THE STATE OF OHIO : SS:
COUNTY OF CUYAHOGA. :

Doc. 451

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IN THE COURT OF COMMON PLEAS

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TINA HAYBURN, administratrix,
plaintiffs,

vs. : ~~Case No: 224348~~

DEACONESS HOSPITAL, et al.,
defendants.

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Deposition of EDWARD L. WESTBROOK, M.D., a witness herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Frank P. Versagi, RPR, CLVS, a Notary Public within and for the State of Ohio, at University Hospitals of Cleveland, Cleveland, Ohio, on Monday, the 18th day of January, 1993, commencing at 2:08 p.m. pursuant to notice.

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FLOWERS & VERSAGI
COURT REPORTERS
Computerized Transcription
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THE 113 SAINT CLAIR BUILDING - SUITE 505
CLEVELAND, OHIO 44114-1273
(216) 771-8018
1-800-837-DEPO

APPEARANCES:

ON BEHALF OF THE PLAINTIFFS:

Charles Kampinski, Esq.
Donna Kolis, Esq.
Charles Kampinski, Co., L.P.A.
1530 Standard Building
Cleveland, Ohio 44113
(216) 781-4110

- - - - -

ON BEHALF OF THE DEFENDANT GLEB MOYSAENKO, M.D.

Marc William Groedel, Esq.
Reminger & Reminger
The 113 Saint Clair Building
Cleveland, Ohio 44114-1273
(216) 687-1311

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I N D E X

WITNESS: **EDWARD L. WESTBROOK, M.D.**

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NO EXHIBITS MARKED

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OBJECTION INDEX

EDWARD L. WESTBROOK, M.D.

of lawful age, a witness herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, being first duly sworn, as hereinafter certified, was examined, and testified as follows:

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CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Would you state your name, please?

A. Edward Lloyd Westbrook, M.D.

Q. Doctor, I'm going to ask you a number of questions. If you don't understand any of them tell me, I'll be happy to rephrase any questions you don't understand.

When you respond to my questions, please do so verbally. He is going to take down everything we say. He can't take down a nod of the head.

A. Yes.

Q. What did you do from 1975 to 1978?

A. I was at the Cleveland Clinic until '77. I went into practice in '77 at Saint Luke's, subsequently in '78 at Marymount.

Q. I've just been handed your CV. On it it's

got clinical visiting neurologist from '73 to '75, Cleveland Metro?

A. That was a part-time appointment, Really what I was really doing here, let's see, you really have to look down here.

Q. I see,

A. Okay. I was on the staff there, full-time staff from '72 to '77.

Q. At the Clinic?

A. Yes. Private practice from '77 to 1990 here, and Marymount from '78 to '90.

Q. When you say "here" you mean Saint Luke's?

A. Yes, here and Marymount, too, from '78 to 1990. I'm still on the consultant staff there only because I am a member of the Board of Trustees at that hospital.

Then I came here. This is -- is incorrect. This is 1990. Well now, it's not incorrect. I'm sorry. That was my -- no, I think -- well, it was changed from -- it was neurology and medicine from about 1978 to '80, then I believe it got dropped. This may be an error on here, but at any rate.

Q. Which?

A. Here. On the staff here as a assistant

clinical professor of neurology since about 1978, probably, and I am full time now here since 1990.

Q. Which is in error?

A. This date here.

Q. The date?

A. Yes. The first day here is probably in error.

Q. When you were at Marymount -- you say you're still on the Board?

A. Consultant, and I am on the Board of Trustees of the hospital.

Q. Did you have any involvement with Dr. Moysaenko or his father --

A. No.

Q. -- while you were at Marymount?

A. No.

Q. How about Dr. Juguilon?

A. I know Dr. Juguilon.

Q. How do you know him?

A. He was at Marymount.

Q. Still there?

A. 1 don't know that. I am not sure. I don't think he's very active there.

Q. Did you have any discussion with Dr. Juguilon about this case?

A. No.
Q. How is it you got involved in this case?
A. Through asking -- being asked by Mr. Groedel to review the case.
Q. Had you done any reviewing for Mr. Groedel previously?
A. Not for him before.
Q. Any members of his firm?
A. 1 have for his firm.
Q. How many would you say?
A. I'd say a total three or four a year, and I would say probably three-quarters of them are for that firm.
Q. Two or three a year?
A. Yes.
Q. Who would you typically review them for?
A. Gary Goldwasser is usually the point person that approaches me.
Q. Have you yourself been involved in any litigation?
A. You mean directly directed against me?
Q. Yes, sir.
A. I have been named in suits that have been dropped, yes.
Q. None that's gone to trial?

A. None that have ever gone to trial. I don't believe we ever went to deposition in any of these cases.

Q. Any of them been resolved by way of settlement?

A. No.

Q. Have you testified as an expert in any case?

A. Yes.

Q. How many would you say?

A. Actually -- well, are you talking about reviewing jackets, that's one thing. If you're talking about going to court, I would say four or five, something like that.

Q. Over how many years?

A. Well, the first time I was ever formally in court was when the Gilliam Barry cases came in in the early '80s. I went and defended the federal government over that for many years.

Probably after that many times, rather infrequently. In other words --

Q. From the early '80s to now --

A. The number of times I've actually been in the courtroom, are you asking about this kind of deposition?

Q. We'll break it down.

Let's start out with courtroom.
A. Courtroom I'd say probably four or five times maximum.
Q. Over what period of time, since the '80s?
A. Yes, early '80s.
Q. Has all that been here in town?
A. Yes.
Q. When is the last time you would have testified?
A. Probably within six or eight months.
Q. What case was that?
A. It was a Reminger & Reminger case about post concussion seizures, I don't remember the defendant. I think it was -- or the plaintiff -- was Ridenour, if I am not mistaking.
Q. Who was the plaintiff's attorney?
A. That, I don't remember.
Q. Whose courtroom was it, do you know?
A. I can see the judge, but I don't remember his name. Sorry.
Q. How about before that?
A. 1 really can't tell you the last time I have been in that situation. I don't remember.
Q. How about testimony by way of deposition either video or written, how many times would you

say you have done that?
A. Well, as I say, I've probably reviewed maybe four cases a year, and probably it comes to some sort of a written report two out of those four. They may not want what I want to know -- what I have to say, then they don't ask for reports or whatever. One out of those two times, maybe one gets into something further.

I certainly haven't been in the courtroom very often, nor have come to depositions particularly frequently.
Q. You are saying approximately once a year?
A. Probably less than that overall, yes. I'm by no means a professional witness.
Q. How many times would you say percentagewise you've been retained on behalf of the defendant?
A. Probably the majority.
Q. When you say "majority," 99 percent?
A. No. 80/20, something like that would probably be fair. Something like that, 75/25.
Q. Would the Reminger office be the primary office?
A. The primary ones. I have a long time personal friendship with some of the members of the firm, that's how I got -- they started out as my

friends and they were lawyers, they were involved in malpractice work and -- and as I became more established in the community, they would -- would begin to approach me about what do I think. That's gone on from there.

They are not the only firm I do. I tend to disclaim a lot of it.

Q. Who else do you do it for?

A. You know, right offhand I can't tell you. I've done a case in the last year for somebody else. I don't remember what it was.

Q. Jacobson, Maynard firm?

A. I think it might be, I am not sure, but it's -- again, I'm called a lot. I turn them down.

I take cases based upon interest, what I think should be defended properly, and so it limits a lot of it.

Q. What did you review in this case, Doctor?

A. What did I review?

Q. Yes, sir.

A. Everything that -- do you have the letter I've written to Mr. Groedel?

Q. I do.

A. I have reviewed all that, and only other

thing that I reviewed is the deposition of Dr. Dunham or Durham.

Q. Since the time of your letter?

A. Yes.

Q. I'm still trying to absorb what is in your CV.

A. I can summarize if for you, if you wish.

Q. Go ahead.

A. You can see that the college and medical school is straightforward. I did a year of medical internship, a year of medical residency at Presbyterian Saint Luke's in Chicago, in between which were two years with the public health service, doing jackets, Food and Drug admission, then I came here to.

Q. What does that mean, "Doing jackets"?

A. INA'S and MDA'S, when a drug company submits a new drug for consideration of safety and efficacy it goes through an investigational period, and that's an INA, investigational new drug; and if it looks like there's a potential market for it, they will do marketing, safety, and efficacy considerations, which are much more thorough, much more prolonged. There are many jackets and many, many investigators.

We did that kind of work for two years.

Q. Then you went back?

A. Back to Chicago. Then I came here to Cleveland Metropolitan to be with Morris Victor in neurology, and trained at Cleveland Metropolitan between '69 and '72.

Then I was on the Cleveland Clinic staff for five years from 1972 to 1977, then I left to go to private practice in '77; went initially to Saint Luke's, right to Marymount, and the next year off to --

Q. Why did you leave the Clinic?

A. I left because I wanted -- I didn't like the size of the place, some of the things that were happening I -- and the best thing for me was to leave.

Q. Why did you leave Saint Luke's?

A. I -- because I wanted to come here. The world has changed since 1977.

In other words, I left the Clinic on my own, when I went to leave the Clinic --

Q. Why did you leave Marymount?

A. Well, I didn't like Marymount, I was in private practice and felt that things are changing

dramatically.

I feel neurologists are probably going to be working for hospitals in the future. I was offered a full-time position here and felt this was a much more significant thing for me over the long haul to come here at this considerable reduction in my income.

Q. Do you have a private practice?

A. I see lots and lots of patients here on these floors in the next examining room over here five days a week. I see them every day.

Q. Do you have a --

A. It's a University Hospital practice. Actually the Neurology -- University Neurology Association, Inc. owns the patients and practices.

Point of fact, I am a daily practitioner in neurology.

Q. What is University Neurology Associates --

A. It's --

Q. -- Inc.?

A. -- all the neurologists in this department, anything that they bill for is direct to the corporation.

Q. Are you a shareholder of the corporation?

A. No, there is no money involved. It's a

salary thing, but money that I create is put through University Neurologists, distributed back to the University. The University actually pays me.

Q. Is the University then the only shareholder of the corporation?

A. They are not even a shareholder, I don't believe. I don't know how that works.

Q. But you get paid through the university?

A. I get paid by the University on salary.

Q. When you say "University," University Hospitals?

A. That's right. Actually the check does come through the University.

Q. Case Western?

A. There's another -- there is another additional contract there somewhere.

Q. Your paycheck actually is by Case Western?

A. That's right.

Q. And they have some contract with University Hospitals?

A. Yes, they do. I don't know how that works. We are given a salary, we're allowed to use the perks from the University.

Q. When you see patients then here at University

Hospital, is it by referral from other physicians?
A. Yes.
Q. If you are referred patients, do you continue to follow them?
A. Yes.
Q. Either as inpatient or outpatient?
A. That's right. Unlike the Clinic, which was one of my concerns, we saw the patients in the office, somebody else would take care of the patient in the hospital. I might be or may not be the person who took care of the patient over the hospitalization. I had too big an ego to deal with those kind of things.
Q. How much of your time would you say weekly, monthly, annually, however you want to give it to me, is spent in the clinical setting as opposed to the university setting?
A. Well, formally more than half in the sense of actually scheduled time, but I am sure you're well aware there's tremendous amount of paperwork involved in the management of patient practice.
Point of fact, lot longer than that. It depends on what you consider 40-hour week, or a 60-hour week, or an 80-hour week. It's a very large percentage.

I also rotate on the neurology services here, that's additional time in seeing patients on a daily basis, usually it's two months a year in the ward service, a month of consultation, so there's another three months where it's almost full time.

Q. What are your academic responsibilities?

A. I am head of the section of general clinical neurology, which is a -- mainly the people who see patients in this practice that we're talking about.

Q. Do you teach?

A. Yes, I teach. Mostly most of the -- my teaching is making rounds of residents and students, some of it's lecture, not in and out an awful lot at this point.

Q. Do you have any offices within the hospital?

A. Well, I see patients regularly in this first room on the right down the hall here. I've my own --

Q. That's not what I mean. That was poorly phrased.

Are you an officer or director of the hospital?

A. No. I am statistics chairman of general

clinical neurology and a titular head of vascular disease. I have committee appointments, that kind of thing.

Q. What kind of committees?

A. I am on the computer committee to re-review our system here with an idea of replacing the software and hardware, I am involved in the continuing medical education committee, I am involved in the intensive care units planning for the new hospital as it relates to neurology and neurosurgery, and that situation also tends to get involved in bird-dogging problems between neurology, neurosurgery, and other services that may occur, intensive care unit that we all share.

Q. How would you define the practice of neurology?

A. Well, I don't quite know whether I understand. I assume that you mean --

Q. What do you you?

A. I see patients with stroke, with headaches, with seizures, with Parkinson's, with multiple sclerosis, degenerative genetic or degenerative disorders of the nervous system, patients with dementia, patients with spinal cord diseases, and diseases of nerves and muscles.

