

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

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

 Plaintiffs,

7
8 -vs-

9 THE CLEVELAND CLINIC FOUNDATION, JOSEF APONTE, MD,
10 MICHAEL CUDNIK, MD, and MARK KROFINA, MD,
11 Defendants.

12
13 DEPOSITION OF JOSEF APONTE, MD

14
15 Thursday, September 22, 2005
16 10:10 a.m. - 1:59 p.m.

17 Radision Suite Hotel Oceanfront
18 3101 North Highway A1A,
19 Melbourne, FL 32940

20 Reported By:

21 Donna D'Alessandro

 Notary Public, State of Florida

22 Esquire Deposition Services, LLC

 Orlando Office #(758141)

23 Phone - 877.546.7676

24 321.541.1082

Page 2	
1	APPEARANCES:
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3	
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INDEX	
	WITNESS DIRECT CROSS REDIRECT
21	JOSEF APONTE, MD
22	By Ms. Severyn 4 --
23	By Ms. Henry 128
24	
25	

Page 3	
1	EXHIBITS
2	
3	NUMBER DESCRIPTION PAGE(S)
4	1 Metro Life Flight document
5	(5 pages) 29, 44, 58
6	2 Cleveland Clinic E.D. Ledger
7	(1 page) 33, 40, 42, 83, 87, 97, 98
8	3 Cleveland Clinic E.D. Care Record
9	(1 page) ---
10	4 Cleveland Clinic E.D. Report
11	(2 pages) 39, 42, 70, 72, 78
12	5 Cleveland Clinic Document (2 pages) ---
13	6 Cleveland Clinic E.D. Consult Document
14	(1 page) 101, 103
15	7 Cleveland Clinic CT Report (1 page) 64, 68
16	8 Cleveland Clinic E.D. Continuing Care
17	Record (1 page) 60, 85, 90, 92
18	9 Cleveland Clinic Expiration Discharge
19	Summary (1 page) 106, 107
20	10 Cleveland Clinic CPR Data Sheet & Emergency
21	Medical Response (2 pages) 96, 98, 100, 116
22	11 Cleveland Clinic Expiration Discharge
23	Summary (1 page) ---
24	12 Cleveland Clinic Deficiency Slip (1 page) 126
25	13 Cleveland Clinic Em-STAT document
	(1 page) 31, 104
	14 Cleveland Clinic E.D. Care Record
	(1 page) 50

Page 4	
1	Deposition taken before DONNA D'ALESSANDRO, Court
2	Reporter and Notary Public in and for the State of
3	Florida at Large, in the above cause.
4	---
5	(Deposition Exhibits 1 through 13 were premarked
6	for identification.)
7	Thereupon,
8	JOSEF APONTE
9	having been duly sworn or affirmed, was examined and
10	testified as follows:
11	DIRECT EXAMINATION
12	BY MS. SEVERYN:
13	Q. Dr. Aponte, can you please state and spell
14	your full name for the record?
15	A. Josef, J-O-S-E-F, middle initial, H, Aponte,
16	A-P-O-N-T-E.
17	Q. What does the H stand for?
18	A. Henrich.
19	Q. Have you ever given a deposition before?
20	A. Yes, ma'am.
21	Q. On approximately how many occasions?
22	A. I think two occasions.
23	Q. At the risk of repeating some of the things
24	you already know about depositions, and at the risk of
25	repeating things you may have been told, I just want

Page 5	
1	the record to be clear, so I'm going to tell you a
2	little bit about how the deposition process works.
3	First of all, the oath that was just administered
4	is the very same oath that you would have if you were in
5	court testifying before a judge and a jury; you
6	understand that?
7	A. Yes.
8	Q. Everything that is said here today and that is
9	taken down is basically the oral. So it is important to
10	give all of your answers verbally, rather than nods or
11	gestures of the head, or uh-huh, or uh-huh. That's for
12	two reasons, the first is that we need to keep the
13	record clear, and the second is to make the court
14	reporter's job that much easier. We don't want her to
15	interpret what a nod or gesture means from actually any
16	of us; okay?
17	A. Yes.
18	Q. If at any time you have a question about
19	anything that I've asked, or one of my questions is
20	unclear to you, please let me know, I'll be happy to
21	repeat or rephrase the question as necessary.
22	If however you answer a question of mine, I am
23	going to go ahead and assume that you understood it.
24	A. Yes.
25	Q. I'm also going to be asking you questions that

Page 6

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

5 A. Yes, ma'am.

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

8 A. Yes.

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

11 A. I do.

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

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

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

22 A. Yes.

23 Q. What do you remember?

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

Page 7

1 remember waiting in the room for his arrival.
 2 The description was of someone who was complaining
 3 of shortness of breath -- shortness of breath, and I
 4 think that's about all that I can recall.

