IN THE COURT OF COMMON PLEAS

Doc. 207

CUYAHOGA COUNTY, OHIO

TINA HAYBURN, Adm.
of the Estate of
Halyna Skyrl,

Plaintiff,

-vs-

JUDGE TIMOTHY McMONAGLE
CASE NO. 224348

DEACONESS HOSPITAL,
et al.,

Defendants.

- - - -

Deposition of AUGUST0 C. JUGUILON, M.D., taken as if upon cross-examination before Dawn M. Fade, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Charles Kampinski Co., L.P.A., 1530 Standard Building, Cleveland, Ohio, at 3:10 p.m. on Wednesday, April 22, 1992, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

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Gleb Moysaenko, M.D.

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

CROSS-EXAMINATION OF AUGUSTO C. JUGUILON, M.D.

BY MR. KAMPINSKI:

Q. Doctor, would you state your full name, please.

A. My first name is Augusto, A-u-g-u-s-t-o, last name is Juguilon, spelled J-u-g-u-i-l-o-n.

Q. All right. Your address, sir?

A. It's 18599 Lake Shore Boulevard, Euclid.

Q. All right. Is that your residence or your work?

A. That's my work.

Q. All right. And that's what hospital?

A. University Mednet.

Q. All right. What is your residence address?

A. It's 8320 Oak Knoll, K-n-o-l-l, Court, North Royalton.

Q. The ZIP?

A. 133, 44133.

Q. All right. Do you have a CV, doctor?

A. I didn't bring it with me.

Q. All right. You have been deposed before. I'm

going to ask you a number of questions this afternoon. If you don't understand, tell me, I'll be happy to rephrase any question you don't understand.

When you respond to any question, please do so verbally. She can't take down a nod of your head.

Run through your education. High school?

A. I finished four years of high school called Paco, P-a-c-o.

Q. Paco?

A. Paco Catholic school.

Q. Where is that?

A. That's in Manila, Philippines.

Q. When was that?

A. Graduated in 1962.

Q. All right. What did you do after that school?

A. I went, had three years of premed.

Q. Where at?

A. At University of Santo, S-a-n-t-o, Tomas, T-o-m-a-s. That's in Manila.

Q. Three years premed?

A. Three years premed.

Q. Okay. Then what?

A. Then followed by four years of medical school in

the same school.
Q. Okay. Then what?
A. Followed by one year of internship at U.S. Air Force Base Hospital, Clark Air Base, one year of internship.
Q. Okay. In what specialty, or was that a rotating?
A. Rotating.
Q. Okay. Go ahead.
A. Followed by one year of preceptorship in neurology at University of Santo Thomas Hospital.
Q. All right. What is preceptorship?
A. Meaning I learned with the chief of neurology seeing patients.
Q. Who was he?
A. Dr. Gilberto Gamez.
Q. Gilberto?
A. Yes, Gamez, G-a-m-e-z.
Q. So you would see patients with him?
A. Yes.
Q. Is that for a year?
A. Yes. These were all his private patients that I see.
Q. Okay. Then what did you do?
A. Then I came to the United States and did one year

of rotating internship at Lakewood Hospital.
Q. When was that?
A. 1971.
Q. Okay. What did you do after that?
A. Followed by two years of neurology -- not two years, one year of neurology residency at Albany Medical Center in Albany.
Q. New York?
A. New York. And then I completed two years to make a three-year neurology residency at University of Cincinnati Medical Center and Children's Hospital.
Q. When was that?
A. I finished in 1975.
Q. Okay.
A. Then 1975 through '76 I was a staff physician at St. Alexis Hospital. Then from '76 to '77 I did one year of fellowship in EEG and epilepsy at University of Texas Medical School, Houston.
Q. Okay.
A. Followed by one year of fellowship in EMG at University of New Mexico. Then I did another year of research in EMG, Harvard Medical School, Massachusetts Med General Hospital.
Q. Okay.

A. Then my final year of fellowship, MDA, in neuromuscular research.
Q. Where was that?
A. That's at Tufts New England Medical Center.
Q. All right.
A. Followed by, I became an assistant professor of neurology for the Tufts University and the director of the EMG laboratories for the medical center.
Q. All right. How long did you do that?
A. One year. And then since 1981 I have been with University Mednet.
Q. And what have you done at University Mednet, what positions?
A. I'm in private practice there.
Q. What is the name of your private practice?
A. The original name was Euclid Clinic, and then changed to Mednet in 1985, and then changed to University Mednet in 1989 when we were bought by University Hospitals.
Q. All right. So your private practice is called University Mednet?
A. That's correct.
Q. That's a corporation?
A. I think so.

Q. All right. Are you a shareholder?
A. I may be. I'm not certain.
MR. KALUR: I don't know.
A. I'm not certain.
Q. Do they declare dividends? Do you get dividend checks?
A. What we do is we get equipment, equipment leasing.
Q. You get equipment?
A. Yes.
Q. Well, they lease equipment to who?
A. I think they buy equipment and then they -- it's called equipment leasing.
Q. Yes.
A. And we get a check once a year.
Q. You are a neurologist, right?
A. Yes.
Q. Do you specialize in anything in neurology, EEGs, EMGs?
A. I subspecialize in neuromuscular diseases, EEG, and EMG.
Q. And to do EEGs and EMGs, what equipment do you need?
A. We have our own machines, EEG machines.
Q. When you say your own, your group?

A. The group, yes, of the University Mednet.
Q. The machines are owned by University Mednet?
A. That's correct.
Q. And they lease them from somebody or they own them?
A. No, they own them.
Q. Who do they lease them to?
A. It's called an equipment leasing -- I don't know exactly what it is, but they pay us one check a year.
Q. All right. Let me see if I understand this. When you perform services for somebody in terms of an EEG, okay, the equipment that's used to do that EEG is owned by University Mednet?
A. Yes.
Q. That patient or their insurance carrier gets billed for that service, right?
A. Yes.
Q. Who bills them?
A. University Mednet.
Q. So they get money from that, right?
A. Yes.
Q. Do you then get paid for having read that EEG?
A. It's incorporated into our salary structure for the year.

Q. When you said dividends for leasing, what did you mean?
A. Dividends, it has nothing to do with that. I think it has something to do with -- I don't know what other equipment they have, but they give, once a year, a check to the physicians. It's called equipment leasing.
Q. Equipment leasing. Okay. So they lease out the equipment to somebody and you get, you somehow get paid for that?
A. Maybe. I'm not certain.
Q. Who is the president of the corporation?
A. Richard Hammond.
Q. Richard Hammond?
A. Hammond.
Q. How do you spell that?
A. H-a-m-m-o-n-d.
Q. What kind of doctor is he or isn't he a doctor?
A. He's not a doctor. He's a lawyer.
Q. Yeah?
A. Yes. He used to be with McGuire & Company.
Q. Oh. All right. He is the president of the corporation?
A. Yes. He's the CEO.
Q. CEO. Where is he located?

A. His number is **383-8500**.
Q. Yes. Where is he located at?
A. Same address as I gave you.
Q. Your address?
A. **18599** Lake Shore.
Q. All right. Have you ever been an officer of the corporation?
A. No.
Q. Where do you have privileges at, doctor?
A. Parma Hospital, Deaconess, Marymount, Southwest, and University Hospitals.
Q. And how is it that you're at any particular hospital at any particular time? Do you have a monthly schedule where you're assigned certain hospitals?
A. No.
Q. All right. Well, for example, when would you be at Deaconess?
A. If I get called in consultation or if I have an admission to the emergency room or if I have an elective admission.
Q. Okay.
A. So if they call me in the emergency room or the doctor who admitted the patient in the emergency room calls me in consultation and I have to go.

Q. All right. How many neurologists are there in University Mednet?
A. Five of us.
Q. All right. Who are the others?
A. Arthur Brickel.
Q. Okay.
A. Norton Winer, James Napier, and Larry Dashefsky.
Q. How do you spell that?
A. D-a.
Q. I'm sorry?
A. D, like in dog, a-s-h-e-f-s-k-y,
Q. And do all five of you have privileges at these five hospitals?
A. No.
Q. All right. Are you the only one that has privileges at these five hospitals?
A. Dr. Brickel and Dr. Winer have privileges in Deaconess.
Q. Yes.
A. And Dr. Brickel has privileges in Parma.
Q. All right.
A. Parma and Marymount.
Q. Okay. And how about Dr. Napier and Dr. Dashefsky?
A. Dr. Napier goes to Marymount, Dashefsky doesn't

go to any of them except for University, Euclid, Lake County, all that.

Q. You go to all five of them?

A. Yes.

Q. If somebody wants a consult, a physician wants a consult at Deaconess, for ex mple, would it be up to that physician, then, to call whoever he wanted within your group, Dr. Brickel, yourself, or Dr. Winer?

A. Yes, he specifies who he wants.

Q. Does your group have some type of contract to provide consulting services at Deaconess?

A. No.

Q. So if a physician wanted a neurologist from somewhere else, he could call?

A. Oh, yes.

Q. All right. Had he -- well, what is your relationship with Dr. Moysaenko?

A. I have known him now, I would say, about three years.

Q. Okay. And how is it that you came to know Dr. Moysaenko?

A. I think he called me in consultation in one of his patients three years ago.

Q. Had you ever done work for his father?

A. I don't know his father.
Q. Okay. And is that how you first became acquainted with him, by his having called you as a consult?
A. That's correct.
Q. All right. And has he called you as a consult since that time when he needs neurological assistance on his patients?
A. Yes, I think he uses me and probably another physician.
Q. All right. Do you know who the other one is?
A. Dr. Pedro See.
Q. Pedro See?
A. S-e-e.
Q. Where is he out of?
A. He's also out of Deaconess, Parma, Southwest.
Q. Well, what group is he with?
A. Oh. He's alone.
Q. Alone. All right. Have you been sued other times other than the case with Dr. Moysaenko?
MR. KALUR: Show an objection. Go ahead.
A. Yes.
Q. All right. What other lawsuits have you been involved with?

