IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

TONI L. BIANCHI, Executrix of the Estate of FRANCES R. BRONCACCIO, Deceased,

Plaintiff,

-vs- CASE NO. 370551

KAISER FOUNDATION HEALTH PLAN OF OHIO, et al.,

Defendants.

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Deposition of STEPHEN W. RYDER, M.D., taken as if upon cross-examination before Laura L. Ware, a Notary Public within and for the State of Ohio, at the Kaiser Permanente Emergency Room at the Cleveland Clinic, 9500 Euclid Avenue, Cleveland, Ohio, at 10:12 a.m. on Wednesday, December 8, 1999, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

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APPEARANCES:

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On behalf of the Plaintiff;

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On behalf of the Defendants.

STEPHEN W. RYDER, 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 STEPHEN W. RYDER, M.D.

BY MR. RUF:

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

A. My name is Stephen W. Ryder, S-T-E-P-H-E-N, W, Ryder, R-Y-D-E-R.

Q. What is your address?

A. 2761 North Park Boulevard, Cleveland Heights, Ohio, 44118.

Q. I'm sorry, 44 --

A. 118.

Q. Dr. Ryder, my name is Mark Ruf. I'm a lawyer representing the Estate of Frances Broncaccio. 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 that you have understood the question. Okay?

A. (Indicating.)

Q. You need to give a verbal answer.

A. Yes.

Q. Who is your employer?
A. Ohio Permanente Medical Group.
Q. Was Ohio Permanente Medical Group your employer in December of '97?
A. Yes.
Q. How long have you been employed by Ohio Permanente Medical Group?
A. Since July of 1978.
Q. What is your position with Ohio Permanente Medical Group?
A. I am an internist and I work in the Clinical Decision Unit, and I also work as a hospitalist.
Q. What is a hospitalist?
A. I care for patients who are admitted to the hospital.
Q. Back in December of '97 were you covering both the CDU and acting as a hospitalist?
A. I think in '97 I was only working in the CDUs.
Q. Back in December of '97 did you only work at the Parma location or did you work at other locations as well?
A. We also have a CDU here at the Cleveland Clinic and I also worked there.
Q. Was Frances Broncaccio a patient of yours?
A. Yes.

Q. How was she a patient of yours?
A. She was admitted to the CDU on the date that I was working there.
Q. That was 12-8-97? And if you need to refer to the records to refresh your memory, please do so.
A. I met her there on December 8th, '97.
Q. What shift were you working December 8th of '97?
A. During the daytime.
Q. So what would have been your hours?
A. Roughly 9:00 a.m. to 5:00 p.m.
Q. Was there a physician that was covering the CDU from the time she was admitted at 2:25 up until 9:00 a.m.?
A. Yes.
Q. Do you know who that physician would have been?
A. I believe Dr. Haluska.
Q. Even though Dr. Haluska transferred her to the CDU he would still be the physician responsible for her care?
A. Yes.
Q. So in the evening does the ER doctor also cover the CDU?
A. Yes.
Q. At 9:00 when your shift started, do you know how many physicians were covering the CDU?

A. Just one, me.
Q. And the CDU has 23 beds?
A. I believe that's accurate.
Q. Do you know if the CDU was full?
A. I don't recall.
Q. Do you know if you were busy during your shift?
A. I don't recall exactly, but I expect that I was. It's a rare day that I'm not busy throughout the day.
Q. Typically is the CDU at capacity or close to capacity?
A. I really don't know, because I'm not there all the time, so I don't know the answer to that question. I'm sorry.
Q. What time was Frances Broncaccio admitted to the CDU?
A. I'd have to get that from the record.
MS. REINKER: You can look at the nurse's notes.
A. It looks like probably at 2:25 in the morning is when she arrived in the CDU, from the nursing notes.
Q. The CDU is called the critical decision unit, correct?
A. Clinical, C-L-I-N-I-C-A-L, Clinical Decision Unit.

Q. And what is the purpose of keeping a patient in the --

MS. REINKER: Do you need to go off the record for a moment?

THE WITNESS: No.

MS. REINKER: Off the record.

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

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A. Ask me that question again. Sorry.

Q. Sure. What is the purpose of keeping a patient in the Clinical Decision Unit?

A. The Clinical Decision Unit is sort of an extension of the emergency department. It's immediate between the emergency department and the hospital and a number of different types of clinical problems could be evaluated there.

Q. Do you agree that Frances Broncaccio was admitted to the CDU because she was being evaluated for a suspected cardiac event?

A. Yes.

Q. And do you agree that a cardiac event includes both myocardial infarction and aortic dissection?

MS. REINKER: Objection.

Q. Go ahead, you can answer.

MS. REINKER: I'm objecting to the characterization of an aortic dissection as a cardiac event, but that's for you to answer.

A. Would you repeat the question?

Q. Sure. Does the definition of a cardiac event include both a myocardial infarction and aortic dissection?

A. In the way I would use the term cardiac event, it's not a precisely defined term, but in common usage I would take it to mean a heart attack, myocardial infarction.

