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1	IN THE COURT OF COMMON PLEAS	4
	LORAIN COUNTY, OHIO	
2		
	J. TERRY ROBINSON, Administrator	
3	of the Estate of ELSIE A. ROBINSON,	
4	Case No. 99 CV 122855	
5	Plaintiff,	
6		
7	VS.	
8		
9	LYNN CHRISMER, JR., M.D., et al.,	
10		
11	Defendants.	
12	\sim	
13		
14	VIDEOTAPED DEPOSITION OF	
15		
16	ALLEN SOLOMON, M.D.	
17		
18	July 14, 2004	
19	10:08 a.m.	
20		
21	2150 Pennsylvania Avenue, Northwest, Suite 4/414	
22	Washington, D.C. 20036	
23		
24	ALDA MANDELL, Registered Professional Reporter and Notary Pub	lic
25		

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	Page 2		Page 4
1	APPEARANCES	1	represent the plaintiffs in this case.
2		2	MR. LEAK: I am Doug Leak. I
3	ON BEHALF OF PLAINTIFF:	3	represent Dr. Hulyalkar in this case.
4	BECKER, MISHKIND & CO., LPA	4	THE VIDEO OPERATOR: The court
5	JOHN W. BURNETT, ESQUIRE	5	reporter today is Alda Mandell of Set Depo.
6	134 Middle Lane	6	Would the reporter please swear in the
7	Elyria, Ohio 44035	7	witness.
8	(440) 323-7070	8	ALLEN SOLOMON, M.D. having been
9		9	duly sworn, testified as follows:
10	ON BEHALF OF DEFENDANT DR. HULYALKAR:	10	EXAMINATION
	ROETZEL & ANDRESS	1	
		11	BY-MR.LEAK:
12	DOUGLAS G. LEAK, ESQUIRE	12	Q. Can you please introduce yourself
13	One Cleveland Center - 9th Floor	13	for the ladies and gentlemen of the jury.
14	1375 East 9th Street	14	A. My name is Allen Solomon.
15	Cleveland, Ohio 44114	15	Q. Dr. Solomon, what is your
16	(216) 615-4835	16	profession?
17	•	17	A. I am a cardiologist.
18		18	Q. Dr. Solomon, I am handing you what
19	ALSO PRESENT: DANA CAMPBELL - Video Operator	19	has been marked as Defendant's Exhibit A.
20		20	Can you please identify that for the jury.
21		21	A. This is my CV, my curriculum
22		22	vitae.
23		23	Q. And what is a curriculum vitae?
24		24	A. It's a resume.
25		25	Q. Doctor, I'd like to begin with
	Page 3	1	Page 5
1	Videotaped Deposition of Allen Solomon, M.D.	1	going through your background a little bit
2	July 14, 2004	2	with the jury. Can you take us through your
3	(Defendant's Exhibit-A was marked	3	education, starting with undergraduate.
4	for identification and was attached to the	4	A. I went to undergraduate school at
5	transcript.)	5	the University of Maryland in College Park.
6	THE VIDEO OPERATOR: We are on	6	I then went to medical school at the
7	record at 100743. Here begins tape number	7	University of Maryland, which is in Baltimore
8	one in the deposition of Allen Solomon, M.D.	8	City. I then did my residency in internal
9	in the matter of J. Terry Robinson,	9	medicine, still at the University of Maryland.
10	Administrator of the Estate of Elsie A.	10	I then came to Washington, D.C. where I did
11	Robinson versus Lynn Chrismer, Jr., M.D., et	11	a cardiology fellowship at Georgetown
12	al in the Court of Common Pleas for Lorain	12	University Hospital, followed by a cardiac
13		3	- <u>-</u> - <u>-</u>
	County, Ohio. Case Number 99 CV 122855.	13	electrophysiology fellowship, which is the
	County, Ohio. Case Number 99 CV 122855. Today's date is July 14th. 2004.	1	electrophysiology fellowship, which is the study of heart arrhythmias, and then I began
14	Today's date is July 14th, 2004.	14	study of heart arrhythmias, and then I began
14 15	Today's date is July 14th, 2004. The time is 10:08:12. The video operator	14 15	study of heart arrhythmias, and then I began on staff at Georgetown University.
14 15 16	Today's date is July 14th, 2004. The time is 10:08:12. The video operator today is Dana Campbell of Set Depo. This	14 15 16	study of heart arrhythmias, and then I began on staff at Georgetown University. Q. Doctor, with regard to
14 15 16 17	Today's date is July 14th, 2004. The time is 10:08:12. The video operator today is Dana Campbell of Set Depo. This video deposition is taking place at the	14 15 16 17	study of heart arrhythmias, and then I began on staff at Georgetown University. Q. Doctor, with regard to electrophysiology, can you explain a little
14 15 16 17 18	Today's date is July 14th, 2004. The time is 10:08:12. The video operator today is Dana Campbell of Set Depo. This video deposition is taking place at the office of George Washington University, 2150	14 15 16 17 18	study of heart arrhythmias, and then I began on staff at Georgetown University. Q. Doctor, with regard to electrophysiology, can you explain a little bit more about what that entails?
14 15 16 17 18 19	Today's date is July 14th, 2004. The time is 10:08:12. The video operator today is Dana Campbell of Set Depo. This video deposition is taking place at the office of George Washington University, 2150 Pennsylvania Avenue, Northwest, Suite 4-413,	14 15 16 17 18 19	 study of heart arrhythmias, and then I began on staff at Georgetown University. Q. Doctor, with regard to electrophysiology, can you explain a little bit more about what that entails? A. Sure. It's the study of fast and
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14 15 16 17 18 19 20 21 22 23	Today's date is July 14th, 2004. The time is 10:08:12. The video operator today is Dana Campbell of Set Depo. This video deposition is taking place at the office of George Washington University, 2150 Pennsylvania Avenue, Northwest, Suite 4-413, Washington, D.C. and was noticed by Anna M. Carulas, counsel for the defendant, North Ohio Heart Center. Would the counsel please identify themselves and state whom they	14 15 16 17 18 19 20 21 22 23	 study of heart arrhythmias, and then I began on staff at Georgetown University. Q. Doctor, with regard to electrophysiology, can you explain a little bit more about what that entails? A. Sure. It's the study of fast and slow heart rhythms. Essentially some people have problems when their heart rhythm goes too slow and some people have heart rhythms that go quite fast like atrial fibrillation

	Page 6		Page 8
1	people with these heart rhythm abnormalities.	1	A. I lecture locally, regionally,
2	Q. Doctor, where are you licensed to	2	nationally and I've even done some
3	practice medicine?	3	international talks as well.
4	A. I'm licensed to practice in the	4	Q. And have you provided any
5	state of Maryland and in the District of	5	publications for the medical literature out
6	Columbia.	6	there or any medical journals?
7	Q. And are you board certified?	7	A. I've written approximately 60
8	A. I'm board certified in internal	8	manuscripts and somewhat more than that
1	medicine, in cardiology and in cardiac	9	abstracts.
9			
10	electrophysiology.	10	Q. Doctor, I'd like to turn to the
11	Q. Doctor, I have seen in your CV	11	nature of your practice. We're here in
12	that you have received some awards. Can you	12	Washington, D.C. Can you explain for the
13	please mention some of the awards that you	13	jury what is the nature of your practice?
14	believe are important to you?	14	A. My practice is divided between
15	A. I think the awards that are most	15	general cardiology and electrophysiology. My
16	important to me are the teaching awards. One	16	normal day would be probably about half the
17	of my roles at the university is in teaching	17	time I spend in the hospital seeing
18	medical students, residents and fellows, and	18	inpatients about a third of the time
19	I've received several awards regarding my	19	seeing inpatients, about a third of the time
20	teaching of those folks.	20	seeing outpatients, and about a third of the
21	Q. And do you belong to any	21	time in the laboratory doing procedures.
22	professional societies or hold any positions	22	Q. And what percentage of your
23	with any committees?	23	professional time is devoted to the clinical
24	A. I belong to the American Heart	24	practice of cardiology?
25	Association, the American College of	25	A. Almost all of it, but certainly
	Page 7		Page 9
1	Cardiology, a society called Heart Rhythm	1	more than 90 percent of it.
2	Association, which is for electrophysiologists,	2	Q. Doctor, I'd like to turn to your
3	and I sit on several committees for each of	3	involvement in this case, and you have been
4	these associations.	4	retained by my law firm, Roetzel & Andress,
5	Q. And do you presently have any	5	to be an expert. Have you ever worked or
6	academic positions here in the D.C. area?	6	had any contact with my law firm before?
7	A. My current academic position is at	7	A. This is the first and only time.
8	George Washington University Hospital where I	8	Q. And do you routinely get involved
9	am in charge of the fellowship training	9	in expert reviews of medical malpractice
10	program and I'm an associate professor of	10	cases?
11	medicine.	11	A. It depends how you define
12	Q. And what does that involve, the	12	routinely. I enjoy doing this. I learn a
13	fellowship training?	13	lot as a result of these. Helps sometimes in
14	A. There is a small administrative	14	training the next generation of cardiologists.
15	role which deals with making sure that each	15	I would say on average maybe five cases a
15	of the fellows going through the program,	16	year I participate in.
10	which are young men and women who have	17	Q. Doctor, I want to turn to this
18	already completed their internal medicine	18	case involving Mrs. Robinson. And you have
10	residency training who are learning how to be	19	reviewed records and depositions in this case?
20	cardiologists, to make sure they receive	20	A. I have indeed.
1		20	Q. Okay. And what have you reviewed
21 22	proper training in all the fields of	21	in general?