MR. KALUR: Same objection. Go ahead.

MR. KAMPINSKI: You can have a continuing line.

MR. KALUR: I have a continuing line for all questions about prior lawsuits. Go ahead, answer his questions.

A. I finished a trial last November 1991.

Q. What was the name of that case?

A. They found that I, there was no negligence on my part.

Q. What was the name of the case?

A. Dudas.

Q. Dudas?

A. Yes.

Q. And who was the plaintiff's attorney?

A. Wasserman.

Q. Okay. That was in Judge Carol's or Feighan's room?

A. He was a retired judge.

Q. Okay. What were the allegations in that case?

A. Should I --

MR. KALUR: Go ahead.

A. It was a 35 year old woman who had recurrent headaches, recurrent nasal complaints, sensory

complaints, and eventually, it took about one-and-a-half years to make a diagnosis, not only by us but also at Mt. Sinai, where she was for one year. Multiple biopsies, multiple consultants, finally they found she had a very rare form of CNS lymphoma. It finally came out a year after we saw her. And what the allegation was, we should have made the diagnosis long before and could have probably changed the outcome of her problem.

Q. Okay. Any other suits?

A. That's it.

Q. And then there's the one involving --

A. Deaconess.

Q. Any others that haven't gone to trial yet?

A. None. This is --

Q. These are the only two that you have ever been sued on?

A. That I came into a deposition.

Q. Well, have you ever been sued where there wasn't a deposition?

A. I received a notice on another case that was dropped six months ago.

Q. Okay. What were the allegations in that case?

A. Allegations were, this was a case that was seen

by a family doctor, I was called in because the patient was having a seizure, and the patient eventually turned out to have a very rare form of thrombotic thrombocytopenic purpura, and the hematologist on the case, it took a while for him to make a diagnosis, so by the time the steroids were instituted the patient was really very bad, but then the steroids saved him, and he got well. And he was alleging that everyone was negligent.

Q. All right. Was that a suit that was filed?

A. Yes, it was filed.

Q. And dismissed?

A. Yes.

Q. What was the name of the case?

A. It's long. I can't remember the last name.

Q. Was it here in Cuyahoga County?

A. Yes.

Q. And do you remember who the attorney was?

A. I can't remember. They sent me a letter six months ago and then they dropped the case.

Q. Was Mr. Kalur representing you in that case?

A. No. It was his partner.

Q. All right. Who?

A. I don't remember the case.

Q. Mr. Bonezzi?
A. No. Bonezzi represented me in the other case.
Q. Right. Okay. How were you contacted as it related to Mrs. Skyrl?
A. To recollect these.
Q. If you need to look at he records at an time, go ahead.
A. Dr. Moysaenko called me, I think on the day before this patient was transferred to Cleveland Clinic. He wanted me to render a neurologic opinion on this patient, I think because he felt that the patient had to be seen by a specialist in view of the patient's problem.
Q. Well, let's go slow. You said the day before the patient was transferred. When was the patient transferred?
A. The patient was transferred to Cleveland Clinic on the 16th.
Q. All right. ***So*** it's your testimony that he called you on the 15th?
A. On the 15th.
Q. Did you read an **EEG** in this case?
A. Yes, I read an **EEG**.
Q. When did you read that?
A. I read the **EEG** on the case -- I think the **EEG** was

done on the 14th.

Q. Well, so how is it that you read an EEG on the 14th if you weren't called until the 15th?

A. Dr. Moysaenko --

MR. KALUR: You asked him when he was called to see the patient before.

MR. KAMPINSKI: I asked him when he was called in regarding Mrs. Skyrl's case, I think.

MR. KALUR: I won't argue about what you said or didn't say.

MR. KAMPINSKI: That's fine.

Q. I'm not here to confuse you or to trick you. The fact of the matter is you read an EEG on the 14th, all right. You have testified they called you on the 15th. Why is it that you read an EEG on the 14th if he didn't call you until the 15th?

A. Okay. It is a practice among internists when they admit patients with neurologic problems to take care of the patients themselves unless they call a consultant neurologist or neurosurgeon. And one of the workups they do is an EEG. So he ordered the EEG, and he asked if I would read the EEG that was done on the 14th, which I did.

Q. When did he ask that?

A. He specified on the orders, when he wrote the orders.
Q. Right. I saw that.
A. EEG to be read by me.
Q. Right.
A. So when the EEG was done on the 14th, which was a day after admission --
Q. Right.
A. -- I came and read it on the same day.
Q. How did you know to come and read it?
A. Oh, I am notified by the technician that an EEG was done for his patient and that he wants me to come in.
Q. So you didn't talk to him then before you came in to read the EEG?

MR. KALUR: Him being Moysaenko?

MR. KAMPINSXI: Yes.

A. That's correct.
Q. And was that the only reason you came to Deaconess on the 14th, was to read this EEG that the technician had told you that had been taken that Moysaenko wanted you to read?
A. That is correct.
Q. You didn't call Moysaenko to see what was the story with this patient?

A. What I do is I write, I usually write my impression, and if they are inpatients I usually call into the floor to tell them that the reading is such and such if it is abnormal.
Q. And it was abnormal?
A. Yes. And they put it on top of the chart, that it is abnormal.
Q. What was abnormal about it?
A. Well, I knew there was a focal slowing on the **EEG**.
Q. What does that mean?
A. That means, as I read the **EEG**, the left side of her brain was showing a slow activity compared to normal.
Q. Well, is that consistent with an evolving stroke?
A. Consistent with anything. It doesn't have to be a stroke.
Q. All right. But one of the differentials, I take it, would be an evolving stroke?
A. Evolving stroke, a massive stroke, bleeding, hemorrhage.
Q. Okay. So it's definitely an indication to you that there is some potential problem with this lady?

A. Yes.
Q. What time did you read the EEG?
A. I can't remember.
Q. Is there anything in the chart that tells you that?
A. I don't know.
Q. I beg your pardon?
A. I don't know what time.
Q. Do you have the EEG there?
A. I have the --

MR. KALUR: It doesn't say what time he read it.

A. I don't know what time.
Q. Well, who was the technician that called you?
A. There are three technicians. I don't know who called me.

MR. KAMPINSRI: Do you have the EEG, Jerry?

A. The actual EEG?
Q. Yes, the actual EEG.
A. I don't have it.
Q. It's not here?
A. No.
Q. Where would it be?
A. It should be in Deaconess.

Q. You don't have a copy of it?
A. The actual tracing?
Q. Yes.
A. No.
MR. KAMPINSKI: You didn't bring the chart with you, Dale?
MR. MARKWORTH: That's not part of the chart. I have the chart, but I don't have the EEG tracing.
MR. KAMPINSKI: That's kept separately?
A. Yes.
MR. KAMPINSKI: Can we be provided with that.
MR. MARKWORTH: I would expect we are all going to want one.
Q. Have you looked at it before coming here today?
A. No.
Q. Does that reflect what time it's taken?
A. I can't remember.
Q. Do you know what day it was taken on?
A. I know it was taken on the 14th.
Q. How do you know that?
A. Because that's the date that it says here.
Q. Well, that's the day you read it?

A. Yes. But that's the date that it was done.
Q. All right. You know that from memory or is there something else in the chart that would tell you that?
A. Let me see the orders.
Q. All right. If you look at the, I guess it's the progress notes, doctor's clinical notes. On the 14th there is a note that says EEG completed 1/14. Here, look at this.
A. Yes.
MR. KALUR: The nurses' notes show transferred down for the EEG at 11:55.
MR. KAMPINSKI: On the 14th?
MR. KALUR: That's right.
Q. Can you tell whose initials that is for the technician?
A. I can't tell.
Q. All right. Doctor, would you tell me what the significance is to you as a neurologist -- well, not to you as a neurologist, but to any physician, of the symptomatology that Mrs. Skyrl presented with in terms of potential stroke? I mean, you have reviewed this chart before coming here?
A. Yes.

Q. So you are aware of the fact that she had waxing and waning symptoms?
A. Yes.
Q. Okay. I mean, that's even in the discharge summary, isn't it?
A. Yes.
Q. As a matter of fact, you put it in your history and physical?
A. Yes.
Q. What is the significance of this, when you put, these symptoms tend to wax and wane, is that significant to a physician?
A. I'm sorry. This was written by Dr. Moysaenko?
Q. No. It was written by you.
MR. KALUR: What are you looking at?
MR. KAMPINSKI: I'm looking at his history and physical.
A. Wax and wane?
Q. Yes.
A. I specifically dictated wax and wane.
Q. Yes?
MR. KALUR: Are you talking about on the consult?
MR. KAMPINSKI: Yes. Isn't that

part --

A. Let's use the right name.

MR. KAMPINSKI: Wait a minute, I have three pages here. Maybe I'm incorrect.

A. It must be Dr. Moysaenko, because I rarely use wax and wane.

MR. KALUR: The H and P, those three pages are by Moysaenko. There is a consult written by you, which is one page.

MR. KAMPINSKI: All right. I got you. That's fair. All right. It is in Dr. Moysaenko's physical and history then.

