In The Matter Of:

Estate of Peter Restivo, etc. v. Community Health Partners Home Health Care, et al.

Charles L. Emerman, M.D.

May 2, 2003

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IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO
ESTATE OF PETER RESTIVO
BY AND THROUGH CATHY RESTIVO,
ETC., EXECUTRIX,
Plaintiff,
JUDGE FRIEDLAND
-vs- CASE NO. 445732
COMMUNITY HEALTH
PARTNERS, et al.,

Defendants.

Deposition of CHARLES L. EMERMAN, M.D., taken as if upon cross-examination before Tami A. Mitchell, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at The Cleveland Clinic, 9500 Euclid Avenue, Cleveland, Ohio, at 4:03 p.m. on Friday, May 2, 2003, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

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On behalf of the Defendants
Community Health Partners Home Health
Care and Alanna Verlei

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CHARLES L. EMERMAN, M.D., of lawful age, called by the Plaintiff for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF CHARLES L. EMERMAN, M.D.

BY MS. EKLUND:

Q: Doctor, would you state your name for the record and spell it for the court reporter.

A: Charles Louis, L-o-u-i-s, Emerman, E-m-e-r-m-a-n.

Q: Did you bring a CV with you?

A: No. I can get one if you would like one.

Q: I don't need — can you order one and send it in and we can continue with the questioning? Can it work that way?

A: Yeah.

Q: I take it you're with The Cleveland Clinic and you have a position within the emergency department?

A: I'm actually an employee of MetroHealth Medical Center and I am also the chairman of Emergency Medicine at The Cleveland Clinic.

Q: Where do you primarily practice medicine?

A: I practice at both locations.

Q: 50-50?

A: Yes.

Q: Do you know Dr. Carroll at MetroHealth?

A: Dr. Carroll?

Q: Marion Carroll?

A: I don't know her.

Q: Do you know of her?

A: I know of her.

MS. HARRIS: She's not at Metro.

Q: You know of her but you don't know her personally, correct?

A: I know that she is at UH.

Q: How do you know of her?

A: Well, she practices at a hospital four blocks down the street that's how I know she's there.

Q: You know her by name?

A: Yes.

Q: Do you have any, I guess, friends or acquaintances in common?

A: I wouldn't know that. I have never, as far as I know, I have never met her. I don't have a personal relationship with her. I don't have a business relationship with her.

Q: I assume you're board certified in emergency medicine?

A: Yes, I am.

Q: And when were you board certified?

A: 1983.

Q: Have you been recertified recently?

A: 1993.

Q: When are you next due to be recertified?

A: November.

Q: Of 2003. Every ten years?

A: That's correct.

Q: How long have you been at MetroHealth?

A: Since 1982.

Q: And when did you assume some responsibilities at The Cleveland Clinic?

A: 1996.

Q: How many hours a week do you work?

A: I'm paid 40 hours a week.

Q: And that time is split between Cleveland Clinic and MetroHealth?

A: That's correct.

Q: Have you ever worked at Elyria Memorial Hospital?

A: No, I have not.

Q: Do you know any of the physicians involved in the care rendered to Mr. Restivo?

A: No, I do not.

Q: Who asked you to become involved as an expert

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witness in this case?
A: Ms. Reid.
Q: Have you had other cases with Ms. Reid?
A: Yes.
Q: Can you tell me how many?
A: One or two.
Q: I assume all of your expert work with Ms. Reid has been on the subject of emergency medicine?
A: Yes.
Q: Do you have any subspecialties?
A: No, I do not.
Q: Have you worked with Beverly Harris before?
A: I have been on both sides of the table with Ms. Harris before.
Q: Meaning working with her and against her?
A: I wasn't working against her but I was an expert for the plaintiff's case and she was the defense lawyer.
Q: Who was the plaintiff's attorney?
A: I don't recall.
Q: Did the case go to trial?
A: It did.
Q: And do you remember what the allegations were?
A: Yes. It was a delay in diagnosis of a neck abscess.

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Q: And did you offer testimony on behalf of the plaintiff?
A: Yes.
Q: And that was in regard to the standard of care by the emergency room physician?
A: That's correct.
Q: What was the outcome of the case?
A: Ms. Harris won the case.
Q: How many cases per year do you review for medical-legal purposes?
A: Between 12 and 18.
Q: How do these cases come to you?
A: I'm not sure what you're asking. Lawyers call me up and ask me to review cases.
Q: It's word of mouth, that kind of thing?
A: Yes.
Q: You're not affiliated with any kind of a service that contacts you and asks you to review files?
A: Sometimes services contact me but I don't have a relationship with any.
Q: No contracts?
A: That's correct.
Q: You're not affiliated them?
A: No, I'm not.
Q: What is the breakdown between plaintiff versus

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defendant in cases that you review?
A: It's about one-third plaintiff, two thirds defense.
Q: Have you ever been a party as a defendant to a lawsuit?
A: Yes, I have.
Q: How many times?
A: Five times.
Q: Did any of those cases go to trial?
A: No, they did not.
Q: Were they settled?
A: Not on my behalf.
Q: Were you dismissed somewhere along the line?
A: That's correct.
Q: Can you tell me what you reviewed in the case of Peter Restivo?
A: Certainly. I have the report of Dr. Janiak. I have the deposition of Alanna Verlei, V-e-r-l-e-i. I have the deposition Catherine Restivo part one, Catherine Restivo part two, Peter Restivo. Marion Carroll, M.D., Debra Schwan, S-c-h-w-a-n, R.N., Linda Herman, M.D.
Q: Can I see what you were just referring to, Doctor?
A: Yes. I have the report of Jane Bennett, R.N.,