1 1 1			
1	cardiology so that they can then leave this		
23	program and practice as a cardiologist.	23	A. In general I reviewed multiple
23 24	program and practice as a cardiologist. Q. And do you lecture in your field	23 24	A. In general I reviewed multiple records concerning her medical condition before
23	program and practice as a cardiologist.	23	A. In general I reviewed multiple

			
_	Page 10		Page 12
[1	I apologize before February of 1997. I've	1	flow to all of the important organs. And
2	specifically looked at the medical records	2	clearly that was weakened in her which would
3	involving this hospitalization which we're	3	result in many symptoms like shortness of
4	going to discuss today which was February and	4	breath and exercise intolerance, things like
5	March of 1997. I've also looked at multiple	5	that.
6	depositions taken over the past few years.	6	She also had an arrhythmia which
7	Q. And would that be depositions of	7	for many years was an intermittent problem
8	doctors involved in the case?	8	which was controlled with medication; however,
9	A. Either doctors involved in the case	9	over the past year prior to this
10	or experts for either side.	10	hospitalization it was really a chronic
11	Q. Doctor, I will be asking you some	11	problem. Atrial fibrillation is the most
12	questions that ask for opinions. Are your	12	common heart rhythm abnormality we see in
13	opinions to a reasonable degree of medical	13	which the top chambers of the heart, the
14	probability in this case?	14	atria, beat very rapidly and often that
15	A. Yes.	15	results in a very fast heart rate which gives
16	Q. Doctor, let's first start with Mrs.	16	people symptoms of shortness of breath,
17	Robinson's medical history. Can you please	17	lightheadedness, dizziness, decreases in
18	explain to the jury the significance of her	18	stamina, shortness of breath.
19	medical history.	19	And so the treatment of atrial
20	A. Okay. I think, going into the	20	fibrillation is to treat two major problems.
21	hospitalization of February 1997, this was a	21	First of all they're on treatments so their
22	72-year-old lady with multiple medical problems	22	heart doesn't race, which alleviates many of
23	involving multiple organ systems. She clearly	23	those symptoms, and she was on a drug called
24	had a weakened dilated heart which we call a	24	Digoxin and a beta blocker called Atenolol to
25	cardiomyopathy. She also had a chronic	25	slow her heart rate down. In addition, these
	Page 11		Page 13
1	arrhythmia known as atrial fibrillation. She	1	people are high risk for having strokes. The
2	also had severe emphysema involving her lungs.	2	most important complication of atrial
3	She had well known chronic kidney disease as	3	fibrillation is the risk of forming blood
4	well. She had poor circulation, what we call	4	clots within your heart which can go
5	peripheral vascular disease. There's mention	5	anywhere, most importantly to your brain,
6	of deep venous thrombosis which is a disease	6	which results in a stroke. In someone like
7	involving the veins the her lower extremities.	7	her that risk may be as high as about 8
8	There is thought that have she may have had	8	percent each year. And as a result of that,
9	a blood clot in her lung called a pulmonary	9	we put people on blood thinners, most
10	embolus. And there was even a mention of a	10	importantly Coumadin, which significantly
11	stroke in the past. So clearly she had	11	decreases the risk of having a blood clot and
12	multiple medical problems going into this and	12	a stroke.
13	she was obese as well.	13	Q. And was Mrs. Robinson on Coumadin
14	Q. With regard to her cardiac	14	prior to February 25th, 1997?
15	condition, you have mentioned the atrial	15	A. She was indeed.
16	fibrillation, cardiomyopathy. Can you explain	16	Q. You had mentioned she had some
17	a little bit more about her cardiac condition	17	valve disease?
18	when she was admitted to Elyira Memorial	18	A. Correct.
19	Hospital on February 25th, 1997?	19	Q. And what exactly is that?
20	A. Certainly. I think they fall into	20	A. She also has there is a series
20	two major categories. One is more of a	21	of valves which are essentially should be
22	mechanical problem and that's her	22	one-way valves which allow blood to flow from
23	cardiomyopathy or weakened dilated heart. In	23	the top chambers down to the bottom chambers.
24	fact the heart is a muscle which pumps blood	24	The one on the right side is called the
25			The one on the right side to called the
וצח	throughout the circulation which provides blood	25	tricuspid valve and the left side is called

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1	Page 14 the mitral valve. And both those valves	1	Page 16 chances of having a blood clot. If you
$\begin{vmatrix} 1\\ 2 \end{vmatrix}$	leaked at least moderately, if not severely,	$\begin{vmatrix} 1\\2 \end{vmatrix}$	throw in the fact that she's also had clots
$\frac{2}{3}$	the mitral and tricuspid valves. And clearly	$\frac{2}{3}$	in her legs previously, again that further
1	that can further deteriorate heart function	4	increases the risk. The fact that she may
45		5	have had a stroke before would further
	because when the heart functions, ideally the	6	increase that risk. So she has a number of
6 7	blood should all go forward out the aorta to the body. When you have these leaky valves,	7	risk factors which increase the risk of
8	some of it goes backwards into the lung or	8	forming blood clots.
9	into the veins which further decreases the	9	So clearly in her you would say
10	ability of your heart to pump blood	10	she's at high risk for forming blood clots
10	effectively.	11	and in her, unless there was a very strong
12	•	11	indication not to, this would be a lady you
12	Q. And there's a term called ejection fraction. What exactly is that and what was	12	would put on blood thinners, Coumadin.
13	Mrs. Robinson's?	13	Q. Now, regarding Mrs. Robinson and
14	A. Okay. Injection fraction is the	15	the February 25th admission, what was the
15	ability of the heart to pump blood to the	15	treatment plan for Mrs. Robinson upon
17	body. Essentially the heart should be able	10	presentation and after the initial workup?
17	to eject or pump about half the blood with	18	A. I think that her initial
10	each beat. So a normal ejection fraction	19	presentation was mostly shortness of breath
20	would be 50 percent, again meaning that you	20	and cough, respiratory symptoms. In people
20	can eject half the blood from your heart with	20	with a history like hers of having heart
21	each beat. In her case it was somewhere	21 22	failure history and having emphysema history,
22	between 25 percent and 30 percent depending	22	it's always a bit questionable which part of
23	on which echocardiogram you look at. But	24	the shortness of breath is due to the heart
24	essentially her heart function was reduced by	25	and which part is due to the lungs. And I
23	essentially her heart function was reduced by	25	and which part is due to the rungs. This i
	Page 15		Page 17
1	at least 50 percent.	1	think their initial plan was to treat her
2	On top of that, on top of her	2	lung function and try to give her medications
3	reduction in heart function, some of that was	3	to improve emphysema and wheezing and to give
4	going actually the wrong way because of these	4	her a second set of medicines to improve her
5			
	regurgitant valves, these leaky valves, so in	5	heart function as well and try to treat heart
6	fact her heart function was actually worse	5 6	
6 7		1	heart function as well and try to treat heart
1	fact her heart function was actually worse	6	heart function as well and try to treat heart failure. On top of that she was admitted yet again with rapid atrial fibrillation, a
7	fact her heart function was actually worse than the reported 25 to 30 percent.	6 7	heart function as well and try to treat heart failure. On top of that she was admitted
7 8	fact her heart function was actually worse than the reported 25 to 30 percent. Q. Doctor, I want to go back to her	6 7 8 9 10	heart function as well and try to treat heart failure. On top of that she was admitted yet again with rapid atrial fibrillation, a very fast heart rate, which were they were having more and more difficulty controlling
7 8 9	fact her heart function was actually worse than the reported 25 to 30 percent.Q. Doctor, I want to go back to her condition with regard to risk for blood	6 7 8 9 10 11	heart function as well and try to treat heart failure. On top of that she was admitted yet again with rapid atrial fibrillation, a very fast heart rate, which were they were having more and more difficulty controlling with medications. And at that point one of
7 8 9 10	fact her heart function was actually worsethan the reported 25 to 30 percent.Q. Doctor, I want to go back to hercondition with regard to risk for bloodclotting and you already talked a little bit	6 7 8 9 10 11 12	heart function as well and try to treat heart failure. On top of that she was admitted yet again with rapid atrial fibrillation, a very fast heart rate, which were they were having more and more difficulty controlling with medications. And at that point one of the options is to do a procedure called a
7 8 9 10 11	fact her heart function was actually worse than the reported 25 to 30 percent.Q. Doctor, I want to go back to her condition with regard to risk for blood clotting and you already talked a little bit about that. How would you label Mrs.	6 7 8 9 10 11 12 13	heart function as well and try to treat heart failure. On top of that she was admitted yet again with rapid atrial fibrillation, a very fast heart rate, which were they were having more and more difficulty controlling with medications. And at that point one of the options is to do a procedure called a catheter ablation which essentially what
7 8 9 10 11 12	fact her heart function was actually worse than the reported 25 to 30 percent.Q. Doctor, I want to go back to her condition with regard to risk for blood clotting and you already talked a little bit about that. How would you label Mrs.Robinson in terms of risk for blood clotting?	6 7 8 9 10 11 12	heart function as well and try to treat heart failure. On top of that she was admitted yet again with rapid atrial fibrillation, a very fast heart rate, which were they were having more and more difficulty controlling with medications. And at that point one of the options is to do a procedure called a catheter ablation which essentially what happens is the atria beat very, very quickly
7 8 9 10 11 12 13	 fact her heart function was actually worse than the reported 25 to 30 percent. Q. Doctor, I want to go back to her condition with regard to risk for blood clotting and you already talked a little bit about that. How would you label Mrs. Robinson in terms of risk for blood clotting? A. I think the risk is very high in 	6 7 8 9 10 11 12 13	heart function as well and try to treat heart failure. On top of that she was admitted yet again with rapid atrial fibrillation, a very fast heart rate, which were they were having more and more difficulty controlling with medications. And at that point one of the options is to do a procedure called a catheter ablation which essentially what happens is the atria beat very, very quickly and those electrical impulses go down to the
7 8 9 10 11 12 13 14	 fact her heart function was actually worse than the reported 25 to 30 percent. Q. Doctor, I want to go back to her condition with regard to risk for blood clotting and you already talked a little bit about that. How would you label Mrs. Robinson in terms of risk for blood clotting? A. I think the risk is very high in her. Obviously what we do in all people, and 	6 7 8 9 10 11 12 13 14 15 16	heart function as well and try to treat heart failure. On top of that she was admitted yet again with rapid atrial fibrillation, a very fast heart rate, which were they were having more and more difficulty controlling with medications. And at that point one of the options is to do a procedure called a catheter ablation which essentially what happens is the atria beat very, very quickly and those electrical impulses go down to the ventricle below and can make the ventricle,
7 8 9 10 11 12 13 14 15	 fact her heart function was actually worse than the reported 25 to 30 percent. Q. Doctor, I want to go back to her condition with regard to risk for blood clotting and you already talked a little bit about that. How would you label Mrs. Robinson in terms of risk for blood clotting? A. I think the risk is very high in her. Obviously what we do in all people, and the conversation that all physicians have with 	6 7 8 9 10 11 12 13 14 15	heart function as well and try to treat heart failure. On top of that she was admitted yet again with rapid atrial fibrillation, a very fast heart rate, which were they were having more and more difficulty controlling with medications. And at that point one of the options is to do a procedure called a catheter ablation which essentially what happens is the atria beat very, very quickly and those electrical impulses go down to the ventricle below and can make the ventricle, which is your heartbeat, go very, very fast.
