

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.

AA

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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2           I N D E X  
3           - - -  
4 WITNESS:     DIRECT CROSS REDIRECT RECROSS  
5 Todd D. Eisner, M.D.  
6 BY MR. KELLEY 3  
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8           E X H I B I T S  
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1 medicine boards?  
2 A. 1993.  
3 Q. And what about your GI boards?  
4 A. 1995.  
5 Q. Have you ever had your depo taken  
6 before?  
7 A. Yes.  
8 Q. And on how many occasions, if you  
9 know?  
10 A. Approximately 13, 12, 12 to 15 say.  
11 Q. Okay. In the capacity as a Defendant  
12 at any point?  
13 A. No.  
14 Q. In the capacity as medical expert in  
15 a medical negligence case?  
16 A. In all except for one.  
17 Q. Okay. What was the other one?  
18 A. The other one was as a treating  
19 physician.  
20 Q. Okay. So approximately a dozen times  
21 you have been an expert witness to date?  
22 A. Correct.  
23 MR. MISHKIND: I think he said 12 to  
24 15.  
25 THE WITNESS: 12 to 15.

1           P R O C E E D I N G S  
2           - - -  
3           Deposition taken before Denise T.  
4 Medina, Registered Professional Reporter and  
5 Notary Public in and for the State of Florida  
6 at Large, in the above cause.  
7           - - -  
8 Thereupon,  
9 (TODD D. EISNER, M.D.)  
10 having been first duly sworn or affirmed, was  
11 examined and testified as follows:  
12 DIRECT (TODD D. EISNER, M.D.)  
13 BY MR. KELLEY:  
14 Q. Could you state your name, please?  
15 A. Todd David Eisner.  
16 Q. And it is my understanding you are a  
17 physician, Dr. Eisner?  
18 A. That's correct.  
19 Q. Okay. What area of specialty do you  
20 practice in?  
21 A. Gastroenterology and internal  
22 medicine.  
23 Q. And are you double boarded, then?  
24 A. Yes.  
25 Q. And when did you get your internal

1 BY MR. KELLEY:  
2 Q. And that's over the course of the  
3 last, is that in the last five years?  
4 A. It would probably be since 1997. So  
5 the last three and a half years.  
6 Q. Why did you start doing expert work?  
7 A. Initially one of the partners in my  
8 group had been doing work for a couple of the  
9 companies locally here. And at one point in  
10 time, they came looking, calling the office  
11 looking for him to look at a case. He wasn't  
12 around. I ended up reviewing the case, and I  
13 just took an interest to it.  
14 Q. When you say local companies, you  
15 mean law firms?  
16 A. Law firm, law firm.  
17 Q. Do you belong to any referral  
18 services?  
19 A. No.  
20 Q. Have you ever advertised your  
21 services for expert work?  
22 A. I have never advertised, no.  
23 Q. Okay. The rules of a deposition  
24 you're familiar with. But I want to make sure  
25 we have them set tonight in the transcript.

1 I'm going to ask you a series of questions.  
 2 The rules are pretty simple. Don't answer my  
 3 question if it doesn't make any sense to you.  
 4 If you want me to clarify a question, I will or  
 5 you can always have the court reporter read it  
 6 back. Okay?  
 7 A. Okay.  
 8 Q. Our exchange has to be verbal.  
 9 Ah-has, ah-ahs, nods and points won't show up  
 10 in the transcript. All right?  
 11 A. Okay.  
 12 Q. Have you ever worked with Mr.  
 13 Mishkind before?  
 14 A. Yes.  
 15 Q. How many times?  
 16 A. Two other issues.  
 17 Q. Okay. And when was the first time  
 18 you worked with Mr. Mishkind?  
 19 A. Some time I believe either the end of  
 20 '98, the beginning of '99.  
 21 Q. So is this the third case you have  
 22 done with Mr. Mishkind?  
 23 A. Correct.  
 24 Q. Any idea how he got your name?  
 25 A. I'm not sure.

1 Q. Have you worked with anyone else in  
 2 his law firm?  
 3 A. No.  
 4 Q. Have you done any other cases  
 5 involving care and treatment out of Cleveland,  
 6 Ohio?  
 7 A. Not that I can recall.  
 8 Q. Okay. Let me go through -- we don't  
 9 have your CV here. So let me go through it  
 10 pretty quickly. Where did you go to medical  
 11 school?  
 12 A. Medical school at State University of  
 13 New York at Stonybrook.  
 14 Q. Okay. And when did you finish up?  
 15 A. I finished up there in 1989.  
 16 Q. Okay. And then I assume you did a  
 17 four-year program with an internship and a  
 18 residency?  
 19 A. Right. It was actually a three-year  
 20 internship residency at North Shore University  
 21 Hospital, Cornell Medical Center.  
 22 Q. Okay. New York City?  
 23 A. Long Island and New York City.  
 24 Q. Okay. And after that, you went into  
 25 some training I assume for GI?

1 A. Right. First I did an extra year as  
 2 a chief resident and then did gastroenterology  
 3 training for two years after that.  
 4 Q. Where did you do your GI training?  
 5 A. It was all done at the same  
 6 institution.  
 7 Q. Same institution. Did you have as  
 8 far as GI training any sort of proctors or  
 9 mentors within that program?  
 10 A. Well, there were four full-time  
 11 attendings basically that their primary job was  
 12 to instruct the fellows.  
 13 Q. Have you ever heard of Aaron  
 14 Brzyzanski before this case?  
 15 A. Not before this case.  
 16 Q. Okay. You're familiar with The  
 17 Cleveland Clinic Foundation, though?  
 18 A. Yes.  
 19 Q. Before this case?  
 20 A. Yes.  
 21 Q. Have you ever visited The Cleveland  
 22 Clinic Foundation to give or receive any sort  
 23 of lectures?  
 24 A. No.  
 25 Q. Have you ever referred any patients

1 to The Cleveland Clinic Foundation either in  
 2 Cleveland or down here in Florida?  
 3 A. In Florida.  
 4 Q. And who do you refer patients to at  
 5 the Cleveland Clinic down here in Florida?  
 6 A. Just the department. Nobody in  
 7 particular.  
 8 Q. Which department?  
 9 A. Gastroenterology.  
 10 Q. Okay. How frequently do you refer  
 11 patients to the Cleveland Clinic?  
 12 A. I would say over the five years,  
 13 five-and-a-half years I've been here, I've  
 14 referred two or three patients.  
 15 Q. Any particular reason that you would  
 16 refer those patients instead of caring for them  
 17 yourself?  
 18 A. Basically every once in a while you  
 19 are going to have a patient that is going to  
 20 want a second opinion but they don't want to go  
 21 just to another doctor in town and they will  
 22 ask you, you know, about going to another  
 23 institution. And that's the closest to us. So  
 24 we would recommend that or University of Miami.  
 25 Q. Okay. And you have never been to any

1 lectures at the Cleveland Clinic down here in  
2 Florida?

3 A. No.

4 Q. Have you ever had any privileges  
5 suspended?

6 A. No.

7 Q. Have you ever had your license  
8 suspended?

9 A. No.

10 Q. Have you ever been the subject of any  
11 disciplinary action?

12 A. No.

13 Q. I think you have already answered  
14 this. I know you haven't given a deposition.  
15 But have you ever been sued for malpractice?

16 MR. MISHKIND: Objection.

17 THE WITNESS: Yes.

18 BY MR. KELLEY:

19 Q. Okay. How many times?

20 A. Once.

21 Q. Is that lawsuit pending?

22 A. Yes, it is.

23 Q. Okay. In a very broad general sense,  
24 do you know what the subject of that lawsuit  
25 is?

1 BY MR. KELLEY:

2 Q. Without delving into that lawsuit too  
3 much, if I understand what you just said, the  
4 allegations against a lot of physicians from  
5 different specialties for failing to diagnose  
6 something in a timely manner? Is that the  
7 allegation?

8 A. I don't know about a timely manner.

9 But --

10 Q. I know that's not your position. But  
11 is that what the Plaintiffs are saying?

12 A. I don't believe that their claim said  
13 timely manner. I just think they said failure  
14 to recognize the drug interaction.

15 Q. Okay. You completed your two-year GI  
16 training. Did you do any additional  
17 fellowships or things of that sort afterwards?

