

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



Mehler & Hagestrom

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[1] IN THE COURT OF COMMON PLEAS
[2] CUYAHOGA COUNTY, OHIO
[3] ESTATE OF PETER RESTIVO
[4] BY AND THROUGH CATHY RESTIVO,
[5] ETC., EXECUTRIX,
[6] Plaintiff,
[7] JUDGE FRIEDLAND
[8] -vs- CASE NO. 445732
[9] COMMUNITY HEALTH
[10] PARTNERS, et al.,
[11] Defendants.
[12]
[13] Deposition of CHARLES L. EMERMAN, M.D.,
[14] taken as if upon cross-examination before Tami A.
[15] Mitchell, a Registered Professional Reporter and
[16] Notary Public within and for the State of Ohio,
[17] at The Cleveland Clinic, 9500 Euclid Avenue,
[18] Cleveland, Ohio, at 4:03 p.m. on Friday, May 2,
[19] 2003, pursuant to notice and/or stipulations of
[20] counsel, on behalf of the Plaintiff in this
[21] cause.
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Care and Alanna Verlei
[21]
[22]
[23]
[24]
[25]

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[1] CHARLES L. EMERMAN, M.D., of lawful age,
[2] called by the Plaintiff for the purpose of
[3] cross-examination, as provided by the Rules of
[4] Civil Procedure, being by me first duly sworn, as
[5] hereinafter certified, deposed and said as
[6] follows:
[7] CROSS-EXAMINATION OF CHARLES L. EMERMAN, M.D.
[8] BY MS. EKLUND:
[9] Q: Doctor, would you state your name for the record
[10] and spell it for the court reporter.
[11] A: Charles Louis, L-o-u-i-s, Emerman, E-m-e-r-m-a-n.
[12] Q: Did you bring a CV with you?
[13] A: No. I can get one if you would like one.
[14] Q: I don't need — can you order one and send it in
[15] and we can continue with the questioning? Can
[16] it work that way?
[17] A: Yeah.
[18] Q: I take it you're with The Cleveland Clinic and
[19] you have a position within the emergency
[20] department?
[21] A: I'm actually an employee of MetroHealth Medical
[22] Center and I am also the chairman of Emergency
[23] Medicine at The Cleveland Clinic.
[24] Q: Where do you primarily practice medicine?
[25] A: I practice at both locations.

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[1] Q: 50-50?
[2] A: Yes.
[3] Q: Do you know Dr. Carroll at MetroHealth?
[4] A: Dr. Carroll?
[5] Q: Marion Carroll?
[6] A: I don't know her.
[7] Q: Do you know of her?
[8] A: I know of her.
[9] MS. HARRIS: She's not at Metro.
[10] Q: You know of her but you don't know her
[11] personally, correct?
[12] A: I know that she is at UH.
[13] Q: How do you know of her?
[14] A: Well, she practices at a hospital four blocks
[15] down the street that's how I know she's there.
[16] Q: You know her by name?
[17] A: Yes.
[18] Q: Do you have any, I guess, friends or
[19] acquaintances in common?
[20] A: I wouldn't know that. I have never, as far as I
[21] know, I have never met her. I don't have a
[22] personal relationship with her. I don't have a
[23] business relationship with her.
[24] Q: I assume you're board certified in emergency
[25] medicine?

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[1] A: Yes, I am.
[2] Q: And when were you board certified?
[3] A: 1983.
[4] Q: Have you been recertified recently?
[5] A: 1993.
[6] Q: When are you next due to be recertified?
[7] A: November.
[8] Q: Of 2003. Every ten years?
[9] A: That's correct.
[10] Q: How long have you been at MetroHealth?
[11] A: Since 1982.
[12] Q: And when did you assume some responsibilities at
[13] The Cleveland Clinic?
[14] A: 1996.
[15] Q: How many hours a week do you work?
[16] A: I'm paid 40 hours a week.
[17] Q: And that time is split between Cleveland Clinic
[18] and MetroHealth?
[19] A: That's correct.
[20] Q: Have you ever worked at Elyria Memorial Hospital?
[21] A: No, I have not.
[22] Q: Do you know any of the physicians involved in the
[23] care rendered to Mr. Restivo?
[24] A: No, I do not.
[25] Q: Who asked you to become involved as an expert

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[1] witness in this case?
[2] A: Ms. Reid.
[3] Q: Have you had other cases with Ms. Reid?
[4] A: Yes.
[5] Q: Can you tell me how many?
[6] A: One or two.
[7] Q: I assume all of your expert work with Ms. Reid
[8] has been on the subject of emergency medicine?
[9] A: Yes.
[10] Q: Do you have any subspecialties?
[11] A: No, I do not.
[12] Q: Have you worked with Beverly Harris before?
[13] A: I have been on both sides of the table with
[14] Ms. Harris before.
[15] Q: Meaning working with her and against her?
[16] A: I wasn't working against her but I was an expert
[17] for the plaintiff's case and she was the defense
[18] lawyer.
[19] Q: Who was the plaintiff's attorney?
[20] A: I don't recall.
[21] Q: Did the case go to trial?
[22] A: It did.
[23] Q: And do you remember what the allegations were?
[24] A: Yes. It was a delay in diagnosis of a neck
[25] abscess.

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[1] Q: And did you offer testimony on behalf of the
[2] plaintiff?
[3] A: Yes.
[4] Q: And that was in regard to the standard of care by
[5] the emergency room physician?
[6] A: That's correct.
[7] Q: What was the outcome of the case?
[8] A: Ms. Harris won the case.
[9] Q: How many cases per year do you review for
[10] medical-legal purposes?
[11] A: Between 12 and 18.
[12] Q: How do these cases come to you?
[13] A: I'm not sure what you're asking. Lawyers call me
[14] up and ask me to review cases.
[15] Q: It's word of mouth, that kind of thing?
[16] A: Yes.
[17] Q: You're not affiliated with any kind of a service
[18] that contacts you and asks you to review files?
[19] A: Sometimes services contact me but I don't have a
[20] relationship with any.
[21] Q: No contracts?
[22] A: That's correct.
[23] Q: You're not affiliated them?
[24] A: No, I'm not.
[25] Q: What is the breakdown between plaintiff versus