Q. When you --

A. So cardiac event is not a precise term.

Q. When you use the term cardiac event does it include any other cardiac conditions other than myocardial infarction?

A. Yes.

Q. What other --

A. You could also include in that angina factors and chest pain presumed to be related to myocardial ischemia.

Q. So would you or would you not include an aortic dissection in the definition of a cardiac event?

A. I would not use the term that way.

Q. Do you agree that the acceptable standard of care requires the monitoring of a patient in the CDU?
A. Ask that question again. I'm sorry.
Q. Sure. Do you agree the acceptable standard of care requires the monitoring of a patient in the CDU?
A. By monitoring do you mean cardiac monitoring, EKG monitoring?
Q. And monitoring by the nursing staff.
A. Checking vital signs and so forth?
Q. Yes.
A. Yes.
Q. How should a patient be monitored that is suspected of having either a myocardial infarction or an aortic dissection? Do you want me to break that down into separate questions?
A. Yeah, I think they're separate issues.
Q. All right. First of all, how should a patient be monitored that is suspected of a myocardial infarction?
A. Well, vital signs, meaning blood pressure, pulse, heart rate -- or respiratory rate and temperature should be recorded. Another thing that we record is -- well, we use EKG monitoring.
Q. Any other monitoring that should be done on a patient suspected of having a myocardial

infarction?
A. Well, in addition to monitoring, it's the attention to a patient's symptoms.
Q. Do you agree that the acceptable standard of care requires the nursing staff to take vital signs pursuant to physician orders?
A. I'm not sure if that -- I'm not sure what you mean by the question, pursuant to doctor's orders.
Q. Well, do you expect the nurses in the CDU to follow the doctor's orders?
A. Yes.
Q. And do you expect the nurses in the CDU to observe a patient and record the patient's signs and symptoms?
A. Yes.
Q. Do you expect the nursing staff to inform a physician if there is a change in a patient's signs and symptoms?
A. It depends. It depends on the change.
Q. If there was a change in either the character or location of Frances Broncaccio's pain, would that be something that the nursing staff should inform the physician of?
A. If there was a change in the location of her pain?
Q. Or the nature of her pain.

A. Or the nature of her pain, in many -- in some cases, yes, that would be something I would want reported to me.
Q. Would you also expect the nursing staff to notify the physician covering the CDU?
A. Yes.
MS. REINKER: In those cases you mean?
MR. RUF: Yes.
Q. How should a patient be monitored that is suspected of an aortic dissection?
A. Well, first of all, a patient suspected of having an aortic dissection would not have been admitted to the CDU.
Q. And why is that?
A. It's an unstable situation which would require admission probab y to an Intensive Care Unit, again, depending on the nature of the problem.
Q. If you're at the Parma facility and you suspect that a patient has an aortic dissection, do you transfer that patient to another facility?
A. Yes.
Q. Is the facility that you transfer the patient to the Cleveland Clinic?
A. You -- yes, that would be the routine under routine circumstances.

Q. Do you transfer the patient to another facility because the Parma facility does not have the appropriate personnel and equipment to monitor a patient with an aortic dissection and provide medical intervention, if necessary?
A. The Parma facility is not a hospital and an aortic dissection should be managed in not just a hospital but a very highly specialized hospital.
Q. What do you mean by highly specialized hospital?
A. I mean a tertiary care level hospital like the Cleveland Clinic which is equipped to handle complex diagnostic procedures and vascular surgery procedures.
Q. So would you agree that if a patient is suspected of having an aortic dissection at the Parma facility that that patient needs to be transferred to a tertiary care hospital?
A. Yes.
Q. Could you tell me what the signs or symptoms are of an aortic dissection?
A. Probably the most prominent symptom for an aortic dissection is a tearing or ripping pain.
Q. Is that a tearing or ripping pain in the chest?
A. Chest or back.
Q. Do you agree that with an aortic dissection you can

have a migration of the pain in the patient?
A. Yes, you can.
Q. Do you agree that with an aortic dissection a patient could initially have chest pain and then subsequently develop back pain?
A. Yes.
Q. Is nausea a potential sign or symptom of an aortic dissection?
A. Nausea is a symptom of a lot of different things, so it's certainly not a specific symptom of dissection.
Q. Do patients that have an aortic dissection suffer from nausea sometimes?
A. It's such a nonspecific symptom. I am sure that someone with an aortic aneurysm could at some time -- let me put it this way. Some patients with an aortic aneurysm could have nausea. It's not part of the things that would tip you off to that diagnosis.
Q. Is syncope a potential sign or symptom of an aortic dissection?
A. It can be, but it's a rare -- that's a rare presentation of an aortic dissection. Actually, I didn't mean it that way. I meant aortic dissection is a rare -- let me phrase this accurately.