Q. Would you tell me what the significance of that is?

MR. KALUR: Of waxing and waning symptoms?

MR. KAMPINSKI: Yes.

A. By themselves the word means, wax means that it occurs, wane means it goes away.

Q. Yes.

A. That's what it means.

Q. Yes. I know you are apparently a well-trained neurologist. I guess my question is what is the significance of that kind of a description of

these symptoms?

A. It can really mean anything.

Q. Can it?

A. Yes.

Q. What does it classically mean?

A. Classically?

Q. Yes, sir.

A. Well, if, it depends on the -- I'll specify some diseases.

Q. As it relates to a potential stroke what does it mean?

A. If it is on a stroke, it can mean that the patient is having TIA.

Q. Yes.

A. Or if the patient has hypertensive episodes, it can also mean that the blood pressure goes up and down. Or if the patient has cardiac arrhythmia, it could also mean that the heart goes into an arrhythmia and then a normal rhythm, that's wax and wane.

Q. Doesn't it mean, doctor, that the stroke or the potential stroke has not yet occurred if the symptoms are waxing and waning?

A. If it is, if you are talking about stroke, yes, it can mean that.

Q. All right. Now, what classically do you, would you be looking for if you had a patient who had complaints of right-sided weakness, numbness, difficulty in speech, aphasia, some problems with her left eye, and a history of TIA the week before, and waxing and waning, what would jump into your mind if you had such a patient, doctor, the very first thing?
A. The very first thing I'm going to look at as a neurologist would be to look into the carotid.
Q. Absolutely. And that's not just as a neurologist, that's any well-trained physician. Those are classical symptoms, aren't they?
A. You can term them as classic, but it can be caused by other problems.
Q. Yes. But that's the first thing you think of?
A. As a neurologist, yes. As a cardiologist, he may think of other things.
Q. Well, if he did he would be wrong, wouldn't he?
MR. KALUR: No, you just answer the question.
A. Not really.
MR. KALUR: Let Dr. Moysaenko or whoever is representing him worry about him.
Q. Okay. You as a neurologist would certainly

Q. How would you do that?
A. A stethoscope.
Q. Would you do anything other than that?
A. Yes. In the old days --
Q. What would you do in the new days, January 13th, 19911
A. Okay. 1991?
Q. Yes, sir.
A. Okay. I would do, I can do two things, I can do a carotid duplex.
Q. Yes.
A. Or I can go ahead and do an invasive study called a DSA.
Q. Well, carotid duplex is not invasive?
A. Right.
Q. You don't have to cut her, you don't have to

anesthetize her. How long does that take to do, about an hour?

. Carotid duplex, I used to do them about -- yes, an hour.

Q. Do you do them anymore?

A. I don't do them anymore.

Q. Why not?

. My machine broke.

Q Do they have a machine at Deaconess?

Yes.

Q That machine isn't broke, is it?

.. No.

Q. Was it working in January of 1991?

.. I think the radiologists have them.

Q. So, in other words, you wouldn't even be the one to do it, you would order it and the radiologist would do it?

.. Yes.

). Okay. And they did have that capability in Deaconess in January of 1991?

.. I would presume, yes.

). Why wasn't it done on Mrs. Skyrl?

MR. GROEDEL: Objection.

MR. KALUR: If you know. Don't speculate. If you know, say so; if you

don't know, just say you don't know.

A. Okay. I think the problem, as I look back at the chart, the main problem with her when she came in was that she had a very dangerously high blood pressure. That's the reason why she had a stroke that precipitated the admission.

Q. Doctor, did you look at the autopsy?

A. I looked at the autopsy, yes.

Q. What did that show?

A. It showed a complete thrombosis of left carotid.

Q. Where did that come from, carotid?

A. Yes.

Q. I see. That was her problem, wasn't it?

A. Yes, it is a problem.

Q. Well, it was a problem that killed her?

MR. KALUR: What problem killed her?

MR. KAMPINSKI: I said it was a problem that killed her.

MR. KALUR: Don't answer that. I mean, you are not being specific with the question.

MR. KAMPINSKI: I thought we --

MR. KALUR: If you are talking about coming from a carotid that eventually killed

her, that's specific.

MR. KAMPINSKI: I think that's just what we said.

MR. KALUR: It might have been secondary to the carotid.

MR. KAMPINSKI: Secondary to the carotid.

MR. KALUR: Secondary to a problem in the carotid arteries. Let's be specific,

Q. What is it, to your understanding, that caused Mrs. Skyrl's death, doctor?

A. My understanding is that her stroke is massive.

Q. Yes. And what was it caused by?

A. Infarction of the brain --

Q. And --

A. -- from an occluded artery.

Q. And what artery was occluded, the carotid, correct?

A. Yes.

Q. And the symptoms were indicative of an occluded carotid, weren't they?

MR. GROEDEL: Objection.

MR. KALUR: If you know, go ahead.

A. Yes, the symptoms were from a carotid lesion.

Q. All right. Well, when you got this abnormal --

well, all right.

You weren't contacted, then, by Dr. Moysaenko from January 13th when she was admitted until, even on November 14th when you came in to read the EEG, I mean he didn't call you to come in to consult on this lady who was having classic carotid symptoms, did he?

A. I was not consulted.

Q. All right. To your knowledge, was any other neurologist consulted?

A. None that I saw in the chart.

Q. If you would have been consulted, I know you weren't, on January 13th when she first came in, would you, in fact, have done a duplex scan?

MR. GROEDEL: Objection.

A. You want me to answer?

MR. KALUR: You may answer.

A. Okay. The way I do my own patients is that when they are admitted and I strongly suspect a carotid source, I would do that.

Q. Okay. Certainly you would suspect it in this case, correct?

MR. GROEDEL: Objection.

Q. I think we went through that.

A. Yes.

Q. All right. After you read the EEG, I think you testified earlier that if it's abnormal you then report the results to the floor verbally, correct?
A. Usually I do.
Q. And is that what you did in this case, to the best of your recollection?
A. That is my practice. If it's abnormal I call the floor.
Q. All right. So you assume you did that in this case as well?
A. I probably did.
Q. Well, by calling the floor, you mean the nurses on duty?
A. Yes. I usually call the floor or notify the secretary that I read an EEG that was abnormal and paste the impression on the front of the chart.
Q. You paste it on the front of the chart?
A. No, the secretary should.
Q. Okay. Well, what do you do as far as advising the attending of your findings, if anything?
A. I don't do any advice, because I was not consulted on the case. I was consulted to read a test.

Q. Yes.
A. But I was not consulted to give advice on management of the patient.
Q. No. You didn't understand my question. I apologize.
What did you do to advise the attending of your finding of the abnormal results?
MR. KALUR: Objection. If you want to ask him what did he do in addition to writing his findings and calling the floor to advise this doctor, I'll let him answer.
MR. KAMPINSKI: I see what you are saying. That's not unfair.
MR. KALUR: That's better than usual.
MR. KAMPINSKI: That's a good question. If you want to answer that one, I'll listen to the answer to that one.
MR. KALUR: Did you do anything more than take care of putting this either in the chart, did you do anything to contact Dr. Moysaenko directly and talk to him about it?
Q. Good. Or any other doctor?
A. No.

Q. Okay. Why not?
A. It is not a practice for a reading neurologist to call an attending and tell him what to do with a patient.
Q. I'm not suggesting that you should tell him what to do, I'm suggesting that perhaps it might have been a nice thing for you to tell him of your findings and then maybe he could decide what to do, maybe he couldn't. But if you're reading them -- I'm sorry, what time did you say you read them or you don't remember?
MR. KALUR: He said he didn't know. It had to be afternoon, though, because they weren't taken --
Q. Sure. Was it 6:00 at night, midnight, 1:00 in the afternoon? How do we find that out?
A. I don't know.
Q. Do you keep a car log for mileage?
No.
Q. Do you keep a log at work?
A. No.
Q. A calendar?
A. I don't do any log or anything like that.
Q. How about billing?
A. Billing, no. We just billed on the day we read

them.
Q. How about checking in or checking out to the lab?
A. There is no check-out time.
Q. Would the technician know the time you read it?
A. I don't know. But all I can tell you is that if I called it into the floor and talked to the nurse or the secretary --
Q. Yes.
A. -- then I entrust that once the reading is on the chart that they notify, the nurse notifies.
Q. Okay. So is this pursuant to hospital policy, some written policy that this procedure go the way you just indicated you do it?
A. It is not a hospital policy, it's a practice by physicians.
Q. By physicians at Deaconess?
A. Yes. It's like the radiologist reading an abnormal chest x-ray calls the floor, this is abnormal, I call back, what was the reading, and I know what was abnormal.
Q. Have you looked at the nurses' notes for the 14th, doctor?
A. On the 14th?
Q. Yes, sir.
A. Are we saying now or after I saw the patient or

prior?

Q. Any time that these notes have existed in the manner that they are in now.

MR. KALUR: Up till today have you looked at the notes?

MR. KAMPINSKI: Yes.

A. Yes, I read the chart.

Q. All right. Is there any indication in the nurses' notes that they received any communication from you on the 14th advising them of the results of the EEG?

A. On the 14th?

Q. Yes, sir.

A. I don't see any nurses' notes.

Q. And we have the note that Mr. Kalur referred to before where they were talking about transferring her for an EEG at 11:55, but I don't see anything reflecting that they noted at least your communication to them that you had informed them of the results of the EEG at any time. I mean, if I'm wrong tell me.