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[1] defendant in cases that you review?
[2] A: It's about one-third plaintiff, two thirds
[3] defense.
[4] Q: Have you ever been a party as a defendant to a
[5] lawsuit?
[6] A: Yes, I have.
[7] Q: How many times?
[8] A: Five times.
[9] Q: Did any of those cases go to trial?
[10] A: No, they did not.
[11] Q: Were they settled?
[12] A: Not on my behalf.
[13] Q: Were you dismissed somewhere along the line?
[14] A: That's correct.
[15] Q: Can you tell me what you reviewed in the case of
[16] Peter Restivo?
[17] A: Certainly. I have the report of Dr. Janiak. I
[18] have the deposition of Alanna Verlei,
[19] V-e-r-l-e-i. I have the deposition Catherine
[20] Restivo part one, Catherine Restivo part two,
[21] Peter Restivo. Marion Carroll, M.D., Debra
[22] Schwan, S-c-h-w-a-n, R.N., Linda Herman, M.D.
[23] Q: Can I see what you were just referring to,
[24] Doctor?
[25] A: Yes. I have the report of Jane Bennett, R.N.,

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[1] Linda Herman, M.D., deposition of Diane Tucker,
[2] R.N. and Diane Shimko, R.N. I already stated
[3] that one, Linda Herman, M.D. deposition. And I
[4] have the medical records which include portions
[5] of an admission to Community Health Partners in
[6] September of 1999. Elyria Emergency Medical
[7] Center records for January 20th through February
[8] 10th, 2000. And then some miscellaneous records
[9] from February 24 of 2000. I believe that's it.
[10] Q: Doctor, can I see the pile of correspondence you
[11] have? Doctor, I notice on April 28th, eight
[12] different — seven depositions and one report was
[13] sent to you by Ms. Reid. That was just a few
[14] days ago. Have you read all those depositions?
[15] A: Yes, I have.
[16] Q: Have you made any notes for your file as you went
[17] along and reviewed the medical records in this
[18] case?
[19] A: I have not.
[20] Q: And the report you prepared is dated December 13,
[21] 2002?
[22] A: That's correct.
[23] Q: Is that the only report you prepared in this
[24] case?
[25] A: Yes, it is.

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[1] Q: Did you make a draft of this report before
[2] putting it in final form?
[3] A: No. I would have typed that up myself.
[4] Q: Okay. And did you make any changes or have any
[5] conversation with counsel prior to preparing this
[6] report in terms of what would be in the report?
[7] MS. REID: Objection. You can
[8] answer.
[9] A: I would imagine I would have called Ms. Reid and
[10] told her my opinion before I prepared the report.
[11] Q: Did Ms. Reid have any input into what was
[12] contained in your report?
[13] A: No.
[14] Q: You reviewed records and depositions subsequent
[15] to authorizing this report. Are there any
[16] additions or changes to this report you would
[17] like to make in light of reading additional
[18] material?
[19] A: It does not change my opinion.
[20] Q: Doctor, I take it you are skilled in the placing
[21] of a Foley catheter in a patient?
[22] A: Yes.
[23] Q: Can you tell me what the procedure is for correct
[24] placement of a Foley catheter?
[25] A: Certainly. We have a kit that has all the

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[1] materials in it. We would clean the area off
[2] with betadine solution, put drapes around the
[3] area to be catheterized.
[4] Are you asking about a male?
[5] Q: Yes.
[6] A: So we would clean the penis with betadine
[7] solution. We would drape it using sterile
[8] technique. We would insert the Foley catheter
[9] into the bladder. We would then inflate a
[10] balloon, attach the Foley catheter to a bag,
[11] secure the Foley to the leg and be done.
[12] Q: How do you know when you're putting a Foley
[13] catheter you actually have the Foley in the
[14] bladder?
[15] A: You would either get return of urine or you would
[16] insert the Foley to a length you would expect to
[17] be in the bladder.
[18] Q: Would you ever inflate the balloon if you hadn't
[19] observed return of urine coming from the
[20] catheter?
[21] A: Could you say the question one more time? I
[22] want to make sure I heard you correct.
[23] Q: Would you ever inflate the balloon before
[24] observing flow of urine coming from the catheter?
[25] A: If I had thought I had inserted it into the

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[1] bladder then I would.
[2] Q: Did you have a practice of observing the Foley
[3] after you inserted it to make sure that you have
[4] flow through the catheter?
[5] A: You mean after I inserted it —
[6] Q: Yes.
[7] A: — and inflated the balloon?
[8] Q: Yes.
[9] A: Then I would want to see I was getting urine out.
[10] Although there are some patients that aren't
[11] going to make any urine, then I would note that.
[12] Q: And how long would you observe for flow of urine
[13] before you felt comfortable the Foley was in
[14] properly?
[15] A: I would know immediately the Foley was in
[16] improperly.
[17] Q: How would you know?
[18] A: I would inflate the balloon and try to withdraw
[19] the Foley. And if it's in the bladder, you
[20] would not be able to withdraw the Foley.
[21] Q: If it was in the urethra, it would come right
[22] out?
[23] A: If it was in the urethra, you would be able to
[24] withdraw it.
[25] Q: There would be no resistance to withdrawing it if

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[1] it's in the urethra?
[2] A: If it's in the bladder — you reach a surface
[3] when you withdraw it if it's in the bladder. If
[4] it's in the urethra — let me start it again so
[5] that it's clear.
[6] If it's in the bladder as you withdraw it
[7] when you come up to the —
[8] Q: The neck of the bladder?
[9] A: No. The word I'm blanking on. When you come to
[10] the junction between the bladder and urethra the
[11] Foley will stop. If it's in the urethra it will
[12] continue to allow you to withdraw. There will
[13] not be a lot of resistance with withdrawal.
[14] Q: Am I correct the bladder is a hollow organ?
[15] A: Sphincter is the word I was thinking of. I
[16] couldn't think of it.
[17] Q: When you have the Foley properly placed and
[18] balloon inflated, when you tug the sphincter will
[19] prevent the Foley from coming out?
[20] A: That's correct.
[21] Q: Because of the balloon inflation?
[22] A: That's correct.
[23] Q: That's the way the Foley is designed to work?
[24] A: Yes.
[25] Q: The balloon is what keeps it in place in the