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7 8 9 10 11 12 13 14 15 16 17	 fact her heart function was actually worse than the reported 25 to 30 percent. Q. Doctor, I want to go back to her condition with regard to risk for blood clotting and you already talked a little bit about that. How would you label Mrs. Robinson in terms of risk for blood clotting? A. I think the risk is very high in her. Obviously what we do in all people, and the conversation that all physicians have with their patients when they're given a diagnosis of atrial fibrillation is we discuss the 	6 7 8 9 10 11 12 13 14 15 16 17	heart function as well and try to treat heart failure. On top of that she was admitted yet again with rapid atrial fibrillation, a very fast heart rate, which were they were having more and more difficulty controlling with medications. And at that point one of the options is to do a procedure called a catheter ablation which essentially what happens is the atria beat very, very quickly and those electrical impulses go down to the ventricle below and can make the ventricle, which is your heartbeat, go very, very fast. The structure, the electrical structure, that allows the ventricle to go very fast is
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Page 181The good part about that is you1generally stay overnight at most2heart can never race again out of control.2then be discharged the followin3The bad part is you require a pacemaker3With regard to the Court4afterwards. But at least with this procedure4is always a little tricky because	
2heart can never race again out of control.2then be discharged the followin3The bad part is you require a pacemaker3With regard to the Countrol4afterwards. But at least with this procedure4is always a little tricky because	Page 20
3The bad part is you require a pacemaker3With regard to the Count4afterwards. But at least with this procedure4is always a little tricky because	st hospitals and
3The bad part is you require a pacemaker3With regard to the Count4afterwards. But at least with this procedure4is always a little tricky because	
4 afterwards. But at least with this procedure 4 is always a little tricky because	U
5 the pacemaker will make sure your heart rate 5 want to do these procedures w	
6 is always slow and regular or appropriate and 6 anticoagulation level too high,	
7 regular so that even though your heart will 7 generally done is you stop the	
9 heartbeat will essentially be 60 and regular 9 the procedure, just so the Cour	
10 when you sleep, 80 and regular when you walk, 10 drift down. And in her case he	
11 110 and regular when you jog, so that 11 level was fine on the day of ad	
12 people's symptoms of rapid heart rate all go 12 was low enough to safely perfe	
13away.13procedure. And then we gener	
14Q. Now, we know that the procedure14Coumadin either that evening	
15 was performed in this case by Dr. Moore. 15 evening, hoping to get their Co	
16 A. Correct. 16 back up to the therapeutic rang	e within the
17 Q. How – based upon your review of 17 next three to four days.	
18 the records, how did the procedure itself go? [18 Often in the interim peop	ple will
19 A. Okay. Essentially it went fine. 19 use various forms of Heparin t	o get them
20 The two parts of the procedure first part 20 anticoagulated a little earlier b	ecause it
21 would be to eliminate conduction or do the 21 does take three or four days be	
ablation procedure of the AV node. Generally 22 Coumadin reaches its effective	
23 we try to completely eliminate electrical 23 often that's done as an outpatie	
24 conduction from the top chambers to the 24 Q. With regard to the	
25 bottom chambers. He partially interrupted 25 anticoagulations, you talked at	out the
Page 19	Page 21
1 that conduction so – and there was even some 1 Coumadin. When is the Hepari	-
2 talk later on of whether he would have to 2 either before, during or after a p	
3 finish up the procedure later on. 3 like this?	
4 Despite the fact that he didn't 4 A. Again much of this, like	much of
5 completely eliminate conduction, the heart rate 5 medicine, is weighing risk and l	
6 seemed to be well controlled through the rest 6 people that you think are at very	
7 of the hospitalization. So at least when the 7 for forming blood clots you may	
A CONTRACT AND A CONTRACT	
	чр.
8 goal was to make sure her heart didn't race 8 them on Coumadin on the eveni	
8goal was to make sure her heart didn't race8them on Coumadin on the eveni9any more, he seemed to accomplish that9three or four days before they get	•
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	Page 22		Page 24
1	because I think they realized that she was an	1	the most difficult decisions that we wrestle
2	older lady with multiple medical problems and	2	with in medicine. In Mrs. Robinson, like in
3	rather than do this as an outpatient	3	all patients, you want to weigh risk versus
4	procedure, they elected to keep her in	4	benefit. In her case she clearly was a sick
5	hospital so they could watch her more	5	woman with multiple medical problems and
6	closely. They gave her Heparin, followed her	6	multiple things which put her at risk for
7	blood counts on a daily basis, began the	7	having a blood clot. So I think the normal
8	Coumadin, and then kept her for multiple days	8	thing you do in someone like this is you
9	after the procedure, I gather so they could	9	weigh the risk of having a blood clot, which
10	catch her more carefully and look for the	10	could be catastrophic in her, versus the risk
11	complications that we've talked about.	11	of having a bleed, which could also be
12	Q. And we know that Dr. Hulyalkar was	12	catastrophic, and you try to make your best
13	part of that postoperative care and treatment.	13	guess of which is more likely to occur and
14	Do you have an opinion as to whether or not	14	you treat accordingly. I think the ckc this
15	his treatment plan postoperatively was within	15	woman, as we talked initially, with a
16	the standard of care?	16	cardiomyopathy, with atrial fibrillation, with
17	A. I think it certainly was within	17	a past history of a stroke, with a past
18	the standard of care. I think in fact, he	18	history of blood clots in her legs, you had
19	went above the standard of care by keeping	19	to say that her risk of forming a blood clot
20	her in the hospital for multiple days while	20	was substantial and I think it was reasonable
20	he watched her.	20	and certainly within the standard of care
21		21	
22	Q. Based upon your review of the		that you would anticoagulate her. You know
1	medical records, how did Mrs. Robinson do	23	that there's a risk of bleeding alongside
24	postoperatively?	24	that and that would be a reason, A, to keep
25	A. Well, initially she certainly did	25	her in the hospital a little longer; B, to
	Page 23		Page 25
1	very well. What we'd like to see as a result	1	watch her for any complications of bleeding;
2	of the procedure is we like to see her heart	2	and C, to follow things like blood count and
3	not race and we like to see the pacemaker	3	pulse and blood pressure on a regular basis.
4	function appropriately. And both those things	4	Q. Doctor, we know that the procedure
5	occurred following the procedure. So as far	5	was on February 27th and then March 2nd she
6	as the ablation went and the placement of the	6	started to complain of right flank pain.
	pacemaker, there didn't seem to be any	7	+
1 '			Exactly what is right flank pain?
8	initial complications from that. Certainly in	8	A. Okay. Well, right flank pain is
9	the early part of her hospitalization her	9	just pain on your side, essentially on the
10	mental status remained fine, her blood	10	right side. Usually it's the lower chest,
11	pressure and pulse remained in the normal	11	the upper abdomen region.
12	range, her hematocrit and hemoglobin, her	12	Q. What is the significance of that
13	blood counts, remained in the normal range.	13	if you're following a patient like Mrs.
14	They gave her Heparin to immediately thin her	14	Robinson?
15	blood and that for the most part was in the	15	A. The significance could be anything.
16	normal range. And they began Coumadin which	16	It could be a kidney problem, it could be a
17	gradually later on in her hospitalization,	17	bleeding problem, it could be a lung problem.
18	which gradually started to creep up towards	18	There's multiple things that could enter into
19	normal, although it never reached a	19	your thought process. But the first thing you
20	therapeutic level.	20	obviously want to do is take a look and
21	Q. During the postoperative period	21	examine the patient and try to sort out what
22	after the procedure, was it within the	22	is going on.
23	standard of care to continue the Heparin	23	Q. And what is your understanding as
24	therapy?	24	to what was discovered around this time frame
	ulorapy:		
25	A. I think those decisions are always	25	of March 2nd when she rendered these

	Page 26		Page 28
1	complaints?	1	in but certainly well within an acceptable
2	A. Okay. Well, when they went to	2	range. And they did the CAT scan to see if
3	examine her they found that she had a	3	she had any severe bleeding and there was no
4	hematoma or a severe bruise involving the	4	evidence. It seemed to be a very localized
5	right side of her chest and upper abdomen.	5	bleeding area involving the skin and soft
6	I think immediately in somebody that's on a	6	tissues.
7	blood thinner in which you see a hematoma,	7	Q. Was there any reference to the
8	that's certainly the most likely cause of her	8	retroperitoneal area in the CT scan report?
