IN THE COURT OF COMMON PLEAS
IN AND FOR CUYAHOGA COUNTY, OHIO
CASE NUMBER:CV-05-552863

SUZANNE I. STANSBURY, Individual and as Administrator of the Estate of HAROLD DEAN STANSBURY, Deceased,

Plaintiffs,

-vs-

THE CLEVELAND CLINIC FOUNDATION, JOSEF APONTE, MD, MICHAEL CUDNIK, MD, and MARK KROFINA, MD,

Defendants.

_____/

DEPOSITION OF JOSEF APONTE, MD

Thursday, September 22, 2005
10:10 a.m. - 1:59 p.m.

Radision Suite Hotel Oceanfront
3101 North Highway A1A,
Melbourne, FL 32940

Reported By:
Donna D'Alessandro
Notary Public, State of Florida
Esquire Deposition Services, LLC
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APPEARANCES:

On Behalf of the Plaintiffs:

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On Behalf of the Defendants:

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APPEARING BY TELEPHONE:
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LAUREN KINKOPF, ESQUIRE
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EXHIBITS

Deposition taken before DONNA D'ALESSANDRO, Court Reporter and Notary Public in and for the State of Florida at Large, in the above cause.

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(Deposition Exhibits 1 through 13 were premarked for identification.)

Thereupon,

JOSEF APONTE

having been duly sworn or affirmed, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. SEVERYN:

Q. Dr. Aponte, can you please state and spell your full name for the record?

A. Josef, J-O-S-E-F, middle initial, H, Aponte, A-P-O-N-T-E.

Q. What does the H stand for?

A. Henrich.

Q. Have you ever given a deposition before?

A. Yes, ma'am.

Q. On approximately how many occasions?

A. I think two occasions.

Q. At the risk of repeating some of the things you already know about depositions, and at the risk of repeating things you may have been told, I just want

the record to be clear, so I'm going to tell you a little bit about how the deposition process works.

First of all, the oath that was just administered is the very same oath that you would have if you were in court testifying before a judge and a jury; you understand that?

A. Yes.

Q. Everything that is said here today and that is taken down is basically the oral. So it is important to give all of your answers verbally, rather than nods or gestures of the head, or uh-huh, or uh-uh. That's for two reasons, the first is that we need to keep the record clear, and the second is to make the court reporter's job that much easier. We don't want her to interpret what a nod or gesture means from actually any of us; okay?

A. Yes.

Q. If at any time you have a question about anything that I've asked, or one of my questions is unclear to you, please let me know, I'll be happy to repeat or rephrase the question as necessary.

If however you answer a question of mine, I am going to go ahead and assume that you understood it.

A. Yes.

Q. I'm also going to be asking you questions that

obviously go back a couple of years, to the extent that you don't have any independent recollection, you can at any time refer to the records you have available to you; okay?

A. Yes, ma'am.

Q. You understand we're here to talk about a patient of yours, Harold Dean Stansbury?

A. Yes.

Q. As we sit here today, do you have any independent recollection of Mr. Stansbury?

A. I do.

Q. Okay. What memory do you have of this particular patient?

A. I remembered him coming in to the Emergency Department on the day that I saw him, and I'm pretty sure that I recall correctly, a large, robust, white male, a full head of hair, white wavy kind of hair, and that's what I recall.

Q. Do you recall any aspects of the treatment independently, separate and apart from the medical chart?

A. Yes.

Q. What do you remember?

A. I remembered getting a call, that he was being Life Flighted to the Emergency Department, and I

remember waiting in the room for his arrival.

The description was of someone who was complaining of shortness of breath -- shortness of breath, and I think that's about all that I can recall.

Q. So you received this call in advance of actually seeing the patient at the hospital?

A. Yes.

Q. Would you have received the call through the Life Flight personnel?

A. I'm not sure how I received the call, but I just knew that it was received.

Q. All right, and you expected that he would be coming in through Life Flight?

A. Yes.

Q. We'll get back to the treatment. Other than that memory, do you have any other independent recollection of what happened that night, when at the emergency room, once the patient arrived?

A. I remember him arriving, as I said, robust, while male, white hair, pink cheeks, rosy pink cheeks, almost like a Santa Claus type of an image. He was brought in, and I remember speaking to him and him telling me that he had experienced some shortness -- some severe shortness of breath.

Q. Okay, anything else?

A. I remember asking him some questions, examining him quickly, and ordering labs and other tests that I wanted performed on him.

Q. Did you by any chance, Doctor, bring a copy of your C.V.?

A. No, ma'am.

Q. We are going to take just a few minutes to get a background. If you would, let's digress for a minute. On January 25, 2003, you understand that's the date we're talking about?

A. Yes.

Q. Were you employed by the Cleveland Clinic Foundation?

A. Yes, ma'am.

Q. In what capacity?

A. I was an Attending in the department of emergency medicine.

Q. Is emergency medicine your specialty?

A. Yes, ma'am.

Q. Where are you currently employed?

A. Holmes, H-O-L-M-E-S, Regional Medical Center.

Q. In what capacity?

A. An Attending.

Q. Again as an emergency room physician?

A. Yes, ma'am.

Q. Are you currently licensed to practice medicine in the State of Florida?

A. Yes, ma'am.

Q. Are you still licensed to practice in the State of Ohio?

A. Yes, ma'am.

Q. Are you licensed to practice medicine in any other state?

A. No, ma'am.

Q. Has your license to practice medicine at any time been revoked or suspended?

A. No, ma'am.

Q. As far as you're aware, is your license to practice medicine, in both Ohio and Florida, in good standing?

A. Yes, ma'am.

Q. Are you board certified?

A. Yes, ma'am.

Q. Tell me what it means to be board certified?

A. The route that I achieved board certification was, I did a residency in emergency medicine and subsequently took the oral and written examinations, and since then I was also re-certified in my specialty.

Q. You're board certified in what specialty?

A. Emergency medicine.
Q. When were you first board certified?
A. I think 1993.
Q. You became board certified in what year?
A. 1993.
Q. I'm sorry, re-certified I meant.
A. 2003.
Q. I think you already told us that the board examination comprises of an oral and a written portion; correct?
A. Yes, ma'am.
Q. And obviously in order to become board certified and then re-certified, you had to do both of them?
A. Both, yes, ma'am.
Q. Did you have to take those or any portion of those exams more than once?
A. I think the oral I had to repeat.
Q. What are the restrictions on becoming board certified? In other words, do you have to practice medicine for a certain period of time before you're eligible – board eligible?
A. Well, usually you do an internship and a residency, and once you've successfully completed your residency you're board eligible as of that date.

Q. So after your residency, you're board eligible?
A. Right.
Q. Tell us, if you would, briefly your educational background, beginning where you attended and graduated medical school?
A. New York Medical College.
Q. What year did you graduate?
A. 1981.
Q. What did you do after that?
A. I immediately went into active-duty service in the military, Army.
Q. How long were you with the Army?
A. From '81 till '89.
Q. Were you in the Army as a physician?
A. Yes, ma'am.
Q. Were you in the Army -- strike that. Did you practice emergency medicine while with the Army?
A. Yes, ma'am.
Q. Were you practicing any other type of medicine at that time?
A. No, ma'am.
Q. So you were discharged in 1989?
A. Yes, ma'am.
Q. And I take it that was an honorable discharge?

MR. MYERS: You know what, I'm losing you guys a little bit. I don't know if you need to get a little closer to the phone, but you're fading in and out a little.
MS. SEVERYN: I'll try to keep my voice up.
BY MS. SEVERYN:
Q. What did you do when you left the Army?
A. Continued working as an emergency medicine specialist in a civilian capacity.
Q. Did you go through any type of internship or residency program?
A. Yes, ma'am.
Q. Where and when?
A. William Beaumont Army Medical Center, I did my internship. Thereafter, I did active duty, I functioned as a line officer in Europe.
Q. All right. You indicated you completed your internship at the William, is it Beaumont?
A. Yes. William Beaumont Army Medical Center.
Q. What year did you complete your internship?
A. 1982.
Q. Where is the William Beaumont Army Medical Center?
A. Fort Bliss, Texas.

Q. Then you mentioned you functioned as a line officer in Europe. What is a line officer?
A. A line officer, you're attached as a physician to a unit. It could be a battalion, it could be a brigade, it could be a division.
Q. How long did you serve in the capacity of a line officer?
A. About two years.
Q. Again, did you serve in the capacity of an emergency medicine --
A. No, at that time I had not done my residency. I had just done an internship. I worked as a general medical officer.
Q. Where were you stationed?
A. Goeppingen --
THE COURT REPORTER: I'm sorry?
THE WITNESS: G-O, with two dots above it E-P-P-I-N-G-E-N, Federal Republic of Germany, as it was known at that time.
MR. TABER: Is that the umlaut?
THE WITNESS: Yes, it gives you that er sound.
BY MS. SEVERYN:
Q. After you completed those two years as a line officer in Germany, what did you do then in terms of

your profession?
A. Then I was reassigned to -- let's see if I can remember the name. I was reassigned to Fort Bragg.
Q. Georgia? No.
A. No, that's in North Carolina.
Q. What did you do there?
A. I worked as a general medical officer, the department of ambulatory care.
Q. How long did you serve in that capacity?
A. I think about one year.
Q. All right. After you completed that duty as general medical officer at Fort Bragg, what did you do following that?
A. I was reassigned to Fort Hood, Texas.
Q. All right. What did you do at Fort Hood?
A. I did a residency in emergency medicine.
Q. How does that work with the Army, can you request what you're going to be trained in?
A. Well, it's a free country you can request anything.
Q. Did you request a residency in emergency medicine?
A. Technically no, but when I was assigned at -- it almost came to me, the name of the hospital at Bragg. When I was assigned to the hospital at Fort

Bragg, there was a Major Dice who worked there, who was residency trained board certified in emergency medicine, and he just thought that that's probably where I belonged.
Q. So you basically respected his recommendation?
A. Yes, ma'am. And he was assigned to Fort Hood to become the Chairman of the residency program.
Q. Did you then study under him?
A. I studied under his department, under his staff.
Q. How long was the residency program at Fort Hood?
A. Two years.
Q. What was the facility?
A. Darnall Army Community Hospital, D-A-R-N-A-L-L.
Q. What year did you complete your residency training at Darnall?
A. 1987.
Q. For the next two years you still continued to serve in the Army?
A. Yes, ma'am.
Q. Were you at all times at Fort Hood for the remaining two years?
A. Yes, ma'am.

Q. What happened after your discharge in the Army in 1989?
A. I stayed in the City of El Paso, and worked at two hospitals there.
Q. What hospitals?
A. Sierra Medical Center, and I think it was called Vista Hills, was the second hospital.
Q. I think you mentioned you stayed there and worked in the capacity of an emergency medicine physician?
A. Yes.
Q. How long were you in El Paso at either -- actually collectively, at Sierra and Vista Hills?
A. I think I may have spent six months in each one.
Q. Where did you go after that?
A. After that I went to Brooksville, Florida.
Q. Brooksville?
A. Yes.
Q. Where did you work?
A. Lykes, L-Y-K-E-S, like the hot dog. Lykes Community Hospital.
Q. Where is Brooksville, Florida, in relation to where we are now?
A. Straight across latitude, but on the Gulf.

Q. On the Gulf side. How long were you at Lykes Community Hospital?
A. I think that was a grand total of ten months.
Q. Why did you leave?
A. The hospital was just wrought with a lot of internal problems. The medical staff and the C.E.O. were just going at it. It may have even come down to legal issues. So I just thought this is not exactly a good place to be.
Q. At this point are we in around 1991?
A. I think so.
Q. Where did you go after Brooksville?
A. To the Medical Center of Central Georgia, that's in Macon, Georgia.
Q. I know I keep asking the same question, but is it fair to say that after your residency -- you completed residency training, did all the rest of your professional career involve emergency medicine?
A. Yes, ma'am, to this date.
Q. So I don't have to ask you that.
A. No, ma'am.
Q. How long were you at the Medical Center of Central Georgia?
A. I was there for about approximately two years.

Q. Where did you go after that?
A. I went to Elyria, Ohio.
Q. What brought you to Elyria?
A. Career advancement. I was supposed to be an assistant medical director there.
Q. Where were you practicing?
A. Elyria Memorial Hospital.
Q. How long were you at Elyria?
A. It's kind of tough to say, I think about a year, maybe a little bit more.
Q. Where did you go after Elyria?
A. The Cleveland Clinic.
Q. What year did you begin working for the Cleveland Clinic Foundation?
A. I think it was in 1995.
Q. How long were you with the Clinic?
A. I was there till December of -- actually technically, January of 2004.
Q. Did you come down to Melbourne or to Holmes Regional Medical Center after you left the Cleveland Clinic?
A. Yes, ma'am.
Q. Were you anywhere else during the course of your professional career?
A. No, ma'am.

Q. Why did you leave the Cleveland Clinic Foundation?
A. Just a change. I have friends down here that I knew while I was working at the Clinic.
Q. Did your decision to relocate in any way involve this case or anything that happened here?
A. Absolutely not.
Q. During the course of your professional career, have you had any teaching appointments?
A. Yes, ma'am.
Q. What teaching appointments have you had?
A. Ohio State Medical School, which is -- that's at the Clinic, and then oddly enough we -- when Dr. Emmerman became Chairman of our department of MetroHealth, we became Prudential at MetroHealth Medical Center, and we would work shifts over at MetroHealth Medical Center. And we were on staff with that facility, also in a teaching capacity, affiliated with the residency program.
Q. Have you ever had any other teaching appointments?
A. When I was in Macon, Georgia, the medical school that they were affiliated with, but that was through the department of surgery, not the department of emergency medicine.