A. I don't see it.

Q. All right. And as we sit here today, I apologize if I'm being at all repetitive, but maybe something has jogged your memory, you don't have

any recollection of what time you did read it?
A. I don't have any recollection.
Q. All right.
MR. KAMPINSKI: Did you find something, Mr. Kalur?
MR. KALUR: Yes, something I'm showing my client.
THE WITNESS: Uh-huh.
MR. KALUR: Keep that in mind.
THE WITNESS: Okay.
MR. KAMPINSKI: What is it -- does it have to do with the EEG, Jerry?
MR. KALUR: No. It's not anything about that, which, of course, wouldn't be in the chart anyway.
MR. KAMPINSKI: It wouldn't.
MR. KALUR: I have never seen that. There are charts I haven't seen, but I have seen a lot.
Q. Well, what do you do when you have gotten done calling the nurses' station, which you typically do, as far as memorializing your findings from reading the EEG?
A. Memorializing?
Q. Yes. Do you dictate your conclusions?

A. Yes. I write.
Q. You write it?
A. I write -- no, I write a very short impression on the actual EEG tracing,
Q. Aha.
A. On the very top.
Q. Do you date and put the time on that?
A. No.
Q. No?
A. No. I just write read, abnormal, signed, and then dictated.
Q. So you do dictate something?
A. I do dictate.
Q. All right. Where do you do the dictation, do you do that when you get back to your office or do you do that at Deaconess?
A. I do that at Deaconess.
Q. All right. And who is it that takes the dictation?
A. Should be transcription.
Q. All right. There's secretaries that work for the hospital that transcribe your interpretations?
A. I would say.
Q. Okay. When did you transcribe your interpretations, doctor?

MR. KALUR: When did he dictate them?

MR. KAMPINSKI: Yes, dictate them.

A. I dictate them on the same day.

MR. KALUR: He means within minutes or hours or what, that's what he wants to know. You saw the strip and then when do you dictate your interpretation, minutes or hours, or days?

A. Oh. I'm dictating as I'm reading.

Q. Well, if you would look at the EEG report, would you tell me what date is on there as far as, you know, I don't know if that's dictation or transcription, but there is a date on the bottom left-hand corner?

A. The EEG?

Q. Yes, sir.

MR. KAMPINSKI: Got it?

MR. KALUR: He wants to know what this date is. He can't read it, I guess.

A. It says 1/17/91.

Q. Ha. Well, that was after she was transferred, right?

A. Yes.

Q. So this actual record didn't get in the chart

until three days after the EEG, right? You have to answer verbally, doctor.

A. Yes.

Q. Yes, Well, help me out here. How is it that we are going to know whether or not your findings on EEG were ever transmitted to anybody?

A. Okay.

Q. All right. Now show me what Mr. Kalur showed you.

A. I am trying to see what I wrote.

Q. Yes. Okay.

MR. KAMPINSKI: You can show it to him again.

MR. KALUR: I don't want to coach the witness.

MR. KAMPINSKI: I just want the truth. I don't care where it comes from.

A. I'm trying to see what I wrote on the chart.

Q. All right.

A. Because I must have written something.

Q. All right. Probably.

A. Here.

Q. Got it?

A. Yes.

Q. Good. What are we looking at?

A. This is when I saw the patient in consultation, when I was formally consulted.
Q. All right. Later on?
A. Yes. On the 15th.
Q. Yes. Go ahead.
A. This is a day after I read the EEG.
Q. Yes. Right.
A. Then here I put the date and the time.
Q. Of what?
A. When I saw the patient.
Q. Yes. So?
A. All right. So I said, neuro dictated. So I wrote a short note, then I put EEG.
Q. Yes?
A. Left-sided slowing.
Q. Okay. So you knew that you put it in the chart --
A. Yes.
Q. -- on the 15th at 6:30?
A. Yes. That's when I was formally consulted.
Q. That's great. And I'm going to get to that.
A. So they knew and we knew that it's already in there even before the transcription date.
Q. You will excuse me, but you knew, I mean, that's, that indicates to me that you knew.

A. Yes.
Q. Let's go back to my question earlier, help me out, and, you know, assist me in determining how I figure out whether or not somebody else knew prior to --
A. The 15th?
Q. No. Prior to actually the 17th. I mean, your dictating your note in there indicates that you knew?
A. This is a progress sheet.
Q. That's great.
A. People read it.

MR. KALUR: He wants to know before that. This thing was done around noon on the 14th, the EEG.

MR. KAMPINSKI: Right.

MR. KALUR: Between noon on the 14th and 6:30 p.m. on the 15th when you wrote something in the chart --

THE WITNESS: Oh.

MR. KALUR: -- in the chart, and we know this other formal EEG thing wasn't put in the chart until the 17th, probably.

A. All right.

MR. KALUR: What is there in the

chart, if anything, that indicates that it was, Dr. Moysaenko gained knowledge of your EEG interpretation?

A. I don't have any proof of that except to say in my practice if I read an EEG I call the floor, and I usually talk either to the secretary or to the nurse and whoever takes it, I tell them it is abnormal and to paste it on the front of the chart, that it is an abnormal EEG. That's the only thing I can say.

MR. KALUR: That's why I'm --

Q. If we look at the notes of Dr. Moysaenko, okay, he's got a note, which is an admit note, on the 14th, right?

A Okay.

O That doesn't say anything about the results of the EEG, does it?

A. No.

Q. Okay. Then the next note says, EEG completed, then there's a dietary report, then it says CT scan completed, then there's another note by Dr. Moysaenko on the 14th at 7:30 p.m., and it's got the results of the CT, right?

A. Uh-huh.

Q. Abnormal. Do you see anywhere where he indicates

the results of the EEG?
A. No, I don't read it in his notes.
Q. I see. Well, let's go to the 15th, then, and his note on the 15th, does it say anything there about the results of the EEG?
A. No.
Q. No?
A. I don't see anything.
Q. At the bottom of that particular note, by the way, he does indicate that he requests that you consult if the patient does not transfer. That's what it says, right, at the bottom?
A. Yes.
Q. Okay. Okay. Then it is the, the next page where you put in your consult, and you do say something about the EEG being left-sided, what does that say, slurried?
A. Slowing.
Q. Slowing. Slowing. What was your diagnosis?
A. Massive left cerebral hemispheric infarction with brain edema.
Q. Is that what the EEG showed or was that your diagnosis at that time on the 15th based upon your clinical observations and any additional testing that was done in addition to the EEG?

A. This is my neurologic diagnosis.
Q. Okay. So that is not based just on the EEG, because I think you told us before the EEG could have been reflective of a lot of things?
A. Yes, the EEG could be normal.
Q. No. No. It wasn't normal. But what you said earlier was that the abnormalities didn't necessarily lead you to conclude that she had had an infarction, is that correct?
A. That's correct.
Q. So that your diagnosis now on the 15th at 6:20 p.m. is obviously based on something in addition to the EEG?
A. It's my neurologic exam.
Q. You examined her when you came in and you saw that she had a massive stroke?
A. Yes.
Q. Okay. How do you treat an evolving stroke, doctor? Surgically?
A. No. Maybe I will put it to you in several different scenarios. If the evolving stroke is secondary to a carotid artery that is, that's got a stenotic lesion that's open but got a plaque in there that's throwing a plaque up and the patient has TIA, meaning the deficits are minimal and

transient, the best way to really do them is to heparinize them if they don't have a hemorrhage up there.

Q. Okay.

A. And as soon as you finish the heparinization, do a quick endarterectomy.

Q. She didn't get that word, a quick?

A. Endarterectomy, if you can, if the patient is not moribund and doesn't have a congestive failure, doesn't have an hypoxic state, the blood pressure is not extremely high.

Q. If she is surgically able to undergo the surgery?

A. That would be the most ideal.

Q. Okay.

A. Sometime we take risk if it's a real slight stenosis, let's say over 95 percent, he has a minimal deficit, meaning there is a mild right hemiparesis, not severe, the patient is conscious, blood pressure slides right down, I would take a risk and send her for surgery because maybe I can reverse it.

If this is severe, almost completely closed, and you have a massive hemorrhage there, then you forget it, don't do anything.

Q. The CT scan, by the way, that was taken on her

was normal, wasn't it?

A. Yes. If it's completely closed --

MR. KALUR: It was read as normal.

MR. KAMPINSKI: Are you suggesting that it's not, that it was misread? Mr. Kalur.

MR. KALUR: I said it was read as normal. That doesn't mean normal to me, but it was read that way.

MR. KAMPINSKI: All right, doc.

A, If it's completely closed you forget about it, you can't do a surgical treatment. If the carotid is open and she is having an active TIA, then you go for the heart, you are going to probably look for a thrombi in the heart or valvular lesion, and heparinize her if she is not bleeding.

If you can't see any source of emboli and there is no cardiac arrhythmia and the blood pressure is not high, you take a chance and heparinize them.

If the blood pressure is very high you don't heparinize them irregardless of whether you see sources of emboli because they are going to bleed.

So there are many scenarios on how you would approach. Each patient is so different that you have to make a decision right there and then, sometimes in conjunction with what you see.

Q. Okay. But in order to find that out you have to do the duplex scan to determine what kind of condition the person has?

A. Yes. The duplex, maybe. Maybe I should inject some --

Q. Sure.

A. Something into the duplex scan.

Q. Sure.

A. People who are not very knowledgeable about duplex scan think that to do a duplex scan would give you all the answers. Since I have experience in doing duplex scans and looking at them and correlating them, many times a duplex scan, even if done correctly, you can miss a significant plaque, you can misread it as abnormal and read it as falsely abnormal when in fact it's normal or read it as normal when it's falsely, when it was in reality abnormal.

