IN THE COURT OF COMMON PLEAS
SUMMIT COUNTY, OHIO
PETER YACECZKO,
et al.,

Plaintiffs,

JUDGE WILLIAMS
-vs- CASE NO. 2001-10-4854

PERANTINIDES & NOLAN CO., LPA,
et al.,

Defendants.

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Deposition of CHARLES L. EMERMAN, M.D., taken as if upon cross-examination before Laura L. Ware, a Notary Public within and for the State of Ohio, at The Cleveland Clinic Foundation, Emergency Department Conference Room, 9500 Euclid Avenue, Cleveland, Ohio, at 12:58 p.m. on Thursday, August 22, 2002, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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APPEARANCES:

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On behalf of the Plaintiffs;

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On behalf of the Defendants.

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(Thereupon, Plaintiffs' Emerman Exhibits A through F were mark'd for purposes of identification.)

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CHARLES L. EMERMAN, M.D., of lawful age, called by the Plaintiffs 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 MR. RUF:

Q. Could you please state your name and spell your name.

A. Charles Louis, L-O-U-I-S, Emerman, E-M-E-R-M-A-N.

Q. Dr. Emerman, my name is Mark Ruf. I represent the Yaceczkos in a legal malpractice case against some lawyers. If at any time I ask you a question and you do not understand my question, please tell me. If you give me an answer to a question, I'll assume you've understood the question. Okay?

A. All right.

Q. Were you made aware that this is a legal malpractice case that's being asserted against some lawyers?

A. Yes.

Q. And are you aware that those lawyers are medical malpractice lawyers?

A. Yes.

Q. Have you ever missed the diagnosis of a TIA or stroke?

A. I'm not sure, possibly. There was a patient that I saw a number of years ago who had a hypoglycemic episode who came back the next day with a stroke, but I can't be sure whether it was really a TIA that she was having when I saw her or not. She was having hypoglycemia.

Q. Was that patient ever definitively diagnosed with a TIA or stroke?

A. Well, she was definitively diagnosed with a stroke but not with a TIA.

Q. So to the best of your knowledge you might have missed the diagnosis of TIA once during your career?

A. Well, as I said, it's not clear to me that I missed it. She clearly had a stroke the next day, so there was a question in my mind what was happening the day before. That's the only one I recollect.

Q. How long have you been practicing?

A. 20 years.

Q. Approximately how many patients have you seen during

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that 20-year period?
A. I couldn't tell you.
Q. Thousands?
A. Probably somewhere between fifty and 100,000.
Q. For the times that you've diagnosed a TIA or a stroke, how have you made the diagnosis?
A. Generally the same way I make a diagnosis of most things; I take a history, I do a physical examination, I do testing if indicated.
Q. What would you look for in the patient's history to diagnose a TIA or stroke?
A. Well, a TIA by definition is a transient neurological deficit that's consistent with a central origin, so I would look for evidence of that.
A stroke is a neurological deficit of central origin that lasts for more than 24 hours, presumably of a vascular cause.
Q. Is there anything else you would look for in the patient's history?
A. There's lots of things I would look for in their history.
Q. Okay. What types of things?
A. I would ask them about the events that brought them to the emergency department, I would ask them about

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associated symptoms, ask them about their past medical history, see if there's anything else going on with them.
Q. Are there any risk factors you would ask about?
A. Yes, there are.
Q. What are the risk factors you would ask about?
A. Well, generally the risk factors for atherosclerotic disease, advancing age, hypertension, diabetes, atrial fibrillation, depending on the age of the patient, cocaine use, previous episodes of TIA or CVA.
Q. What would you look for on physical examination?
A. I would do a neurological examination, I would do a vascular examination, in a patient like this I would do a general examination of the patient, listen to their lungs, listen to their heart, check their abdomen, things such as that.
Q. What would you do in the neurological examination?
A. Some of it would depend on what the presentation of the patient was, how evident the problem was, how -- if the patient is having subtle problems I might do a more detailed examination, if the patient is having a stroke in which I'm considering giving TPA I might do a more abbreviated examination so I can get things moving. It depends on the situation.

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Q. Well, for Mr. Yaceczko, as he presented at Akron City Hospital on April 19th, 1996, could you tell me the neurological exam that you would have performed on him?
A. Generally I would have asked him questions to determine his state of alertness and orientation, I would have done a cranial nerve examination, I would have done a peripheral motor examination, I would have checked reflexes, I would have checked sensation, I would have checked him for dysmetria.
Are you asking me what the standard is or what I normally would do?
Q. What you would have done if he was your patient back in '96.
A. That's what I would have done.
Q. Is there anything else you would have done on physical examination?
A. Yeah, the things that I mentioned before.
Q. Anything else?
A. Neurological examination, cardiac examination, listen to his lungs, checked his abdomen, done a general overall examination of him.
Q. What would you have done with respect to the cardiac examination?
A. Listened to his carotids, listened to his heart.

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Q. Could you give me an estimate as to the number of times you've diagnosed a patient with a TIA or a stroke?
A. No, I wouldn't be able to do that.
Q. You can't give me any kind of estimate?
A. I wouldn't really have any way of giving you anything other than a guess.
Q. Would it be more than 100, less than 100?
A. Oh, certainly it would be more than 100.
Q. Would it be more than 500?
A. I would be guessing. I mean, it might be 1,000, it might be 2,000, it might be 500, but it's a common thing for me to see.
Q. When Mr. Yaceczko presented to Akron City Hospital on April 19th, 1996, was he having a stroke or a TIA when he presented?
A. He was having a stroke.
Q. Why do you say he was having a stroke?
A. He had evidence of the stroke on CT scan.
Q. Is the CT scan read that you're talking about the final report that was produced by Dr. Roy?
A. Yes.
Q. Was he having an ischemic or hemorrhagic stroke?
A. He had an ischemic stroke.
Q. And why do you say he had an ischemic stroke?