9	pain. This is an inflammatory process. It's	9	A. In fact the report said no
10	certainly painful in most people. It's not	10	retroperitoneal bleeding and no intraperitoneal
11	at all uncommon. In fact, it's very common	11	bleeding. So within the abdomen itself or
12	that we put pacemakers in people who are on	12	behind.
13	anticoagulation, on Coumadin. And quite	13	Q. Doctor, do you have an opinion to
14	commonly they'll have a hematoma or a big	14	a reasonable degree of medical probability as
15	bruise and a collection of blood within the	15	to how this hematoma was caused?
16	pacemaker pocket. That's unfortunately a rather	16	A. It almost certainly was caused by
17	common procedure.	17	the ablation procedure. To do the ablation
18	Our tact is to watch it. You	18	procedure you actually put a catheter within
19	want to make sure that it doesn't expand in	19	one of the veins in the groin and certainly
20	size. You want to make sure that it's	20	what you hope to happen is you easily go
21	located pretty superficially, that it doesn't	21	into the vein and at the end you hold
22	go anywhere else. You want to make sure	22	compression and a little plug seals the vein
23	that their hemoglobin, their hematocrit, their	23	and you don't have any more problem.
24	blood counts are okay. And I think in this	24	If somebody's on blood thinner it
25	case you clearly saw she was having flank	25	often doesn't heal as well as you would like
1	Page 27	1	Page 29
1	pain, she was having this hematoma, and I	1	and it's possible for it to open up at a
2	pain, she was having this hematoma, and I think the first thing you want to do is make	2	and it's possible for it to open up at a later date often in response to something
2 3	pain, she was having this hematoma, and I think the first thing you want to do is make sure she's okay. You want to check her	2 3	and it's possible for it to open up at a later date often in response to something like coughing or laughter or moving in a
2 3 4	pain, she was having this hematoma, and I think the first thing you want to do is make sure she's okay. You want to check her blood count. You want to check her pulse	2 3 4	and it's possible for it to open up at a later date often in response to something like coughing or laughter or moving in a certain position. But I think that's the
2 3 4 5	pain, she was having this hematoma, and I think the first thing you want to do is make sure she's okay. You want to check her blood count. You want to check her pulse and blood pressure. And then the worst	2 3 4 5	and it's possible for it to open up at a later date often in response to something like coughing or laughter or moving in a certain position. But I think that's the most likely cause of the bleeding problem.
2 3 4 5 6	pain, she was having this hematoma, and I think the first thing you want to do is make sure she's okay. You want to check her blood count. You want to check her pulse and blood pressure. And then the worst catastrophe that could be involved here is a	2 3 4 5 6	and it's possible for it to open up at a later date often in response to something like coughing or laughter or moving in a certain position. But I think that's the most likely cause of the bleeding problem.Q. Does that mean that something wrong
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	Page 30		Page 32
1	hematoma to make sure it's not expanding with	1	safe to actually stop the anticoagulation.
2	time.	2	Specifically in her case, if the
3	Q. Did they do that?	3	hematoma was expanding in size, if her blood
4	A. And they did that.	4	count was dropping precipitously, if her blood
5	Q. And what did that reveal?	5	pressure was dropping, if her pulse rate was
6	A. Well, originally they made the	6	increasing, her mental status was changing,
7	outline and over the next several days it	7	then you'd be worried that this process was
1		1	v 1
8	didn't seem to extend past that marking so it	8	continuing. You'd obviously have to stop
9	seemed to be stable in size.	9	anticoagulation straight away.
10	Q. Go ahead. I'm sorry.	10	Q. And what do the records indicate
11	A. The second thing you want to do is	11	to you as to whether or not there's active
12	look at the patient and make sure that they	12	bleeding or worsening bleeding in this case?
13	still look well and are speaking to you and	13	A. Again until the evening before her
14	are you know, look as they had before	14	death all of the things, as far as how she
15	this came up.	15	felt, her vital signs, the size of the
16	Q. And was that done?	16	hematoma, the blood counts, were all quite
17	A. And that was done. And in fact,	17	stable. It wasn't until the evening of the
18	even on the morning of the 5th, the notes	18	5th where she began to have some changes in
10	say feeling better, doing well. So the	10	how she looked. She began to have some
•		1	
20	patient seems to be doing fine.	20	changes in her vital signs. She began to
21	Q. And what else?	21	have some changes in the blood count. And
22	A. You also want to follow her	22	clearly at that point you have to say some
23	hematocrit. You want to make sure that's not	23	process is ongoing and you have to reassess
24	changing dramatically. So you want to check	24	the judgment of whether anticoagulation is
25	at least every day. You want to check her	25	proper or not.
	Page 31		Page 33
1	hematocrit and hemoglobin level to make sure	1	Q. What is your understanding for this
2	that that's remaining stable.	2	time period of March 2nd through the evening
	that that S remaining stable.		
	And what did that way and in this		
3	Q. And what did that reveal in this	3	of March 5th? Who was following Mrs.
4	case?	3 4	of March 5th? Who was following Mrs. Robinson in the hospital?
4	case? A. And up until the evening of the	3 4 5	of March 5th? Who was following Mrs. Robinson in the hospital? A. It sounds like she was followed by
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	Page 34		Page 36
1	have raised in this case. The first one is	1	the more significant bleed happened. But
2	do you have an opinion as to whether Dr.	2	retrospectively it's easy to know when that
3	Hulyalkar was required to stop anticoagulation	3	is. Prospectively, you don't know when the
4	before the evening of March 5th, 1997?	4	bleed was. So it is possible that they
5	A. Again I would say that that is a	5	would have done a CT scan the next day, it
6	judgment call and you use your best judgment	6	might have looked exactly like the first one
7	as a physician to weigh risk versus benefit.	7	and falsely reassured the physicians that she
8	I think in a lady who seems to be stable,	8	was at no risk. So I think the standard of
9	•	9	care is to get a CT to rule out a
	not bleeding actively, I think you still	10	0
10	worry about the risk of clotting is higher		catastrophic bleed initially, which was done,
11	than the risk of bleeding and I think it's	11	and then to get a second one only if her
12	perfectly reasonable to have continued	12	clinical status dictates it.
13	anticoagulation.	13	Q. Well, let's go to the evening of
14	Q. The plaintiffs have also suggested	14	March 5th, 1997.
15	that there should have been serial H and H,	15	A. Okay.
16	hemoglobin, hematocrit tests done. Do you	16	Q. What is your understanding, based
17	have an opinion regarding that issue?	17	upon a review of the medical records, as to
18	A. Well, I certainly think there needs	18	what happened that night?
19	to be serial hemoglobin and hematocrit. We	19	A. I think what we know now is
20	can argue what the right frequency is. But	20	clearly she began to bleed, probably from the
21	at least every blood value they received up	21	initial puncture site from her ablation which
22	until the evening of the 5th was pretty close	22	was done now approximately six days earlier.
23	to the same value. So it was clearly	23	Actually would be seven or eight days
24	stable. I think what would dictate you to	24	earlier. But she started to bleed and that
25	increase the frequency or get one off your	25	bleeding resulted in a drop in her
1	······		
	Page 35		Page 37
1	normal schedule would be a change in clinical	1	hematocrit, a drop in her blood pressure, a
2	status. So if suddenly her blood pressure	2	change in her mental status. So something
3	dropped or suddenly her hematoma expanded or	3	acutely seemed to happen on the evening of
4	suddenly she was unresponsive, I think at	4	March the 5th.
5	that point you certainly want to interrupt	5	Q. And when you have a patient like
6	your normal schedule. But I think as long	6	that under those circumstances, what are you
	as the patient is clinically doing fine, I	7	supposed to do if you're following that
8	don't think you have to sort of change your	8	patient?
9	schedule.	9	A. Okay. I think you want to
1		10	stabilize them as quickly as possible. This
10	· · · ·	10	patient, as we discussed earlier, is
11	status, was there a change in her status at	12	chronically ill who has had an acute event,
12	some point?	8	
13	A. Well, her status seemed to be very	13	you want to move to a more intensive setting.
14	stable until the evening of March 5th.	14	So either an intensive care unit, a coronary
15	Q. Doctor, plaintiffs' experts also	15	care unit, you certainly want to do.
16	suggest that there should have been serial CT	16	Q. Was that done in this case?