If you took a number of people who present with syncope, the number of those people who would have aortic dissection as the cause of their syncope would be very, very small. That's what I meant.

Q. Are there any other potential signs or symptoms that could occur in a patient with an aortic dissection?

MS. REINKER: Objection. I'm objecting to the could occur, but you can answer.

A. Would you repeat the question?

MR. RUF: Sure. Could you please read back the question.

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

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A. Yes, and a number of them are nonspecific. Someone could have hypotension, someone -- there are many presentations of aortic dissection. People can present with the appearance of a stroke.

MS. REINKER: I'm going to object because he's just speculating as to anything in the world.

A. What I was going to say is there are a number of different presentations of this which often look like something else. For instance, someone could

present as a stroke and have neurologic symptoms and the underlying problem might be a dissection, if you dissect off an artery to the brain the primary presenting symptom might be a stroke, but the underlying problem is the dissection, and there are a host of other presentations.

MS. REINKER: You needn't speculate about all that.

. Well, if you were evaluating a patient for whether or not they had an aortic dissection, what signs and symptoms would you look for, other than tearing or ripping pain in the chest?

MS. REINKER: Objection. Mark, he can't answer that. I mean, a patient comes in and they do the best they can to evaluate him.

Doctor, would you agree that there are known signs and symptoms of an aortic dissection?

MS. REINKER: Well, objection. He's already answered that, the tearing pain.

Please answer the question.

I think what I'm trying to answer is that are there specific signs and symptoms that would alert you to the presence of a dissection, aortic dissection. The symptom that's the chief one is the ripping, tearing pain.

Q. Okay. Let me ask this then. What other potential symptoms could accompany the tearing or ripping pain in the chest?

MS. REINKER: Objection. I'm objecting because I think he's told you what the cardinal symptom is. Anything in the world could probably accompany it, I just don't think it's fair to make him speculate.

Q. Please answer the question, Doctor

A. Could you repeat the question then.

MR. RUF: Sure. Could you please read it back.

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

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A. If a person presents with a tearing and ripping pain, what other signs and symptoms might they have?

Q. Yes.

MS. REINKER: Objection. Doctor, I won't let you speculate. If you can't answer without speculating, just tell him that and we'll go on to something else.

A. I would be speculating. I don't know how to answer

your question better than that right now. If you want to rephrase the question, I'll be happy to try and answer.

Q. Are there any emergency room textbooks that you regularly consult?

A. Let's see, there's one emergency textbook which I use more than others. I think it's Terrantelli, Tintinalli.

Q. Tintinalli?

A. Tintinalli.

Q. Do you refer to that textbook because you find the information in that textbook to be reliable information?

A. I refer to it because it's a recognized emergency text.

Q. Do you utilize any internal medicine textbooks in practicing medicine?

A. Yes.

Q. What internal medicine textbooks do you utilize?

A. Probably the one I use most commonly is Cecil and Lowe, internal medicine.

Q. Is that because you've found that to be a reliable source of information?

A. Again, it's a generally recognized source.

Q. Do you also use Harrison's textbook of internal

medicine?

MS. REINKER: You're talking about books he goes to consult with on a regular basis?

MR. RUF: Yes.

A. I rarely use Harrison's.

Q. Do you agree that in Cecil's textbook of internal medicine there's a discussion of aortic dissections in that book?

MS. REINKER: Objection. I'm going to instruct him not to answer unless he has personally looked at that and can say under oath he knows what's in that book.

A. I am sure there must be.

MS. REINKER: Doctor, if you don't -- if you're not personally -- if you don't know of personal knowledge, under oath you should not be answering what is or is not in a book.

MR. RUF: Could you please stop trying to coach the witness.

MS. REINKER: Well, that's not appropriate. You can't ask him what's in a book that's --

MR. RUF: If you want to make an objection, make an objection, don't lecture him

on what the answer should be.

MS. REINKER: I'm telling him he can't possibly answer a question as to what is in a lengthy textbook.

Q. Does Cecil's textbook of internal medicine cover cardiovascular diseases?

A. Yes.

Q. And to the best of your knowledge is there a discussion about aortic dissections in that book?

A. Yes.

Q. And would you agree that in a textbook such as Cecil's textbook on internal medicine there are known signs or symptoms listed for aortic dissections?

MS. REINKER: I'm objecting and instructing him not to answer that question. You're instructed not to answer.

MR. RUF: What's the basis for instructing him not to answer?

MS. REINKER: He cannot possibly know what's in the book. He cannot know. If you want to hand him a copy of it, Mark, then we'll look at it and we'll answer the question, but other than that, I'm not going to permit him to answer.

Q. Doctor, would you agree that known signs or symptoms of aortic dissections are reported in medical textbooks in the medical literature?
A. Yes.
Q. And have you read medical textbooks in the medical literature in your education and training and to stay current on your medical knowledge?
A. Yes.
Q. Do you know of any other signs or symptoms of an aortic dissection reported in the medical literature, other than a tearing or ripping pain in the chest?