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Linda Herman, M.D., deposition of Diane Tucker, R.N. and Diane Shimko, R.N. I already stated that one, Linda Herman, M.D. deposition. And I have the medical records which include portions of an admission to Community Health Partners in September of 1999. Elyria Emergency Medical Center records for January 20th through February 10th, 2000. And then some miscellaneous records from February 24 of 2000. I believe that's it.
Q: Doctor, can I see the pile of correspondence you have? Doctor, I notice on April 28th, eight different — seven depositions and one report was sent to you by Ms. Reid. That was just a few days ago. Have you read all those depositions?
A: Yes, I have.
Q: Have you made any notes for your file as you went along and reviewed the medical records in this case?
A: I have not.
Q: And the report you prepared is dated December 13, 2002?
A: That's correct.
Q: Is that the only report you prepared in this case?
A: Yes, it is.

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Q: Did you make a draft of this report before putting it in final form?
A: No. I would have typed that up myself.
Q: Okay. And did you make any changes or have any conversation with counsel prior to preparing this report in terms of what would be in the report?
MS. REID: Objection. You can answer.
A: I would imagine I would have called Ms. Reid and told her my opinion before I prepared the report.
Q: Did Ms. Reid have any input into what was contained in your report?
A: No.
Q: You reviewed records and depositions subsequent to authorizing this report. Are there any additions or changes to this report you would like to make in light of reading additional material?
A: It does not change my opinion.
Q: Doctor, I take it you are skilled in the placing of a Foley catheter in a patient?
A: Yes.
Q: Can you tell me what the procedure is for correct placement of a Foley catheter?
A: Certainly. We have a kit that has all the

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materials in it. We would clean the area off with betadine solution, put drapes around the area to be catheterized.
Are you asking about a male?
Q: Yes.
A: So we would clean the penis with betadine solution. We would drape it using sterile technique. We would insert the Foley catheter into the bladder. We would then inflate a balloon, attach the Foley catheter to a bag, secure the Foley to the leg and be done.
Q: How do you know when you're putting a Foley catheter you actually have the Foley in the bladder?
A: You would either get return of urine or you would insert the Foley to a length you would expect to be in the bladder.
Q: Would you ever inflate the balloon if you hadn't observed return of urine coming from the catheter?
A: Could you say the question one more time? I want to make sure I heard you correct.
Q: Would you ever inflate the balloon before observing flow of urine coming from the catheter?
A: If I had thought I had inserted it into the

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bladder then I would.
Q: Did you have a practice of observing the Foley after you inserted it to make sure that you have flow through the catheter?
A: You mean after I inserted it —
Q: Yes.
A: — and inflated the balloon?
Q: Yes.
A: Then I would want to see I was getting urine out. Although there are some patients that aren't going to make any urine, then I would note that.
Q: And how long would you observe for flow of urine before you felt comfortable the Foley was in properly?
A: I would know immediately the Foley was in improperly.
Q: How would you know?
A: I would inflate the balloon and try to withdraw the Foley. And if it's in the bladder, you would not be able to withdraw the Foley.
Q: If it was in the urethra, it would come right out?
A: If it was in the urethra, you would be able to withdraw it.
Q: There would be no resistance to withdrawing it if

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it's in the urethra?
A: If it's in the bladder — you reach a surface when you withdraw it if it's in the bladder. If it's in the urethra — let me start it again so that it's clear.
If it's in the bladder as you withdraw it when you come up to the —
Q: The neck of the bladder?
A: No. The word I'm blanking on. When you come to the junction between the bladder and urethra the Foley will stop. If it's in the urethra it will continue to allow you to withdraw. There will not be a lot of resistance with withdrawal.
Q: Am I correct the bladder is a hollow organ?
A: Sphincter is the word I was thinking of. I couldn't think of it.
Q: When you have the Foley properly placed and balloon inflated when you tug the sphincter will prevent the Foley from coming out?
A: That's correct.
Q: Because of the balloon inflation?
A: That's correct.
Q: That's the way the Foley is designed to work?
A: Yes.
Q: The balloon is what keeps it in place in the

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bladder?
A: Yes, that's correct.
Q: And am I correct the bladder is basically a hollow organ that basically holds urine?
A: Yes.
Q: When you inflate the balloon on the Foley am I correct that you should not need any resistance to that inflation since you're in a hollow organ?
A: Well, the balloon has its own properties so there is some resistance when you go to blow up the balloon. Just as if you are to blow up a party balloon, when you first go to inflate there's more resistance then as it distends.
Q: The normal resistance of the balloon. But you shouldn't feel the resistance from the tissues or constriction from the body part, correct.
A: Yes, that's correct.
Q: Do you normally have bleeding around the meatus when a Foley catheter is inserted?
A: In some patients.
Q: Is it a common occurrence?
A: It's not uncommon.
Q: Does it indicate any trauma to urethra if you have bleeding around the meatus?
A: Just from the urethra being irritated from a

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chronic Foley placement you might have some abrasion of the urethra after you place the Foley.
Q: What about blood in the urine when you put a Foley in, is that a sign of a problem?
A: It may be a sign of a problem of some sort but not necessarily a sign of urethral trauma. There's a lot of reasons to have blood in the urine.
Q: Is it normal to have a little bit of blood in the urine?
A: In the case of indwelling Foleys it would be common to find blood in their urine.
Q: Does it take a significant amount of force to pull an inflated Foley from the bladder down into the urethra?
A: No, it would not take an excessive amount of force. It's possible to do so.
Q: But it does take some amount force to do that?
A: Some amount of force, of course.
Q: Do you agree that if a Foley is pulled from the bladder into the urethra that you'll have bleeding?
A: Yes.
Q: Do you agree with Dr. Carroll's testimony that

