DOC. 383

IN THE COURT OF COMMON PLEAS OF
CUYAHOGA COUNTY, OHIO

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TINA HAYBURN, Administrator of the Estate of HALYNA SKRYL,
Plaintiff,
vs.
DEACONESS HOSPITAL, et al,
Defendants.

: CASE NO. 224348

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Oral deposition of LUIS E. SALA, M.D., taken at his offices at 1801 Pine Street, Philadelphia, Pennsylvania, on Tuesday, January 19, 1993, at 10:00 p.m., before Patricia Crudo, Court Reporter and Notary Public, pursuant to notice.

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SCHULMAN/DeSIMONE
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(It is agreed by and between counsel that certification, sealing and filing are hereby waived; and that all objections, except as to the form of the questions, are reserved until the time of trial.)

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LUIS E. SALA, M.D., having been duly sworn, was examined and testified as follows:

BY MS. KOLIS:

Q. Just for the record, could you please state your name and your professional address?

A. Luis, L-U-I-S, middle initial E, Sala, S-A-L-A, 1801 Pine Street, Philadelphia, Pennsylvania, 19103.

Q. And, Doctor, have you given a deposition before?

A. Yes.

Q. You certainly don't need any reminders about the rules of deposition. Basically, however, let me say that if I ask a question which is unintelligible to you for whatever reason, you can tell me that you don't understand what information I'm seeking, and we will attempt to reach some common ground to get

the information out. Okay?
A. Okay.
Q. And you, of course, know to answer verbally so the court reporter is not placed in a position of interpreting your body language.
A couple of preliminary matters, this morning I was provided with a copy of your CV. I'm assuming this is your current one? If you would like to see it just to make sure I received the appropriate document?
A. Right. Yes. The only addendum I would put in that -- no, it's there.
Q. Okay. You were looking for an addendum but it is included; is that correct?
A. It is, yes.
Q. I'm probably going to go through a little bit of your medical background and we won't belabor all the points but there are a couple of things I wanted to ask you about the information that is contained on here. I didn't note that your CV contained a list of any publications.
A. Yes.
Q. Have you authored any articles?
A. Yes.

Q. Can you tell me approximately how many?

A. Three.

Q. Do you know the titles of those three articles and their dates of publication?

A. Not the exact titles. I know the subject matters.

Q. So could you just tell me what subject matter is?

A. One was about -- it was a letter to the editor in the New England Journal about a recurrence of a thyroid carcinoma thirty-three years after the primary. Another one is about axilla-femoral bypass graphs. That was in S T and L in 1978. And another one about the effects of parietal cell vogotomy on the lower esophageal sphincter, which was also published in the late seventies.

Q. Okay. Have you other than those that you have just mentioned done any research and writing in the area which concerns the case which you have been retained to be an expert in?

A. No.

Q. I just want to be clear on that. Would you for my convenience provide Mr. Groedel with the precise names and citations of the articles that you

just referred to so I can look them up?
A. Sure.
Q. Thank you very much. All right.
Let's go through basically your medical education if we can quickly. You're CV indicates that you are a doctor of medicine with your degree being obtained in 1969 from the University of Puerto Rico; is that correct?
A. Correct.
Q. You received your undergraduate degree from Georgetown in 1965?
A. Correct.
Q. Can you tell me just so that I have some understanding what type of training or schooling you received at the University of Puerto Rico?
A. It's a double AMC-approved medical school.
Q. Okay.
A. So the training and the textbooks and everything is identical to stateside.
Q. That's what I was really trying to elicit, the comparison to education in this country.
A. It's identical.
Q. Okay. And then you did your internship at the University of Pennsylvania; correct?

A. At Graduate Hospital, two blocks from here.
Q. And then you did your residency at the Graduate Hospital from '70 to '71?
A. That was in internal medicine.
Q. Okay. And then you followed up with a general surgery residency?
A. At Presbyterian Hospital and the University of Pennsylvania also.
Q. This sounds like a silly question, but during your residency program in general surgery, did you develop any specialty?
A. Not while I was doing general surgery other than general surgery.
Q. Okay. Following that, you had a surgical fellowship, is that accurate?
A. I did two surgical fellowships.
Q. Why don't you just briefly tell me about each surgical fellowship?
A. '75 through '76 at Leahy Clinic in Boston, I did a surgical fellowship in gastrointestinal surgery.
Q. Okay?
A. And the following year I did one at Pennsylvania Hospital, also a University of

Pennsylvania affiliate, in general vascular surgery.

Q. All right. And that took us up to 1977 at which point you took your first board in general surgery; is that correct?

A. I believe that was about the same time.

Q. I'm just cheating. I'm reading it off your CV.

A. Fine.

Q. Did you pass your boards in general surgery the fisrt time?

A. Yes, I did.

Q. It looks like about five years later you were certified in vascular surgery?

A. Correct.

Q. How many times were you required to sit for that board?

A. You're required to pass it once.

Q. Okay.

A. Well, I'm asking if it took more than one try to pass it.

A. That was the first time they gave the test.

Q. It was the first time?

A. The very first time I was given the test.

My certificate number is 310. I was one of the very few nonprofessors to even sit for the test. This paper isn't here. I'm sorry.

Q. That's okay. I will take you at your word. And then I see numerous employment situations. Following that, we might touch on some of those, but let me ask you have you been involved at all in teaching medicine?

A. Since my residency.

Q. Are you currently holding a teaching position?

A. I'm an associate clinical professor of surgery at the University of Pennsylvania.

Q. What time commitment does that take from you?

A. It varies. It's mostly with the residents; some are with the medical students.

Q. Okay. I don't know that that specifically answered my question. Is this something you do on a weekly basis?

A. Yes.

Q. What time commitment per week would you say you're involved in that?

A. It varies.

Q. Are you teaching a classroom setting or is this strictly clinical?
A. Mostly clinical, occasionally lecture. I also lecture out of their continuing medical education courses around the area.
Q. Okay. We are here today at your medical offices at 1801 Pine Street and I did receive a medical report which you drafted in this particular matter which indicates that you're in the practice of general and vascular surgery. So that I can understand the perspective from which you wrote this report, tell me what your practice consists of. What are you doing on a regular basis?
A. I do about seventy-five percent vascular surgery and about twenty-five percent general surgery.
Q. Okay. Contained within that seventy-five percent that you are calling your practice of vascular surgery, generally speaking what kinds of vascular surgery are you doing?
A. Everything except the heart.
Q. Define for me vascular surgery.
A. It's surgical endeavors geared mostly at diseases of the arteries, veins, and very, very

infrequently at lymphatics, both of an acute and a chronic nature, acquired infrequently hereditary.

Q. Okay. Within that subset of seventy-five percent vascular surgery, is there a particular surgical procedure that you specialize in, something that you do more than anything else in that group?

A. No.

Q. Okay. How do you obtain your patients?

A. Referral either mostly by other physicians, not infrequently by patients.

Q. Okay. In terms of physicians that refer patients to you, what specialties would you say refer patients to you?

A. General practice, internists, orthopods, neurologists, hematologists, gastroenterologists.

Q. So you get referrals from a wide variety of sources?

A. Right.

Q. I was going to ask you at what point you became involved in those cases, but I'm assuming it's the point at which the primary physician perceives a surgical consultation is needed?

A. Occasionally it's not just surgical. Frequently they are not sure whether it is or isn't

surgical. And in the field of vascular, I'm called upon not infrequently to treat situations that are nonsurgical but that are vascular.

Q. During your career as a surgeon, how many carotid endarterectomies would you say you performed?

A. I do about twenty to twenty-five a year.

Q. How many years have you been a surgeon?

A. Fifteen. I don't think they were that frequent early on. I would say that rate has been over the last ten years.

Q. So over the last ten years about twenty to twenty-five a year?

A. About.

Q. And you indicated earlier on they weren't that frequent. Do you know why they weren't that frequent earlier on?

A. The Philadelphia area was very conservative about carotid endarterectomies. In the late seventies it was unclear to many people. That's I believe mostly the cause of that.

Q. When you say it was unclear to most people, what do you mean?

A. Many of the neurologists were extremely

conservative at that point in time and did not recommend carotid surgery be done.

Q. In other words, as a treatment of carotid disease, they were not looking for surgical intervention, they were medically managing patients?

A. Correct.

Q. Okay. What do you attribute the turn from that conservative bent on the part of the neurologist, if anything, if you have some perception of it?

A. Some haven't changed.

Q. Well, let's not worry about the some that haven't. Taking into account what you said, early in your career there apparently was a conservative group of neurologists who didn't perceive surgical intervention as -- I don't want to use the word if it's not correct, but appropriate for the care of carotid disease. At some point I gather from what you're telling me, that perception changed to some degree causing you to do more carotid surgeries per year. Am I misstating what you told me?

A. That's a long statement with many pieces to it. It's partially true. It didn't cause me to do anything. It allowed me to use my surgical

expertise. I was kind of convinced that it was a good operation all along.

Q. Okay. Well, let me ask you something. How did you become kind of convinced that it was a good operation all along?

A. Because I thought that it prevented strokes.

Q. Simple.

A. Yes.

Q. And was that based on your clinical experience?

A. And my reading.

Q. And can you refer me to anything that might occur to you at the moment as I ask the question that you did in the nature of reading to support that it was helpful in the prevention of strokes?

A. No, nothing specific.

Q. Okay. No problem.

How is it that you became involved in this particular case?