MS. REINKER: Objection. He's asking you to try to speculate what might be in various sources of literature about various possible symptoms.

MR. RUF: No, I'm asking him about his personal knowledge.

MS. REINKER: No, you're not, you asked him what was in the literature. There's no question before you, Doctor. Stop a second.

THE WITNESS: Okay.

MS. REINKER: Your question was does he know what's in the literature as various reported signs and symptoms of aortic

dissections. If you want to, rephrase the question.

MR. RUF: Fine.

Q. Doctor, based on your own personal review of the medical literature and your education and training, are you aware of any signs or symptoms of aortic dissection, other than tearing or ripping pain in the chest?

MS. REINKER: Objection. He's already answered that. He said he can't elaborate any more than he has, so I'm going to instruct him not to answer because that one has been asked and answered.

MR. RUF: No, it hasn't. It hasn't been answered and your instructions are improper.

MS. REINKER: You asked him to list all the possible signs and symptoms of aortic dissection other than what he already answered and --

Q. Doctor, are you refusing to answer that question?

MS. REINKER: I'm instructing him not to answer that question unless you want to rephrase it. It's been asked and answered.

MR. RUF: What's the legal basis for

your instruction not to answer?

MS. REINKER: I'm not aware that I need a legal basis other than my -- what I've already stated, that this question has already been answered and you're trying to harass this witness.

MR. RUF: So you're instructing him not to answer on a legal basis, correct?

MS. REINKER: I'm instructing him not to answer for the same legal basis I stated before. You're trying to harass this witness to try to get him to change an answer.

MR. RUF: No, I'm not.

MS. REINKER: Go on to something else, Mark. He's produced as a fact witness here.

Q. Doctor, what are the signs or symptoms of a myocardial infarction?

A. The symptoms primarily are chest pain and often associated with shortness of breath, nausea, light-headedness. The signs usually we're talking about -- you're talking about physical exam signs?

Q. Yes.

A. They're nonspecific. The EKG findings are very helpful. Often you need laboratory confirmation, chemical laboratory confirmation.

Q. Let me go back. Would you agree that with a myocardial infarction you often have arm pain accompanying the chest pain?
A. It can occur, but it often doesn't occur.
Q. Do you agree that with myocardial infarction you usually do not have back pain?
A. You can have back pain with a myocardial infarction. Depends on the location of the infarction.
Q. Then when you're evaluating a patient with chest pain, what symptom do you look for to differentiate an aortic dissection. from a myocardial infarction?
A. The big symptom is the one I talked about before, which is that specific character of the pain, the ripping, tearing pain, so that's the big one.
Q. Do you agree that usually with an aortic dissection you have a normal EKG?
A. I don't think I can say that. I can say that the EKG doesn't -- there are no EKG findings that would tell you that you're having an aortic dissection. The EKG can be abnormal with an aortic dissection.
Q. And what type of abnormalities would you see with an aortic dissection?
A. Well, sometimes with an aortic dissection you can block a coronary artery and actually have a

myocardial infarction, so you can see an EKG change that looks like and it is a myocardial infarction, so that can be a very inconclusive picture because the person can have both. But an EKG finding of a myocardial infarction doesn't make you think of aortic dissection.

Q. Well, what type of abnormality would you see on EKG with an aortic dissection if the patient was not also suffering from a myocardial infarction?

A. You could see anything. It could be -- I guess the reason it's hard to give an answer, because the EKG could show anything. People who have aortic dissections often have coronary disease, so their EKG could show anything. It could be a normal EKG, it could be an abnormal EKG. The EKG just isn't really helpful in making the diagnosis of an aortic dissection.

Q. What would you look for on EKG with myocardial infarction?

A. You look for ST elevations, the presence of Q waves, you look for changes in T waves.

Q. And when you referred to the lab work, were you talking about cardiac enzymes?

A. Yes.

Q. Would you agree that with a myocardial infarction

you want to look for positive cardiac enzymes?
A. Yes.
Q. And with aortic dissection typically you do not have positive cardiac enzymes?
A. In a pure aortic dissection you shouldn't see abnormal cardiac enzymes.
Q. What diagnostic testing should be done to rule out an aortic dissection?
MS. REINKER: In the case of a suspected aortic dissection?
MR. RUF: Yes.
MS. REINKER: Okay.
A. First of all, you have to suspect aortic dissection. If you suspect an aortic dissection, there are a number of -- you have to do some sort of imaging of the aorta. A very good one is a transesophageal echocardiogram, other tests can also be a CT scan or an MRI or an aortagram where you inject dye into the aorta and x-ray that.
Q. Would any of those tests have been available to Dr. Haluska during his shift on December 7th and 8th?
A. They would not have been available to him at the Parma CDU, but if he was entertaining the diagnosis he wouldn't have kept the patient there, he would have sent the patient to the hospital, so then they