So there is a lot of pros and cons in reading a duplex. You have got probably between 60, 70 percent chance of getting an accurate

duplex scan.

Q. What chance did you have seeing her carotids without a duplex scan?

A. Without a duplex scan?

Q. Yes.

A. Then you got no pictures.

Q. Oh. Okay. I just wanted to, since you are an expert, I wanted you to clarify that.

MR. KALUR: Do we have Dr. Moysaenko's depo set?

MR. GROEDEL: Early May.

MR. KAMPINSKI: May 6th.

Q. I take it by the time that you saw her, then, on the 15th, it was really too late to do anything for her, she had already had the stroke?

A. She had a completed stroke, if that's what you mean.

Q. That's what I mean.

A. Not too late to help her.

Q. Really?

A. No.

Q. How were you going to help her?

A. Well, people have completed strokes, they will survive.

Q. People have completed strokes that die?

A. Yes.
Q. So what would you do to help her?
A. What I did?
Q. Yes.
A. The first thing I did when I saw her was put her in intensive care where she can be monitored more close.
Q. Where had she been?
A. She was in a progressive care, which is a, just a, one step down to the ICU, but still monitored.
Q. By the way, let me just stop you for a second, you came in because Dr. Moysaenko requested you to on a consult, is that correct?
A. That's correct.
Q. You didn't come in because you got an urgent call from anybody saying this lady is in bad shape, please come in to see her, I mean on an emergency basis?
A. No.
Q. Okay. So it was just your coming in and evaluating her that led you to reach the conclusion that she had had a stroke; nobody knew that before you got there, is that correct?
A. Nobody --
MR. GROEDEL: Objection.

MR. MARKWORTH: Objection.

A. Dr. Moysaenko knew she had a stroke.

Q. When did he tell you that? When did she have a stroke?

A. On the 13th.

Q. What led you to conclude that?

A. She was having a right hemiparesis.

Q. Was it waxing and waning?

A. It says here --

Q. I beg your pardon?

A. It says here, admit note.

MR. KALUR: Tell us what you are reading from.

A. On the **1/14/91**.

Q. What on the **1/14/91?**

A. There is an admit note, it says admit note of Dr. Moysaenko.

Q. All right.

A. 67 year old white female with history of hypertension brought into the ER with one week history of impaired gait and right-sided numbness and increasing headaches and impaired vision. Came in with a blood pressure 200 over **120** and benign fundi. He said, neuro, moderate fluent aphasia, mild right-sided ataxia, weakness,

improved from yesterday, plantars left and right, CVA, rule out subarachnoid hemorrhage. So he knew she had a stroke.

Q. Where does it say she had a stroke?

A. Right here, CVA.

Q. Cerebral vascular --

A. Rule out subarachnoid hemorrhage.

Q. I see.

A. Right. So he knew from the beginning.

Q. Why didn't he call you from the beginning?

MR. GROEDEL: Objection.

MR. KALUR: Wait a minute. If he has ever made a statement to you about why he didn't call you from the beginning. If you don't know, don't answer it.

A. Why he didn't call me?

Q. Yes, sir.

MR. GROEDEL: Objection.

A. No, I can't answer that question. I don't know.

Q. Is he a neurologist?

A. He's a board certified internist.

Q. Is that an answer to my question? Maybe I missed it.

A. He is not a neurologist.

Q. And who is it that typically deals with strokes,

internists or neurologists?
A. Well, maybe I will give you a background.
Q. Just answer me, doctor, do you have an answer to the question?
MR. KALUR: You answer him the way you want.
A. Both. Both.
Q. Do internists deal with treatment of strokes?
A. Yes, An internist that goes through two years of residency rotates through neurological service for six months.
Q. Yes.
A. Plus they take care and admit inpatient stroke patients without a neurologist. It's part of their training.
Q. All right. How is it that he diagnosed -- what is it in his note that causes you to conclude that his diagnosis of stroke was accurate on the, according to the 14th admit note?
A. Was accurate?
Q. Yes.
A. He found deficits on this woman.
Q. Does that mean she had a stroke or could it be an impending stroke or stroke in progress?
A. She had a stroke.

Q. When did she have it?
A. Right on the day she was admitted. She had an aphasia, that's a stroke.
Q. Can you have aphasia without having a stroke?
A. No, that's part of the stroke.
Q. What is a stroke, doctor?
A. Stroke is a, diminished blood flow to any particular part in the brain because of either an occlusion of a vessel or an embolic lesion.
Q. Can you have an aphasia as a result of decreased blood flow to the brain because of a partial stenosis of the carotid?
A. Partial stenosis?
Q. Yes, sir.
A. The only way you can do that is to throw an emboli.
Q. In other words, a decreased blood supply through the carotid won't cause somebody to have an aphasia?
A. I would say it has to be very critically low.
Q. Well, did she have any type -- what is an aphasia, doctor?
A. Aphasia is difficulty either understanding or talking.
Q. Okay. Did she have that the week before she was

admitted?
A. What she had is an intermittent right-sided weakness.
Q. Did she have an aphasia, is my question, the week before?
A. None that I saw in the chart. She was complaining of right-sided numbness and headaches and vision for one week.
Q. Well --
A. That's what it said in the chart.
Q. Well, doctor, even your consult record indicates supposedly on 1/30/91 she became suddenly slurred in her --
A. 1/13.
Q. I see.
A. That was a typographical error.
Q. Could it have been 12/30?
A. No. 1/13. I said 13 but they type it as 30.
Q. I see.
MR. KALUR: You can see that on the line above, it says 1/13.
Q. Doctor, if you look at Dr. Moysaenko's history and physical, see that, sir?
A. Typewritten?
Q. Yes, sir.

A. Patient is questioned with regard to duration of symptoms and indicates that she has had, in fact had trouble with ambulation for the past week and has had some difficulty with speech for a similar period of time.
Q. All right. Does that indicate any type of stroke in progress?
A. Not stroke in progress, maybe a TIA, transient ischemic attack.
Q. What is that?
A. It's a phenomenon that occurs when there is a diminished blood flow to a particular area and the function of that particular part of the brain doesn't function a hundred percent.
Q. Is that a result of reduced blood supply to the brain or can it be?
A. The typical TIA is usually secondary to an emboli.
Q. Small emboli?
A. Small emboli.
Q. So you could have small emboli causing aphasia as well?
A. Yes, it can.
Q. All right. Well, then, the CVA that is described by Dr. Moysaenko could be due to small emboli, if

I understand what you are saying, the impairments that he saw when she was admitted, is that correct, as opposed to a completed stroke?

A. Let me look into that again.

Q. Sure.

A. Okay. What is your question again?

MR. KAMPINSKI: Read it back.

- - - -

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

- - - -

MR. GROEDEL: Objection.

A. Okay. I'll answer it this way, when he saw her, because I saw the notes here, her pressure was very high, malignantly high, 200 over 120, and he also noted that she had moderate, moderate fluent aphasia, meaning the patient was densely unable to recognize speech.

Q. Wait a second. Moderate means that she was what?

A. Unable, fluent aphasia, unable to recognize speech, talk to her.

Q. Yes.

A. So it was moderate. And a right-sided ataxia.

Q. Well, let me just stop you one second. I

apologize, but if you go back to the typewritten, I mean --

A. Typewritten.

Q. Yes, in conjunction with her inability to understand speech, would you please tell me what it is he is writing in that first paragraph under history where it says she complains of rather severe bitemporal headache and states that has been present off and on for the past week. She also complains of neck pain, again this has been present for several days to a week. Other complaints include impaired vision, she indicated she felt as if there was something in her left eye nasally, which was impairing her vision. This is all coming from her?

A. Yes.

Q. She denies any history of head trauma, denies any loss of consciousness. All right?

A. Yes.

Q. Is this coming from a lady who you are saying doesn't understand?

A. I'll tell you how it happened.

Q. Sure. Were you there, by the way?

A. No, no. I'm trying to reconstruct it from the chart.

Q. Great.

MR. KALUR: Well, you are asking him to do all this now based on speculation.

MR. KAMPINSKI: No. I'm wondering if he is speculating, if he was just trying to read in here to help a fellow doctor, Dr. Moysaenko, or whether he is picking and choosing those parts that help tell a particular story he wants to recall and is ignoring other parts of the chart.

MR. KALUR: If you ask him specific questions he will give you specific answers.

MR. KAMPINSKI: Well, that's not what he is doing, because he is going on to --

MR. KALUR: We are getting into the scheme of consciousness here. He will answer your questions if you will ask a direct question.

MR. KAMPINSKI: I thought I was, he was telling me how it is.

MR. KALUR: If you want to argue.

MR. KAMPINSKI: No.

MR. KALUR: If he was going to take the words out of here and --

MR. KAMPINSKI: If he is going to take a position that a certain thing happened when he wasn't there and it was appropriately diagnosed by somebody who is not trained to diagnose it, then he is going to have to explain that to me, and he is going to have to explain the inconsistencies to me.

MR. KALUR: I think you are way beyond what he is saying. I think if you phrase the questions in an appropriate way you will get a direct answer, and I will try to see that you do get a direct answer.

Q. Well, I mean, is it your testimony that you believe she had a stroke in progress when she presented on January 13th, 1991 based upon what you see in this chart or don't you have an opinion on that?