A. I wasn't involved. I was asked by Mr. Groedel to review the case,

Q. Had you ever prepared a review of a medical case for Mr. Groedel or his law firm before this one?

A. No.
Q. How is it that they became acquainted with you, if you know?
A. No.
Q. You have no id-a?
A. I believe that I gave a deposition in Cleveland some years ago, and 1 assume out of that my name became known to him.
Q. Let's spend a brief amount of time hopefully discussing medical reviews. I'm going to assume that you do do medical reviews for malpractice cases?
A. Yes, I do.
Q. All right. How frequently do you review cases?
A. A lot more requently than I have to testify.
Q. We are going to break that down.
A. I'm sure that doesn't answer your question. I don't know. I cannot give you number of cases per year because I think it's varied. I can't give you percentage of time dedicated, but it's minimal if that's the way you want to phrase it.
Q. Well, let me ask you how many years have you

been reviewing medical negligence cases?
A. I'm not sure I can answer that, but I think somewhere since about 1985 or six.
Q. And how is it that you became involved in the review of medical negligence cases?
A. Initially I got on my white horse and I thought that I could really have an impact.
Q. An impact upon what?
A. On the controversy of medical malpractice claims, in the sense that I thought that maybe there weren't enough honest people out there saying, yes, this is good and, B, that was bad. And maybe I for some reason or other, again, in my naivete, I thought I could influence it. So I made myself available. I truly do not recall what the first time was or anything such as that.
Q. I'm not asking you to actually recall that, but at some point in the mid-eighties you determined that you wanted to become involved, I guess I'm going to call it forensic medicine, sort of looking into and exploring things not as the actual physician?
A. I always associated forensic medicine with legal and pathology rather than with clinical.

Q. Okay. Well, assume for the moment that you don't agree with my characterization in that regard, did you when you began this endeavor in 1985 place yourself on a service of expert witnesses?
A. No.
Q. How did you make it known to the general legal public I suppose that you would be available to be an expert witness?
A. In all honesty, I do not know. I honestly do not recall. It made my former associate did seek out this endeavor for his own reasons. I don't want to characterize him, but I wouldn't be surprised if it was for financial reasons. And it's possible that my name became known that way because we shared a letterhead.
Q. Who was your former associate?
A. Michael S. Weingarten, W-E-I-N-G-A-R-T-E-N.
Q. And is he still a physician?
A. To the best of my knowledge.
Q. Do you know where he practices medicine?
A. Graduate Hospital.
Q. So he is located here in Philadelphia?
A. Correct.
Q. So you began this in 1985.

A. Plus or minus.
Q. Plus or minus. You have already indicated that you can't tell me the precise number, but I would like an approximation of how many cases you think you reviewed since 1985 through the present.
A. I would be purely guessing, somewhere in the vicinity of twenty or twenty-five, maybe.
Q. Twenty to twenty-five in this eight-year period?
A. I'm guessing, but I don't think it's much more than that.
Q. All right. Of those twenty to twenty-five, can you give me an approximation in terms of a percentage whether the reviews were done for the patient or the physician?
A. You mean plaintiff or defendant?
Q. Whichever you choose to call them.
A. Fine. I would say about sixty percent for defendant and forty percent for plaintiff.
Q. When is the last time you testified in court on behalf of a plaintiff?
A. In court?
Q. Yes.
A. I don't think I ever have.

Q. Okay. When is the last time you testified in court for a physician defendant?
A. Last fall.
Q. Can you tell me what kind of case it was?
A. Vascular trauma.
Q. And where did this case go to trial?
A. Philadelphia.
Q. What was the name of the plaintiff's attorney?
A. I honestly do not know.
Q. What was the name of the defendant's attorney?
A. Mr. McGilvery from Wright, with a W, Young and McGilvery.
Q. And who was the defendant physician?
A. Initially there were two. There was a Dr. Franklin and a Dr. Karnik. I believe that is spelled K-A-R-N-I-K.
Q. Okay. Moving on from that area, you did prepare a report at the request of Mr. Groedel and I have received one report dated October twenty-seventh, 1992. Is this the only report which you prepared in this particular case matter?
A. To the best of my knowledge, yes.

Q. Okay. When did you become involved in this case?

A. I don't recall.

Q. Do you have some documents that might refresh your memory as to when you actually became involved?

A. I have to keep on going reading these letters until I find which was the first one.

Q. That would be fine.

MR. GROEDEL: I think it's in that stack there, Doctor.

THE WITNESS: I just don't know which is the first one. I have one here. Oh, yes. April fifteenth, 1992, was the date of the letter, so sometime in April.

BY MS. KOLIS:

Q. When you were first contacted, what were you asked to do?

A. To review the data that he would provide me.

Q. And did he send data with that letter in April?

A. Yes.

Q. What did you receive in April?

A. I believe I received a copy of the

admissions at the Deaconess and at the Cleveland Clinic, and subsequently to that I believe I received copies of the depositions of Lucy -- I can't pronounce that.

Q. Trusalka (phonetic)?

A. Yes, Tina Hayburn, and Dr. Moysaenko.

Q. All right. The report --

A. But I believe they came separately.

Q. That's fine. I wasn't going to pick at what dates. I was just curious when you were initially contacted.

All right. In the report which you prepared dated October twenty-seventh, 1992, there is a listing of material which you reviewed. And pretty much you have recapped it for me, Deaconess Hospital, Cleveland Clinic, deposition of Moysaenko, Trusalka, Hayburn, and plaintiff's expert report by Dr. Joseph Durham. Those were the materials which you indicated furnished the basis of the preparation of the report of October twenty-seventh, 1992.

Since the time that you prepared that report, have you been supplied with additional information by way of medical records, deposition or other expert reports?

A. Yes. I have received two things: One, the final amended anatomic diagnosis of the autopsy report and, second, the deposition by Dr. Durham.

Q. Have you had an adequate opportunity to review those additional documents?

A. Yes, I have.

Q. Do the additional documents which you have received to review in any shape or form change any contention which you included in your original report?

A. I do not believe so, no.

Q. Other than receiving those pieces of material and everything preceding it, do you feel that you received everything from Mr. Groedel that you possibly needed to evaluate this case?

MR. GROEDEL: Objection. Go ahead.

THE WITNESS: Yes.

BY MS. KOLIS:

Q. I'm just asking if for some reason you feel disadvantaged if there is missing information.

A. Not off the top of my head, no.

Q. Okay. What amount of time did you spend reviewing the medical records of Deaconess and the Cleveland Clinic in preparation of this report?

A. Those two specific --
Q. Just those two things.
A. About four hours.
Q. Did you take notes as you read?
A. No; I seldom do that.
Q. So you did not take notes of any sort, you just read them for an overall picture?
A. Correct.
Q. So sitting on your desk is a stack of materials. Can I assume those are the only materials in your possession as it regards this case?
A. Correct.
Q. Did you prior to the date of October twenty-seventh, 1992, prepare a preliminary report of any sort?
A. No.
Q. I want to ask you several questions about the report that you prepared. You obviously have a copy sitting in front of you to refer to. The initial portion of your report undoubtedly is your synopsis of what you think the medical records state. One of the first statements that you made in your report is that this patient presented with a

known history of hypertension. Is that accurate?
A. To the best of my understanding, yes.
Q. And you took that out of the medical summary; is that correct?
A. Some place.
Q. All right. Define for me if you will hypertension.
A. Hypertension is a blood pressure above the norm for the age, sex, comparable patient population.
Q. Do you have an opinion based upon the age, sex and normal population as it relates to Mrs. Skryl what a normal blood pressure would be?
A. No.
Q. Is that something out of your field of expertise?
A. I'm not an internist, but I just don't know how heavy she was. I understand that the term obese was used several times.
Q. Well, can you not locate the data in the medical records?
A. I don't think they weighed her.
Q. Correct me if I am wrong, did you say that you weren't an internist?

A. I am not an internist, no. I did two years in medical residency. I'm board eligible but did I not sit for my board.

Q. In evaluating people for surgery, do you not have to have some understanding of what a normal blood pressure is for a person?

A. Yes.

Q. Do you have to consult with another physician to determine the accuracy of your recommendation?

A. No, but I do for whether there is a need for treatment, yes.

Q. Excuse me. Could you explain that answer?

A. Well, somebody -- if you had a blood pressure of one hundred fifty over ninety -- let me make that different -- one hundred fifty over eighty-five, some people might consider that need for therapy, yet somebody who is sixty-eight and overweight, they might consider one fifty over eighty-five not to be hypertensive. But I really don't know.

Q. Okay. So that really is not your forte, is that what you're telling me?

A. Obviously.

Q. Other than pulling out of the record that she had a known history of hypertension, to what degree do you know what that history of hypertension consisted of in terms of duration, severity, and ability to have it under control, or do you have no information?

A. Absolutely none prior to the visit to the emergency room.

Q. Okay. But you do know that she was being treated by the administration of a drug called Lopressor; is that correct?

A. To the best of my understanding, yes.

Q. All right, Let me digress from your report and let me ask you a nice, broad general question. You have read the deposition of Dr. Durham, have you not?

A. Correct.

Q. Do you understand his point of view in believing that Mrs. Skryl was a candidate for surgical intervention?

A. I don't believe it was as Mrs. Skryl, was it?

Q. Yes.

A. That's right. There's --

Q. The administratrix's name is different.
A. Fine. That gets me confused. I'm sorry. Do you want to repeat that question?
Q. Sure. You told me that you read the deposition of Dr. Durham?
A. Correct, I did.
Q. And I assume you read it so that you could understand the basis for his opinions, the facts upon which he concluded what he did?
A. Correct.
Q. Did you get the understanding from reading his deposition that he believed that Mrs. Skryl was a person who was a candidate for surgical intervention?
A. Yes.
Q. Do you disagree with his conclusion?
A. Yes.
Q. Okay. Can you in medical language or simple English, whichever you're more comfortable with, explain to me specifically why you disagree with his conclusion?
A. I guess it's less of an either/or than a matter of timing.
Q. Okay.

A. At that particular point in time, I do not believe she was a candidate for surgical intervention.

Q. Why is that? First of all, at what point in time do you believe that she was not a candidate for surgical intervention?