17	scans performed after the March 3rd one. Do	17	A. That was done the evening of the
18	you agree with that opinion?	18	5th. Yes. You also want to follow their
19	A. I think that would only be	19	blood counts. You want to make sure that if
20	dictated by a change in the patient's	20	there is a drop in blood count, meaning
21	clinical status. I think again, looking	21	they're bleeding actively, you want to replace
22	back I think it's easy to say that she was	22	that. So generally they get some volume,
23	stable at the time of the initial CAT scan	23	usually saline solution initially just to try
24	and something happened later. It would be	24	to increase their blood pressure. And as
	and something happened later. It would be nice to have received a CT scan right before	24 25	to increase their blood pressure. And as soon as you can get it from the laboratory,

Page 38 Page 38 1 you want to ger ed cells. You want to give them a blood transfusion and the tight and and blood pressure back to normal, to get the their menal status back towards normal, to get them renal status of the amount is. 9 One thing I don't know if we discussed was what was the status of the status of them into heart failure. So you the proving out how to be very certain that you don't to give them too much blood and cause yet to give them too much blood and cause yet to partent. So you want to give them just to give them too much blood and cause yet to hear they diagnosed this problem, it was topped. A. Well, her Cournadin level is - as to whether or not these resultation therarge but it was least/increasing. And she was on them result and get them somewhat more table. 21 Q. What did the blood count on the cevening of March 5th in the early morning hours of March 5th in the bed status for them get the blood to get their blood pressure back to whether or not these resultation therarge, again was involved late evening on March 5th in the dealse table. Page 41 1 <th>Г</th> <th></th> <th>1</th> <th></th>	Г		1	
2 them a blood ransfusion and you wart to give them - the question's what's the right amount of blood and the right amount is blood is whatever blood is required to get their blood and the right amount is blood the matcori towards normal, to get and blood pressure back to normal, to get the mental status back towards normal, to get the status of the amount is. 9 One thing I don't know if we - discussed was what was the status of the antice status of the antice status of the antice status of the and put them into heart failure. So you want to be very careful that you don't want to get them too much blood a cause yet another problem in an already compromised to whether or not these resuscitation efforts administred were within the evening of the stable. 10 A. Well, her Coumadin level is - as to whether or not these resuscitation efforts administred were within the standard of care? 2 Q. What did the blood count on the stable. 11 12 A. The leve within the standard of care? 2 Q. What you anderstanding of who was involved late evening on March 5th into the early morning hours of March 6th in addressing this change in status? 12 N. Well, were within the standard of care? 24 2 Q. What is preprisions involved. In cerain In the stat				
3 them - the question's what's the right 3 at least from the late evening of the 5th 4 amount of blood and the right mount is blood 5 is whatever blood is required to get their 6 hematocrit towards normal, to get 7 will. 7 and blood pressure back to normal, to get 7 8 their mental status back towards normal. And 9 Q. One thing I don't know if we 9 uo don't know beforehand what the right 0 One thing I don't know if we 10 and blood pressure back to normal, to get 1 1 11 In this lady you have to be very 11 1 and the right and what the right 12 careful because what we know about giving 12 A. Well, her Courmadin level is - as 13 blood transfusions to people with a 11 hadh't reached the therapoutic range but it 14 tax so get give them to mach blood 11 hadh't reached the therapoutic range but it 14 tax beginning to increase. It still 14 hadh't reached the therapoutic range but it 15 mother problem in an already compromised 19	1	you want to get red cells. You want to give	1	blood transfusion a little later on. And all
3 them - the question's what's the right 3 at least from the late evening of the 5th 4 amount of blood and the right mount is blood 5 is whatever blood is required to get their 6 hematocrit towards normal, to get their pulse 7 well. 7 up to don't know beforehand what the right 8 Q. One thing I don't know if we 9 up don't know beforehand what the right 9 Gene thing I don't know if we 10 and blood pressure back to normal, and 9 Q. One thing I don't know if we 11 In this lady you have to be very 11 11 into equestion to people with a 12 cardiomyopathy with a weakend beart muscle, 12 A. Well, her Courmadin level is - as 13 blood transfusions to people with a 12 14 was beginning to increase. It still 14 tax stopped. 14 tax beginning to increase. It still 16 and put them in the attrafuers. So you 17 hadn't reached the therapouting of the still 16 another problem in an already compromised 19 10 hadn't reached the sersensing. And she was on	2		2	of those things seemed to benefit her in that
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6 hermatorit towards normal, to get their pulse 6 better range and her blood count came up as 7 and blood pressure back to normal, and 8 Q. One thing I don't know if we 9 you don't know beforehand what the right 9 discussed was what was in othe wery 11 In this lady you have to be very 11 anticoagulation therapy during this period of 12 cardiomyopathy with a weakened heart muscle, 14 14 A. Well, her Coumadin level is - as 13 blood transfusions to people with a 13 hadn't reached the therapactic range but it 14 tay out how weakened heart muscle, 14 it was beginning to increase. It still 16 and put them into heart failure. So you 16 hadn't reached the therapacuic range but it 18 to give them too much blood and cause yet 18 hadn't reached the therapacuic range but it 19 another problem in an already compromised 19 point. But immediately on the evening of the 21 enough blood to get their blood pressure back 21 Q. Dototr, do you have an opinion as 22 Q. What did the blood count on the 22 A. I believe they and think you 23 stable	4	=		· · ·
7 and blood pressure back to normal, kng get 7 well. 8 their mental status back towards normal. And go you don't know beforehand what the right amount is. 7 Q. One thing I don't know if we			4	
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24 moved to an intensive care unit setting. She 24 Q. Doctor, some of the terms we've	1			
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25 was given saline initially, two units of 25 heard in this case. Hypovolemic shock. What				
	1			and the support of the off office of the

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1	Page 42 is that and does that apply here?	1	Page 44 A. It was not.
2	A. Yes, it does. Hypovolemic shock	2	MR. LEAK: Thank you, Doctor. I
3	just means your blood pressure has dropped to	$\begin{vmatrix} 2\\3 \end{vmatrix}$	have no further questions.
4		4	EXAMINATION
4	an extent where you can't profuse your organs	5	BY-MR.BURNETT:
5	properly as a result of losing volume. One	1	
6	of those volume is bleeding. Also it could	6	Q. Hi, Doctor. I'm John Burnett. We
7	be done by things like severe dehydration as	7	met before the deposition, sir.
8	well. But it was bleeding in her case that	8	A. Good morning.
9	caused the shock.	9	Q. The standard of care. We've used
10	Q. How about compensatory mechanism?	10	that phrase. Can we agree that that is what
11	What is that?	11	a reasonably careful and prudent doctor would
12	A. Compensatory mechanism essentially	12	do under the same and similar circumstances?
13	means that your body does things to try to	13	A. Yes.
14	return your status as close to normal as	14	Q. Okay. And certainly Dr. Hulyalkar
15	possible so if your blood pressure were to	15	owed his patient, Mrs. Robinson, the duty of
16	drop, the body has things like adrenaline	16	acting as a reasonably prudent and careful
17	which kick in to increase your heart rate, to	17	doctor. Is that fair?
18	increase your blood pressure, to increase the	18	A. Yes.
19	contractility of the heart to try to	19	Q. Okay. Now, by the way, obviously
20	compensate for the fact that you're bleeding.	20	if her physicians undertook the trouble to
21	Often the body can keep up with that for a	21	perform an ablation procedure and then a
22	period of time but the older you are, the	22	pacemaker insertion, there was an expectation
23	more chronic medical conditions, I think the	23	that this would benefit this patient. Fair?
24	less ability you are to compensate and the	24	A. Correct.
25	less long that compensation can occur for.	25	Q. Okay. There was an expectation
	Page 43		Page 45
1	Q. And is that what happened with	1	that it would stabilize her heart and she
2	Mrs. Robinson in this case?	2	could lead a normal life for a period of
3	A. I believe so. Yes.	3	time at least. Fair?
4	Q. Doctor, is there any way that this	4	A. Correct.
5	death was either predictable or foreseeable?	5	Q. Okay. And she was 72, right?
6	A. I don't think it was predictable	6	A. Yes.
7	or foreseeable. Again I think there's always	7	Q. Is that a yes?
8	a risk of bleeding in people like her and	8	A. Yes.
9	the doctors were fully well aware of that.	9	Q. Now, I want to discuss compensatory
10	But I don't think anyone could have known	10	mechanisms with you.
11	that on the evening of the 5th that this was	11	A. Okay.
11	going to happen.	12	Q. And I may be restating some of the
13		13	things we discussed but I want to make sure
1		13	we agree. These compensatory mechanisms can
14	issues already in this case but I briefly	1	
15	want you to express whether or not you have	15	allow a patient to maintain a somewhat stable
16	an opinion that Dr. Hulyalkar met the	16	blood pressure while they're experiencing a
17	standard of care in this case. Do you have	17	bleeding, even an internal bleeding. Fair?
18	an opinion?	18	A. That is correct.
19	A. I believe he did meet the standard	19	Q. Okay. And this can help them
20	of care.	20	survive the bleeding. Fair?
21	Q. And do you have an opinion to a	21	A. Correct.
22	reasonable degree of medical probability as to	22	Q. Now, if a person has heart
23	whether Mrs. Robinson's death was as a result	E	problems, lung problems, and kidney disease,
24	of any deviation from the standard of care in	24	that person's compensatory mechanisms may not
25	this case?	25	be as good as a person's compensatory
		1	

r		1	
	Page 46		Page 48
1	mechanisms who doesn't have these conditions.	1	initially, right?
2	Fair?	2	A. Yes.
3	A. I agree.	3	Q. Okay.
4	Q. Okay. Now, Mrs. Robinson had	4	A. That's part of the procedure.
5	we talked about this she had heart	5	Q. Yeah. And cardiologists know
6	disease, lung disease, and kidney problems,	6	you've got to be aware that this may have
7	right?	7	occurred even with the best of care.
8	A. Correct.	8	A. That's correct.
9	Q. Okay. Because of these conditions,	9	Q. Okay. Now, just by virtue of the
10	her compensatory mechanisms were not as good	10	ablation procedure itself, she was at risk
11	as someone who didn't have these conditions.	11	for internal bleeding because of the
12	Fair?	12	possibility of puncturing a vein or artery,
12		12	
1		1	right?
14	Q. Okay. I mean her compensatory	14	A. That risk is small but clearly
15	mechanisms weren't as good as your or mine	15	that risk exists.
16	would be right now. Fair?	16	Q. Okay. Now, we know that Coumadin
17	A. I hope so.	17	and Heparin are anticoagulants.
18	Q. Okay. All right. Put another	18	A. That's correct.
19	way, because of those conditions she was less	19	Q. Okay. And those are commonly
20	likely to survive the type of bleeding event	20	referred to by people as blood thinning
21	she experienced than you or I might. Fair?	21	medication, right?