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[1] bladder?
[2] A: Yes, that's correct.
[3] Q: And am I correct the bladder is basically a
[4] hollow organ that basically holds urine?
[5] A: Yes.
[6] Q: When you inflate the balloon on the Foley am I
[7] correct that you should not need any resistance
[8] to that inflation since you're in a hollow organ?
[9] A: Well, the balloon has its own properties so there
[10] is some resistance when you go to blow up the
[11] balloon. Just as if you are to blow up a party
[12] balloon, when you first go to inflate there's
[13] more resistance then as it distends.
[14] Q: The normal resistance of the balloon. But you
[15] shouldn't feel the resistance from the tissues or
[16] constriction from the body part, correct.
[17] A: Yes, that's correct.
[18] Q: Do you normally have bleeding around the meatus
[19] when a Foley catheter is inserted?
[20] A: In some patients.
[21] Q: Is it a common occurrence?
[22] A: It's not uncommon.
[23] Q: Does it indicate any trauma to urethra if you
[24] have bleeding around the meatus?
[25] A: Just from the urethra being irritated from a

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[1] chronic Foley placement you might have some
[2] abrasion of the urethra after you place the
[3] Foley.
[4] Q: What about blood in the urine when you put a
[5] Foley in, is that a sign of a problem?
[6] A: It may be a sign of a problem of some sort but
[7] not necessarily a sign of urethral trauma.
[8] There's a lot of reasons to have blood in the
[9] urine.
[10] Q: Is it normal to have a little bit of blood in the
[11] urine?
[12] A: In the case of indwelling Foleys it would be
[13] common to find blood in their urine.
[14] Q: Does it take a significant amount of force to
[15] pull an inflated Foley from the bladder down into
[16] the urethra?
[17] A: No, it would not take an excessive amount of
[18] force. It's possible to do so.
[19] Q: But it does take some amount force to do that?
[20] A: Some amount of force, of course.
[21] Q: Do you agree that if a Foley is pulled from the
[22] bladder into the urethra that you'll have
[23] bleeding?
[24] A: Yes.
[25] Q: Do you agree with Dr. Carroll's testimony that

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[1] would cause a tremendous amount of bleeding?
[2] A: I'm not sure what tremendous amount is supposed
[3] to imply. You may have some bleeding. You may
[4] have a small amount of bleeding. Depends on
[5] where the balloon is sitting in relationship to
[6] the bleeding. If the balloon is sitting distal
[7] to the area of bleeding, you may not have much
[8] bleeding externally. The bleeding may all be
[9] internal.
[10] Q: If the balloon is not sitting distal to the area
[11] of bleeding you may see a significant amount of
[12] bleeding?
[13] A: You might.
[14] Q: Do you know the other expert witnesses who
[15] provided reports in this case, Dr. Janiak?
[16] A: Yes, I know Dr. Janiak.
[17] Q: How do you know Dr. Janiak?
[18] A: I went to medical school in Toledo.
[19] Q: He was a fellow student?
[20] A: No, faculty there.
[21] Q: I haven't seen him in awhile. Do you know
[22] Dr. Herman?
[23] A: No, I do not.
[24] Q: Do you know any of the health care nurses?
[25] A: No, I do not.

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

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[1] that the patient has an indwelling Foley catheter
[2] and there would be no mention of urine or
[3] anything else?

[4] **A:** It would depend what their problem was whether I
[5] mention it. I might or might not.

[6] **Q:** You agree Mr. Restivo presented with some
[7] complaints with regard to the insertion of the
[8] Foley catheter earlier that day.

[9] **MS. HARRIS:** Objection. It's not
[10] complaints. It's history.

[11] **MS. REID:** Objection.

[12] **Q:** Go ahead.

[13] **A:** Yes, he had complaints of hematuria or complaints
[14] were given to the in-take nurse.

[15] **Q:** And in your review of the emergency room records
[16] do you find any mention of any examination of the
[17] penis or the hematuria that was complained of on
[18] presentation?

[19] **A:** You're referring to Dr. Carroll's note.

[20] **Q:** Any note in the emergency room, nurses,
[21] Dr. Carroll, anybody?

[22] **A:** As I recall Dr. Carroll has documented the
[23] results of her abdominal which would include
[24] palpation of the suprapubic area.

[25] **Q:** My question, Doctor — I'm not talking about

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[1] deposition testimony. I'm talking in the
[2] emergency room record in Dr. Carroll's
[3] handwritten notes do you find any specific
[4] reference to conditions, observation of the penis
[5] or any mention of hematuria?

[6] **A:** I don't recall any documentation about her
[7] examination of the penis or mentioning about the
[8] hematuria.

[9] **Q:** Did you find the history and physical worksheet
[10] that Dr. Carroll completed for Mr. Restivo to be
[11] incomplete?

[12] **A:** Well, there are portions of it that aren't filled
[13] out.

[14] **Q:** Would you consider that incomplete?

[15] **A:** I think she considered it to be incomplete.

[16] **Q:** What do you consider it?

[17] **A:** A completed record is one where the physician
[18] documents everything they intended to document.
[19] If she thinks she didn't get to document
[20] everything she intended to, it would be
[21] incomplete.

[22] **Q:** Doctor, in your emergency rooms do you expect
[23] nurses to keep an accurate account of the
[24] patient's fluid in-take and fluid output?

[25] **A:** Not for most patients, no.

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[1] **Q:** When would you expect nurses to keep track of
[2] fluid in-take and output?

[3] **A:** If we were doing something to manipulate their
[4] in-take or output I would expect them to document
[5] that.

[6] **Q:** If you ordered an IV infusion of some type you
[7] would expect nurses to keep track of input and
[8] output?

[9] **A:** There are sometimes where the amount of urine
[10] that is put out is important, such as a patient
[11] with heart failure. In that case we would want
[12] to know that. There are other circumstances
[13] similar to that but other than that it would not
[14] be a routine expectation of mine.

[15] **Q:** In a patient who is receiving IV saline solution
[16] in the emergency department would you expect
[17] someone to keep track of how much he received?

[18] **A:** If I was resuscitating them, I would expect to
[19] have that. If they were getting routine
[20] maintenance fluids, it wouldn't make any
[21] difference to me.