A. At any point in time during her stay at the Deaconess.

Q. At any point in time. All right. Can you tell me the basis for that opinion on your part?

A. Yes.

Q. Okay.

A. She had not been completely evaluated, she had not had an arteriogram, and she was hypertensive.

Q. Let's sort of break that down, because each of these areas was covered in your report but now I think you are probably in a position to be a little more complete about it.

When you say she was not completely evaluated, what do you mean?

A. The complete evaluation would have included an arteriogram --

Q. Okay.

A. -- would have eventually been an arteriogram which would have been the definitive study off of which a decision to undergo surgery, to recommend surgery or not would have been based.

Q. Why didn't that occur in this case?

A. I guess several factors: Number one, and most important, I think that she was hypertensive, that blood pressure was very labile. It was fluctuating fifty to sixty millimeters of mercury systolic and a good twenty to thirty millimeters diastolic; and number two, she had had a completed stroke; and number three -- those are the two main reasons. Number three, I think that she was -- I hate to open up a can of worms, but it seems to me like the rest of the therapy was not going to be taken care of at the Deaconess.

Q. Why does it seem that way to you?

A. Because she was supposed to be transferred.

Q. Okay. Well, let's go backwards a little bit. I like to jump around just because certain questions occur to me at certain times.

A. Not because it confuses me?

Q. Let me -- no, certainly not.

A. Okay.

Q. Let me ask you, I am going to have to assume that you are involved as part of your practice of vascular surgery in the diagnostic function, diagnosing vascular diseases; right?
A. Correct.
Q. That is probably elementary. You have indicated that she had a completed stroke.
A. Correct.
Q. You tell me your definition of a stroke.
A. An irreversible neurologic deficit or a fixed neurologic deficit lasting more than twenty-four hours.
Q. How does one establish that a neurological deficit has become fixed?
A. You go to medical school and you learn about it.
Q. Good answer. For what period of time does a neurological deficit have to exist for it to become determined fixed?
A. I already said that, twenty-four hours.
Q. I just wanted to make sure that I heard you correctly. I didn't mean to --
A. It can improve over the course of time, but if it has lasted for twenty-four hours, it is now a

completed stroke as opposed to a transient ischemic attack, which by definition is less than twenty-four hours.

Q. When you use the word transient ischemic attack, is that interchangeable with your use of RIND?

A. No.

Q. Briefly can you distinguish for me the difference between a TIA and an RIND?

A. You're going to have to let me define them. A TIA is a transient ischemic attack, which is a hemispheric, not a cerebral vascular, but hemispheric dysfunction, motor, sensory, or mixed, which lasts less than twenty-four hours, and there is total regression and no symptoms beyond that.

Q. No symptoms beyond --

A. That episode. It resolves completely. There is no deficit downstream from that.

Q. Is there a time frame in which it must resolve?

A. Twenty-four hours.

Q. So it stays on the other side of the line of the definition of stroke?

A. Yes.

Q. Okay.
A. Anything that lasts more than twenty-four hours by convention, by definition is a completed stroke.
Q. Okay. Definition of RIND?
A. An RIND, which is also called by others, not by me, a crescendo TIA, is a series of completed strokes which keep on getting worse. It has no particular time limit. It's usually defined in a matter of hours or one, two, three days, no more than that, in which a stroke occurs, there is improvement, it extends, there is improvement, it extends, there is improvement.

And the reason I distinguish between crescendo TIAs and RIND is because in my mind, although they end up being the same in terms of what I think needs to be done about it, 1 believe that a crescendo TIA lasts less than twenty-four hours, does not have a fixed deficit, the next time you have it, the symptoms may or may not be more, but they keep on coming in sequence without a definite irreversible portion to a clinically -- and I emphasize clinically -- whereas an RIND has portions of that which the symptoms do not regress. In other

words, it does get worse or deeper and then it gets a little bit better or lighter, but does not always come back to fully normal, where a TIA should come back by definition. So they are very similar, but in one the neurologic deficit comes back completely and in the other one it doesn't clear up completely. That is my definition of it.

Q. All right. I assume that you are acquainted with the admission history of Halyna Skryl?

A. That's a correct assumption.

Q. And you can refer to your medical notes at any time that you need to. If you had been the physician on duty, just you with your specialty just for some strange reason you're in an emergency room one night --

A. It would have been strange, yes.

Q. Of course, based upon your CV. And you had seen this patient, and you had recorded the findings that are in the chart, what would have been your initial diagnosis, or your admitting diagnosis I suppose is more accurate?

A. TIA versus completed stroke.

Q. Right. And why would that be your diagnosis?

A. Because she still had -- she had had symptoms developing that morning, there were still ongoing symptoms present on physical examination, and the twenty-four hour period was not over with.

Q. All right. And it does matter that you would be diagnosing a TIA versus a completed stroke; correct?

A. You said that, I didn't.

Q. Does it matter?

A. To what? To whom?

Q. Well, does it matter in terms of what the course of treatment or intervention will be on behalf of this person that you leave open that it is not yet a completed stroke?

A. Would I have done anything differently?

Q. That is not the question I'm asking.

A. Does it matter -- it's the "does it matter" that bothers me, because I'm not sure what you mean by that.

Q. Well, let's put it this way. If you had evaluated this person given this set of symptoms that she presented with and you made an admitting diagnosis of stroke, would you have been doing

something less than adequate from a medical point of view, or doesn't it make any difference?

A. Less than adequate?

Q. Yes.

A. No. I would never have done anything less than adequate.

Q. I'm asking you --

A. That's what you said.

Q. Okay. I didn't mean to imply that you personally would do something like that, but if for some reason your admitting diagnosis read stroke versus TIA versus stroke, would you be doing something that might potentially compromise the patient?

MR. GROEDEL: Objection. *Go* ahead.

THE WITNESS: I knowingly or wittingly would never have done anything that would have compromised the patient.

MS. KOLIS: That is not the question.

THE WITNESS: I obviously don't understand it.

BY MS. KOLIS:

Q. Do you know what the admitting diagnosis was in this case?

A. Whose?
Q. Well, we can start with the emergency room physician.
A. CVA.
Q. Meaning cerebral vascular accident?
A. Correct.
Q. Does an admitting diagnosis by the ER physician of CVA include within it TIA?
MR. GROEDEL: Objection.
THE WITNESS: No.
BY MS. KOLIS:
Q. Okay. What does it mean to you as a physician when you see the admitting diagnosis listed as CVA?
A. It means that it patient has had a completed stroke.
Q. It sure does, doesn't it?
A. Yes.
Q. Okay. Can you find in the record what Dr. Moysaenko's admitting diagnosis was?
A. On his note of 1/14 it says cerebral vascular accident, rule out subdural hemorrhage and hypertension.
Q. Okay. Based upon your medical background

and experience as a surgeon, when you see that assessment does that include within it TIAs?
A. At what time did he write this?
Q. Well, looking at the chart can you tell what time Dr. Moysaenko examined Mrs. Skryl?
A. No.
Q. All right. If I told you based on his testimony that he saw her in the morning of the fourteenth, does that help you in terms --
A. I don't recall exactly what time her symptoms occurred. I know that she went to the emergency room at approximately three p.m.
Q. Okay.
A. And it says that the symptoms had happened that morning. Wait a minute. It says -- it just says "today."
Q. Okay. Did you read Dr. Moysaenko's deposition?
A. Yes, but I don't remember it word-for-word.
Q. Did you index it in any method?
A. No.
Q. Does it strike your recollection that he was actually called on the thirteenth and conferred with the emergency?

A. Over the phone, yes.
Q. And in fact, he made the decision to admit her; is that accurate?
A. He accepted the patient I believe is correct.
Q. Sure. Did he not issue orders --
A. Yes.
Q. -- for the patient?
A. Over the phone.
Q. Right, based upon what was described to him as the set of symptoms; correct?
A. I assume so, yes.
Q. Just to make sure we are on the same page here. Based upon hypothetically having placed the patient in your care, we are going to go back again. Based upon the set of symptoms she presented with and your initial admitting diagnosis of TIA versus completed stroke, what tests would you have ordered for this person?
A. A CT scan, a cardiac monitor, an electrocardiogram, a halter is probably more efficient, a cardiac echo, and a Doppler -- a Duplex evaluation -- not a Doppler, but a Duplex evaluation of the carotid arteries.

Q. Let's just real quick go through each thing that you would have ordered and you tell me why you would have ordered it. CT?
A. Basically to make sure that there was no intracranial hemorrhage.
Q. Was there any set of symptoms that she presented with that were suggestive of an intracranial hemorrhage?
A. The fact that she was hypertensive.
Q. Okay. And I believe, and I'm doing this from memory, you might want to look at your paper, that you felt that that would have to be the highest level of concern is the intracranial hemorrhage aspect. Am I wrong about that?
A. Yes.
Q. All right. And why is that?
A. Because there are things that not infrequently need to be done acutely if that is the case. And then there is contraindications to doing other things if that is the case.
Q. Let's evaluate that just for a second because I did note that you felt that was an important diagnosis to exclude or include. If it had been determined that there was an intracranial

hemorrhage, what would have been done acutely or what could have been done acutely?

A. Well, the primary thing would have been to control the blood pressure, and second, get a neurosurgeon in and see if -- again, now I'm out of my field. At that point in time, Luis backs out and says go see the neurosurgeon.

Q. Okay.

A. Because intracranial hemorrhages can be subarachnoid. They can be due to aneurysms. They can be to trauma, which may or may not have been recalled by the patient, et cetera. So I am now out of my field of expertise.

Q. Okay. Can I gather from your answer that depending upon the diagnosis if there had been an intracranial hemorrhage detected on the CT, that surgical intervention, not by yourself, not by the vascular surgeon, but by a neurosurgeon would have to be contemplated?