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would cause a tremendous amount of bleeding?
A: I'm not sure what tremendous amount is supposed to imply. You may have some bleeding. You may have a small amount of bleeding. Depends on where the balloon is sitting in relationship to the bleeding. If the balloon is sitting distal to the area of bleeding, you may not have much bleeding externally. The bleeding may all be internal.
Q: If the balloon is not sitting distal to the area of bleeding you may see a significant amount of bleeding?
A: You might.
Q: Do you know the other expert witnesses who provided reports in this case, Dr. Janiak?
A: Yes, I know Dr. Janiak.
Q: How do you know Dr. Janiak?
A: I went to medical school in Toledo.
Q: He was a fellow student?
A: No, faculty there.
Q: I haven't seen him in awhile. Do you know Dr. Herman?
A: No, I do not.
Q: Do you know any of the health care nurses?
A: No, I do not.

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Q: Doctor, I'm looking at the report you wrote on December 13, 2002 and I'm just a little bit confused about a couple things. When you mentioned the materials you reviewed, item number four mentions Elyria Memorial Hospital emergency department records 2-24-00. Is that an incorrect date?
A: I believe that, as I recall, he was taken there for pronouncement.
Q: On the second page of your report at the — beginning second line you say Alanna Verlei saw the patient in his home 1-99-00?
A: That should be 19. I told you I typed it up myself.
Q: Oh, you typed it up.
MS. REID: Spell check doesn't check those things.
Q: Doctor, when you examine a patient in the emergency room setting and have a Foley catheter, do you typically mention it in your history or your examination notes?
A: No, not necessarily. It would depend what they are there for.
Q: So you wouldn't — in the normal course of practice it wouldn't be your practice to mention

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that the patient has an indwelling Foley catheter and there would be no mention of urine or anything else?
A: It would depend what their problem was whether I mention it. I might or might not.
Q: You agree Mr. Restivo presented with some complaints with regard to the insertion of the Foley catheter earlier that day.
MS. HARRIS: Objection. It's not complaints. It's history.
MS. REID: Objection.
Q: Go ahead.
A: Yes, he had complaints of hematuria or complaints were given to the in-take nurse.
Q: And in your review of the emergency room records do you find any mention of any examination of the penis or the hematuria that was complained of on presentation?
A: You're referring to Dr. Carroll's note.
Q: Any note in the emergency room, nurses, Dr. Carroll, anybody?
A: As I recall Dr. Carroll has documented the results of her abdominal which would include palpation of the suprapubic area.
Q: My question, Doctor — I'm not talking about

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deposition testimony. I'm talking in the emergency room record in Dr. Carroll's handwritten notes do you find any specific reference to conditions, observation of the penis or any mention of hematuria?
A: I don't recall any documentation about her examination of the penis or mentioning about the hematuria.
Q: Did you find the history and physical worksheet that Dr. Carroll completed for Mr. Restivo to be incomplete?
A: Well, there are portions of it that aren't filled out.
Q: Would you consider that incomplete?
A: I think she considered it to be incomplete.
Q: What do you consider it?
A: A completed record is one where the physician documents everything they intended to document. If she thinks she didn't get to document everything she intended to, it would be incomplete.
Q: Doctor, in your emergency rooms do you expect nurses to keep an accurate account of the patient's fluid in-take and fluid output?
A: Not for most patients, no.

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Q: When would you expect nurses to keep track of fluid in-take and output?
A: If we were doing something to manipulate their in-take or output I would expect them to document that.
Q: If you ordered an IV infusion of some type you would expect nurses to keep track of input and output?
A: There are sometimes where the amount of urine that is put out is important, such as a patient with heart failure. In that case we would want to know that. There are other circumstances similar to that but other than that it would not be a routine expectation of mine.
Q: In a patient who is receiving IV saline solution in the emergency department would you expect someone to keep track of how much he received?
A: If I was resuscitating them, I would expect to have that. If they were getting routine maintenance fluids, it wouldn't make any difference to me.
Q: Mr. Restivo was admitted or I guess initially worked up for stroke, correct? Is that correct?
A: Well, I think he was being worked up for possibility of stroke and for these convulsions

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he was having.
Q: And they also worked him up for cardiac problems, correct?
A: Yes, they did.
Q: And in a patient with that presentation and that workup would you expect the nurses to keep track of urine output?
A: No.
Q: Do you anticipate that a patient will stay hydrated while they're in the emergency room?
A: It would depend how long they're there for.
Q: If they're in for five hours do you expect some attention to be paid to their level of hydration?
A: If somebody comes in hydrated do I think they might get dehydrated five hours in the emergency department, is that your question?
Q: My question is do you pay attention to whether there is fluid in-take from the patient in a five hour period of time?
A: I wouldn't think a five hour period of time would be long enough for them to become dehydrated.
Q: Do you agree that an emergency room physician has an obligation to investigate all of the complaints of the patient when they come into the emergency department?