18 A. No.

19 Q. Okay. And you sat for your GI boards  
20 and passed them in 1995?

21 A. Correct.

22 Q. Was that your first attempt?

23 A. Yes.

24 Q. Have you stayed current with your  
25 CMEs?

1 A. Yes.

2 MR. MISHKIND: Before you answer the  
3 question, let me do two things. One, let  
4 me pose an objection and, secondly, not  
5 knowing what stage it's at and whether or  
6 not you are, whether it is in litigation  
7 or your deposition has been taken, and  
8 Mr. Kelley would know as well, that you  
9 may or may not want to discuss the details  
10 of that.

11 BY MR. KELLEY:

12 Q. That is why I said in a broad sense I  
13 just want to know what. Did it involve a Peg  
14 tube by any chance?

15 A. I guess in a broad. It involves an  
16 uncommon drug interaction of two medications  
17 that myself or my partners did not prescribe.  
18 However, we were one of many physicians that  
19 were seeing the patient in the hospital and  
20 essentially the lawsuit was against basically  
21 all, it was all treating physicians failing to  
22 recognize this unusual drug interaction.

23 MR. MISHKIND: Let's go off the  
24 record for one second.

25 (Discussion held off the record.)

1 A. Yes.

2 Q. It is my understanding that in this  
3 lawsuit you do not have opinions regarding  
4 polymyositis as it pertains to life expectancy  
5 and quality of life for Mr. Brooks. Is that  
6 fair?

7 A. That's correct.

8 Q. Okay. It is my understanding you  
9 have opinions, though, where you believe the  
10 physicians at the Cleveland Clinic deviated  
11 from the standard of care, correct?

12 A. Correct.

13 Q. What is your definition of standard  
14 of care that you're using in your report?

15 A. I basically use the standard of care  
16 as the appropriate medical care to be given to  
17 a patient based on the physician providing the  
18 care's education, experiences, training and  
19 basically what would be the normal treatment  
20 for a patient presenting with those symptoms  
21 and condition.

22 Q. And then do you have any opinions  
23 regarding causation? And by that, I mean  
24 whether or not timely intervention by a surgeon  
25 or earlier intervention by a surgeon would have

1 affected the outcome in this case.  
 2 A. Yes.  
 3 Q. Okay. You are not a surgeon, though,  
 4 correct?  
 5 A. Correct.  
 6 Q. Have you consulted with any other  
 7 physicians to formulate your opinions?  
 8 A. No, I haven't.  
 9 Q. What have you reviewed as it pertains  
 10 to this case?  
 11 A. I've reviewed the medical records of  
 12 Mr. Brooks, two volumes basically, and multiple  
 13 depositions.  
 14 Q. Do you have any notes?  
 15 MR. MISHKIND: And also you have  
 16 reports from --  
 17 THE WITNESS: Correct. Correct.  
 18 MR. MISHKIND: Depositions. And he  
 19 has got reports too.  
 20 THE WITNESS: A couple of reports  
 21 from experts.  
 22 BY MR. KELLEY:  
 23 Q. Okay. Do you have any notes?  
 24 A. The only notes I have, I just made  
 25 myself a little list here of all the

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

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

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

1 your report of March 22nd to any criticisms  
2 that you have of nursing personnel or any  
3 personnel prior to 2 a.m. on June 5th?  
4 A. Basically I think at the end here  
5 that the care, the patient was clearly below  
6 accepted standards of care -- sorry -- care by  
7 the medical team, essentially meaning, medical  
8 team meaning physicians, nurses. It's  
9 basically I think everybody is kind of covered  
10 under medical team.

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

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

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

20 BY MR. KELLEY:

21 Q. So nothing before midnight, though?

22 A. Correct. In this report, correct.

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

1 A. No.

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

5 A. No.

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

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

13 BY MR. KELLEY:

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

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

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

1 A. Correct.

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

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

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

12 A. That's correct.

13 Q. And when you reviewed this chart  
14 before writing this report on March 22nd of  
15 2000, you reviewed it I assume with a critical  
16 eye?

17 A. Correct.

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

22 A. That is correct.

23 Q. And do you have any notes in the  
24 margins of the depositions or anything like that that  
25 would --

1 not have done?

2 A. Well --

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

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

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

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

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

23 BY MR. KELLEY:

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

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

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

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

15 BY MR. KELLEY:

16 Q. Sure.

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

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

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

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

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

13 Q. Okay. When did this patient start  
14 bleeding?

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

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

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

1 Q. You believe he was in shock by  
2 midnight?

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

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

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

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

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

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

23 A. That's correct.

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

1 saw that, correct?

2 A. Right.

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

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

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

12 A. Yes.

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

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

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

1 A. Well, again, we are -- a dressing  
2 change at 9:45. There is a whole issue there  
3 as to why the dressing was changed. He had  
4 most likely pulled the dressing off which was  
5 evidence of some type of agitation as well.

6 Q. Don't a lot of patients pull on their  
7 Peg tube?

8 A. People, patients pull on their Peg  
9 tube.

10 Q. They don't pull on their Peg tube  
11 because they are bleeding. They pull on their  
12 Peg tube because they have a tube sticking out  
13 of their abdominal wall, correct?

14 A. Some patients do. Also some patients  
15 that are having pain at the site hold the site,  
16 pull the tube as well.

17 Q. Don't most patients tend to push in  
18 the area where there is pain instead of pull?

19 A. No. I think that is very  
20 non-specific. If somebody is having pain and  
21 they look down and they see a tube, they might  
22 think that is what is causing the pain and pull  
23 it out, try to pull it.

24 Q. Could that have caused the bleeding?

25 A. It could have. But very unlikely.

1 Q. Why?

2 A. Because the tube being on the inside  
3 of the stomach has already gone through the,  
4 the tube has gone through the skin into the  
5 stomach. It is a relatively soft tube. And  
6 the sheer force of pulling the tube would be  
7 unlikely to cause bleeding from the blood  
8 vessel that was felt to be pierced and  
9 bleeding. It was, more likely would have been  
10 a direct stick of the needle used to insert the  
11 tube.

12 Q. Was there any evidence of where the  
13 bleeding originated from at the time of  
14 surgery?

15 A. There was just hypothesized in the  
16 note by the surgeon that the gastro epiploic  
17 artery. And it would be more likely that that  
18 occurred at the time of the piercing of the  
19 needle through the skin to help place the tube.

20 Q. When you pierce an artery during the  
21 placement of a Peg tube, aren't there typically  
22 findings that are visible such as a hematoma?

23 A. Not always because it is underneath  
24 the skin. So you would not see that in many.  
25 In most cases, you would not see that.

1 Q. Okay. Would, if the Peg tube pierced  
2 an artery going in, the needle and then the  
3 tube going over that needle, wouldn't there  
4 typically be bleeding into the stomach as well?

5 A. Not always. Again, not even a lot of  
6 the time. We can commonly, we commonly see  
7 instances where you are going to pierce through  
8 organs and not recognize that fact when the  
9 tube is placed. You don't always see bleeding  
10 in the stomach. The bleeding is usually  
11 outside of the stomach in the abdomen.

12 Q. Just so we are clear while we are on  
13 this point, you don't have any criticisms of  
14 the placement of this tube even if it caused  
15 the bleed?

16 A. That's correct.

17 Q. Okay. That's an accepted risk of  
18 this procedure?

19 A. That's correct.

20 Q. The signs and symptoms that you are  
21 relying on to form the opinion that the patient  
22 had a slow, ongoing bleed are the nature of a  
23 Peg tube insertion first?

24 A. Correct.

25 Q. I guess as a foundation, agitation,

1 heart rate and the fact the patient was pulling  
2 on his tube?

3 A. Right. Heart rate increased, blood  
4 pressure decreased and the fact that he was  
5 pulling on his tube, pulling on the dressing.

6 Q. What was his baseline for his heart  
7 rate and blood pressure prior to the placement  
8 of the Peg tube?

9 A. Baseline he had a hypertensive, he  
10 was generally hypertensive previous to the Peg  
11 tube.

12 Q. And what were his vital signs during  
13 the course of the day? We'll say since you put  
14 it on the note from up until 12 p.m., from the  
15 time of the Peg tube placement, until  
16 12:12 a.m?