Q. All right. So in terms of your employment or career as an emergency medicine physician, all of your teaching appointments would have been in connection with the Cleveland Clinic Foundation and the Ohio State Medical School?
A. I think Case Western was affiliated with Metro.
Q. To the extent that you went over to Metro sometimes, you also worked with the medical students from Case Western?
A. Right. And when I was in Macon, Georgia, I worked with the students and the residents that were affiliated with their medical school, and I don't remember the name of their medical school.
Q. Okay, but that was through the surgical department?
A. Right.
Q. In lay terms, would you describe what it means to have a teaching appointment?
A. Basically, you're responsible for bedside teaching, which is basically clinical teaching. That can also include courses, lectures.
For example, at Macon when you would do an A.T.L.S. course, you would do an entire week and you would do several chapters, several lectures. When you

did A.C.L.S. that was very rugged so to speak, because you didn't teach one topic, you taught the entire book for one whole week to about 12 to 15 students. So you went from chapter one to the end, to include codes, mega codes, everything in the book.
Q. When you were with the Clinic, what portion of your professional time was devoted to the teaching aspect?
A. I'd say about 20 percent.
Q. Did you have occasion to give any lectures or teach any courses while affiliated with the Cleveland Foundation?
A. Yes, ma'am.
Q. How often would you do that?
A. Once every few months.
Q. Have you ever lectured or written on the topic of emergency medicine and the treatment of pulmonary embolism?
A. Well, I had one lecture that touched on it.
Q. When did you give that lecture?
A. I cannot recall.
Q. Did you publish any articles or any literature on the topic of pulmonary embolism?
A. No, ma'am.
Q. Have you ever published any documents --

excuse me, any articles or texts?
A. Yes, ma'am.
Q. What have you published?
A. A paper on acute plastic bone deformities, children. A paper on ovarian hyper-stimulation syndrome. And about six papers with Frank Peacock on congestive heart failure.
Q. Are you presently associated with any -- are you presently a member of any associations?
A. The American Academy of Emergency Medicine.
Q., How long have you been a member of that association?
A. Off and on, I'd say for the past ten years I think, or 12 years. I can't remember when the organization first came into being. It was informal and then it became more of a formal thing, and then as more members came in, it became more of a recognized body.
Q. Have you ever served in any capacity with that organization, in terms of being an officer or committee member or chair?
A. No, ma'am.
Q. Are there any texts in emergency medicine that you would consider authoritative texts?
MR. TABER: Objection, over broad.
THE WITNESS: Say that again?

BY MS. SEVERYN:
Q. Sure. Are there any texts in emergency medicine that you would consider authoritative?
A. No.
Q. If you had a question about any aspect of emergency medicine, is there a book or text that you would turn to?
A. There's a slew of text that you could turn to, and whatever the current literature.
Q. Okay, I'm asking you if you have habitually or customarily turned to any particular text, if you have a question on emergency medicine?
A. There's a number of textbooks that I would turn to look at, and as I said, then after that I would look at the current literature to see what's going on.
Q. Over the last let's say five years, what are some of the texts that you would turn to, if you had a question with respect to, let's say the management of a patient that has a suspected or actual pulmonary embolism?
A. Well, you could read Rosen's Textbook of Emergency Medicine. You have Schwartz's Textbook of Emergency Medicine. You have Tintinalli's Textbook of Emergency Medicine. I'm sure there are a few other

people who have textbooks of emergency medicine.
And then you can always look up any journals that you read, at the Clinics of North America or Evidence Based Emergency Medicine, E.R. Reports, Journal of Emergency Medicine. There's a lot of journals around.
Q. All right. Let me just make sure I'm asking my question clearly. I appreciate that there's a lot of literature that is available out there, and a number of texts that can be referred to. My question is, is there a text that you habitually would refer to if you had question on that topic?
A. Everything I just said.
Q. Okay. Have you at one time or another turned to each and every one of the texts you've talked about?
A. Yes.
Q. When Harold Stansbury was a patient of yours, did you have occasion to refer to any text or literature during the course of that evening?
A. No, ma'am.
Q. After the fact, did you look into any issues having to do with Mr. Stansbury's treatment?
A. No, ma'am.
Q. What information or documents have you reviewed in preparation for this deposition?
A. I was given -- I was provided with the run

sheet from a local emergency transport unit. I was given the run sheet for Metro, Metro Life Flight, and his medical records of that evening.
Q. Are you talking about the Clinic's medical records?
A. Yes, ma'am.
Q. Now, the Clinic's medical records are extensive, they involve the treatment of Mr. Stansbury --
A. Well, I was given the dictated portion and the nursing notes that went with that, and the printed Em-STAT sheets.
Q. Did you review only the medical records having to do with the emergency treatment on January 25, 2003, or did you look at any of the records having to do with Mr. Stansbury's prior treatment at the Clinic?
A. Okay, ask me that question again? I'm confused.
Q. Sure. Mr. Stansbury had been treated at the Clinic before he came to emergency on January 25, 2003; are you aware of that?
A. After the fact, yes.
Q. Okay, and I'm asking today, in preparation for this depo, or at some point prior to today, have you reviewed any portions of the Cleveland Clinic's chart, other than just the emergency room information for

January 25, 2003?
A. I looked at a deposition by Dr. Krofina.
Q. Okay.
A. And I think there was an operative report there from a Dr. Swenson or Svenson.
Q. Anything else?
A. Not off the top of my head at this time.
Q. Mr. Stansbury had just had an aortic aneurysm repair surgery at the Clinic. I believe it was on the 13th of January 2003; are you aware of that?
A. I am now.
Q. Were you aware of that information on the evening of January 25, 2003?
A. No, ma'am. I was aware that he had had that surgery, but as to where it was performed, there was a lot of confusion with that.
Q. So as we sit here, you don't have any independent recollection of having reviewed any of the Clinic information relative to that repair, other than what you may have seen attached to Dr. Krofina's deposition, that operative report?
MR. TABER: Objection.
THE WITNESS: Yeah, that's -- say that again?
BY MS. SEVERYN:

Q. You mentioned that you believe you saw an operative report from Dr. Swenson, and that that information was something that was attached as part of Dr. Krofina's deposition?
A. No. That was something that was provided to me for review --
Q. Okay.
A. -- for this deposition.
Q. All right. Other than your review of that operative report, do you have any independent recollection of having seen anything else in that Cleveland Clinic chart relative to the aneurysm repair?
A. At what time?
MR. TABER: -- time go ahead.
THE WITNESS: Ask me the question again. I'm sorry.
MS. SEVERYN: Why don't we read it back.
(Thereupon a portion of the record was read back.)
BY MS. SEVERYN:
Q. I'm not trying to trick you, Doctor, I'm just --
A. I apologize. I'm just not understanding you.
Q. That's okay, and believe me I get all excited

when I'm asking questions, and a lot of this is not artfully stated. Very simply, I know you reviewed records regarding the ER visit; right?
A. Right.
Q. Did you review anything else?
A. For the deposition I was provided the Em-STAT print out sheet the dictation, a copy of Dr. Krofina's deposition, and in there -- not in there, but also an operative report of a Dr. Swenson regarding the surgery itself.
Q. Okay.
A. And I think there was also attached to that piece a discharge sheet, indicating his medication upon discharge, his condition, et cetera.
Q. The reason I ask is, you have a copy of the Clinic's chart that I also have a copy of, and I know it has hundreds of pages. Have you reviewed everything in the document in front of you?
A. No.
MR. TABER: Just for clarification that's my sub-set.
MS. SEVERYN: Okay -
THE WITNESS: Yeah, my sub-set is like that. (Witness indicates.)
BY MS. SEVERYN:

Q. All right. Now, getting into again this initial contact with Mr. Stansbury, I think you said you looked at some run sheets; right?
A. Right.
Q. And that would involve the E.M.S.?
A. Yes.
Q. And then also the Life Flight; correct?
A. Yes.
Q. Let me direct your attention to what has been marked as Plaintiff's Exhibit 1.
Q. Would you take a look at these documents and identify them for the record.
A. Okay.
Q. Are you able to identify these documents, Doctor?
A. Well, it says MetroHealth Medical Center, Life Flight -- Metro Life Flight.
Q. Let me direct your attention to the lower-right-hand corner. I believe these are documents that are stamped with CCF 0246, 0247, 0248, 0249, and 0250; is that correct?
A. I don't know what you're referring to.
Q. These numbers?
A. Yes.
Q. Beginning with 46 and ending with 50.

A. Yes.
Q. Have you seen any of these documents prior to today?
A. I'm not certain about this cover sheet here, this document I think I saw, this one.
Q. Doctor, for the record, can you refer to the bottom number?
A. CCF 0247.
Q. You've seen that one?
A. CCF 0248, CCF 0249. I'm not certain about this CCF 0250, or CCF 0246.
Q. All right. So you're not sure if you saw 46 and 50, but you saw the other three, 47, 48, and 49?
A. I have seen them in preparation for this deposition.
Q. When you talk about the run sheet for the Life Flight, what is that?
A. The sheet that they use to transport a patient.
Q. That's something other than what you have there; correct?
A. I don't know.
MR. TABER: I think it's --
THE COURT REPORTER: I'm sorry?
MR. TABER: Aurora, A-U-R-O-R-A.
THE WITNESS: This Aurora Fire

Department run sheet, that's what I call it, a run sheet. This I recall seeing.
BY MS. SEVERYN:
Q. All right.
A. Again, in preparation for the deposition.
Q. Going back to the evening that Mr. Stansbury was admitted, can you tell from any of the documentation before you, what time Mr. Stansbury arrived at the Cleveland Clinic Foundation?
A. From these documents?
Q. Or from any documents available to you?
A. I would be looking at the print out, Cleveland Clinic Foundation, Em-STAT system.
Q. And we'll get to that document. Well, let's get to it now. The document that you're referring to, is that the same as what has already been premarked as Exhibit 13? No, that's the same copy, those are just multiple copies.
A. Of this page, here?
Q. Yes.
A. Yes.
Q. All right. So the document you're referring to is the same as Plaintiff's Exhibit 13; correct?
A. Yes.
Q. All right. What information are you able to

gather from this document, regarding the date that Mr. Stansbury arrived -- excuse me, the time that Mr. Stansbury arrived at the Cleveland Clinic Foundation?
A. At 17:33 hours.
Q. Where do you get that information?
A. At the lower-left-hand side, the third time stamp from the bottom.
Q. Received patient?
A. Yes, ma'am.
Q. All right. Now, is that received patient time the date the patient was received or the date -- excuse me, I keep saying date, excuse me, or the time that he was admitted?
A. No, that would be the time that he was received.
Q. All right, and then the admission time is some other time?
A. Yes, ma'am.
Q. And what is the admission time?
MR. TABER: Time received --
THE WITNESS: No, the time of admission.
MR. TABER: Admission to the hospital?
I don't think he ever left the emergency room.
THE WITNESS: I don't --

BY MS. SEVERYN:
Q. Let me ask it this way, is time received time admitted, or is there a difference between those two?
A. Yes, ma'am.
Q. Well, there's an admission order here, but it's not timed.
Q. What document are you referring to? If you could look at the stamp at the bottom.
A. Well, it's the Cleveland Clinic Foundation Emergency Department Ledger.
Q. Just for the record, is that what has been premarked as Plaintiff's Exhibit 2?
A. Yes, ma'am.
Q. Typically would you expect to see that time noted somewhere on this document?
A. Yes, ma'am.
Q. What is the difference between time received and time admitted?
A. Time received is when you receive the patient, and time admitted is when the patient was admitted to the hospital or to a service.
Q. Is there any other document that you would typically expect to find that information on at the Clinic?
A. I'm not sure.

Q. Going back to earlier, I'd asked you about your independent recollection of this patient, and what independent recollection you have at this point. Now, that we've talked about this, and if you need to refer to any documents, I have some specific questions about the care that was rendered and the condition of the patient. So starting with when you first saw Mr. Stansbury, what information did you have with regard to what brought him to the Clinic?

A. The information that I had was the information that was conveyed to me by nursing, that they received a call and that they're bringing a patient in, complaining of shortness of breath.

Q. All right. Is that the call you're referring to that you received prior to the patient coming in?

A. I didn't receive it personally, it's --

Q. Nursing did?

A. Yes.

Q. But you personally did not speak to anybody about Mr. Stansbury, other than what was conveyed through nursing before he came in?

A. Right.

Q. Then Mr. Stansbury came in; correct?

A. Yes, ma'am.

Q. When was the first time you actually saw him,

in relation to when he arrived at the Clinic?

A. When he was brought into the room.

Q. What room?

A. The room that he was assigned, that he was taken to.

Q. When did you first see him in relation to when he was received at the hospital?

MR. TABER: I think he just answered that.

MS. SEVERYN: No, I want a time. In other words, if there's something you can refer to that would refresh your recollection.

THE WITNESS: No, madam, they brought -- I watched them as they brought him in.

BY MS. SEVERYN:

Q. All right. So it would have been within minutes of receiving the patient?

A. Yes.

Q. What occurred when you first saw him? Was there something that you did immediately upon having the patient wheeled into the room?

A. Well, what I would normally do under those circumstances is physically -- visually inspect and assess the patient, and communicate with the patient, and ask him what seems to be the problem, and just take it from there, ask routine questions.

Q. Okay. Prior to having this exchange with the patient, would you have spoken with anybody from the Life Flight team?

A. I don't recall speaking to anyone.

Q. Do you typically speak with the Life Flight team if there's a patient that's being brought in?

A. No.

Q. Do you typically look at the records from Life Flight prior to either speaking with the patient or examining the patient?

A. It depends on the circumstances of the situation. If they're readily available, I'll look at them, if not, I'm assuming that patient is going to be able to communicate to me everything that's already been communicated to Metro or whatever transporting unit there is. I have a tendency to get it from the horse's mouth so to speak, so that there's no interpretation. I can just quote a patient as this is what he told me.

Q. Okay, and certainly at this time you were able to speak with Mr. Stansbury?

A. Yes.

Q. Is it fair to say that based upon your recollection then, you did not have any independent discussion with any Life Flight personnel, and you had

no recollection of reviewing the Metro Life Flight's records prior to actually speaking with Mr. Stansbury?

MR. TABER: Two questions. The first he's already answered and said he couldn't recall, and the second one, go ahead.

THE WITNESS: What was the second one again?

BY MS. SEVERYN:

Q. Let me ask them as two questions. Is it fair to say that you have no recollection of speaking with any of the Life Flight personnel in connection with Mr. Stansbury, before you actually spoke with him yourself?