A. I have an opinion she had a stroke that already started on the 13th.

Q. That already started?

A. Yes.

Q. What do you mean by that, meaning that there was some diminished blood supply to her brain that had commenced?

A. Meaning a week prior to that --
Q. Yes.
A. -- she had TIAs.
Q. Right.
A. But on the 13th when he came in, when she came in, she already had significant diminished blood flow to that left side of the brain.
Q. There was still some blood flow is what you are telling me?
A. Yes.
Q. So it was not a completed stroke at that time?
A. Well, I can't answer that, because a diminished blood flow could be coming from the other side of the brain. When you decrease the blood flow on one side it crosses.
Q. Through the circle of Willis?
A. Not the circle of Willis necessarily, but it can cross through through some of the main arteries where they cross through the circle of Willis, it can be the meningeal, lacrimal anastomotic, the temporal anterior, the mid meningeal, all those circuits, so a person who has a complete sudden loss of flow from one side may stagger that by getting, stealing blood from the other side.
Q. In other words, they could still be getting blood

supply through collateral --

A. That's correct.

Q. -- sources in the brain even if it's totally occluded?

A. That's correct. Unless there are --

Q. Okay. I understand. How could we tell, though, if that was the case with Mrs. Skyrl if the appropriate testing wasn't done? I mean, we can't, can we?

MR. GROEDEL: Objection.

A. Maybe in fairness to everyone, not just to Dr. Moysaenko, as a neurologist I always like to see the circulation inside the brain, but we can't always do' that. The carotid duplex, you can only see two inches of the carotid at the bottom, we can't even see anything beyond that, *so* if we are going to depend everything on the carotid duplex when in fact there is already a cross collateral circulation coming from the other side, despite the fact the main blood flow is cut down here and she is stealing through the ophthalmic artery and through the meningeal, and through the interior communicating, it is still supplying the brain, but certainly much diminished, probably less than 20 percent.

Q. Did you understand my question?
A. Well, what was the question?
Q. In the absence of doing the tests, how can we tell how stenosed the carotid was when she appeared at the hospital on January 13th?
A. You are talking about carotid duplex?
Q. I'm talking about any test that tells you how stenosed the carotid was. Was any test done?
A. No test was done.
Q. All right. So that if I understand, then, you are guessing as to what the extent of the stenosis was on the 13th and the extent of the blood supply that was or wasn't getting through the carotid on that date, is that correct?
A. Well, I'm only guessing that the left carotid was completely closed on that day.
Q. All right. So that's a guess?
A. That's a guess.
Q. Do you know if Dr. Moysaenko had originally planned to call you in as a consult on this case and at some point changed his mind?
A. I don't know that.
Q. Would you look at his note on the 14th at 7:30 p.m. Do you have that there, doctor?
A. Yes.

Q. Can you read that bottom note?
A. 1/14/91, 7:30 p.m.
Q. Yes.
A. At the bottom?
Q. Yes, sir.
A. Family requests transfer to Cleveland Clinic.
Q. Why don't you start right at the beginning, CT head normal.
A. CT head normal, BP 134 over 90, alert and coherent with fluent aphasia, no new neural --
Q. That said alert and coherent?
A. Yes, with fluent aphasia.
Q. Is that inconsistent?
A. That's not inconsistent, you can have an aphasic patient that is alert.
Q. And coherent?
A. Coherent, *yes.*
Q. I thought you told me before that somebody with fluent aphasia couldn't understand?
A. There are several grades of fluent aphasia.
Q. Go ahead. No new neural deficits?
A. No new neural deficit. Family requests transfer to Cleveland Clinic as soon as possible.
Q. Okay.
A. Contacted neuro service, will arrange for

tomorrow.
Q. All right. When it says neuro service, do you know what neuro service he is talking about?
A. At Cleveland Clinic.
Q. All right. How do you know that he contacted the neuro service at Cleveland Clinic?
A. Because he said he talked to Dr. Lederman.
Q. When did he tell you that?
A. I think I talked to him after I saw the patient.
Q. Well, you didn't talk to him until --
A. After I saw the patient.
MR. KALUR: The next sentence on 1/15 says, spoke with Dr. Lederman.
Q. All right. What is your understanding as to why Mrs. Skyrl wasn't transferred immediately as soon as the patient's family requested that she be transferred?
MR. GROEDEL: Objection.
MR. KALUR: Go ahead.
A. My understanding was that he tried to arrange the transfer as soon as he could.
Q. When was when?
A. This was on the day that they told him to.
Q. The 14th?
A. The 14th. But that he talked to Dr. Lederman and

they couldn't get a bed for her.
Q. At the Clinic?
A. At the Clinic.
Q. Okay. Now, let's assume just for the sake of argument that that's true, and we will find out whether it is or isn't, who did you hear that from? Did that information come to you from Dr. Moysaenko? Is that what he told you?
A. It may be. I'm not certain now. But it may be from him.
Q. What do you mean may be?
A. That he did talk to Dr. Lederman and that they couldn't get a bed for her.
Q. My question is who told you that, did Dr. Moysaenko tell you that's what happened?
A. I would say, yes.
Q. When did he tell you that?
A. The day I saw the patient in consultation.
Q. On the 15th?
A. Yes.
Q. Let's assume that that's true just for the sake of argument, if in fact you have a patient who, that you, who you are going to be taking care of that you can't transfer somewhere else, do you as a physician not do the tests that you should do

or do you go ahead and do them as long as you are the attending and taking care of that patient?

A. You mean what test, the carotid duplex?

Q. I mean, it's not something that he didn't think of because he had it as one of the tests that he was planning to do and then he cancelled it.

MR. KALUR: The question just is now generally if you have a patient, you can't transfer them, do you stop doing the tests you know you should do or do you do the tests while you wait for the transfer; just generally, not even this case he is talking about.

MR. KAMPINSKI: Right. That's right.

MR. KALUR: What is proper?

A. Well, generally what I do in my practice is I do what I think is most appropriate test for that particular problem if it is available.

Q. Yes.

A. If the family tells me not to do it, then I don't proceed, then I talk to them of the necessity of that.

Q. That's not what I asked you.

A. Okay. I said in a particular patient case, I

would do what is appropriate for that patient.
Q. So if in fact there is a potential transfer and it can't be accomplished, you don't stop the tests that should be done, you complete the ones that need to be done, is that correct?
A. I try to.
Q. All right. Well, who is it, to your knowledge, that cancelled the duplex, was it the family or was it Dr. Moysaenko?
A. Well --
Q. If you know. You may not know.
A. Yes. I had an inkling on this, because I came in at the tail end, and there was already a fight when I came in.
Q. Do you understand my question, sir?
A. Yes.

MR. KAMPINSKI: Mr. Kalur.

MR. KALUR: He is going to answer the question in a little bit.

A. I'm trying to give a background how I got in the case.

MR. KALUR: I wouldn't want you to be operating in the dark.

A. There was already an argument between Dr. Moysaenko and one of the daughters.

Q. Yes.
A. Supposedly one of the daughters wanted this patient to have immediately an MRI.
Q. Okay.
A. But since we have to transfer a patient from Deaconess way, all the way to the West Side Imaging to get an MRI, and the patient was not medically stable, Dr. Moysaenko said that it cannot be done.
Q. Uh-huh.
A. So I think as a result of that they requested an immediate transfer to a facility that has a built-in facility to do all the tests they wanted.
Q. Okay.
A. So that's what precipitated the argument and the transfer.
Q. Well, let's go -- all right. My question, and I thought, Mr. Kalur asked me to ask direct questions, I'm really trying.

MR. KALUR: You sure are, but go ahead.

Q. Was who cancelled the duplex scan, was it the family or was it Dr. Moysaenko? Really easy question.

MR. KALUR: Just tell him if you know. If you don't know tell him.

A. I really don't know.

Q. Oh. Was Dr. Moysaenko going to do an MRI when Mrs. Skryl was admitted?

MR. GROEDEL: Objection.

A. I don't know that.

Q. Well, I mean, did he tell the family he wanted to do an MRI, but they didn't have the capability to do it at Deaconess?

MR. GROEDEL: Objection.

A. I don't see --

MR. GROEDEL: Go ahead.

A. I don't see it in the order sheet or in the notes.

Q. Well, he couldn't order it because they couldn't do it there, could they?

A. No, we transfer them.

Q. Doctor, I mean, for him to put it in the order sheet couldn't have resulted in it being done because they don't have the capability to do an MRI at Deaconess, do they?

A. Not physically in the hospital, but it is done outside of the hospital.

Q. Right. Well, did he tell the family that he

wanted an MRI done but it couldn't be done within the hospital?

MR. GROEDEL: Objection.

A. I don't know what the argument was between the daughter and Dr. Moysaenko.

Q. The order to discontinue the carotid was on the 14th at 12:40 p.m., correct?

A. Yes.

Q. And also discontinue an echo?

A. Yes.

Q. What time did the family, according to the record, indicate to Dr. Moysaenko that they wanted their mother transferred to the Clinic?

A. Well, there is an order prior to that where he ordered please Xerox all the copies and patient to be transferred and then after that he ordered the DC, DC, I don't know what time this is.

Q. My question is what time did the family indicated to him that they wanted their mother transferred?

A. I don't know what time this is.

MR. KALUR: Is it somewhere in the record or are you asking him if he knows?

MR. KAMPINSKI: No, I think it's in the nurses' notes.

Q. I'm sorry, the progress note. The note of

1/14/91 at 1:00 p.m. What time did you tell me?

MR. KALUR: 1/13 at 7:30.

MR. KAMPINSKI: That's what it says?