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

7 A. Yes.

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

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

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

14 A. Yes.

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

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

25 Q. Okay, anything else?

Page 8

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

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

6 A. No, ma'am.

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

11 A. Yes.

12 Q. Were you employed by the Cleveland Clinic
 13 Foundation?

14 A. Yes, ma'am.

15 Q. In what capacity?

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

18 Q. Is emergency medicine your specialty?

19 A. Yes, ma'am.

20 Q. Where are you currently employed?

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

22 Q. In what capacity?

23 A. An Attending.

24 Q. Again as an emergency room physician?

25 A. Yes, ma'am.

Page 9

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

3 A. Yes, ma'am.

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

6 A. Yes, ma'am.

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

9 A. No, ma'am.

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

12 A. No, ma'am.

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

16 A. Yes, ma'am.

17 Q. Are you board certified?

18 A. Yes, ma'am.

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

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

25 Q. You're board certified in what specialty?

<p style="text-align: right;">Page 10</p> <p>1 A. Emergency medicine.</p> <p>2 Q. When were you first board certified?</p> <p>3 A. I think 1993.</p> <p>4 Q. You became board certified in what year?</p> <p>5 A. 1993.</p> <p>6 Q. I'm sorry, re-certified I meant.</p> <p>7 A. 2003.</p> <p>8 Q. I think you already told us that the board</p> <p>9 examination comprises of an oral and a written portion;</p> <p>10 correct?</p> <p>11 A. Yes, ma'am.</p> <p>12 Q. And obviously in order to become board</p> <p>13 certified and then re-certified, you had to do both of</p> <p>14 them?</p> <p>15 A. Both, yes, ma'am.</p> <p>16 Q. Did you have to take those or any portion of</p> <p>17 those exams more than once?</p> <p>18 A. I think the oral I had to repeat.</p> <p>19 Q. What are the restrictions on becoming board</p> <p>20 certified? In other words, do you have to practice</p> <p>21 medicine for a certain period of time before you're</p> <p>22 eligible -- board eligible?</p> <p>23 A. Well, usually you do an internship and a</p> <p>24 residency, and once you've successfully completed your</p> <p>25 residency you're board eligible as of that date.</p>	<p style="text-align: right;">Page 12</p> <p>1 MR. MYERS: You know what, I'm losing you</p> <p>2 guys a little bit. I don't know if you need</p> <p>3 to get a little closer to the phone, but</p> <p>4 you're fading in and out a little.</p> <p>5 MS. SEVERYN: I'll try to keep my voice</p> <p>6 up.</p> <p>7 BY MS. SEVERYN:</p> <p>8 Q. What did you do when you left the Army?</p> <p>9 A. Continued working as an emergency medicine</p> <p>10 specialist in a civilian capacity.</p> <p>11 Q. Did you go through any type of internship or</p> <p>12 residency program?</p> <p>13 A. Yes, ma'am.</p> <p>14 Q. Where and when?</p> <p>15 A. William Beaumont Army Medical Center, I did my</p> <p>16 internship. Thereafter, I did active duty, I functioned</p> <p>17 as a line officer in Europe.</p> <p>18 Q. All right. You indicated you completed your</p> <p>19 internship at the William, is it Beaumont?</p> <p>20 A. Yes. William Beaumont Army Medical Center.</p> <p>21 Q. What year did you complete your internship?</p> <p>22 A. 1982.</p> <p>23 Q. Where is the William Beaumont Army Medical</p> <p>24 Center?</p> <p>25 A. Fort Bliss, Texas.</p>
<p style="text-align: right;">Page 11</p> <p>1 Q. So after your residency, you're board</p> <p>2 eligible?</p> <p>3 A. Right.</p> <p>4 Q. Tell us, if you would, briefly your</p> <p>5 educational background, beginning where you attended and</p> <p>6 graduated medical school?</p> <p>7 A. New York Medical College.</p> <p>8 Q. What year did you graduate?</p> <p>9 A. 1981.</p> <p>10 Q. What did you do after that?</p> <p>11 A. I immediately went into active-duty service in</p> <p>12 the military, Army.</p> <p>13 Q. How long were you with the Army?</p> <p>14 A. From '81 till '89.</p> <p>15 Q. Were you in the Army as a physician?</p> <p>16 A. Yes, ma'am.</p> <p>17 Q. Were you in the Army -- strike that. Did you</p> <p>18 practice emergency medicine while with the Army?</p> <p>19 A. Yes, ma'am.</p> <p>20 Q. Were you practicing any other type of medicine</p> <p>21 at that time?</p> <p>22 A. No, ma'am.</p> <p>23 Q. So you were discharged in 1989?</p> <p>24 A. Yes, ma'am.</p> <p>25 Q. And I take it that was an honorable discharge?</p>	<p style="text-align: right;">Page 13</p> <p>1 Q. Then you mentioned you functioned as a line</p> <p>2 officer in Europe. What is a line officer?</p> <p>3 A. A line officer, you're attached as a physician</p> <p>4 to a unit. It could be a battalion, it could be a</p> <p>5 brigade, it could be a division.</p> <p>6 Q. How long did you serve in the capacity of a</p> <p>7 line officer?</p> <p>8 A. About two years.</p> <p>9 Q. Again, did you serve in the capacity of an</p> <p>10 emergency medicine --</p> <p>11 A. No, at that time I had not done my residency.</p> <p>12 I had just done an internship. I worked as a general</p> <p>13 medical officer.</p> <p>14 Q. Where were you stationed?</p> <p>15 A. Goeppingen --</p> <p>16 THE COURT REPORTER: I'm sorry?</p> <p>17 THE WITNESS: G-O, with two dots above it</p> <p>18 E-P-P-I-N-G-E-N, Federal Republic of Germany,</p> <p>19 as it was known at that time.</p> <p>20 MR. TABER: Is that the umlaut?</p> <p>21 THE WITNESS: Yes, it gives you that</p> <p>22 er sound.</p> <p>23 BY MS. SEVERYN:</p> <p>24 Q. After you completed those two years as a line</p> <p>25 officer in Germany, what did you do then in terms of</p>