A. To the best of my recollection at this time, I don't recall speaking with someone.

Q. Do you remember ever speaking with any Life Flight personnel in connection with the treatment of Harold Deans Stansbury?

A. There is a vague recollection of speaking to someone, but the information at that time, my global impression of that conversation was that it was a very confusing conversation.

Q. All right. This vague recollection that you have, does it involve speaking with the physician that

was on Life Flight?
A. I don't recall.
Q. Okay, what do you remember, in terms of this vague recollection of possibly having spoken with someone associated with the Life Flight team?
A. I recall speaking with someone and there was some confusion as to whether he had had his surgery at the Clinic or somewhere else.
Q. Did that have any special significance for you?
A. Well, it depends. I mean in one respect you can say no, because it's not going to change how I manage the patient. And -- well, not really.
Q. Other than having this recollection of some confusion as to understanding where Mr. Stansbury had had surgery, is there anything else that you can recall about this conversation?
A. At this point in time, no.
Q. Do you have any idea or recollection as to whom you spoke with?
A. Not at this time.
Q. Is it fair to say, based on what we talked about earlier, that you do not have any recollection of having reviewed the Metro Life Flight document prior to speaking with Mr. Stansbury personally?

A. I don't recall reading anything about him prior to speaking to him. I may have afterwards, when they would have a chance to finish writing up their report, et cetera. But as I said, once he was present, I made contact with him immediately.
Q. Now, is there anything in the chart that reflects what information you would have obtained from Mr. Stansbury, during that initial conversation with him?
A. I would -- well, I would think that the history that Dr. Cudnik obtained should reflect -- or rather would reflect basically the gist of the information that we obtained from Mr. Stansbury.
Q. Let me direct your attention to what's been premarked as Plaintiff's Exhibit 4, can you identify that document for the record?
A. Deposition Exhibit Number 4, CCF 0302, Cleveland Clinic Foundation Emergency Department Report.
MS. HENRY: Off the record.
(Thereupon, an off the record discussion was held.)
BY MS. SEVERYN:
Q. Is that the report or history you were referring to when you spoke that Dr. Cudnik's history would reflect the information that was obtained from the

patient?
A. Yes, ma'am.
Q. Was Dr. Cudnik present during this initial discussion with Mr. Stansbury?
A. Oh, I believe he was.
Q. Separate and apart from what Dr. Cudnik dictated, what has been included in what's again been marked and identified as Plaintiff's Exhibit 4, is there any portion of the chart where you personally would have handwritten any information during that initial assessment or conversation with the patient? Okay -- off the record.
(Thereupon, an off the record discussion was held)
A. It would be this document here, the Emergency Department Ledger.
Q. Let me direct your attention to what we've already identified as Exhibit 2; is that what you're referring to, Doctor?
A. Yes, ma'am.
Q. What portions of this document, the Emergency Department Ledger, what portions of that document reflect your handwriting?
A. The signature at the lower right hand side. I circled the medical decision making formulated, and the admission order that was written was written by myself,

and the order to initiate Heparin was written by me.
Q. When you talk about the initial order, what order are you referring to?
A. I'm sorry?
Q. When you referenced the initial order, you said that was written by you, what --
MR. TABER: He said admission order.
BY MS. SEVEYRN:
Q. Oh, admission order, excuse me, I'm sorry. Which is the order relative to the administration of Heparin?
A. The one circled, number one.
Q. And that's in your handwriting?
A. Yes, ma'am.
Q. We'll get to that. What about 2 and 3 is that in your handwriting as well?
A. Yes, ma'am.
Q. Down below that, are I believe a number of medications, is that your handwriting?
A. No, ma'am.
Q. Anything else on the chart that's in your handwriting?
A. I think the CT at 19:34 and number sign, the pound sign 29022.
Q. What does that number reference, Number 29 --

A. 022?
Q. 022?
A. A dictation number.
Q. So other than what's on this document the Emergency Department Ledger and what's contained in Dr. Cudnik's history, which is Exhibit 4, there's nothing else you can reference -- or is there anything else that you can reference that would contain information that you obtained from the patient, during that initial conversation?
A. The question again?
Q. Sure. You've pointed out two documents that would have information that you obtained or was obtained from the patient, initially after he arrived at Cleveland Clinic.
A. Yes, ma'am.
Q. The first was the history of Dr. Cudnik as contained in the Emergency Department Report, Exhibit 4; do you recall that?
A. Yes.
Q. The second was information contained in the Emergency Department Ledger that you've just gone over, Exhibit 2 --
A. Yes, ma'am.
Q. Other than what's in these two documents, if

there is anything else that you can reference in the chart that would contain information that you obtained or that was obtained from the patient initially.
A. The question is, is there anything -- any other source of information?
Q. Sure.
A. That was available to me at that time?
Q. No, after -- strike that. Is there any other source of information or documentation that was generated as a result of that initial dialog or interview with the patient?
A. Oh, no, ma'am, not that I can see.
Q. What information did you obtain after Mr. Stansbury's admission to the Clinic as to what treatment had already been rendered to him?
A. I was informed that he had had a repair of the aortic root and that was pretty much what I recall, regarding his most recent surgery.
Q. What about treatment that had already been rendered by the E.M.S. personnel, or the Life Flight team?
A. That would have been on the run sheets or that would have been conveyed as a verbal report to nursing, and then subsequently to myself. And also the units, as they bring the patients in they would give a little bit,

you know, like a blast of information about the patient; 57 year old white male, complaining of shortness of breath, and what may have been done to relieve it, what they would normally do. For example, I.V. initiate, oxygen administered, patient no better, patient worse, patient stable, information along those lines.
Q. What treatment had already been provided to Mr. Stansbury prior to his admission to Cleveland Clinic?
A. He had I.V.s established. He had oxygen given.
Q. Do you remember where the I.V.s were established?
A. I'd have to go back to the records and look to see who established what I.V.
Q. Would you have that information from the Life Flight documents we've already looked at, and marked as Exhibit 1?
A. I'd need to look at it. It's usually indicated on their report, but I don't specifically see the I.V. although they reference I.V. infusion of some fluid.
Q. All right. So that reference would suggest to you that I.V.s were established?

A. Yes, ma'am.
MR. TABER: I.V. or I.V.s?
MS. SEVERYN: I.V.s.
MR. TABER: Let's be clear.
THE WITNESS: The Aurora Fire Department specifically references an 18 to 20 gage I.V. left hand, and right hand. So two I.V.s were initiated.
BY MS. SEVERYN:
Q. What are the locations of the I.V.s?
A. Left hand, right hand.
(Thereupon, an off the record discussion was held.)
Q. Back on the record. Other than the fact that oxygen was given and I.V.s established, is there anything else that was done by way of treatment?
A. He was given 200 cc's of fluid by Metro Life Flight.
Q. What information was given by Mr. Stansbury himself regarding what brought him to the hospital and to the attention of E.M.S. that day?
A. I recall him telling me that he had experienced some severe shortness of breath and some chest pain.
Q. When you obtained this history or after you obtained this history, what did you do after that?

A. Once I finished obtaining the history and examining him, I requested the labs that I wanted drawn on Mr. Stansbury and the test to be performed.
Q. Let's talk about the examination that you performed. What did you do by way of examination?
A. Inspected him, palpation and auscultation. I looked at him, I looked at his extremities, his face, his color, assessed how well he was answering questions, examined his neck, his chest, his abdomen, his extremities.
Q. Were there any abnormal findings on examination?
A. Nothing that was grossly abnormal.
Q. After you completed the examination on the patient, you indicated that you had some labs drawn; is that correct?
A. Yes, ma'am.
Q. You ordered labs. What do you order by the way of laboratory results or tests?
A. I'd have to refer to the chart to be specific.
Q. Absolutely, please do so.
A. Cardiac Troponin, a brain natriuretic N-A-T-R-I-U-R-E-T-I-C, peptide. A C.B.C., Chem.8, PT/PTT, and EKG, a chest x-ray, a blood gas, and a CAT

scan and a D-dimer.
Q. What were you considering by way of a differential diagnosis at that time?
A. Well, with the chest pain and shortness of breath I would think of a pneumothorax, a myocardial infarction, cardiac tamponade, because of the type of surgery he supposedly had, a pulmonary embolism, pneumonia, pleural effusion, an abscess, and a slew of other things.
Q. Were you considering all of these at the time you saw Mr. Stansbury in emergency, and at the time you ordered these tests?
A. Yes, ma'am.
Q. Going through each of the tests, can you tell why the tests were ordered and what information you expected to get back that would assist you in reaching a diagnosis as to the ideology of the patient's problems?
A. Well, name a lab or a test, and I'll --
Q. Sure. You went down the list of tests and you were referring to something, can we do it that way? For instance, I think you started with Troponin --
A. Troponin, that's just to see if he had a heart attack.
Q. Okay.
A. The C.B.C. would be to see if he has an

infection like a pneumonia.
Q. Okay.
A. The clotting, the PT/PTT to ensure that his clotting parameters were normal. The chemistries are to make sure that his renal function was normal, nothing out of the normal there, and since a CAT scan would be required for other reasons, make sure that his creatinine, that is the renal function, make sure that was normal.
His blood gas was to see how much oxygen he had in his blood, the EKG was to see if he was having obvious signs of a myocardial infarction.
The chest x-ray was to see was there anything abnormal as far as the operative site, was there an abscess in that area, was there a mass, a pleural effusion, unilateral, bilateral, did he have pneumonia with a sub-harmonic effusion, did he have a pneumothorax?
Q. And that would be from the blood gas?
A. No, the chest X-ray.
Q. The chest x-ray, okay.
A. But the blood gases would also reflect somewhat if he had a very large pleural effusion, he may not have as much oxygen as one would expect him to have.

And finally the CAT scan to basically confirm any abnormality, or better define any abnormality you see on the chest x-ray, because some things are there but you really can't see or appreciate well on a chest x-ray.
Q. Would you indicate for us, Doctor, what the results were of these tests and when the results came in?
A. At 18:00 hours his Troponin was recorded here as negative. His BNP is registered as I think 189 -- 187 which would be normal under these circumstances.
Q. What time was that?
A. At 18:00 hours. His blood gas, it says here 17:50, between 17:50 and 18:07 hours, his blood gas came back and his oxygen supply was changed from four liters to a 50 percent Venturi mask.
Those are the only lab results I see on this document here on this page.
Q. When you referenced the page, what page -- what is the number of the page you're referencing?
A. You'd have to show --
Q. Okay, it's not stamped.
A. The Emergency Department Ledger, if you have a copy of that. The page right after that one.
MR. TABER: It should be 0046, probably in your set.

MS. SEVERYN: Donna, could you go ahead and mark this document, I think we are at 14.
(Thereupon, Exhibit Number 14 was marked for identification)
BY MS. SEVERYN:
Q. Doctor, directing your attention to what's been marked as Plaintiff's Exhibit 14, is that document that you just referred to and read the results for, the Troponin, the BNP, and the blood gases?
A. Yes, ma'am.
Q. With regard to other tests that were ordered, can you tell us what the results of those tests were?
A. I don't know what time they were made available, but as I recall the chest x-ray was normal --
MR. TABER: Which one do you want to do first?
MS. SEVERYN: Whatever the Doctor is comfortable with.
THE WITNESS: The chest x-ray. That was read, by Dr. Belhobek, B-E-L-H-O-B-E-K.
BY MS SEVERYN:
Q. Is there a time referenced on the report?
A. On the bottom it says finalized on 01/25/03, 7:44 p.m.
Q. Okay, what about the remaining tests? The

C.B.C. the Chem.8 --
A. I don't know what time those were made available. I'd have to look through and find the results.
The D-dimer was valued at 10,940, but I don't know what time that was made available.
Q. What does that result mean to you?
A. It's a fibrin and split product, suggestive of a clotting process going on and a degradation process going on.
Q. Would you consider that result abnormal?
A. Markedly.
MR. TABER: For this patient?
THE WITNESS: No, not for this patient, but as far as your normal value, it would be abnormal.
BY MS. SEVERYN:
Q. So it's markedly abnormal for --
A. For you it would be markedly abnormal.
Q. And why is it not markedly abnormal or why was it not markedly abnormal for Mr. Stansbury?
A. Well, it would not be markedly abnormal for Mr. Stansbury because he had had surgery.
Q. All right. How would the surgery that he had -- and I take it that you're referring to the aortic

aneurysm repair?
A. Right.
Q. What affect would the fact that he had surgery have on this result?
A. It would falsely elevate the result.
Q. So is it fair to say that this test result, the D-dimer didn't really give you any useful information in treating this patient?
A. Right.
Q. What other test results came in and what were the results?
A. His hemoglobin was 9 and 28.
Q. What does that result suggest to you?
A. It suggests that he had a surgery.
Q. Again, was there anything about that result that would any way assist you to figure out what was going on with Mr. Stansbury?
A. No. His blood gas.
Q. What was the result of that?
A. He had a PO2 of 59, a pH of 7.48 on four liters of nasal cannula.
Q. Is that a normal or abnormal result?
A. That's an abnormal result.
Q. What information would that have conveyed to you regarding this patient's condition?

A. That he was hypoxic.
Q. And does that suggest to you a lack of oxygen?
A. Yes, ma'am.
Q. Does it help you to determine the cause of his problems that day?
A. No, ma'am.
Q. What other test results came back?
A. His -- let's see his Chem.8, I'm sorry KP-7.
Q. All right. And what is the result of that?
A. It shows his creatinine was 1, B.U.N. was 17, potassium was low normal, 3.9.
Q. Are those findings in any way abnormal?
A. Not really.
Q. So was there anything about this test or the results that in any way assisted you, in again determining what was going on with Mr. Stansbury that day?
A. No, ma'am.
Q. With regard to any of the other tests that were ordered, was there any information on any of those other tests that you obtained that in any way helped you either determine what was going on with this patient, or rule out for certain some of the problems that you had been considering?
MR. TABER: Well, you can answer if you

want, but the form is defective. I'm not clear what other tests you're referring to.
BY MS. SEVERYN:
Q. Well, any of the other tests that we haven't talked about. I mean there was -- let's make it global then. Out of the tests that you ordered, which of these tests, and the results that came back, actually helped you either come up with a diagnosis, or rule out some of the differential diagnoses you had been considering?
A. Well the EKG did not show that he was having a heart attack. The chest x-ray was interpreted as clear, so the hypoxia demonstrated on his blood gas was not due to a pneumonia, that we could see any way, pleural effusion, or pneumothorax.
Q. All right. By the time you got the EKG you -- is it fair to say you were able to rule out a heart attack?
A. Well, with some certainty, yes.
Q. And once you had the results of the chest x-ray, is it fair to say you were able to rule out pneumonia, pleural effusion -- and what else?
A. Pneumothorax.
Q. You were able to basically rule out all three of those once that chest x-ray came in; is that correct?
A. Yes, ma'am.