Q. How has your practice changed since the onset of the use of CAT scans and MIR's?
A. Well, I think everybody's practice changed drastically in the sense we now know a lot more about what we were looking at that than we did previously.

Saw a patient this morning, lady had a small hemorrhage -- elderly lady came in and we would have never known it was there in the past, it was too small to be displayed in the cerebellar sphere. We wouldn't have seen the area of abnormality if some technician just did a brain scan in the past, now CAT scans have changed the practice quite a bit.

Q. In other words, before the use of CAT scans and MIR's, I mean you had to use almost exclusively clinical signs and symptoms?
A. That's right.
Q. Now you have those tools that assist you in the diagnosis, I take it, of various diseases that you deal with?
A. That's right.
Q. That would be true, I take it, also of Doppler scans?
A.

that it tells indirectly what is going on, for instance, with a carotid.

Q. Right.

A. I don't feel comfortable -- 1 can only vaguely take the data that you can give me and interpret it, but it's a test that let's somebody else interpret, then I take the interruption and deal with it.

Q. In other words, you yourself don't do the test?

A. No.

Q. You don't do any of the tests you just mentioned, you have other technicians do it and you deal with the result of it?

A. Right. I feel much more comfortable with CAT scans, having grown up with them since the '70s when we had the first scanner at the Cleveland Clinic, maybe 1974.

Q. In other words, you use that much more than the Doppler?

A. I think in the last ten years for carotid Dopplers have become much more helpful than they had been and much more reliable, and indeed we can get good information out of them in terms at least to give us direction, which way to go with the

patient; depends, but then again, on who is doing them.

Q. Who does do them?

A. There's two labs, there's a radiology lab, and there's a vascular lab here.

Q. Any of --

A. I tend to use almost exclusively the vascular lab. I started out there, I know the person there, and I know what I can expect to get from people, I think when you're talking about carotid Dopplers and what the reliability of the test you are doing.

Q. What does a Doppler tell you about the carotid arteries or what can it tell?

A. It tells you whether you got flow and tells you whether there -- it can tell you whether you got degree of stenosis and it sometimes gives you a picture of the real situation beyond the flow characteristics of a diseased arteries that you can see, actual ulceration, that kind of thing.

Q. Can you see thrombus formation?

A. Sometimes you can. Sometimes you can see a thrombus migrating in a -- I had one case like that, I recognized those findings, to be confirmed by more specific tests.

Q. Coronary angiography?
A. No. Carotid angiography.
Q. Who could do these?
A. Usually the radiologist does it, neuroradiologist, or radiologist do it.
Q. In other words, if you saw on the Doppler something that was problematic to you, the next step would be carotid angiography?
A. Not necessarily, unless you have -- thought the patient -- a patient has to be able to handle the next step, meaning --
Q. Medically?
A. Medically. The risk of doing carotid angiography is not negligible. Then the question is what are you going to do with the carotid angiogram what -- once you get it, are you going to act differently because you got it, or can I act differently.
Q. So it's a risk/benefit analysis at that point?
A. Yes.
Q. Depending upon your findings on the Doppler?
A. Yes, and the patient's clinical state.
Q. What do you think the Doppler would have shown if it would have been done on Mrs. Skyrl?

A. It might have shown that there was either a serious narrowing of the carotid artery or might have shown that there's even a suggestion of occlusion, which -- well, doesn't tell you that there is occlusion, you have to confirm that also.

Q. Did you get anything other than Dr. Durham's deposition since writing your report? In other words, did you get --

A. I had his letter originally.

Q. But I mean anything else? Did you receive any further autopsy information?

A. I am sorry. 1 did. I have the autopsy report.

Q. When did you get that?

A. Fairly recently.

THE WITNESS: Do you remember when you sent it to me?

MR. GROEDEL: I think it's in your file.

A. Three weeks.

Q. Any time you need to look at any of this, go ahead.

A. Dated January 7, the letter from Mr. Groedel.

Q. '93?

A. Yes.

Q. Did you have that before you wrote your report?
A. I don't think I did.
MR. GROEDEL: Take a look at what you had in your original records.
A. Let me see what I had here.
No, I don't believe so.
Q. Well, Doctor, referring to page 3 --
A. Excuse me. You can correct me here.
MR. GROEDEL: It's the Cleveland Clinic record.
A. I certainly saw the first couple pages. That, I saw then.
Q. Referring to page 3 of your report, you do indicate in the middle of the second paragraph --
A. I see it.
Q. -- sentence says "Data forthcoming from an echocardiogram, could have awaited transfer and there was no significant suspicion of fever and endocarditis, a condition not mentioned in the autopsy report?
A. But I think I saw an abbreviation, I don't remember seeing all the -- that 1 have from the -- what I've seen recently.
Q. When do you think that Mrs. Skyrl had a

completed stroke?
A. That's hard to say, but she entered the hospital on the 13th, and if I -- reading the record completely, we don't know whether she stroked that morning before church; but we certainly know when the family got back after church, whenever that was, that she had a stroke, and I assume that's probably midday.
Q. So you think she had one on the 13th?
A. She may have had a stroke before that. I can't tell you.
Q. But did she have one at least on the 13th?
A. Yes.
Q. How would you define the stroke that we're referring to now?
A. That's a problem in the sense of definition.
Q. That's why I am asking.
A. If people have used 24 hours as being time for a TIA, transient ischemic attack. In point of fact, in people who have had significant deficit or even mild deficit in the course of TIA, this then clears at less than 24 hours, a large percent of those patients will reference -- actually be shown to have a stroke underlying.
Q. So you are saying that the deficit itself

doesn't necessarily tell you if there was or isn't a stroke?

A. That's right. So you have to go -- you really have to go beyond two hours to be sure of the situation.

Q. Well then, if what you're telling me is the definition, if you're --

A. That's right.

Q. -- if you're telling me that you have to wait at least 24 hours until you are certain if there was a stroke, then how could you know on the 13th if there was; by the definition you gave me, she wouldn't have one until the 14th?

A. That's true. But you don't know when you got the significant deficit. You're concerned that the patient may have a significant stroke and in point of fact there is history going back over time here, that she gave us on admission to the hospital at Deaconess, and also it's passed onto the Cleveland Clinic, that she was experiencing deficit prior to that.

She definitely has a stroke by the time you have the 14th, even if you don't accept -- if you take the beginning of the clock running at midday on the 13th, she has a stroke on the 14th,

if you want to look at it that way.
Q. By definition?
A. By definition. If you believe that definition, that 24 hour time period of TIA is being shorten --
Q. I am asking what your definition is. If yours is something different, then tell me.
A. No. That's still used, but it's being questioned in the literature how long a TIA runs.

The usual TIA is five to ten minutes with complete clearing, that's the usual TIA; but in somebody who's got a deficit running six hours, you don't know yet until you've gotten -- whether the patient has a stoke or not, if you want to use the definition.

In point of fact, what I am looking to, we think that patients who have had serious deficit lasting more than 10 or 20 minutes are -- probably have some damage; and in addition to that, you are beginning to see, look more carefully with better scans to see better patients who do have damage subsequently.

In other words, let's take somebody who comes in, has a ischemic event, it lasts six hours then totally clears, three or four days

you have a significant change after seeing some damage on **CAT** scan.

Q. What if you don't see such damage, would you then define it as a **TIA?**

A. I suppose you still would in this situation.

Q. You would define it as a **TIA?**

A. **I** think **so**, but with the reservation that **I** have given you.

Q. You are saying there is no.

Real hard and fast rule then?

A. No, but you have to draw some kind of line as to acceptable and what's irreversible.

Q. You mentioned a couple times earlier that when you have a significant deficit, then you would be concerned in having the significant stroke, those are your words, I tried to **--**

A. **I** don't know whether I'm getting the point across to you.

The point is, if you have a deficit that they had some **--** were questioning whether there was a field cut or hemiparesis or she has a face with right-sided weakness lasting more than six hours, I would be concerned that she has a stroke. Would I be convinced, I don't know. I wasn't there.

By the 14th you are convinced if it hasn't cleared.

Q. One of things you read was Lucy Skyrl's deposition, I believe; is that correct -- Lucy Strzalka?

A. Yes. The daughter, I believe.

Q. As a matter of fact, you referred to it in your report.

A. Yes.

Q. I assume then that you saw her testimony wherein she indicated that Dr. Moysaenko wasn't at all that interested in transferring her mother because of his belief that there was nothing significant going on with her; do you recall that testimony?

A. I have to look at that particular sentence. Can you direct me to that?

Q. I can't. I am doing this from memory.

A. I am too.

Q. Do you recall that or not?

A. I don't remember that she said that, I'd have to look again.

Q. If she did say that --

A. Now, you think --

MR. GROEDEL: Let him **ask** the

question.
Q. If she did say that, if that's what Dr. Moysaenko told her, what would that indicate to you about his belief as to whether or not there had been a stroke that occurred?
MR. GROEDEL: Objection. Go ahead.
A. I don't think you can answer that from her point of view because of what exists in the record.
Q. I am asking you to assume that in fact -- you extracted portions of her testimony for purposes of setting forth --
A. Understanding better what is going on.
Q. I am always a little troubled by the extraction of portions and the failure to extract other portions.
I am asking you now to assume other portions of her testimony are accurate, in that Dr. Moysaenko indicated to her a reason that he wasn't going to transfer --
A. Let's look at the records, then I don't have to assume that we're --
Q. I just told you that I can't point out a page to you right now. I am asking you to assume it, that the --

A. I am not sure what you're asking.

MR. GROEDEL: Try to let him finish, Doctor.

A. I don't have a feeling that the doctor or family or anybody else thinks that this was a benign condition.

Q. The doctor did think it was benign enough not to transfer her, that it was nothing serious, therefore she didn't require transfer?

MR. GROEDEL: Objection.

Q. What does that tell you?

A. I don't know whether I can say that he thought that.

Q. I am not asking you to say. You weren't there. All we can do is go back and look at what people have testified to, and I am asking you to assume that.

A. You have got to show me before I --

Q. I am going to ask --

A. I am not going to assume --

MR. GROEDEL: You can assume for the purpose of his question.

A. Start over again. We're not --

Q. Assuming that Dr. Moysaenko told the daughters of Miss Skyrl that he didn't believe her

condition was serious enough to warrant transfer to the Cleveland Clinic, and that's the reason that he had not undertaken steps to ensure that such a transfer occurred, assuming those facts to be true, if they're not true, obviously your answer wouldn't be applicable, you've done this often enough to know what assumed facts do and don't do; assuming those facts to be true, what does that tell you about
Dr. Moysaenko's belief with respect to the severity of her deficit and/or whether or not she had sustained a stroke?

MR. GROEDEL: Objection. Go ahead.

A. Well, as I already implied from what I said, I don't think he thought that; but if you thought that, what does it say about him?

Q. Sure.

A. What are you asking?

Q. What does it say about his understanding of her condition?

MR. GROEDEL: Objection. Go ahead.

A. He knew that she was having a stroke. He was worried about her blood pressure.

Q. Did you understand my --
A. No, I am --
Q. -- question?
A. -- not sure I do.
You're trying to depict him as not being concerned about this patient's care.
Q. That's exactly what he indicated to the daughters.
No, I don't want you to mischaracterize what 1 said.
What you said was that he told them that she was not having any major problems requiring her transfer to the Cleveland Clinic?
A. All right. What does that say about -- let's assume he felt that he can handle the case here in Deaconess Hospital. I think that's a reasonable thing to say. He may also have been saying to the family that this thing hopefully will be all right.
Q. The fact that her conditions were waxing and waning prior to her admission on January 13th, what does that tell you, Doctor, with respect to the symptomatology and the etiology of what occurred to her on the 13th?
A. That would concern me, that she was not stable.

Q. What does it say about whether or not she had suffered a stroke prior to her coming in on the 13th?
A. Well, it doesn't tell you that she suffered a stroke that we can determine necessarily, although we're not sure of that because you can have deficit which doesn't appear on scans. We know her scan -- and I have never seen it -- I believe is said to be normal when it was first done.
Q. What does that tell you?
A. At that point you don't have any changes on the scan, that does not mean she doesn't -- hadn't had a stroke.
Q. Certainly means that she didn't sustain any brain damage --
A. No, it does not mean --
Q. Let me finish.
I understand what you are saying. It certainly means that she hasn't suffered any brain damage that can be viewed on a CAT scan?
A. That's true.
Q. That's why I wanted you to let me finish.
A. Sorry.
Q. Isn't that a rather classical description of a stroke in progress or an evolving stroke, that is

symptomatology that waxes and wanes?
A. Yes.
Q. That was certainly described in the record upon admission, you don't have any quarrel with that description?
A. No, I don't, except as I point out in my letter, I have some concern about the validity of history in light of the fact that the daughter that lives with her doesn't pick it up. I find that bizzare, If it's really --
Q. You say she lives with her. The mother lived upstairs.
A. But she saw her every day. The daughter doesn't remember being told, her -- didn't acknowledge being told anything about stroke like symptoms.
Q. Stroke like symptoms can be headaches?
A. Yes, but you talk about arm and leg problems, as I remember.
Q. Whether or not the daughter has a good memory of those things, whether the mother told the daughter, certainly the mother told the physicians upon admission?
A. Maybe, but you're only asking --
Q. Fine. Many older people probably don't

relate symptoms to their daughters depending upon their situation, if they don't want to worry them.