MR. GROEDEL: Objection.

THE WITNESS: Contemplated?

BY MS. KOLIS:

Q. Right.

A. I'm out of my field of expertise.

Q. All right. But suffice it to say there was no evidence of intracranial hemorrhage; is that correct?
A. Correct.
Q. Do you have a recollection as we sit here or can you look at it in your notes at what time that CAT scan actually occurred on this patient?
A. I do not recall.
Q. Can you locate the test results in the chart?
MR. GROEDEL: Look under x-ray.
THE WITNESS: That is kind of where I'm going.
BY MS. KOLIS:
Q. Can you locate it?
A. Yes, I believe it was both done and reported on the fourteenth.
Q. Okay. Can you find an indication in terms of time when it occurred?
A. Not on the official report. Let me look under progress notes. It was completed by twelve thirty p.m.
Q. On what date?
A. On the fourteenth.

Q. And how do you know that?
A. Because there is a stamp on the progress notes. It says CT scan completed, twelve thirty p.m.
Q. Moving to the three other tests that you indicated you would have ordered, and just to expedite this, all four of these were written as orders by this physician, Dr. Moysaenko; is that correct?
A. I believe that they were not written by him. They were given to a nurse who translated them. They were verbal orders given.
Q. Right. We are playing with semantics. When I say written, I mean he indicated by telephone that that's what he wanted to occur since he wasn't there to examine the patient and that someone recorded them and they became orders by that mechanism, I guess?
A. They were ordered by him. They were not written by him.
Q. All right. That's fine. The halter, what was the purpose of the halter monitor?
A. To find out if there was any cardiac arrhythmia or irregularity to the heartbeat which

would decrease the efficiency of the heart and potentially cause a neurologic problem, or cause embolization of something which in turn could have caused the neurologic event.

Q. All right, What in her presentation to the hospital would have required this particular test?

A. A stroke.

Q. The stroke-like symptoms, is -- are you --

A. The stroke or the **TIA** at that point.

Q. Right. And it was a **TIA** at that point, was it not?

A. By definition.

Q. All right.

A. It was a stroke. We just didn't know that it was not.

Q. Okay. And the cardiac echo?

A. What?

Q. Purpose?

A. To make sure there wasn't any clot in the heart or any source of any material that could have embolized like from mitral or aortic valve.

Q. And the Duplex evaluation of the carotids?

A. **To** ascertain whether there was or not any disease in the carotid arteries which could have

contributed to the stroke, TIA.

Q. Doctor, I think you and I agree that it's necessary for the proper care and treatment of a person who presents with the symptoms that Mrs. Skryl had to attempt to determine the source of that set of symptoms? Is that an accurate statement that you would agree with?

A. If you let me say cause, yes.

Q. Okay.

A. "Source" implies to me for some reason or other it would have implied that something went from one place to another, as an emboli.

Q. Okay. I will take cause.

A. The cause is the broader.

Q. And there are numerous or could be numerous causes for the set of symptoms which she presented with; is that correct?

A. Absolutely.

Q. Once again, you're that person who has examined Mrs. Skryl.

A. Yes.

Q. What things cross your mind as the cause of the set of symptoms that she presented with?

A. Under her particular circumstances?

Q. Absolutely.
A. I would think first, second, and third of her hypertension.
Q. When you say first, second, and third of her hypertension, what does that mean?
A. Her blood pressure was two hundred over one hundred twenty.
Q. Right.
A. I would have thought the history of hypertension on therapy, and somebody coming in with a stroke, slash, TIA I would have thought first that that is the more likely cause of her neurologic problem at that moment.
Q. What other possible causes were there based on the set of symptoms that she presented with?
A. How much time do you have?
Q. The time that you have limited me to, twelve o'clock.
A. There are other. There are many, many causes of stroke. By definition a stroke is a cerebral vascular accident such that anything that causes a neurologic problem in the central nervous system that has as its etiology any of the many vascular problems that can occur is a stroke. Do

you want a list of all of them?
Q. No.
A. Good.
Q. In Mrs. Skryl's case, the set of symptoms that she had -- first of all, what do you recall to be her predominant neurological symptoms that she presented with? And you may read from the chart, of course.
A. Right-sided weakness and aphasia.
Q. Okay. By the way, did you track for yourself those two neurologic deficits through her hospital course?
A. Track?
Q. Yes. I'm aware there was improvement, but I'm also aware that there was not complete resolution.
Q. All right. That's what I meant by track. Did you follow them through the chart to see in what form they existed?
A. Yes. There was improvement but not complete resolution.
Q. That was right-sided weakness --
A. And aphasia.
Q. All right. Could you please give me your

definition of aphasia?

a. Aphasia?

Q. Yes.

A. Aphasia is inability to communicate from the individual with the rest of the world. There is dysphasia which is function, there is dysfunction, there is receptive aphasia, there is expressive aphasia.

Q. Do you have a recollection of what type of aphasia?

A. Aphasia. Forget the PH, you make it an F. It's simple.

Q. Of what type, if any, she actually had documented in this chart?

A. They use a term called fluent aphasia, which I don't understand what that is. I don't know that. But when they speak of slow, garbled speech, I usually consider that to be an expressive aphasia.

Q. Okay.

A. The person has either mechanical disability in forming the words, or could also have a difficulty finding the right word for what they are trying to say, as opposed to a receptive aphasia

which is when I am trying to communicate with a person who has that problem, I am not sure whether they understood what I said. When it's an expressive, it's I don't understand what they say.

Q. Do you have an opinion as to -- well, let me ask you this. In terms of neurological deficits, we grade them, don't we, in terms of mild, moderate, severe? Do you or don't you?

A. Emotionally, no. Personally, if I had any kind of stroke, mild, moderate, severe would be severe to me. Yes, people do. I have difficulty doing that because I'm not quite sure what is mild to one person and moderate to another. Personally. I mean that. You asked me, you got my opinion.

Q. No, I do believe you. Let me ask you a question. You spent some time with Mr. Groedel this morning, didn't you?

A. Yes.

Q. Did you and Mr. Groedel discuss the testimony of Dr. Westbrook which occurred yesterday?

A. He made reference to the fact that there had been a neurologist who had been deposed yesterday but I didn't know the doctor's name.

Q. You don't know Dr. Westbrook?
A. No.
Q. You haven't seen a report that was prepared by Dr. Westbrook?
A. No.
Q. And Mr. Groedel did not tell you what Dr. Westbrook testified to yesterday generally or specifically?
A. I think generally is all his comments were, and I can probably recollect even less than that.
Q. Can you tell me what you can recollect about what you were told about the testimony of Dr. Westbrook?
A. I'm drawing a blank honestly. If you asked me something specific, I may be able --
Q. If you unblank, will you let me know?
A. Sure. I think there was no more than four or five sentences to the whole thing.
Q. Okay. Well, there could have been four or five important sentence, but if you claim that you don't remember what you were told this morning, that is fine.
A. I don't remember.
Q. What you're indicating to me is that you,

yourself, in the determination of the care and treatment of a patient don't grade the severity of the deficits; is that what you're telling me?

A. No, no.

Q. What are you telling me?

A. What I'm saying is that to me any neurologic deficit is severe. I know that there are people that have systems in their own mind, but I'm not sure that these systems are meaningful in the sense that they are not comparable from one person to another and from one neurologist to another, and, for that matter, from one physician to the same physician the following day. I know what I would call a profound stroke. I know what I would think is mild, but to me personally, if it occurred to me is what I said, any stroke would be pretty severe.

Q. So that we don't get confused, you're using the word stroke and I'm using the word neurological deficit.

A. Fine.

Q. Okay. Do you have an opinion whether grading the severity of the neurological deficits is in any way meaningful in the determination of

whether a person needs surgical intervention to deal with those neurological deficits?

A. In the sense that if you have what you're going to call a profound or a deep stroke or a more severe stroke, you have less to gain by intervening surgically. Some people would look at that and say you also have more to lose if you don't do something because that's -- the person is only left with ten percent function. If you lose that ten percent, it could be worse. On the other hand, you could also argue that if an individual has a less severe or very mild stroke and you define it any way you want, then you have more to gain and more to lose if you err.

Q. I do understand what you're saying.

A. But the problem is that different individuals would look at the same set of circumstances two extremes of each other and look at it and act differently.

Q. When you say different individuals, are you referring to different physicians?

A. Individuals within the same specialty and certainly individuals within different specialties.

Q. Individuals within the subspecialty of

vascular surgery, I guess that's who I was referring to.

A. Well, once you get a vascular surgeon involved, you're almost, but not necessarily, almost made your decision already, if there is something surgical.

Q. You don't mean to imply that a vascular surgeon who is asked to evaluate a person is always going to recommend surgery?

A. No; quite the contrary. I was implying or stating that most of the time when the neurologist or the internist gets the vascular surgeon involved, he has already cleared the patient for surgery if it comes to that, if the surgeon says yes, you should, I can do something.

Q. Whose job is it to clear the patient, quote, unquote, for surgery?

MR. GROEDEL: Medically or surgically?

MS. KOLIS: Well, in the context which you just used it.

THE WITNESS: This is a team effort ultimately. The ultimate decision is a team thing. There are things that they are aware

of that I may not be. A lot of these things are judgment calls. I think that whoever the primary attending physician is who in turn calls the consultants in, that is the individual who is paving the way or blocking the way.

BY MS. KOLIS:

Q. But you can't become part of the team --

A. Unless I'm invited to the party.

Q. That's right. Unless that individual person in the different specialty understands and perceives the need for a surgical consult; is that a fair statement?

A. Understands and/or perceives or believes that there is a need for that, yes.

Q. Right. Did you get the impression in reviewing the medical chart and Dr. Moysaenko's deposition, and you did review Dr. Moysaenko's deposition; correct?