A. Family requests to transfer to Cleveland Clinic as soon as possible.

Q. Sure. And then you just told me that the note per telephone order with Dr. Moysaenko to discontinue the echo and carotid was at 12:40, right?

A. Okay. But prior to that order there is an order by him that says to Xerox all copies, which means he got already, I'm inferring that he already got a directive from the family to transfer her because the order was before.

Q. All right. Well, so the times are wrong somewhere, then, right?

A. No, this is the time when he came to the hospital and wrote the progress sheet.

Q. No, it isn't.

A. Yes. He wrote the progress sheet, but the order was given ahead of time.

Q. Let's assume, just for the sake of argument, that your answer has some relationship to reality and the 14th, January 14th entry that says simply Xerox all reports, progress notes, admission

history and physical, have ready to transfer to Cleveland Clinic tomorrow a.m., is that signed by Moysaenko?

A. Yes.

Q. Okay. Does that indicate to you that he had arranged for her transfer the next morning?

MR. GROEDEL: Objection.

A. I can't tell. Only I can see that she is ready for transfer in the morning.

Q. Did he make any attempts to try to get the family to change their mind *so* that he could retain her as a patient at Deaconess, to your knowledge? Do you know?

A. I don't know that.

Q. Do you know whether or not he told the family at any point in time that she wasn't bad enough to be transferred to the Clinic?

A. I don't know that.

Q. If he did tell them that, that certainly is wrong, because she was in bad shape according to what you have testified to here today?

MR. GROEDEL: Objection.

MR. KALUR: At what time?

MR. KAMPINSKI: According to him from the 13th on.

MR. KALUR: The question from him is was she in bad shape from the 13th on?

A. Yes. She had a very high blood pressure, I think that was the main problem, plus the stroke.

Q. Okay. Did you write the orders on the 15th at 6:20, doctor, to transfer to ICU?

A. Yes, I did.

Q. So all those were your orders?

A. Yes.

Q. Was she medically stable to transfer to the Clinic at that point in time?

A. Not at that point.

Q. But she was in fact transferred?

A. The next day.

Q. Yes. What was the difference between her condition the next day versus that day?

A. The next day her pressure was better.

Q. Her pressure in her brain?

A. No, the blood pressure.

Q. Blood pressure?

A. Blood pressure.

Q. What was her blood pressure at that time?

MR. KALUR: At what time?

MR. MARKWORTH: This time?

MR. KAMPINSKI: No, at the time he

said she wasn't medically stable.
A. At this time she had hypotension.
Q. What was the blood pressure, doctor? That wasn't a tough question.
A. What?
MR. KALUR: He wants a specific pressure.
A. Oh. I think, let me look at my notes, because I put it on my notes when I saw her, her blood pressure was palpable at about 80, I think, so she was hypotensive at the time I saw her.
MR. KALUR: Here it is. 6/14, unable to hear BP, palpable at 60.
A. Palpable was --
Q. You are looking at the nurses' notes?
A. Yes.
Q. I thought he was talking about his notes.
A. My note.
Q. Your consult note?
A. Yes.
Q. As opposed to your written note?
A. That is correct.
Q. Okay. Wait a second.
A. Several typographical errors there, but.
Q. Uh-huh. Go ahead.

A. I said the blood pressure now was palpable systolically only, so she was not stable. That's what precipitated me to transfer her to intensive care.
Q. What was the diastolic?
A. I couldn't tell it. Palpable, which means you can't hear the diastolic, you can only palpate the systolic.
Q. Where does it say it wasn't palpable?
A. When you get a palpable systolic.
Q. Yes.
A. It means you can't get a diastolic.
Q. How do you get a diastolic?
A. You are going to have to hear it.
Q. How do you get it versus a systolic?
A. A systolic, anything above 100 usually --
Q. I asked you how you get it, I mean, what do you do to obtain the reading?
A. The diastolic?
Q. Yes, and the systolic.
A. Okay. You pump the mercury cuff and then you listen to the first pulse, that's the systolic.
Q. Yes.
A. The second pulse that you hear is the diastolic.
Q. Okay. So you do the same thing to get them both?

A. Yes.
Q. Go ahead.
A. So when you can't hear the systolic, you get it by feeling the pulse.
Q. Yes.
A. And when you feel the pulse, which is very low, systolic pulse, that's palpable, you cannot get the diastolic by hearing it, because you can't feel it.
Q. What was her pulse?
A. Her pulse was 60.
Q. And is that abnormal for a 67 year old woman?
A. Slow, well, it's slowed down, I would say, at the time it happened.
Q. What was it on admission?
MR. MARKWORTH: You are asking the pulse now?
MR. KAMPINSKI: Yes.
Q. It was 70?
A. 70 regular.
Q. And what was the systolic on admission?
A. Over 200.
Q. Well, I'm sorry, after initial treatment in the emergency department it was 150 over 88, wasn't it?

A. I think it went up again.

MR. KALUR: After Lopressor?

A. 150 over 84.

Q. Okay. You are telling me it's, when you saw her it was 80?

A. Yes. Excuse me.

Q. Want some water or something?

A. No. I'm fine.

Q. You don't know what the diastolic was?

A. You cannot get a diastolic when you can only palpate the systolic.

MR. KAMPINSKI: Where was that nurses' note, Jerry? Did it have it?

MR. KALUR: They can't get it either, they are using a Doppler and they can't get it. That's not a good way to be.

Q. What was it the next day on the 16th when she was transferred, 140 over 90?

A. Yes. 140 over 90.

Q. So you felt she was okay for transfer then?

A. Yes.

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(Thereupon, a discussion was had off the record.)

- - - -

Q. Have you looked at the CAT scan, doctor?
A. Yes.
Q. What did you see?
A. For the age of the patient, nothing remarkable.
Q. Is that what you have got here today?
A. Yes.
Q. And who were you provided the CAT scan by?
MR. KALUR: I gave it to him. We got a copy from the hospital.
MR. KAMPINSKI: I see. Can I get a copy of the CAT scan?
MR. MARKWORTH: Sure. Can I get a copy of those Bates stamped records?
MR. KAMPINSKI: Yes, you can. See how easy that was.
MR. MARKWORTH: Thank you.
MR. KAMPINSKI: You are welcome.
Q. What else have you reviewed other than the record and the CAT scan; and I think you said you didn't look at the EEG, is that correct?
A. No. I saw them once. I read them once.
Q. Right. Other than that when you initially read them, have you looked at them since?
A. No.
Q. Anything else that you reviewed here, doctor?

A. Just the records.
Q. Which records? Never mind. I'll withdraw that.
Have you gone and looked at the original of the hospital record since the incident?
A. Yes.
Q. When was that?
A. I think when I got the letter from you.
Q. You mean the lawsuit?
A. Yes.
Q. Did you remove anything from the original chart?
A. No. I called Deaconess to pull the chart so I can pull it and make copy.
Q. Did you make copies or did they make copies?
A. They made copies for me.
Q. All right. How many patients a year or a week or a month, however, you know, whichever time frame you want to use, would you say that Dr. Moysaenko refers to you?
A. This is both in the office and in the hospital?
Q. Yes.
A. I probably see probably about five patients a month.
Q. A month from him?
A. Yes.
Q. Okay.

A. About, approximately.
Q. And if you had to give me some idea of what kinds of billings you generated as a result of these referrals, if you want to do it per patient, per month, per year, what are we talking about?
A. Seeing the patients I see for him?
Q. Yes.
A. I usually charge for my initial consultation.
Q. Uh-huh.
A. And then whatever follow up days that I see them in the hospital, plus if I read the EEG, and that's the fees that I collect.
Q. Yes. I guess I'm looking for an amount, if you can give me that?
A. Amount?
Q. Yes.
A. I guess I have to give this to you.

MR. KAMPINSKI: Yes, you do, whatever it is.

MR. KALUR: Just sit calmly there.

MR. KAMPINSKI: Anything that says amount on it, I get uncontrolled high blood pressure.

MR. KALUR: Well, I can't let you see this document -- no. Oh, no. Yes, it

does, it's the patient herself.

MR. KAMPINSKI: I had a feeling it was.

MR. KALUR: I suppose you are entitled to see that.

MR. KAMPINSKI: Good.

MR. KALUR: Yes, we brought that down at your request, as a matter of fact. That's why it's here, yes. Now I recall. Trying to help you.

MR. KAMPINSKI: Sure.

Q. This was just generated April 22nd, 1992. Is that when you called it up out of the computer?

A. Yes.

MR. KALUR: You filed a request for production, and I asked him to get it out.

A. Yes.

MR. KAMPINSKI: I understand.

MR. KALUR: We don't wait 28 days, we try to get it to you right away.

Q. Going back to my earlier question, though, and maybe you can't answer this, and that's fine if you can't, but what I was asking, what I was looking for, doctor, if you could give me some idea of what kind of billings you generate as a

result of referrals by Dr. Moysaenko, either on a patient basis, monthly basis, annual basis, however you could do it. I don't know if you can do that or not.

MR. KALUR: He wants you to estimate, if you can, how much financial business Dr. Moysaenko sends to Mednet through your services?

A. To me?

MR. KALUR: Yes.