A. I am surprised that if she was having a stroke, she didn't say something about it.

Q. Are you saying the mother should have diagnosed herself?

A. Yes, many times patients will tell us what they think.

Q. She did tell the physician when she went on the 13th?

A. That's right when it was listed, history, she told them.

Q. Do you disagree she told them?

A. There is difference and --

Q. But nonetheless she told them?

A. Okay.

Q. You don't have any quarrel, do you, with the fact that she did tell them, that was an accurate history?

A. That's right.

Q. Would you characterize her condition on the 13th as mild, moderate, or severe?

A. I would have been concerned and been concerned about her being severe.

Q. In your opinion was she severe?

A. She had a serious elevation of blood pressure, she had focal neurological deficit, so I would have been concerned?
Q. How was the weakness on her right-side characterized by Dr. Moysaenko in the admitting physician?
A. When he sees her I think -- I think we decided he saw her -- this was the note of the 14th, correct.
Q. Yes.
A. He talks about mild weakness on the right side, difficulty with coordination.
Q. So it was mild according to him?
A. That's right.
Q. You considered that severe?
A. Well, no. The potential condition I thought you were asking about.
Q. I asked about her symptomatology, if mild, moderate, or severe?
A. But I was --
Q. Which was it?
A. I will tell you, if you wait.
Q. Okay.
A. He talks in the progress notes here about her being aphasic on the same day.

Q. What is aphasia?
A. Difficulties with speech.
Q. How much difficult was she having?
A. He also talked about problems with visual field in spite of the fact that he doesn't have a good test of visual field in his original note.
Q. My question is how much difficulty was she having?
A. I can't tell you. The notes that -- doesn't really say.
Q. Was she communicating with the nurse, with her family?
A. She was but in certain types of aphasia people can without necessarily being a severe aphasia.
Q. So it wasn't severe then?
A. I don't know how severe she is.
Q. You read the depositions of the daughters, you read the nurses' notes, you read the record, in your opinion what was it?
A. Probably not terribly severe at that time.
Q. Was it mild?
A. Yes, I would think so.
Q. You say visual fields he was not able to test?

A. Apparently. I don't know why he doesn't test them, but he doesn't. He says that in his own admitting notes.

Then he talks about getting I believe it's Dr. Zachary to see her about testing her visual fields.

Q. So are you saying --

A. So he is concerned about visual fields being abnormal.

Q. Well, can we characterize that then as mild, moderate, or severe --

A. I don't think --

Q. -- condition, or can't we characterize it at all?

A. I don't think we know. Go ahead.

Q. So there was mild weakness on the right side, there was mild aphasia?

A. Yes.

Q. Would it then be fair to say that her deficits were mild?

A. Yes, they were mild, but the significance of the deficit with the hypertension would concern me somewhat and taking care --

Q. Well, the hypertension on admission was elevated, the blood pressure was elevated?

A. Certainly was.
Q. They gave her some medication?
A. Yes, they did.
Q. What happened to the blood pressure?
A. Blood pressure bounces around the first two days but not seriously. It goes up as high as 180 over 110 on the 14th, I believe.
Q. Did it decrease to 133 over 66?
A. I did -- I don't know where you are seeing that. It did decrease.
Q. Right at Dr. Moysaenko's note.
A. That's the next morning.
Q. Okay.
A. Then it goes back up on the 14th. The nurse note somewhere for the -- the 14th, it requires medication being given at that time.
Q. It went up to 150 over 88?
A. No. It went up higher than that. It went up to -- let's see if I can find it for you.

Well, that's the 15th. On the 14th I thought I remember I saw it earlier today, blood pressure elevations.

Here on the 14th, 3:00 p.m. a nurse note, 180 over 110.

Q. What was it before?

A. I don't know that I can tell you here. Let's see if we can get another one.

The last one, nurses' note recorded looks like -- I can't read it very well. I don't even know whether or not that's blood pressure, but the point I am making, that there are significant elevations still. There is another one down here on the 15th, 11:30 a.m., 170 over 108. In patients who are getting antihypertension medication and diuretics and also receiving additional medications along the way to keep the pressure under control --

Q. Did they admit her to intensive care unit for her blood pressure?

A. No, they didn't.

Q. Why not?

A. I don't believe they did.

Q. Why not?

A. I don't know why they didn't.

Q. Should they have?

A. Maybe.

Q. In your opinion should they have?

A. He didn't seem to have much trouble with the blood pressure after the first couple of days. I mean, if they were able to watch on the floor

carefully, this patient didn't have such sustained hypertension that they necessarily had to have her in the intensive care unit.

Q. As a matter of fact, on the 14th that's when you were referring to with different times it was 150 over 84 --

A. Yes, and --

Q. Let me finish, please.

134 over 90, so there were times during the day that it seemed as they though they had gotten it under some control; isn't that true?

A. Yes, but it's not sustained control, long term sustained control. As I said, three different drugs were listed for her chronic hypertension.

Q. Why did Dr. Moysaenko originally recommend doing a Doppler, do you know?

A. Oh, I assume that he wanted to know what the condition of the carotid artery is.

Q. Be a good thing to know?

A. Sometimes it's a knee-jerk reaction, some people --

Q. It would be a good thing to know in this patient?

A. Yes, it would.

Q. In light of her signs and symptoms, certainly

they were suggestive of carotid stenosis or occlusion?

A. They certainly could have been, yes.

Q. 1 take it you have no quarrel with his having ordered a CAT scan?

A, No.

Q. Or the Doppler, for that matter?

A. Right.

Q. Both of those would be appropriate tests in someone presenting such as Mrs. Skyrl?

A. Right.

Q. Should a Doppler have been done, Doctor?

A. Yes, it would have been nice to have it done. I think I have pointed out why it was apparently delayed.

I gathered this was a weekend; am I correct?

Q. She was admitted on a Sunday.

A. Admitted on a Sunday?

Q. Yes.

A. It would have been nice to have known what it was. I am not sure that we could have acted on it.

Q. That's a different question.

A. Yes.

Q. Let's deal with one at a time.

In your opinion should a Doppler have been done?
A. Yes.
Q. And the reason again was because of her symptomatology?
A. Yes.
Q. I take it that your basic thrust is that you're not sure it would have mattered even had it been done --
A. Yes.
Q. -- would that be fair statement?
A. Right.
Q. And to some extent that is based upon the findings at autopsy?
A. No, it's based on her clinical condition.
Q. Of course because it wasn't done, we don't have the benefit of knowing what it would have shown?
A. You can assume that it would have shown the worse possible scenario.
Q. What are you assuming that it would have shown in terms of reaching your conclusion that it might not have mattered?
A, It wouldn't make any effect on would -- what I was going to do in the patient who has a dominant

hemispheric lesion, who is chronically hypertensive, who if -- whom you are still having serious significant problems -- not serious in the sense of admitting her to the unit -- you still having enough problems that required added medication in the first days of hospitalization.

Q. Once again, the hypertension?

A. Yes.

My contention -- we're looking backwards here -- is that I don't feel had I been taking care of her that I would have felt safe in anticoagulating a patient like this under the circumstances of blood pressure difficulties.

In point of fact, if indeed you saw high grade stenosis in a situation where you have what you think is a fixed lesion, I would not have felt comfortable anticoagulating that patient. That was a decision that they made at the time.

Q. Well, all right. You have had an opportunity to read Dr. Durham's deposition?

A. Yes.

Q. He addresses that contention with respect to using Heparin or not using it, based on the pages 66 and 67 of his deposition.

A. Okay.

Q. By the way, when did you review that?
A. Sometime early January, sent to me on the 8th of January.
Q. Sometime within the last week then?
A. Yes.
Q. 66 and 67, Doctor, actually it starts around 66.
A. Okay.
Q. Do you disagree with what Dr. Durham is saying about her hypertension and about what effect it may have had on her treatment.

I will give you a minute to look at it?

A. Not specifically, the premise now that he's coming from is different than mine.
Q. We'll go slow.

Mr. Groedel asked him if hypertension with her history would have contraindicated the use of Heparin, he said no --
A. Well --
Q. -- unless she was malignantly hypertensive, which I take it she wasn't?
A. No, I don't think either.
Q. Let's just take it one step at a time. I'm going to give you a chance to tell me the

differences and the distinctions. I want to hear them.

A. Okay.

Q. And he goes to know to say that -- I am now on page 67 -- that the doctor seems to have done a nice job in controlling the hypertension because she was basically stable even in a nonintensive care unit setting; do you disagree with that?

A. No, not particularly.

Q. Then further on down he indicates that any diastolic under 95 or systolic under 180 would constitute an acceptable risk for heparinization; do you agree with that?

A. Well, that's a tough situation.

If you are talking about heparinizing somebody now for short term, the answer is no; but the problem you got in this case is you're talking about heparinizing this lady, carrying her on Coumadin to the point of six weeks out, if you -- you felt you can operate, that's a different problem.

Q. Well, let's go slow.

You are saying if you are going to operate on her, you would want to follow --

A. In other words --

Q. -- her physically after surgery?
A. No, before surgery.
My contention is that this patient had a fixed deficit in the dominant hemisphere. Now it doesn't -- as you tried to characterize -- doesn't seem like it's much of a deficit, but any deficit is significant in the hemisphere where it involves -- the dominant hemisphere -- involves the kind of factors we're talking about: we got speech, we got vision, we got weakness.
Q. Why do you say it's fixed?
A. It is fixed because it doesn't go away by the 14th.
Q. In other words, going back to the definition of a completed stroke?
A. That's right. In other words, let's assume we don't know on the 13th but on the 14th it -- in my opinion we're quite clear that we're out more than 24 hours -- I'm happy to call it stroke, give it stroke beyond what the scan -- I know the scan doesn't show anything, that doesn't help me any; but it may develop something three days -- we're now three days from that time. By the 14th I no longer feel that she can be operated acutely.
In other words, she's been many,

many hours with a deficit. We know she's been -- when did she arrive in the emergency room, I think it was 3:00 or something like that --

Q. Yes?

A. -- on the 13th, so that by the time you get to that time you already have a stroke, and be it large or small, you have stroke.

Let's assume for purposes of discussion we have a high grade carotid stenosis, if you were talking what should have been done in terms of operating or being interventional, that's exactly a patient that I will not see operated right away because of the concerns about bleeding into the area of infarcted or ischemic tissue, particularly when it comes behind a highly stenotic area.

And the other problem you got here, if you don't operate right now at the time when this thing is developing and you reach this point of stroke, you don't operate, what you have is a stroke, then you can't operate in my opinion for six weeks because of this concern, so that you are faced with caring for a chronically hypertensive lady on three drugs, plus additional drugs through that six-week period on anticoagulation and

diuretics and it's not fun. It's very significant risk.

Q. I'm trying -- I think you are saying two different things, and let me make sure that I understand.

A. Okay.

Q. You're saying on one hand because she has a fixed deficit, in other words, by definition a stroke?

A. Stroke.

Q. That you can't operate on her for the fear of a bleed occurring --

A. That's right.

Q. -- intra-operative?

A. No.

Q. Or postoperative?

A. Postoperatively, sometimes; and it can occur both places, by the way.

Q. Sure. Let me ask you this --

A. That's right.

Q. -- in someone who has a completed stroke --

A. That is correct.

Q. -- another risk I take it is throwing a clot while you're doing the surgery?

A. That's right.

Q. And that's a risk with any carotid endarterectomy?
A. Right.
Q. I assume it's a risk in any endarterectomy in somebody who is hypertensive?
A. Worse.
Q. Okay. But I mean it's a risk that exists even in somebody who hasn't had a completed stroke?
A. Right.
Q. But you are saying the risk increases sufficiently *so* that you don't do surgery on someone since you say they had a stroke?
A. Yes.
Q. You have to wait then for their neurological symptoms to what, plateau over a period of time of six weeks?
A. Yes.
Let me back up a -- a little bit.
Q. Let me just follow-up on that point.
A. Okay.
Q. A completed stroke occurred in her definitionally within two hours because of the continuance of symptomatology?
A. That's right.
Q. Even though the symptomatology we agree was

mild?
A. That's right.
Q. Was that due to a total occlusion, in your opinion?
A. I don't know that. I don't think we can tell that.
Q. Could it be due to partial occlusion?
A. Yes.
Q. If in fact it's a partial occlusion, at whatever, for whatever reason, the stenosis, whether it is clot; partially blocking the artery, it's not a total occlusion even though you have some symptomatology as a result of a partial blockage of blood supply to the brain and oxygen to the brain, then don't you have to operate to prevent it from totaling occluding if it's not totally occluded?
A. No. No, because we have been using definition of stroke, you can't operate on a fixed stroke.