A. Based on the CT scan reading.
Q. And what's the difference between an ischemic and hemorrhagic stroke?
A. Well, with an ischemic stroke you have interruption of the blood supply to a portion of the brain, but you do not have extravasation of blood into the brain tissue.
Q. What do you mean by ex -- what is the word you used?
A. Extravasation.
Q. What is that?
A. Leakage.
Q. Please continue. Thanks.
A. Where was I?

MR. TREADON: You were describing the difference between an ischemic and hemorrhagic stroke.

THE WITNESS: Yeah, I just don't remember where I was when I was interrupted.

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(Thereupon, the requested portion of the record was read by the Notary.)

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A. With a hemorrhagic stroke then you would have extravasation of blood into the brain tissue.
Q. Do you agree that Mr. Yaceczko was not definitively

diagnosed by Dr. Henschen as having a stroke?
A. Yes, that's true.
Q. Was Mr. Yaceczko having progressive strokes or a stroke in evolution on April 19th, 1996?
A. Well, he appears to have had a single stroke which had fluctuating symptoms.
Q. When did the stroke occur?
A. As I recall from the nursing notes, it would have been two days prior to his initial visit. That would have made it, well, let me just look so I'm clear on the dates, two days prior to this visit, so that would have made it April 17, yes, April 17th, 1996.
Q. Would you disagree that Mr. Yaceczko was having a stroke in evolution on April 19th, 1996?
A. No, I agree with that.

MR. TREADON: You agree that he was having a stroke in evolution? You said not. I think it was a negative question.

MR. RUF: I'm sorry, do you want me to clarify?

MR. TREADON: I'd like it clarified, yes.

Q. Do you agree that Mr. Yaceczko was having a stroke in evolution on April 19th, 1996?

A. Well, by definition a stroke in evolution is one that changes over time. Since Mr. Yaceczko's stroke changed between April 17th and his discharge on April 29th from Akron General Hospital, it would be, using that definition, a stroke in evolution.
Q. Do you agree that the acceptable standard of medical practice in 1996 required Dr. Henschen to form a differential diagnosis for Mr. Yaceczko?
A. Emergency physicians many times do not form formal differential diagnoses, as you might see done in the hospital, so, no, the center did not require him to document the differential diagnosis.
Q. Well, even if it wasn't documented, would the standard of care require him to form a differential diagnosis list for Mr. Yaceczko?
A. No, the standard would not have required him to list a differential diagnosis.
Q. Isn't that something that you do on every patient, you form a differential diagnosis for that patient?
A. That's when you evaluate patients you think about the different things that could be causing the patient's problem, but emergency physicians are not required to list a differential diagnosis and frequently do not.
Q. Well, weren't you taught and trained to form a

differential diagnosis for a patient given their history and signs and symptoms?
A. You mean as an emergency physician?
Q. Yes.
A. We're taught to consider the different things that can be causing the patient's problem but not to list a differential diagnosis, as you're describing it.
Q. Do you agree that the acceptable standard of medical practice in 1996 required Dr. Henschen to rule in and rule out diagnoses for Mr. Yaceczko?
A. Well, he would have been required to consider diagnoses for Mr. Yaceczko. We frequently are not in a position to rule in or rule out diagnoses in the emergency department. We may come to some consideration of what is a likely cause of the patient's problem. We don't always rule them in or rule them out.
Q. So you disagree that the acceptable standard of medical practice would require him to rule in and rule out diagnoses?
A. The way you've stated it, yes.
Q. What would the acceptable standard of medical practice require Dr. Henschen to do with respect to making a diagnosis of Mr. Yaceczko?
A. To consider the things that could be causing his

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problems by doing first a history and physical, based on the history and physical decide what those things are that rise to a high enough likelihood that they need further diagnostic testing or treatment, and based on that act on his information.
Q. Do you agree that Dr. Henschen's differential diagnosis for Mr. Yaceczko was stroke versus neuropathy?
A. I would agree that that is what he's documented, but until you ask him what his differential diagnosis is, I can't make an assumption that you've asked me.
Q. Attorneys Perantinides and Parker never asked Dr. Henschen that question, did they?
A. Not that I'm aware.
Q. How would you rule out neuropathy for Mr. Yaceczko?
A. We would not be able to rule that out in the emergency department. To rule it out you'd have to do an EMG, so we would consider that diagnosis based on the clinical impression in the emergency department.
Q. Could you bring in a consult to perform an EMG?
A. Not in the emergency department.
Q. If you wanted to have a patient have an EMG, what

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would you do?
A. I've never ordered an EMG, and if I wanted a patient to have an EMG I would need to refer them back to their primary care doctor.
Q. Do you agree that a diabetic neuropathy would be systemic in Mr. Yaceczko?
A. I don't understand what you're asking me with that question.
Q. Well, do you know what kind of neuropathy was being considered in Dr. Henschen's differential diagnosis?
A. I would presume he's considering that he has a diabetic peripheral neuropathy based on the presentation of what he has here.
Q. And would a diabetic neuropathy be systemic in Mr. Yaceczko?
A. Why don't you explain to me what you're trying to get at because what you're saying doesn't make sense.
Q. Well, if Mr. Yaceczko, in fact, had a diabetic neuropathy, wouldn't you expect it to affect Mr. Yaceczko bilaterally?
A. No. You can get bilateral diabetic peripheral neuropathy, but you can also get unilateral neuropathies.

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Q. You've seen a unilateral diabetic neuropathy?
A. Oh, certainly.
Q. Wouldn't you expect to see numbness and weakness in Mr. Yaceczko's feet and arms as just opposed to one arm if he had a diabetic neuropathy?
A. Not necessarily, no.
Q. Do you agree that with a diabetic neuropathy you do not have an acute onset of symptoms?
A. No, I don't agree with that.
Q. Do you agree that a diabetic neuropathy would not affect speech?
A. I've not personally seen a patient with a diabetic neuropathy with dysarthria, but I'd have to review that to see whether that can occur, so I can't agree or disagree with your question.
Q. Are you aware of any medical text or any medical article that would document a diabetic neuropathy affecting speech?
A. Well, as I said, there may be. You can get diabetic neuropathy of other cranial nerves, so I don't see why you couldn't get one affecting speech, but I'd have to review that.
Q. But as we sit here today, are you able to tell me one medical textbook or article that would document a diabetic neuropathy affecting speech?