[22] **Q:** Mr. Restivo was admitted or I guess initially
[23] worked up for stroke, correct? Is that correct?

[24] **A:** Well, I think he was being worked up for
[25] possibility of stroke and for these convulsions

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[1] he was having.

[2] **Q:** And they also worked him up for cardiac problems,
[3] correct?

[4] **A:** Yes, they did.

[5] **Q:** And in a patient with that presentation and that
[6] workup would you expect the nurses to keep track
[7] of urine output?

[8] **A:** No.

[9] **Q:** Do you anticipate that a patient will stay
[10] hydrated while they're in the emergency room?

[11] **A:** It would depend how long they're there for.

[12] **Q:** If they're in for five hours do you expect some
[13] attention to be paid to their level of hydration?

[14] **A:** If somebody comes in hydrated do I think they
[15] might get dehydrated five hours in the emergency
[16] department, is that your question?

[17] **Q:** My question is do you pay attention to whether
[18] there is fluid in-take from the patient in a five
[19] hour period of time?

[20] **A:** I wouldn't think a five hour period of time would
[21] be long enough for them to become dehydrated.

[22] **Q:** Do you agree that an emergency room physician has
[23] an obligation to investigate all of the
[24] complaints of the patient when they come into the
[25] emergency department?

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- [1] MS. HARRIS: Objection.
- [2] A: No, not necessarily.
- [3] Q: In Mr. Restivo's case do you agree there was an
- [4] obligation to investigate the Foley catheter and
- [5] hematuria that was reported?
- [6] A: No. Generally we would address the things that
- [7] are most critical, which in this case would be
- [8] the possibility of stroke and convulsions.
- [9] Q: That doesn't preclude you from also investigating
- [10] the complaints of difficult Foley insertion and
- [11] hematuria, does it, Doctor?
- [12] A: No, it does not.
- [13] Q: It's a very simple thing to check whether the
- [14] Foley is positioned properly and whether it's
- [15] draining properly, correct?
- [16] MS. HARRIS: Objection.
- [17] MS. REID: Objection. You can
- [18] answer.
- [19] A: You would do that by palpating the bladder and
- [20] visualizing the Foley and whether there's any
- [21] urine in the Foley bag.
- [22] Q: And if you suspect the Foley isn't placed
- [23] properly, how would you check to see whether
- [24] you're right or wrong?
- [25] A: If I thought the Foley wasn't placed properly?

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- [1] Q: Yes?
- [2] A: I would remove it and reinsert it.
- [3] Q: I'm sorry I couldn't hear.
- [4] A: I would remove and reinsert it.
- [5] Q: Would irrigation tell you whether it's
- [6] functioning properly?
- [7] A: If I thought it wasn't — you changed your
- [8] question. Are you asking about positioning or
- [9] function?
- [10] Q: If it's not positioned properly, it's not going
- [11] to function properly; is that fair?
- [12] A: That's true but that's not an inclusive answer.
- [13] It could be positioned properly and still not be
- [14] functioning. So if I thought it was positioned
- [15] properly but not functioning I would try to
- [16] irrigate it. If I thought it was improperly
- [17] positioned, I would remove it.
- [18] Q: Have you ever had a patient in the emergency room
- [19] who pulled his own indwelling Foley catheter into
- [20] the urethra?
- [21] A: Yes.
- [22] Q: How many times?
- [23] A: I couldn't tell you how many times.
- [24] Q: Is it a frequent occurrence?
- [25] A: It's not an unusual occurrence.

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- [1] Q: Do those patients present in a great deal of
- [2] pain?
- [3] A: Some of them do.
- [4] Q: Do they present with bleeding?
- [5] A: Sometimes.
- [6] Q: What is the normal amount of urine output per
- [7] hour for an adult?
- [8] A: An adult without renal disease, is that your
- [9] question?
- [10] Q: Yes re.
- [11] A: .5 ccs per kilogram per hour.
- [12] Q: Per kilogram of weight?
- [13] A: Yes.
- [14] Q: In an individual with renal insufficiency they
- [15] may have normal urine output, correct?
- [16] A: Depends on the type of renal insufficiency and
- [17] sometimes it would be normal, most times it would
- [18] be diminished.
- [19] Q: The problem with renal insufficiency is not the
- [20] urine output, it's the inability of the body to
- [21] clear toxins from the body, is that correct, or
- [22] is it both?
- [23] A: Well, people with renal insufficiency don't put
- [24] out normal amounts of urine.
- [25] Q: Are you able to quantify how much you would

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- [1] expect to see in reduction of urine output in a
- [2] patient with renal insufficiency?
- [3] A: There's not an easy correlation you can make and
- [4] it would depend on the severity of their renal
- [5] disease; anywhere from mildly diminished to
- [6] completely absent.
- [7] Q: Is that true in patients who has an indwelling
- [8] Foley catheter?
- [9] A: Yes. If you have renal insufficiency the amount
- [10] urine you make is unrelated to whether or not you
- [11] have a Foley catheter.
- [12] Q: When a Foley catheter is changed, is it normal
- [13] for the patient to experience some pain?
- [14] A: Yes.
- [15] Q: When is it first documented in the Elyria
- [16] admission that Mr. Restivo's urine output was
- [17] low?
- [18] A: It's documented in the notes that he had no urine
- [19] output at 2:00 in the morning on the morning of
- [20] the 21st.
- [21] Q: What time frame did that cover?
- [22] A: It was a nursing notation that he had no urine
- [23] output and they called the physician.
- [24] Q: What had his urine output been prior to that 2:00
- [25] a.m. note?