would have been available.
Q. What diagnostic studies do you perform to rule in or rule out myocardial infarction?
A. We do a series of electrocardiograms over a period of hours, we do a representative series of blood tests over a period of hours. That's really, for myocardial infarction, those are the key tests right there.
Q. Is the appropriate equipment and is the appropriate personnel available at the Kaiser Parma facility to treat myocardial infarctions?
A. Yes.
Q. Is that during both the evening hours and the daytime?
A. Yes.
Q. What types of consults can you obtain during the evening for a patient suspected of having a cardiac problem?
A. You can call the cardiologist that would be readily available.
Q. Would a cardiologist have to be called in to the facility?
A. Not usually, but I mean the cardiologist would be available by telephone for a consultation.
Q. But there wouldn't be a cardiologist physically

present at the facility in the evening?
A. No, nor would I expect there to be a need to be.
Q. When you started your shift on December 8th, did you review Frances Broncaccio's chart?
A. I don't recall exactly -- if you mean specifically in the morning when I came in did I look at her chart?
Q. Yes.
A. I don't recall looking at her chart in the morning.
Q. Do you know if you reviewed her chart at any time before 13:00 hours on the 8th?
A. I do not recall doing so.
Q. Did you perform a physical exam on her before 13:00 hours?
A. No.
Q. If you had done a physical exam, would that have been recorded in the chart?
A. Yes, it would be.
Q. Based on your personal knowledge and the record, did any physician perform an examination on Frances Broncaccio from 2:25 up until 13:00 hours --
A. During --
Q. -- on December 8th?
A. During that period of time, I'm not aware of a physical exam being done by a physician.

Q. Based on the record, did any physician even see her during that time period?
A. I think during that period of 2:25 and when she came to the CDU until I saw her later in the day, I don't believe a physician saw her during that period of time.
Q. Was the first time that you saw her the time of arrest?
A. Yes.
Q. Did you talk to Dr. Haluska when your shift started on December 8th?
A. I do not recall doing so.
Q. Did you talk to any of the nursing staff or were you given report by any of the nursing staff when you started your shift on December 8th?
A. Yes.
Q. What did the nursing staff report to you as far as Frances Broncaccio's condition?
A. I can't recall exactly. I only -- I can guess that what I heard was that there was a patient with -- who presented with chest pain and was undergoing an evaluation for a cardiac problem and had a scheduled stress test later in the day.
Q. Were you informed of any change in her signs or symptoms from 2:25 until your shift started?

A. To the best of my recollection, no.
Q. When you started your --
A. Until the big change at 1:00 or so, but prior to 1:00 I don't recall being informed of any changes.
Q. Were you aware that Frances Broncaccio was short of breath at 2:25?
MS. REINKER: Objection.
Q. Let me rephrase the question. Before 1:00 on --
A. In the afternoon?
Q. Yes, in the afternoon on December 8th, were you aware that Frances Broncaccio was suffering shortness of breath at 2:25?
A. No.
Q. Before 1:00 on December 8th, were you aware that Frances Broncaccio was complaining of back pain at 3:00 in the morning?
A. To the best of my recollection, no.
Q. Before 1:00 in the afternoon on December 8th were you aware that Frances Broncaccio was complaining of nausea at 6:00, that she had diarrhea at 8:00 and was vomiting at 10:00?
A. I don't remember.
Q. Before 1:00 were you aware that Frances Broncaccio was complaining of chest and back pressure at 12:00?

A. I don't remember.
Q. Do you know if any of those complaints were a change in her condition?
A. I understand that she presented to the emergency room with a history of some chest pain, so that's some more chest discomfort. I'm not sure it would have been necessarily registered as a change.
Q. Well, based on the ER record, she did not come in complaining of shortness of breath, correct?
A. I don't recall any comments about shortness of breath. In fact, specifically a statement in Dr. Haluska's note, she denied any difficulty breathing, and in my review of the chart I don't recall any shortness of breath.
Q. And based on the ER record, she was not complaining of back pain when she came in, correct?
A. To the best of my recollection of the reading of this, she did not have -- ask me the question again just so --

MR. RUF: Could you please read back the question.

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

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A. May I take a moment --
Q. Sure.
A. -- to review the record again. She had complained of some --
MS. REINKER: Review it to yourself because she has to take down everything you say.
THE WITNESS: Sorry.
A. I don't see anything in the emergency doctor's note talking about her complaining of back pain.
Q. Based on the emergency room record did she have nausea, diarrhea or vomiting while she was in the emergency room?
A. Based on the emergency room doctor's note?
Q. Yes.
A. No, I don't see that.
Q. Do you agree that the acceptable standard of medical care requires a CDU physician to be aware of a patient's condition while that patient is in the CDU?
A. Yes.
Q. And that's because you cannot reach a diagnosis and provide treatment without knowing of a patient's condition, correct?
A. Yes.