17 A. His blood pressure was in the  
18 morning, right after the Peg tube placement was  
19 it looks like 158 over 82.

20 Q. Is that hypotensive?

21 A. No, it is not.

22 Q. Is that blood pressure in any way,  
23 shape or form indicative of a bleed or volume  
24 loss?

25 A. No.



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

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

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

1 That could be dangerous and cause  
 2 significant sepsis and infection if they  
 3 pull the tube before a tract can mature.  
 4 So in combination with the patient pulling  
 5 the dressing when it was specifically  
 6 ordered that the dressing not be touched  
 7 for 24 hours, that the patient was  
 8 agitated. Whether the patient had been  
 9 continuously agitated or intermittently  
 10 agitated, there appeared to be some degree  
 11 of agitation going on around from 9  
 12 o'clock at night, 10 o'clock at night, 11  
 13 o'clock where he is pulling at the tube,  
 14 pulling at the dressing, that in  
 15 combination with a mild change in vital  
 16 signs, I would expect that the physicians  
 17 at least be called to say the patient is  
 18 pulling at the tube. If they are agitated  
 19 and you can't really get a history, we  
 20 don't know if it is because they are  
 21 having pain or not and I would think that  
 22 a physician should have been notified to  
 23 come up and evaluate the patient some time  
 24 around the midnight area at the latest.  
 25

1 BY MR. KELLEY:

2 Q. Prior to the midnight hour, should a  
3 physician have been called to see this patient?

4 A. I would say yes. I would say  
5 100 percent at the midnight hour. But I would  
6 say even before when the dressing was changed,  
7 I would think that once the patient had pulled  
8 the dressing off and the nurse has an order not  
9 to change the dressing and something is being  
10 done that is not ordered, it is their  
11 obligation to call the physician and say, "This  
12 is what happened. What should we do?"

13 Q. Regardless of whether it is the fact  
14 that the patient pulled his own dressing off?

15 A. Because I think you have to be  
16 considerate to the fact that is there a reason  
17 why the patient pulled their dressing off.

18 Q. Regardless if it is just  
19 serosanguineous fluids?

20 A. Yes. Regardless of anything that is  
21 external.

22 Q. I would like you to look at the  
23 nursing narrative at 4:30.

24 A. 4:30 p.m.?

25 Q. Yeah.

1 exactly, why was he not happy about his  
2 medical care.

3 BY MR. KELLEY:

4 Q. Okay. Let me phrase it this way. Do  
5 you believe that his anxiety at that point was  
6 related to pain or because he was dissatisfied  
7 with his medical care?

8 MR. MISHKIND: Objection. Go ahead.

9 THE WITNESS: From looking at this  
10 note, he denies pain. So he was not  
11 having pain apparently at that point at  
12 4:30.

13 BY MR. KELLEY:

14 Q. Okay. If he is having a slow bleed  
15 that had started around between 9 and 10 a.m.  
16 when the tube was placed and we are now several  
17 hours out -- we are at 4:30 p.m. -- why is the  
18 patient pain free?

19 A. Well, you don't have to have pain  
20 from the bleed. A lot of the pain can come  
21 from after there is enough blood in the abdomen  
22 causing decreased blood flow to different  
23 organs. If you have collection of blood, like  
24 a hematoma or blood clots, that can cause pain  
25 as well. Just the bleeding itself may not

1 A. Okay. See where it says the patient  
2 denies pain? He is claiming that no one there  
3 knows what they are doing.

4 A. I see it says patient hard to  
5 understand at times.

6 MR. MISHKIND: General weakness.

7 THE WITNESS: General weakness.

8 Something not assessed -- okay. I see.

9 Denies pain.

10 BY MR. KELLEY:

11 Q. Moderate anxiety?

12 A. Moderate anxiety. States no one  
13 knows what they are doing around here.

14 Q. So his anxiety appears to be rather  
15 focused?

16 A. Correct.

17 Q. It is that he is not satisfied with  
18 the quality of medical care he is receiving,  
19 correct?

20 MR. MISHKIND: Objection. You're  
21 asking him to interpret what the nurse --

22 MR. KELLEY: He is interpreting the  
23 chart. That is his role as an expert.

24 THE WITNESS: I think from this I  
25 think it's hard to say what the patient

1 cause pain.

2 Q. Okay. And you see if you read on  
3 that the last line of that note is the patient  
4 is comfortable and lying on back?

5 A. Correct.

6 Q. Okay. At 2145, then, the 9:45 is  
7 when the dressing is changed to the Peg tube,  
8 correct?

9 A. Correct.

10 Q. Do you see any notation that it was  
11 because the patient was in pain?

12 A. No.

13 Q. Do you see any notation that it was  
14 because there was bleeding?

15 A. No.

16 Q. Do you see any evidence that when the  
17 nurse changed the dressing that there was  
18 anything abnormal or unusual that she found?

19 A. No.

20 Q. Do you see in her data charts which  
21 are the graphs with kind of the boxes to check  
22 any evidence that they found any bleeding or  
23 abnormalities in the area of the Peg tube?

24 A. I don't believe so.

25 Q. Do you see that they charted that the

1 abdomen was soft and nontender?

2 MR. MISHKIND: At what time are you  
3 talking about now?

4 MR. KELLEY: During that shift.  
5 During the shift between -- the shift runs  
6 between 1500 and 2300.

7 MR. MISHKIND: But does it indicate  
8 what time that note of soft and --

9 MR. KELLEY: It is for the shift.

10 MR. MISHKIND: Okay. I'm just asking  
11 you--

12 MR. KELLEY: That is all I'm asking.

13 BY MR. KELLEY:

14 Q. Any evidence of that during that  
15 shift?

16 THE WITNESS: Do you have that there?

17 MR. MISHKIND: Yeah. Hold on one  
18 second.

19 THE WITNESS: I don't believe so.

20 (Pause)

21 THE WITNESS: Soft, non-tender up  
22 until I guess through the 11 p.m. shift,  
23 soft non-tender with bowel sounds present.

24 BY MR. KELLEY:

25 Q. And do you see that there was no

1 Q. Okay. What are those criticisms?

2 A. There was similar criticisms that the  
3 patient was again pulling at the tube, pulling  
4 the dressing off and appeared to be in a  
5 somewhat agitated state and not being  
6 reasonable, basically talking about eating  
7 food, and seemed to be confused in that he was  
8 not understanding of the situation. Because if  
9 he was coherent and understanding, he would not  
10 have felt that he wanted to eat food. He would  
11 have understood that the reason why he had the  
12 feeding tube in was because it was not safe for  
13 him to eat food. So it didn't sound like he  
14 had all his wits about him again during that  
15 time period.

16 Q. Okay. Obviously this is a patient  
17 who had mumbled speech?

18 A. Right.

19 Q. During the whole hospitalization?

20 A. Correct.

21 Q. Okay. Do you believe it was good  
22 medicine for the nurse to sit with him for that  
23 extended period of time to try and calm the  
24 patient down and reorient the patient?

25 MR. MISHKIND: Let me object to the

1 nausea or vomiting either?

2 A. Correct.

3 Q. Okay. Assuming that the Peg tube was  
4 changed for, dressing was changed for an  
5 innocuous reason, whether it be the patient  
6 pulled it off, whether it was coming off a  
7 little bit or because there was a little bit of  
8 serosanguineous fluid, do you believe the  
9 standard of care required the GI physician to  
10 be called at 9:45, or is that something that is  
11 optional?

12 A. If it was not because the patient  
13 appeared to be confused and in pain, then I  
14 would say no.

15 Q. Okay. The next note that we have  
16 after that goes to in essence the midnight hour  
17 and the nursing progress note is written at  
18 2455. Do you see that note?

19 A. Yes.

20 Q. Okay. I assume from some of your  
21 discussions and some of the things you have  
22 written you have criticisms of the nursing care  
23 at midnight or between 12 and 1 a.m. in  
24 essence?

25 A. Correct.

1 term extended period of time. I'm not  
2 sure what you mean by that. But go ahead.  
3 BY MR. KELLEY:

4 Q. If the nurse testifies that she sat  
5 with the patient for between a half hour and an  
6 hour after she found him pulling his Peg tube  
7 off or trying to pull on his Peg tube, would  
8 that be good medicine for her to spend that  
9 time with the patient to try to reorient the  
10 patient?