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[1] A: It was 200 ccs on the day shift and 100 ccs on
[2] the night shift.
[3] Q: Do you consider 200 ccs to be a low output?
[4] A: No. I would think that would be normal.
[5] Q: What time frame did the 200 ccs cover?
[6] A: Documented from the day shift from the time upon
[7] the floor. 10:00 in the morning.
[8] Q: 10:00 to?
[9] A: 3:00.
[10] Q: What was his fluid in-take in that period of
[11] time?
[12] A: 200 ccs.
[13] Q: And that's from the 10:00 to 3:00 time frame?
[14] A: It's actually 2:00.
[15] Q: The next reading on urine output is 100 ccs.
[16] You consider that to be low urine output?
[17] A: For a person who did not have renal insufficiency
[18] that would be low. For a person with renal
[19] insufficiency that may be low.
[20] Q: Do you know what Mr. Restivo's urine output was
[21] while he was in the emergency department?
[22] A: No, I do not.
[23] Q: Do you know what his fluid in-take was while he
[24] was in emergency?
[25] A: I can't read it on this copy. I'm sorry. I

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

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[1] might. In a patient who has a chronic indwelling
[2] Foley they frequently have colonization without
[3] infection.
[4] Q: In a hospital admission urine goes from a clear
[5] yellow to a hazy or darker yellow, you see a
[6] change in the color, that's an indication of
[7] infection, isn't it?
[8] A: It might be or might be a sign of irritation from
[9] the Foley.
[10] Q: And it's also important to measure the volume of
[11] urine output in a patient who has been
[12] hospitalized, would you agree with that?
[13] A: It would depend on the setting. It can be
[14] important. Sometimes it's not particularly
[15] helpful.
[16] Q: It's routinely done, though, isn't it?
[17] A: In hospitalized patients it's frequently done,
[18] yes.
[19] Q: Particularly in a patient who is known to have
[20] renal insufficiency, wouldn't you agree?
[21] A: Again, it would depend on the setting.
[22] Q: For Mr. Restivo was it important during his
[23] admission to Elyria, his urine output?
[24] MS. REID: In the emergency
[25] department or on the floor?

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

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

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[1] while he was in the emergency department?
[2] A: Yes.
[3] Q: What is it?
[4] A: He had renal function tests performed.
[5] Q: In the emergency department?
[6] A: Yes.
[7] Q: Can you point those out to me?
[8] A: Certainly. They're in his chemistry report.
[9] Q: Okay.
[10] A: And it appears in their chart they combine all
[11] the laboratory tests in one big chart so you
[12] would look on his chemistry report under January
[13] 20th lab test performed at 5:20 and you see that
[14] his BUN is 60.
[15] Q: Is that elevated?
[16] A: Yes. And his creatinine is 4.2 which is also
[17] elevated.
[18] Q: Would urinary obstruction cause elevation in
[19] those lab values also?
[20] A: If it had been going on for a long enough period
[21] of time you could develop renal insufficiency
[22] from complete obstruction.
[23] Q: How long is a long enough period of time?
[24] A: I'm not sure I would run any study on that.
[25] However, we see people who have been obstructed

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[1] to 24 hours without having impairment of renal
[2] function.
[3] Q: Have you seen patients in that time frame who
[4] have had impairment of renal function?
[5] A: Not as a new finding, no.
[6] Q: What is urosepsis?
[7] A: Sepsis occurring from a site of infection in the
[8] kidney or bladder.
[9] Q: In the instance of complete urinary obstruction
[10] how does urosepsis set in?
[11] A: Well, urosepsis sets in having infection in the
[12] urinary tract someplace along its course. It
[13] could be contamination from the urinary tract or
[14] spreading through the blood. There would be a
[15] few other ways but those are the primary two.
[16] Q: In the case of obstruction how does that cause
[17] urosepsis?
[18] MS. HARRIS: Objection.
[19] A: I'm sorry?
[20] MS. HARRIS: Objection.
[21] A: It's the same answer. Infection forms somewhere.
[22] Q: What is the mechanism of it I'm asking you.
[23] A: Your question is not clear to me.
[24] Q: How does urinary obstruction cause urosepsis?
[25] A: I guess that's the part I'm having trouble

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[1] answering. You can get urosepsis in the absence
[2] of obstruction. You can have obstruction without
[3] urosepsis. You can have urosepsis and
[4] obstruction at the same time. I'm having trouble
[5] answering your question.
[6] Q: What happens to the kidneys when there is
[7] complete urinary obstruction?
[8] A: They continue to make urine until they shut down.
[9] Q: What happens to the individual when the kidneys
[10] shuts down?
[11] A: They would have renal failure. They would have
[12] to go upon dialysis.
[13] Q: In the last page of your report you basically
[14] summarize your opinions in this case; is that
[15] correct?
[16] A: Yes.
[17] Q: And it's your opinion that the emergency
[18] department nurse appropriately assessed
[19] Mr. Restivo and gave him medication in accordance
[20] with the physician's notes; is that correct?
[21] A: Yes.
[22] Q: That's despite the fact that there was no
[23] documentation of fluid in-take, fluid output,
[24] correct?
[25] A: Well, you showed me his fluid in-take.

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

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

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[1] Q: You can still have some urine draining with a
[2] urinary obstruction, am I correct?
[3] A: No. If you have an obstruction, you would not
[4] have urine draining.
[5] Q: You can have an incomplete obstruction, can't
[6] you, Doctor?
[7] A: If you have urinary tract obstruction, you don't
[8] have any urine output.
[9] Q: None at all?
[10] A: That's correct.
[11] Q: Mr. Restivo had urine output throughout his
[12] hospitalization when it started to be documented,
[13] do you agree with that?
[14] A: Up until 2:00 in the morning.
[15] Q: After 2:00 in the morning he still had urine
[16] output?
[17] A: I have to look at it again. I think it was
[18] pretty minimal amount, as I recall.
[19] Q: Minimal or not he did have urine flow, didn't he?
[20] A: My records have fallen apart.
[21] Q: You don't need to look because you and I both
[22] recall he did have some urine output even after
[23] the 2:00 note?
[24] A: My recollection it was about 10 ccs. But I'm
[25] just guessing at that because I can't get my

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[1] records back together.
[2] Q: I will tell you at 6:00 he had 84 ccs. At 1400
[3] he had 46. That would indicate some urine
[4] output, wouldn't it, Doctor?
[5] A: Yes.
[6] Q: Do you disagree with the fact that the Foley
[7] catheter was found in the urethra in Mr. Restivo?
[8] A: The next day?
[9] Q: Yes.
[10] A: I agree with that.
[11] Q: You agree that would cause some urinary
[12] obstruction?
[13] A: Yes.
[14] Q: And do you agree that that would cause urinary
[15] urosepsis in this patient?
[16] MS. HARRIS: Objection.
[17] A: I think we covered this, didn't we?
[18] Q: Well, can you answer my question?
[19] A: No, I don't think I can for the same reasons we
[20] talked about before.
[21] Q: So I'm clear if Mr. Restivo with a Foley catheter
[22] found to be in his urethra, you cannot render an
[23] opinion whether that would cause urosepsis?
[24] A: Well, you can have urosepsis for a variety of
[25] reasons. And if you have contamination of the

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[1] urine and you have obstruction you can develop
[2] urosepsis. But you can develop urosepsis in the
[3] absence of that occurring.