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MS. HARRIS: Objection.
A: No, not necessarily.
Q: In Mr. Restivo's case do you agree there was an obligation to investigate the Foley catheter and hematuria that was reported?
A: No. Generally we would address the things that are most critical, which in this case would be the possibility of stroke and convulsions.
Q: That doesn't preclude you from also investigating the complaints of difficult Foley insertion and hematuria, does it, Doctor?
A: No, it does not.
Q: It's a very simple thing to check whether the Foley is positioned properly and whether it's draining properly, correct?
MS. HARRIS: Objection.
MS. REID: Objection. You can answer.
A: You would do that by palpating the bladder and visualizing the Foley and whether there's any urine in the Foley bag.
Q: And if you suspect the Foley isn't placed properly, how would you check to see whether you're right or wrong?
A: If I thought the Foley wasn't placed properly?

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Q: Yes?
A: I would remove it and reinsert it.
Q: I'm sorry I couldn't hear.
A: I would remove and reinsert it.
Q: Would irrigation tell you whether it's functioning properly?
A: If I thought it wasn't — you changed your question. Are you asking about positioning or function?
Q: If it's not positioned properly, it's not going to function properly; is that fair?
A: That's true but that's not an inclusive answer. It could be positioned properly and still not be functioning. So if I thought it was positioned properly but not functioning I would try to irrigate it. If I thought it was improperly positioned, I would remove it.
Q: Have you ever had a patient in the emergency room who pulled his own indwelling Foley catheter into the urethra?
A: Yes.
Q: How many times?
A: I couldn't tell you how many times.
Q: Is it a frequent occurrence?
A: It's not an unusual occurrence.

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Q: Do those patients present in a great deal of pain?
A: Some of them do.
Q: Do they present with bleeding?
A: Sometimes.
Q: What is the normal amount of urine output per hour for an adult?
A: An adult without renal disease, is that your question?
Q: Yes re.
A: .5 ccs per kilogram per hour.
Q: Per kilogram of weight?
A: Yes.
Q: In an individual with renal insufficiency they may have normal urine output, correct?
A: Depends on the type of renal insufficiency and sometimes it would be normal, most times it would be diminished.
Q: The problem with renal insufficiency is not the urine output, it's the inability of the body to clear toxins from the body, is that correct, or is it both?
A: Well, people with renal insufficiency don't put out normal amounts of urine.
Q: Are you able to quantify how much you would

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expect to see in reduction of urine output in a patient with renal insufficiency?
A: There's not an easy correlation you can make and it would depend on the severity of their renal disease; anywhere from mildly diminished to completely absent.
Q: Is that true in patients who has an indwelling Foley catheter?
A: Yes. If you have renal insufficiency the amount urine you make is unrelated to whether or not you have a Foley catheter.
Q: When a Foley catheter is changed, is it normal for the patient to experience some pain?
A: Yes.
Q: When is it first documented in the Elyria admission that Mr. Restivo's urine output was low?
A: It's documented in the notes that he had no urine output at 2:00 in the morning on the morning of the 21st.
Q: What time frame did that cover?
A: It was a nursing notation that he had no urine output and they called the physician.
Q: What had his urine output been prior to that 2:00 a.m. note?

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A: It was 200 ccs on the day shift and 100 ccs on the night shift.
Q: Do you consider 200 ccs to be a low output?
A: No. I would think that would be normal.
Q: What time frame did the 200 ccs cover?
A: Documented from the day shift from the time up on the floor. 10:00 in the morning.
Q: 10:00 to?
A: 3:00.
Q: What was his fluid in-take in that period of time?
A: 200 ccs.
Q: And that's from the 10:00 to 3.00 time frame?
A: It's actually 2:00.
Q: The next reading on urine output is 100 ccs. You consider that to be low urine output?
A: For a person who did not have renal insufficiency that would be low. For a person with renal insufficiency that may be low.
Q: Do you know what Mr. Restivo's urine output was while he was in the emergency department?
A: No, I do not.
Q: Do you know what his fluid in-take was while he was in emergency?
A: I can't read it on this copy. I'm sorry. I

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can't read the infusion rate on this copy.
Q: What sheet are you looking at?
A: I'm on the emergency department medical record. It has 18 at the top of it.
Q: Where on that page do you think there's an indication of fluid?
A: I can't read what that says in my copy.
Q: Okay. Can you flip to a few pages beyond there? There's an intravenous therapy flow record. Keep going. It's this sheet, Doctor .
A: I don't have that in my copy.
Q: I will show you mine.
A: His rate is keep vein open so he would have minimal fluid in-take from that and then he's got heparin started at 9:50 and it looks like 10 ccs per hour. So he would have been getting about 10 ccs an hour from the time the IV was started.
Q: Okay. Doctor, in a patient with a Foley, what is the importance of observing the color of the urine?
A: Well, that's a pretty broad question. It would depend on the setting.
Q: Color of the urine can indicate the possibility of infection, can't it?
A: In a patient who's never had a Foley before, it

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might. In a patient who has a chronic indwelling Foley they frequently have colonization without infection.
Q: In a hospital admission urine goes from a clear yellow to a hazy or darker yellow, you see a change in the color, that's an indication of infection, isn't it?
A: It might be or might be a sign of irritation from the Foley.
Q: And it's also important to measure the volume of urine output in a patient who has been hospitalized, would you agree with that?
A: It would depend on the setting. It can be important. Sometimes it's not particularly helpful.
Q: It's routinely done, though, isn't it?
A: In hospitalized patients it's frequently done, yes.
Q: Particularly in a patient who is known to have renal insufficiency, wouldn't you agree?
A: Again, it would depend on the setting.
Q: For Mr. Restivo was it important during his admission to Elyria, his urine output?
MS. REID: In the emergency department or on the floor?