Q. Yes.

A. I know it's very little.

Q. Well, I don't know what that means.

A. Well, like what you see there.

Q. In other words, $172 a patient? Oh, I'm sorry, $225 a patient, roughly?

A. I would say.

Q. Okay. And there's five a month?

A. Maximum, yes.

Q. How about your group, does he refer to any other members of your group?

A. Just to me.

Q. I assume some patients that he refers to you you have to see in follow up for some extended period of time both in the hospital as well as

outpatient?
A. I do sometimes, but the majority of those patients go back to him, so when I see them once, they always want to go back to him.
Q. You cure them and then they go back to him?
A. I don't cure them. They get better.
MR. KALUR: Diagnose and adios, that's neurology.
Q. Did you ever talk to anybody at the Clinic about the transfer or about the proposed transfer?
A. Not me. I talked to the daughter.
Q. And when did you talk to her?
A. I think on the same day the patient was being transferred.
Q. All right. And what was your conversation?
A. I just said that the patient is being transferred to the Clinic.
Q. All right. What did she say?
A. That's what they wanted.
Q. Okay. Any other discussion with her?
A. That's it.
Q. All right. How about any discussion with any personnel of Deaconess as it related to the transfer of Mrs. Skyrl, did you have any discussions with them?

A. On how the patient was, I know that I came that morning before she was transferred and looked in on her before she was transferred. I might have talked to the nurses, I'm not certain.
Q. No, no. I meant any administrative personnel in terms of the transfer itself.
A. No.
Q. Do you ever socialize with Dr. Moysaenko?
A. No.
Q. Do you make rounds at all at Deaconess?
A. If I have a patient there.
Q. Did you have any other patients on the 15th?
A. I can't recall.
Q. It's your testimony you were called in as a consult as opposed to doing rounds on other patients on the 15th?
A. That's correct.
Q. Before the records were released to the people in this case, did you review them?
A. Before the records were released?
Q. Yes, sir.
A. When was that?
Q. I don't know. Did you have to review them before the hospital would release the records to anybody, to your knowledge?

A. Did I have to review them?
Q. Did you have to review them?
A. No.
Q. Did you ask to review them?
A. The only time I reviewed the chart was when I received your letter.
Q. Okay. When you did your consult note, your dictated one, and signed it, did you review the chart before you signed it?
A. I don't know whether I signed my consult or not.
Q. Is that your signature?
A. Let me take a look. Okay. I may have signed these way after the patient is gone.
Q. Well, it looks like it was dictated on the 15th and transcribed on the 16th.
A. Yes.
Q. Okay. And then --
MR. KALUR: That doesn't mean he signed off on it that day.
A. Usually that doesn't come in until later on and I just sign it.
Q. That's your signature?
A. Yes.
Q. All right.
MR. KAMPINSKI: You guys have

questions for the doctor?

MR. GROEDEL: No, I do not.

MR. MARKWORTH: No questions.

MR. KAMPINSKI: One minute. Chris will tell me what I forgot to ask.

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(Thereupon, a recess was had.)

- - - -

Q. Doctor, I just have a couple more questions, then I will be done. I think your testimony was that you were just guessing as to the extent of the blockage in the carotid on the 13th, correct?

A. Uh-huh.

Q. Okay. Let's just assume two different things just for a minute, one, that there was not a complete blockage, that what she had was an evolving stroke, okay, I just ask you to assume that for the sake of answering the next question.

A. Okay.

Q. And you may have answered this already, and I apologize if you did, under those circumstances, would surgical intervention, assuming that you then proved there was partial blockage and an evolving stroke, have been appropriate?

MR. GROEDEL: Objection.

A. If it was an evolving stroke and it was an open artery, but --

Q. Right.

A. -- in her condition I probably will not go for surgery.

Q. Well, it would be up to the surgeon, wouldn't it?

A. No, I still advise the surgeon.

Q. All right. Would you call in a vascular surgeon as a consult?

A. I generally call a neurosurgeon.

Q. Neurosurgeon?

A. Yes.

Q. So you wouldn't have operated on her anyhow?

A. I would not, not in her case.

MR. KALUR: He would not have advised.

A. In this case.

Q. How about if it was completely occluded, what would you have done then?

A. Definitely there is no surgical intervention.

Q. Okay. What would you have done, anything?

A. Medically, yes.

Q. What, heparin?

A. No.
Q. At that point it's too late?
A. It's dangerous to heparinize them.
Q. What would you have done?
A. I put them on steroids, just like what I did.
Q. What would that have done?
A. Try to contain the swelling that will develop from an occluded artery.
Q. Okay.
A. Get a cardiac consultation as soon as possible to check the heart, make sure there are no thrombotic lesions in the heart, run a vascular workup, make sure there is no vascularities in the brain and, of course, I would keep her in a monitored bed throughout this time.
Q. What would you have done in the absence of recommending surgery if she was only partially occluded?
A. If she was partially occluded and her blood pressure is not critically hypertensive --
Q. Yes?
A. -- I would talk to the family and tell them that I would take a chance and heparinize the patient, but there is a 50 percent chance of the patient bleeding, and if they take that chance I will do

it.

Q. Did they get her hypertension under control after her admission, doctor?

A. They did. But she is a malignant hypertensive, so I would be, I would be very, very uneasy about herparinizing her.

Q. Is the reason that you would not recommend surgery, I mean, when you said she was medically unstable, is that because of the blood pressure, is that what you are talking about?

A. No.

Q. What else?

A. That's just one of them. The other thing, she had a stroke, she had a most recent stroke.

Q. Well, I asked you to assume --

MR. KALUR: The problem is the term stroke, Chuck. If you get away from that term I think you will get an answer to what you are asking about.

MR. KAMPINSRI: I didn't use the term stroke, he brought it in. I'm talking about partial occlusion, he is throwing in the term stroke to redefine what I'm asking.

MR. KALUR: All right. Doctor, leave out the word. He was asking you to

assume right now she didn't have a stroke on the 13th.

MR. KAMPINSKI: Right. Absolutely.

A. There wasn't an area in her brain that was infarcted?

Q. Yes. You just told me the CAT was unremarkable, didn't you?

A. Well, that's usually the case even in a completed stroke on the earliest day.

Q. At least the evidence we have in the CAT is there was no damage to her brain on the day the CAT was done, right?

A. That's not true.

Q. All right. Great.

A. I can't assume that because that's not true.

MR. KALUR: He said it read as normal.

Q. Right. So there is no evidence on there of any damage to the brain?

A. On the CAT scan.

Q. Yes, right. Right. And if we assume, which I thought I asked you to assume --

A. Okay.

Q. -- that the carotid was only partially occluded --

A. Partially occluded.
Q. -- so that she had blood flow through to the brain on the 13th, that she had an evolving stroke or an impending stroke, all right, that she hadn't already had a completed stroke on the 13th.
A. She did not have, is that what you are saying?
Q. That's exactly what I'm saying, sure.
A. Okay.
Q. Under those circumstances, was she surgically treatable on the 13th?
MR. GROEDEL: Objection.
Q. All right.
A. You want me to answer that?
MR. KALUR: If you can.
A. I can answer that. In this particular case I will not.
Q. All right. And why not?
A. All right. The reason for that, she already had a damaged part of the brain.
Q. Damaged part of the brain?
A. She had a damaged part of brain from infarct.
Q. When did that occur?
A. She had a fluent aphasia, right hemiparesis, so there is already damage there. So for a surgeon

to go in and open up the artery, she will bleed in there inside her brain, so I will not. That's just one reason. The other reason is she was malignantly hypertensive.

Q. Hold it. Hold it. Hold it. When they open up the carotid she will bleed in her brain?

A. That is correct.

Q. I see.

A. That's correct.

Q. Do they use shunts during endarterectomies to shunt blood around the area which they were going to?

MR. KALUR: You are talking about the reflow phenomenon in the brain.

A. When you open up the artery that has originally a diminished blood flow, you have a blood influx, and you rush the blood up there, at this open you are going to have a hemorrhage.

Q. You do endarterectomies for, or aren't endarterectomies done for people who have blocked carotids, isn't that the reason they do it?

A. Yes, if they were not symptomatic at that time, meaning they have TIAs, severely compromised carotid, but the brain itself shows very minima damage or no damage at all, yes, you do.

Q. TIAs are nonsymptomatic?
A. Usually by the time they do their surgery they are not symptomatic, yes, they do progress well.
Q. Are you board certified?
A. Yes.
Q. When were you board certified?
A. I have three board certifications, one in neurology in 1977, one in EEG in '78, and one in EMG in '79.
Q. Did you pass the first time you took the boards?
A. All of them.
Q. Have you been recertified in any of them?
A. There is no recertification.
Q. All right. And when you said malignant hypertension, the fact that they got it under control doesn't, is not meaningful as it relates to whether or not she is medically competent to undergo a carotid, is that your testimony?
A. My testimony is that she came in with a malignant hypertension.
Q. Well, all right. That's great. But they got it under control, I think you said that?
A. Yes.
Q. So once the blood pressure is in fact under control, you are saying the fact that she came in

with it too high makes her medically unstable even after they got it under control, right?

A. Yes. You have the chance that she can get worse.

Q. And that, therefore, you couldn't do surgery on her?

A. That's not the only reason.

Q. But that's one of the reasons you gave me?

A. That's one of the reasons.

Q. That plus the fact that she already had brain damage?

A. Yes.

Q. All right. When did she sustain the brain damage?

A. When she came in.

Q. On the 13th?

A. Yes.

MR. KAMPINSKI: That's all.

MR. GROEDEL: Still have no questions.

MR. MARKWORTH: None.

AUGUST0 C. JUGUILON, M.D.

C E R T I F I C A T E

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

I, Dawn M. Fade, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named AUGUSTO C. JUGUILON, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of _____, A.D. 19 __.

_____
Dawn M. Fade, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires October 20, 1992