<p style="text-align: right;">Page 14</p> <p>1 your profession?</p> <p>2 A. Then I was reassigned to -- let's see if I can</p> <p>3 remember the name. I was reassigned to Fort Bragg.</p> <p>4 Q. Georgia? No.</p> <p>5 A. No, that's in North Carolina.</p> <p>6 Q. What did you do there?</p> <p>7 A. I worked as a general medical officer, the</p> <p>8 department of ambulatory care.</p> <p>9 Q. How long did you serve in that capacity?</p> <p>10 A. I think about one year.</p> <p>11 Q. All right. After you completed that duty as</p> <p>12 general medical officer at Fort Bragg, what did you do</p> <p>13 following that?</p> <p>14 A. I was reassigned to Fort Hood, Texas.</p> <p>15 Q. All right. What did you do at Fort Hood?</p> <p>16 A. I did a residency in emergency medicine.</p> <p>17 Q. How does that work with the Army, can you</p> <p>18 request what you're going to be trained in?</p> <p>19 A. Well, it's a free country you can request</p> <p>20 anything.</p> <p>21 Q. Did you request a residency in emergency</p> <p>22 medicine?</p> <p>23 A. Technically no, but when I was assigned at --</p> <p>24 it almost came to me, the name of the hospital at</p> <p>25 Bragg. When I was assigned to the hospital at Fort</p>	<p style="text-align: right;">Page 16</p> <p>1 Q. What happened after your discharge in the Army</p> <p>2 in 1989?</p> <p>3 A. I stayed in the City of El Paso, and worked at</p> <p>4 two hospitals there.</p> <p>5 Q. What hospitals?</p> <p>6 A. Sierra Medical Center, and I think it was</p> <p>7 called Vista Hills, was the second hospital.</p> <p>8 Q. I think you mentioned you stayed there and</p> <p>9 worked in the capacity of an emergency medicine</p> <p>10 physician?</p> <p>11 A. Yes.</p> <p>12 Q. How long were you in El Paso at either --</p> <p>13 actually collectively, at Sierra and Vista Hills?</p> <p>14 A. I think I may have spent six months in each</p> <p>15 one.</p> <p>16 Q. Where did you go after that?</p> <p>17 A. After that I went to Brooksville, Florida.</p> <p>18 Q. Brooksville?</p> <p>19 A. Yes.</p> <p>20 Q. Where did you work?</p> <p>21 A. Lykes, L-Y-K-E-S, like the hot dog. Lykes</p> <p>22 Community Hospital.</p> <p>23 Q. Where is Brooksville, Florida, in relation to</p> <p>24 where we are now?</p> <p>25 A. Straight across latitude, but on the Gulf.</p>
<p style="text-align: right;">Page 15</p> <p>1 Bragg, there was a Major Dice who worked there, who was</p> <p>2 residency trained board certified in emergency medicine,</p> <p>3 and he just thought that that's probably where I</p> <p>4 belonged.</p> <p>5 Q. So you basically respected his</p> <p>6 recommendation?</p> <p>7 A. Yes, ma'am. And he was assigned to Fort Hood</p> <p>8 to become the Chairman of the residency program.</p> <p>9 Q. Did you then study under him?</p> <p>10 A. I studied under his department, under his</p> <p>11 staff.</p> <p>12 Q. How long was the residency program at Fort</p> <p>13 Hood?</p> <p>14 A. Two years.</p> <p>15 Q. What was the facility?</p> <p>16 A. Darnall Army Community Hospital, D-A-R-N-A-L-L.</p> <p>17 Q. What year did you complete your residency</p> <p>18 training at Darnall?</p> <p>19 A. 1987.</p> <p>20 Q. For the next two years you still continued to</p> <p>21 serve in the Army?</p> <p>22 A. Yes, ma'am.</p> <p>23 Q. Were you at all times at Fort Hood for the</p> <p>24 remaining two years?</p> <p>25 A. Yes, ma'am.</p>	<p style="text-align: right;">Page 17</p> <p>1 Q. On the Gulf side. How long were you at Lykes</p> <p>2 Community Hospital?</p> <p>3 A. I think that was a grand total of ten months.</p> <p>4 Q. Why did you leave?</p> <p>5 A. The hospital was just wrought with a lot of</p> <p>6 internal problems. The medical staff and the C.E.O.</p> <p>7 were just going at it. It may have even come down to</p> <p>8 legal issues. So I just thought this is not exactly a</p> <p>9 good place to be.</p> <p>10 Q. At this point are we in around 1991?</p> <p>11 A. I think so.</p> <p>12 Q. Where did you go after Brooksville?</p> <p>13 A. To the Medical Center of Central Georgia,</p> <p>14 that's in Macon, Georgia.</p> <p>15 Q. I know I keep asking the same question, but is</p> <p>16 it fair to say that after your residency -- you</p> <p>17 completed residency training, did all the rest of your</p> <p>18 professional career involve emergency medicine?</p> <p>19 A. Yes, ma'am, to this date.</p> <p>20 Q. So I don't have to ask you that.</p> <p>21 A. No, ma'am.</p> <p>22 Q. How long were you at the Medical Center of</p> <p>23 Central Georgia?</p> <p>24 A. I was there for about approximately two</p> <p>25 years.</p>