22	A. I think that's true.	22	A. That's right.
23	Q. Okay. Now and I think you	23	Q. Okay. And the effect of blood
24	stated this on your direct examination	24	thinning medication on a person's ability to
25	really the cause of death here was that her	25	cope with a cut or a puncture is that those
	Page 47		Page 49
1	compensatory mechanisms gave out and her heart	1	blood thinning medications inhibit the body's
2	essentially failed. Is that fair?	2	ability to clot. Fair?
3	A. I'm not sure I'd say her heart	3	A. You're correct. Yes.
4	failed but she clearly bled extensively and	4	Q. Okay. And following the procedure
5	was not able to meet her compensatory	5	she was started back on Coumadin and she was
6	mechanisms. I agree with that.	6	placed on Heparin, right?
7	Q. Okay. All right. And this was	7	A. That is correct.
8	from the internal bleeding we discussed.	8	Q. Okay. Dr. Hulyalkar put her on
9	A. That is correct.	9	these medications, didn't he?
10	Q. All right. And we know that the	10	A. Yes.
11	source of this bleeding was from the site of	11	Q. Okay. And when they're on these
12	the ablation procedure where a vein or artery	12	medications, by virtue of the fact that
13	was punctured.	12	they're on these medications, they are at
14	A. I agree.	14	further risk for bleeding. Is that fair?
14		15	A. Yes.
		15	
16	on February 27th, right?	10	· ·
17	A. Yes.	1	bleeding?
18	Q. Okay. And certainly that puncture	18	A. Yes.
19	wound was never closed by anyone, by any	19	Q. Okay. There's also the risk of a
20	surgeon. Fair?	20	spontaneous retroperitoneal bleed as a result
21	A. That's correct.	21	of being on Heparin. Fair?
22	Q. Okay. Now, cardiologists know that	22	A. I don't know if I'd call it
23	when there is an ablation procedure, there is	23	spontaneous but clearly you can have a
24	a risk of puncturing the vein or artery in	24	retroperitoneal blood following a catheter
25	the groin where the procedure takes place	25	procedure.
1		1	

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	Page 50		Page 52
1	Q. Okay. All right. Isn't there a		I mean the more likely it would be that she
2	risk from being on blood thinning medications	2	would survive this bleed given her weakened
3	that just by being on the medication	3	physical condition.
4	themselves, you can have a spontaneous	4	A. That's correct.
5	retroperitoneal bleed?	5	Q. Okay. Now, active bleeding in a
6	A. It's extremely rare but, yes, it's	6	patient who's on blood thinning medication, I
7	reported.	7	think we can probably agree that once active
8	Q. Okay. So she essentially had	8	bleeding is discovered, the standard of care
9	three risk factors for bleeding in this case,	9	requires that the doctor stop the blood
10	didn't she? And I'll go through them. She	10	thinning medication until the wound is closed
11	had the ablation procedure. That created a	11	and there's no more risk of bleeding from
12	risk, didn't it?	12	that wound. Is that fair?
13	A. Yes.	13	A. I think that still depends on what
14	Q. Okay. There was the possibility	14	bleeding we're talking about and what the
15	that any puncture wound created by the	15	risk of forming a blood clot is. For
16	ablation procedure may not clot over because	16	instance, if we felt somebody was at very
17	of the Coumadin and Heparin, the	17	high risk for blood clot and the bleeding
18	anticoagulants or blood thinners, right?	18	episode was a cut on their finger, you'd
19	A. I think that's part of number one,	19	probably still say they should continue their
20	but yes.	20	blood thinner.
21	Q. Okay. And there was also this	21	Q. Okay.
22	risk of a spontaneous retroperitoneal bleed?	22	A. Again it's always weighing risk and
23	A. Yes.	23	benefits. If they had a little bit of blood
24	Q. Okay. Now, we already agreed that	24	in their stool, you may still opt to continue
25	Mrs. Robinson was less likely to survive the	25	the anticoagulation even though you could
20	with the first was less interval of survive the	2.5	the unitedugatution even though you could
1	Page 51		Page 53
1	bleeding event she eventually had than a	1	argue that they're actively bleeding
2	person without her other her conditions,	2	internally. I think if you're talking about
3	the heart disease, lung disease, kidney	3	a more brisk bleed which is causing a drop
4	disease. Fair?	4	in hematocrit, a drop in blood pressure, then
1			IB REHALCELL A GRUD HEDRARE BESSURE, INCH 5
		1	
5	A. Fair.	5	certainly at that point you would say the
6	A. Fair.Q. Okay. Her body's ability to	5 6	certainly at that point you would say the risk of anticoagulation is greater than its
6 7	 A. Fair. Q. Okay. Her body's ability to compensate for blood loss was weakened. 	5 6 7	certainly at that point you would say the risk of anticoagulation is greater than its benefit and you would stop the
6 7 8	 A. Fair. Q. Okay. Her body's ability to compensate for blood loss was weakened. Fair? 	5 6 7 8	certainly at that point you would say the risk of anticoagulation is greater than its benefit and you would stop the anticoagulation.
6 7 8 9	 A. Fair. Q. Okay. Her body's ability to compensate for blood loss was weakened. Fair? A. I agree. 	5 6 7 8 9	certainly at that point you would say the risk of anticoagulation is greater than its benefit and you would stop the anticoagulation. Q. What if we're concerned about
6 7 8 9 10	 A. Fair. Q. Okay. Her body's ability to compensate for blood loss was weakened. Fair? A. I agree. Q. Okay. Now, given her heart, lung 	5 6 7 8 9 10	certainly at that point you would say the risk of anticoagulation is greater than its benefit and you would stop the anticoagulation. Q. What if we're concerned about bleeding from the site of the ablation
6 7 8 9 10 11	 A. Fair. Q. Okay. Her body's ability to compensate for blood loss was weakened. Fair? A. I agree. Q. Okay. Now, given her heart, lung and kidney disease that we discussed and the 	5 6 7 8 9 10 11	certainly at that point you would say the risk of anticoagulation is greater than its benefit and you would stop the anticoagulation. Q. What if we're concerned about bleeding from the site of the ablation procedure internally. If the doctor thinks
6 7 8 9 10 11 12	 A. Fair. Q. Okay. Her body's ability to compensate for blood loss was weakened. Fair? A. I agree. Q. Okay. Now, given her heart, lung and kidney disease that we discussed and the fact that she had the ablation procedure and 	5 6 7 8 9 10 11 12	certainly at that point you would say the risk of anticoagulation is greater than its benefit and you would stop the anticoagulation.Q. What if we're concerned about bleeding from the site of the ablation procedure internally. If the doctor thinks there is active bleeding going on, is it fair
6 7 8 9 10 11 12 13	 A. Fair. Q. Okay. Her body's ability to compensate for blood loss was weakened. Fair? A. I agree. Q. Okay. Now, given her heart, lung and kidney disease that we discussed and the fact that she had the ablation procedure and was on blood thinning medication, is it fair 	5 6 7 8 9 10 11 12 13	 certainly at that point you would say the risk of anticoagulation is greater than its benefit and you would stop the anticoagulation. Q. What if we're concerned about bleeding from the site of the ablation procedure internally. If the doctor thinks there is active bleeding going on, is it fair to say that under those circumstances, the
6 7 8 9 10 11 12 13 14	 A. Fair. Q. Okay. Her body's ability to compensate for blood loss was weakened. Fair? A. I agree. Q. Okay. Now, given her heart, lung and kidney disease that we discussed and the fact that she had the ablation procedure and was on blood thinning medication, is it fair for us to conclude that the standard of care 	5 6 7 8 9 10 11 12 13 14	certainly at that point you would say the risk of anticoagulation is greater than its benefit and you would stop the anticoagulation. Q. What if we're concerned about bleeding from the site of the ablation procedure internally. If the doctor thinks there is active bleeding going on, is it fair to say that under those circumstances, the blood thinning medication should be stopped
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I		I	
	Page 54		Page 56
1	the anticoagulation.	1	A. Correct.
2	So if you're defining the hematoma	2	Q. Okay. Maybe thready peripheral
3	in the skin as active bleeding, I would say	3	pulse also?
4	I don't think that would necessitate stopping	4	A. Yes.
5	anticoagulation given the patient was otherwise	5	Q. Okay. And peripheral pulse means
6	stable. If you're talking about an event	6	what? Tell us what that means.
7	like happened on the evening of the 5th, I	7	A. Usually it's the pulse in your
8	would say clearly you would stop it at that	8	wrist.
3		9	Q. Okay. Now, these are things the
9	point.	10	doctor can look at to see if a patient is
10	Q. Okay. Now, stopping the blood	1	A
11	thinning medication enables the body's natural	11	getting in trouble with an internal bleed.
12	healing; in other words, clotting mechanisms,	12	A. That's correct.
13	to kick in and help stop the bleeding	13	Q. Fair? Now, you know Mrs. Robinson
14	internally. Fair?	14	had a history of hypertension, right? She
15	A. That's true. Yes.	15	had high blood pressure?
16	Q. Okay. If there was a slow steady	16	A. Yes. She had a history in the
17	bleed from the site of the ablation procedure	17	past. Yes.
18	okay which occurred on February 27th	18	Q. Okay. Now, we also know Dr.
19	A. Right.	19	Hulyalkar changed her medicine. He prescribed
20	Q and this bleed continued	20	Isordil and Hydralazine on March 3rd and
21	throughout the early part of March into the	21	March 4th, correct?
22	3rd, 4th and 5th, and Dr. Hulyalkar knew	22	A. That's right.