In point of fact, to operate on anything that's progressed this far, even at our hospital, is considered still highly experimental.
Q. Experimental?
A. Well, in the sense we're still trying to find

out whether you can get away with it or not. Let me back up and review this.

In the past this was done, Dugan did it at Mass General Hospital in the past. I can remember cases where vascular surgeons won't touch a case three hours out, and here people won't touch a patient two or three hours out. We don't do it because of difficulties in all these areas that we have been talking about.

My difference of opinion with Dr. Durham is that the fact that I -- I don't think that's standard of care to operate early. It is still -- we're still trying to figure out those parameters.

Q. Who is the head of surgery here, is it Dr. Rubin?

A. Dr. Rubin I think -- I believe has left.

Q. Has he?

When he was here, is it your testimony he wouldn't have done this?

A. He -- no, he may have. Certainly may have.

Q. Of course he would have.

A. He would have.

Q. Do you know who sent me to Dr. Durham?

A. But --

MR. GROEDEL: Objection.

A. He may have, but let me tell you, in point of fact, I know several vascular surgeons who don't do it.

Q. For you to say that people around here wouldn't do it, you are wrong about that.

A. I'm sorry about it. One of the -- our surgeons wouldn't do it, as we have talked about it, and I have not been able to get other good vascular surgeons to do it. Now --

Q. Why have you tried to get --

A. Yes.

Q. -- why have you tried to do that?

A. Out of interest, can we do something for this poor patient going sour in front of us. We all feel terrible, and I had a case the other day --

Q. What you're saying, if you have a situation like this, surgery is in fact something that has to be done --

A. No.

Q. -- emergently --

A. No.

Q. -- to try to prevent precisely what happened to Mrs. Skyrl from happening?

A. No. It's -- we're not working on plumbing

here. We're working on brains and arteries leading to brains.

Q. You don't do surgery?

A. No, 1 don't, but I've worked in the area a long time. We know that the risk of operating -- operating early is extremely high, very, very high, and in neurology we do not do this.

There is a tendency to look now, again at early operation. 1 don't think in any way, shape, or form this should be considered standard of care. Early operation, it is -- isn't standard of care. It's getting out beyond the reasonable and expected. I think it's risky. I still don't do it and most neurological colleagues do not do it.

Q. Should a neurologist have been consulted --

A. I would --

Q. __ regarding -- let me finish -- regarding Mrs. Skyrl's care prior to the time that Dr. Juguilon actually saw her?

A. I would thought -- I would have thought it would have been desirable.

Q. And/or a vascular surgeon?

A. Depends on your bent. Yes, perhaps.

Q. Either one would have been appropriate?

A. Yes, it would have been appropriate.
Q. Would you agree that Dr. Moysaenko appropriately controlled her blood pressure?
A. I think within reason, yes. There were periods when there were elevations, but we see those on our own service in the best of situations, trying to control patients in intensive care unit you might have a little bit of tighter control. I can't say she suffered particularly from hypertension.
Q. So this was not severe uncontrolled hypestension?
A. Yes, it was. The concerns that I have over the long haul --
Q. While she was in the hospital?
A. He couldn't have kept her in the --
Q. While she was in the hospital, when I say severe uncontrolled hypertension?
A. Not initially on admission. On the day of the 14th, you were having trouble controlling, but by -- by and large of itself, the rest of it is reasonably controlled.
Q. Could a carotid arteriogram been done on her?
A. With increased risk, yes, very much so.
Q. It wouldn't have been contraindicated, you

might have to factor in --
A. You have -- you have to tell the family, look, we're going to do the test which is dangerous to start with, and it makes it much worse; and I think that you got to understand, are you going to do something with a test, if you got it.
So my feeling, because of the clinical situation I outlined to you, I wouldn't have exposed her to a carotid arteriogram at the present time. I would have tried to manage it medically.
Q. Was it contraindicated because of the hypertension?
A. I think relatively so, it could have been done, but relative contraindicated, would have been difficult to do safely.
Q. How much of a risk is there in the absence of hypertension?
A. Somewhere between a half and one percent.
Q. This is a risk of what, stroke, maybe?
A, Yes.
Q. In the presence of hypertension how much of a risk is it?
A. It's hard to figure the --
Q. Two percent?

A. It's probably two or three percent. Two or three percent, something like this I would say.

The other thing to say is --

Q. Let me just follow-up on that.

A. -- two or three percent is not contraindicated in hypertension, this lady also has a stroke. Okay?

Q. Okay?

A. That increases the risk.

Q. So what four, five, percent?

A. Wouldn't -- don't know the answer to that. There is a controversy. Some people don't believe that it -- it's a problem. I have personally seen it myself. I know people are doing early angiograms, looking at the TPA and thrombolysis and trying to decide if the patient is a candidate for thrombolysis.

So far there have been very small studies and some people do fairly well, but when you have to do hundreds of patients, then you really see where you are, and I personally even have seen stroke patients get much worse after angiograms, had one last Fall.

Q. Nobody's suggesting that there is no risk.

I guess what I was trying --

A. Lots, a lot of risk.
Q. -- what I was trying to do is quantify it to some degree.
You're talking four or five percent --
A. Probably.
Q. -- so we're not talking about it being contraindicated, rather we're talking about increased risk?
A. Yes.
Q. In your opinion was the left internal carotid occluded on the 13th?
A. I don't know that I can tell you.
Q. There's just no way to tell?
A. There's no way to tell. In fact, even if your carotid ultrasound had told you that, you wouldn't know that because --
Q. For sure?
A. Because of limitations of test, exactly. You have to do an angiogram. You may be 99 percent, that's different than 100 percent.
Q. The stroke that she sustained on the 16th I believe prior to her transfer --
MR. GROEDEL: 15th.
MR. **KAMPINSKI**: Evening of

the 15th, that's right.
Q. Do you have an opinion as to whether or not that was a primary carotid event?
A. I don't think I can tell you that.
Q. Why not?
A. I just don't know that we have any indication that that was the case.
Q. What about now that you got the completed autopsy, you don't think you can tell whether that happened.
A. We're told we have had an ante mortum clot, that's all I can tell. Exactly when it occurred, 1 don't know.
Did it occur before she died, yes, that's all we know. I don't know that I can --
Q. It says the left internal carotid is completed occluded by ante mortum thrombus and atherosclerosis.
A. Right.
Q. Does that tell you it was a carotid event?
A. That what happened with her drop in blood pressure and chest pain at that time?
Q. Yes.
A. No, it doesn't. She developed chest pain apparently and it was assumed -- I would assume

from what they did that he thought it was probably coronary.

Q. What he thought it was at that point --

A. We now have the percentages of occlusion of carotid, it can occur -- it can change slightly without any pain or any other changes at all.

Q. Doctor --

A. Wait. Let me back you up.

Q. -- there were no changes in --

A. Just angiogram, the patient in a hospital who has no knowledge of when her carotid was occluded. She's 54 years old now, doesn't --

Q. Did we have an autopsy --

A. I know,

Q. -- reflecting occluded --

A. Doesn't tell you when it happened.

MR. GROEDEL: Let him finish the question.

Q. That's what we have?

A. Yes.

Q. Is that the most likely cause of her brain damage and ultimate death?

A. Yes. Definitely.

Q. So it was not a cardiac event that was the most likely cause of her brain damage and death,

right?
A. I don't think so. I mean, I don't know that. What happened -- I don't know what happened. At the time she talks about chest pain and drops her pressure. Did she close off the carotid then, I don't know that.
Q. Is that most likely?
A. She may have, but did she also have chest pain and that -- I don't know. I can't tell you.
Q. What is the most likely in light of the autopsy findings?
A. But I have told you already I don't know whether she occluded her carotid.
She occluded her carotid sometime around that time, if that's what you want to know.
Q. Yes. What is there about an autopsy finding on the heart that assists us in determining whether or not this was a heart problem or carotid problem?
A. We are assisted by the fact you don't have any coronary disease described, but that doesn't tell you she doesn't have coronary spasm or some other cause of --
Q. You hear hoof beats, what do you look for?
A. That's what I thought in terms of clinically, he treated as if she had heart disease, not

knowing --

Q. That's terrific. But we now have hoof beats.

A. You are asking me to clinically --

Q. No. I am --

A. I look at the patients clinically. It's --

Q. Doctor, I am asking you to take into account everything you now know, including the autopsy finding. We can now look backwards.

You can have a high degree of assurance as to what it was that was her problem, don't you?

A. We know what her problem was. I am telling you 1 don't know when it occurred.

Q. Doctor, the --

A. I don't know.

Q. -- isn't that the most --

A. You're asking me if the chest pain was a sign of carotid occlusion.

Q. As result of the carotid occlusion?

A. No. No, I don't think so. I can say that.

Q. What was it due to then?

A. 1 don't know. It may be due to coronary spasm, it could be any number of possibilities, but I don't have an answer to that.

Q. Did you review Dr. Sala's report?
A. Who?
Q. Sala.
MR. GROEDEL: No.
A. No.
MR. GROEDEL: I didn't send it to him.
Q. How about Dr. Gardner?
A. No.
Q. Do you know him?
A. Yes, very well.
Q. Have you worked with him before?
A. Yes.
Q. Have you seen his report?
A. No, I haven't.
Q. Do you believe, Doctor, that a complete occlusion had occurred many months prior to her admission on the 13th?
A. I can't really tell you that because the way the clot or the way the thrombus is described. I assume they're talking about real thrombus, in which case it sounds like it occurred sometime before death; but it occurred recently in proximity to the patient getting into trouble with this here.
Q. Which would be contrary to it having existed

many months prior?
A. Yes, because the pathology looks different in that situation.
Q. So I take it there is no evidence then that there was a myocardial dysfunction in Mrs. Skyrl?
A. There is no pathological evidence, okay.
Q. Did you review any literature for purposes of preparing your report?
A. No.
Q. How about since that time?
A. No.
Let me say this, I am on the ward right now. I see probably one or two new strokes a day, we're always talking about this area. This is an area I am very comfortable with because a -- of my association with the Cleveland Clinic going back to lectures about strokes and the management lectures in hospitals about it.
Q. By the way, even a cursory review of the record would reflect that the symptomatology of Mrs. Skyrl was waxing and waning, wouldn't it?
MR. GROEDEL: Objection. At what time?
MR. KAMPINSKI: Prior to --
MR. GROEDEL: Did you recall

that?

MR. KAMPINSKI: Prior to her admission.

A. If you believe the history, yeah.

Q. It's there in the record.

A. I am willing to accept that patient somehow imparted to Dr. Moysaenko the added idea this thing was coming and going before admission, although I am really concerned when I find that a daughter who lives in the same house doesn't recognize that it's happening. That I find bizarre, but that's all right.

Yes. I would be willing to say yes to what you said with -- though with considerations.

Q. A duplex scan is fairly -- it's not invasive?

A. No, it is not.

Q. Pretty easy to do?

A. In good hands.

Q* Yes. Well, I am assuming that it's --

A. You can't have a substitute technician doing it for extra money.

It's easy to do otherwise.

Q. As a matter of fact, of the potential tests that Dr. Moysaenko had ordered, I take it it would

be the easiest one of all to do, easier than a CAT scan?

A. Yes, maybe, but I don't know. We're splitting hairs.

Q. Easier than a Holter?

A. Holter you could wear 24 hours.

Q. Sure.

A. Echocardiogram's about the same type of test. EKG is a lot easier. Okay.

It's not a difficult test, if that's what you're asking, in proper hands.

Q. To your knowledge could it be done at Deaconess?

A. I assume it can be done at Deaconess if you order them. 1 don't see any arrangements to send the patient out to do carotid ultrasound in here or --

Q. Can they do MRI's there?

A. I don't know whether they can or not. I would assume they probably can. I don't remember.

Q. Do you have any criticism at all of the hospital personnel?

A. No.

Q. Any of the Cleveland Clinic personnel?

A. No.

Q. From a timing standpoint there is nothing that would have precluded doing a scan on Sunday had one wanted to do it and bring in the personnel?
A. No.
Q. Or Monday morning, for that matter?
A. No.
Q. Or Monday afternoon, for that matter?
A. Right.
Q. Do you believe that her -- I apologize if I asked this already, I just want to make sure in my own mind I understand -- do you believe that her stroke that occurred on the evening of the 15th was probably caused by the carotid thrombus as opposed to any potential episodes of hypotension related to myocardial dysfunction, which is more --
A. I think so. I think that what she did was occluded, finished off her carotid. If she had a high grade stenosis, that's why she finished the situation.