Q. What other test results helped you to either come up with a diagnosis or to rule out one of the differential diagnoses you'd been considering?
A. At this point the thing that he -- the thing that was missing was a CAT scan of his chest.
Q. And what -- strike that. What information were you anticipating you would obtain from the CAT scan?
A. Well, it would confirm that the x-ray was indeed interpreted correctly and that let us look -- it would indicate whether he had a pulmonary embolism or not.
Q. And of course a P.E. is one of the things that you had been considering on the differential diagnosis?
A. Yes.
Q. And certainly it would have been one of the things you'd been considering, especially from the history, you had a patient that was 12 days post-op; correct?
A. Yes, one of the things you would need to consider.
Q. Other than the CT scan, are there any of these tests that you've already told us about that would have given you any information relative to the P.E.?

A. That's the one test that would have confirmed the chest x-ray and help make a diagnosis.
Q. And I believe you've already told us that you ordered a CT scan initially, it was one of the tests that you ordered shortly after speaking with and examining Mr. Stansbury?
A. Yes, ma'am.
Q. What does the standard of care require with respect to the time in which a CT scan is performed, if it's being performed through the emergency room?
A. I would imagine that's a local type of phenomenon.
Q. What does that mean?
A. Well, if you have an emergency department in I would imagine the upper peninsula, and you have a volume of maybe 6,000 patients a year, I would anticipate you should be able to get a CAT scan almost immediately. If you're in a large teaching urban center, it would probably take longer to obtain your CAT scan, depending on the number of patients presenting that day, the traffic in the E.D. the number of critical patients upstairs, and the physicians who need to utilize that resource for whatever reason.
Q. Let's talk about the Cleveland Clinic Foundation then. Would you describe that then as a

large urban hospital?
A. Yes, ma'am.
Q. Do you have an opinion as to the time frame, that is mandated by the standard of care, in which to obtain a CT scan for an emergency-room patient suspected of a pulmonary embolism?
MR. TABER: Objection, over broad. Go ahead.
THE WITNESS: I do not -- I'm not certain what you're referring to.
BY MS. SEVERYN:
Q. I'm referring to this patient, Mr. Stansbury. Let's assume that we're going back to the date of January 25, 2003, which is the date of the treatment that was rendered to him --
A. Yes.
Q. -- at the Cleveland Clinic Foundation.
A. Right.
Q. Going back to that time and that hospital, what was the standard of care, in your opinion, Doctor, to a reasonable degree of medical certainty, as to how quickly a CT scan should have been performed on that patient.
MR. TABER: Same objection.
MS. HENRY: Join --

THE WITNESS: Well, we try to obtain the CT scan as soon as it's possible.
BY MS. SEVERYN:
Q. Going back to the Life Flight in this case, I think we can all agree that the patient was life flighted in by the Metro Life Flight Service; correct?
A. Yes.
Q. And is it fair to say that when he was life flighted there was information conveyed that the patient needed emergency care?
MR. TABER: Objection.
THE WITNESS: Well, one would assume if a patient is being life flighted that he is in need of emergency care.
BY MS. SEVERYN:
Q. Let me direct your attention to what's already been marked and identified as Exhibit 1. You had indicated on the record that you believe you had seen a third of those documents, which is CCF 0248. Can you read for you us in the middle of that page reason for critical care transfer?
A. "To prevent patient's health being placed in serious jeopardy. To prevent serious impairment to bodily functions. To prevent serious disfunction being caused to any bodily organ or part".

Q. And what does it say below that at Section 1?
A. "Needs emergent definitive cardiac care. Needs emergent operative care".
MR. TABER: Just so the record is clear, the court reporter should have that in quotes, because he was reading off a piece of paper that he was asked to read.
What page is that again?
THE WITNESS: That's CCF 0248. And this is a Physician Certification for Transport Report, but I don't know -- Ginny -- G-I-N-N-Y, G-U-J-R-A-L.
BY MS. SEVERYN:
Q. Would you agree, Dr. Aponte, that Mr. Stansbury needed emergency care when he was transported to the Cleveland Clinic Foundation?
A. Well, I came to that conclusion once I saw the patient myself.
Q. Okay. How would you characterize the nature of his condition? Was he in severe distress? Was he stable? Was he critical?
A. Well, when I saw him myself he appeared to be stable. He was not hypoxic. He was able to speak in full sentences. He was able to hold a conversation with me. And if I recall correctly, I'd have to refer to the

chart, the vital signs were stable also.
Q. Would you tell us from the record at approximately what time the CT scan was performed on Mr. Stansbury at the Clinic?
A. I cannot tell you what time it was performed. I can only tell you when he left the department to obtain to have a CAT scan performed, and what time he returned from CAT scan.
Q. Okay, Doctor, let me direct your attention to what has been premarked as Plaintiff's Exhibit 8. Is that the document that you're referring to?
A. Yes, ma'am.
Q. All right. So what time did Mr. Stansbury leave to go for a CAT scan?
A. 19:27.
Q. When did he come back?
A. 20:15.
Q. Now. One thing that's curious about that there's still a reference at 19:35; correct?
A. Yes.
Q. What does that reference mean to you?
A. That his Heplock number 20 in the left was located in the upper forearm.
Q. What is that H-L?
A. Heplock.

Q. What is a Heplock?
A. That is an intravenous catheter that's placed on a patient for vascular access.
Q. Based upon the fact that there's that reference at 19:35, does that suggest to you that the patient is still in Room 17 at that time?
A. No, ma'am.
Q. All right, it does not?
A. No. It just tells me that that's the time that they recorded that entry.
Q. Does that entry suggest to you that an I.V. was placed on the patient?
A. Not necessarily.
Q. Okay. Do you have any information as to whether or not this patient was -- strike that.
Did you read the deposition of Mrs. Stansbury in this case?
A. No, ma'am.
Q. Are you aware that according to her deposition, Mr. Stansbury was taken to CT and brought back immediately because the I.V. was misplaced for purposes of the CT scan?
MR. TABER: Objection.
THE WITNESS: No, I was not aware of that.

BY MS. SEVERYN:
Q. You were at the Clinic for what, approximately nine years?
A. Approximately.
Q. Was there a requirement as to the placement of an I.V. for a CT scan of the nature that Mr. Stansbury had?
A. What I'm familiar with is that the -- the I.V. or the Heplock should be close to I think the elbow, but you would have to talk to radiology about that.
Q. Do you recall any time or instance where a patient was returned from a CT because the Heplock was not in the proper location and so they weren't able to do the CT scan?
A. Not at this time.
Q. Do you know one way or another as to whether that happened in this case?
A. I'm not aware of that happening in this case.
Q. Okay and is there anything curious to you that there's an entry at 19:35 at Room 17 when the patient left at 19:27 for the CAT scan?
A. Well it seems awkward, but whoever wrote it in you'll have to talk to them about it. It doesn't mean -- as I said, to me that just indicates the time when they made and entry. It could be an afterthought, I

don't know.
Q. Could it also mean the patient was back in the room and there was something that was being done with regard to that Heplock?
A. It could mean anything you want it to mean I would imagine.
Q. Do you recognize the initials at that entry?
A. No.
Q. You did indicate for us that the patient came back from the CT scan at 20:15; correct?
A. That's what the record reflects, yes.
Q. When did you first learn the results of the CT scan?
A. I have no independent recollection of that. I mean I don't know exactly what time that was.
Q. Typically, how do you learn about the results of a CT scan if those results are abnormal?
A. Several modalities, when the patient returns, the transporting personnel can inform us, the radiologist may, if it's slow enough, he may be able to call us and give us an idea as to what he saw and what he's going to be transcribing, you know, interpretation and that's basically those two methods.
Q. Is it fair to say that at some point you did obtain the results of the CT scan in this case?

A. Yes, ma'am.
Q. Let me direct your attention, Doctor, to what has been marked as Plaintiff's Exhibit 7. Can you identify that document for the record?
A. Deposition Exhibit Number 7, CCF 0305.
Q. What is that document?
A. This is the result of a CT chest with contrast.
Q. Is this the report from the CT scan that we're talking about?
A. Yes, ma'am.
Q. There's a number -- excuse me, a time up on top, just above that line 7:58 p.m.; do you see that?
A. Yes, ma'am.
Q. Do you have any information as to what that time references?
A. No. I don't know if that's when the test was started or when it was completed.
Q. All right. So you don't know one way or the other what the time specifically refers to?
A. Right.
Q. But we do know that he was back in Room 17 at 20:15?
A. Yes.
Q. And at least according to one of the entries

we know he left at 19:27?
A. Yes.
Q. All right. And we know you received information about this CT scan; correct?
A. Yes.
Q. But we don't know how or when?
A. I know it was verbal.
Q. Okay.
A. But I don't know if it was telephonically or the radiologist or the nursing personnel coming back saying yes, they read it out as a positive CT.
Q. When you say positive CT, you mean it's abnormal?
A. Yes, ma'am.
Q. What is abnormal about the CT?
A. There are -- I'm quoting. "There are large thrombi within the right pulmonary artery, and the proximal branches of both lower lobes pulmonary arteries. They are probably new since the prior examination of 1/16/03. Ill defined filling defects within the inferior vena cava cannot be excluded. There are small thrombi with the left upper lobe pulmonary artery branches. The patient is status post median sternotomy. There has been improvement of the chest wall subcutaneous emphysema. There is a persistent

small pericardial effusion/pericardial thickening with fluid seen surrounding the ascending aorta with probably a graft within the ascending aorta. I suggest clinical correlation. There is very small residual amount of air within the mediastinum. There is no definitive abnormality involving the lungs, although this somewhat limited examination due to motion artifact. A small sebaceous cyst is seen in the upper posterior right chest wall".

Q. All right. Is it fair to say that the CT scan was positive for pulmonary emboli?

A. Yes, ma'am.

Q. Do you recall if you at any time reviewed the results of the CT scan that was done on January 16th?

A. No, ma'am.

Q. Do you know if any information was conveyed to either nursing or the radiologist regarding the prior result on January 16th?

A. I cannot recall at this time.

Q. What did this report tell you?

A. That Mr. Stansbury had bilateral pulmonary embolism.

Q. And again, is it fair to say that they were large or at least some of those were large emboli?

A. Well, it was interpreted as large thrombi

within the right pulmonary artery.

Q. I know you indicated -- strike that. You recall the information about this CT was communicated to you verbally or orally, but you don't recall if it was from the radiologist or nursing; is that correct?

A. Yes.

Q. It would have been one or the other typically?

A. Yes.

Q. Again, you were at the Clinic for approximately nine years, if the radiology department is interpreting a positive CT like the one at issue here, do they typically pick up the telephone and call you with regard to those results?

A. Yes.

Q. But you don't know if that's what happened in this case?

A. It's -- I don't recall.

Q. All right. Now, if we go back to the information regarding the timing, I believe you indicated early on that the patient was admitted to Cleveland Clinic Foundation at 17:33?

A. I'm sorry, say that again? He was admitted to where?

Q. Excuse me, received.

A. Oh, yeah.

Q. At the Cleveland Clinic at 17:33.

A. Right.

Q. All right, and this CT scan we had the patient arriving back to the room at 20:15?

A. Right.

Q. We have the patient leaving -- well, we don't know for sure when he left, but there is a reference in the CT at I believe 7:58, that time reference we talked about in Exhibit 7.

MR. TABER: What --

MS. SEVERYN: I said there's just a time reference in that Exhibit 7 as to 7:58.

MR. TABER: Oh, right.

THE WITNESS: Meaning what?

MS. SEVERYN: We don't know what it is.

MR. TABER: That's -- sorry.

MS. SEVERYN: That's okay.

BY MS. SEVERYN:

Q. Do you have a professional opinion, a medical opinion based to reasonable degree of medical certainty, as to whether or not the CT scan was performed in a timely fashion in this case?

A. It was performed in a timely fashion in this case, and in general, I would say this is -- this -- anywhere this was performed in a timely fashion.

Q. Is it fair to say that any order for testing through emergency is being done on a STAT basis?

A. It's safe to say that, yes.

Q. And that would be a true statement?

A. I think that's the medical health care system as I know it in this Country, that would be a safe assumption in just about any hospital that I've ever been to.

Q. Okay, and it certainly would be a true statement as to the Cleveland Clinic Foundation?

A. Yes, ma'am.

Q. When the test results came back from the CT scan, what did you do to initiate treatment?

A. Once we obtained the test results we contacted cardiothoracic surgery and cardiology and informed them of the results. At that point in time they requested that I initiate a treatment with Heparin, which was I wrote the order, and I wrote the admission order.

MS. HENRY: What did you say? I wrote the order and what else?

THE WITNESS: The admission order.

MS. HENRY: Thank you.

MS. SEVERYN: Off the record.

(Thereupon, an off the record discussion was held.)