23	there was a bleed going on from that site,	23	Q. Now, these are drugs that can
24	can we agree that the standard of care would	24	serve to lower a patient's blood pressure?
25	require him to stop the anticoagulation, the	25	A. They do indeed.
	Page 55		Page 57
1	blood thinning medication, and get a surgical	1	Q. Okay.
2	consult to close the site of the bleed before	2	A. Also used to improve heart function
3	resuming the anticoagulation?	3	but yes, they also lower blood pressure.
4	A. I still think this is more of a	4	Q. Okay. Now, I think by way of
5	qualitative assessment. If continued bleeding	5	history also she had kidney disease
6	was a trickle that was so small that it	6	A. Yes.
1		7	
7	didn't cause any hemodynamic or clinical	1	
8	consequences, I think that's not true. It	8	right?
9	probably would have stopped eventually on its	9	A. You usually don't use diuretics to
10	own. If it was a little more brisk,	10	treat kidney disease.
	certainly the answer is yes, I would have	11	Q. Okay.
12	stopped anticoagulation.	12	A. She was on diuretics and she did
13	Q. Okay. Let's talk about what	13	have kidney disease. I agree.
14	you're looking for to determine whether or	14	Q. She was on diuretics for what
15	not the bleeding is a trickle or brisk.	15	reason then, please?
16	A. Okay.	16	A. I suspect because she had a
17	Q. Okay? We would be looking at a	17	weakened heart and that was to treat heart
18	manifestation of low blood pressure for	18	failure. It also acts to treat high blood
19	instance. Fair?	19	pressure as well.
20	A. Yes.	20	Q. Okay. Now, the diuretics help one
21	Q. Okay? We would be looking for	21	produce urine?
22	decreased urine output. Fair?	22	A. Yes.
23	A. Fair.	$\frac{22}{23}$	Q. Okay. And you need to produce
24	Q. Okay. We'd be looking for an	24	urine, right?
24	altered mental state, right?	25	A. Yes.
20	anorod montai stato, rigitt:	20	
		A	

	Page 58		Page 60
1	Q. It's better to produce urine than	1	Q. Now, in your mind you can't tell
2	not produce urine?	2	me whether this was a result of Mrs.
3	A. I agree.	3	Robinson's kidneys shutting down from her
4	Q. Okay. Now, we also know that Dr.	4	body's compensatory mechanisms dealing with an
5	Hulyalkar held her diuretic medication as of	5	ongoing internal bleed or from the diuretics
6	March 1st, right?	6	being held, can you?
7	A. Correct.	7	A. That's correct.
8	Q. Okay. Furthermore, on the 5th he	8	Q. Okay. Let's look at her blood
9	prescribed Atarax, right?	9	pressure on the 4th. It's getting
10	A. Correct.	10	progressively lower as the day proceeds. Is
11	Q. Okay. She received a dose at	11	that fair?
12	11:00 o'clock a.m. and had received some	12	A. Her blood pressure on the 4th?
13	doses prior to that. Fair?	13	Q. Yes, sir.
14	A. Fair.	14	A. Is that your question?
15	Q. Okay. Atarax is a sedating	15	Q. Yes.
16	antihistamine, right?	16	A. Yes. It's somewhat lower in the
17	A. That's correct.	17	evening than it is in the morning. I agree.
18	Q. Okay. Now, let's talk about some	18	Q. Let's go through them.
10	clinical findings as were set forth in the	19	A. Okay.
20	record. And sir, for your convenience I'm	20	Q. At 0200 in the morning it was 160
20	going to hand you what we've marked as	21	over 98, right?
22	Plaintiff's Exhibit 2. And if you would like	22	A. Right.
22	to try to find that in the records you	23	Q. At 0900 it was 157 over 78.
23	brought with you, feel free.	24	A. Right.
24	A. If it's okay with you, I'll just	25	Q. At 1800 in the evening, it was 132
2.5	A. If it's okuy with you, i'n just		
	Page 59		Page 61
1	look at this.	1	over 70.
2	Q. That's fine. Her urine output on	2	A. Right.
1 2			A. Englit.
3	the 4th was lower than on well, it was	3	Q. And at 2200 that's 10:00
4		3	
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4	the 4th was lower than on well, it was I'm sorry. Let's talk about her urine	4	Q. And at 2200 that's 10:00 o'clock at night
4 5	the 4th was lower than on well, it was I'm sorry. Let's talk about her urine output. The intake was 2533. And how is	4	Q. And at 2200 that's 10:00 o'clock at night A. Right.
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		1	
	Page 62		Page 64
1	A. Okay.	1	episode when she almost passed out mid to
2	Q. You can't tell me if the	2	late morning on the 5th. Do you remember
3	progressive lowering of the blood pressure is	3	seeing that in the records?
4	from her compensatory mechanism being slowly	4	A. I do not remember seeing that.
5	overwhelmed by a slow ongoing bleed from the	5	Q. Okay. I would like you to assume
6	ablation site or whether it's the desired	6	that she was being walked to the ladies room
7	effects of the Isordil and Hydralazine. Can	7	and she almost passed out.
8	you tell me that?	8	A. Okay.
9	•	9	•
1	A. Can you repeat the question one	1	Q. And but she had been given
10	more time?	10	Atarax. Okay. Would you assume that too,
11	Q. Sure.	11	please, sir?
12	A. You want to know if the lowered	12	A. Yes.
13	blood pressure I can differentiate whether	13	Q. Given that she almost passed out
14	it's due to the medication or due to	14	mid to late morning on the 5th as she was
15	Q. A slow ongoing bleed from the	15	walking to the ladies room and was being
16	ablation site.	16	walked by a nurse, again you can't tell me
17	A. I think that's correct.	17	whether that episode is from the Ativan
18	Q. Okay. Now, let's look at her	18	prescribed by Dr. Hulyalkar or the decreased
19	blood pressure on the 5th. Is it fair to	19	level of consciousness from her compensatory
1	i	20	
20	say it's getting lower then?	E Contraction of the second se	mechanisms being overwhelmed by a slow ongoing
21	A. I think what you can say is the	21	bleed from the ablation site?
22	first one on the 5th is back to 153 again.	22	A. There's many, many causes of
23	Q. Yes.	23	syncope, of fainting.
24	A. So it's sort of back to where we	24	Q. Okay.
25	just were. The next one subsequent ones	25	A. It's hard to know what caused it.
	•		
		[
	Page 63		Page 65
1	Page 63	1	Page 65
1	were all lower and lower and lower. I agree	1	Q. Okay. And she also had some
1 2 2	were all lower and lower and lower. I agree with that. Yes.	2	Q. Okay. And she also had some problems with her peripheral areas, didn't
3	were all lower and lower and lower. I agree with that. Yes.Q. And that 153 over 78 is at 2:00	2 3	Q. Okay. And she also had some problems with her peripheral areas, didn't she? She had a peripheral neuropathy?
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	Page 66	_	Page 68
1	did the CT scan on March 3rd, right?	1	going on rather slowly and it could not be
2	A. Right.	2	detected clinically.
3	Q. Okay. And this is because Mrs.	3	A. I think that's possible.
4	Robinson had an area of ecchymosis on her	4	MR. LEAK: Objection.
5	right flank. Fair?	5	BY MR. BURNETT:
6	A. That's correct.	6	Q. Now, sometimes patients can
7	Q. Okay. Now, an area of ecchymosis,	7	continue to bleed and these compensatory
8	we also call it a hematoma, right?	8	mechanisms we talked about can allow their
9	A. I think that ecchymosis is usually	9	blood pressure to remain somewhat stable.
10	bleeding. Hematoma is usually a little more	10	Fair?
11	significant. That's actually a bigger	11	A. Yes.
12	collection of blood if you will.	12	Q. Okay. And by the way, I note
13	Q. Did she have hematoma or a	13	that the nurses in the chart we see the
14	bruising?	14	nurses marked a line around the edge of the
15	A. It was defined as a hematoma.	15	black and blue mark on her skin.
16	Q. Okay. And that can evidence	16	A. Yes.
17	itself as a black and blue mark on the skin?	17	Q. Okay. This is to determine
18	A. That is correct.	18	this is to ensure that it's not getting any
19	Q. All right. And the CT scan	19	larger, right?
20	actually showed a pooling of blood internally	20	A. That's correct.
20	in her. Fair?	20	Q. Because if it expands beyond that
21		21	line, you've got to be alert that there's
22		23	still bleeding going on, right?
	Q. Okay.	1	
24	A. If that's internally, then yes.	24	A. That's certainly one of the
25	Q. Yeah. And we talked about the	25	possibilities. Yes.
	Page 67		Page 69
1	source of that bleed being from the site from	1	Q. Okay. But I want to make sure
2	the ablation procedure.	2	that I understand if I'm correct here, that
3	A. Yes.	3	there can be continued bleeding internally
4	Q. Okay. Now, we know that after her	4	that can occur without the black and blue
5	death there was an autopsy.	5	mark expanding beyond the lines, okay, but go
6	A. Correct.	6	into different tissue planes internally. Is
	Q. And you've seen the autopsy.		that fair?
8	A. I have.	8	A. That is correct. And in fact with
E		9	these retroperitoneal bleeds there's often no
9	Q. Okay. The autopsy showed a huge	1	-
10	hemorrhage that is a bleed in the	10	external signs that this is ongoing. We're sort of left with blood counts and clinical
11	retroperitoneal space, the anterior abdominal	11	
12	wall on the right, and down into the cubitus	12	status of the patient.
13	and anterior chest wall. Is that fair?	13	Q. Good. Okay. And since you're
14	A. That's fair.	14	talking about blood counts at this point,
15	Q. Okay. This bleed was also from	15	let's talk about the hemoglobin and hematocrit
16	the same site, that site of the ablation	16	test.