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Q: On the floor.
A: I believe they did monitor his urine output.
Q: And that's important to do, right?
A: It can be. It depends on the setting.
Q: For this patient, this setting, was it an important thing to do?
A: Are you asking me in retrospect or asking me prospectively?
Q: Answer it both ways.
A: Well, prospectively you have a patient who is being admitted for stroke and seizures who has renal insufficiency which is apparently something he has had before. What you would want to monitor then would be his renal function test.
Q: Does that include monitoring his urine output?
A: That would be one component although you could check for changes in renal function by doing blood tests.
Q: Is 200 ccs of urine output in a 10 hour period low?
A: It would depend on the patient's weight and depend whether the patient has kidney disease.
Q: In Mr. Restivo's situation would you consider that low urine output?
A: Not with somebody with renal insufficiency, no.

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Q: What is your understanding of the nature of his renal insufficiency disease?
A: Are you asking me why he has it?
Q: Yes, what is it?
A: Most likely etiology would be either diabetes or his hypertension. He has vascular disease. All those things would combine to give him — be reasons for him to have renal insufficiency.
Q: Do you know whether his renal insufficiency included reduced output?
A: I don't believe I have those records.
Q: You're making some assumptions concerning what would be normal for Mr. Restivo, correct?
A: I'm giving an opinion based on reasonable medical probability.
Q: How can you give me an opinion based on medical reliability without the records?
A: I know what his renal function is and it's markedly diminished. It's my expectation, that would lead me to believe he had reduced urine.
Q: Is it markedly diminished because of the urosepsis?
A: Not at the time he was in the emergency department, no.
Q: Was there an evaluation of his renal function

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while he was in the emergency department?
A: Yes.
Q: What is it?
A: He had renal function tests performed.
Q: In the emergency department?
A: Yes.
Q: Can you point those out to me?
A: Certainly. They're in his chemistry report.
Q: Okay.
A: And it appears in their chart they combine all the laboratory tests in one big chart so you would look on his chemistry report under January 20th lab test performed at 5:20 and you see that his BUN is 60.
Q: Is that elevated?
A: Yes. And his creatinine is 4.2 which is also elevated.
Q: Would urinary obstruction cause elevation in those lab values also?
A: If it had been going on for a long enough period of time you could develop renal insufficiency from complete obstruction.
Q: How long is a long enough period of time?
A: I'm not sure I would run any study on that. However, we see people who have been obstructed

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to 24 hours without having impairment of renal function.
Q: Have you seen patients in that time frame who have had impairment of renal function?
A: Not as a new finding, no.
Q: What is urosepsis?
A: Sepsis occurring from a site of infection in the kidney or bladder.
Q: In the instance of complete urinary obstruction how does urosepsis set in?
A: Well, urosepsis sets in having infection in the urinary tract someplace along its course. It could be contamination from the urinary tract or spreading through the blood. There would be a few other ways but those are the primary two.
Q: In the case of obstruction how does that cause urosepsis?
MS. HARRIS: Objection.
A: I'm sorry?
MS. HARRIS: Objection.
A: It's the same answer. Infection forms somewhere.
Q: What is the mechanism of it I'm asking you.
A: Your question is not clear to me.
Q: How does urinary obstruction cause urosepsis?
A: I guess that's the part I'm having trouble

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answering. You can get urosepsis in the absence of obstruction. You can have obstruction without urosepsis. You can have urosepsis and obstruction at the same time. I'm having trouble answering your question.
Q: What happens to the kidneys when there is complete urinary obstruction?
A: They continue to make urine until they shut down.
Q: What happens to the individual when the kidneys shuts down?
A: They would have renal failure. They would have to go upon dialysis.
Q: In the last page of your report you basically summarize your opinions in this case; is that correct?
A: Yes.
Q: And it's your opinion that the emergency department nurse appropriately assessed Mr. Restivo and gave him medication in accordance with the physician's notes; is that correct?
A: Yes.
Q: That's despite the fact that there was no documentation of fluid in-take, fluid output, correct?
A: Well, you showed me his fluid in-take.

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Q: Okay. No fluid output?
A: That was not noted in the record.
Q: And that is acceptable in your mind as a nursing standard not to record urine output in the emergency department, correct?
A: In this setting, yes.
Q: When you say in this setting, why do you qualify it that way?
A: There might be different problems where it would be important to assess. This is not one of those.
Q: So I'm clear, in a patient with a known history of renal insufficiency you don't feel it was important in the emergency department to monitor urine output?
A: Yes.
Q: Yes I did state your opinion correctly?
A: That's correct.
Q: And then you also state, to a reasonable degree of medical certainty, that the nurses would have observed yellow urinary drainage as documented by the in-take nurse. What is your basis for that?
A: He had a Foley that was placed. It was observed a few hours later by a nurse on the floor who documented that the patient had a patent Foley

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with yellow urine draining.
Q: What time was that documented?
A: Around 10:00 in the morning. That leads to my opinion if the nurse in the emergency department had documented several hours earlier, they would have documented the same thing seen at 10:00 in the morning and seen again on the afternoon shift.
Q: Would you agree that the amount of urine output is more important than the fact there is yellow urine?
A: It would depend on the setting. The fact he's putting out yellow urine tells me the Foley is patent and he's making urine.
Q: In a patient who presents in an emergency department with a history of difficult Foley change with bleeding, you are still of the opinion that urine output on that patient does not need to be monitored in the emergency department, am I correct?
MS. REID: Object to your characterization but go ahead and answer.
A: It's my expectation if they had documented that, they would have document the similar findings that they found on the floor.