[4] Q: You're talking generally. I am asking you
[5] specifically.

[6] Do you have an opinion, if you don't you
[7] don't, as to whether or not the Foley catheter in
[8] Mr. Restivo if it's placed in the urethra could
[9] cause urosepsis?

[10] A: I don't think I can answer the question the way
[11] you formulated it.

[12] Q: Why not?

[13] A: Because it doesn't make medical sense.

[14] Q: What doesn't make sense about it?

[15] A: Urosepsis comes from urinary tract infection.
[16] Urinary tract infection comes from placement of
[17] the Foley correctly or incorrectly but it comes
[18] from contamination of the urine or comes from
[19] seeding of the urinary tract from the blood and
[20] the Foley being in the urethra is — it's a
[21] bystandard to that process.

[22] Q: Has nothing to do with that process?

[23] A: He has manipulation of his urinary tract so that
[24] could lead to contamination of the urinary tract.

[25] Q: If you assume that the Foley had been placed in

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[1] the urethra and had been there for almost 48
[2] hours, would you expect that to cause urosepsis?

[3] A: Then you would have to answer the question how
[4] the infection got into the urinary tract in the
[5] first place. If it never transversed the bladder
[6] sphincter, there would be no way for the
[7] infection to get into the bladder in the first
[8] place unless you had a preexisting infection
[9] which is the point I was trying to make in the
[10] first place.

[11] Q: In this case when the physician advanced the
[12] Foley into the bladder after the nurse believed
[13] Mr. Restivo had some bladder distention, would
[14] that have seeded the bladder with infection?

[15] A: Any time you manipulate the Foley you can e
[16] develop a urinary tract infection.

[17] Q: Was that a proper procedure to perform on
[18] Mr. Restivo?

[19] A: Yes.

[20] Q: There's no risk of contamination by advancing the
[21] Foley in that way?

[22] A: I would expect a urologist to have used proper
[23] technique when he did that.

[24] Q: Do you know whether he did?

[25] A: You haven't deposed him so I have no direct

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[1] knowledge of the technique he used but he would
[2] have been trained and experienced in doing so.

[3] Q: What would be the proper technique?

[4] A: Same technique I talked about before.

[5] Q: In a catheter that is already in place, a Foley
[6] that is already in, it's not in all the way, is
[7] it proper just to deflate the balloon and push it
[8] further into the bladder?

[9] A: You would follow the same general things I talked
[10] about before in terms of using sterile technique
[11] and cleaning the area, draping it. You could
[12] then deflate the balloon and advance it.

[13] Q: Doctor, in your opinion Mr. Restivo displaced his
[14] Foley in the evening of 1-20 when he was
[15] documented to be restless and combative. What is
[16] the basis for your opinion?

[17] A: He had urine output prior to that time. There's
[18] a mechanism for having the Foley displaced after
[19] that period of time his urine output drops.

[20] Q: You've read Mrs. Restivo's depositions?

[21] A: Yes.

[22] Q: You read her account what occurred when the Foley
[23] was changed at the home setting?

[24] A: Yes.

[25] Q: And you recall that it was an uncomfortable,

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[1] painful procedure for Mr. Restivo?

[2] A: Yes.

[3] Q: Do you recall that the health care nurse
[4] indicated she had resistance placing the Foley
[5] and resistance on inflating the balloon?

[6] A: Yes.

[7] Q: There was bleeding after the time of insertion
[8] around the meatus?

[9] A: Yes.

[10] Q: You recall Mrs. Restivo's testimony about the
[11] amount blood she found on the sheets when her
[12] husband got up off the bed?

[13] A: Yes.

[14] Q: What do you attribute all the bleeding to?

[15] A: The note by the home healthcare nurses is that
[16] the family told her that it was not unusual for
[17] him to have bleeding for several days after
[18] catheter insertion.

[19] Q: You recall Mrs. Restivo's testimony that the
[20] sheets were soaked with blood so much that she
[21] was afraid her husband would see it and she
[22] rolled the sheets up into a ball and hid it from
[23] him so he wouldn't be alarmed?

[24] A: Yes, I recall that testimony.

[25] Q: Do you think that's the kind of bleeding this

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[1] home healthcare nurse was talking about?

[2] A: The home healthcare nurse was talking about the
[3] bleeding she observed at the time she placed the
[4] Foley. She would not have been there later on
[5] in the day.

[6] Q: I understand. You're not — when you talk about
[7] bleeding when you change a Foley catheter, you're
[8] not talking about bleeding that soaks sheets
[9] underneath the patient with blood, are you?

[10] A: I have no way of quantifying the amount blood she
[11] saw.

[12] Q: What do you typically see when you change a
[13] Foley?

[14] A: It varies.

[15] Q: Do you see enough blood to soak the sheets of the
[16] patient?

[17] A: Well, what I would view as an excessive amount of
[18] bleeding would be very different from what a lay
[19] person views as an excessive amount of bleeding.

[20] Q: You're attributing Mrs. Restivo's concern about
[21] the bleeding to be a normal aftermath of the
[22] Foley change?

[23] A: I'm reflecting on what the home healthcare nurse
[24] documents in her note, he normally has bleeding
[25] after a Foley change.

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[1] Q: What kind of bleeding did Mr. Restivo have around
[2] the meatus or in the urine?

[3] A: I have to look to see specifically what she
[4] documented. It says the caregiver states broad,
[5] bloody drainage occurred following Foley catheter
[6] insertion previous. She does not clarify
[7] further.

[8] Q: And you don't know, do you?

[9] A: I only know what is reflected here.

[10] Q: It makes a difference whether the blood is coming
[11] from the meatus or in the urine, doesn't it?