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A. I might be able to. I'd just have to go look.
Q. As we sit here in this deposition, are you able to tell me one medical textbook or article that documents a diabetic neuropathy only affecting an arm on one side of the body?
A. Certainly any neurology textbook could give you that.
Q. Other than performing an EMG, how would you rule out neuropathy for Mr. Yaceczko?
A. I don't know of any other way to rule out a peripheral neuropathy.
Q. Was there anything about his presentation that was inconsistent with diabetic neuropathy causing his symptoms?
A. I don't believe Dr. Henschen used the words diabetic neuropathy. Is that the basis of your question?
Q. Yes, although we've already gone over that you assume when he talked about neuropathy he was talking about diabetic neuropathy, correct?
A. I didn't say that.
Q. Well, what --
A. You said that.
Q. What other type of neuropathies could he be talking about?
A. Oh, there's lots of other different causes of

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neuropathy.
Q. What other neuropathies were a potential cause of Mr. Yaceczko's symptoms?
A. Well, the causes of neuropathy can be from nerve impingement, they can be from infection, they can be from connective tissue disorders, they can be from -- there's one there that I'm missing. I'll have to think about that.
Q. Is there any evidence that any of those neuropathies applied to Mr. Yaceczko's situation?
A. Not that I see here offhand. You mean in terms of establishing a more likely ideology than diabetic?
Q. Yes.
A. No, not that I see offhand.
Q. What are the signs or symptoms of a diabetic neuropathy?
A. There's a variety of them. They can be motor weakness, they can be loss of sensation, loss of reflexes, they can be pain in the distribution of a nerve, they can have autonomic dysfunction, they can have dysfunction of the cranial nerves.
Q. And typically does that affect a patient bilaterally or unilaterally?
A. Well, there's different types, and some of them would be bilateral and some of them would be

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unilateral.
Q. What about with a diabetic neuropathy?
A. I was referring to a diabetic neuropathy.
Q. What types of diabetic neuropathies are there?
A. I think I went over that, didn't I? I went over the different outcomes.
Q. You went over different types of neuropathies, but now you're telling me there are different types of diabetic neuropathies?
A. That's what I was referring to when I was talking about autonomic and cranial nerves. That's what I was referring to.
Q. I'm sorry, I'm not sure you answered my question. Is there anything that's inconsistent with -- based on Mr. Yaceczko's presentation on April 19th, 1996, is there anything about his presentation that's inconsistent with a diabetic neuropathy?
MR. TREADON: I'm going to object. I think you asked him if there's anything consistent with it already.
MR. RUF: Well, I think I asked inconsistent, although I think we got off on another topic.
MR. TREADON: Well, go ahead, you can answer.

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Q. Is there anything about his presentation on April 19th, 1996 that would be inconsistent with a diabetic neuropathy?
A. Yes, the pattern that's described by the nurse would be inconsistent with a diabetic neuropathy, this pattern of numbness, disorientation, memory loss, that would not be from a diabetic neuropathy.
Q. I'm sorry, did you use the word consistent or inconsistent?
A. Maybe we should come up with a different word to use here.
MR. TREADON: I think he said not consistent.
A. Yeah, maybe so. This pattern that's described by the nurse, numbness, disorientation, memory loss, that would not be from a diabetic neuropathy.
Q. And why wouldn't that be from a diabetic neuropathy?
A. Because this describes a central origin for his problem, not a peripheral origin for his problem.
Q. And typically with a diabetic neuropathy do you have a peripheral origin?
A. Yes, that's correct.
Q. So if there's a peripheral origin with a diabetic neuropathy, do you look for signs or symptoms peripherally in the patient?

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A. When I examine the patient's peripheral nervous system, is that the question you asked me?
Q. Yes.
A. Yes, as we described when we first talked about this.
Q. Do you have an opinion based on reasonable medical probability as to whether or not Dr. Henschen deviated from acceptable medical practice in failing to diagnose Mr. Yaceczko's stroke on April 19th, 1996?
A. Well, I think my impression here is based on the information that Dr. Henschen had, the evaluation by Dr. Salem who apparently reassured him that the patient was at his baseline, and based on the CT scan reading he had that he was within the standard of care to come to a decision to send this patient home for further follow-up.
Q. Do you agree that a CT scan cannot always detect a cerebral infarction?
A. That's true.
Q. And do you agree that because of that an emergency room physician should be able to make the diagnosis of stroke based on clinical signs and symptoms as well as the patient's history?
A. Are you asking me can you or --

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Q. Yes.
A. -- should you in every case?
Q. First of all, can you?
A. Yes.
Q. Second of all, should you if there are signs and symptoms of a stroke and the patient's history indicates that they are a higher risk for stroke?
A. Well, if you have signs and symptoms of a stroke, then you can generally make the diagnosis of a stroke.
Q. Well, do you agree that if a patient has signs and symptoms of a stroke that the ER physician should make the diagnosis of a stroke?
A. Are you asking me whether the standard requires them to be 100 percent accurate?
Q. No, I'm just asking you should they make the diagnosis of a stroke?
A. It would depend on the signs and symptoms that are present.
Q. If the patient has classic signs and symptoms of a stroke, should the ER physician make the diagnosis of stroke?
A. Yes.
Q. Do you agree that with ischemic strokes, ischemic strokes may not show up initially on CT scan?