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Q: You can still have some urine draining with a urinary obstruction, am I correct?
A: No. If you have an obstruction, you would not have urine draining.
Q: You can have an incomplete obstruction, can't you, Doctor?
A: If you have urinary tract obstruction, you don't have any urine output.
Q: None at all?
A: That's correct.
Q: Mr. Restivo had urine output throughout his hospitalization when it started to be documented, do you agree with that?
A: Up until 2:00 in the morning.
Q: After 2:00 in the morning he still had urine output?
A: I have to look at it again. I think it was pretty minimal amount, as I recall.
Q: Minimal or not he did have urine flow, didn't he?
A: My records have fallen apart.
Q: You don't need to look because you and I both recall he did have some urine output even after the 2:00 note?
A: My recollection it was about 10 ccs. But I'm just guessing at that because I can't get my

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records back together.
Q: I will tell you at 6:00 he had 84 ccs. At 1400 he had 46. That would indicate some urine output, wouldn't it, Doctor?
A: Yes.
Q: Do you disagree with the fact that the Foley catheter was found in the urethra in Mr. Restivo?
A: The next day?
Q: Yes.
A: I agree with that.
Q: You agree that would cause some urinary obstruction?
A: Yes.
Q: And do you agree that that would cause urinary urosepsis in this patient?
MS. HARRIS: Objection.
A: I think we covered this, didn't we?
Q: Well, can you answer my question?
A: No, I don't think I can for the same reasons we talked about before.
Q: So I'm clear if Mr. Restivo with a Foley catheter found to be in his urethra, you cannot render an opinion whether that would cause urosepsis?
A: Well, you can have urosepsis for a variety of reasons. And if you have contamination of the

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urine and you have obstruction you can develop urosepsis. But you can develop urosepsis in the absence of that occurring.
Q: You're talking generally. I am asking you specifically.
Do you have an opinion, if you don't you don't, as to whether or not the Foley catheter in Mr. Restivo if it's placed in the urethra could cause urosepsis?
A: I don't think I can answer the question the way you formulated it.
Q: Why not?
A: Because it doesn't make medical sense.
Q: What doesn't make sense about it?
A: Urosepsis comes from urinary tract infection. Urinary tract infection comes from placement of the Foley correctly or incorrectly but it comes from contamination of the urine or comes from seeding of the urinary tract from the blood and the Foley being in the urethra is — it's a bystandard to that process.
Q: Has nothing to do with that process?
A: He has manipulation of his urinary tract so that could lead to contamination of the urinary tract.
Q: If you assume that the Foley had been placed in

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the urethra and had been there for almost 48 hours, would you expect that to cause urosepsis?
A: Then you would have to answer the question how the infection got into the urinary tract in the first place. If it never transversed the bladder sphincter, there would be no way for the infection to get into the bladder in the first place unless you had a preexisting infection which is the point I was trying to make in the first place.
Q: In this case when the physician advanced the Foley into the bladder after the nurse believed Mr. Restivo had some bladder distention, would that have seeded the bladder with infection?
A: Any time you manipulate the Foley you can e develop a urinary tract infection.
Q: Was that a proper procedure to perform on Mr. Restivo?
A: Yes.
Q: There's no risk of contamination by advancing the Foley in that way?
A: I would expect a urologist to have used proper technique when he did that.
Q: Do you know whether he did?
A: You haven't deposed him so I have no direct

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knowledge of the technique he used but he would have been trained and experienced in doing so.
Q: What would be the proper technique?
A: Same technique I talked about before.
Q: In a catheter that is already in place, a Foley that is already in, it's not in all the way, is it proper just to deflate the balloon and push it further into the bladder?
A: You would follow the same general things I talked about before in terms of using sterile technique and cleaning the area, draping it. You could then deflate the balloon and advance it.
Q: Doctor, in your opinion Mr. Restivo displaced his Foley in the evening of 1-20 when he was documented to be restless and combative. What is the basis for your opinion?
A: He had urine output prior to that time. There's a mechanism for having the Foley displaced after that period of time his urine output drops.
Q: You've read Mrs. Restivo's depositions?
A: Yes.
Q: You read her account what occurred when the Foley was changed at the home setting?
A: Yes.
Q: And you recall that it was an uncomfortable,

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painful procedure for Mr. Restivo?
A: Yes.
Q: Do you recall that the health care nurse indicated she had resistance placing the Foley and resistance on inflating the balloon?
A: Yes.
Q: There was bleeding after the time of insertion around the meatus?
A: Yes.
Q: You recall Mrs. Restivo's testimony about the amount blood she found on the sheets when her husband got up off the bed?
A: Yes.
Q: What do you attribute all the bleeding to?
A: The note by the home healthcare nurses is that the family told her that it was not unusual for him to have bleeding for several days after catheter insertion.
Q: You recall Mrs. Restivo's testimony that the sheets were soaked with blood so much that she was afraid her husband would see it and she rolled the sheets up into a ball and hid it from him so he wouldn't be alarmed?
A: Yes, I recall that testimony.
Q: Do you think that's the kind of bleeding this

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home healthcare nurse was talking about?
A: The home healthcare nurse was talking about the bleeding she observed at the time she placed the Foley. She would not have been there later on in the day.
Q: I understand. You're not — when you talk about bleeding when you change a Foley catheter, you're not talking about bleeding that soaks sheets underneath the patient with blood, are you?
A: I have no way of quantifying the amount blood she saw.
Q: What do you typically see when you change a Foley?
A: It varies.
Q: Do you see enough blood to soak the sheets of the patient?
A: Well, what I would view as an excessive amount of bleeding would be very different from what a lay person views as an excessive amount of bleeding.
Q: You're attributing Mrs. Restivo's concern about the bleeding to be a normal aftermath of the Foley change?
A: I'm reflecting on what the home healthcare nurse documents in her note, he normally has bleeding after a Foley change.