[12] A: In terms of knowing what he had before?

[13] Q: Yes.

[14] A: Well, I'm not sure what she's referring to here.

[15] Q: As a physician does it make a difference whether
[16] there is bleeding around the meatus or blood in
[17] the urine?

[18] A: Well, you can get bleeding around the meatus from
[19] irritation in the urethra from the Foley catheter
[20] insertion or from the bladder from the Foley
[21] catheter insertion.

[22] Q: I know those are two possibilities. Does it make
[23] a difference to you as a physician what is
[24] occurring, would you want to know?

[25] A: If I wanted to know, I would be able to observe

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[1] it directly.

[2] Q: Okay. If you were asking a patient about it, you
[3] would ask directly, wouldn't you?

[4] A: If I wanted to know if they had bleeding before?

[5] Q: Yes.

[6] A: Yes, I could ask them or one of the family
[7] members.

[8] Q: Do you use late entries in your practice?

[9] A: Yes.

[10] Q: What are they used for?

[11] A: I need to document something I didn't have time
[12] to document before. I am reviewing charts prior
[13] to closing them so I need to add some

[14] documentation. I get a lab test back late, I
[15] need to document it. I get a telephone call
[16] late, I need to document it. There are many

[17] reasons why I would put in a late addendum.

[18] Q: Do your late addendum usually reflect medical
[19] procedures that were performed or lab results
[20] that were reported after you charted?

[21] A: Those would be reasons in addition to others.

[22] Q: You find the late entries of the home health care
[23] nurses appropriate in this case?

[24] A: Yeah. I don't think it's unusual to put a late
[25] entry into a chart.

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[1] Q: I'm talking about the nature of these late
[2] entries, do you find those to be appropriate?

[3] A: Yes.

[4] Q: Do you have any opinion Mr. Restivo had a stroke?

[5] A: That seems to be a likely occurrence here that he
[6] had a stroke given the symptoms that are
[7] reported.

[8] Q: Do you have any opinion Mr. Restivo was having
[9] seizures?

[10] A: It sounds like he was, yes.

[11] Q: Can sepsis cause seizures?

[12] A: Only if you were in shock and had hypoperfusion
[13] of your brain; otherwise, no.

[14] I will clarify that. You can have sepsis
[15] that's caused from an infection. You can get
[16] seizures from that. There are types of sepsis
[17] relating to the seizure but not urosepsis.

[18] Q: Does your report contain all of the opinions you
[19] intend to offer at the trial of this case?

[20] A: Yes.

[21] Q: Have you talked with any of the healthcare
[22] providers in this case?

[23] A: No.

[24] Q: Doctor, do you agree placing a Foley catheter in
[25] the urethra is a violation of standard of care?

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[1] A: Well, all Foley catheters go into the urethra.
[2] Q: I didn't mean passing it through. I mean placing
[3] and inflating the balloon?
[4] A: In the urethra?
[5] Q: Yes.
[6] A: I'm sorry, what was your original question?
[7] Q: Do you agree that placing a Foley catheter in the
[8] urethra and inflating the balloon is a violation
[9] of standard of care?
[10] A: Yes, I would agree with that.
[11] Q: Doctor, what do you charge for your time?
[12] A: \$350 an hour.
[13] Q: Does that include trial, deposition, everything?
[14] A: Yes.
[15] Q: Reviewing records?
[16] A: Yes.
[17] MS. EKLUND: I think I'm finished,
[18] Doctor.
[19] MS. HARRIS: On behalf of
[20] Dr. Carroll I have a few questions.
[21]
[22] CROSS-EXAMINATION OF CHARLES L. EMERMAN, M.D.
[23] BY MS. HARRIS:
[24] Q: If there was excessive bleeding at the time of
[25] the placement of the Foley catheter, some 12

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[1] hours before the emergency department visit, I
[2] haven't counted up those hours, you would expect
[3] to see a change in the hemoglobin and hematocrit
[4] if there was excessive bleeding?
[5] A: Well, it's a matter of definition of how much
[6] bleeding you're talking about. If there's a lot
[7] of — if there was enough bleeding you might.
[8] Q: If this case was the hematocrit and hemoglobin
[9] normal?
[10] A: Yes, they were.
[11] Q: Would that lead you to conclude at least the
[12] bleeding was not excessive?
[13] MS. EKLUND: Objection.
[14] A: I would agree that if there had been bleeding it
[15] would not have been enough bleeding to lead to a
[16] change in the hemoglobin or hematocrit. Again,
[17] it's a matter of degree.
[18] Q: Am I also correct that for lay persons when they
[19] are trying to describe to physicians, such as
[20] yourself, bleeding, a little bit of blood seems
[21] much more significant to a lay person than to a
[22] physician?
[23] MS. EKLUND: Objection.
[24] Q: Is that a fair statement in general?
[25] MS. EKLUND: Objection.

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[1] A: Yes.
[2] Q: Do you have an opinion as to whether or not
[3] Mr. Restivo was septic in the emergency
[4] department?
[5] A: He does not appear to be septic in the emergency
[6] department.
[7] Q: Was it appropriate in keeping he with standard of
[8] care for Dr. Carroll to have considered a stroke
[9] and seizure disorder in her treatment plan?
[10] A: Yes.
[11] Q: And I take it you have no criticisms of
[12] Dr. Carroll to have proceeded to work that up,
[13] the stroke and seizure?
[14] A: That's correct.
[15] Q: Or the cardiac condition as well?
[16] A: That's correct.
[17] Q: And am I correct that it is your opinion
[18] Dr. Carroll in treating this patient in the
[19] emergency department acted appropriately in
[20] keeping with the standards of care for a
[21] reasonable ER doctor?
[22] A: Yes.
[23] Q: You talked about the complaints in the emergency
[24] department and, Doctor, we have a question of
[25] semantics. Can you look at the secondary

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[1] nursing notes as to what was told as he came into
[2] the emergency room.
[3] A: You're asking about the triage note?
[4] Q: It's either the secondary or triage note.
[5] MS. REID: It's the page before.
[6] Q: There. Is that the secondary note?
[7] A: Yes.
[8] Q: The only thing that was mentioned was I think the
[9] Foley catheter had been changed that day and it
[10] caused moderate to large amount of hematoma and
[11] redness of the head, correct?
[12] MS. EKLUND: Objection.
[13] A: That's correct.
[14] Q: It does not indicate, Doctor, that those — there
[15] was hematuria still or that there was redness of
[16] the head still?
[17] A: That's correct.
[18] Q: That's a past history, correct?
[19] MS. EKLUND: Objection.
[20] A: It's stated in past tense.
[21] Q: Okay.
[22] MS. HARRIS: I don't have any
[23] further questions.
[24] MS. SFISCKO: I have a few. I
[25] represent the home healthcare nurse.