<p style="text-align: right;">Page 18</p> <p>1 Q. Where did you go after that?</p> <p>2 A. I went to Elyria, Ohio.</p> <p>3 Q. What brought you to Elyria?</p> <p>4 A. Career advancement. I was supposed to be an</p> <p>5 assistant medical director there.</p> <p>6 Q. Where were you practicing?</p> <p>7 A. Elyria Memorial Hospital.</p> <p>8 Q. How long were you at Elyria?</p> <p>9 A. It's kind of tough to say, I think about a</p> <p>10 year, maybe a little bit more.</p> <p>11 Q. Where did you go after Elyria?</p> <p>12 A. The Cleveland Clinic.</p> <p>13 Q. What year did you begin working for the</p> <p>14 Cleveland Clinic Foundation?</p> <p>15 A. I think it was in 1995.</p> <p>16 Q. How long were you with the Clinic?</p> <p>17 A. I was there till December of -- actually</p> <p>18 technically, January of 2004.</p> <p>19 Q. Did you come down to Melbourne or to Holmes</p> <p>20 Regional Medical Center after you left the Cleveland</p> <p>21 Clinic?</p> <p>22 A. Yes, ma'am.</p> <p>23 Q. Were you anywhere else during the course of</p> <p>24 your professional career?</p> <p>25 A. No, ma'am.</p>	<p style="text-align: right;">Page 20</p> <p>1 Q. All right. So in terms of your employment or</p> <p>2 career as an emergency medicine physician, all of your</p> <p>3 teaching appointments would have been in connection with</p> <p>4 the Cleveland Clinic Foundation and the Ohio State</p> <p>5 Medical School?</p> <p>6 A. I think Case Western was affiliated with</p> <p>7 Metro.</p> <p>8 Q. To the extent that you went over to Metro</p> <p>9 sometimes, you also worked with the medical students</p> <p>10 from Case Western?</p> <p>11 A. Right. And when I was in Macon, Georgia, I</p> <p>12 worked with the students and the residents that were</p> <p>13 affiliated with their medical school, and I don't</p> <p>14 remember the name of their medical school.</p> <p>15 Q. Okay, but that was through the surgical</p> <p>16 department?</p> <p>17 A. Right.</p> <p>18 Q. In lay terms, would you describe what it means</p> <p>19 to have a teaching appointment?</p> <p>20 A. Basically, you're responsible for bedside</p> <p>21 teaching, which is basically clinical teaching. That</p> <p>22 can also include courses, lectures.</p> <p>23 For example, at Macon when you would do an</p> <p>24 A.T.L.S. course, you would do an entire week and you</p> <p>25 would do several chapters, several lectures. When you</p>
<p style="text-align: right;">Page 19</p> <p>1 Q. Why did you leave the Cleveland Clinic</p> <p>2 Foundation?</p> <p>3 A. Just a change. I have friends down here that</p> <p>4 I knew while I was working at the Clinic.</p> <p>5 Q. Did your decision to relocate in any way</p> <p>6 involve this case or anything that happened here?</p> <p>7 A. Absolutely not.</p> <p>8 Q. During the course of your professional career,</p> <p>9 have you had any teaching appointments?</p> <p>10 A. Yes, ma'am.</p> <p>11 Q. What teaching appointments have you had?</p> <p>12 A. Ohio State Medical School, which is -- that's</p> <p>13 at the Clinic, and then oddly enough we -- when</p> <p>14 Dr. Emmerman became Chairman of our department of</p> <p>15 MetroHealth, we became Prudential at MetroHealth Medical</p> <p>16 Center, and we would work shifts over at MetroHealth</p> <p>17 Medical Center. And we were on staff with that</p> <p>18 facility, also in a teaching capacity, affiliated with</p> <p>19 the residency program.</p> <p>20 Q. Have you ever had any other teaching</p> <p>21 appointments?</p> <p>22 A. When I was in Macon, Georgia, the medical</p> <p>23 school that they were affiliated with, but that was</p> <p>24 through the department of surgery, not the department of</p> <p>25 emergency medicine.</p>	<p style="text-align: right;">Page 21</p> <p>1 did A.C.L.S. that was very rugged so to speak, because</p> <p>2 you didn't teach one topic, you taught the entire book</p> <p>3 for one whole week to about 12 to 15 students. So you</p> <p>4 went from chapter one to the end, to include codes, mega</p> <p>5 codes, everything in the book.</p> <p>6 Q. When you were with the Clinic, what portion of</p> <p>7 your professional time was devoted to the teaching</p> <p>8 aspect?</p> <p>9 A. I'd say about 20 percent.</p> <p>10 Q. Did you have occasion to give any lectures or</p> <p>11 teach any courses while affiliated with the Cleveland</p> <p>12 Foundation?</p> <p>13 A. Yes, ma'am.</p> <p>14 Q. How often would you do that?</p> <p>15 A. Once every few months.</p> <p>16 Q. Have you ever lectured or written on the topic</p> <p>17 of emergency medicine and the treatment of pulmonary</p> <p>18 embolism?</p> <p>19 A. Well, I had one lecture that touched on it.</p> <p>20 Q. When did you give that lecture?</p> <p>21 A. I cannot recall.</p> <p>22 Q. Did you publish any articles or any literature</p> <p>23 on the topic of pulmonary embolism?</p> <p>24 A. No, ma'am.</p> <p>25 Q. Have you ever published any documents --</p>