Let's assume that she enters the hospital on the 13th, it's 97, 98 percent, she finishes the carotid occlusion, if that's what was going on at that time.
Q. On the 15th?
A. Yes.

Q. Or if it was a thrombus, which is indicated on autopsy, ultimately closing that carotid, that's still a carotid event?

A. That's what I mean by carotid occlusion.

Q. In other words, a thrombus is what, a plaque?

A. Well, no. A thrombus is fibrin and platelets and all the coagulation factors that come together to make a clot.

Oftentimes it comes in the situation of atherosclerotic plaques, which is a plaque down in the endothelium and irritation of the wall, the deposition of calcium, and severe atherosclerosis allows plaque to build up and clot, then that narrows things more, and you know, clot then propagates and it closes the thing off.

Q. You say propagates, moves?

A. Not necessarily. It may just extend up an artery. It may move. You don't know whether -- I mean, you can't tell at this point.

I assume that it's totally occluded on the basis of autopsy, but in point of fact, we have seen situations where carotids were not completely closed off and the patient still has the same kind of damage. We're talking about clots broke off and fills a middle cerebellar artery and

causes a patient's demise. There are various different ways it can happen.

Q. In any event, it would have been the carotid, the thrombus in the carotid that caused her massive stroke?

A. In somewhat or other.

Q. Yes. We're talking about that's what caused her stroke.

A. I think what you're getting at is --

Q. Go ahead.

A. You may be getting at did the hypotension cause the ultimate demise.

Q. Right.

A. I can't tell you, exactly tell you. I don't know that. I think she gets -- gets a transient period of time after she gets her pressure back up. She goes on and gets into serious trouble, so I think the end event is the carotid; and I don't know what happened really to cause her blood pressure to drop. It may have been something happening with her, it may have been the addition of the Nitroglycerin.

Q. You can't tell me if --

A. I don't think under the circumstances to have given Nitroglycerin, I can't go back and fault the

doctor in the absence of coronary vessel disease.
Q. I am trying to get at what you believe it was that caused the stroke, was it cardiac related --
A. No.
Q. -- related to thrombus?
A. It's related to whatever pathology based on the carotid with the types of changes that can occur.
Q. If carotid endarterectomy had been done, you don't believe that this would have prevented the ultimate stroke that occurred on the 15th --
MR. GROEDEL: Objection.
Q. -- or do you?
MR. GROEDEL: Go ahead.
A. Could you conceivable get away with it?
Q. No, that's not what I said.
A. What are you asking, I am not quite sure.
Q. The purpose of doing carotid endarterectomy is so someone like Mrs. Skyrl, whether you believe it to be experimental or not --
A. I don't think that's a proper word.
Q. You used it.
A. It's not a good word.
Q. I don't think it's a proper word either.
A. It's something we don't do, but --

Q. When you say "we," you don't do it anyhow, you are not a surgeon?
A. No, but I am -- the point is we don't send people to carotid surgery -- most people don't send people to carotid surgery in situations where a patient had a significant deficit lasting several hours. I think that's -- that you have to understand, although this area that you are alluding to of operating acutely has been looked at in the past, it's been looked at in retrospect with a jaundice eye because of *so* many problems that did occur.
Q. By neurologists --
A. It's not looked at as the -- it's not standard of care.
Q. By neurologists, by surgeons, who are --
A. I know vascular surgeons won't touch it on cases. I've tried, okay.
Q. Perhaps because they don't have the ability to do it.
A. No. No.
Q. Let's get back to had the carotid endarterectomy been done, is it your belief that it would not have prevented the subsequent stroke that occurred on the 15th?

A. Well, I don't know if we were -- if I completely understand you.

If you do a carotid endarterectomy to try to prevent a stroke -- and I think you have to weigh the risk/benefit ratio -- my feeling is that the risk of doing it was higher than the possibility of getting in and out successfully. There I wouldn't --

Q. The risk I think we discussed was between four to five percent?

A. You are talking angiographic.

Q. What is the risk of carotid endarterectomy?

A. It depends on your surgeon.

Q. If Dr. Durham said four to five percent, do you agree or disagree?

A. Four to five, six percent somewhere.

Q. In that area?

A. That's in a good patient.

Q. That was in Mrs. Skyrl?

A. I am not sure I would accept that because in symptomatic patients without stroke, such as the North American Symptomatic Carotid -- Carotid Endarterectomy Trial, you had to have I think what, six percent to beat the medical numbers of disease left alone in high grade stenosis, they did --

didn't operate on stroke, okay.

In other words -- in other words, anybody who had a significant deficit at six hours would not have been taken on, or probably two hours would not have been done on. In a study there you're talking about six percent.

If you're talking about operating on somebody who is already got a stroke, who is in -- got hypertension and bad carotids to start with, I don't know that we know the risk in -- it.s going to be much higher than that.

Q. Ten percent, maybe?

A. I don't know the answer to -- I mean, it's not acceptable to me.

Q. He's a surgeon, he said that percentage is four to five percent.

A. But surgeons tend to be optimistic, and rightly so, but I don't know that we know those answers specifically very well in a situation like this. It's never been, that I know of, specifically looked at.

We know from past history when people operated very early, that the disaster rate was unacceptably high.

Q. Is that when surgically the techniques

weren't as good as they have now?
A. I think we're in a period in the past where they were good enough to say the techniques were similar. Granted, there are -- there has been changes.
The whole question of if you do shunts at the time of surgery, do you use EG monitoring, all that. Given those things, I think that even a period where those things were available and knowledgeably used, that's been a long time now, that we still don't operate on these things.
Q. So your point is you shouldn't operate, but my only question once again though --
A. No.
Q. -- is had the operation occurred --
A. Acutely you mean?
Q. Yes. On the 13th or 14th, at any prior to the actual stroke that occurred on the evening of the 15th, that occurred with whatever risk factor that you are talking about, four or five or ten or you don't know the number, the number we have from Dr. Durham is four or five, but regardless of what a risk factor is, all right, would there then be a 95 percent chance that she would not have had the

stroke --

A. No.

Q. __ or 90 percent --

A. No.

Q. __ chance depending on what risk factor --

A. No. I would be careful. Again, let's clarify his number.

We had the -- to reach six percent as carotid subjects, to even come within acceptable range in terms of operating on patients without stroke. Here we have a stroke. We got a significant deficit,

Q. Wait a minute.

What do you mean, I thought you -- we had agreed, I don't want you to change your terminology on me, that she had a mild deficit?

A. A mild, it's very significant in terms of the dominant hemisphere. If you want to say large, you have to speak, in order to be able to do her work. A lady has to work and anybody's who's sitting on an unstable situation, who is aphasic, is looking at a significant problem.

Q. She was speaking, sir.

A. I understand that. She's aphasic in the notes that Dr. Moysaenko writes.

Q. Can we get back to my question?
A. We can.
Q. What is your answer?
A. In terms of the surgery?
Q. Yes.
A. I think the risks are unacceptably high. They're much more than six percent.
Q. I've gotten past that.
A. What are you --
Q. Had a carotid endarterectomy been done, would she in your opinion have suffered stroke that she did suffer on the 15th?
A. You are out beyond what you can answer. Yes, I told --
Q. I'm asking you to assume that some doctor --
A. Let me tell you --
Q. -- would have performed --
MR'. GROEDEL: If you can't answer --
A. I will answer you this: There are cases where you are sneak ng through a small space in a hole and can make it out luckily, and make it. That is the way you have to make this decision. This is not a given, that surgery would have helped necessarily at this point.

Q. Is that because of tests that weren't done so we can't tell?

A. No. I told you why.

Q. Because the risks were too high?

A. That's right.

Now, does that mean in 100 patients that you are not going to get a few through that, you can possibly sneak through, that's possible; but it is not in a situation where we can say this patient's going to make it, that one isn't, without a big stroke. We don't know how those particular patients will do.

Let me also say that people are looking at this area again of operating early. We have looked at the area of operating in aneurysms, have been successfully operating early there, but we still are nowhere near that definition in the area of surgery on carotid disease with a fixed deficit of certain lengths of time, and you're talking about a dominant hemisphere chronically hypertensive lady.

Q. What is intercavitary clot?

A. Meaning something in the heart that would have been an embolic source of stroke to the carotid or to the head.

Q. She didn't have that?
A. No, she did not. It appears she doesn't have that.
Q. Would you agree that most nonsurgeons elect a nonsurgical approach?
A. No, I don't. I'm sorry. I am just as aggressive when it comes to the right patient. Have been known to be so.
Q. Has this hospital been involved in the North American Symptomatic Carotid Endarterectomy Trial?
A. I have not been involved, but been involved in -- in the finishing of that study.
Q. That was by a neurologist Hugh Barnett?
A. It's not Hugh. It's Henry.
Q. Henry?
A. Yes. And the problem, as you may or may not know, we don't know below 70 percent who should be operated and who shouldn't. We're having trouble finishing the study.
Q. Because of the ethical considerations?
A. Yes. Doctors are nervous about submitting patients to a trial. We know probably below 50 percent, can leave them alone; we know about the 20 percent in between.
Q. You're talking about the degree of stenosis?

A. Yes. People are reluctant to submit patients. I am trying to finish the study so we can find out where they had -- we've been operating, how far down should we go.

Q. Did it make any difference to you in terms of your opinions or findings in your report when you got the complete autopsy or is that something you anticipated?

A. I think it finished the question that I raised about, you know, the business about heart lesions.

Q. That took care of that?

A. Yes, but it doesn't make any difference to me where the carotid is here in terms of open or closed. The patient add a stroke from the bad carotid, I assume. I agree with Dr. Durham, my thought would have been carotid here, too.

So doesn't really matter what percentage it is. To me 1 think it's high grade. We knew that and we knew it was significant enough to cause this disease.

Q. Would it matter if the extent of stenosis was less than the clot itself? In other words --

A. No.

Q. Do you know --

A. Yeah, I think I know what you mean. In terms of Dr. Durham's testimony about percentage and so on?

Q. Yes.

A. Sure. I agree you can't tell at autopsy what your percentage is anymore -- unless the thing is rigid and firm, even then you can't tell because it's been fixed -- no, it doesn't really matter.

The fact that it's got very significant disease, has a significant clot in it is -- that's really the important thing to know.

Q. I guess the reason I am asking, at least in terms of trying to think as to what it was on the 15th versus the 13th, would it have mattered, let's say, if a Doppler would have been done, and the carotid angiogram been done, angiography been done, if you follow what I am saying?

A. I think so.

Q. We know because it was totally occluded?

A. Yes. Would it have mattered then?

Q. Let's assume for purposes of the discussion that the surgeon was going to operate, I don't know whether he would have opened 100 percent, that depends on the surgeon, but --

A. We don't open 100 percent occluded carotids

at any time, even in patients who are asymptomatic, we do not; this lady or anyone on day one, open them and get into trouble.

Q. Okay.

A. If this patient were a much more -- what was the word -- a good candidate, in other words, totally had blood pressure under control and total complete resolution of symptoms, went through that window of opportunity like I have talked about in my letter there, where the patient's symptoms totally resolved, negative CAT scan, no deficit at all, would you then have had to know, you bet you had to know. That's a case where you would have operated.

Q. But I am saying that you had to know, doesn't having the information I guess available now with --

A. You would have had to know then what percentage was the stenosis and what can I do about it.

Q. Let's assume we're talking about the present?

A. Then you need angiogram to be a little sure.

Q. What kind of scenario would we have been -- what kind of emergency or operable scenario would you need to see?

A. Let's say this lady came in with a history that she had a totally cleared blood pressure, wasn't much of a problem, running 180 over 100 or 180 over 90, and you feel that gee, maybe this is a carotid stenosis of significance; you do a Doppler because it's the fastest thing you can get, you decide we're in high grade stenosis, we're in trouble.

Q. "High grade" meaning?

A. Meaning anything above 80 percent you would have been concerned.

Q. Okay.

A. You would have angiogramed her then, but given the fact the deficit never cleared, it's my contention, and I think the majority of contentions, that it is not appropriate at that point --

Q. You're getting back to that. I heard you first, second, and third time.

A. Your surgeon, I don't have much disagreement with your surgeon, but I do have a -- have lots of disagreement somewhat operating on a fixed deficit after a prolonged time. That would --

Q. A fixed deficit of prolonged time? What is prolonged?

A. You are out more than a couple hours.
Q. So in other words, after a couple hours you consider to be a long time?
A. If you're out that long, you can't do it.
Q. Getting back to, though, what I was trying to --
A. I'm sorry if I didn't answer.
Q. It's okay. Maybe you did answer it.
Can you say that anything over 80 percent, whether it be stenosis or stenosis plus clot, occlusion, anything over 80 percent that you would visualize on angiography would then be a surgical emergency if you were in a window?
A. That's right. In other words --
Q. -- at that time, whatever it --
A. You got a history from a lady that she was waxing and waning, she comes into the emergency with reasonable blood pressure and everything goes away, you got 80 plus percent, I go right then before it happens again.
Q. I hear you.
By the way, would it matter to what extent she was able to communicate? You said before that she was speaking.
A. Does matter. You're talking about an

ischemic dominant hemisphere, if you got a lesion, ischemia in the dominant hemisphere, the patient could be ruined, really.