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[1]
[2] CROSS-EXAMINATION OF CHARLES L. EMERMAN, M.D.
[3] BY MS. SFISCKO:
[4] Q: Do you have any criticisms of the home healthcare
[5] nurse in this case?
[6] A: I have no expertise to comment on that one way or
[7] the other but I don't have any criticisms to
[8] state.
[9] Q: Is there anywhere in the emergency room record in
[10] the nursing notes or history that Mr. Restivo was
[11] still experiencing blood in his urine? Was that
[12] reported at all that you could see by the family?
[13] A: I don't see that note.
[14] Q: That he still has blood in his urine or still
[15] bleeding from the meatus, anything like that, any
[16] reference to him having a present problem of
[17] bleeding from the Foley or the meatus or anything
[18] like that in the record?
[19] A: In the emergency department record, no.
[20] Q: So as Bev questioned you about the reference to
[21] any bleeding is in the past tense not in the
[22] present?
[23] A: That's correct.
[24] MS. SFISCKO: I have nothing
[25] further. Thank you.

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[1] MS. EKLUND: I have just a couple
[2] more for you.
[3]
[4] FURTHER CROSS-EXAMINATION OF
[5] CHARLES L. EMERMAN, M.D.
[6] BY MS. EKLUND:
[7] Q: Is Elyria Memorial Hospital part of The
[8] Cleveland Clinic at the present time?
[9] A: Not that I know of.
[10] Q: Do Cleveland Clinic physicians go to Elyria
[11] Memorial Hospital to provide services?
[12] A: Not that I'm aware of.
[13] Q: How long does it take to check the position of a
[14] Foley catheter?
[15] A: You could do so by inspecting it.
[16] Q: How long, seconds?
[17] A: Yes.
[18] Q: Doctor, in regard to the secondary nursing notes
[19] you have been asked about, first of all, this is
[20] a summary of what another person hears what
[21] another person is saying, correct?
[22] A: I'm sorry, can you ask me that again?
[23] Q: The triage nurse, whoever takes this note,
[24] typically don't write down everything the patient
[25] or family members say to that person when they

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[1] bring somebody into the emergency room, do you
[2] agree with that?
[3] A: Do you mean do they write down every single word?
[4] Q: Right.
[5] A: No, they probably don't write down every single
[6] word. It's a summary.
[7] Q: Do you find in your experience on occasion the
[8] triage nurse doesn't get all the important
[9] information?
[10] MS. HARRIS: Objection.
[11] MS. REID: Objection.
[12] A: I think the triage nurses are pretty good.
[13] Sometimes the family will tell one caregiver
[14] something different than they tell another
[15] caregiver.
[16] Q: And sometimes the family tells the nurse more
[17] than they write down, the triage nurse, would you
[18] agree with that?
[19] MS. HARRIS: Objection.
[20] MS. REID: Objection.
[21] A: They usually write down the pertinent things.
[22] Q: On occasion they don't, do you agree?
[23] A: Are you asking me if it ever happened?
[24] Q: Sure.
[25] A: I suppose it's possible.

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[1] Q: Have you ever experienced it yourself?
[2] A: Well, there are times when the patients will tell
[3] me something they haven't told the nurse.
[4] Sometimes they'll tell the nurses and they deny
[5] it to me.
[6] Q: There's inaccuracies when people talk between
[7] themselves when somebody reports something, do
[8] you agree with that?
[9] A: Are you asking me is it possible?
[10] Q: Sure.
[11] A: It's possible.
[12] Q: You read Mrs. Restivo's account what she told the
[13] nurse when she brought her husband to the
[14] emergency room?
[15] A: Yes.
[16] Q: You read her account of bringing in the jar of
[17] urine that her husband had in the bag before she
[18] dressed him to bring him to the emergency
[19] department?
[20] A: Yes.
[21] Q: Do you see any mention of that in the emergency
[22] department records?
[23] A: No, and I wouldn't expect there to be.
[24] Q: Why not?
[25] A: I wouldn't do anything with a jar of urine that

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

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[1] bag.
[2] Q: That wasn't my question. Do you see any
[3] notation by any medical provider that they
[4] checked for redness of the head or bleeding?
[5] A: Not in the emergency department, no.
[6] Q: And there also is not a single notation about
[7] whether or not there is blood in the urine,
[8] correct, in the emergency department?
[9] A: Not in the emergency department.
[10] Q: And how hard is that to check?
[11] A: It's not hard to check.
[12] Q: Seconds, isn't it, Doctor?
[13] A: Yes.
[14] MS. EKLUND: Thank you.
[15]
[16]

CHARLES L. EMERMAN, M.D.

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CERTIFICATE

[1]
[2]
[3] The State of Ohio,) SS:
[4] County of Cuyahoga.)
[5]
[6] I, Tami A. Mitchell, a Notary Public within
[7] and for the State of Ohio, authorized to
[8] administer oaths and to take and certify
[9] depositions, do hereby certify that the
[10] above-named witness was by me, before the giving
[11] of their deposition, first duly sworn to testify
[12] the truth, the whole truth, and nothing but the
[13] truth; that the deposition as above-set forth was
[14] reduced to writing by me by means of stenotypy,
[15] and was later transcribed into typewriting under
[16] my direction; that this is a true record of the
[17] testimony given by the witness; that said
[18] deposition was taken at the aforementioned time,
[19] date and place, pursuant to notice or
[20] stipulations of counsel; that I am not a relative
[21] or employee or attorney of any of the parties, or
[22] a relative or employee of such attorney or
[23] financially interested in this action; that I am
[24] not, nor is the court reporting firm with which I
[25] 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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[24]
[25]

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