11 MR. MISHKIND: Let me just object  
12 because I'm not certain that that is what  
13 her testimony was. But he can go ahead  
14 and answer the question.

15 THE WITNESS: From what I remember  
16 from the testimony, she apparently did  
17 spend a lot of time with the patient. I  
18 don't remember the exact amount of time.  
19 I think it was very nice. But I think  
20 that she also should have picked up on  
21 some of these other things that why, why  
22 all of a sudden did he need someone to be  
23 there for that amount of time.

24 BY MR. KELLEY:

25 Q. Well, you see she described that he

1 has a moderate amount of anxiety, correct?

2 A. Correct.

3 Q. That he was trying to pull on the Peg  
4 tube?

5 A. Correct.

6 Q. Patient at this point denies any pain  
7 or discomfort?

8 A. Correct.

9 Q. And that she was able to reorient the  
10 patient?

11 A. Again, there, you know, there are  
12 parts in there also about him wanting to eat  
13 food and things like that which just to me  
14 makes it seem like he really wasn't oriented  
15 and understanding of the situation. So you  
16 kind of almost have to take, go more on his  
17 actions than on what he is telling you because  
18 he doesn't really appear to understand at least  
19 definitely 100 percent of what is going on.

20 Q. Now, there is, there's not a sentence  
21 in your report that directly -- and I know that  
22 you and Mr. Mishkind said earlier that there is  
23 a sentence that can be inferred -- what I want  
24 to know is is there a direct sentence in your  
25 report that is critical of the nursing care at

1 describe a deviation from the standard of care?

2 It was only with the testimony?

3 A. Correct.

4 Q. So reading the note on its face  
5 without the deposition testimony, you felt that  
6 the care and treatment at 2455 was okay?

7 A. I just did not address that at all.

8 Q. And you didn't address it at all at a  
9 time that you were being paid to review the  
10 chart with a critical eye?

11 MR. MISHKIND: Objection. It is  
12 argumentative.

13 MR. KELLEY: No.

14 BY MR. KELLEY:

15 Q. I'm saying you were reviewing this  
16 chart with a critical eye to find favorable and  
17 not so favorable things for both sides,  
18 correct?

19 A. Correct.

20 Q. I'm not saying it was a biased  
21 review.

22 A. Correct. Correct.

23 Q. And you didn't find based on your  
24 review of the chart that note which is  
25 approximately 10 lines long, you didn't find

1 12a.m.

2 MR. MISHKIND: Before you -- let me  
3 just make an objection. And then you can  
4 go ahead and answer the question. And I'm  
5 not -- my objection is not going to in any  
6 way impact his testimony. I just want the  
7 record to reflect that the doctor has just  
8 received recently, like within the last  
9 two weeks, the deposition testimony and  
10 has not, therefore, written any  
11 supplemental report based upon that.

12 MR. KELLEY: That's not a problem.

13 MR. MISHKIND: But he can go ahead  
14 and answer the question.

15 MR. KELLEY: I'm going to clarify  
16 that.

17 THE WITNESS: That is exactly what I  
18 was going to say. Basically that the  
19 depositions specifically of the nurses and  
20 the residents were basically just read  
21 over the past week or 10 days.

22 BY MR. KELLEY:

23 Q. So the note in and of itself without  
24 the depositions didn't warrant a sentence in  
25 your report where you would specifically

1 any reason to add that to your report?

2 MR. MISHKIND: Let me object because  
3 he has already testified that the care  
4 provided during the early morning hours --  
5 and I'm not sure whether that is what he  
6 is referencing or not.

7 MR. KELLEY: Well, he can tell us  
8 what he is referencing.

9 MR. MISHKIND: Sure. I just don't  
10 want the record to inaccurately reflect  
11 what he has testified.

12 MR. KELLEY: No. You objected and  
13 stated that twice so far tonight.

14 MR. MISHKIND: Okay. I might even do  
15 it a third time.

16 MR. KELLEY: A third time. And I  
17 welcome it.

18 MR. MISHKIND: I appreciate that.

19 THE WITNESS: I did not specifically  
20 in this note concentrate on putting  
21 details of every single criticism and the  
22 exact times and dates, time in the note.  
23 Basically instead of -- actually, if I  
24 remember correctly, I think I had not  
25 written a report after initially reviewing

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

8 BY MR. KELLEY:

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

13 A. Correct.

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

17 A. 12 a.m., correct.

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

21 MR. MISHKIND: Objection. Go ahead.

22 BY MR. KELLEY:

23 Q. -- before 2 a.m.?

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

1 deposition was just something that triggered my  
2 attention.

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

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

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

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

20 MR. KELLEY: I never asked that  
21 question.

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

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

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

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

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

16 A. Okay.

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

20 A. Correct.

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

25 A. Again, just reading through the

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

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

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

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

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

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

21 MR. MISHKIND: I will.

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

24 BY MR. KELLEY:

25 Q. Do you agree with me that a

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

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

7 MR. KELLEY: Him, Dr. Eisner.

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

21 BY MR. KELLEY:

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

24 MR. MISHKIND: Objection.

25 THE WITNESS: It includes a general

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

4 MR. MISHKIND: Objection.

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

12 BY MR. KELLEY:

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

16 A. Correct. I believe that that was  
17 24 -- I don't know what 2455 meant.

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

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

24 BY MR. KELLEY:

25 Q. 1 a.m.

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

7 BY MR. KELLEY:

8 Q. What should the nurse have done?

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

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

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

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

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

25 Q. Okay. And looking at the general

1 A. Correct.

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

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

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

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

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

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

12 A. Correct.

13 Q. And are we using anxiety and  
14 agitation interchangeably?

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

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

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

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

25 A. Well, if there was evidence of

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

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

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

10 Q. Why would do you an EKG?

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

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

25 A. Correct.

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

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

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

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

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

23 A. Yes.

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

1 A. Yes.

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

4 A. Apparently, yes.

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

7 A. Correct.

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

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

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

24 A. Correct.

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

1 patient down or reorient a patient if their  
2 dementia or disorientation was secondary to a  
3 bleed, would you?

4 A. Well, if they are just not saying  
5 anything and they are kind of just out of it,  
6 you could.

7 Q. Does that chart give you that  
8 picture, though, in fairness?

9 A. No. But it doesn't really give you a  
10 great picture at all.

11 Q. There should be more information you  
12 believe in that note?

13 A. No. I'm just saying I don't think  
14 you can tell 100 percent that, you know, I  
15 think you're also doing a lot of inferring into  
16 what she is writing down.

17 Q. Well, my, I'm just trying to get an  
18 understanding of -- and we will call it a  
19 hypothetical so we're fair to both sides -- if  
20 she was able to calm this patient down,  
21 reorient this patient, that's not something  
22 that she would be able to do if the symptoms  
23 were caused by the bleed, correct, typically?

24 A. I would say no.

25 Q. Okay. If we assume that she was able

1 BY MR. KELLEY:

2 Q. Well, you don't restrain a patient  
3 who pulls on a Peg tube once, do you?

4 A. No. But you do restrain patients who  
5 have pulled out IVs and have showed agitation.  
6 Because if they pull on it once, they can pull  
7 it out and cause the tract to close.

8 Q. Is that restraining a patient a last  
9 resort, especially a patient with a cardiac  
10 history?

11 A. Well, it's -- I wouldn't say it is a  
12 last resort. But in someone that has a fresh  
13 Peg tube in, it's, the standard of care is to  
14 try to do everything you can to prevent them  
15 from pulling out the tube, and soft wrist  
16 restraints is really not contraindicated to  
17 someone just because they have a cardiac  
18 history.

19 Q. Anxiety, though, can be a problem for  
20 a patient who has a cardiac history, correct?

21 A. Correct.

22 Q. And restraining someone's ability to  
23 move even with soft restraints because the  
24 theory is it prevents him from getting access  
25 to his abdomen, right? --

1 to reorient the patient, knowing the patient's  
2 history of having agitation for 24 to 48 hours  
3 at least beforehand, knowing the fact that the  
4 patient has been somewhat for lack of a better  
5 term angry with his medical providers -- you  
6 saw from the note earlier he is dissatisfied --

7 A. Correct.

8 Q. -- do you agree that it is reasonable  
9 that these signs and symptoms that you see here  
10 or that the Peg tube, pulling on the Peg tube  
11 may have in fact caused this bleed?