17	procedure. Fair?	17	A. Okay.
18	A. Yes.	18	Q. Again to reiterate, that can
19	Q. Okay. So the blood loss causing	19	essentially tell a doctor among other
20	her death and the blood loss we see in the	20	things, it can tell a doctor if a patient is
21	CT scan on the 3rd was from the same site.	21	losing blood, right?
22	A. Correct.	22	A. That's correct.
23	Q. Okay. I think you'll agree with	23	Q. And that would be even internal
24	me that it's at least possible that, prior to	24	bleeding. If the blood is going out of the
25	the evening of March 5th, this bleed had been	25	spaces where it's normally supposed to be,
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	Page 70		Page 72
1	that can reveal itself in a hemoglobin and	1	Fair?
2	hematocrit test, right?	2	A. She clearly had been her
3	A. That's correct.	3	bleeding didn't start exactly that instant.
4	Q. And what's a normal hemoglobin and	4	It started sometime before. It's hard to
5	hematocrit?	5	know exactly when.
6	A. It's a little different in women	6	Q. Okay. And by the way, during this
7	than men.	7	whole period of time, you know, March 2nd,
8	Q. Okay.	8	March 3rd, March 4th, March 5th, up until
9	A. But it's generally in the mid	9	later that evening, she's still on the blood
10	40's.	10	thinning medicine, right?
11	Q. And that's the hematocrit?	11	A. That's correct.
12	A. That's hematocrit.	12	Q. Okay. Now, the previous test that
12		13	was done by Dr. Hulyalkar was done some 40
		13	hours earlier.
14	A. Hemoglobin is generally about a		1
15	third of that. So it's about 15 in a man	15	A. That's correct.
16	and it's about 13 or 14 in a woman.	16	Q. Okay. And that was done at 4:00
17	Q. Good. Okay. Now, you've	17	o'clock in the morning on March 4th, right?
18	certainly ordered hemoglobin and hematocrit	18	A. That's correct.
19	tests to determine if one of your patients is	1 9	Q. A little low but essentially normal
20	losing blood internally. Fair?	20	on that test, right?
21	A. Yes.	21	A. Yes.
22	Q. Okay. Now, there can be a lag	22	Q. Okay. I think the major area of
23	time between the onset of bleeding and the	23	between you and me of our disagreement
24	drop in the hemoglobin and hematocrit. Is	24	is whether Dr. Hulyalkar was required by the
25	that fair?	25	standard of care to have done more hemoglobin
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	Page 71		Page 73
1	A. That's correct.	1	and hematocrit tests within those 40 hour
2	Q. Okay. That lag time can be	2	period that 40 hour period. Is that
3	anywhere from four to eight hours. Fair?	3	fair?
4	A. I think that's fair.	4	A. Okay.
5	Q. Okay. Now, we know that Dr.	5	Q. Okay. Or whether he should have
6	Hulyalkar ordered a hemoglobin and hematocrit	6	done more CT scans within that 40 hour
1		7	
7	test on the evening of the 5th.		period.
8	A. That's correct.	8	A. Okay.
9	Q. Okay. And as of 10:30 that	9	Q. All right? And I think you'll
10	evening the hemoglobin and hematocrit of Mrs.	10	agree with me that had Dr. Hulyalkar done
11	Robinson was 6.2 and 19.4, right?	11	hemoglobin and hematocrit tests every four to
12	A. Correct.	12	six hours within that time frame, it's
13	Q. She lost a lot of blood.	13	certainly at least possible that they would
14	A. Correct.	14	have been progressively lower and would have
15	Q. I think you don't agree with me it	15	reflected a slow ongoing bleed.
16	was nearly 50 percent but it was certainly at	16	MR. LEAK: Objection.
17	least 30 percent of her blood volume.	17	A. I think that's true. Yes.
18	A. I think that's fair. I think she	18	BY MR. BURNETT:
19	had a significant bleed. Yeah.	19	Q. Okay. Or excuse me. If he
20	Q. And it's likely that as of the	20	had done that, that and he had seen that
21	time of that test at 10:30 at night, there	21	they were going progressively lower, that
21	was a lag time and we were four to eight	21	would have tipped him off to a continued
22		22	internal bleed from the ablation site. Fair?
1	hours behind. It was conceivable that she	23 24	
24	had actually her blood volume was actually		
25	lower than what was reflected at 10:30.	25	Q. Okay. And then he would have been
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	Page 74		Page 76
1	faced with the decision as to whether or not	1	Q. And I don't disagree with you.
2	to stop the anticoagulants, the blood thinning	2	But I think again we're coming to the crux
3	medicine, and to get a surgical consult.	3	of our disagreement, and that is, given the
4	Right?	4	fact that he had held the diuretics,
5	A. Right. I think you know, it's	5	prescribed the medicine, and was not doing
6	easy knowing what happened knowing that her	6	serial hemoglobin and hematocrit tests, he
7	bleeding was severe on the evening of the	7	could be falsely reassured that everything was
8	5th, had he done something a few hours before	8	okay during that period of time if she was
9	then, he probably would have caught it	9	experiencing a slow ongoing bleed because he
10	earlier and maybe been able to intervene	10	could attribute altered mental state to the
11	successfully. But you could argue for now	11	Ativan or the decrease in blood pressure to
12	many days she had been very, very stable and	12	the Isordil.
13	had he gotten CAT scans every six hours for	13	A. I agree with that.
14	the days before, everything probably would	14	Q. Okay. And I think also when we
15	have looked fine and he would have been	15	talk about clinically, I think you told me in
16	falsely reassured that she was not in any	16	your deposition that as long as things are
17	trouble.	17	okay hemodynamically, there's no reason to
18	Had he gotten you know, every	18	suspect a bleed. Fair?
19	four to six hours gotten a hemoglobin	19	A. Yeah. I think in somebody who's
20	analysis on the 1st and the 2nd and the 3rd	20	now six or seven days out from the procedure,
21	and the 4th, he would again have been falsely	21	that would be a very unusual time. I think
22	reassured that she was stable and not	22	you're much more confident that things are
23	bleeding and would have been fine. I think	23	stable at this point.
24	it's easy to say after the fact that, gee,	24	Q. But to really get a handle on her
25	since she had this catastrophic event then,	25	hemodynamics, you need to do a hemoglobin and
r	Page 75		Page 77
1	if we would have had the values right before	1	hematocrit test, don't you?
2	then, we could have predicted it a little bit	2	A. It depends how hemodynamics are
3	earlier. That is true I agree. But there	3	usually pulse and blood pressure. They had
4	was nothing clinically to suggest she was	4	been measuring them on a routine basis.
5	having any problems just because for the most	5	Q. And just so the jury understands
6	part her blood pressure was pretty reasonable,	6	your position, again given the fact that the
7	she was awake, she was feeling pretty well.	7	diuretics were held, Ativan was prescribed,
8	The hematoma hadn't expanded in size.	8	Isordil was prescribed, under these
9	Q. But we also know that on the 4th	9	circumstances he was still not outside the
10	and certainly on the 5th he had prescribed	10	standard of care to have not done a
11	medications and held her diuretics in such a	11	hemoglobin and hematocrit test for that 40
12	way that certainly changes clinically okay	12	hour period of time.
13	 what might tip a physician off that a 	13	A. I agree that was still within the
14	patient is experiencing an internal bleed	14	standard of care.
15	could also be attributed to those medications	15	Q. Okay. And it was still not
16	or the fact of holding the diuretics.	16	outside the standard of care, in your
17	A. I think that's true. But again,	17	opinion, not to have done a hemoglobin and
18	these are life sustaining medicines that are	18	hematocrit test at least once in the early
19	starting I guess now that she's almost a	19	morning hours of the 5th.
20	week out of her procedure and you're starting	20	A. I think in retrospect, that clearly
21	to think about discharge, you want to put her	21	would have been helpful but I don't think
22	on the best medications to give her the best	22	there was any reason in her clinical
23	possible chance at a good quality of life and	23	situation to dictate that it was needed.
24	improved heart function, decreased	24	MR. BURNETT: Thank you. I don't
25	hospitalization. So I think	25	have any other questions.

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1	THE WITNESS: You're welcome.	1	CERTIFICATE OF SHORTHAND REPORTER - NOTARY
2	MR. LEAK: I have no further	2	PUBLIC
3	questions.	3	I, Alda Mandell, Registered
4	THE VIDEO OPERATOR: This concludes	4	Professional Reporter, the officer before whom
5	the deposition. We are off record at	5	the foregoing proceedings were taken, do
6	11:17:59.	6	hereby certify that the foregoing transcript
7	(The deposition was concluded at	7	is a true and correct record of the
8	11:17 a.m.)	8	proceedings; that said proceedings were taken
9	,	9	by me stenographically and thereafter reduced
10	•	10	to typewriting under my supervision; and that
11	·	11	I am neither counsel for, related to, nor
12	•	12	employed by any of the parties to this case
12	•	13	and have no interest, financial or otherwise,
1	•	14	in its outcome.
14	•	1	
15		15	IN WITNESS WHEREOF, I have hereunto
16		16	set my hand and affixed my notarial seal this
17		17	20th day of July 2004.
18		18	My commission expires: June 30,
19		19	2006
20		20	
21		21	NOTARY PUBLIC IN AND FOR THE
22		22	DISTRICT OF COLUMBIA
23		23	
24	•	24	
25	·	25	•
25	•	20	·
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	DESCRIPTION OF EXHIBITS	1	
2	EXHIBIT DESCRIPTION		
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	A Curriculum vitae		
4	A Curriculum vitae (Attached to the Transcript)		
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