BY MS. SEVERYN:

Q. Back on the record. Doctor, directing your attention to what has been previously marked and identified as Exhibit 4, do you see that document?
A. Yes, ma'am.
Q. What is that document?
A. This is the transcription of the Emergency Department Report.
Q. Who prepared this document?
A. Michael Cudnik, MD, C-U-D-N-I-K.
Q. Who was Michael Cudnik, MD, on January 25, 2003?
A. He was a resident from MetroHealth Medical Center who was rotating through the emergency department at the Cleveland Clinic Foundation and was present in taking care of the patient with me.
Q. I think you've stated that Dr. Cudnik actually prepared the report?
A. He dictated this report.
Q. And I do note at the top that it was authenticated by you?
A. Yes, ma'am.
Q. And what does authenticated mean?
A. That means that I read the report and signed the report.
Q. Essentially, that means you agreed to it, you

agreed with its contents?
A. Yes, ma'am.
Q. Let's talk a little bit about Dr. Cudnik's role in the treatment of Mr. Stansbury on January 25, 2003. What was Dr. Cudnik's role as a resident in the treatment of Mr. Stansbury?
A. He was the resident who was assisting in the managing of the patient.
Q. Was the overall responsibility for the care and treatment of Mr. Stansbury at all times upon you?
A. Yes, ma'am.
Q. Okay. So you were essentially supervising Dr. Cudnik?
A. Yes, ma'am.
Q. So when you say that Dr. Cudnik was responsible for assisting in the management of this patient you're talking -- you're not putting him on par with you, in terms of responsibility with you in terms of management?
A. Right.
Q. What treatment did Dr. Cudnik render to Mr. Stansbury during that emergency visit on January 25, 2003?
A. He would check on the patient's periodical, ensure that I.V. O2 monitor were initiated, that

his labs were obtained and sent off, and as the labs were made available he would interpret them and inform me if there was anything grossly abnormal, given the circumstances of this patient.
Q. Do you recall having discussions with Dr. Cudnik about Mr. Stansbury that evening?
A. Yes.
Q. What are your recollections about that?
A. Well, after we had evaluated him we discussed the differential diagnosis and the approach to the patient. At that point in time, I asked him to contact cardiology and cardiothoracic surgery to inform them that this patient was in the department and within our institution and for them to offer us any information or any advice as we evaluated this patient.
Q. Actually, that brings me to my next question. Let me direct your attention to that Exhibit 7 that's in front of you -- did I say -- Exhibit 4, excuse me.
A. Yes.
Q. If you would turn to the second page, there's a reference there about two thirds down the page, the patient will be signed out to Doctor -- is it Disch?
A. Disch.
Q. Who is Dr. Disch?
A. He's a resident -- he was a resident rotating

through the department of emergency medicine of the Cleveland Clinic Foundation.
Q. What does that entry mean to you?
A. That means with respect to this patient to expect Dr. Disch to report back to me on the condition of the patient or the labs obtained, et cetera.
Q. What was Dr. Cudnik's role after this patient was assigned to Dr. Disch?
A. He was no longer involved with the care.
Q. Do you recall speaking with Dr. Disch on January 25, 2003 about this patient?
A. Yes.
Q. At what point in the care, if you can recall, did Dr. Cudnik end his involvement and Dr. Disch begin his involvement in Mr. Stansbury's care?
A. That would be approximately 19:00 hours, because that's the time when they would change shifts.
Q. All right. So going back to that second page of Exhibit 4, there's also a reference that cardiology and cardiothoracic surgery were consulted; do you see that?
A. Yes, ma'am.
Q. Do you have a recollection as to who actually consulted cardiology and cardiothoracic?
A. That would have been Michael Cudnik, Dr.

Cudnik.
Q. Did you personally ever speak with either the cardiologist that was consulted or the cardiothoracic specialist that was consulted?
A. Yes.
Q. At what point did you speak with either of them?
A. That I cannot recall.
Q. Which one did you speak with?
A. I would imagine both. I don't have a specific recollection, but I know that I had spoken with them.
Q. Is there any note that you would have made in the chart with regard to those conversations?
A. No, ma'am.
Q. So you don't have any specific recollection of speaking to the cardiologist or the cardiothoracic specialist in this case?
MR. TABER: Objection --
THE WITNESS: I just told you the direct opposite. I did speak with them, I just don't have a specific time that I can tell you I spoke with them.
BY MS. SEVERYN:
Q. All right. So you do have an independent recollection of having spoken with both specialists?

A. I have an independent recollection that I spoke with them, because I had asked them to be contacted. And I recall being on the phone and discussing Mr. Stansbury with someone, but when that occurred I cannot tell you.
Q. All right. This recollection that you have of being on the phone and speaking with someone, do you have a recollection as to whom you spoke with?
A. No.
Q. So you spoke with someone, is that a one someone or multiple someones?
A. I can't tell.
Q. Going back to my question, do you have any independent recollection as to whether you spoke at any time with a cardiologist that was consulted about Mr. Stansbury?
MR. TABER: Objection --
THE WITNESS: You'll have to define independent recollection, because I recall speaking to actually several people about Mr. Stansbury. Who they were, and what we talked about, I can't tell you exactly.
BY MS. SEVERYN:
Q. All right.
A. But I know it was my intention to have

cardiothoracic surgery and cardiology contacted and have them made aware of who this person was, and that he was here, and what the situation was that we were facing.
Q. All right, let me --
A. They may have called back again, if I put out a call like that and the resident is unavailable, I'm more than happy to pick up the phone and help a resident out by talking to the consultant, giving them the gist of what's going on and just take it from there.
Q. All right. In this particular case, do you know who initially contacted cardiology and or cardiothoracic?
A. Well, what do you mean by who specifically? We usually just ask the secretary to consult the service. So for the physician or to the secretary who was sitting down, because no matter who -- I could have told a nurse to contact services and they would have relayed that information to the secretarial services and that consult would have been put forward.
Q. Typically, how do you do it?
A. Exactly as I just described it. I can ask a nurse. I can ask a technician. I could tell the secretary. I can ask the resident. I can ask anyone there, because basically it's a group effort, a group function to obtain what we need for the patient.

Q. All right. And you're going to ask someone to do what?
A. Contact cardiothoracic, whoever is on call for cardiothoracic and cardiology service.
Q. In this case do you know who initially spoke with either cardiology or cardiothoracic?
A. It may have been me, it may have been Michael, I don't know.
Q. But you don't know?
A. No.
Q. All right. And again, when I'm talking about independent recollection, I'm talking about your memory versus your reliance on a document; okay?
A. Right, okay.
Q. Do you have any knowledge as to what information was conveyed to cardiology about the patient?
A. If I had spoken with them that this is a patient who was life flighted in, had this aortic repair and is complaining of chest pain and shortness of breath.
Q. Did you have any knowledge at the time that the patient came in as to when that aortic repair had taken place?
A. My understanding was that it was about a week

earlier.
Q. Do you have any knowledge as to what information was conveyed to cardiothoracic about this patient?
A. If I had spoken with them, I would have told them that this was a patient who had this procedure, who presented to the E.D. complaining of chest pain and shortness of breath.
Q. But again, we don't know who initially contacted them or --
A. Right.
Q. -- how they were contacted?
A. Well, we know how they were contacted, the secretarial support was asked to generate a consult.
Q. All right, so it always starts there?
A. Right.
Q. There is a reference on Page 2 of Exhibit 4, following what we've already looked at, cardiothoracic wished to be called when patient returned from a CT of the chest, and before Heparin was to be started on the patient. Do you see that note?
A. Yes, ma'am.
Q. Do you recall whether this information was conveyed to you at any time during your treatment of this patient on January 25, 2003?

A. What information?
Q. The information I just read, that cardiothoracic wished to be called when the patient returned from the CT scan and before Heparin was started?
A. Yes, we knew that -- my global recollection in managing Mr. Stansbury was we have to wait to get the CAT scan result, and then contact the consultants again.
Q. Do you know why cardiothoracic wanted to wait for the CT scan results prior to administering Heparin?
MR. TABER: Go ahead.
THE WITNESS: You would have to ask them, but I would assume that it was because of the nature of the surgery he had had a week earlier.
BY MS. SEVERYN:
Q. And based upon your professional opinion, what role would that surgery have with respect to whether or not he was Heparinized immediately or after CT scan results came in?
Q. Again, I would assume it would be to justify the use of a drug on a patient who clearly has a contraindication and may be a life threatening

indication.
Q. What's the contraindication that you're referencing?
A. Well, usually major surgery, you try not to give lytics or an anticoagulate to someone who has had major surgery.
Q. Assuming hypothetically that you had a patient come in with the same reported symptoms as Mr. Stansbury, the shortness of breath, the chest pain, but no history of having had a surgery at any immediate point in time, would your treatment of this patient have been any different under those circumstances?
MR. TABER: Objection, hypothetical, contrary in facts and nothing to do with this case and totally irrelevant.
MS. SEVERYN: You can go --
THE WITNESS: Throw me a hint here, what do I do now?
MS. SEVERYN: You answer.
MR. TABER: Well, you don't have to answer. If that has anything to do with this case go ahead, but if it doesn't, I don't know why we're wasting time on a hypothetical that's clearly contrary to the facts by anyone's assertion. It's totally irrelevant

and need not be answered, but you can do whatever you want with it.
THE WITNESS: I'll elect not to answer that question.
BY MS. SEVERYN:
Q. Why not?
A. It's a hypothetical situation.
Q. You are permitted to answer hypothetical questions, Doctor.
MR. TABER: Based on the case, yes, based on some other case, no.
THE WITNESS: Right, my understanding was I'm here to answer questions about what happened this evening and what we did as -- I'm here to answer questions regarding what actually did happen, not theoretically what could have happened or a hypothetical situation.
BY MS. SEVERYN:
Q. Well, you wanted cardiothoracic involved, Doctor, why?
A. Because this was a person who had had a major surgery.
Q. So that fact played a role in your treatment of the patient?

A. Yes, ma'am.
Q. Now, you've already talked earlier about, again a recollection of having spoken with someone on the telephone that you think may or may not be cardiology or cardiothoracic?
A. Yes, ma'am.
Q. What do you remember about what was discussed during that telephone conversation?
A. Specifically, I cannot tell you, I remember I could quote him saying these things. I just know my impression on my interactions with these services.
Q. All right, and what are your impressions?
A. The impression was obtain the CT and then contact the service. They will decide if and when he was to be treated with Heparin.
Q. Do you have any recollection of contacting the cardiothoracic specialist after the CT scan results were obtained?
A. I do not recall specially speaking with him, but I have a global impression that I had spoken with them, and that decision afterwards was to go ahead and Heparinize him, but I'm not certain.
Q. All right.
A. I just know that the key element there was obtain the CAT scan, confirm the pulmonary embolism to

justify the use of this medication, that information was relayed and a decision was made by the appropriate services. And at that point in time, I wrote the order for the Heparin to be administered, and for the patient to be admitted to the cardiology services.
Q. In your opinion, Doctor, what is the risk to the patient if Heparin is administered 12 days post-op?
A. Depending on the type of surgery that you have. A major surgery you may have some complications such as bleeding, surgical anastomosis.
Q. Is it fair to say that a pulmonary embolism is also a life threatening -- or is a life threatening event?
A. Yes, ma'am.
Q. I believe we've already marked and identified Exhibit 2. You indicated that that order, that Number 1 order, to administer Heparin is in your handwriting; correct?
A. Yes, ma'am.
Q. So I think you've mentioned you don't recall specifically speaking with cardiothoracic, but the order to initiate Heparin came from you?
MR. TABER: Objection --
THE WITNESS: No, specifically --
MR. TABER: Hold on.

THE WITNESS: I'm sorry.
MR. TABER: The first part I think he's answered three or four times. The second part, go ahead. I think you should clarify.
THE WITNESS: Say that again, I'm sorry.
BY MS. SEVERYN:
Q. I'm truly not trying to trick you. I'm having a hard time understanding your recollection, from a global impression, from yes I remember. So as I understood your testimony cardiothoracic wished to be called after the CT scan. You don't have any independent recollection of talking to them, but you have this global impression that you did?
A. Uh-huh.
Q. Is that a fair characterization --
A. Yes.
MR. TABER: -- what he says, let's move on to the second part.
MS. SEVERYN: I will when I understand it, thank you, Counselor.
MR. TABER: Well, I will instruct him not to answer, because he has answered it more than once which is all he's required to do. It's been at least four times. I don't mean

to interrupt, but he will not answer the same question five times, please go ahead.
BY MS. SEVERYN:
Q. From whatever source it is, the order to initiate Heparin is in your handwriting; is that correct?
A. Yes, ma'am.
Q. When was the Heparin first administered?
A. I have to refer to this document here. At 20:30 hours. "Patient came back at 20:15, vital signs were obtained two minutes later and at 20:30 hours Heparin was started per order".
Q. What document are you referring to?
A. The Continuing Care Form.
MS. HENRY: Is that Exhibit 8?
MS. SEVERYN: Yes, it is. I think we've already marked that as Exhibit 8.
THE WITNESS: This is it.
BY MS. SEVERYN:
Q. Just if you would confirm that Exhibit 8 is in fact the document that you're referring to?
A. Exhibit 8 is.
Q. I'm reading here, Heparin started per order. There is a reference after that to cardiology. What do you understand that reference to cardiology to mean?

A. That cardiology was at the bedside, and okay with the Heparin dose.
Q. Do you have any knowledge or recollection as to why cardiology was present versus cardiothoracic?
A. Well, because cardiology would be managing the patient for cardiothoracic, that's the way they usually function.
Q. Why?
A. I have no idea.
Q. Do you know whether two different doctors were actually contacted, when we referenced cardiology contacted and cardiothoracic contacted?
A. I would have to assume that they were because that's what was requested.
Q. And it would have been whoever was on duty?
A. Right.
Q. Is there a document within the hospital that would reflect who was on duty on that date?
A. I wouldn't know that information.
Q. Have you seen anything in the emergency records for January 25, 2003, that would reflect anything that was actually written by cardiothoracic?
A. To my knowledge I had not seen anything written by cardiothoracic.
Q. What was the dose of Heparin that was

administered?
A. I'm looking at Exhibit 2, "80 units per kilogram, and then 18 units per kilogram".
Q. What is your understanding as to why Heparin was administered to this patient?
A. It was administered to the patient because they felt that the patient -- given the risk and benefits, would benefit from being Heparinized.
Q. And how would the patient benefit from Heparin?
A. It would hopefully keep the clots from extending, from growing.
Q. Okay, is it fair to say that Heparin prevents the clots from growing and or prevent the formation of new clots?
A. Well, same thing.
Q. Okay, is it fair to say that the Heparin would not address the clots that were already formed?
MR. TABER: Objection, what do you mean address?
MS. SEVERYN: Effect.
MR. TABER: Could you start over?
BY MS. SEVERYN:
Q. Sure. Would the administration of the Heparin have any impact or medical effect on the clots that had

already formed that were documented in the CT scan report?
A. To my knowledge they would not.
Q. Why would a patient who has been confirmed for a pulmonary emboli, what are the treatment options for that patient?
MR. TABER: Objection, over broad.
THE WITNESS: With respect to what?
By MS. SEVERYN:
Q. Treating the patient to address the pulmonary emboli that had already formed, what are the treatment options?
MR. TABER: Same objection, over broad.
THE WITNESS: Well, okay, if you're talking about treating a patient with pulmonary embolism that have already formed, you treat them with Heparin.
BY MS. SEVERYN:
Q. But you've indicated Heparin does not effect in any way, treat the clots that have already formed?
A. Right.
Q. What can we do by way of treatment as to the clots that are already in place?
MR. TABER: Objection, over broad. Are we talking about this guy?