Q. What was the differential diagnosis for Frances Broncaccio while she was in the CDU from 2:25 until 13:00?
A. It was -- Dr. Haluska's note, his impression was chest pain, rule out myocardial infarction, bradycardia, hypotension, rule out vasovagal even , history of aortic insufficiency, history of arthritis, history of tobacco abuse and history of hypertension, but the main active diagnoses were rule out myocardial infarction and rule out vasovagal event.
Q. Is there any difference between aortic insufficiency and aortic regurgitation?
A. Those are synonymous terms, in my mind.
Q. Do you agree that the majority of patients who have an aortic dissection suffer from hypertension?
A. That's a very -- there's a high association between hypertension and aortic dissection.
Q. Would you also agree that there is an association between aortic insufficiency and aortic dissection?
A. There is a connection.
Q. Dr. Haluska's ER note actually states that Frances Broncaccio was having chest pain, correct?
A. She had, yes, she had complained of substernal chest pain, pressure.

MS. REINKER: You mean in the past, is that your question, Mark?

Q. Well, his note actually states on it chest pain, correct?

A. It says at the time of arrival she denied any chest pain or pressure. She had complained of it in the earlier part of the -- before she presented.

Q. Well, under impression number one it states chest pain, correct?

A. Correct, which she's referring to the chest pressure she had complained of earlier because later in his note, actually it's in the history of present illness, it states at the time of her arrival she denied any chest pain or pressure. Oops. But after she was here for a while she indicated that she had some substernal chest pain, but this was improved after Mylanta was given by mouth.

Q. Do you agree that with Frances Broncaccio's medical history and symptoms that she presented with to the ER aortic dissection was part of the differential diagnosis?

A. Are you asking me should it have been --

Q. Yes.

A. -- part of the diagnosis? In retrospect it's easy to say that, but the problem is we don't see people

in retrospect, we see them as they present. And she presented with an episode of unresponsiveness, she had a slow heart rate and low blood pressure, complained of indigestion type symptoms, I think she mentioned she had had this chest pressure which she attributed to drinking coffee which she doesn't usually do, so I think the presentation didn't suggest aortic dissection. That's the problem with that diagnosis, is that it often presents in a masked form.

Q. Well, with the way she presented would you agree that both myocardial infarction and aortic dissection were part of the differential diagnosis?

MS. REINKER: Objection. Mark, I'm going to instruct him not to answer any more questions along this line because you're trying to turn him into an expert witness and he's not here for that purpose. If you want to ask him anything more about his care, he can answer, otherwise we're going to end the deposition.

Q. Are you refusing to answer the question?

MS. REINKER: I'm instructing him not to answer the question, so he's refusing to answer on advice of counsel.

MR. RUF: I believe your instruction

not to answer is improper and it's contrary to the rules.

MS. REINKER: Well, why don't you go ahead and ask him fact questions, that's what he's here for.

Q. Doctor, at any time during your shift on December 8th did you review Frances Broncaccio's chart?

A. I would have reviewed it when I first got called to see her -- well, I probably didn't review it immediately before I saw the patient because I got called for an emergency situation to the bedside, so I didn't really probably look at her chart until after events were over because I was summoned to an arrest situation.

Q. And when were you first called to her bedside?

A. My note indicates 13:14, and I usually -- it might have been earlier than that because when I routinely write a note I date it and time it when I'm writing it, and I wouldn't have sat and written a note while the person was arresting, so I must have written this after.

Q. At any time on December 8th did you review her entire chart?

A. I don't recall, actually.

Q. Is that your note listed in the progress sheet dated

12-8-97, 13:14?
A. Yes.
Q. Is that your handwriting?
A. Yes.
Q. What was Frances Broncaccio's condition when you were called to her bedside?
A. She was, as I observed in the note here, I was called to see here for nonresponsiveness, and I saw gasping respirations. Clearly she was in dire straits and we bagged the patient, summoned help from the emergency department, Dr. Gajdowski came over, she was intubated, then the events proceeded from there.
Q. Could you please read into the record your note.
A. 12-18-97, 13:14. Subjective information. Called to see patient for nonresponsiveness. Patient's daughter reported patient's eyes rolled back, had complained of chest pain, upper back pain.
Q. And there's --
A. After --
Q. Excuse me, Doctor. There's a line through upper and error is written?
A. That's what I was going to explain. After that note was written at a later time there's a note where I wrote at 14:07 that a nurse indicated to me that the

pain was lower back pain. I had originally gotten the idea it was upper back pain. **I** went back to my note, put a single line through upper and wrote error, and that refers to the note down below.

Q. At 13:14 where did you obtain the information that she had complained of chest pain and back pain?

A. The daughter.

Q. Do you know which daughter?

A. I wrote the name Toni Antonetti. That daughter was present. This was at the time that the patient was pronounced dead and I presume -- I don't recall anybody else there. I remember meeting a daughter, and I presume it was this daughter, Toni. I don't know if other daughters were present or not or other people were present.