12 MR. MISHKIND: Objection.

13 BY MR. KELLEY:

14 Q. Has that become a reasonable  
15 possibility?

16 MR. MISHKIND: Objection.

17 THE WITNESS: I think it's possible,  
18 but I think it is unlikely. And I think  
19 that if it did it would probably even be,  
20 they would have a big fault because one of  
21 the faults is also someone if they were  
22 concerned that he was agitated and  
23 whatnot, is this somebody who should have  
24 been restrained so as not to pull on the  
25 tube?

1 A. Right.

2 Q. -- that can cause anxiety, right?

3 MR. MISHKIND: Objection.

4 THE WITNESS: It can.

5 BY MR. KELLEY:

6 Q. It wouldn't be your first step if a  
7 patient pulled on a Peg tube one time, would  
8 it?

9 MR. MISHKIND: Objection. I think he  
10 has already said --

11 THE WITNESS: If he had shown  
12 evidence of pulling on other things, I  
13 would say yes.

14 BY MR. KELLEY:

15 Q. What else has he pulled on?

16 A. I believe it was the morning of or  
17 the night before he had pulled out his IV, and  
18 if he is showing evidence of agitation, then  
19 that is something you want to pay attention to  
20 and you don't want them to pull it out. I  
21 don't think that in my opinion that with him  
22 pulling the tube caused the bleed, but if it  
23 did, then I think that that is something that  
24 should have been prevented.

25 Q. When he pulled on his IV, did he pull



1 it out because he was bleeding or in pain?

2 A. I'm not sure why he exactly pulled it  
3 out.

4 Q. You are really not sure why he pulled  
5 on his Peg tube either, are you?

6 A. No.

7 Q. Now, the next note is at 2:20. And  
8 it is the patient complains of overall pain,  
9 pain medication Percocet given.

10 A. Correct.

11 Q. Do you see that?

12 A. Yes.

13 Q. And then 2:25 patient complains of  
14 pain, holding chest, anxious, short of breath,  
15 taking clothes off.

16 A. Correct.

17 Q. Now, in your note, your letter, you  
18 had the time at 2 a.m. In looking at the chart  
19 with me, you will agree that it was actually  
20 between 2:20 and 2:25 that these symptoms  
21 started, correct?

22 MR. MISHKIND: Let me object that I  
23 think the reference is, Dr. Stanisic's  
24 reference is at 2 o'clock.

25 THE WITNESS: The resident's note was

1 Q. And you have had a chance to see  
2 Dr. Lisgaris' deposition?

3 A. Saying that she was there.

4 Q. That she came some time thereafter,  
5 correct?

6 A. Correct.

7 Q. And you can see, can you not, from  
8 several of the things that were ordered  
9 including blood work -- I think at 2:45 it was  
10 drawn --

11 A. Correct.

12 Q. -- the typing and crossing which was  
13 ordered at 3 a.m.?

14 MR. MISHKIND: Let me object because  
15 I'm not -- I'm not sure that they typed  
16 and cross matched.

17 THE WITNESS: I saw it typed.

18 MR. MISHKIND: I don't think that  
19 there was a cross match.

20 BY MR. KELLEY:

21 Q. The typing at 3 a.m.

22 A. Correct.

23 Q. That there were physicians present  
24 doing things prior to 3 a.m.?

25 A. That's correct.

1 written when he arrived at 3:15 the  
2 patient was having chest pain at 2  
3 o'clock. And this is the nursing note.  
4 She wrote here 2:20. I don't know if she  
5 wrote the note at 2:20. But, yeah, from  
6 looking at this sheet, 2:20 was when she  
7 wrote this down, patient complained of  
8 pain. Pain --

9 BY MR. KELLEY:

10 Q. We know he wasn't holding his chest,  
11 anxious, short of breath prior to 2:20 because  
12 she has a separate note for 2:20, correct?

13 A. That's correct.

14 Q. So really that's at least we will say  
15 between 2:20 and 2:25 that he develops this  
16 chest pain?

17 A. Correct.

18 Q. Now, do you see that she paged the  
19 resident, Dr. Goldman?

20 A. At that point, just looking at this,  
21 I wasn't sure if he was the intern or resident  
22 or whatnot. Correct.

23 Q. Okay. And Dr. Goldman was there it  
24 looks like at least within the same note?

25 A. Correct.

1 Q. Okay. So you agree now, do you not,  
2 that there at least was a resident present  
3 before 3:15 a.m.? Correct?

4 A. Correct.

5 Q. You realized that it was the MICU  
6 resident who didn't get there until 3:15?

7 A. That's correct.

8 Q. Okay. Do you have any criticisms of  
9 the timeliness of the nurse contacting  
10 Dr. Goldman or Dr. Goldman getting in touch  
11 with Dr. Lisgaris?

12 MR. MISHKIND: Let me just object.  
13 Assuming that there shouldn't have been  
14 contact before that time?

15 MR. KELLEY: Yeah. Assuming no  
16 contact before 2:25.

17 THE WITNESS: Okay. That was an  
18 appropriate thing to do.

19 BY MR. KELLEY:

20 Q. Okay. And you have seen  
21 Dr. Lisgaris' deposition where she attempted to  
22 contact surgery but they weren't able to get  
23 the x-ray films because of other patient needs  
24 within the hospital?

25 MR. MISHKIND: Let me object.

1 THE WITNESS: Right. That is what  
 2 she says; she contacted them.  
 3 MR. KELLEY: Let me just finish  
 4 before you object.  
 5 MR. MISHKIND: Sure. Too late. I  
 6 already objected.  
 7 MR. KELLEY: I know.  
 8 BY MR. KELLEY:  
 9 Q. And that she then went and sought  
 10 assistance from the MICU? You saw that in her  
 11 depo, correct?  
 12 A. Yes.  
 13 Q. Do you believe that that was a  
 14 reasonable course for her to take to contact  
 15 surgery, realized that they couldn't get the  
 16 radiology tests and then contacted the MICU?  
 17 MR. MISHKIND: Let me object because  
 18 the record -- I'm not sure that her  
 19 testimony is supported by the evidence in  
 20 this case. You are asking hypothetically  
 21 if one believes that Dr. Lisgaris  
 22 contacted --  
 23 MR. KELLEY: I'm just saying her  
 24 testimony --  
 25 THE WITNESS: If she contacted the

1 surgeon at 3:15 or around there, then I  
 2 think that that was appropriate what she  
 3 did. But from reading some of the other  
 4 depositions, I have a question as to  
 5 whether a surgeon wasn't contacted until I  
 6 think 5:30.  
 7 BY MR. KELLEY:  
 8 Q. We know surgery never got there until  
 9 5:30?  
 10 A. Correct.  
 11 Q. But you saw where Dr. Lisgaris  
 12 described that she called back to say that,  
 13 assuming she is being truthful, that they  
 14 couldn't get the KUB or the CT scan?  
 15 A. Correct.  
 16 THE STENOGRAPHER: Excuse me. I need  
 17 to change paper.  
 18 (Thereupon, a recess was held.)  
 19 BY MR. KELLEY:  
 20 Q. What I want to do now is talk about  
 21 2:25 going forward.  
 22 A. Okay.  
 23 Q. Okay. You obviously completed your  
 24 residency, you completed two residencies in  
 25 internal medicine, then also in GI?

1 A. Yes.  
 2 Q. Did you staff a hospital during the  
 3 evening hours as a resident?  
 4 A. For residency, yes.  
 5 Q. And there is nothing abnormal about  
 6 residents being the ones inhouse during the  
 7 evening hours, correct?  
 8 A. No, correct.  
 9 Q. You don't have any criticisms of the  
 10 fact that residents were involved in the care  
 11 and treatment here, do you?  
 12 A. No.  
 13 Q. Have you had occasion during your  
 14 residency or even since if you have been  
 15 covering a hospital during the evening to be  
 16 paged in the middle of the night for an  
 17 emergency?  
 18 A. Yes.  
 19 Q. Okay. Is it more difficult to get  
 20 things accomplished at 2 a.m. than 2 p.m. on  
 21 average?  
 22 A. Certain things are more difficult.  
 23 Certain things are not.  
 24 Q. Give me an idea of some of the things  
 25 that are easier or the same versus more

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

1 be more difficult during the night.  
 2 Q. Okay. At 2:25 a.m., were you the  
 3 individual called, if you were the person there  
 4 to evaluate this patient, what sort of things  
 5 would have been on your differential diagnosis?