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Q: What kind of bleeding did Mr. Restivo have around the meatus or in the urine?
A: I have to look to see specifically what she documented. It says the caregiver states broad, bloody drainage occurred following Foley catheter insertion previous. She does not clarify further.
Q: And you don't know, do you?
A: I only know what is reflected here.
Q: It makes a difference whether the blood is coming from the meatus or in the urine, doesn't it?
A: In terms of knowing what he had before?
Q: Yes.
A: Well, I'm not sure what she's referring to here.
Q: As a physician does it make a difference whether there is bleeding around the meatus or blood in the urine?
A: Well, you can get bleeding around the meatus from irritation in the urethra from the Foley catheter insertion or from the bladder from the Foley catheter insertion.
Q: I know those are two possibilities. Does it make a difference to you as a physician what is occurring, would you want to know?
A: If I wanted to know, I would be able to observe

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it directly.
Q: Okay. If you were asking a patient about it, you would ask directly, wouldn't you?
A: If I wanted to know if they had bleeding before?
Q: Yes.
A: Yes, I could ask them or one of the family members.
Q: Do you use late entries in your practice?
A: Yes.
Q: What are they used for?
A: I need to document something I didn't have time to document before. I am reviewing charts prior to closing them so I need to add some documentation. I get a lab test back late, I need to document it. I get a telephone call late, I need to document it. There are many reasons why I would put in a late addendum.
Q: Do your late addendum usually reflect medical procedures that were performed or lab results that were reported after you charted?
A: Those would be reasons in addition to others.
Q: You find the late entries of the home health care nurses appropriate in this case?
A: Yeah. I don't think it's unusual to put a late entry into a chart.

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Q: I'm talking about the nature of these late entries, do you find those to be appropriate?
A: Yes.
Q: Do you have any opinion Mr. Restivo had a stroke?
A: That seems to be a likely occurrence here that he had a stroke given the symptoms that are reported.
Q: Do you have any opinion Mr. Restivo was having seizures?
A: It sounds like he was, yes.
Q: Can sepsis cause seizures?
A: Only if you were in shock and had hypoperfusion of your brain; otherwise, no.
I will clarify that. You can have sepsis that's caused from an infection. You can get seizures from that. There are types of sepsis relating to the seizure but not urosepsis.
Q: Does your report contain all of the opinions you intend to offer at the trial of this case?
A: Yes.
Q: Have you talked with any of the healthcare providers in this case?
A: No.
Q: Doctor, do you agree placing a Foley catheter in the urethra is a violation of standard of care?

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A: Well, all Foley catheters go into the urethra.
Q: I didn't mean passing it through. I mean placing and inflating the balloon?
A: In the urethra?
Q: Yes.
A: I'm sorry, what was your original question?
Q: Do you agree that placing a Foley catheter in the urethra and inflating the balloon is a violation of standard of care?
A: Yes, I would agree with that.
Q: Doctor, what do you charge for your time?
A: $350 an hour.
Q: Does that include trial, deposition, everything?
A: Yes.
Q: Reviewing records?
A: Yes.
MS. EKLUND: I think I'm finished, Doctor.
MS. HARRIS: On behalf of Dr. Carroll I have a few questions.

CROSS-EXAMINATION OF CHARLES L. EMERMAN, M.D.
BY MS. HARRIS:
Q: If there was excessive bleeding at the time of the placement of the Foley catheter, some 12

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hours before the emergency department visit, I haven't counted up those hours, you would expect to see a change in the hemoglobin and hematocrit if there was excessive bleeding?
A: Well, it's a matter of definition of how much bleeding you're talking about. If there's a lot of — if there was enough bleeding you might.
Q: If this case was the hematocrit and hemoglobin normal?
A: Yes, they were.
Q: Would that lead you to conclude at least the bleeding was not excessive?
MS. EKLUND: Objection.
A: I would agree that if there had been bleeding it would not have been enough bleeding to lead to a change in the hemoglobin or hematocrit. Again, it's a matter of degree.
Q: Am I also correct that for lay persons when they are trying to describe to physicians, such as yourself, bleeding, a little bit of blood seems much more significant to a lay person than to a physician?
MS. EKLUND: Objection.
Q: Is that a fair statement in general?
MS. EKLUND: Objection.