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A. Yes.
Q. Do you agree that 50 percent of ischemic strokes will not be apparent on CT scan between 24 and 48 hours?
A. That sounds too high.
Q. Are you aware of what the literature reports as far as what percentage of ischemic strokes are apparent between 24 and 48 hours?
A. Not off the top of my head, but 50 percent sounds too high.
Q. Have you ever read studies that report what percent of ischemic strokes are apparent between 24 and 48 hours?
A. I probably have, but I don't recall them off the top of my head.
Q. Well, based upon your education and experience, what percentage of ischemic strokes may not show up between 24 and 48 hours?
A. If you're asking me to guess, I would say 25 percent, but I'd have to look it up.
Q. Is that just a guess?
A. Yes.
Q. Because ischemic strokes may not show up initially in a patient, do you agree it would be a mistake for an emergency room physician to rely exclusively on

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the reading of a CT scan to determine whether or not a patient is suffering from a stroke?
A. Yes.
Q. What risk factors did Mr. Yaceczko have for a stroke?
A. His age, the fact that he has diabetes, and the fact that he has hypertension, and the fact he's had a previous stroke, of course.
Q. Are you able to quantify how much higher of a risk he was for stroke based upon those factors?
A. Compared to what?
Q. Compared to the average person.
MR. TREADON: Average 70-year-old?
MR. RUF: Sure.
A. Compared to a 70-year-old who had not had a stroke, does not have diabetes, and does not have hypertension?
Q. Sure.
A. He's at increased risk. I can't quantify it for you.
Q. You couldn't give me a multiplication factor?
A. Not for the combination of the three, no.
Q. Have you ever read medical literature that indicates that a person with diabetes has three times the risk of a person that does not have diabetes for getting

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a stroke?
A. That sounds about right.
Q. What about for hypertension?
A. I would imagine it would be very similar.
Q. And what about for a patient with a previous stroke?
A. A patient with previous stroke has between a five and ten percent risk per year of having another stroke.
Q. Did Mr. Yaceczko have signs or symptoms of a stroke when he presented to Akron City Hospital on April 19th, 1996?
A. Depending on whose history and physical you're reading, yes.
Q. What do you mean by that?
A. As I said, if I take the history and physical -- if I take the information that the nurse has, those are signs and symptoms of a stroke. It appears that the evaluation by Dr. Salem provided Dr. Henschen with some information to suggest that this was not a stroke.
Q. Well, based upon the emergency room record, what signs or symptoms did Mr. Yaceczko have of a stroke?
A. Confusion, memory loss, numbness. The question is

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whether or not he actually had a change in speech pattern, that seems to be part of the question here, in part why Dr. Salem was asked to come to see the patient, so those are all things that could be from a stroke.
Q. Are those classic signs or symptoms of a stroke?
A. They can be signs of a stroke. They're not what generally you would think of as a classic sign of a stroke.
Q. Okay. What are classic signs or symptoms of a stroke?
A. Loss of motor power, loss of speech, abnormalities of the cranial nerves, loss of sensation, abnormal reflexes.
Q. Isn't weakness or numbness a classic sign or symptom of a stroke?
A. Are you asking me that in isolation, or are you asking me in the context of this case?
Q. I'm asking you in isolation.
A. Well, you can have weakness without having a stroke, you can have numbness without having a stroke.
Q. But aren't weakness and numbness classic signs of a stroke?
A. They can be. It depends on the context in which you're seeing them.

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Q. You're director of emergency medicine both at The Cleveland Clinic as well as Metro Hospital; is that correct?
A. Correct.
Q. Are you aware that The Cleveland Clinic has information about stroke on its web site?
A. It wouldn't surprise me.
Q. Would The Cleveland Clinic web site be a reliable or accurate source of information on stroke?
MR. TREADON: Objection. Are you talking -- give him something specific.
Q. Are you able to answer the question?
A. I would think they have information directed to the public. They may have information directed at medical providers, but I don't know that. I haven't seen it.
Q. Would you expect them to have inaccurate or unreliable information in their web site?
A. I would hope not.
Q. Have you ever reviewed the information listed for stroke on The Cleveland Clinic's web site?
A. No, I have not.
Q. What about for MetroHealth, are you aware that they have a web site containing information about stroke?

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A. It wouldn't surprise me.
Q. And would you consider the information that MetroHealth would put on its web site to be accurate and reliable information?
A. I would hope it would be, but I'd want to review it.
Q. Well, would you expect that they would put inaccurate or unreliable information on their web site?
A. I would hope not.
Q. Could you tell me physiologically what would account for Mr. Yaceczko having problems with weakness or numbness on one side of his body, difficulty with speech or difficulty understanding speech and memory loss, and then those symptoms improving once he got to the emergency room?
A. Are you posing that as a hypothetical?
Q. Yes.
A. Okay, because I'm not seeing the weakness on the right side as documented in here. Maybe I'm just missing it.
Q. Do you agree that weakness is checked under neuro?
A. That's a weakness on the left side.
Q. Okay.
A. That's a residual result of a stroke.

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Q. At the top does it say whether it's on the right or left side?
A. No, it says that in the narrative.
Q. Do you know whether or not Mr. Yaceczko had weakness prior to his presentation at Akron City Hospital?
A. Yes, he had a previous stroke.
Q. Did he have weakness on the right side prior to presentation at the Akron City Hospital emergency room?
A. Not that I see documented here.
Q. I'm sorry, let me go back.
A. Okay.
Q. Physiologically what could account for him having numbness in the right arm and hand, difficulty with speech, disorientation and memory loss and then those symptoms improving once he was in the emergency room?
A. Sometimes when patients have stroke they have an area of edema around the stroke site that can vary, so their symptoms may fluctuate a little bit.
Q. Could one explanation be that there was increased blood flow to the area that was affected ischemically?
A. Once you have an infarction, that area will not recover, so change in blood flow wouldn't affect

that.
Q. Is there an area around the infarction that may be compromised as far as blood flow but still may be viable tissue?
A. Well, there's an area that may be compromised and may be potentially viable, but that's related to edema and to toxic chemicals that are put out by dead cells. That's the aspect of a stroke that we try and address with studies, unfortunately we've not been successful yet.
Q. What's the penumbra?
A. That is what I just described.
Q. Do you know whether or not there was an area of brain tissue that had compromised blood flow but was still potentially viable when Mr. Yaceczko presented to Akron City Hospital on April 19th, 1996?
A. In retrospect, the answer to that is no. The penumbra did not appear to be viable.
Q. Do you agree that Mr. Yaceczko had a worsening of symptoms by the time he presented to General Hospital?
A. His symptoms when he presented to Akron General Hospital were similar to his symptoms when he presented to Akron City.
Q. You wouldn't consider that he had a worsening of