6 A. I think at that point when you see  
 7 the patient hypotensive, having initially pain  
 8 in, I think they said total body pain, even  
 9 though he is holding his chest. But then they  
 10 said he denied chest pain. Again, you are  
 11 worried about a cardiac event. So you get an  
 12 EKG first to see if the patient is having a  
 13 heart attack. You are worried about volume  
 14 depletion. So you are going to draw blood and  
 15 see if there is any abnormalities in the blood  
 16 count. Is the hemoglobin low?

17 You are worried about infection,  
 18 sepsis. You are going to look at the white  
 19 blood cell count. With hypotension, you are  
 20 worried about bleeding. You are worried about  
 21 initially is the blood pressure low because the  
 22 patient got Percocet and is it from the  
 23 Percocet being low.

24 That would give two things because it  
 25 would give a reason for pain not causing the

1 A. Correct.

2 Q. The fact that he was short of breath,  
 3 correct?

4 A. Correct.

5 Q. I know some of these may go in  
 6 multiple columns because they are not  
 7 pathopneumonic to one thing or another. But  
 8 the fact that he was anxious could be  
 9 consistent with a heart attack too, correct?

10 A. Correct.

11 Q. The description of all over body pain  
 12 can be consistent with a heart attack, can't  
 13 it?

14 A. Sure.

15 Q. The heart rate and blood pressure  
 16 could be consistent with a cardiac event,  
 17 correct?

18 A. Correct.

19 Q. It would be contraindicated to do an  
 20 exploratory surgery on a patient who could be  
 21 having an MI, correct?

22 A. Correct. Unless the reason why they  
 23 were having the MI was because of the --

24 Q. The bleed?

25 A. Correct. They were losing blood. It

1 blood pressure which we usually don't like to  
 2 give two different diagnoses. But that would  
 3 be another possibility to explain the  
 4 significant drop in blood pressure at that  
 5 time.

6 Q. Okay. So there would be -- I'm not  
 7 putting these in any particular order. Just  
 8 how I was trying to write them as you went  
 9 in -- you would have in your mind could the  
 10 vital signs be accounted for based on a  
 11 pharmacologic reason, that being Percocet,  
 12 could there be bleeding, could it be cardiac,  
 13 could it be volume, which seems like it would  
 14 overlap with bleeding, correct? --

15 A. Correct.

16 Q. --or sepsis?

17 A. Correct.

18 Q. Okay. Let's start with cardiac. The  
 19 fact that the patient had a history, one would  
 20 be relevant, correct?

21 A. Correct.

22 Q. The fact that he was clutching his  
 23 chest even though he denied chest pain would be  
 24 indicative of something perhaps cardiac,  
 25 correct?

1 is easy enough to rule out a cardiac event by  
 2 getting a quick EKG and listening to the heart  
 3 and lungs and whatnot.

4 Q. With volume -- shall we put a volume  
 5 and bleeding together?

6 A. That's fine.

7 Q. Okay. Is chest pain or clutching  
 8 one's chest consistent with bleeding into --  
 9 you're talking about blood in the abdomen,  
 10 correct?

11 A. Correct.

12 Q. Would clutching one's chest be  
 13 consistent with bleeding into the abdomen?

14 A. Well, again, if the hemoglobin has  
 15 dropped low enough to cause a decreased cardiac  
 16 output, then you can get chest pain as a result  
 17 of that.

18 Q. How low would the hemoglobin have to  
 19 be to create chest pain?

20 A. It really wouldn't be a specific  
 21 number as opposed to a time factor. In other  
 22 words, I believe his hemoglobin was 9 which can  
 23 be a lot of people walking around with a  
 24 hemoglobin of 9. If their hemoglobin has  
 25 dropped from 14 to 9 over a year or even over a

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

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

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

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

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

25 Q. Hemoglobin.

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

4 (Pause)

5 A. His hematocrit at 1:52 p.m. was 39  
 6 with a hemoglobin of 13.3 and then at  
 7 3:08 a.m. -- so over 12, 13 hours -- his  
 8 hemoglobin had dropped from 13.3 to 8.6. So  
 9 that's the five -- the hemoglobin goes up one  
 10 with each unit. The hematocrit goes up three  
 11 with each unit. The hematocrit drops from 39  
 12 to 24 and a half. So, again, a third.

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

15 A. Correct. 1:47.

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

19 A. Correct.

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

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

1 A. From 14 to 9.

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

4 A. Correct.

5 Q. And how many are in the body?

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

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

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

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

17 A. No. Those are calculated numbers.

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

21 A. On a hematocrit.

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

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

1 normal.

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

4 A. Correct.

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

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

11 Q. Low blood pressure?

12 A. -- low blood pressure.

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

15 A. Correct.

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

20 A. Correct.

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

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

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

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

9 MR. KELLEY: 2:45. It comes back at  
10 2:56.

11 THE WITNESS: I didn't see that in  
12 the lab section here. Here we go. 2:45  
13 was when they drew the blood gas because  
14 of the respiratory rate which was also a  
15 reasonable thing to do. That is where the  
16 9.1 was.

17 MR. MISHKIND: What is that?

18 MR. KELLEY: Those are pages that  
19 clearly demonstrate there was no  
20 negligence in the case. Those are also  
21 pages that clearly demonstrate there was  
22 no negligence in the case.

23 MR. MISHKIND: We had this  
24 conversation before.

25 (Laughter)

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

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

14 A. Correct.

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

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

21 MR. KELLEY: Right.

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

1 MR. KELLEY: Off the record.

2 (Discussion held off the record.)

3 BY MR. KELLEY:

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

6 A. Correct.

7 Q. Anything else?

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

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

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

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

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

6 BY MR. KELLEY:

7 Q. Okay.

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

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

12 MR. MISHKIND: 2:45 and 3.

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

15 THE WITNESS: Correct.

16 BY MR. KELLEY:

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

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

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

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

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

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

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

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

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

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

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

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

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

16 Q. By 4:30?

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

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

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

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

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

6 THE WITNESS: Correct.

7 BY MR. KELLEY:

8 Q. When does this patient get to  
9 surgery?

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

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

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

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

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

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

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

14 BY MR. KELLEY:

15 Q. Okay.

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

18 Q. Starting from that point.

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

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

1 A. Correct.

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

4 A. Correct.

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

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

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

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

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

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

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

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

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

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

5 A. Right. Where were you reading from?

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

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

12 (Pause)

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

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

4 MR. MISHKIND: Supposedly.

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

15 BY MR. KELLEY:

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

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

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

24 A. Yes.

25 Q. The risk is a hemolytic reaction?

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

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

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

20 Q. Now, did you see in his deposition  
21 where he said that this note was written around  
22 5 a.m.?

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

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

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

6 A. Correct.

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

9 A. No.

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

14 ^A. Correct.

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

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

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

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

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

8 A. Correct.

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

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

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

25 A. Correct.



1 Q. And that the purpose of that is to  
2 increase the volume, to try to benefit the  
3 profusion, correct?

4 A. Correct. Although the standard is  
5 losing blood you really have to replace with  
6 blood better than with fluids. But that was --

7 Q. 8.6 and 9.1 for hemoglobin, that is  
8 not a critically low hemoglobin, correct?

9 A. I think we discussed that already.

10 MR. MISHKIND: I'm going to object.  
11 It has been asked and answered.

12 THE WITNESS: You don't look at an  
13 isolated value as the change.

14 BY MR. KELLEY:

15 Q. Is that number nonconductive with  
16 life?

17 A. Again, we discussed as well. I'll  
18 say no.

19 Q. Okay. The arrest which occurred  
20 first at 4:10 a.m., you saw the code sheet?

21 A. Yes.

22 Q. Okay. Do you believe that to be a  
23 cardiac, cardiorespiratory or simply a  
24 respiratory arrest?

25 A. Again, there is a lot of confusion

1 brought up in the depositions as well. But  
2 forgetting about the depositions and just  
3 looking at the note, Number 1, it clearly says  
4 cardiac arrest, no; respiratory arrest, yes, as  
5 opposed to the second code which is listed as a  
6 cardiac arrest and then looking just to see  
7 where they may put it on the first code, the  
8 second code is under significant events, they  
9 list CPR. There is no evidence under  
10 significant events in the first code that CPR  
11 was performed.