A. And I mentioned that I don't recall everything about it.

Q. All right. Did you get the impression that he was on top of the situation medically?

MR. GROEDEL: Objection. Go ahead.

MS. KOLIS: You can answer it.

THE WITNESS: Absolutely.

BY MS. KOLIS:

Q. Okay. Do you believe that it would have been medically indicated and appropriate for Dr. Moysaenko to have called in a neurological consult or a surgical consult prior to Mrs. Skryl's major stroke event?

A. I believe he did call a neurologist.

Q. In consultation?

A. I believe he did. I may be wrong but I believe.

Q. Can you show me where you can find that in the chart? And if so, indicate when he consulted with a neurologist.

A. Off the top of my head 1 believe that the neurologist was on his way to see her at the time she had her big event.

Q. Okay. Let me ask you this.

A. Let me just -- you asked me to look at it and that's what I'm going to do.

Q. Okay.

A. I don't know who Dr. I. Zackery is.

MS. KOLIS: He is not a neurologist,

if I'm allowed to testify.

THE WITNESS: I believe he is an ophthalmologist.

MS. **KOLIS:** He is an ophthalmologist.

MR. GROEDEL: Doctor, look at the **1/15** progress note.

THE WITNESS: Yes. It says Dr. A.A. Jucalong (phonetic) on consult, will call myself.

BY MS. KOLIS:

Q. Do you know what time of day that was written?

A. No.

Q. Doctor, she was admitted at three o'clock in the afternoon on the thirteenth. And just assuming for the moment that the note you're reading from the fifteenth is really a note indicating that a consultation has been called, that's a two-day delay or a two-day time period. Do you not believe based on the set of symptoms she presented with and her course in the hospital that a consult with a neurologist would have been warranted sooner?

MR. GROEDEL: Objection. You mean was required by the standard of care?

MS. KOLIS: Yes.
THE WITNESS: Absolutely not.
MS. KOLIS: Okay.
THE WITNESS: You smile a lot, but you asked me a question and I told you.
MS. KOLIS: That's fine. But you believe that one wasn't required?
THE WITNESS: Required, no.
MS. KOLIS: As the standard of care.
THE WITNESS: Absolutely not.
MS. KOLIS: Okay.
THE WITNESS: Now remember, you're asking about Sunday. Admittedly Monday when this process was, no. You pay for all those consults out of your taxes, you know, and they don't add anything. They confuse issues quite frequently.

BY MS. KOLIS:

Q. Are you saying a neurological consulation would have confused the issue in this case?

A. Could very well have confused the issue, yes.

Q. What issue would have been confused by a neurological consulation in this case?

A. I don't know.
Q. You're the one who just said it might have confused the issue, so I'm curious how you feel a neurologist could have hampered this case?
A. That depends upon who was consulted.
Q. Well, what does that mean?
A. I know a lot of neurologists that have made up their mind already about what they do in every case and they do the same thing in every case.
Q. Well, perhaps I should have inserted hypothetically maybe a consultation with a vascular surgeon, would that have confused the issue in this case?
A. I wouldn't consult a vascular surgeon unless I thought that the patient was a candidate for surgery at that point in time. That's not a hypothetical. That is a direct answer.
Q. Okay. What would have been the medical purpose in ordering a Duplex evaluation of the carotids?

MR. **GROEDEL**: Objection. Asked and answered.

MS. **KOLIS**: I'm sorry. If we covered that, that was a while ago.

THE WITNESS: To see if there is any pathology in the carotid arteries that could have explained what was going on.

MS. KOLIS: Okay.

BY MS. KOLIS:

Q. Once the CT results were in and subarachnoid hemorrhage was ruled out --

A. May I modify that?

Q. Sure.

A. I say once intracranial hemorrhage or the whole host of areas had been ruled out.

Q. Once that had been ruled out, what choices, if you will, or what on the menu of things should the doctor have been looking for further?

A. The primary things were exactly the other three that we talked about, the halter monitor, the cardiac echo, and the carotid Duplex.

Q. I don't know that you understood the question I asked, and that's okay. In terms of evaluating what was causing the problem, what would have been the next thing in terms of a priority to be included or excluded in this patient?

A. I don't think you prioritize these things in a one, two, three. The CT scan of a head, yes,

because we agreed that there was a significant danger. But the other three things that were requested are virtue of equal of importance in the workup.

Q. They are?

A. I think so, yes.

Q. Do you have Duplex scans performed on your patients? Let me ask that. Have you?

A. Come on. Sure.

Q. Sure, of course you do. All right. Where are those done?

A. In the vascular laboratory.

Q. Vascular versus the radiology department?

A. It depends. One hospital or another, yes.

Q. Right. But you usually use your vascular lab to do that?

A. Yes, but the vascular lab could be in the radiology department or in the department of vascular surgery. It depends upon hospital to hospital. It's a turf battle.

Q. Let's make it not a turf battle. I just wanted to know where you had yours done?

A. It depends upon the hospital.

Q. What is the duration of that test

generally?

MR. GROEDEL: Do you mean how long does it take to accomplish?

MS. KOLIS: Yes. Duration I think means that.

THE WITNESS: It depends upon how cooperative the patient is, what the anatomy of the particular is, and the expertise of the ultrasonographer, the technician.

BY MS. KOLIS:

Q. Let's take average, average, average in every regard, you know, a general average.

A. Hour and a half to two, I guess.

Q. And it is a noninvasive study, is it not?

A. Yes. Technically, yes.

Q. Can you discern a reason in the medical chart of Halyna Skryl that the Duplex scan could not have been performed upon her?

A. Can I find an absolute contraindication to doing the Duplex?

Q. Let's deal with contraindications.

A. No.

Q. Then let's deal with the strict limitation based on the record in terms of time.

A. Yes, in terms of time I think they did a hell of a lot in a great period of time.
Q. You do?
A. Yes, yes.
Q. First of all, the Duplex scan wasn't contraindicated, was it?
A. We agreed to that.
Q. All right. And my next question was do you or can you determine some limitation from that chart that prevented this examination from occurring on the fourteenth?
A. On the fourteenth she underwent two or three other studies. She underwent an EEG, which takes at least a couple hours, she underwent a CT scan, which also was both with and without contrast, and although the study itself may take a little bit of time, there is pre and post stuff going on. That's the only limitation that I can see.
Q. Could it have been done on Monday afternoon, say between one o'clock and five o'clock? Do you see anything in the chart that was actually going on at that time?
A. No.
MR. GROEDEL: Objection.

THE WITNESS: But it's just --

MS. KOLIS: If you want to look at the chart to be sure, that's fine.

THE WITNESS: No, I just read that. No, I do not see anything that was going on that would have precluded it, but I see nothing in the chart that made it that urgent either.

BY MS. KOLIS:

Q. Okay. Let me ask you a question. Did something need to happen to Mrs. Skryl to make the Duplex scan a more urgent event than it was when the doctor originally ordered it? Do you understand my question?

A. No.

Q. I think that we agreed maybe some fifteen, twenty minutes ago that given the presenting symptomatology in this person that the Duplex scan was a necessary and medically indicated examination?

A. It was an indicated study.

Q. And you seem to disapprove of unnecessary consultations and I would assume, therefore, testing. So you wouldn't be discussing with me some

testing that was just peripheral or unnecessary, would you?

A. Not at that particular stage, no.

Q. What you just suggested in your most latest answer about the scan in response to my question could it have been done in the afternoon, I think you're indicating you didn't see anything happening that made it an emergency test?

A. Correct.

Q. Well, wasn't it already ordered to be performed as a diagnostic tool?

A. But that doesn't make it an emergency test.

Q. Well, when do you think would have been a real good time to give her the Duplex scan?

MR. GROEDEL: Objection.

MS. KOLIS: What were you waiting for?

THE WITNESS: I didn't like the tone of that voice, but --

MS. KOLIS: That's okay if you don't like my tone of voice.

THE WITNESS: Okay. Fortunately, it doesn't translate. When would it have been done?

BY MS. KOLIS:
Q. Yes.
A. It could have been done at any point in time. Let me explain to you. A person comes in with a completed stroke and is stable from the stroke point of view, there is no urgency to do anything other than a CT scan to make sure there is nothing that needs to be done emergency.
Q. Mrs. Skryl did not come in with a completed stroke, did she?
A. You didn't know that until about eleven, twelve noon the following day, I assume.
Q. Sure. Well, you're doing a definition. Unless I misunderstood what you said initially, the diagnosis should have been TIA versus stroke?
A. And that makes it even less urgent.
Q. Why is that?
A. Because a TIA by definition is going to resolve completely.
Q. But you don't know what it is when a person presents; that's probably the fairest statement, isn't it?
A. Let me try to explain to you. I have a patient that is in the hospital being admitted today

that had a TIA before Christmas. That patient wanted to go home for Christmas, went home for Christmas and is being admitted today. And he had had a Duplex scan that says that he has a stenosis. It's been four, five, six weeks. I don't see where the urgency is. Your expert wants to make it urgent. I don't agree.

Q. So it just wasn't a very important test in your opinion?

A. That's not a correct statement.

Q. Then what are you saying?

A. I said it's an important diagnostic test. It was not an emergency and it was not urgent. The patient was completely neurologically stable, was not getting any worse. By this time it had had a completed stroke. You asked me why it wasn't done on the morning of the fourteenth. She was having other studies done. She could have had -- you had to rule out the CT scan, okay. She had to have the EEG. You can't do all these tests at once, ma'am, I'm sorry.

Q. And I agree that you can't do them all at once.

A. Fine. We finally agree on something.

Q. That might be the only thing we are going to agree on.

Let me ask this. Given the set of symptoms which she presented with and then her CAT scan results, and anything else that you can recall, of what value would an MRI have been in this patient?