symptoms when he went to General?
A. Are you asking me whether he had different symptoms; is that the question?
Q. I'm asking you whether his symptoms worsened.
A. The history is that he had increasing numbness, so I suppose the answer to your question is, yes, he had worsening symptoms.
Q. And didn't his numbness and other symptoms also become more persistent by the time he got to General Hospital?
A. He did have persistent symptoms after he came to Akron General, yes.
Q. If there was a worsening of his symptoms, wouldn't that be caused by increased brain damage?
A. Yes.
Q. Do you agree that with a stroke the amount of brain damage increases as time passes?
A. No, that's not -- that can't be answered yes in a general sense.
Q. Do you agree that damage occurs due to interference with blood flow to a portion of the brain with an ischemic stroke?
A. Yes.
Q. And other than the area of immediate infarct, does it take time for damage to occur due to the

penumbra?
A. It can, yes.
Q. Is the treatment of a stroke related to the fact that it takes time for the damage to occur to the penumbra?
A. Unfortunately, no, that's not the case.
Q. Well, isn't the theory behind treatment that if you can increase the blood flow to the area you can reduce the amount of brain damage that occurs?
A. No.
Q. What's the theory behind treatment for a stroke then?
A. It depends on which phase of the stroke you're talking about. During the first three hours of a stroke we can occasionally give people thrombolytics and reverse the ischemia. Beyond that three-hour period, we do not have effective therapy to reverse a stroke. The treatment is supportive.
Q. Back in 1996, what were the potential treatments for a stroke?
A. Aside from thrombolytics, which were introduced sometime in 1996, there was no effective treatment for a stroke.
Q. I'm asking you about recognized treatments.
A. There were no recognized effective treatments for

stroke.
Q. Wasn't heparin being used to treat stroke back in 1996?
A. Some people used heparin, but it was not recognized as an effective therapy.
Q. Have you ever used heparin to treat a stroke?
A. No, I haven't.
Q. Not at any time during your career?
A. No.
Q. Typically when you diagnose a patient with a stroke, do you determine what treatment to provide or do you bring in a neurologist to consult on that issue?
A. Well, anybody that I would diagnose with an acute stroke would be referred to somebody else for admission. They may choose to put them on heparin, but I would not.
Q. For a patient that was diagnosed with stroke in 1996, would the standard of care require admission of that patient to the hospital?
A. It would depend on the time frame. Somebody who has an acute stroke the standard of care would require them to be admitted.
Q. And why would the standard of care require them to be admitted?
A. To monitor them for deterioration, hemorrhagic

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transformation of the stroke, beginning their therapy, do diagnostic testing.
Q. Are you aware of any of your patients being treated with heparin for stroke after you've diagnosed a stroke and brought in a neurologic consult?
A. Well, some of them have been, yes.
Q. Have you had patients in which you've diagnosed a stroke that have had a good outcome with treatment with heparin?
A. Some patients that I've taken care of have had a good outcome but it was not because of the heparin.
Q. Have you had patients that have been treated with heparin that have had a good outcome?
A. Has anybody who I've ever seen treated with heparin had a good outcome?
Q. Yes.
A. Yeah, I would imagine the answer to that would be yes.
Q. Do you agree that heparin was being widely used to treat strokes back in 1996?
A. It was used some of the time but not most of the time.
Q. So if you, back in 1996, if you diagnosed a patient with a stroke, was it outside your area of expertise to determine what particular treatment to provide to

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that patient?
A. No.
Q. Although you said that it was your practice to consult with a neurologist to determine treatment?
A. I would not have started heparin because the evidence was not there to demonstrate its effectiveness. Sometimes neurologists would choose to put patients on heparin, but I would not have started it.
Q. But my specific question is if you diagnosed a patient with a stroke back in '96 was it your typical practice to consult a neurologist to determine what treatment was appropriate for the patient?
A. Some treatment I would provide without their advice, some treatment I would provide with their advice.
Q. And what treatment would you provide without their advice?
A. I would control their blood pressure, I would give them aspirin, I would address any other medical problems they might be having, I personally would give them TPA, although generally I would consult them if I could get a hold of them.
Q. Back in 1996 was TPA a recognized treatment for stroke?

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A. Are you asking me whether it was the standard of care to give TPA for stroke?
Q. No, I'm asking you was it an accepted treatment for stroke in '96?
A. Some people used it for stroke, some people would not. Some people today would use it, some people would not.
Q. Are there certain types of patients for which you would not give TPA that were suffering from a stroke?
A. Many times.
Q. What types of patients?
A. Well, most patients are not eligible for TPA. They have to be very rigid criteria to get TPA.
Q. And what are those criteria?
A. Generally you have to see them within three hours of the onset of the stroke, they have to have enough of a neurologic deficit that the benefit outweighs the risk, their blood pressure has to be reasonably controlled, they cannot have too high of a glucose, they cannot be anticoagulated, they cannot have had a recent head trauma, there's other similar criteria.
Q. For patients in which TPA was not indicated, what type of treatment would you provide those patients

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back in 1996?
A. I would give them an aspirin, control their blood pressure, and admit them.
Q. Would you admit them for consultation with a neurologist?
A. Some would be admitted and would get a consultation. It would depend who they would be admitted to. They might be admitted directly to a neurologist or their primary care doctor and get a neurology consultation.
Q. Do you agree that when Mr. Yaceczko was given heparin at General Hospital his condition improved?
A. No, his condition worsened with the heparin. Mr. Yaceczko had a pattern of worsening with heparin.
Q. Do you disagree that he had restoration of strength on the right when heparin was administered?
A. He had a loss of strength on the right.
Q. Do you agree that by the time Mr. Yaceczko presented to General Hospital his stroke had completely evolved?
A. No, his stroke worsened after he was admitted to Akron General Hospital.
Q. Based upon a reasonable medical certainty by the time he reached General Hospital was it too late to prevent any further damage?