<p style="text-align: right;">Page 22</p> <p>1 excuse me, any articles or texts?</p> <p>2 A. Yes, ma'am.</p> <p>3 Q. What have you published?</p> <p>4 A. A paper on acute plastic bone deformities,</p> <p>5 children. A paper on ovarian hyper-stimulation</p> <p>6 syndrome. And about six papers with Frank Peacock on</p> <p>7 congestive heart failure.</p> <p>8 Q. Are you presently associated with any -- are</p> <p>9 you presently a member of any associations?</p> <p>10 A. The American Academy of Emergency Medicine.</p> <p>11 Q., How long have you been a member of that</p> <p>12 association?</p> <p>13 A. Off and on, I'd say for the past ten years I</p> <p>14 think, or 12 years. I can't remember when the</p> <p>15 organization first came into being. It was informal and</p> <p>16 then it became more of a formal thing, and then as more</p> <p>17 members came in, it became more of a recognized body.</p> <p>18 Q. Have you ever served in any capacity with that</p> <p>19 organization, in terms of being an officer or committee</p> <p>20 member or chair?</p> <p>21 A. No, ma'am.</p> <p>22 Q. Are there any texts in emergency medicine that</p> <p>23 you would consider authoritative texts?</p> <p>24 MR. TABER: Objection, over broad.</p> <p>25 THE WITNESS: Say that again?</p>	<p style="text-align: right;">Page 24</p> <p>1 people who have textbooks of emergency medicine.</p> <p>2 And then you can always look up any journals that</p> <p>3 you read, at the Clinics of North America or Evidence</p> <p>4 Based Emergency Medicine, E.R. Reports, Journal</p> <p>5 of Emergency Medicine. There's a lot of journals around.</p> <p>6 Q. All right. Let me just make sure I'm asking</p> <p>7 my question clearly. I appreciate that there's a lot of</p> <p>8 literature that is available out there, and a number of</p> <p>9 texts that can be referred to. My question is, is there</p> <p>10 a text that you habitually would refer to if you had</p> <p>11 question on that topic?</p> <p>12 A. Everything I just said.</p> <p>13 Q. Okay. Have you at one time or another turned</p> <p>14 to each and every one of the texts you've talked about?</p> <p>15 A. Yes.</p> <p>16 Q. When Harold Stansbury was a patient of yours,</p> <p>17 did you have occasion to refer to any text or literature</p> <p>18 during the course of that evening?</p> <p>19 A. No, ma'am.</p> <p>20 Q. After the fact, did you look into any issues</p> <p>21 having to do with Mr. Stansbury's treatment?</p> <p>22 A. No, ma'am.</p> <p>23 Q. What information or documents have you</p> <p>24 reviewed in preparation for this deposition?</p> <p>25 A. I was given -- I was provided with the run</p>
<p style="text-align: right;">Page 23</p> <p>1 BY MS. SEVERYN:</p> <p>2 Q. Sure. Are there any texts in emergency</p> <p>3 medicine that you would consider authoritative?</p> <p>4 A. No.</p> <p>5 Q. If you had a question about any aspect of</p> <p>6 emergency medicine, is there a book or text that you</p> <p>7 would turn to?</p> <p>8 A. There's a slew of text that you could turn to,</p> <p>9 and whatever the current literature.</p> <p>10 Q. Okay, I'm asking you if you have habitually or</p> <p>11 customarily turned to any particular text, if you have a</p> <p>12 question on emergency medicine?</p> <p>13 A. There's a number of textbooks that I would</p> <p>14 turn to look at, and as I said, then after that I</p> <p>15 would look at the current literature to see what's going</p> <p>16 on.</p> <p>17 Q. Over the last let's say five years, what are</p> <p>18 some of the texts that you would turn to, if you had a</p> <p>19 question with respect to, let's say the management of a</p> <p>20 patient that has a suspected or actual pulmonary</p> <p>21 embolism?</p> <p>22 A. Well, you could read Rosen's Textbook of</p> <p>23 Emergency Medicine. You have Schwartz's Textbook of</p> <p>24 Emergency Medicine. You have Tintinalli's Textbook of</p> <p>25 Emergency Medicine. I'm sure there are a few other</p>	<p style="text-align: right;">Page 25</p> <p>1 sheet from a local emergency transport unit. I was</p> <p>2 given the run sheet for Metro, Metro Life Flight, and</p> <p>3 his medical records of that evening.</p> <p>4 Q. Are you talking about the Clinic's medical</p> <p>5 records?</p> <p>6 A. Yes, ma'am.</p> <p>7 Q. Now, the Clinic's medical records are</p> <p>8 extensive, they involve the treatment of Mr. Stansbury --</p> <p>9 A. Well, I was given the dictated portion and the</p> <p>10 nursing notes that went with that, and the printed</p> <p>11 Em-STAT sheets.</p> <p>12 Q. Did you review only the medical records having</p> <p>13 to do with the emergency treatment on January 25, 2003,</p> <p>14 or did you look at any of the records having to do with</p> <p>15 Mr. Stansbury's prior treatment at the Clinic?</p> <p>16 A. Okay, ask me that question again? I'm</p> <p>17 confused.</p> <p>18 Q. Sure. Mr. Stansbury had been treated at the</p> <p>19 Clinic before he came to emergency on January 25, 2003;</p> <p>20 are you aware of that?</p> <p>21 A. After the fact, yes.</p> <p>22 Q. Okay, and I'm asking today, in preparation for</p> <p>23 this depo, or at some point prior to today, have you</p> <p>24 reviewed any portions of the Cleveland Clinic's chart,</p> <p>25 other than just the emergency room information for</p>