Q. Okay. Please continue, Doctor.

A. Back to my progress note. Objective information, no pulse palpable, neck veins distended, gasping respiration, patient bagged, intubated, breath sounds present bilaterally or breath sound bilaterally, pulse not obtained, rhythm wide complex, see arrest records, patient pronounced dead at 13:35, CKs negative. And in the margin I wrote the note chest x-ray, no widened mediastinum.

Under assessment, cardiovascular collapse, rule

out ruptured thoracic aneurysm, doubt cardiac tamponade, doubt acute MI. Plan, diagnostic coroner consult, therapeutic patient pronounced at 13:35, daughter present, Toni Antonetti, and then my signature.

Q. What does CK mean?

A. That refers to cardiac enzymes, creatinine, phosphokinase, CPK is another abbreviation for it. It's cardiac enzymes.

Q. At 13:14 how many cardiac enzymes had been done?

MS. REINKER: You can look at the labs.

A. Yeah, I'll have to refer to the labs.

Q. That's fine.

A. Obviously more than one because I wrote plural.

MS. REINKER: You said at 13:14?

THE WITNESS: Yes.

A. By that time there were three sets of cardiac enzymes.

Q. And were all of them normal?

A. Yes.

Q. Why did you write down rule out ruptured thoracic aneurysm?

A. At that time, because of the patient's sudden collapse and the absence of evidence for acute MI, I

was entertaining other diagnoses why would this happen, and that was a diagnosis that seemed likely to me.

Q. Why did you write down doubt cardiac tamponade, doubt acute MI?

A. I wrote down doubt acute MI because of the negative cardiac enzymes. I can't recall at this time why I wrote doubt cardiac tamponade. I'm sorry, I just don't remember my thought process at this time.

Q. Was one of the things that brought ruptured thoracic aneurysm to the front of the potential diagnoses the chest pain plus the back pain?

A. Yes.

Q. And those symptoms plus negative cardiac enzymes caused you to believe that she was suffering from a thoracic aneurysm rather than an MI?

A. Yes.

Q. Is that your note under 12-8-97, 14:07?

A. Yes.

Q. Could you please read that into the record.

A. I wrote that. It says nurse reports patient complained of chest pain and lower back pain, lower was underlined. And I wrote, consider abdominal aortic aneurysm rupture.

The idea that I had gotten earlier from the

daughter was that it was upper back pain. The nurse, as we discussed, you know, after, because this was at 14:07, after everything was over, that the pain had been -- her understanding was it was lower back pain and I made that correction.

Q. So the daughter --

A. So it was not clear, really, whether the pain was upper back pain or lower back pain. I -- I don't know why **I** wrote that note because it was after the event. I guess because my thought that maybe it was lower. I thought it was an aortic aneurysm because of the lower back, I thought maybe it was abdominal.

Q. Do you know what nurse you spoke with?

A. I don't recall.

Q. But the daughter related a different location for the back pain than the nurse did?

A. To the best of my recollection reading my note, because this first paragraph in my progress note, called to see patient for nonresponsive --

MS. REINKER: You don't need to reread everything because she has to take down every word you say, so if you keep your answers shorter, just answer his questions and we'll move along quicker.

A. I got the idea from the daughter that the pain was upper, upper back.
Q. Have you reviewed the autopsy report for Frances Broncaccio?
A. No.
Q. Can you say whether or not Frances Broncaccio was suffering from an aortic dissection while she was at the Kaiser Parma facility?
A. At this time retrospectively, yes.
Q. And could you please tell me what your opinion is on that?

MS. REINKER: Objection. That's not a proper question.

Q. *Go* ahead, Doctor.

MS. REINKER: No, that's not a proper question. Do you want to ask him what his opinion is about what --

A. Just ask me the question again so I'm clear on it.
Q. Could you tell me whether or not Frances Broncaccio was suffering from an aortic dissection during the time she was at the Kaiser Parma facility?
A. Based on what we know after the autopsy, I did hear that the autopsy showed something to do with an aortic dissection. Based on that, yes.
Q. Do you have any type of training or experience in

treating aortic dissections or the survivability of an aortic dissection?
A. Yes.
Q. What training do you have on either of those?
A. My training as a board certified internal medicine doctor or board certified internist, which includes that diagnosis in the training.
Q. Have you ever treated a patient with an aortic dissection?
A. Mrs. Broncaccio, in retrospect. I have been involved in some other cases over the years. They're relatively uncommon.
Q. In the patients in which you've suspected or diagnosed an aortic dissection, do you get a specialist involved?
A. Oh, yes.
Q. What type of specialist?
A. Often cardiology is involved and often a chest surgeon or vascular surgeon is involved.
Q. So in the cases you've been involved with you've actually called in a specialist to make the determination as to what type of treatment the patient should receive?
A. Yes.
Q. What type of training or education have you had on

the issue of survivability of an aortic dissection?
A. Again, my internal medicine training and reading about the problem.
Q. Do you claim to be an expert on that issue or have any specialized knowledge on that issue?
A. I wouldn't claim to be an expert on that, beyond m expertise in internal medicine.
MS. REINKER: Mark, do you know how much longer you're going to be?
MR. RUF: I'm going to try and finish up.
Q. Did you talk to Frances Broncaccio's family either before or after her death?
A. Yes.
Q. You already mentioned you spoke to one of the daughters, correct?
A. Yes.
Q. Did you speak to anybody else before her death?
A. My only recollection is what my progress note indicated about the daughter. I don't recall any others.
Q. And other than the daughter telling you about complaints, do you remember discussing anything else with her?
A. I don't.