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A. It was too late when he presented to Akron City Hospital, so I would agree that when he presented two days later at Akron General Hospital it was still too late.
Q. Isn't heparin given to a stroke patient to try and increase the blood flow to the affected area in that patient?
A. Heparin is not effective for stroke. For whatever reason people initially thought it might have been useful, it is not useful.
Q. Well, wasn't the theory for administering heparin to increase the blood flow to the area that was affected?
A. Maybe, but it doesn't work.
Q. Well, what was your understanding of the theory of giving patients who were suffering from stroke heparin?
A. I think the theory was that you would give them heparin and the blood clot would break up, and then they would re-perfuse and their brain would be fine. It just didn't work.
Q. Do you agree that back in 1996 heparin was indicated for patients with a stroke in evolution to prevent progression?
A. It was a matter of physician preference, it was not

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the standard of care.
Q. Whose preference was it, the neurologist's?
A. The treating physician.
Q. If you diagnosed a patient with a stroke and they were admitted, who would the treating physician be?
A. I don't understand the question. I would admit -- I mean, there are dozens of physicians I might admit a patient to. You're not asking me that, are you?
Q. What I'm asking you is once you admit the patient, are you the treating physician any longer or does somebody else take over as the treating physician?
A. Yes, once I admit them somebody else becomes the treating physician.
Q. So back in 1996 was your job to diagnose a person with a stroke and then admit them for a different physician to follow up and treat them?
A. I would diagnose them, I would initiate treatment, and then I would admit them.
Q. Was Mr. Yaceczko's blood pressure properly controlled by Dr. Henschen?
A. Sorry, I'm looking at the wrong record here. Yes, his blood pressure, diastolic blood pressure, is only 70.
Q. Do you agree that at Akron City Hospital there was a misread of his CT scan initially?

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A. That appears to be the case.
Q. And do you agree that would be a deviation from acceptable medical practice to misread the CT scan?
A. Well, it's not the standard that you are 100 percent accurate in reading a CT scan, so not having seen the CT scan I cannot say that it was so obvious that everybody should have picked it up.
Q. Well, do you think it was acceptable to misread the CT scan; do you consider that to be acceptable medical practice?
A. Well, we try not to make mistakes, but sometimes that happens.
Q. Well, do you agree that when mistakes are made that can be a deviation from acceptable medical practice?
MR. TREADON: Could be? Anything is possible. Go ahead.
A. There are some mistakes that are deviations from acceptable standards of care, there are some mistakes that are not a deviation of the standard of care.
Q. Well, in your opinion does a mistake have to be intentional in order to be a deviation from acceptable medical practice?
A. No.

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Q. What's your definition of acceptable medical practice?
A. The standard of care is the care provided by a reasonable physician under similar circumstances.
Q. Do you agree it would be reasonable and prudent to call Mr. Yaceczko back to the hospital after it was discovered that there was a misread of the CT scan?
A. Or to notify his primary care physician, yes.
Q. Do you agree that that was not done in this case?
A. That appears to be the case.
Q. Do you agree that the misread of the CT scan was at least one of the factors which caused Mr. Yaceczko to be discharged from Akron City Hospital?
A. Yes.
Q. Do you agree that if Dr. Henschen had diagnosed Mr. Yaceczko with a stroke that the standard of care would have required him to admit Mr. Yaceczko for the hospital?
A. Yes.
Q. To the hospital?
A. Yes.
Q. I'm sorry.
What are your charges for being involved as an expert witness in this case?
A. $300 per hour.

Q. And how much time have you spent on this case?
A. In preparing for this deposition, about eight hours, and I can't recall how much time I spent prior to this.
Q. How many bills have you sent to Mr. Treadon?
A. One that I can recall.
Q. And what was the amount of that bill?
A. I can't recall.
Q. Could you give me an approximate amount?
A. I would imagine it would have been around $1,200, but I can't recall exactly.
Q. Did you produce a report in this case?
A. I don't think I did.
THE WITNESS: Did I give you a report?
MR. TREADON: No.
A. No.
Q. How many times have you been an expert?
A. About 100 times. Well, I've reviewed about 100 cases. I haven't always agreed to or been asked to produce a report.
Q. Have you ever been an expert on behalf of a plaintiff/patient?
A. Yes.
Q. How many times have you done that?
A. Oh, about 30.

Q. So what percent of the time have you served as an expert for the defense?
A. About two-thirds of the time.
Q. Have you actually issued a report or testified that a doctor was negligent?
A. Yes.
Q. How many times have you done that?
A. I'd be guessing, but I would think of the approximately 36 times I've been a plaintiffs' expert I've probably gone to deposition or issued a report maybe half of that.
Q. Have you ever been an expert on a stroke case?
A. Yes.
Q. How many times?
A. A half a dozen, maybe.
Q. Do you know the names of any of those cases?
A. Yes.
Q. What are the names of those cases?
A. I did a case last year in Akron by the name of Konstand.
Q. Who was the plaintiffs' attorney?
A. Mister -- what was his name?
MR. TREADON: Perantinides.
A. Perantinides, yes. I couldn't remember how to pronounce his name. Thank you.

MR. TREADON: Irishman.
THE WITNESS: Yes.
Q. Do you know the physician that was involved in that case or physicians?
A. The physician involved was Chris --
MR. TREADON: Gradisek?
A. Gradisek, yes, thank you.
Q. And you were an expert for the patient in that case?
A. No, for the defense.
Q. Who was defending that case?
A. (Indicating.)
Q. Tom Treadon?
A. Yes.
Q. How many times have you served as an expert witness for Mr. Treadon?
A. Two or three. I guess this will be three.
Q. And the Konstand case Mr. Perantinides was a lawyer for the patient/plaintiff?
A. That's correct.
Q. Did that case only involve ER care or other physicians' care as well?
A. I don't recall there being anybody else involved, other than the hospital and the emergency physicians, but there may have been. That was a year ago.