<p style="text-align: right;">Page 26</p> <p>1 January 25, 2003?</p> <p>2 A. I looked at a deposition by Dr. Krofina.</p> <p>3 Q. Okay.</p> <p>4 A. And I think there was an operative report</p> <p>5 there from a Dr. Swenson or Svenson.</p> <p>6 Q. Anything else?</p> <p>7 A. Not off the top of my head at this time.</p> <p>8 Q. Mr. Stansbury had just had an aortic aneurysm</p> <p>9 repair surgery at the Clinic. I believe it was on the</p> <p>10 13th of January 2003; are you aware of that?</p> <p>11 A. I am now.</p> <p>12 Q. Were you aware of that information on the</p> <p>13 evening of January 25, 2003?</p> <p>14 A. No, ma'am. I was aware that he had had that</p> <p>15 surgery, but as to where it was performed, there was a</p> <p>16 lot of confusion with that.</p> <p>17 Q. So as we sit here, you don't have any</p> <p>18 independent recollection of having reviewed any of the</p> <p>19 Clinic information relative to that repair, other than</p> <p>20 what you may have seen attached to Dr. Krofina's</p> <p>21 deposition, that operative report?</p> <p>22 MR. TABER: Objection.</p> <p>23 THE WITNESS: Yeah, that's -- say</p> <p>24 that again?</p> <p>25 BY MS. SEVERYN:</p>	<p style="text-align: right;">Page 28</p> <p>1 when I'm asking questions, and a lot of this is not</p> <p>2 artfully stated. Very simply, I know you reviewed</p> <p>3 records regarding the ER visit; right?</p> <p>4 A. Right.</p> <p>5 Q. Did you review anything else?</p> <p>6 A. For the deposition I was provided the Em-STAT</p> <p>7 print out sheet the dictation, a copy of Dr. Krofina's</p> <p>8 deposition, and in there -- not in there, but also an</p> <p>9 operative report of a Dr. Swenson regarding the surgery</p> <p>10 itself.</p> <p>11 Q. Okay.</p> <p>12 A. And I think there was also attached to that</p> <p>13 piece a discharge sheet, indicating his medication upon</p> <p>14 discharge, his condition, et cetera.</p> <p>15 Q. The reason I ask is, you have a copy of the</p> <p>16 Clinic's chart that I also have a copy of, and I know it</p> <p>17 has hundreds of pages. Have you reviewed everything in</p> <p>18 the document in front of you?</p> <p>19 A. No.</p> <p>20 MR. TABER: Just for clarification that's</p> <p>21 my sub-set.</p> <p>22 MS. SEVERYN: Okay -</p> <p>23 THE WITNESS: Yeah, my sub-set is like</p> <p>24 that. (Witness indicates.)</p> <p>25 BY MS. SEVERYN:</p>
<p style="text-align: right;">Page 27</p> <p>1 Q. You mentioned that you believe you saw an</p> <p>2 operative report from Dr. Swenson, and that that</p> <p>3 information was something that was attached as part of</p> <p>4 Dr. Krofina's deposition?</p> <p>5 A. No. That was something that was provided to</p> <p>6 me for review --</p> <p>7 Q. Okay.</p> <p>8 A. -- for this deposition.</p> <p>9 Q. All right. Other than your review of that</p> <p>10 operative report, do you have any independent</p> <p>11 recollection of having seen anything else in that</p> <p>12 Cleveland Clinic chart relative to the aneurysm</p> <p>13 repair?</p> <p>14 A. At what time?</p> <p>15 MR. TABER: -- time go ahead.</p> <p>16 THE WITNESS: Ask me the question again.</p> <p>17 I'm sorry.</p> <p>18 MS. SEVERYN: Why don't we read it</p> <p>19 back.</p> <p>20 (Thereupon a portion of the record was read back.)</p> <p>21 BY MS. SEVERYN:</p> <p>22 Q. I'm not trying to trick you, Doctor, I'm</p> <p>23 just --</p> <p>24 A. I apologize. I'm just not understanding you.</p> <p>25 Q. That's okay, and believe me I get all excited</p>	<p style="text-align: right;">Page 29</p> <p>1 Q. All right. Now, getting into again this</p> <p>2 initial contact with Mr. Stansbury, I think you said you</p> <p>3 looked at some run sheets; right?</p> <p>4 A. Right.</p> <p>5 Q. And that would involve the E.M.S.?</p> <p>6 A. Yes.</p> <p>7 Q. And then also the Life Flight; correct?</p> <p>8 A. Yes.</p> <p>9 Q. Let me direct your attention to what has been</p> <p>10 marked as Plaintiff's Exhibit 1.</p> <p>11 Q. Would you take a look at these documents and</p> <p>12 identify them for the record.</p> <p>13 A. Okay.</p> <p>14 Q. Are you able to identify these documents,</p> <p>15 Doctor?</p> <p>16 A. Well, it says MetroHealth Medical Center, Life</p> <p>17 Flight -- Metro Life Flight.</p> <p>18 Q. Let me direct your attention to the lower-</p> <p>19 right-hand corner. I believe these are documents that</p> <p>20 are stamped with CCF 0246, 0247, 0248, 0249, and 0250;</p> <p>21 is that correct?</p> <p>22 A. I don't know what you're referring to.</p> <p>23 Q. These numbers?</p> <p>24 A. Yes.</p> <p>25 Q. Beginning with 46 and ending with 50.</p>