Q. So if she's speaking, if she can verbalize, if she can talk to the doctor, the family, the nurses, that would be a better indication for you as a physician from a neurological standpoint as to potential surgical intervention?

A. Yes. I think we're on the same frequency here. If I thought the patient had minimal deficit, were you -- I remember when Eisenhower had a stroke, he had trouble finding words.

Q. I am old enough.

A. He didn't have massive hemiparesis and he didn't have a visual problem. He would --

Q. Didn't affect his golf game.

A. Right. I would accept a little bit, I would accept a minor diagnosis; but once you start with high blood pressure and blurriness and the family practitioner who doesn't really appreciate how to do fields, apparently doesn't do them himself, he's got a problem without visual, that works all along with a stroke. I am not sure, but I think it does.

He's got clumsiness and weakness

later the next day. He described 3 over 5, which is pretty darn weak, and aphasia, that's too much.

Q. So in other words, one of the problems that maybe we're having is his ability to define her deficit? In other words, if I asked you to assume that she was verbalizing with him, with the family, with the nurse and with almost no deficit whatsoever, would that affect your opinion?

MR. GROEDEL: Deficit with regard to the speech or --

MR. KAMPINSKI: Yes.

A. If we had no demonstrable deficit, you know, and I -- all of€ us are dealing with not knowing what it really is, but when you start talking about what is coming out of the left hemisphere, if somebody who is not a neurologist tells me the patient sounds aphasic, we got right-sided weakness, visual stuff, that's enough for me to tell you that you can't get aggressive.

Q. So your opinion then is based upon his clinical description?

A. I have to base it on that.

Q. They have to base to it on clinical symptomatology is what you are saying?

A. In other words, to the nurses' notes or

anyone else's notes of surgery that she totally cleared, these are the things you look to see.

Sometimes you see that a particular patient looks to be okay by the intensive care nurse, that would be helpful. We don't have that here.

Q. When she came in had her vision improved?

A. I don't know that I can tell you that because I had that sinking feeling I didn't know exactly what was happening when it was described as being a problem. Although I think he describes her somewhere is that she has trouble with -- let me see if I can find that here.

Q. This is Dr. Moysaenko's admitting history and physical dictated on January 13?

A. Not dictated in there.

Q. You got that.

A. Let me see. She indicated she felt there was something in her left eye nasally, which was impairing her vision.

Now, couple possibilities: one is that she has a problem with her hemisphere, in that she's really describing a visual field cut; other possibility that she -- again, to get her circulation to her eye from an occluded carotid, I

don't know that we're ever going to know that. He doesn't do his fields, which is unfortunate.

Q. You got his note of the 13th in front of you there, Doctor?

A. History and physical, yes.

Q. Let me just go through that just a little bit.

I mean, it's got she's alert and oriented times 3, okay; what does that mean?

A. Where are you now?

Q. Right at the beginning, physical examination.

A. It means she was aware, knows where she is, knows time, place, and person.

Q. So she has to be able to verbalize that to him for him to put that down?

A. Yes. Then he goes on to say extremely slow and deliberate speech with errors in word selection. That suggests to me a patient has aphasia, but I don't know that without specific testing.

Q. He goes on --

A. Not only -- it's not only -- I just don't know what kind of aphasia it is or how dense it is.

Q. Sure.
A. Some aphasia will cause an increase of normal manipulation of speech rates and another aphasia will often cause a decrease in speech rate and trouble with word finding alone, which is not necessarily indicative of location, so you --
Q. But you don't know --
A. Not enough on exam.
Q. Pupils equal and reactive to light and accommodation, they are mid point and --
A. What are you --
Q. -- I see no hemorrhage, no exudate no papilledema, what does that tell you with respect to her eyes, anything?
A. Well, it doesn't tell me anything about her vision. It tells me the pupils are round and reactive, that whatever is going on has not affected her pupils. He didn't see anything in the fundi.

In terms of hemorrhages or exudate, the papilledema is swelling from increased pressure, but we don't have either of --
Q. But those are good things in terms of what he reports?
A. Yes.

Q. Carotid up, stroke, plus 2 bilaterally; what does mean?

A. I don't know what means to him. I guess it means he wants to know -- I think they're equal in pulsation, but that is of doubtful benefit no matter who does it.

You can have a completely occluded carotid up above, just beyond a certain angle and the pulse will feel the same on both sides, so that doesn't help you.

Q. Under neurological, she's alert, oriented times 3, with cranial nerves 2 through 12 intact; does that tell you anything?

A. Well, within the limits of testing, no. Visual fields are not tested.

Does she have a subtle facial weakness going along with that, I don't know that.

Q. We can only deal with what is here?

A. That's right. You can, and --

Q. Based on what is here --

A. That's all I can tell.

Q. -- what does this tell you, her motor strengths was questionable, slightly diminished on right as compared to the left, however, this is subjective; doesn't sound like he's describing any

type of deficit; does it, Doctor?
A. Apparently this -- I agree it's not terribly severe in terms of the degree of motor weakness, okay, the constellation, the picture put together with knowing the potential down the line of what could happen to a patient with a potential serious problem.
Q. I am trying to deal with the clinical symptomatology here, which is what I'm presuming you're basing your opinion on here, and looking at the clinical symptomatology it doesn't appear to be that significant, does it?
A. It's pretty significant.
If you go back from that note alone?
Q. Yes.
A. I would rephrase the question. When you get back in the note of, let's see --
Q. This is here, a dictated note based on his history and physical at her admission, isn't it?
A. Yes, but other -- other reasons I felt that there was -- you go onto the 14th at seven o'clock --
Q. Just a minute. Let's deal with the 13th for a minute.

A. He didn't actually -- he sees her on the 13th. I don't believe he --

Q. Well then, how can he dictate a history and physical?

A. 1 think the hospital did that.

Q. Whoever saw her on the 13th, that's what he based -- you know, you have to deal with residents all the time. I guess a lot of times this will happen, you sign stuff and it's really dictated by somebody else?

A. And timing. We don't do it for the legal system, we do it for the situation.

His admitting notes here and written notes is on the 14th, and this thing says it was dictated on the 13th.

Q. That's what it says?

A. Transcribed on -- one is dated the 13th, but I don't have any other evidence that he saw the patient before the 14th, but 1 don't know. I may be wrong about that.

Q. Dealing with that dictated note that we just looked at --

A. Would I be aggressive with her?

Q. Yes.

A. No.

Q. Still not?
A. No, because of the aphasia, and the aphasia and weakness and the whole picture.
Q. So it doesn't matter that his description was that -- I mean, it's not even clear that she has weakness from this description, it says questionable?
A. Yes, but somewhere --
Q. Well, let's deal with this for a second. I can appreciate that you --
A. My point --
Q. You may want to go --
A. -- my point in my letter to Mr. Groedel is that she never completely resolves.
That much speech deficit is --
Q. How much speech deficit?
A. We don't know. Gets back to what you said, wouldn't it be nice if a neurologist had seen the patient. We really knew that's a problem all over the country.
Q. What if I told -- what if I asked you to assume that she was having, you know, total conversations with her family, with the nurse, with the doctor; I mean, she was cognizant of what they were saying, she was able to respond, she

participated in the decision as to whether or not to go to the Clinic, she was cognizant of what was going on, she was able to communicate, would that matter to you?

MR. GROEDEL: Objection. Go ahead.

A. No.

Q. No?

A. No.

Q. Okay.

A. My point is she still has a deficit, a significant deficit in the sense of the potential for this thing extending. It's never clear, as we have discussed here, it's never cleared, that's critical. She always has weakness, she always has aphasia.

I hate to tell you how many times I am called to see patients in all kind of hospitals, it's please see this patient, she's just a little off there, or a little off; then you're looking at them, they are severally affected when you consider the constellation of what you find as a experienced neurological examiner. Okay. Big difference.

Q. I take it then your difference and really maybe the only difference with Dr. Durham is his

opinion that because the deficits were so minimal, that she was in fact an appropriate candidate for surgery, that that's what you disagree with; you are not -- to you it doesn't matter whether they were severe or minor, the fact that they were there at all?

A. In time.

Q. He agrees with you, if you read it --

A. In time.

Q. That definitionally if they're there €or hours, that's a stroke; he agrees with you?

A. But I also point out to you, I feel strongly you can't operate beyond an hour or two.

Q. That's fine.

A. I can't find surgeons that used to do it anymore.

Q. When he says that the symtomatology was mild --

A. I'll turn it around. Here is vascular surgeons, and I have had trouble with other vascular surgeons, just a little stroke. A stroke, is a stroke, is a stroke, okay, whether it's in the dominant hemisphere. It not more serious if it's a little stroke in the non-dominant hemisphere, but it becomes real serious if it becomes a major

completed stroke as did --
Q. Mrs. Skyrl?
A. -- this. We as doctors must not create this disastrous or -- well, as doctors there shouldn't be intervention where we shouldn't be.
Q. You should prevent it, if you can?
A. My contention --
Q. Your disagreement with Dr. Durham is that you don't believe a surgeon should be entering into this at this time without the --
A. That it's still not accepted, regular accepted care. This is way beyond expectation. We would have --
Q. In your opinion?
A. No, I think it's --
Q. I'm talking -- only talking to you.
A. Exactly. It's the opinion of lots of people and --
Q. We don't have lots of people here.
A. This does not get done in this hospital either by neurologists, does not get done by one of the vascular surgeons.
Q. Gets done by the other one?
A. We don't -- we don't agree with him. We've had some real problems.

Q. I see.

In terms of the transfer to the Clinic, should Dr. Moysaenko have been more aggressive in ensuring she got transferred once the family requested that?

A. You don't know. You know what I wrote in my letter, and I know how hard it is sometimes to find a bed.

First of all, you find the Fellow, and the patient may or may not be an urgent problem in the eyes of the person who is on the expecting end, who may or may not --

Q. How about the sending end?

A. Okay. That's possible, too. But for reasons that I suggest, didn't make any difference in the sense that it was completed and you no longer could operate if he had -- had been calling, whether he realized or not, it didn't make any difference or not.

Q. Okay.

A. So he calls, he finds a Fellow who thinks, was it Letterman in this case, okay and whatever it was, it was Letterman, I guess, and they get around and you're talking about the patient, the doctor calls you back, you say gee, you got a bed, I'll be

right over, maybe we don't have a bed, we'll take the patient tomorrow. These are things that happened in the course of transfer to big institutions.

Now, if somebody's got a risk of stroke, if there's not any room in the manger, you make room; but if the thing is felt to be a completed stroke, or the thing is felt to have been a stroke which is relatively stable, you can't operate at this point. I don't think you move them out just to move a patient.

I suspect there were problems on both ends, from what I can gather in reading what we have. I think he made an effort to get ahold of the surgeon, he did make an effort to get ahold of the patient, the patient -- or the physician rather at the Clinic, and you know, whether he communicated what exactly what he was doing to the family, I don't know that, but he says this in depositions and other places, and I can understand the difficulties. I been there myself.

I happen to know the inner workings at Cleveland Clinic. 1 know exactly who you could call. I don't have any problem. You want to get a patient to the Clinic tonight, I can do it if it

were appropriate; but I can understand that somebody who doesn't deal with the Clinic every day may not know the system, may not be able to affect a transfer quickly. So in that respect --

Q. Let me ask it differently then: If you can't, you as a physician, can't get a patient transferred promptly, should you then undertake the tests that they indicated ought to be done in the interim, the person's still a patient?

A. I understand. I also pointed out in that letter that the two tests that we have in contention that are remaining are the carotid ultrasound --

Q. And the echo?

A. Yes. And probably would the patient have been changed there, they would have been done at some point at the Clinic anyway, therefore you're not going to act on them differently at this point. The person -- I would have probably cancelled them myself.

Now, the reason being that it all goes on somebody's bills, so whether it be Medicare or Clinic bills, the Deaconess bill, or whatever, depending on how the DRG works, how long the length of stay, I don't know completely. The point is,

you have a window of change, what are you going to do then.