A. In the acute situation?

Q. In the situation that she was in.

A. Probably none. The only thing that an MRI I think could have added would have been whether she had had evidence of previous strokes, IPSI or contralateral. And not everybody has an MRI available.

Q. You mean not every medical facility.

A. Not every medical facility. I don't know whether the Deaconess did or didn't, does or doesn't.

Q. Okay. And would you place an MRI in front of, just based on what she had and where we were at in terms of the evaluation after the CT, would you think that an MRI would be more important or less important at that point than a Duplex?

A. Less important.

Q. Okay. Do you recall what the EEG results were?
A. No.
Q. Would you like to find them?
A. I will. This is an abnormal EEG. Focal slowing seen over the left temporal region consistent with a temporal subcortical lesion.
Q. Do you know approximately -- that was done on the fourteenth; correct?
A. In the morning.
Q. So you know that was done on the fourteenth in the morning?
A. Yes.
Q. Now in light of that EEG finding, once again let's make you the physician, would that have caused you some concern?
A. I was concerned when she hit the emergency room.
Q. I believe that you were. But now you have got this particular test result. Is that suggestive of anything to you at that time?
A. It's suggestion according to the report which was dictated three days later, or transcribed three days later, by the way, that this could have

been associated with an ischemic event. That's what it says here.

Q. Right.

A. And it also says other causes will be left to the referring physician to correlate clinically or radiographically, which to me means one of the explanations could have been a cerebral infarction, which I guess I knew since I examined the patient and decided the patient had had a completed stroke and had not had a hemorrhage. So did it add anything? No. Do you want to ask me why did they do an EEG?

Q. No.

A. Okay.

Q. So if you received that, that wouldn't cause you to want to do any more exploration than you had already done at that point; is that what you're saying?

A. No. Because they do an EEG more to rule out other causes of symptoms like this, namely a seizure.

Q. Now let's ask you a few questions about some things that are in your report.

A. Yes.

Q. Let me -- I'm not sure what page this is on, but you describe as part of your report that you perceived that the transfer of Mrs. Skryl was commenced on the fifteenth. Can you tell me where in the record that you made that determination from?

MR. GROEDEL: Where did he say that in this report?

MS. KOLIS: Let's see if I can -- to the best -- it's page two, towards the bottom. To the best of my understanding arrangements to that effect, meaning transfer, were commenced for transfer on January fifteenth. In the light of this and the fact that the patient was clinically stable, blood pressure under better control without new neurologic deficits, dah, dah, dah, dah, dah, that sentence. It's a real nice, long sentence.

THE WITNESS: Okay. So the question?

BY MS. KOLIS:

Q. I'm asking you if you can indicate for me where in the chart you gained that understanding.

A. Okay. And the progress note of 1/15 by Dr.

Moysaenko, it says spoke with Dr. Lederman, will attempt to transfer to Cleveland Clinic.

Q. Okay. That's all I wanted to know about that.

In her admission history, and I believe that you referred to it in your report, page one, you indicate that the patient made a statement that her left eye was foggy and you put that word in quotes. I'm assuming that was the words the patient used?

A. I don't know where I got that.

Q. Did you --

A. I can look for it if it's important.

Q. No, that's okay. I'm just trying to get you referenced in that area.

Regarding any complaints about vision, did you note any testing that was performed for visual interference or acuity, however you choose to term it, anywhere in the chart?

A. Yes.

Q. Okay.

A. We noted earlier that there had been a consult to an ophthalmologist about visual fields.

Q. Do you believe that that consultation

occurred?
A. I don't see it in the consult.
Q. So in answer to my question was there any testing done on the vision during this hospitalization?
A. No.
Q. If you want to refer to page five of your report for a moment. We can go back and forth, I'm sure, first paragraph, regarding the carotid Duplex, just previous to that paragraph, I think that on page four, essentially you were trying to distill this case down to your opinion and Dr. Durham's opinion about the necessity and what would have been the future in this patient based upon this particular test. And if you don't like my characterization of that, that's okay, but what I'm leading to is this: Essentially, what you have said in a single sentence is this would have been contraindicated in light of the severe uncontrolled hypertention, meaning the carotid arteriogram which would have been what would have followed the Duplex scan; am I correct?
A. Had the Duplex scan shown something needed --

Q. Okay.
A. -- to be done. But also, it's an incomplete statement, if I may.
Q. Sure, go ahead. Explain away.
A. If the patient had had a completed stroke and you decided that on the basis of the completed stroke you did not think it was appropriate to proceed with surgery, then the arteriogram would also not have been ordered.
Q. We keep running into a semantical problem about completed stroke, so I'm going to try as best I can to construct these questions so that you and I are talking about the same situation.
A. I do get confused a little bit when you go from the hypothetical to the particular, I do.
Q. Okay. In this person, Mrs. Skryl --
A. Right.
Q. -- we only end up being able to call her condition a completed stroke by virtue of the passage of time; am I correct?
A. By twelve noon the following day, yes, it was a completed stroke.
Q. And you're using twelve noon. Okay.
A. Yes, because by that time the CAT scan had

been performed. That's the only marker of time.

Q. Is it your believe that Mrs. Skryl had a second stroke while she was confined in the hospital, just so we are clear?

A. Certainly.

Q. I just want to make sure that nobody says otherwise. Okay. So there were two stroke events. However, let's say, and we are just hypothetically saying this, okay?

A. Now we are in the hypothetical.

Q. We are hypothetical at this moment. Let's say that history had been otherwise in this case, that at nine a.m. in the morning Mrs. Skryl had been taken for a Duplex scan. Are you with me?

A. Sure.

Q. Now at that point she is not labeled with a diagnosis of a completed stroke, she is still TIA versus completed stroke; am I right?

A. Yes.

Q. Okay. Let's say she is scanned. Now I'm going to take you from your hypothetical and move you into some form of reality for the moment. Do you based upon what you have read in the autopsy or anything else in any of the medical records have an

opinion as to what would have been seen on that Duplex scan if it had been done at nine a.m. on January fourteenth, 1991?

A. More likely than that it would have shown arteriosclerosis of the left carotid artery with a stenosis of some degree or not, maybe with or without ulceration, maybe with or without clot.

Q. And what do you base that opinion on?

A. Only on the autopsy finding subsequent.

Q. So let's take -- and I understand you're not saying with one hundred percent certainty because you have given me a couple of combinations of what might have been there; correct?

A. Correct. Three.

Q. Well, we can work with any one of your three and we are going to do that in a second.

Let's take what you believe based upon all the medical evidence what would have been on that scan at nine a.m. hypothetically on the fourteenth of January. Sort out for me, if you will, the three possible combinations that you believe were in existence.

A. She could have had a stenosis, an ulcerative plaque, with or without stenosis, and possibly clot.

Q. Taking the stenosis in the first instance, okay, we will use that hypothetical or what you think might be a potential probable that you would have seen. If that's what you would have seen on that scan at nine a.m. on January fourteenth, 1991, what do you believe would be indicated as the next necessary medical step in the care of this patient, if that's what you would have seen on the scan?
A. That depends upon what degree of stenosis.
Q. Why don't you give me the range of possibilities if you can break it down that way as to degrees of stenosis and how it affects what you would then do?
A. In this particular?
Q. Absolutely.
A. Now we are not hypothetical.
Q. No, we are not hypothetical. In this person.
A. In ninety-nine percent stenosis I would have had to consider seriously doing an arteriogram. Underneath that, I would have had to discuss it with the family as to what the risks were. I would have discussed it with the patient and the family in either case, what the risks were. If it was a

stenosis under ninety-five percent, I probably would have tried to temporize and not do the arteriogram thinking there was no urgency to doing the surgery.

Q. If it was under ninety-five percent?

A. If it was under ninety-five percent.

Q. And can you explain to me since I'm only a lawyer what you mean by temporize?

A. Temporize, wait out the period of time as long as she is neurologically stable without trying to make things worse for her.

Q. I didn't know anyone who uses that nomenclature, so that's why I asked you what you meant by temporize.

So there is only two categories of possibilities in your mind in terms of stenosis. You're saying ninety-nine percent or greater if that's what you find on your scan, you do an arteriogram at that point.

MR. GROEDEL: Objection. That's not what he said.

MS. KOLIS: Okay. I'm sorry. What did you say? You believe that would be indicated but you would discuss the risks

with the family, is that --

THE WITNESS: I would discuss either way.

MS. KOLIS: Okay. I'm not sure what your objection was, but --

MR. GROEDEL: I think you were misstating his testimony, that's why I objected.

THE WITNESS: I believe you did.

MS. KOLIS: Did I misstate it? Let's go through it again. It's important for me to understand it. She can read it back or you can tell me. At ninety-nine percent or greater, if that's what degree of stenosis you had seen in this scan --

THE WITNESS: I don't think that anybody calls it more than ninety-nine percent. After that somewhere along the line the door is closed and it's occluded, it's no longer just a stenosis.

MS. KOLIS: Okay. So then I didn't misstate your testimony. If that's what you would have seen in this patient, what would have been your recommendation?

MR. GROEDEL: Objection. Go ahead.

THE WITNESS: I have a problem again. I have a philosophy that a person who has had a completed stroke is at higher risk for any surgical endeavor than a person who has had a TIA. And now we are at twelve noon -- no, we are at nine a.m.

MS. KOLIS: We moved it back, if it had happened.

THE WITNESS: Fine.

MR. GROEDEL: Are you assuming the time it takes to complete the test, the time it takes for him to get the information?

THE WITNESS: And then the time to go do the arteriogram and go do that. I would not have proceeded with surgery at that particular point in time, if that's what you're going to ask me.

MS. KOLIS: I hadn't gotten that far yet.