<p style="text-align: right;">Page 30</p> <p>1 A. Yes.</p> <p>2 Q. Have you seen any of these documents prior to</p> <p>3 today?</p> <p>4 A. I'm not certain about this cover sheet here,</p> <p>5 this document I think I saw, this one.</p> <p>6 Q. Doctor, for the record, can you refer to the</p> <p>7 bottom number?</p> <p>8 A. CCF 0247.</p> <p>9 Q. You've seen that one?</p> <p>10 A. CCF 0248, CCF 0249. I'm not certain about</p> <p>11 this CCF 0250, or CCF 0246.</p> <p>12 Q. All right. So you're not sure if you saw 46</p> <p>13 and 50, but you saw the other three, 47, 48, and 49?</p> <p>14 A. I have seen them in preparation for this</p> <p>15 deposition.</p> <p>16 Q. When you talk about the run sheet for the Life</p> <p>17 Flight, what is that?</p> <p>18 A. The sheet that they use to transport a patient.</p> <p>19 Q. That's something other than what you have</p> <p>20 there; correct?</p> <p>21 A. I don't know.</p> <p>22 MR. TABER: I think it's --</p> <p>23 THE COURT REPORTER: I'm sorry?</p> <p>24 MR. TABER: Aurora, A-U-R-O-R-A.</p> <p>25 THE WITNESS: This Aurora Fire</p>	<p style="text-align: right;">Page 32</p> <p>1 gather from this document, regarding the date that</p> <p>2 Mr. Stansbury arrived -- excuse me, the time that</p> <p>3 Mr. Stansbury arrived at the Cleveland Clinic</p> <p>4 Foundation?</p> <p>5 A. At 17:33 hours.</p> <p>6 Q. Where do you get that information?</p> <p>7 A. At the lower-left-hand side, the third time</p> <p>8 stamp from the bottom.</p> <p>9 Q. Received patient?</p> <p>10 A. Yes, ma'am.</p> <p>11 Q. All right. Now, is that received patient time</p> <p>12 the date the patient was received or the date -- excuse</p> <p>13 me, I keep saying date, excuse me, or the time that he</p> <p>14 was admitted?</p> <p>15 A. No, that would be the time that he was</p> <p>16 received.</p> <p>17 Q. All right, and then the admission time is some</p> <p>18 other time?</p> <p>19 A. Yes, ma'am.</p> <p>20 Q. And what is the admission time?</p> <p>21 MR. TABER: Time received --</p> <p>22 THE WITNESS: No, the time of admission.</p> <p>23 MR. TABER: Admission to the hospital?</p> <p>24 I don't think he ever left the emergency room.</p> <p>25 THE WITNESS: I don't --</p>
<p style="text-align: right;">Page 31</p> <p>1 Department run sheet, that's what I call</p> <p>2 it, a run sheet. This I recall seeing.</p> <p>3 BY MS. SEVERYN:</p> <p>4 Q. All right.</p> <p>5 A. Again, in preparation for the deposition.</p> <p>6 Q. Going back to the evening that Mr. Stansbury</p> <p>7 was admitted, can you tell from any of the documentation</p> <p>8 before you, what time Mr. Stansbury arrived at the</p> <p>9 Cleveland Clinic Foundation?</p> <p>10 A. From these documents?</p> <p>11 Q. Or from any documents available to you?</p> <p>12 A. I would be looking at the print out, Cleveland</p> <p>13 Clinic Foundation, Em-STAT system.</p> <p>14 Q. And we'll get to that document. Well, let's</p> <p>15 get to it now. The document that you're referring to,</p> <p>16 is that the same as what has already been premarked as</p> <p>17 Exhibit 13? No, that's the same copy, those are just</p> <p>18 multiple copies.</p> <p>19 A. Of this page, here?</p> <p>20 Q. Yes.</p> <p>21 A. Yes.</p> <p>22 Q. All right. So the document you're referring</p> <p>23 to is the same as Plaintiff's Exhibit 13; correct?</p> <p>24 A. Yes.</p> <p>25 Q. All right. What information are you able to</p>	<p style="text-align: right;">Page 33</p> <p>1 BY MS. SEVERYN:</p> <p>2 Q. Let me ask it this way, is time received time</p> <p>3 admitted, or is there a difference between those two?</p> <p>4 A. Yes, ma'am.</p> <p>5 Q. Well, there's an admission order here, but</p> <p>6 it's not timed.</p> <p>7 Q. What document are you referring to? If you</p> <p>8 could look at the stamp at the bottom.</p> <p>9 A. Well, it's the Cleveland Clinic Foundation</p> <p>10 Emergency Department Ledger.</p> <p>11 Q. Just for the record, is that what has been</p> <p>12 premarked as Plaintiff's Exhibit 2?</p> <p>13 A. Yes, ma'am.</p> <p>14 Q. Typically would you expect to see that time</p> <p>15 noted somewhere on this document?</p> <p>16 A. Yes, ma'am.</p> <p>17 Q. What is the difference between time received</p> <p>18 and time admitted?</p> <p>19 A. Time received is when you receive the patient,</p> <p>20 and time admitted is when the patient was admitted to</p> <p>21 the hospital or to a service.</p> <p>22 Q. Is there any other document that you would</p> <p>23 typically expect to find that information on at the</p> <p>24 Clinic?</p> <p>25 A. I'm not sure.</p>

<p style="text-align: right;">Page 34</p> <p>1 Q. Going back to earlier, I'd asked you about 2 your independent recollection of this patient, and what 3 independent recollection you have at this point. Now, 4 that we've talked about this, and if you need to refer 5 to any documents, I have some specific questions about 6 the care that was rendered and the condition of the 7 patient. So starting with when you first saw 8 Mr. Stansbury, what information did you have with regard 9 to what brought him to the Clinic? 10 A. The information that I had was the information 11 that was conveyed to me by nursing, that they received a 12 call and that they're bringing a patient in, complaining 13 of shortness of breath. 14 Q. All right. Is that the call you're referring 15 to that you received prior to the patient coming in? 16 A. I didn't receive it personally, it's -- 17 Q. Nursing did? 18 A. Yes. 19 Q. But you personally did not speak to anybody 20 about Mr. Stansbury, other than what was conveyed 21 through nursing before he came in? 22 A. Right. 23 Q. Then Mr. Stansbury came in; correct? 24 A. Yes, ma'am. 25 Q. When was the first time you actually saw him,</p>	<p style="text-align: right;">Page 36</p> <p>1 Q. Okay. Prior to having this exchange with the 2 patient, would you have spoken with anybody from the 3 Life Flight team? 4 A. I don't recall speaking to anyone. 5 Q. Do you typically speak with the Life Flight 6 team if there's a patient that's being brought in? 7 A. No. 8 Q. Do you typically look at the records from Life 9 Flight prior to either speaking with the patient or 10 examining the patient? 11 A. It depends on the circumstances of the 12 situation. If they're readily available, I'll look at 13 them, if not, I'm assuming that patient is going to be 14 able to communicate to me everything that's already been 15 communicated to Metro or whatever transporting unit 16 there is. I have a tendency to get it from the 17 horse's mouth so to speak, so that there's no 18 interpretation. I can just quote a patient as this is 19 what he told me. 20 Q. Okay, and certainly at this time you were able 21 to speak with Mr. Stansbury? 22 A. Yes. 23 Q. Is it fair to say that based upon your 24 recollection then, you did not have any independent 25 discussion with any Life Flight personnel, and you had</p>
<p style="text-align: right;">Page 35</p> <p>1 in relation to when he arrived at the Clinic? 2 A. When he was brought into the room. 3 Q. What room? 4 A. The room that he was assigned, that he was 5 taken to. 6 Q. When did you first see him in relation to when 7 he was received at the hospital? 8 MR. TABER: I think he just answered that. 9 MS. SEVERYN: No, I want a time. In 10 other words, if there's something you can 11 refer to that would refresh your recollection. 12 THE WITNESS: No, madam, they brought -- 13 I watched them as they brought him in. 14 BY MS. SEVERYN: 15 Q. All right. So it would have been within 16 minutes of receiving the patient? 17 A. Yes. 18 Q. What occurred when you first saw him? Was 19 there something that you did immediately upon having the 20 patient wheeled into the room? 21 A. Well, what I would normally do under those 22 circumstances is physically -- visually inspect and 23 assess the patient, and communicate with the patient, 24 and ask him what seems to be the problem, and just take 25 it from there, ask routine questions.</p>	<p style="text-align: right;">Page 37</p> <p>1 no recollection of reviewing the Metro Life Flight's 2 records prior to actually speaking with 3 Mr. Stansbury? 4 MR. TABER: Two questions. The first 5 he's already answered and said he couldn't 6 recall, and the second one, go ahead. 7 THE WITNESS: What was the second one 8 again? 9 BY MS. SEVERYN: 10 Q. Let me ask them as two questions. Is it fair 11 to say that you have no recollection of speaking with 12 any of the Life Flight personnel in connection with 13 Mr. Stansbury, before you actually spoke with him 14 yourself? 15 A. To the best of my recollection at this time, I 16 don't recall speaking with someone. 17 Q. Do you remember ever speaking with any Life 18 Flight personnel in connection with the treatment of 19 Harold Deans Stansbury? 20 A. There is a vague recollection of speaking to 21 someone, but the information at that time, my global 22 impression of that conversation was that it was a very 23 confusing conversation. 24 Q. All right. This vague recollection that you 25 have, does it involve speaking with the physician that</p>