A. That's --

A. So I would have not have done it probably.

Q. You keep getting back to the proximate cause. I know you're saying it wouldn't have mattered what time it was --

A. Right.

Q. -- or nothing mattered, so once she had the stroke on the 13th she was dead?

A. I can't criticize -- also I might have done it, but if it were all set up, ran through, I may have not have done it, so you --

Q. So Mrs. Skyrl should have just stayed at home as opposed to going to the hospital for any help?

MR. GROEDEL: Objection.

A. No.

Q. All you are --

A. I don't think that's true at all. I talk about a window of opportunity. You were reviewing the first hours of hospitalization, she received medical care in the form of antihypertension that were -- she was watched. She didn't get into progressive stroke.

Q. She stroked and died.

A. They were trying to prevent progressive trouble.
Q. What did they do to prevent her from having massive stroke and dying, what treatment?
A. I told you what they --
Q. Tell me how --
A. -- controlled her blood pressure.
Q. -- they helped prevent --
A. I think I did. You don't over control it.
Q. The stroke?
A. Yes. To say that she didn't receive any benefit from going to Deaconess Hospital I think is fallacious. I'm sorry.
Q. Can you tell if a clot is fresh from a carotid angiography?
A. Sometimes you can. If you got a tail sitting out in the stream of a certain type you might be able to tell, yes.
Q. Would that be an indication for emergency surgery?
MR. GROEDEL: Objection. Go ahead.
A. Well, we have already testified here we thought it was --
Q. Fresh?

A. -- beyond the time when he could have operated.

Q. Based on clinical symptomatology, I am not --

A. That's right.

Q. -- talking radiological testing.

A. Yes, but I can't -- you don't treat x-rays, you treat patients.

Q. X-rays help you to treat them?

A. You do, but you got to interpret it within the realm of the whole picture. Sou just can't pick out one thing and go on after it because you're going to get in trouble if you do.

Q. But my question --

A. What I would have --

Q. Yes.

A. What would I have done in this situation. I can conceivably might have really crunched her blood pressure down to be sure, and heparinized her so we can get to her. I don't know if I would have gotten away with it. It's very risky in the face that just four days ago here I decided not to do it because I felt the size of the stroke was too great a risk in its own sense, let alone the hypertensive condition which exists in

this lady for many reasons that you discussed already today. I don't know really how much deficit this lady has.

Q. Prior to her final stroke?

A. Yes. We really don't know. We have --

Q. Because of the descriptions?

A. Right. We have an examiner who is not a full well, who doesn't really -- is not able to -- I know there's deficit and I know it's in the dominant hemisphere, I know it's not insignificant in the sense that it's just nothing, it's important, potentially very important in terms of what we do, as we have testified here --

Q. It's significant because it brought her to the hospital?

A. Yes, it is.

Q. I guess what you are telling me is, to the extent that it lasted or diminished, that's just not something a physician looking at a test can tell with any degree of assurance?

A. I do not think that it ever went away. I think you know that from reading the record, even the next day, the 14th and 15th, she still has deficit. Never disappeared.

Q. Totally clears?

A. That's right. Very important concept.
Q. Going back to my question.
If it was fresh clot that was observed on carotid angiography, would that be an emergent situation?
MR. GROEDEL: You mean if the patient is clinically indicated for this type of procedure?
Q. Emergency is emergency, that means you got to go right then and there, otherwise the patient is going to die probably?
A. Let me tell you what --
Q. You want you answer my question. Add whatever you want to it. Let's deal with Mrs. Skyrl.
MR. GROEDEL: You didn't make your question clear, that's why I asked.
A. I'll try to. Very hard question.
In any situation -- and I can answer, I have had that experience once -- and I don't remember exactly the patient's intentions about surgery, she had a large stroke, we took the whole family aside and the patient wasn't able to really participate in this decision, and decided we'd take the risk of anticoagulating the patient

in that situation, realizing full well we could have had a horrible disaster.

Those are difficult decisions. Those are really tough.

Q. The reason you did that was because you had fresh clots on angiography?

A. Yes.

Q. So I take it the answer then is yes, that does create --

A. It's does create an emergency situation if you see it. It's not a blanket answer. I can't answer that for you.

Q. Probably an emergency if you see that?

A. Right. But you are talking --

Q. Right?

A. You're talking to me, a neurologist, and I'm very comfortable with vascular disease, as opposed to here we're dealing with here, we got a patient in a hospital that is not a major center, that is a good hospital; big hospitals deal with stroke all the time, but it's not a huge hospital like this or the Clinic where stroke is a specialty and who -- where people take care of strokes and understand the problem of how aggressive can you expect people to get, that's the problem. You

cannot --

Q. It's a simple question, really a very simple question. I didn't want to get into a philosophical question of --

A. It isn't philosophical. It comes up all the time.

Q. If you see a fresh clot --

A. What do you do about it?

Q. Yes, is it an emergency?

A. In this situation?

Q. Yes.

A. It might have been, been considered as such. I can't tell you that. It's very difficult to decide what to do with those things, because a big hemispheric lesion, to anticoagulate a big hemispheric lesion, you're agonizing over this.

Q. Hemispheric lesion, now you're talking about damage in the brain?

A. Yes. You were talking about hemispheric --

Q. Doctor, the CAT scan reflected no damage to the brain.

A. That's too early to show it.

Q. Well, that may well be, but you know what, there is -- you didn't want to deal with the hypothetical earlier, and for you to throw out

facts that may not have been in existence --
A. You're asking me hypothetical questions.
Q. But now you're throwing -- the fact is that we have a normal CAT scan, that is the fact?
A. That doesn't help you. You don't know whether --
Q. Is that a fact?
A. You have a normal CAT, that doesn't tell you about the patient's state.
Q. It tells me that there is no demonstrable lesion in a hemisphere.
A. No, it doesn't.
Q. It doesn't?
A. No, it does not.
Q. Would you point --
A. You need to know --
Q. Would you point out on CAT scan any demonstrable --
A. I don't need the CAT, that does not --
Q. That's how it was --
A. I don't need to know if it was normal or not.
Q. You are saying there can be delay?
A. There is a delay. Usually is a delay, Okay.
Q. Are you suggesting that she had a massive

lesion on the 13th when she arrived?
A. Probably not, from what we know.
Q. I see.
A* But I don't know that either. We get --
Q. We don't know any of this because the tests weren't done.
A. No. No. We think -- I don't think we can say just because we -- I don't know what the aphasia was or if she had visual field cuts, if --
Q. She may not have had any of these things.
MR. GROEDEL: Objection.
A. I don't think -- 1 have to go with at least this.
Q. Why?
A. What do you mean?
MR. GROEDEL: Objection.
A. If we're not going to take anything as fixed here, I mean, he's described aphasia, and he described weakness, and he described visual defects with field cuts and --
Q. He describes her as being lucid.
A. That's fine, I have had patients like that, that -- patients that chatter a mile a minute, they're still aphasic, you wouldn't operate on them, depends on the type of aphasia.

Q. Okay?
A. Okay.
Q. I think you answered it, just want to make sure.
This was the statement from Dr. Durham, just tell me if you agree or disagree, "If one saw flesh clot within the arteries, particularly if it was not completely blocking the arteries, that would constitute an emergent indication for surgery"; would you agree with that?
MR. GROEDEL: For any patient?
MR. KAMPINSKI: Yes.
A. Well, for the reason that 1 said -- 1 mean, I can't -- we talked about that. I mean, I can't tell you because I don't know exactly the patient, but I understand his point of view. As a surgeon I have similar concerns. 1 would have to agonize over whether I thought I can get away with it.
I'm telling you, you're walking right along the edge of Niagra Falls. You -- you don't know whether you'll worsen or --
Q. Is that a surgical decision --
A. No.

Q. __ to make it better --
A. No.
Q. __ or neurological or is both?
A. It's a combination of people. It is again whoever -- how well you relate it to the neurologist, the surgeons, what descriptions you make.

There are times when I can envision -- I have been asked, as a matter of fact, I have acute lesion an hour and a half, two hours old, three hours old, asked by a surgeon do you want to operate on it. Those are things that we'll discuss, but not beyond two or three hours.

Q. Okay.
A. Okay. Tough, tough problems. Not easy. There is no specific answer to things like that. You'd like to think there is. We're not doing plumbing, unfortunately. I wish we were.
Q. Well, that's not a decision then that realistically ought to be made by a family practitioner, I mean, it ought to be made by --
A. I will give you that, yes.
Q. Okay?
A. Yes. In point of fact, what happens in the United States of America, in small hospitals,

having been in lots of them, is what we see --
Q. Is that they are made by family practitioners as opposed to neurologists or vascular surgeons?
A. Absolutely. We even see that in this hospital where people take care of strokes and wish they had called us earlier, wish they had done something different. In point of fact, a standard of care is that.
Q. That a family practitioner often does it?
A. Does makes decision. Stroke is not evidenced everywhere you go, that -- you just can't, you know -- it depends a lot on personnel as to how early he calls a neurologist and the whole thing.
Q. I think you already agreed he should have called one in this case?
A. I would -- would have certainly been happier if he had. I certainly have to admit that to you.
Q. Other than what we have already discussed, is there anything else you disagree with Dr. Durham with? I think I've touched --
A. No.
Q. -- just about everything.
A. Not really. No major disagreements.
We discussed on the telephone briefly after I read that deposition, and I said

gee, Dr. Durham sounds like a nice guy, I agree with most of the -- what he says; but the critical factor we discussed here this afternoon is where I disagree. I think that's a very, very important major disagreement.

Q. Okay.

A. And I think that it has to be looked at within the context of time, fixed deficit, the condition of the patient and where she was, those are considerations. I think it's unfair to fault somebody in retrospect for not doing something in those situations, given the type of problems we're dealing with here.

Q. Wait a minute.

You're saying you have a problem with Dr. Durham faulting Dr. Moysaenko for not doing the duplex, you are faulting him for that?

A. No. No.

Q. And for not calling neurology, you would fault for that?

A. I understand that, but --

Q. We're talking --

A. Here is something totally differently, but these things happen.

Q. The fact that they happen didn't make them

right?
A. I know, but nationally, across the country, unfortunately we are not called earlier enough, surgeons are not called earlier.
Q. That doesn't make it right, Doctor.
A. I think it's not right, but that's it's the way it is. I think that from having gone around and having ridden circuit in hospitals, I know what happens, standard of care in a hospital of a certain situation.
My contention though is --
Q. I understand.
A. -- this patient had a fixed deficit, therefore you couldn't have done anything about it.
Q. I heard you now about seven or eight times.
A. I don't see that expressed in these, what has been passed to me in terms of the documents, that that was properly understood by other people. That's where Durham and 1 disagree.
Q. You are saying that the people who were treating her didn't understand that?
A. I don't know whether they did or not, but it's never mentioned.
Q. Of course not, that's not something that they put down?

A. Okay. But even Durham doesn't get the point across. Fixed deficit, it's a different situation. I don't get that from reading his testimony. He alludes to it at page 66, I believe, or **70**.

Q. I'm almost done.

The point he makes is that after she had her major stroke on the 15th --

A. We all agree with that. You can't do anything.

Q. Yes.

A. Yes.

MR. KAMPINSKI: Let's take a minute.

(Recess had.)

BY MR. KAMPINSKI:

Q. Doctor, could you define aphasia for me?

A. Acquired difficulty in speech or in understanding or expressing a thought.

Q. That, plus the right-sided weakness is what you are pointing to as having existed throughout that would have contraindicated surgery?

A. And whatever visual defect. I don't know

what means yet. We don't know.
Q. There is no --
A. We don't know what she had, number one, if she had one; or number two, that it was sustained. That the --
Q. I think we can say based on the --
A. I don't know that he ever -- if he tested, he talks about it in two days running, I believe.
Q. But when he talks about it on the 14th, he's referring back to the admission?
A. Maybe he is. The point is, I don't think he brings up the point again. It's those things that keep me away from the patient, yes.
Q. Let's just --
A. Doesn't matter if you got aphasia, we agree on that, and the weakness.
Q. So if she has this continued difficulty in speech without it improving, that to you indicates a contraindication to doing surgery?
A. Yes.
Q. That, plus the right-sided weakness?
A. That's right.
Q. Now, if those got better, for example, that would then describe the patient that you were talking about earlier, where you got that window of

opportunity?
A. What I had hoped, though, the patient would get almost 100 percent better, to have really nothing.
Q. If she comes in with a mild deficit to begin with, you want it to disappear entirely?
A. Absolutely. Within the limits of what we talked about earlier, but I don't think she ever gets better, that's the problem.
Q. Well, if she did, would your opinion be different?
A. Yes.
Q. Would you go to the discharge summary of Dr. Moysaenko, dated January 16.
He didn't dictate it, by the way, until February 14th, a month later, so he had lots of time to think about it, look back at the records.
A. Where is it here?
Q. It's typed, three-page report.
THE WITNESS: Do you know where it is in your records?
MR. GROEDEL: It's at the beginning here.
Q. This is under narrative, after administration

of Procardia and controlled blood pressure.