MS. SEVERYN: Let's talk about this guy.
MR. TABER: Okay. Please clarify your questions as such.
MS. SEVERYN: Sure.
THE WITNESS: Okay. If you wanted to treat the clots themselves in general, you treat them with Heparin. The Heparin will not effect the clots that are already there, that's for the body to take care of. And if you follow the patient with serial CT's you'll see them autolysing these clots.
BY MS. SEVERYN:
Q. Autolysing, getting smaller?
A. Right. Splitting the fibrin split products et cetera, and making them smaller and making them go away.
Q. What are the risks to the patient that the clots, the emboli that have already formed and are already in place, will break off?
A. Say that again?
Q. All right. If we have a patient such as Mr. Stansbury, and we know that he has multiple emboli that's already formed in the lungs; right?
A. Yes.
Q. What are the risks of one or more of those emboli break off in the location that they're at?

A. What location for example?
Q. Strike that. At some point in time Mr. Stansbury went into respiratory distress; correct?
A. Yes.
Q. Tell us what information you have about that, when did it first occur?
A. According to Deposition Exhibit 8, at 20:46 about 16 minutes after he got his Heparin he was complaining of severe shortness of breath, cardiology and myself were at the bedside. His pulse-ox went down to 95 on 50 percent Venturi mask. Thereafter two minutes later it was noted to have audible wheezing and his respiratory rate increased to 44 breaths per minute. His pulse-ox decreased to 83 percent on a non re-breather mask. Blood pressure was 195 over 88 and his heart rate was 113.
Q. All right. I think you indicated that you were present at this time as well as cardiology?
A. Yes.
Q. What was done for Mr. Stansbury by way of treatment after the onset of respiratory distress?
A. According to this Deposition Exhibit 8, at 20:56 after re-assessing, the patient was intubated with an 8.0 endotracheal tube.
Q. Can we go off the record, I need a two minute

break.
(Thereupon, there was a short recess in the proceedings.)
Back on the record. At the point in time when Mr. Stansbury went into the respiratory distress, and I think you already told us you were at hand and so was cardiology?
A. Yes.
Q. Both of you were bedside. Who was in charge of Mr. Stansbury's care between you and the cardiologist?
A. I was.
Q. Right before the break, you had referred to Exhibit 8, and was answering my question regarding what treatment was initiated in response to the respiratory distress, and I believe you had indicated that 20:56 the patient was intubated; is that correct?
A. Yes, ma'am.
Q. What is the purpose of intubation?
A. Well, the patient had become unresponsive so you have to maintain a patient's airway, you have to take control of the patient's airway. So you do that by intubating the patient, that is putting a tube into their throat, into their lungs, so that you can oxygenate the patient.

Q. Who actually intubated this patient?
A. I did.
Q. You put the endotracheal tube in place?
A. Yes, ma'am. Now, again I don't specifically recall doing that, but that's something that I would have done.
Q. You wouldn't have had cardiology do it, or one of the residents on hand?
A. No. I think at that time Paul and I were the only ones in the room.
Q. Now, you indicated the intubation was done in part because the patient was unresponsive. What do you mean when you say unresponsive?
A. He was not breathing on his own.
Q. Was he still conscious?
A. I don't think so.
Q. Was there a point in time after the onset of respiratory distress when a code was called?
A. Probably within minutes.
Q. And I think this Exhibit 8 references the type of endotracheal tube that was put in place?
A. Well, the size, 8.0. He was a large person.
Q. Okay. What does the standard of care require to ensure that an intubation has been properly performed?

A. You would listen to both sides of his chest. You would look to make sure that the chest wall is rising bilaterally. You would auscultate, listen to both sides of his chest. You would look to ensure that there's a fogging of the tube. You would auscultate his epigastric region to see if there's air traveling into the stomach. You would obtain a chest x-ray after you've intubated them, and my practice has always been to the End-Tidal CO2 detector.
Q. Was a chest x-ray obtained in this case?
A. I don't recall.
Q. Would that be typically documented somewhere in the chart?
A. It would be, but I don't see anything here.
Q. Would there be a report or any documentation that was generated if a chest x-ray had been done?
A. It should be written down in the nurse's note and it should be Em-STAT documentation that a post intubation chest x-ray was obtained, but in his case not necessary.
Q. Why not?
A. I told you about a slew of things you can do to confirm it, but one of the most important is an End-Tidal Co2 detector.
Q. Okay. So was a CO2 detector used in this case?

A. Yes. Here it says positive color change to purple with CO2 detector.
Q. All right. What does that mean, color change?
A. They're yellow, and if you've intubated the patient appropriately they'll change to a purple color. If you're in the stomach it will stay yellow.
Q. Do you know the type of CO2 detector that was used at the Clinic on January 25, 2003?
A. It's the -- the one that's the quantitative type. I'm sorry the qualitative type.
Q. What do you mean when you say that?
A. It indicates a color change. They have another one that will actually measure CO2 for you.
Q. Are there different types of CO2 detectors that measure or reflect a color change?
A. There probably are.
Q. Again, your information is that the CO2 is going to be yellow and if the patient is properly intubated --
A. -- then it will change color.
Q. To purple?
A. Yes.
Q. If the intubation is successful?
A. Yes, right.
Q. Are you able to describe the type of CO2

detector that was used at the Clinic?
A. It's one that I've seen frequently. It's clear plastic with a flat surface on top and the central area is yellow.
Q. Are there different CO2 detectors where the color change is varied?
A. There may be, I don't know.
Q. Do you use a CO2 detector now at Holmes Hospital where you presently work?
A. Yes.
Q. Does that also work --
A. Same one
Q. -- qualitative basis?
A. Yes.
Q. All right. So it is normally yellow in color, and if proper intubation, that color change on the CO2 is to purple?
A. Yes.
Q. What else was done for Mr. Stansbury by way of treatment in response to that respiratory distress?
A. Well, at that point in time, once you intubate a patient you have to -- and resuscitate them we saw that there was electrical activity on the monitor, but we could not feel a pulse. So we -- well, I decided he's in pulseless electrical activity.

Q. What does that mean to you?
A. That means that he's got electrical activity but is not generating a pulse.
Q. Did you do anything by way of treatment in response to that?
A. Yes, we gave him some Epinephrine and some Atropine.
Q. What did you give him and when?
A. There was one amp of Atropine given at 20:57.
Q. How much was given?
A. One amp, roughly one milligram.
Q. Let me direct your attention to what's been premarked as Exhibit 10, can you identify that document?
A. It's the C.P.R. Data Sheet and Emergency Medical Response.
A. Is that one of the documents that you were referring to?
A. Yes, ma'am.
Q. Where on that document does it indicate the medication given?
A. Where it says Atropine along the top.
Q. Okay.
A. Rather at the junction between the top and middle third.

Q. Okay.
A. The time, heart rate, and lists medications.
Q. So the Atropine was given at 20:57?
A. Yes, ma'am.
Q. And you said one amp is equivalent to one milligram?
A. Yes, ma'am.
Q. What else was administered by way of treatment?
A. Epinephrine.
Q. What dosage was administered?
A. He again received one amp.
Q. And what was the time?
A. At 20:59.
Q. Anything else?
A. He was given another dose of Atropine.
Q. What time was that?
A. At 21:02.
Q. So about seven -- no, five minutes later?
A. Yes.
Q. Any other medications --
MR. TABER: Just past the arrest -- you forgot one at the time of intubation as well.
THE WITNESS: Well, no -- yes, those are listed on Exhibit Number 2.
BY MS. SEVERYN:

Q. What medications were administered during intubation?
A. Etomidate 30 milligrams and Lidocaine and Suxamethonium.
Q. What is the purpose of these medications during the intubation process?
A. It's to allow us to relax the patient so that we can intubate them.
Q. Specifically what part of the body is being relaxed?
A. The larynx.
Q. Did the patient respond to the administration of the Epinephrine and the Atropine?
A. No, he did not.
Q. Did you administer any other medications in addition to the two doses of Atropine and the dose of Epinephrine?
A. He received Activase.
Q. Where is that noted?
A. That's on part of Exhibit 10 page, number 2, lower right hand corner, and also on Exhibit Number 2, middle of right-hand column, TPA 50 milligram bolus I.V. then 50 milligram drip I.V. over two hours.
Q. What is Activase?
A. It's a thrombolytic agent in what they call a

clot buster.
Q. So that was administered I take it in response to the pulmonary emboli that were noted on the scan?
A. No, that was administered to his clinical condition deteriorating.
Q. Okay, to the respiratory distress?
A. The respiratory distress, his becoming cyanotic, unresponsive, requiring intubation.
Q. Other than these medications that you've listed, the Activase, the Epinephrine, and the Atropine, were there any other medications that were administered after the patient went into respiratory distress?
A. At this time I'd have to say no.
Q. There's a references on that Exhibit, under the rhythm section, P.E.A., what does the P.E.A. reference?
A. Pulseless Electrical Activity.
Q. All right, and that's what you had described for us?
A. Right.
Q. Electrical activity but no pulse?
A. Right.
Q. There's also a reference below that to asystole, what does that mean?
A. That means that now he has no electrical

activity.
Q. We've talked about the fact after respiratory distress the patient was intubated and certain medications were administered, was there anything else that was done by way of treatment?
A. C.P.R.
Q. Who administered that?
A. I'm sure I gave the order, but who actually was pressing on his chest that would depend of the type of personnel that we had available.
Q. Where is there a reference -- okay, I take that back. That Exhibit 10 references the C.P.R.; correct, under significant event?
A. Where are you?
Q. I'm on page 2 of that document, Exhibit 10, Significant Events column?
A. Right.
Q. Looking at the top of that page, is it accurate to state that the C.P.R. was started at 20:56 as noted?
A. Yes, ma'am.
Q. Did the patient ever recover from the deteriorating condition, the respiratory distress?
A. No, ma'am.
Q. What was the time that the patient expired?

A. It's noted here, 21:16 hours.
Q. Is there any record that would reflect everyone who was present during the respiratory distress?
A. I would not know.
Q. Do you have a recollection as to who was present during the respiratory distress?
A. I know I was there, and I know cardiology was there, and I know other people were there. Again, like a global sense of other bodies present, but I don't know specifically. I don't recall specifically who was there.
Q. So as we sit here today, you don't have a recollection of the nursing staff that was present?
A. Right.
Q. Who was the cardiologist who consulted in this case?
A. Paul Showenhaugen. (phonetic spelling)
Q. Let me direct your attention to what has been premarked as Exhibit 6. Can you identify that document for the record?
A. Deposition Exhibit Number 6, Consult Document.
Q. Is that the cardiologist consultation?
A. Yes, ma'am.
Q. Is there anything significant about the findings in this case?
A. With respect to what?

Q. Anything significant with respect to either condition or treatment of the patient?
MR. TABER: Objection, over broad.
THE WITNESS: No. I'm not trying to be obtuse, I'm just not sure --
BY MS. SEVERYN:
Q. There is a portion at the bottom A/P, does that typically stand for assessment slash plan?
A. Yes, ma'am.
Q. What was the assessment of the cardiologist, according to your review of this document?
A. "Post-op aortic root replacement and shortness of breath secondary to P.E., question mark".
Q. What is your understanding, if you have one, as to the initial note of a post-op aortic root replacement?
A. What is my understanding of the?
Q. Of that entry on this consult note?
A. Just what it says, this is a patient who is post-op aortic root replacement.
Q. Okay. Do you have any knowledge or information as to what the cardiologist's plan of treatment was in this case?
MR. TABER: Objection.
THE WITNESS: Yeah, at what point in

time? He's got a lot of things down here.
BY MS. SEVERYN:
Q. Can you tell from this Exhibit 6 when the cardiology consult occurred?
A. Not from this document.
Q. Is there any other --
A. Oh, no it says patient is in CT. So that means I guess sometime 19 something, 19:00 hours somewhere around there. Probably when he came down to see the patient.
Q. Where is your reference that you're noting that patient is in CT?
A. I'll have to look --
Q. Oh, on top.
A. Oh, you mean on his document?
Q. On his document.
A. Right up on top.
Q. Okay, I got you. Is the information contained in this consult, is that information that you recall being communicated to you by cardiology during the course of your treatment of Mr. Stansbury?
A. What information are you referring to?
Q. Well, you asked early on for a consult with cardiology?
A. Right.

Q. Okay, and at some point after cardiology performs the consult, I would assume they communicate their findings?
A. Yes.
Q. Now that you've looked at the consult book -- the consultant document, the entry by the cardiologist, does that in any way refresh your recollection as to what information was conveyed to you by cardiology in that phone conversation that you recall?
A. No, not really.
Q. Is it fair to say that after this consult, at least from the cardiologist's note down below at Number 2, there was still a consideration that the shortness of breath may be secondary to a pulmonary emboli or embolism?
A. Yes.
MR. TABER: Off the record.
(Thereupon an off the record discussion was held.)
BY MS. SEVERYN:
Q. On the record. Doctor, let me direct your attention to what's been premarked as Exhibit 13, can you identify this document?
A. Exhibit 13 it looks like a printed sheet from Em-STAT system.
Q. What is that, the Em-STAT system?

