copy. We both need it by Tuesday.

MR. KELLEY: Yes.

(Witness excused.)

(Thereupon, the deposition was concluded at 9:05 p.m.)

THE STATE OF FLORIDA
COUNTY OF PALM BEACH COUNTY.

I, the undersigned authority, certify that the aforementioned witness personally appeared before me and was duly sworn.

WITNESS my hand and official seal this 20th day of November, 2000.

Denise T. Medina
Notary Public-State of FL
My Commission Expires: 4/22/01
My Commission No.: CC633839

CERTIFICATE

THE STATE OF FLORIDA
COUNTY OF PALM BEACH COUNTY

I, Denise T. Medina, Registered Professional Court Reporter, State of Florida at Large, do hereby certify that the aforementioned witness was by me first duly sworn to testify the whole truth; that I was authorized to and did report said deposition in stenotype; and that the foregoing pages, numbered from 1 to 116, inclusive, are a hue and correct transcription of my shorthand notes of said deposition.

I further certify that said deposition was taken at the time and place hereinabove set forth and that the taking of said deposition was commenced and completed as hereinabove set out.

I further certify that I am not attorney or counsel of any of the parties, nor am I a relative or employee of any attorney or counsel of party connected with the action, nor am I financially interested in the action.

The foregoing certification of this transcript does not apply to any reproduction of the same by any means unless under the direct control and/or direction of the certifying reporter.

IN WITNESS WHEREOF, I have hereunto set my hand this 20th day of November, 2000.

_____
Denise T. Medina
Notary Public - State of Florida
My Commission No : CC633839
My Commission expires 4/22/01

CERTIFICATE

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THE STATE OF FLORIDA
COUNTY OF PALM BEACH COUNTY

I hereby certify that I have read the foregoing deposition by me given, and that the statements contained herein are true and correct to the best of my knowledge and belief, with the exception of any corrections or notations made on the errata sheet, if one was executed.

Dated this _____ of _____,2000

_____
TODD D. EISNER, M.D.

ERRATA SHEET

IN RE: BROOKS V. CLEVELAND CLINIC
DEPOSITION OF: TODD D. EISNER, M.D.
TAKEN: 11/16/00
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Please forward the original signed errata sheet to this office so that copies may be distributed to all parties.

Under penalty of perjury, I declare that I have read my deposition and that it is true and correct subject to any changes in form or substance entered here.

DATE:_____

SIGNATURE OF DEPONENT:_____

Q

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