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A: Yes.
Q: Do you have an opinion as to whether or not Mr. Restivo was septic in the emergency department?
A: He does not appear to be septic in the emergency department.
Q: Was it appropriate in keeping he with standard of care for Dr. Carroll to have considered a stroke and seizure disorder in her treatment plan?
A: Yes.
Q: And I take it you have no criticisms of Dr. Carroll to have proceeded to work that up, the stroke and seizure?
A: That's correct.
Q: Or the cardiac condition as well?
A: That's correct.
Q: And am I correct that it is your opinion Dr. Carroll in treating this patient in the emergency department acted appropriately in keeping with the standards of care for a reasonable ER doctor?
A: Yes.
Q: You talked about the complaints in the emergency department and, Doctor, we have a question of semantics. Can you look at the secondary

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nursing notes as to what was told as he came into the emergency room.
A: You're asking about the triage note?
Q: It's either the secondary or triage note.
MS. REID: It's the page before.
Q: There. Is that the secondary note?
A: Yes.
Q: The only thing that was mentioned was I think the Foley catheter had been changed that day and it caused moderate to large amount of hematoma and redness of the head, correct?
MS. EKLUND: Objection.
A: That's correct.
Q: It does not indicate, Doctor, that those — there was hematuria still or that there was redness of the head still?
A: That's correct.
Q: That's a past history, correct?
MS. EKLUND: Objection.
A: It's stated in past tense.
Q: Okay.
MS. HARRIS: I don't have any further questions.
MS. SFISCKO: I have a few. I represent the home healthcare nurse.

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CROSS-EXAMINATION OF CHARLES L. EMERMAN, M.D.

BY MS. SFISCKO:

Q: Do you have any criticisms of the home healthcare nurse in this case?

A: I have no expertise to comment on that one way or the other but I don't have any criticisms to state.

Q: Is there anywhere in the emergency room record in the nursing notes or history that Mr. Restivo was still experiencing blood in his urine? Was that reported at all that you could see by the family?

A: I don't see that note.

Q: That he still has blood in his urine or still bleeding from the meatus, anything like that, any reference to him having a present problem of bleeding from the Foley or the meatus or anything like that in the record?

A: In the emergency department record, no.

Q: So as Bev questioned you about the reference to any bleeding is in the past tense not in the present?

A: That's correct.

MS. SFISCKO: I have nothing further. Thank you.

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MS. EKLUND: I have just a couple more for you.

FURTHER CROSS-EXAMINATION OF CHARLES L. EMERMAN, M.D.

BY MS. EKLUND:

Q: Is Elyria Memorial Hospital part of The Cleveland Clinic at the present time?

A: Not that I know of.

Q: Do Cleveland Clinic physicians go to Elyria Memorial Hospital to provide services?

A: Not that I'm aware of.

Q: How long does it take to check the position of a Foley catheter?

A: You could do so by inspecting it.

Q: How long, seconds?

A: Yes.

Q: Doctor, in regard to the secondary nursing notes you have been asked about, first of all, this is a summary of what another person hears what another person is saying, correct?

A: I'm sorry, can you ask me that again?

Q: The triage nurse, whoever takes this note, typically don't write down everything the patient or family members say to that person when they

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bring somebody into the emergency room, do you agree with that?

A: Do you mean do they write down every single word?

Q: Right.

A: No, they probably don't write down every single word. It's a summary.

Q: Do you find in your experience on occasion the triage nurse doesn't get all the important information?

MS. HARRIS: Objection.

MS. REID: Objection.

A: I think the triage nurses are pretty good. Sometimes the family will tell one caregiver something different than they tell another caregiver.

Q: And sometimes the family tells the nurse more than they write down, the triage nurse, would you agree with that?

MS. HARRIS: Objection.

MS. REID: Objection.

A: They usually write down the pertinent things.

Q: On occasion they don't, do you agree?

A: Are you asking me if it ever happened?

Q: Sure.

A: I suppose it's possible.

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Q: Have you ever experienced it yourself?

A: Well, there are times when the patients will tell me something they haven't told the nurse. Sometimes they'll tell the nurses and they deny it to me.

Q: There's inaccuracies when people talk between themselves when somebody reports something, do you agree with that?

A: Are you asking me is it possible?

Q: Sure.

A: It's possible.

Q: You read Mrs. Restivo's account what she told the nurse when she brought her husband to the emergency room?

A: Yes.

Q: You read her account of bringing in the jar of urine that her husband had in the bag before she dressed him to bring him to the emergency department?

A: Yes.

Q: Do you see any mention of that in the emergency department records?

A: No, and I wouldn't expect there to be.

Q: Why not?

A: I wouldn't do anything with a jar of urine that

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somebody brought in from home.
Q: Why not?
A: Well, because if we are going to do a urinalysis, we would want a fresh urine sample.
Q: Do you think that's why Ms. Restivo brought that urine in, she wanted them to test it?
A: She may have but I would not have done so.
Q: Wasn't her testimony that she brought the jar of urine to show how little urine output he had over night, do you recall that?
A: Yes.
Q: And is that an important factor when you're examining this patient?
A: It would cause me to want to look at the Foley and see if there's urine in it.
Q: Doctor, other than the mention of the change of the Foley with moderate amount of hematuria and redness of the head, do you find any notation in the emergency department that anybody, any medical person, doctor or nurse, ever looked to see whether there was bleeding or there was redness of the head?
MS. REID: Objection.
A: Well, I note they changed the bag. They would have had to see the Foley when they changed the

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bag.
Q: That wasn't my question. Do you see any notation by any medical provider that they checked for redness of the head or bleeding?
A: Not in the emergency department, no.
Q: And there also is not a single notation about whether or not there is blood in the urine, correct, in the emergency department?
A: Not in the emergency department.
Q: And how hard is that to check?
A: It's not hard to check.
Q: Seconds, isn't it, Doctor?
A: Yes.
MS. EKLUND: Thank you.

CHARLES L. EMERMAN, M.D.

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CERTIFICATE

The State of Ohio,) SS:
County of Cuyahoga.)

I, Tami A. Mitchell, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named witness was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action; that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of _____, A.D. 20_____.

Tami A. Mitchell, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires October 23, 2004

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