Q. After Frances Broncaccio's death, did you speak with any family members?
A. Yes.
Q. Do you know who you spoke with?
A. I'm sure I spoke with Toni Antonetti. That's the name I wrote in my progress note.
Q. Do you remember speaking with a male as well as a female?
A. I don't.
Q. Do you know for sure who you talked to after Frances Broncaccio's death?
A. I know for a fact that I wrote in my progress note the name Toni Antonetti, so that's the one person I recall, and I recall speaking to a daughter, and beyond that I don't really recall.
Q. Did you tell the family that you believe Frances Broncaccio died from an aortic aneurysm?
A. I think I told them I suspected an aneurysm, yes.
Q. Did you tell any of the family members that that is a diagnosis that is commonly missed?
A. I don't remember my exact words, but I do recall trying to convey to the family that this was a diagnosis that was extremely difficult to make and often presented as other problems.

I was trying to comfort the family and I may

not have comforted them with that fact, but my intent was that this was a difficult to diagnose problem.

Q. As a CDU physician, do you have admitting privileges at the Clinic?

A. Independent of my being a CDU physician, I have admitting privileges at the Clinic. I actually -- that's part of my hospitalist role, which I think actually came at a later time. I don't remember exactly.

Q. Let me ask you, in December of '97, if you had suspected that a patient had an aortic dissection, would you have privileges to admit that patient to the Cleveland Clinic?

A. I don't recall that in December of '97 I had admitting privileges at the Cleveland Clinic. I think it was at about that time I was getting them. I'm not sure the point of your question.

Q. Well, if in December of '97 you wanted to transfer a patient, such as Frances Broncaccio, to the Cleveland Clinic, how would you do that?

A. I would have made arrangements to get her admitted. I could have gotten her admitted. I would have called the internist on call, who would have authorized the admission. That's actually how the

scenario happens. The CDU physician has to call the internist on call who authorizes the admission.

Q. Have you ever had a problem doing that?

A. No.

Q. Are you board certified in any area of medicine?

A. Yes.

Q. What area of medicine?

A. Internal medicine.

Q. Any other areas?

A. No.

Q. Do you agree that the diagnosis of aortic dissection was not made prior to Frances Broncaccio's arrest?

A. Yes.

Q. And do you agree that she did not receive treatment for an aortic dissection prior to her arrest?

A. Yes.

Q. Do you agree that an aortic dissection is fatal if untreated?

A. Much of the time. There are nonfatal aortic dissections, but it's a disease with a high mortality.

Q. And do you know what the treatment is for an aortic dissection?

A. Yes. It depends on the type of aortic dissection that you have.

Q. What types of treatment are available?
A. Medical and surgical.
Q. What type of medical treatment can be used to treat a patient with an aortic dissection?
A. Again, it depends on the type of aortic dissection because the aorta is a long organ --
Q. For a thoracic --
A. -- and can dissect in several areas. Thoracic dissections there are two major types, proximal and distal. Distal aortic dissections may often be managed medically without surgery and just treated with lowering the blood pressure, often with a Beta blocker.

Initial management of a proximal aortic dissection includes usually a Beta blocker to lower the blood pressure and to reduce the shearing forces of the blood flow, and then you need to image the patient and find out the extent of the dissection, and then you need to involve your surgical colleagues because it's usually required surgery and even then there's a high mortality.

Q. Do you have Beta blockers available to you at the Kaiser Parma facility?
A. Yes.

MR. RUF: Okay. Thank you, Doctor,

that's all I have.

MS. REINKER: Okay. I presume you're going to request this written?

MR. RUF: Yes.

MS. REINKER: When the transcript is written up, you have an opportunity to review it, make any corrections that you think are indicated. I suggest that you not waive signature so you have a chance to do that. So signature is not waived.

And can we also agree he has more than seven days and he doesn't have to go to the Court Reporter's office?

MR. RUF: That's fine.

MS. REINKER: Okay. Are you going to request this right away, Mark?

MR. RUF: Yes.

MS. REINKER: Would you send me a copy and I'll get it to him.

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STEPHEN W. RYDER, M.D.

C E R T I F I C A T E

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, STEPHEN W. RYDER, 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 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 8th day of December, 1999.

Laura L. Ware, Ware Reporting Service
3860 Wooster Road, Rocky River, Ohio 44116
My commission expires May 17, 2003.