By the way, that was immediately?

A. Yes.

Q. Had developed improvement in her right-sided weakness and speech; do you remember seeing that?

A. Yes.

Q. Does that affect you?

A. No, because you still see on the 14th that she's still got deficit.

Q. On the 14th?

A. Yes. In other words, if it's gone, I don't know. Actually I don't know. There's not enough written into in the charts to know how much improvement there was, if there was any.

I didn't have the feeling it was any better on the 14th.

Q. Didn't you? What is the --

A. Except for one little thing. I said 1 think somewhere he alludes to she may be --

Q. What is receptive aphasia?

A. Mean? I don't understand.

Q. Is that different than --

A. Expressive aphasia?

Q. Yes.

A. Yes.

Q. Could you have one without the other?
A. Yes.
Q. So if one got better, that really wouldn't necessarily tell you that it was gone?
A. That's right.
Q. But would it matter in terms of your opinion?
A. Not overall, but she never completely gets rid of the whole thing, and I know that.
Q. When you say the "Whole thing," you mean the receptive?
A. In other words, I think we look here on the 14th, ran here in the progress notes on the 15th.
MR. GROEDEL: 15th on the progress.
A. We're still significantly impaired.
Q. Doctor, when you say "we" --
A. You have discussed the symptoms and I was saying --
Q. Wait a minute.
Did you review the nurses' notes --
A. Yes.
Q. -- on the 13th at 6:00 p.m., no receptive aphasia noted?
A. Where is this on the 13th?

Q. At 6:00 p.m. No receptive aphasia noted.
A. Okay.
Q. Does that make any difference to you?
A. I don't know that this person can be relied on to check that, okay.
Q. Well, she wasn't put into an intensive care setting, was she?
A. No, she wasn't.
Can I clarify something further for you?
Q. No. I understand what you're saying.
A. Okay.
We have patients where even some residents don't understand first that there's aphasia. You have to test.
Q. Well then, why in the world, Doctor, would you sit here and tell me, especially in light of this record as a whole, where we already agreed that Dr. Moysaenko probably was not the appropriate person to be dealing with her condition, would you rely on him if you're telling me on the one hand that he didn't do things --
A. You are asking the obvious logical question about what I just said.
I hope he knows a little bit more

than ancillary personnel about aphasia and stroke.
Q. Well, I don't know whether that's true or not.
A. I can't answer that. I'm sure he does know something more about it.
Q. Once again, I assume that when you read the testimony of the daughters, that you saw that she was in fact responding well?
A. But again, I go back to the same thing we discussed when you talked about history and physical, she's alert, oriented, does talk, but she has deficit, okay.
Q. Okay.
A. You let me also clarify -- if it happened today, my husband understands well, I think he does understand some things, he doesn't understand everything, he certainly doesn't -- isn't able to speak, he's still aphasia, significant reply to --
Q. Let me just take a look at everything you reviewed and I will get out of your hair here.
A. This, that's the volume from Deaconess and the Clinic.
Q. Did you make any notes?
A. I don't write in --
Q. In **the chart?**

A. No, I don't write in these documents. That's a reproduction of that page.
Q. You got one that you couldn't read real well?
A. Right.
Q. I see.
I assume you agree that once you reach the Clinic there's really little anyone could do?
A. Absolutely.
Q. What else do you have there, Doctor?
A. That's a letter to Mr. Groedel.
Q. Was there a draft of it, by the way?
A. No, there was -- I don't have it here, but there was a draft originally, that's been destroyed.
Q. Why?
A. Why not?
I don't keep anything.
Q. What was changed?
A. I don't even know. It was just --
Q. Did you send it out?
A. Did I send him a previous draft, no, I did not.
Q. Did you call him on the phone and read it to him?

A. Yes.
Q. Why was it changed then?
MR. GROEDEL: Objection.
A. It wasn't changed.
Q. You just told me that it was.
A. No. No. Wait a minute.
You're assuming something. If -- you asked me -- I dictated it triple spaced and I make corrections and I send it back to the typist, I have that, that letter was not changed after talking to him.
Q. Where is the initial draft?
A. It's destroyed. May still be in the computer. It's been changed to that.
Q. You don't have the original draft that you made?
A. No.
Q. Let me see if I got this right.
You reviewed the records, you prepared a report?
A. We talk -- no. I talked to him first.
Q. As to what should be in the report?
A. No. No. I have -- I have a firm opinion. As a matter of fact, if I don't agree with a case, 1 think it's not defensible, 1 won't even write the

report. Okay.

So no, those are my words.

Q. I'm sure they are.

My question though is: How do I know what your words were before these words?

A. They're the same.

Q. You already told me you changed them, Doctor.

A. I did not. Look, let's be honest.

Q. That's exactly what I want to know.

A. Exactly. I did not change this document after talking to him.

In other words, I reviewed the records, we talked about the case, I wrote -- already I referred to the document on the phone. It was the same as we sent it off. I didn't change it. We did not change it.

Q. Okay.

A. Okay?

Q. Sure.

A. In point of fact, I have another case with their office where I turned them down in terms of defending of the doctor. I didn't think I could do it. I couldn't write -- or defend the doctor, okay.

Q. Was this your initial billing up through the point in time where you wrote your letter?
A. Yes. Probably.
Q. So $250 an hour, three and a half hours for reviewing the record?
A. And writing, discussions, and whatever.
Q. Writing the report?
A. Yeah.
Q. The date of your statement is October 27 --
A. Yes.
Q. -- 1992?
A. I don't know. Let's see here. Where is this letter?
Yes.
Q. Correct?
A. Yes, that's what it says.
Q. The date of your report is October 28, 1992?
A. I don't know why that is. I can't tell you.
Q. The reason it is, is because it's a day after your statement.
A. Yes, I understand that. I don't know where -- why that was done that way. I really don't know.
Let me see the letter. Does that refer to that? For some reason 1 must have taken

out a piece here.

MR. GROEDEL: I don't know.

A. I don't either.

Q. You got two copies of Dr. Juguilon's deposition, one depo of Tina Hayburn, Lucy Strzalka, Dr. Moysaenko, Dr. Durham; those are all the depositions you have reviewed in this case?

A. Right.

MR. KAMPINSKI: Okay. That's all I have. Thank you. Send me the bill for your time.

- - - - -

(Deposition concluded; signature not waived.)

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ERRATA SHEET

PAGE LINE

I have read the foregoing transcript and the same is true and accurate.

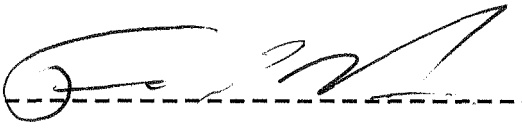
EDWARD L. WESTBROOK, M.D.

The State of Ohio, .
County of Cuyahoga. CERTIFICATE:

I, Frank P. Versagi, RPR, CLVS, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, EDWARD L. WESTBROOK, M.D. was by me first duly sworn to testify 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 onto a computer 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 25th day of January, **1993**.



Frank P. Versagi, RPR, CLVS,
Notary Public/State of Ohio.
Commission expiration: **2-25-93**

August 1992

CURRICULUM VITAE

WESTBROOK, Edward Lloyd, M.D.

~~Date~~ ~~of~~ Birth:	August 8, 1939
Office Address:	Department of Neurology University Hospitals of Cleveland 2074 Abington Road Cleveland, OH 44106 (216) 844-3191
Home Address:	2520 Wellington Road Cleveland Heights, OH 44118 (216) 932-0378
Wife:	Suzanne Mahnke Westbrook
Children:	Charles Edward, 29 years William Lloyd, 27 years Leslie Suzanne, 25 years

EDUCATION:

1957-1961	Harvard College, B.A.
1961-1965	Cornell University Medical College, M.D.
1965-1966	Intern, Straight Medicine Presbyterian-St. Luke's Hospital Chicago, Illinois 60612
1966-1968	Senior Assistant Surgeon to Surgeon U. S. Public Health Service Assigned to the Food and Drug Administration Neuropsychiatric Section
1968-1969	Resident, Medicine Presbyterian-St. Luke's Hospital Chicago, Illinois 60612
1969-1970	Resident, Neurology Cleveland Metropolitan General Hospital Cleveland, Ohio 44109
1970-1971	Fellow, Neuropathology Cleveland, Metropolitan General Hospital Cleveland, OH 44109
1971-1972	Resident-in-Charge, Neurology Cleveland Metropolitan General Hospital Cleveland, Ohio 44109

ACADEMIC APPOINTMENTS:

1968-1969	Teaching Assistant, Medicine University of Illinois School of Medicine Chicago, Illinois 60612 (Presbyterian-St. Luke's Hospital)
1969-1970	Teaching Assistant, Neurology Case Western Reserve University School of Medicine Cleveland, Ohio 44106
1970-1971	Teaching Fellow and Demonstrator in Pathology Neuropathology Case Western Reserve University School of Medicine Cleveland, Ohio 44106
1973-1975	Clinical Visiting Neurologist Neurology Department Cleveland Metropolitan General Hospital Cleveland, Ohio 44109
1978-1990	Assistant Clinical Professor of Neurology Assistant Clinical Professor of Medicine Case Western Reserve University School of Medicine 2119 Abington Road Cleveland, Ohio 44106
1985-Present	Adjunct Staff Department of Neurology Cleveland Clinic Foundation 9500 Euclid Avenue Cleveland, Ohio 44106
1990-Present	Associate Professor of Neurology Case Western Reserve University Cleveland, Ohio 44106

HOSPITAL APPOINTMENTS:

1972-1977	Cleveland Clinic Foundation 9500 Euclid Avenue Cleveland, Ohio 44106 Department of Neurology Full Staff

1977-1990 St. Luke's Hospital
11311 Shaker Boulevard
Cleveland, Ohio 44104

Department of Medicine (Neurology)
Active Staff

Director, Division of Neurology
04/29/85 to 1990

1978-1990 Marymount Hospital
12300 McCracken Road
Garfield Heights, Ohio 44125

Department of Medicine and (NeurologyDivision)

08/16/78 Provisional Staff
01/01/80 Associate Staff
01/01/81 Active Staff

09/03/81 to 1990: Division Director, Neurology

1987 to Present: Member, Board of Trustees
1990 to Present: Consulting Staff

1980-Present University Hospitals of Cleveland
2074 Abington Road
Cleveland, Ohio 44106

Department of Neurology
Department of Medicine
Active Staff

1984-1989 St. Vincent Charity Hospital and Medical Center
2351 East 22nd Street
Cleveland, Ohio 44115

Department of Medicine, Neurology Division

07/01/84 to 12/31/84: Courtesy Staff
01/01/85 to 07/24/87: Active Staff
02/01/85 to 09/09/87: Director Division of Neurology
07/24/87 to 04/87: Courtesy Staff

Resigned from Staff 4/89

1977-1989	Hillcrest Hospital 6780 Mayfield Road Mayfield Heights, Ohio 44124 Consultant Staff (Resigned 1989)
1987-1992	Cleveland Metropolitan General Hospital 3395 Scranton Road Cleveland, Ohio 44109 Associate Staff- Visiting Neurologist Department of Neurology

MILITARY STATUS:

1966-1968	Obligation completed by active duty in U. S. Public Health Service
1968-1980	U. S. Public Health Service Senior Surgeon Resigned January, 1980

LICENSURE AND SPECIALTY CERTIFICATION:

1. Licensed to practice medicine - State of Ohio 032044 - July, 1969
2. Certified American Board of Psychiatry and Neurology (Neurology), October 1976

HONORS AND AWARDS:

1966	John B. Drake Award for excellence as a Medical Intern
1968	Certificate of Appreciation for Service from the Food and Drug Administration

SOCIETY MEMBERSHIPS:

1. Cleveland Academy of Medicine
2. Ohio State Medical Association
3. American Academy of Neurology
4. Northern Ohio Neurological Association
5. Association for Research in Nervous and Mental Diseases
6. Harvard Schools and Scholarship Committee of the Harvard Club of Cleveland

7. Multiple Sclerosis Society of Northeast Ohio
Medical Advisory Committee, 1973-present
Chairman, Medical Advisory Committee, and
Member, Board of Trustees, 1974-1985

PUBLICATIONS:

1. Ray W. Gifford, Jr. and Edward L. Westbrook, "Hypertensive Encephalopathy: Mechanism, Clinical Features and Treatment," Progress in Cardiovascular Diseases, Vol. XVII, #1, Sept/Oct 1974, pp. 115-124

2. Neil T. Peterson, Paul M. Duchesneau, Edward L. Westbrook and Meredith Weinstein, "Basilar Artery Ectasia Demonstrated by Computed Tomography," Journal of Radiology, Vol. 122, March 1977, pp. 713-715