A. It's a computerized patient documentation program.
Q. There are some names here Wayne Kupetz, RN; do you see that?
A. Kupetz, K-U-P-E-T-Z, RN.
Q. Melissa Wysocky? That's Melissa two S's W-Y-S-O-C-K-Y, RN. Mike Cudnik, MD, yourself. Are these all individuals that would have had a role in caring for Mr. Stansbury?
A. Yes, ma'am.
Q. Seeing this document, does it in any way refresh your recollection as to who was present during the respiratory distress?
A. No, not really. Not really in that even if I was again globally aware of who actually was there, once something like this happens, you become so focused on the individual that it's almost like having antegrade amnesia, you forget about everything that just happened and you're all of a sudden -- it means nothing literally exists in the world, except for this person and you.
I mean someone could be right by your side for two hours doing things with you, and someone will ask you, and you'll tell them I think it was this person. Why? That's the last person I remember seeing. Things like that.

Q. Let me direct your attention to what's been premarked as Exhibit 9, can you identify this document for the record?
A. That is as Expiration Discharge Summary.
Q. Is that typically what is dictated after a patient expires at the Clinic?
A. Not typically, I mean -- well let me read this document.
Q. Sure, take whatever time you need.
(Thereupon, an off the record discussion was held, and Mr. Myers was replaced by Lauren Kinkopf on the telephone at approximately 1:15 p.m.)
A. Usually to be complete, something like this would be dictated regarding the patient who had expired.
Q. Who is Dr. Walts?
A. I don't know.
Q. Is that someone that you understood to have a role in Mr. Stansbury's care on January 25, 2003?
A. I'm not certain. There was no Attending noted there and he did not identify his service.
Q. Have you ever met or spoken with Peter Walts, MD?
A. Not to my knowledge, but I may have not knowing.
Q. But as we sit here today, you don't know who

he is in relation to the Clinic or indeed why he dictated this Expiration Discharge Summary?
A. The only thing I could guess is he may be part of the cardiothoracic service that came down after being contacted by cardiology, and told of the patient's expiration.
Q. Okay, but you don't know that?
A. No, I don't know that.
Q. Is there an expiration discharge summary that is prepared or dictated after a patient expires at the Clinic?
A. Usually you just dictate it into the chart.
Q. Is this document, this Exhibit 9, the Expiration Discharge Summary, is any way unusual or atypical of what you routinely recalled was done at the Clinic.
MR. TABER: Objection.
THE WITNESS: Well, I'm not sure what is routinely done at the Clinic outside of my department.
BY MS. SEVERYN:
Q. Okay --
A. Within our department we usually dictate the events as they happen as part of the patient's medical records, his chart and there is usually someone from the

coroner's office notified, and we sign a certificate of death form if the primary care physician does not wish to sign it.
Q. The Expiration Discharge Summary reflects that Mr. Stansbury expired from bilateral pulmonary emboli; do you see that?
A. Yes, ma'am.
Q. Would you agree with that statement?
A. He could have, there's a possibility. I'm not saying that he actually did from these, but he could have.
Q. Was there an autopsy done in this case?
A. No, ma'am.
Q. Did you speak with Mrs. Stansbury after her husband died?
A. Yes, ma'am.
Q. So were you the person responsible for communicating to her of his passing?
A. Yes, ma'am.
Q. What do you remember about your conversation with her?
A. I remembered her being in the room before that, but that conversation I recall explaining to her that her husband had expired, that he was no longer alive. And I'm not sure of anything else, I may have

said to her -- but I think that was basically my function was to tell her that her husband had died.
Q. How did she take the news?
MR. TABER: Objection, that's up to her --
BY MS. SEVERYN:
Q. Well, what did you observe or do you have a recollection of what her reaction was at the time?
A. She didn't have any reaction.
Q. None at all?
A. Not that I can recall.
Q. Did you speak to Mrs. Stansbury with respect to whether or not an autopsy would be performed?
A. No, I did not.
Q. Typically, who at the Clinic would have that conversation with the surviving spouse?
A. Either one of the residents may ask them, but usually I think the nursing -- the administrative personnel. There's a packet and there's a checklist of things that need to be done, and one of them would be to ask if they wish to have an autopsy performed.
Q. Do you have any knowledge or understanding as to what information is conveyed to the surviving spouse about the autopsy, other than asking do you want one done?
A. No, ma'am.

Q. Now that we've actually spent quite some time talking about the treatment of Mr. Stansbury on January 25, 2003, does that in any way refresh your recollection as to the identity of the cardiothoracic specialist that was consulted in this case?
A. No, ma'am.
Q. Do you recall at what point in your treatment of Mr. Stansbury on January 25, 2003, the focus of the differential diagnosis if you will, turned to a potential embolism?
A. Say that again?
Q. Sure. At what point in your treatment of Mr. Stansbury, on that E.R. admission, did your focus turn to a P.E. as opposed to some of the other differential diagnoses you were considering?
MR. TABER: Objection, over broad.
Go ahead.
THE WITNESS: Definitely once I had the CT results.
BY MS. SEVERYN:
Q. Once you had obtained the EKG result and the chest x-ray, other than the CT scan, what other results helped you to remove some of those differential diagnoses or eliminate them?
MR. TABER: Objection, over broad, vague.

THE WITNESS: I'm not sure I understand your question.
BY MS. SEVERYN:
Q. Sure. Let me try it again. Your testimony earlier, my recollection is that the EKG assisted you to rule out myocardial infarction, heart attack; right?
A. Uh-huh.
Q. That's a yes?
A. Yes, ma'am.
Q. And the CT -- excuse me, the chest x-ray helped you to rule out, because it was clear, pneumonia, pleural effusion, pneumothorax?
MR. TABER: Objection, asked and answered.
THE WITNESS: I said that the chest x-ray looked clear, but the CT would be definitive, because there are a lot of things that you don't see on a chest x-ray that are actually there. For example, the chest x-ray was interpreted as normal, but there was a pericardial effusion, there was a pleural effusion. There were massive pulmonary emboli that never showed up, and pneumonia could still be present, but not seen. A CAT scan would help and definitively tell me that the chest x-ray was read correctly, and whatever

else is there.
BY MS. SEVERYN:
Q. Do pulmonary emboli ever show up on --
A. No.
Q. So there's nothing unusual about the fact that it didn't show up here?
A. No, but it points out the fact that you could have bad things there that don't show up on a chest x-ray.
Q. What other possible diagnoses were you considering or that were left, after you were able to at least get information that would suggest that you're ruling out a myocardial infarction, the pneumonia, the pleural effusion, the pneumothorax, other than the P.E. what else were you considering?
A. You could still have a pneumonia, it just doesn't show up because of let's say dehydration and you could have something behind -- you could have something involving the heart itself.
For example, he could be having cardiac tamponade, you just don't appreciate it because this is an AP of the chest and the heart may look large, but it may be larger than it really should be. You really don't know that, you're just assuming that it's large because of the type of chest x-ray that you're getting.

But a CAT scan will show you that there is pericardial effusion in there. Is there something behind like a pneumonia, what we call a retrocardiac pneumonia. You cannot -- usually you get a PA and lateral of the chest so that you can look at the back part -- yeah, the back part of the -- the area behind the heart, and sometimes you'll see a low-lying pneumonia that otherwise you'll look at the AP of the chest, and you don't see it there. This was, would also -- the CT would let us know if there was something there, is this a pneumonia or is this a pulmonary embolism.
Q. Was Dr. Disch present during the respiratory distress?
A. He may have been but I don't recall seeing anyone at that time except Mr. Stansbury.
Q. Did you speak with anyone else that was present at the hospital that evening about Mr. Stansbury, other than the patient himself, family members, anyone else?
A. I spoke to his wife and like I said, she didn't have any reaction at all. And I guess when, you know, probably collectively looked at him and may have discussed it amongst ourselves. Let's say other physicians, other residents, nurses, you know, just as a

post significant event type of round-robin. But specifically, what we said, who said what, I couldn't really say.

Q. Did you review the deposition transcript of Michael Chrisman?

A. No, ma'am.

Q. Did you ever speak with anyone at the hospital that evening that you understood to be the paramedic that had responded to the home of Mr. Stansbury initially that afternoon?

A. If he was the paramedic from the Metro Life Flight?

Q. No. They would have been with the Aurora E.M.S.

A. If I spoke with that person that would have been telephonically, because there was no other way for us to really communicate.

Q. But you don't have any recollection today of having any such conversation; correct?

A. Right.

Q. Going back to the intubation, you indicated typically you would check for breath sounds --

A. Uh-huh.

Q. -- use the CO2 detector --

A. Yes, ma'am.

Q. -- in assisting in the process to ensure the intubation was done correctly. Do you recall following your typical protocol to ensure that the intubation was proper in this case?

A. I would usually request that an End-Tidal CO2 detector be attached to ensure that there is color change.

Q. What does the standard of care require in your opinion, Doctor, to a reasonable degree of medical certainty, regarding your obligation to chart the intubation process?

MR. TABER: Objection.

THE WITNESS: I'm not sure what you mean by that. I mean usually if I'm intubating someone I will request my medication, I would perform the procedure, ensure that the intubation was appropriate and successfully completed, and just mention that the patient was intubated.

BY MS. SEVERYN:

Q. Do you typically make any chart entry anywhere in the patient's chart with respect to that intubation?

A. Typically, no.

Q. What is the role of the nursing staff in a respiratory distress situation?

A. They're there to assist in performing the resuscitation.

Q. When you talk about assisting, what types of assistance are you referring to?

A. Various types of assistance.

Q. Is there typically a nurse or member of the nursing staff, who charts what is happening and what is occurring by way of treatment during the respiratory distress and or code?

A. There usually is one person assigned to document the events of a code.

Q. Can you tell from the records in this, who would have done the documentation in this matter?

A. Not by looking at signatures or initials. Wait a minute, I'm sorry, there's a recording nurse, Kristina Vaji.

Q. Vaji?

A. I think so.

Q. And you're referring to Exhibit Number?

A. Exhibit Number 10.

Q. And that's the recording nurse?

A. Right.

Q. Do you know nurse Vaji?

A. I remember her, yes.

Q. Any reason to believe she was not charting

accurately in this case?

A. No, she's a good nurse and she -- a good nurse in that patient care is primary concern.

Q. When we talk about the administration of A.C.L.S. medication, do you know what we're referring to?

A. Not specifically.

Q. That doesn't have any medical significance to you?

A. No, it tells me that there's probably a code situation and medications are required.

Q. What does the standard of care mandate regarding treatment -- the administration of medicine treatment during a code?

MR. TABER: Objection, over broad.

THE WITNESS: I'm not sure --

BY MS. SEVERYN:

Q. Let's assume, hypothetically, that we have a code situation where there are -- there's electrical activity but no pulse, during that phase of the code, what is the standard of care regarding the administration of medicine?

MR. TABER: Objection, over broad not about this case.

MS. SEVERYN: I'm asking a general

question.
MR. TABER: I know, and that's why I objected. Go ahead if you can.
THE WITNESS: If you request medication you administer it.
BY MS. SEVERYN:
Q. All right. If we have a patient such as Mr. Stansbury who has electrical activity but no pulse, what does the standard of care require as to the type of medication and the dosage of medicaiion that needs to be administered under those circumstances?
A. Oh, well I think I understand what you're saying now. Medications that you would use would be Atropine and Epinephrine.
Q. What is the dosage that you would use?
A. One milligram.
Q. How frequently would you use them?
A. One every five minutes or as needed depending on their effectiveness.
Q. Is that true for both of them, once every five minutes or as needed?
A. No, the Atropine you may only need once.
Q. All right, then let's take them one at a time. What does the standard care require, regarding how much and how frequently you want to administer the

Atropine --
A. The Atropine --
Q. -- in a situation where there's electrical activity but no pulse?
A. Okay, the Atropine you should administer no more than two milligrams.
Q. During what period of time?
A. During any period of time.
Q. What about the Epinephrine?
A. The Epinephrine you can administer as often as you wish to continue coding the person with pulseless electrical activity.
Q. As often as you want?
A. Once every five minutes.
Q. Once you've administered a first dose of Epinephrine, again the situation being that the patient has electrical activity no pulses, what events or what would determine whether or not a second dose is administered?
A. Well, patient's response, and basically how long the person's been in that condition.
Q. What if after five minutes there is no change in the patient's condition?
A. Well, at that point you can repeat it again if you wish.

Q. What is the Epinephrine designed to do in a code situation?
A. Well, it's designed to help the heart reestablish mechanical activity, theoretical.
Q. Again, as an emergency room physician what factors do you typically consider when determining whether or not to administer additional doses of the Epinephrine under a code situation?
A. In Mr. Stansbury's case how is the patient responding at that point in time.
Q. Again, let's assume after five minutes there's no response?
A. You may wish to repeat it, you may wish to not repeat it.
Q. What are the considerations as to whether to repeat, to not to repeat?
A. Again, the patient's clinical condition.
Q. Again, assuming nothing's changed?
A. You may wish to repeat it, you may not wish to repeat it.
Q. What clinical considerations would help you in determining whether or not you wish to repeat or not?
A. If he had a pulse.
Q. What if he did?
A. If he had a pulse then you would observe him

at that point in time to see how he's doing, what his blood pressure is.
Q. What if he didn't have pulse?
A. If he didn't have a pulse, as I said before not to be redundant, but you can give him another dose or you can just continue with your C.P.R. it's not really -- at that point in time, it's not going to make much of a difference.
Q. Would you agree that in the United States at least in the metropolitan areas that there is one standard of care?
A. There can be one standard of care --
Q. Okay.
MR. TABER: Object, that's a legal question, not a medical question, but you can go ahead.
THE WITNESS: Well, it depends on how you interpret that.
BY MS. SEVERYN:
Q. Well, do you believe you're held to the same standard of care here at the Holmes Hospital as you were at the Cleveland Clinic Foundation?
MR. TABER: Objection, that's a legal term, you can answer if you want, but it's not a question --

THE WITNESS: I would practice medicine the same here as I would there, except for modifying local factors.
BY MS. SEVERYN:
Q. Okay.
A. Whatever they may be.
Q. What types of things do you mean to include in that local factors?
A. Too numerous to elaborate. It depends on the actual situation as you see it. Certain protocols are generated to give you a guideline, but they're not absolute. They're simply a guideline and clinical discretion overrides those guidelines at any given time.
Q. Dr. Aponte, do you believe to a reasonable degree of medical certainty, that you met the standard of care in your treatment of Mr. Stansbury in this case?
A. Yes, ma'am.
Q. Do you have any criticisms with respect to any of the treatment that was rendered at the Cleveland Clinic Foundation with respect to Mr. Stansbury on January 25, 2003?
MS. KINKOPF: I'm going to object to that.
THE WITNESS: On the day that I saw him?
BY MS. SEVERYN:
Q. Yes.