BY MS. KOLIS:

Q. You wouldn't have proceeded with the arteriogram is what you're saying?

A. But if I'm not going to proceed with

surgery, then I'm certainly not going to do the arteriogram.

Q. Because the arteriogram is a definitional tool, isn't it, for you? It's a precursor to surgery?

A. It's going to tell me whether I'm going to be able to do it or not. There is no reason to do the arteriogram unless I'm considering surgery.

Q. What is the surgical risk for a person with a completed stroke?

A. It's higher than without a completed stroke --

Q. Okay.

A. -- in the acute phase. I believe that Dr. Durham doubles the stroke rate, and I guess that that's fine, but he is making it up as much as I am. It's greater.

Q. How do you know he is making it up?

A. Because there is no literature to that effect.

Q. Is the way that a person becomes acquainted with their medical opinion is by the use of literature, or can it be based on their experience?

A. Some. I do it mostly by my own experience

at this particular point in time.
Q. Have you sought out the surgical risk number in this particular kind of procedure in a completed stroke person?
A. In generalities, yes, and I have not found the answer. Just greater risk is the word that's used.
Q. All right. So how would you advise a patient on what the greater risk was?
A. It's greater.
Q. Greater than?
A. Greater than if we wait.
Q. In the determination of whether or not the surgery could be performed, what's the benefit in performing the surgery?
MR. GROEDEL: Objection to the word could as opposed to should, but go ahead.
THE WITNESS: I truly didn't understand that question. He did but I didn't.
MS. KOLIS: Okay.
BY MS. KOLIS:
Q. There is a risk. We are back, way back on our ninety-nine percent stenosis and --

A. Theoretical at nine a.m. by Duplex.
Q. Right. But we are moving it into something you have moved it into, which is by the time you got the information and the results, it's your opinion that Mrs. Skryl would have then been determined to have been a completed stroke person by twelve noon, and that you would not be recommending an arteriogram in a person who had just had a completed stroke?
A. And who still had labile hypertension, yes. Let's not forget that.
Q. I don't want to forget that.
A. And who still hasn't had the CAT scan because the CAT scan wasn't done until after that.
Q. Now we are really getting our hypotheticals and our realities mixed up, but in any event --
A. Well, the CAT scan wasn't completed until twelve thirty. I'm sorry. It's there.
Q. That's perfectly okay. Let's just assume that everything was done. Just make the CAT scan done, the EEG done. Just make it all done.
A. Okay.
Q. Put Dr. Moysaenko in the wonderful position of having had the Duplex done, and this is what we

found the stenosis --

A. And the only variable remains is that the twenty-four hour period is not yet up?

Q. No, we are going to make the twenty-four hour period up.

A. She has had a completed stroke?

Q. Yes.

A. And now?

Q. And now what is her surgical risk?

MR. GROEDEL: Objection. *Go* ahead.

THE WITNESS: Probably the same as it was before except we just didn't know it. It is greater than if we wait and do it electively.

Now I don't know where Dr. Durham got the doubling of the risk. I do exactly the same thing, but I have never read anything to that effect.

I do know that historically where carotid endarterectomies got themselves in trouble twenty, thirty years ago when they started doing them was by with all the best of intentions and without the available paraphernalia today, they used to go in and

operate on strokes as an emergency and they used to kill more people than they would help. That's where that historically comes from. But I don't know of anybody who is dumb enough to try to prospective randomize controlled study to prove that point today.

BY MS. KOLIS:

Q. Okay. There is a risk obviously in the procedure as we have outlined it to be. What is the benefit to the patient who elects to go ahead with this surgery?

A. If all goes well?

Q. Yes.

A. And if there has been a stenosis of -- okay. Without crystal balls, I didn't get one, if an individual has a TIA or a stroke, that person, if unattended, has a thirty-five percent plus or minus incidence of restroking within five years. That could be that afternoon or it could be in five years. It also means that sixty-five percent of people don't. A lot of them die of their heart in the interim. So that's the other side.

So you could reduce that stroke rate percentage-wise to five years, thirty-five percent,

to I'll buy Dr. Durham's five percent, so you improve it by thirty percent, but you don't know if that particular individual was going to be in the sixty-five percent that would never have a problem again.

Q. And we never do know that; right?

A. Correct; correct.

Q. Of course, What about a person, and I think you just described the person's benefit in the category of a person with TIAs?

A. No, TIA and/or stroke.

Q. You said and/or stroke?

A. Yes.

Q. Okay.

A. The percentages are about the same. TIAs are looked upon as precursors to stroke.

Q. So there is some benefit for the patient to consider?

MR. GROEDEL: Objection. Go ahead.

Asked and answered.

BY MS. KOLIS:

Q. All right. Under ninety-five percent stenosis, I think that you said you would temporize, wait and see. What are you waiting and seeing, or

waiting to see I guess is a good way to describe it?

MR. GROEDEL: Objection. Go ahead.

THE WITNESS: To see if the patient has anymore symptoms or not.

BY MS. KOLIS:

Q. What symptoms would you be looking for?

A. Progression of stroke, recurrence of TIA symptoms, improvement, lack of.

Q. And if there was a recurrence, what would you do?

A. Within what period of time?

Q. Well, you need to tell me if there is differences as into the time when those symptoms were to occur.

A. I think that I have made those differences when I explained the differences between TIA and RIND.

Q. All right. What if the symptoms recurred within the day?

MR. GROEDEL: Objection. Go ahead.

MS. KOLIS: Within the twenty-four hour period of time.

THE WITNESS: In other words, she had

a progression of her stroke?

MS. KOLIS: Correct.

THE WITNESS: Then I would think that this person is significantly more unstable and I may put on a little more speed to the workup. If it happened two weeks later, maybe, maybe not. Do I have her blood pressure controlled? Are any other factors going around? Yes.

BY MS. KOLIS:

Q. Okay. What about the hypertension made the use of the carotid arteriogram contraindicated in your mind, would have made one contraindicated?

A. Well, for the first part is that the arteriograms are usually performed by angiographers who, with all due respect to many of them, are not real doctors. They kind of become mechanics. And when somebody has hypertension, they literally really fear side effects, such as bleeding from the site, as well as a reaction to the dye, which is accentuated as Dr. Durham states during an individual being hypertensive. So the incidence of complications is higher and they shy away from it. I don't know of any angiographer who will do -- with

a blood pressure diastolic over a hundred, I don't know of any angiographer that will do that.

Q. Is there someone besides those persons in the medical field that can do these examinations?

A. Can do?

Q. Yes.

A. 1 can do them.

Q. Do you?

A. No.

Q. Would you?

A. No.

Q. Why?

A. Because of the same reasons the angiographers don't.

Q. So it's your testimony that they are contraindicated in her circumstance; is that what you're telling me?

A. Other people might look at it differently, but I believe so, yes.

Q. And what are the numbers that you believe make that contraindicated?

A. A diastolic blood pressure of one hundred or above. And hers was one hundred ten to one hundred twenty.

Q. During what period of time?
A. Wednesday -- I'm sorry. Let me go by numbers of days. Throughout; her blood pressure on the thirteenth and fourteenth was certainly in that range, and in the morning of the fifteenth just as well.
Q. Did her blood pressure see improvement during her hospitalization with the use of meds?
A. Certainly.
Q. Do you believe that Dr. Moysaenko properly controlled her hypertension?
A. Yes. He did as much as is reasonable to be doing, yes. He treated her with four different medications.
Q. You don't see anything that he could have done differently as it regards those medications?
A. Could have done?
Q. Yes.
A. Yes, he could have done other things but I don't think they were necessary, no,
Q. Okay. So you were satisfied within your review of the chart that he properly controlled the hypertension?
MR. GROEDEL: Objection. Go ahead.

THE WITNESS: Yes, I think he did a reasonable job in controlling the hypertension.

MS. KOLIS: Okay.

BY MS. KOLIS:

Q. Going back for a moment to what you think might have shown up on the scan based upon the documents in your possession, if the Duplex scan had showed stenosis and a clot, was that one of your choices?

A. It was one of the things I mentioned.

Q. Right. 1 didn't want to call it choices. You gave me three things or three combinations and you said clot sort of standing by itself, but I'm assuming that you meant that the clot could be in conjunction with stenosis or plaque?

A. Stenosis usually, yes.

Q. What would have been the indications for this person given that finding?

MR. GROEDEL: Which person are we talking about now?

MS. KOLIS: Mrs. Skryl.

THE WITNESS: Specifically Mrs. Skryl, not a hypothetical?

MS. KOLIS: Right.

THE WITNESS: What would have been the indications for what? What would have been indicated?

BY MS. KOLIS:

Q. Right. If you found that on a scan, what do you think, if anything, would have been further indicated to do for this person?

A. Some people would have have considered anticoagulation. I would have had some difficulty if her blood pressure was out of control recommending that.

Q. Why is that?

A. Because people with hypertension are at a higher risk of bleeding if you anticoagulate them.

Q. And how much higher is that risk?

A. Significant.

Q. How significant?

A. I don't know that anybody is going to give you that number, but it's higher.

Q. If you had determined you could not anticoagulate this person because of their hypertension, what risk did the patient face by having nothing occur, or was there something else

you could do?

MR. GROEDEL: Objection.

THE WITNESS: Not that I know of.

BY MS. KOLIS:

Q. So it left the person at what risk if there had been stenosis and a clot?

A. At risk for having more problems. But if she had a clot, that is the subgroup of individuals that ill-advised surgical interventions in the past caused more problems than solved problems. That was exactly the subgroup. They operated on these people and they killed them. It's real simple.