12 So if it was a cardiac arrest and CPR  
13 was not performed, then that would be below the  
14 standard of care. But there is nothing to  
15 suspect from the code sheet or the notes and  
16 from some of the physicians' depositions that  
17 that occurred. It seems that what occurred was  
18 that this was a respiratory arrest first code  
19 and second code of cardiac arrest.

20 Q. What was the patient's blood pressure  
21 from 4:10 a.m. to 4:22?

22 A. It is listed as unable.

23 Q. So they were unable to trace any sort  
24 of blood pressure during that time?

25 A. Correct.

1 Q. And how do you define a cardiac  
2 arrest?

3 A. A cardiac arrest basically is when  
4 the heart stops pumping. Now, you can have  
5 what we call a dissociation between the heart  
6 and the blood system or you can have a heart  
7 rate without any pumping of blood. That would  
8 be a cardiac arrest. But there are, it is very  
9 difficult in blood pressure listed usually  
10 during a code before more significant  
11 monitoring.

12 In other words, if a patient had an  
13 arterial line in the groin or wherever they are  
14 going to put it, monitoring the blood  
15 pressures, then you can say for sure what the  
16 blood pressure was. It is very difficult to  
17 auscultate a blood pressure sometimes if the  
18 blood pressure is very low. And just because  
19 it's unable doesn't mean that it's not there.  
20 And, again, the major thing in addition to that  
21 would be that there was no evidence that any  
22 CPR was performed.

23 Q. When it says in the nurse's note  
24 decreased mental status, unresponsive, triple  
25 initiated patient and then it shows that the

1 patient is transferred to the ICU, what does it  
2 mean when it says triple initiated?

3 A. I'm not sure what triple means.

4 Q. If triple included CPR, would that  
5 change your opinion as to --

6 A. 2:25 --

7 MR. MISHKIND: No. The testimony in  
8 the case was that was -- she did not time  
9 it. And I think this is at the time --

10 MR. KELLEY: That the patient was  
11 transferred to the ICU.

12 MR. MISHKIND: Right. Which would be  
13 in between the two codes. So I'm not  
14 sure, in fairness to the doctor, I'm not  
15 sure whether we can correlate that. In  
16 fact, if anything, it would correlate to  
17 the second.

18 MR. KELLEY: The timing issue is  
19 aside.

20 THE WITNESS: If triple means CPR,  
21 then at some point CPR was administered.

22 BY MR. KELLEY:

23 Q. Have you ever heard of a double or a  
24 triple in terms of codes?

25 A. No.

1 Q. Okay. What is epinephrine given for?

2 A. Usually to patients that do not have  
3 a heart rate to stimulate the heart.

4 Q. Any respiratory benefit?

5 A. No.

6 Q. What about Atropine?

7 A. Again, to speed up the heart if there  
8 is a heart rate present.

9 Q. And you see that this patient in the  
10 first code was given epinephrine --

11 A. Correct.

12 Q. -- and was given Atropine?

13 A. Correct.

14 Q. And the sole purpose of those are to  
15 pharmacologically stimulate heart function,  
16 correct?

17 A. Correct.

18 Q. Truly there is two ways you can,  
19 there is multiple ways you can get someone's  
20 heart back in rhythm. Pharmacologic, right?

21 A. Correct.

22 Q. You can use electrical paddles that  
23 we have all seen several times on TV. You have  
24 seen it in real life, correct?

25 A. Correct.

1 Q. Or chest compressions with someone's  
2 hands, correct?

3 A. Well, but a standard of a code is to  
4 continuously be giving chest compressions to  
5 facilitate, you know, circulation of the blood.

6 Q. And what is a CVP?

7 A. It's basically central venous  
8 pressure.

9 Q. And what is that for?

10 A. Like basically just to get access.

11 It's a large bore -- CVP is basically a line.  
12 CVP stands for central venous pressure. But  
13 reading it in the context here, CVP inserted,  
14 it is basically a large bore IV to be able to  
15 give medications and fluids through more  
16 rapidly.

17 Q. Is that also a method that would  
18 allow you to measure blood pressure?

19 A. Well, that measures -- no. A CVP  
20 line would not measure blood. It measures  
21 venous pressures which are not ...

22 Q. And you see that throughout this the  
23 saline is wide open, correct?

24 A. Correct.

25 Q. Do you believe that the patient

1 following 4, the events of 4:10 to 4:25 we'll

2 say -- let me just start over. Following that

3 first code from 4:10, had this patient been  
4 taken to surgery and survived as you allege the  
5 patient should have been, would the patient  
6 have had any residual brain damage?

7 A. I think at this point in reviewing  
8 through the code sheet, the patient had a heart  
9 rate throughout the whole code. I think -- I  
10 don't think that I would be able to say if  
11 there would have been any residual brain  
12 damage.

13 Q. You can't say yes; you can't say no?

14 A. Correct. If I -- again, I think it  
15 would be more likely that he would not have.  
16 But at this point just from looking through  
17 this code sheet, I think it's not clear to me  
18 of the damage that was done to the patient  
19 during those, during those 20 minutes.

20 Q. Okay. Let me make sure because you  
21 added to that more likely than not. Do you  
22 have an opinion based on your training and your  
23 experience that the patient would not have been  
24 impaired neurologically or cognitively  
25 following the first code or is that outside

1 your specialty?

2 MR. MISHKIND: More likely than not.

3 MR. KELLEY: More likely than not.

4 THE WITNESS: I would say in my  
5 opinion but, again, as a caveat that that  
6 would be outside my specialty. So you are  
7 asking my opinion. I would say my  
8 opinion --

9 BY MR. KELLEY:

10 Q. I understand.

11 A. I don't make myself to be a  
12 neurologist in assessing brain function after  
13 codes.

14 Q. Okay. Just so I understand, you  
15 don't believe you're qualified to render that  
16 opinion in a courtroom?

17 A. Correct.

18 Q. Okay. And no disrespect meant by  
19 that. Just the fact that there is different  
20 specialties. What about the code at 4:50? Do

21 you believe that the patient following that  
22 code, do you have an opinion based on your  
23 education, your training and experience as to

24 whether or not that patient to a probability

25 would have suffered brain damage or neurologic

1 deficits following that event or is that  
2 outside your specialty?

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

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

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

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

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

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

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

25 But I don't think that a CT scan

1 should have been said, "All right. It is 3:15,  
2 4 o'clock, 5 o'clock in the morning. We get a  
3 CT scan at 9 o'clock in the morning and see  
4 what that shows and then maybe take the patient  
5 to surgery."

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

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

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

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

3 BY MR. KELLEY:

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

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

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

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

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

21 A. Yes. There were various degrees of  
22 shock. At one point, the blood pressure was  
23 76. At one point, at 3 o'clock the blood  
24 pressure -- I don't know if it is 109. At  
25 3:15, it was 120. So there are -- it's not

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

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

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

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

1 the blood should be given at that point right  
 2 away.

3 You don't know what is going to  
 4 happen. I said the blood pressure reading at  
 5 3:15 was 120. But you didn't know that. I  
 6 think at 2:25, you have the decrease in  
 7 hemoglobin, a marked decrease in hemoglobin,  
 8 the low blood volume. That is when the patient  
 9 should have been given typed blood.

10 Q. We don't even get the type back until  
 11 3.

12 A. Right. 3:08.

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

16 A. Correct.

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

21 A. Correct.

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

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

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

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

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

18 A. I don't understand the question.

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

21 BY MR. KELLEY:

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

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

1 80 over 50. At 3:30 it was 87 over 60. At  
 2 3:35 it was 85. At 3:50 it was 83. I think at  
 3 that 3:25 when the blood pressure is 80, that's  
 4 when I would have given the unmatched blood.