Q. Were the facts of that case similar to the Yaceczko case or were they different?
A. They were different.
Q. How were they different?
MR. TREADON: Well, I'm going to object. That's a pretty tall order. This is a case -- I mean, if you can remember, that's fine.
Q. Just tell me based on your recollection how they were different.
A. Most of my testimony in that case revolved around the use of TPA, which isn't an issue in this case.
Q. Can you remember the name of -- let me go back. Did you give a deposition in the Konstand case?
A. Yes.
Q. And did that case go to trial?
A. Yes.
Q. Did you testify at trial?
A. Yes.
Q. Do you know what the verdict was in that case?
A. It was a defense verdict.
Q. What were the other one or two cases you served as an expert on involving a stroke?
A. Let's see, I'm an expert now on a case near Sandusky. I was asked by a couple plaintiffs'

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lawyers to review other stroke cases related to whether the patient should have gotten TPA or not. They never followed through on those cases.
Q. So you never rendered a formal opinion in those cases?
A. That's correct.
Q. Okay.
A. There were probably a couple of others in there. I can't recall them offhand.
Q. Is the research that you've done in this case Exhibits A through F?
MR. TREADON: Is there a question?
MR. RUF: Yeah.
Q. Have you done research for this case?
A. Well, I'm generally aware of the issues related to stroke and the use of heparin and TPA, so I would imagine that in my position I have other articles, but these are ones that were particularly pertinent to this case.
Q. Did you --
A. All the other ones are pertinent also, but these happened to be handy.
Q. Did you actually find Plaintiffs' Exhibits A through F?
MR. TREADON: As opposed to somebody

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else finding them?
MR. RUF: Yes.
Q. Are you the one that pulled these articles?
A. Yes, I did.
Q. Are you aware of a study in the New England Journal of Medicine by Kay that found heparin to be effective for the treatment of stroke?
A. Which study was that?
Q. A study in 1995.
A. Do you have the name of the study?
Q. Do you consider the publication New England Journal of Medicine to be a quality publication?
A. A quality publication?
Q. Yes.
A. Is that the same as authoritative or reliable?
Q. No, I'm just asking you is it a quality publication?
A. Oh, it's a good journal, yes.
Q. Is that a publication that you've referenced and reviewed?
A. The New England Journal of Medicine, yes.
Q. Is that a publication that you subscribe to?
A. Yes.
Q. Have you ever reviewed an article entitled Low Molecular Weight Heparin for the Treatment of Acute Ischemic Stroke published December 14th, 1995 in the

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New England Journal of Medicine?
A. Can I see the title?
Q. Sure.
A. Yes. This is actually not heparin, it's a heparin related compound that's not available in the United States. It's an interesting article. It was done in the far east involving a patient population that's, of course, different than the one that's at issue here, and the interesting thing about it is that they repeated the study and it was a negative trial.
Q. Did you review any medical text in order to prepare yourself today for this deposition?
A. No.
Q. Other than Exhibits A through F, did you review any medical articles in order to prepare yourself for today's deposition?
A. I review medical articles about stroke on a frequent basis, so I am aware of other articles about stroke.
Q. And what publications do you review articles about stroke?
A. In whatever ones they appear. I'm not sure what you're asking me.
Q. What periodicals do you review on a regular basis?

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A. I review articles when I'm interested in a topic, when I'm preparing lectures, when I'm preparing articles, or if I just happen to be interested. Are you asking me what I subscribe to?
Q. Yes, what do you subscribe to?
A. Oh, okay. Of course you're aware I have access to many other things than what I subscribe to through the computer or through the library.
Q. Yes.
A. I subscribe to the New England Journal, the Journal of the American Medical Association, the Annals of Emergency Medicine, Academic Emergency Medicine, the American Journal for Emergency Medicine, and the Journal of Emergency Medicine, and Chest.
Q. Do you subscribe to those publications because you've found them to be reliable sources of information?
A. Well, some of them I get just as a result of membership in various organizations. Some of them I get because they frequently have articles of interest to me.
Q. Well, I don't think you've answered my question. Have you found those to be reliable sources of information?
A. Sometimes yes, sometimes not.

Q. Have you ever published on stroke?
A. Yes.
Q. What publication of yours relates to stroke?
A. Can I have my CV back?
Q. Sure.
MR. TREADON: Here you go.
A. Do you want me to just circle or read them?
Q. Sure, why don't you circle them.
MR. TREADON: Tell me what you're circling so I can circle mine.
A. Okay. Let's see here, this is abstract number 49.
Q. What's the title of that abstract?
A. Effect of a Stroke Protocol on Management of Out of Hospital Stroke Patients. Article number 73.
MR. TREADON: What page? Oh, is this in your publications?
THE WITNESS: Yes, this would be the publications.
A. I'm not a listed author on that, but I was a listed investigator.
Q. What's the title of that article?
A. Glycine Antagonist and Neuro Protection for Patients with Acute Stroke.
Q. Under other publications?
A. Carotid Artery Disease.

Q. Can I go back for one minute?
A. Yes.
Q. Was glycine a potential treatment for stroke in '96?
A. No.
Q. Go ahead.
A. It was an investigational agent that did not prove useful.
Q. Okay. Go ahead.
A. Carotid Artery Disease. This is in other publications. Then articles 13 and 14 under other publications, Ischemic Stroke Syndromes, part one and part two. I believe that's it.
Q. Have you ever served as an expert for the Perantinides & Nolan law firm?
A. I don't think so.
Q. Can you remember the name of any plaintiffs' lawyers that you've served as an expert for?
A. William Knapp, K-N-A-P-P, in Cincinnati.
Q. Anyone else?
A. Abramson, Reiss, R-E-I-S-S, and Dugan in New Hampshire. Let's see here. There's a West Virginia lawyer that I've reviewed a couple cases for. Let me see if I can think of his name. Wes Graylip. I don't know how to spell that. There's a firm down

in Louisiana that I've reviewed a number of cases for, it will come to me.
Q. Are all the plaintiffs' firms that you've consulted with, are they all out of state?
A. No, Bill Knapp is in Cincinnati.
Q. Other than Bill Knapp, are all the other plaintiffs' firms out of state?
A. No.
Q. Are you the head of the emergency department both at Metro and The Cleveland Clinic?
A. Yes.
Q. I assume that you have administrative duties with both of those positions?
A. Yes.
Q. What percent of your time is spent on administration in both those positions?
A. 60 percent of my time is spent on teaching the practice of emergency medicine, the remainder 40 percent of my time is spent on research and administration.
Q. I'm handing you what was previously marked as Plaintiffs' Exhibit 10. They're answers to interrogatories and request for production of documents that were sent by Defendant Ross Henschen, M.D. If you could take a look at Interrogatory