Now I don't know of anybody who has a recent series comparing that problem to the past. I don't know of anybody that has a scientifically controlled study about acute stroke and intervention within the last twenty years. It's a no-no. Most people do not like that. There is -- I remember a young neurosurgeon that came here to Graduate a number of years ago that thought he walked on water. And it took him several instances until he learned that he sank like everybody else in attempting to do those cases. And it's my personal experience in observing others intervene that way,

not myself, that that is ill advised.

Q. That it's ill advised in that situation to do surgery?

A. In acute stroke, and a thrombosis of the artery, it's ill advised to intervene.

Now there is one difference. There is one subset that is a little bit different, and that is in a patient who has just completed a carotid endarterectomy who postoperatively develops a stroke. That is a completely different horse. Then you must go in and make sure there is nothing you did technically that could be improved upon. And you have to do that within two hours. Completely different from Mrs. Skryl and/or your hypothetical.

Q. Let me ask you in a person who has a completed stroke and you have some concerns about their hypotension, but you also have some concerns that perhaps there is in existence some pathological process or otherwise in the carotid that might need surgical intervention, just sort of try to assume those, and if you want me to read them back, I will.

A. It's hypertension. May I correct? Because

you said hypotension.
Q. I'm looking at something you wrote. I'm sorry. My memory is going that way.
A. Okay.
Q. At what point would you be able to do surgery on the person? What has to change, either symptoms or time-wise?
A. Well, both.
Q. Okay.
A. I would like her hypertension to be controlled so I can, A, do the study and, B, proceed surgically with less risk.
Q. Okay.
A. And I would like the patient to be stable and preferably I would like to wait a period of time, as does Dr. Durham.
Q. Well --
A. He actually likes to wait six weeks if I recall correctly.
Q. It seems like you have read some of what he said. Are you of the school that you wait for the neurological plateau, or do you wait a prescribed period of time, say, six weeks?
A. I used to be of the six week variety. I

think now with the neurologic plateau, plus repeat CT scans of the head, I am bringing that in closer. But with that, I truly, honestly, that is one time I always ask the neurologist.

Q. A neurologist to come in and evaluate for you?

A. And give me his blessings that this is okay.

Q. And we are discussing doing a carotid endarterectomy at that point?

A. Correct.

Q. Define for me from your perspective and the way that you practice vascular surgery what a neurologic plateau is.

A. That is what I ask the neurologist to tell me.

Q. So you don't make that assessment yourself?

A. Absolutely not. If it's obvious that they are unstable, it's obvious. But some of these things are significantly more subtle than my experience allows me to make that decision.

Q. And you think that that is such a subtlety?

A. It can be, That finger to nose business and that kind of stuff, I'm not that well versed.

Q. All right. On page five of your report,

paragraph three, first sentence, you said it's your impression from your appreciation of the chart that what led to Mrs. Skryl's massive stroke, and we are referring to the stroke of the fifteenth, I'm assuming -- am I right, that is what you're calling the massive stroke --

A. Yes.

Q. -- was not a primary carotid event at all, but an episode of hypotension more likely than not related to a myocardial dysfunction?

A. Correct.

Q. Tell me how you reached that conclusion.

A. Reading from the nurse's notes of the events that took place commencing about five fifteen until about six o'clock in the afternoon. That's where I got that.

Q. Have you subsequently reviewed the complete autopsy?

A. Yes.

Q. Does that lend any support whatsoever to the appreciation that you had of the chart?

A. It does not support it and it does not negate it, because notice that I said cardiac dysfunction, not heart attack.

Q. Right. What cardiac dysfunction were you referring to that you think caused this massive stroke?

A. Any form of arrhythmia which in turn can cause hypotension.

Q. I think that you made a notation that Dr. Durham's contention that the patient's symptoms waxed and waned was not supported by a review of the record. Am I right of that? I think I am. Page three, paragraph one, two, three, four.

A. It says what?

Q. The plaintiff's exert witness, Dr. Joseph Durh m, in his opinion states accurately that the first experience of cerebral vascular problem had occurred one week earlier, and that this episode had lasted approximately thirty minutes. Unfortunately, he inaccurately interprets the patient's records as documenting that the symptoms continued to wax and wane until the day of the admission when they became more severe. I find nothing to corroborate that opinion in my review of the chart.

Did you read Dr. Moysaenko's admission and discharge summaries before you wrote this report?

A. Yes.
Q. Did you see that it was Dr. Moysaenko who used that precise phrase that the symptoms waxed and waned?
A. In his discharge summary --
Q. Okay.
A. -- but not in his initial assessment and it is not corroborated by any of the nurse's notes and by the emergency room physician. All of them stipulate specifically that it was an isolated event.
Q. That what was an isolated event?
A. That the event that occurred the week before was an isolated event and that there was not a continuum.
Q. So are you saying that Dr. Moysaenko's discharge summary where he indicates in the narrative portion these symptoms had been waxing and waning, however, on the day of admission they became more severe prompting her to be evaluated in the emergency department is in error?
A. It is my opinion that there is nothing to corroborate that anyplace else in the chart.
Q. So you're saying Dr. Moysaenko was mistaken

in including that in his narrative summary?
A. I believe so, yes. I do not see anything that would -- yes, I don't see anything else other than that statement in the discharge summary.
Q. All right. So Dr. Durham's reliance upon Dr. Moysaenko was just misplaced in this instance, would that be also accurate?
MR. GROEDEL: Objection.
MS. KOLIS: Well, I mean --
MR. GROEDEL: In what regard?
MS. KOLIS: In regards to Dr. Moysaenko is the one who included it in his discharge summary that the symptoms waxed and waned, and from whence he got that information I don't know, but that's what it said in his discharge summary.
THE WITNESS: I do not find that statement about ongoing symptoms from episode number one a week before to subsequent to that in any of the emergency room physician or nurse's notes, nor in the nurse's notes at all, nor in the initial assessment by Dr. Moysaenko. I don't know where he got that from.

BY MS. KOLIS:

Q. Were you aware that Dr. Moysaenko and Mrs. Skryl both spoke a second language other than English?

A. No.

Q. Okay. You don't remember that from the deposition, from Dr. Moysaenko's deposition?

A. It certainly was not something that jumped at me, no.

Q. Is a diagnosis of uncontrolled hypertension one which you could make?

MR. GROEDEL: Objection. In all instances?

BY MS. KOLIS:

Q. Well, let me ask it this way. Way, way back in the beginning of this deposition I asked you something about normal --

A. Defining blood pressure, hypertension.

Q. And you told me that just really wasn't your area?

A. Yes, I don't think that I could make it at one sitting. I think over a continuum, I think that if I see a patient with a fifteen or twenty millimeter elevated systolic blood pressure over the

course of two or three days, yes. I think that if I had somebody with a diastolic blood pressure of one hundred twenty, I think that that is rather hypertensive and certainly out of control. But if that person came in to me without having been under treatment before, I couldn't say it's uncontrolled because nobody tried to control it first.

Q. All right. Doctor, can you give me a couple of minutes? I just want to go over some notes I have and I will see if I can wrap this up.

A. Sure.

Q. There is actually one other brief area that I want to question you in. Page five, I think, last paragraph. Were you asked to comment on the family situation in this matter?

A. Was I asked?

Q. Yes.

A. By anybody?

Q. Yes.

A. No.

Q. That's just something that you gleaned from reading the depositions and reading the chart?

A. Correct.

Q. You said having personally been in that

situation in the past, meaning someone said transfer my family member out of here, this is a social not a medical consideration, but it is my gut feeling, in quotes, that family interference did indeed complicate matters somewhat.

What are you deeming to be family interference in this case?

A. Well, I think that the family wanted things done differently from what Dr. Moysaenko had recommended be done, whether that was the particular studies or the place where everything was to take place. That's what I mean by that.

Q. I'm not sure that I know what you mean by that. Is there something in the chart that -- what is it about the chart or if it's not in the chart, where did you get your information from that they wanted things done differently than how Dr. Moysaenko suggested doing them?

A. No, I said or that they wanted either different things done or in a different location. That's fairly evident since they asked to transfer her.

And then further down on the fifteenth it says family requested a different MD. At that

time the consultation to Dr. Jucalong was put in if the transfer was not effected. So obviously they didn't want Dr. Moysaenko to handle the case.

Q. But how is that interfering? You said it's my gut feeling that family interference complicated matters somewhat. I'm trying to figure out what is family interference and how did it complicate matters?

A. Well, if I prescribe a diagnostic or therapeutic regimen and anybody, family or patient or anybody else does not want that to be done either by me or at my institution and wants to transfer someplace else, that is interfering with what my recommendations were, or declining. Nurses use a term refusing a lot. I find that more negative and I say it's a patient's prerogative or a family's prerogative to decline what I have recommended. It's only a recommendation.

Q. Okay.

A. Did they physically throw themselves across the patient and not let them go down and have the Duplex, no, I didn't see any evidence of that.

Q. Do you see any evidence that the family asked Dr. Moysaenko not to do those tests?

A. No.

Q. Doctor, I would like to just briefly look at the records you have and I think that will probably wrap it up.

Doctor, you have in your, with the medical records and the depositions, one, two, three, four letters from Mr. Groedel. Are you willing to represent to me that this is the sum and substance of the correspondence between yourself and Mr. Groedel?

MR. GROEDEL: And his report.

MS. KOLIS: And your report. I'm sorry. I didn't mean to exclude that.

THE WITNESS: To the best of my recollection.

MS. KOLIS: Okay. There isn't anything else?

THE WITNESS: Not that I have, no.

MS. KOLIS: Okay. Thank you very much for your time today.

THE WITNESS: Thank you.

(Witness excused.)

- - -

TESTIMONY CLOSED

- - -

C E R T I F I C A T I O N

I hereby certify that the proceedings, evidence and objections noted are contained fully and accurately in the notes taken by me in the hearing of the above matter, and that this is a correct transcript of the same.

PATRICIA CRUDO

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