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

7 A. Yes.

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

11 MR. MISHKIND: Objection.

12 THE WITNESS: Correct.

13 BY MR. KELLEY:

14 Q. Especially a patient with low  
 15 reserves?

16 A. Correct.

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

19 A. Correct.

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

1 MR. MISHKIND: And the blood.

2 THE WITNESS: And the blood.

3 BY MR. KELLEY:

4 Q. And the blood. Anything else?

5 A. No.

6 Q. Okay. What about once the surgeons  
7 were consulted and then got there? Any  
8 criticisms after that?

9 A. Yes. Because I believe -- they came  
10 at 5:30.

11 MR. MISHKIND: They were contacted at  
12 5:30. I think the testimony was that the  
13 resident was there at about 6 o'clock.

14 MR. KELLEY: About 6 a.m.

15 THE WITNESS: I think that once they  
16 were there and evaluated the patient I  
17 think it was -- I forget his name, the  
18 resident, the surgical resident. It  
19 didn't appear to me that he was  
20 100 percent on board as to the diagnosis  
21 and what needed to be done. He mentioned  
22 something about considering an endoscopy.  
23 I think that was an inappropriate decision  
24 on his part. He also wanted to get a CAT  
25 scan and whatnot, which I don't think was

1 surgeons -- and I will say that I will

2 defer some of that decision to surgeons.

3 However, as a gastroenterologist taking

4 care of patients that I know -- in other

5 words, if a patient is bleeding from

6 within the stomach, we can do things. We

7 can do an endoscopy, go through the scope

8 and do things to stop the bleeding. If

9 there is nothing I can do to stop the

10 bleeding, I have to rely on the surgeons.

11 I can't take the patient to surgery. So,

12 you know, these are things that we

13 encounter all the time, and I think at

14 this point this was clearly not something

15 that could be treated medically or even

16 conservatively and the patient needed to

17 go to surgery.

18 BY MR. KELLEY:

19 Q. When did the patient stop bleeding?

20 A. I don't think we know for sure when

21 the patient did stop bleeding. I know by the

22 time the patient was operated on about 11

23 o'clock that there was a lot of blood in there

24 and blood had clotted off. I'm not exactly

25 sure when the patient had stopped bleeding. I

1 necessary to do. And he wrote in his note

2 probable exploratory lap this a.m. That

3 should have been exploratory lap ASAP.

4 BY MR. KELLEY:

5 Q. So the surgical resident, even when  
6 he arrived, you can tell from the notes wasn't  
7 told that this was an immediate surgical  
8 situation?

9 MR. MISHKIND: Objection to the form  
10 of the question. But go ahead.

11 THE WITNESS: I think that he did  
12 not, I think he was very blase as to  
13 taking action. And then the surgical  
14 attending in the note, again, writes may  
15 need to repeat EGD which is not, which was  
16 inappropriate. There was something  
17 mentioned in one of the depositions about  
18 the surgical resident, surgical attending  
19 talking about not taking the patient to  
20 surgery until other cases were done. In  
21 other words, when you have an emergency,  
22 things have to be put off at times. And I  
23 just don't think that they took quick  
24 enough action. Even once the surgeons  
25 were consulted, I don't think the

1 would defer that to a surgeon.

2 Q. Okay. Do you agree that the patient

3 was not actively bleeding at the time of

4 surgery, though?

5 A. Correct.

6 Q. Any other criticisms that you have

7 that we haven't talked about?

8 (Pause)

9 A. No.

10 Q. Okay. As it pertains to proximate

11 causation, do you have an opinion as to what

12 moment in time was the last period of time that

13 surgery could have intervened or that blood

14 could have been given and that Mr. Brooks'

15 outcome would have been different?

16 MR. MISHKIND: To a reasonable degree  
17 of probability?

18 MR. KELLEY: To a probability.

19 THE WITNESS: I think that the blood

20 which was initially given at 4:40 should

21 have been given an hour earlier. That

22 would have increased his chances of

23 survivability if it would have been given

24 earlier. However, if the major thing he

25 needed was surgery -- I think surgery

1 ended up being done at 10:45 -- I would  
 2 say, again, I would defer the details of  
 3 that to a surgeon. But I would say  
 4 looking at the numbers -- where do we have  
 5 the vital signs for the next morning?  
 6 (Pause)  
 7 MR. KELLEY: You want the vitals for  
 8 the next --  
 9 MR. MISHKIND: Yeah. I've got it.  
 10 (Pause)  
 11 MR. MISHKIND: Off the record.  
 12 (Discussion held off the record.)  
 13 BY MR. KELLEY:  
 14 Q. When was the last chance for  
 15 intervention? You said the blood needed to be  
 16 there an hour earlier.  
 17 A. Right.  
 18 Q. And surgery needed to be there to  
 19 have altered the outcome?  
 20 A. When he actually should have been  
 21 taken to surgery?  
 22 Q. Yeah.  
 23 A. As opposed to the surgeon coming?  
 24 Q. Yeah.  
 25 A. I would say somewhere by 8 and 9

1 o'clock.  
 2 Q. A.m.?  
 3 A. Yes.  
 4 Q. Do you know Moises Jacobs?  
 5 A. No.  
 6 Q. The other experts in this case,  
 7 Dr. Dineen, do you know Dr. Dineen?  
 8 A. No.  
 9 Q. Dr. Nearman?  
 10 A. No. I know who they are from this.  
 11 Q. From this case. But that's the  
 12 extent of your knowledge?  
 13 A. Yes.  
 14 Q. You haven't talked to any of the  
 15 other experts in regards to this?  
 16 A. Correct.  
 17 Q. Is there anything else that you  
 18 reviewed in preparation for today or of your  
 19 report that we haven't talked about?  
 20 A. No.  
 21 MR. KELLEY: I don't have anything  
 22 further. Thanks a lot.  
 23 MR. MISHKIND: Okay. We will read  
 24 the deposition. And we can go off the  
 25 record.

1 (Discussion held off the record.)  
 2 THE STENOGRAPHER: Are you ordering  
 3 the transcript?  
 4 MR. KELLEY: Yes, I am ordering the  
 5 transcript.  
 6 MR. MISHKIND: And I need a copy. We  
 7 both need it by Tuesday.  
 8 MR. KELLEY: Yes.  
 9 (Witness excused.)  
 10 (Thereupon, the deposition was  
 11 concluded at 9:05 p.m.)  
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1 THE STATE OF FLORIDA  
 2 COUNTY OF PALM BEACH COUNTY.

3  
 4 I, the undersigned authority, certify  
 5 that the aforementioned witness personally  
 6 appeared before me and was duly sworn.  
 7

8 WITNESS my hand and official seal  
 9 this 20th day of November, 2000.  
 10  
 11  
 12  
 13  
 14

15 Denise T. Medina  
 16 Notary Public-State of FL  
 17 My Commission Expires: 4/22/01  
 18 My Commission No.: CC633839  
 19  
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## 1 CERTIFICATE

2  
3 THE STATE OF FLORIDA  
4 COUNTY OF PALM BEACH COUNTY  
5

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

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

21 I further certify that I am not  
22 attorney or counsel of any of the parties, nor  
23 am I a relative or employee of any attorney or  
24 counsel of party connected with the action, nor  
25 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

## 1 ERRATA SHEET

2 IN RE: BROOKS V. CLEVELAND CLINIC

3 DEPOSITION OF: TODD D. EISNER, M.D.

4 TAKEN: 11/16/00

5 DO NOT WRITE ON TRANSCRIPT - ENTER CHANGES HERE

6 PAGE# LINE# CHANGE REASON

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## 1 CERTIFICATE

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4 THE STATE OF FLORIDA  
5 COUNTY OF PALM BEACH COUNTY  
6

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

14  
15 Dated this \_\_\_\_ of \_\_\_\_, 2000  
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20 TODD D. EISNER, M.D.  
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17 Please forward the original signed errata sheet  
18 to this office so that copies may be distributed  
19 to all parties.

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

24 DATE: \_\_\_\_\_

25 SIGNATURE OF DEPONENT: \_\_\_\_\_

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