Number 1, please.
A. Okay.
Q. These interrogatories were actually signed by Christopher Parker. Do you consider the answer to Interrogatory Number 1 to be a false statement?
MR. TREADON: Objection. Go ahead and answer.
A. Well, I think he had a stroke, not a transient ischemic attack. But if you presume that he was having a stroke, then, as I've said, it would be a violation of the standard of care in this instance to send the patient home.
Q. So you think the answer to Interrogatory Number 1 was justified?
MR. TREADON: With that change, with that caveat?
MR. RUF: Yes.
A. Yes.
Q. Could you take a look at answer to Interrogatory Number 13.
A. Okay, I see it. What did you want me to answer?
Q. Can you tell me whether or not that's a false statement?
MR. TREADON: Well, object to the characterization as false. Does he agree with

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it or disagree with it; is that what you're really asking him?
MR. RUF: No, I want him to answer my question as I've asked it.
MR. TREADON: If you can answer that, Doctor, go ahead.
A. I think the scientific basis for this answer is lacking, that Mr. Yaceczko's stroke is not a result -- is not a direct and proximate result of the negligence of the defendant.
Q. So do you think the answer to Interrogatory Number 13 was justified or unjustified?
MR. TREADON: Objection.
A. I do not think that they could have established that there was a direct and proximate result of the negligence of the defendant in this case.
Q. Do you know whether or not they made representations to the physicians' attorneys that they had expert testimony to support the answer to Interrogatory Number 13?
A. I wouldn't have a way of knowing that.
Q. Do you agree that based upon your review of the materials that the Perantinides & Nolan law firm did not hire an ER physician expert like yourself while they represented Peter Yaceczko?

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A. I've only been provided with your experts' reports, no others.
Can we take a break for a minute?
Q. I'm almost finished. I just have two more minutes.
A. I still need to take a break.
Q. Okay.
A. Thanks.
- - - -
(Thereupon, a recess was had.)
- - - -
Q. Do you agree that the appropriate doctor to review emergency room care is an emergency room physician, from a medical perspective?
A. It would depend on the issues in the case.
Q. What about the issues in the Yaceczko case?
A. The Yaceczko case, an emergency physician would be prepared to review the issues, a neurologist would be prepared to review the issues.
Q. Based upon your experience -- strike that.
Do you have any opinions in this case that you have not yet told me about?
A. I related to you that I think that you cannot establish proximate cause in this case, I've related to you that Mr. Yaceczko has a history of worsening on heparin, I think I've related to you that it was

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not the standard of care in 1996 to give heparin. Some people did but some people didn't.
MR. TREADON: Dr. Tucker's assessment of the patient.
THE WITNESS: Oh, yes, yes, thank you.
A. It appears to me from reviewing this case that Mr. Yaceczko deteriorated long after he had the stroke in 1996, and that's evidenced by the difference between what Dr. Tucker found when he did his evaluation last -- was it March?
MR. TREADON: I think whenever his report was authored.
A. Whenever you had Dr. Tucker do a physical exam of the patient to what's reflected in the medical reports here, it appears from these medical records that post stroke Mr. Yaceczko seemed to be doing fairly well and has subsequently deteriorated.
Q. Do you have an opinion as to the cause of that deterioration?
A. There is a number of reasons why it could be, but the most likely thing is that he's continued to have small vessel ischemic disease and possibly more strokes. Let me see here. I note that Dr. Deranek seems to be wrong on some of the facts of this case and seems to be wrong on the medicine that was

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available in 1996.
Q. How is she wrong on the facts or the medicine?
A. She has proposed that Mr. Yaceczko could have been given treatment that was not available in 1996.
Q. And what treatment is that?
A. Plavix. It was not available in 1996, and she has suggested he should have been given that or could have been given that.
Q. How was she wrong on the facts?
A. She was of the opinion that Mr. Yaceczko was given heparin immediately when he got to Akron General Hospital. She was of the opinion he improved after being given heparin at Akron General Hospital and he did not. In fact, he deteriorated as he did when he was admitted for his stroke in 1994. I think there were other things in there that I disagreed with her, but I can't recall them off the top of my head.
Q. Do you have any of those things marked?
A. No, I do not.
Q. You read Dr. Tucker's deposition?
A. Yes.
Q. Based upon your current recall, what do you disagree with as far as Dr. Tucker's opinions?
A. The primary thing is I disagree with him on proximate cause. I do not think that there is

evidence that heparin would have assisted this gentleman. If fact, I think the evidence is that it would not have assisted him.

Q. Any other opinions?

MR. TREADON: Well, I'm going to object because you don't know exactly what I'm -- he doesn't know exactly what I'm going to be asking him, but in summary form have you covered most of the areas that you have opinions about, in general, I guess is a better way to put it; have we covered the areas?

A. Yes, I think we've covered the general areas in which I have opinions.

Q. Okay. Thank you, Doctor.

A. You're welcome.

MR. RUF: That's all I have. Do you want to read this?

MR. TREADON: Yes, I'd like to have the doctor read it.

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CHARLES L. EMERMAN, M.D.

CERTIFICATE

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

I, Laura L. Ware, a Notary Public within and for the State of Ohio, do hereby certify that the within named witness, CHARLES L. EMERMAN, M.D., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed into typewriting under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party, 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), or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 27th day of August, 2002.

_____

Laura L. Ware, Ware Reporting Service
21860 Crossbeam Lane, Rocky River, Ohio 44116
My commission expires May 17, 2003.