A. I have no objections to the medical care that he received on the day of his visit on the 25th of January, 2003.
Q. Have you ever had or been in a situation where a filter was placed by radiology to prevent a blood clot from migrating?
A. Well, when I was doing my residency and when I was doing my internship, perivena cava filter.
Q. Were you ever in a situation at the Cleveland Clinic Foundation where a radiologist would call you with reports of a P.E. and where it was your determination that a filter be placed?
A. No, ma'am.
Q. Would you typically consult with someone before placing a filter?
A. Yes, ma'am.
Q. Who would you consult with, typically?
A. I was consult with the admitting service.
Q. What do you mean admitting service?
A. Well, I function in the Emergency Department, and if a patient needs something like a filter, that's to be determined and implemented by the admitting service.
Q. In the case of Mr. Stansbury who was the admitting service?

A. Cardiology.
Q. All right. So in your opinion, it would have been their decision as to whether or not a filter would have been placed?
A. Yes, ma'am.
Q. Typically, is the filter placed through radiology?
A. To the best of my knowledge, yes.
Q. Are you aware that there are medications that can be given to counteract the effects of Heparin if for any reason it becomes necessary to do so?
A. Yes, ma'am.
Q. What are some of these medications?
A. Vitamin K Protamine.
Q. Do you have an opinion as to how quickly Heparin begins to have an effect, after it's first administered?
A. No, ma'am.
Q. Doctor, do you know whether the circumstances surrounding Mr. Stansbury's demise, were ever considered by any peer-review committee by the hospital?
MR. TABER: Objection --
MS. KINKOPF: Objection --
MR. TABER: I instruct you not to answer that. It's privileged pursuant to Ohio law,

not admissible in lawsuits, that's not relevant.
MS. HENRY: Join in the objection.
MS. SEVERYN: I'll withdraw the question, thank you.
MS. SEVERYN:
Q. Did you speak with any -- strike that. Other than your attorney, is there anyone else that you spoke with about this case since these events occurred on January 25, 2003?
A. No, ma'am.
Q. Do you have any criticisms as to the treatment administered by the Aurora E.M.S. personnel?
A. No, ma'am.
Q. Do you have any criticisms of the treatment administered by the Metro Life Flight personnel?
A. No, ma'am.
Q. You were a physician at the Cleveland Clinic again for a period of time from what, '95 to 2004, roughly?
A. Uh-huh.
Q. If a physician issues discharge orders, and for whatever reason those orders are not communicated to the patient or placed on the discharge sheet, typically whose responsibility is that?

A. I wouldn't know. I don't function – that's not part of my function.
Q. In that capacity?
A. Right.
Q. Do you have any knowledge or information about any telephone calls to the Clinic by either Mr. Stansbury or his widow, after the discharge, after the aneurysm repair, but before the emergency room admission that we're talking about today?
A. Not that I can recall at this time.
Q. Doctor, let me direct your attention to what's been marked as Exhibit 12. Can you identify that document?
A. It's a Deposition Exhibit Number 12, Chart Fact Cleveland Clinic Foundation Deficiency Slip, Friday April 4, 2003 10:07 a.m.
Q. Do you recall receiving that document?
A. No, ma'am.
Q. So that's not something to your knowledge generated to you?
A. No, ma'am.
Q. After having read the document, do you have any understanding as what it's designed to do?
A. This document?
Q. Yes.

A. It's designed to inform me that there's a deficiency in one of my charts and the expiration summary.
Q. Do you know what the deficiency that's being referenced is?
A. I would imagine I'm just guessing an expiration summary.
Q. Off the record.
(Thereupon, as off the record discussion was held.)
Dr. Aponte, were you ever provided with a copy of interrogatories in this case?
MR. TABER: No.
MS. SEVERYN: Off the record.
(Thereupon, an off the record discussion was held.)
BY MS. SEVERYN:
Q. Dr. Aponte, have you reviewed any records or documents, other than those that you've described for us today? Portions of the emergency chart as well as the Life Flight, what you call the run sheet for E.M.S. as well as Dr. Krofina's deposition?
A. No, those are the only documents that I've reviewed in preparing for this deposition.
Q. Did you ever speak with Dr. Krofina about his patient Mr. Stansbury?
A. Off the top of my head I would say, no. There

may have been a phone call after the fact, where someone had asked me some questions about it, but that's the only thing I could really recall regarding that question.
Q. Doctor, do you have an opinion as to whether any of the treatment rendered by the physicians and staff of Cleveland Clinic Foundation at all times adhered to the applicable standard of care in treating Mr. Stansbury?
A. I think that they did adhere to the standard of care.
MS. SEVERYN: I don't have questions at this time, Doctor. You do have an opportunity --
MS. HENRY: I have some questions.
CROSS-EXAMINATION
BY MS. HENRY:
Q. Dr. Aponte, my name is Deirdre Henry I represent Dr.Cudnik. You were the Attending emergency room physician; correct?
A. Yes.
Q. Explain to us what Attending means?
Q. Attending is a fully trained, residency trained board certified physician, considered to be competent in the practice of emergency medicine to the point that he may at least be considered capable of

supervising physicians in training of the same specialty.
Q. Dr. Cudnik was a resident physician rotating through the emergency at the Cleveland Clinic; correct?
A. Yes, ma'am.
Q. You were the supervisor supervising Dr. Cudnik's interactions with Mr. Stansbury; correct?
A. Yes, ma'am.
Q. And part of what Dr. Cudnik was learning at the Cleveland Clinic was evaluation of patients and how to make decisions on differentials, that sort of thing; correct?
A. Yes, ma'am.
Q. As the Attending, you were the physician ultimately responsible for Mr. Stansbury's care?
A. Yes, ma'am.
Q. You were the physician who was responsible once you made the original assessment of him, to determine what was in the differential diagnosis and what needed to be done to come to a final diagnosis; correct?
A. Yes, ma'am, but that's always done in consultation with a resident because you can always learn something.
Q. All right. But you were the one who was making the final decision?

A. Yes, ma'am.
Q. You would be discussing it with the resident as part of the education process?
A. Yes, ma'am.
Q. You would have been the physician who was responsible for deciding what tests were to be done?
A. Yes, ma'am.
Q. And you explained to us the tests that you requested and why they were requested and the results; correct?
A. Yes, ma'am.
MS. KINKOPF: Excuse me, this is Lauren Kinkopf, I'm having a hard time hearing the questions, would it be possible to speak up a little bit?
MS. HENRY: I can speak up.
MS. KINKOPF: Thank you.
BY MS. HENRY:
Q. You would also be as the Attending, the physician who would make the decision as to what consultations you wanted made in this case?
A. Yes, ma'am.
Q. Now it's my understanding that Dr. Cudnik was with you when you initially met Mr. Stansbury?
A. Yes, ma'am.

Q. And you said that you saw him as he was being brought down the hallway and you watched them bring him into the room; correct?
A. Into the room, yes.
Q. Who is the they, that were bringing him into the room?
A. The paramedics, Metro Life.
Q. Once he's brought into the room by Metro Life, then you assume the care of the patient?
A. Yes, ma'am.
Q. So the information that is reflected in the dictated notes by Dr. Cudnik is information that you were aware of?
A. Yes, ma'am.
Q. During the time of the care of the patient?
A. Yes, ma'am.
Q. If there was any additional information that you required, you would have taken whatever steps was necessary to obtain it; correct?
A. Yes, ma'am.
Q. Now, I think you said that Dr. Cudnik would communicate with you as test results were obtained?
A. Yes, ma'am.
Q. Did he communicate with you the test results as they were obtained in a timely manner?

A. To the best of my recollection, yes.
Q. The decision as to what care was to be rendered to Mr. Stansbury along the way, until the time that the CT result came back, was ultimately your decision; correct?
A. Yes, ma'am.
Q. The decision as to if and when Heparin was going to be administered I understand was a decision that was going to made in conjunction with cardiothoracic surgery -- or cardiology rather?
A. Yes, ma'am.
Q. Once the results of the CT came back in, consultation with cardiology, the decision was made to give the Heparin?
A. Yes, ma'am.
Q. And you were the one who ultimately gave the order for the Heparin -- the starting of the Heparin; correct?
A. Yes, ma'am.
Q. Based on what you recall about this case, Dr. Cudnik did what you asked him to do and what was asked of him; correct?
A. Yes, ma'am.
Q. Do you have any criticisms of Dr. Cudnik?
A. No, ma'am.

Q. Do you believe that Dr. Cudnik met the standard of care for the role that he played in the emergency room, as it relates to Mr. Stansbury on January 25, 2003?
A. Yes, I do.
MS. HENRY: Thank you.
MS. SEVERYN: No follow-up questions
MR. TABER: We will not waive signature. Any questions on the phone?
MS. KINKOPF: No.
MR. TABER: Okay, we will not waive signature. And on the record, for the record, as we have discussed, although that does not necessarily need to be identified, Dr. Aponte is expected to testify both as a fact witness, and automatically because he is a physician as an expert witness as to his own care and involvement and as he testified today in great detail.
Accordingly, under the local rule and decisions of the Eighth District, he is not required to issue an expert report. But I want it made clear that this is the one and only opportunity to ask him questions in any of those capacities, and I invite any further

questions that may be necessary. Although, I think we've been extremely thorough today.

MS. SEVERYN: I'm actually thinking about your invitation.

MR. TABER: I don't want any second guessing --

MS. KINKOPFL: I'm sorry, could you repeat that, I didn't get all of that?

MR. TABER: Sorry, I said I don't want there to be any misunderstanding as to what it means to be a hybrid fact/expert Doc testifying. That there is only one deposition in our County, and I just wanted to be clear on that point.

MS. SEVERYN: And I am clear on that. My only question was whether or not I wanted to ask any further standard of care questions, and I don't. I think we are done.

(Thereupon, the deposition was concluded at 1:59 p.m.)

CERTIFICATE

THE STATE OF FLORIDA
COUNTY OF BREVARD

I hereby certify that I have read the foregoing deposition by me given, and that the statements contained herein are true and correct to the best of my knowledge and belief, with the exception of any corrections or notations made on the errata sheet, if one was executed.

Dated this _____ day of _____, 2005.

_____
JOSEF APONTE, MD

ERRATA SHEET (dmd)

IN RE:
DEPOSITION OF: JOSEF APONTE, MD TAKEN: 9/22/05

Do Not Write On Transcript - Enter Changes Here

PAGE	LINE	CHANGE	REASON

Please forward the original signed errata sheet to this office so that copies may be distributed to all parties.

Under penalty of perjury, I declare that I have read my deposition and that it is true and correct subject to any changes in form or substance entered here.

Date: _____ SIGNATURE OF DEPONENT:_____

STATE OF FLORIDA)
COUNTY OF BREVARD)

CERTIFICATE OF OATH

I, the undersigned authority, certify that the witness personally appeared before me and was duly sworn.

Dated this _____ day of _____, 2005.

_____

DONNA D'ALESSANDRO
Notary Public, State of Florida
My Commission No. DD 220006
My Commission Expires 06/21/2007

REPORTER'S CERTIFICATE

THE STATE OF FLORIDA)
COUNTY OF BREVARD)

I, DONNA D'ALESSANDRO, Notary Public in and for the State of Florida at Large, do hereby certify that the aforementioned witness was by me first duly sworn to testify the whole truth; that I was authorized to and did report said deposition in stenotype; and that the foregoing pages are a true and correct transcription of my shorthand notes of said deposition.

I further certify that said deposition was taken at the time and place hereinabove set forth and that the taking of said deposition was commenced and completed as hereinabove set out.

I further certify that I am not an attorney or counsel of any of the parties, nor am I a relative or employee of any attorney or counsel of party connected with the action, nor am I financially interested in the action.

The foregoing certification of this transcript does not apply to any reproduction of the same by any means unless under the direct control and/or direction of the certifying reporter.

Dated this _____ day of _____, 2005.

_____
DONNA D'ALESSANDRO
Notary Public -State of Florida
My Commission No. DD 220006
My Commission Expires: 06/21/2007

September 27, 2005
Josef Aponte, MD
c/o EDWARD TABER, ESQUIRE
TUCKER ELLIS & WEST LLP
1150 Huntington Building
925 Euclid Avenue
Cleveland OH 44115-1475

IN RE: Suzanne Stansbury versus Cleveland Clinic Foundation

Please take notice that on September 22, 2005, you gave your deposition in the above-referred matter. At that time, you did not waive signature. It is now necessary that you sign your deposition.

As previously agreed to, the transcript will be furnished to you through your Counsel. Please read the following instructions:

At Page 136, you will find an errata sheet. As you read your deposition, any changes or corrections that you wish to make should be noted on the errata sheet, citing page and line number of said change. DO NOT write on the transcript itself. Once you have read the transcript and noted any changes, be sure to sign and date the errata sheet and return these pages to the court reporter.

If you do not read and sign the deposition within a reasonable time, the original, which has already been forwarded to the ordering attorney, may be filed with the Clerk of the Court. If you wish to waive your signature, sign your name in the blank at the bottom of this letter and return it to us at 200 East Robinson Street, Suite 425, Orlando, FL 32801.

Very truly yours,

Donna D'Alessandro
Esquire Deposition Services

I do hereby waive my signature.

_____
Josef Aponte, MD