<p style="text-align: right;">Page 38</p> <p>1 was on Life Flight?</p> <p>2 A. I don't recall.</p> <p>3 Q. Okay, what do you remember, in terms of this</p> <p>4 vague recollection of possibly having spoken with</p> <p>5 someone associated with the Life Flight team?</p> <p>6 A. I recall speaking with someone and there was</p> <p>7 some confusion as to whether he had had his surgery at</p> <p>8 the Clinic or somewhere else.</p> <p>9 Q. Did that have any special significance for</p> <p>10 you?</p> <p>11 A. Well, it depends. I mean in one respect you</p> <p>12 can say no, because it's not going to change how I</p> <p>13 manage the patient. And -- well, not really.</p> <p>14 Q. Other than having this recollection of some</p> <p>15 confusion as to understanding where Mr. Stansbury had</p> <p>16 had surgery, is there anything else that you can recall</p> <p>17 about this conversation?</p> <p>18 A. At this point in time, no.</p> <p>19 Q. Do you have any idea or recollection as to</p> <p>20 whom you spoke with?</p> <p>21 A. Not at this time.</p> <p>22 Q. Is it fair to say, based on what we talked</p> <p>23 about earlier, that you do not have any recollection of</p> <p>24 having reviewed the Metro Life Flight document prior to</p> <p>25 speaking with Mr. Stansbury personally?</p>	<p style="text-align: right;">Page 40</p> <p>1 patient?</p> <p>2 A. Yes, ma'am.</p> <p>3 Q. Was Dr. Cudnik present during this initial</p> <p>4 discussion with Mr. Stansbury?</p> <p>5 A. Oh, I believe he was.</p> <p>6 Q. Separate and apart from what Dr. Cudnik</p> <p>7 dictated, what has been included in what's again been</p> <p>8 marked and identified as Plaintiff's Exhibit 4, is there</p> <p>9 any portion of the chart where you personally would have</p> <p>10 handwritten any information during that initial</p> <p>11 assessment or conversation with the patient? Okay --</p> <p>12 off the record.</p> <p>13 (Thereupon, an off the record discussion was held)</p> <p>14 A. It would be this document here, the Emergency</p> <p>15 Department Ledger.</p> <p>16 Q. Let me direct your attention to what we've</p> <p>17 already identified as Exhibit 2; is that what you're</p> <p>18 referring to, Doctor?</p> <p>19 A. Yes, ma'am.</p> <p>20 Q. What portions of this document, the Emergency</p> <p>21 Department Ledger, what portions of that document</p> <p>22 reflect your handwriting?</p> <p>23 A. The signature at the lower right hand side. I</p> <p>24 circled the medical decision making formulated, and the</p> <p>25 admission order that was written was written by myself,</p>
<p style="text-align: right;">Page 39</p> <p>1 A. I don't recall reading anything about him</p> <p>2 prior to speaking to him. I may have afterwards, when</p> <p>3 they would have a chance to finish writing up their</p> <p>4 report, et cetera. But as I said, once he was present,</p> <p>5 I made contact with him immediately.</p> <p>6 Q. Now, is there anything in the chart that</p> <p>7 reflects what information you would have obtained from</p> <p>8 Mr. Stansbury, during that initial conversation with</p> <p>9 him?</p> <p>10 A. I would -- well, I would think that the</p> <p>11 history that Dr. Cudnik obtained should reflect -- or</p> <p>12 rather would reflect basically the gist of the</p> <p>13 information that we obtained from Mr. Stansbury.</p> <p>14 Q. Let me direct your attention to what's been</p> <p>15 premarked as Plaintiff's Exhibit 4, can you identify</p> <p>16 that document for the record?</p> <p>17 A. Deposition Exhibit Number 4, CCF 0302,</p> <p>18 Cleveland Clinic Foundation Emergency Department</p> <p>19 Report.</p> <p>20 MS. HENRY: Off the record.</p> <p>21 (Thereupon, an off the record discussion was held.)</p> <p>22 BY MS. SEVERYN:</p> <p>23 Q. Is that the report or history you were</p> <p>24 referring to when you spoke that Dr. Cudnik's history</p> <p>25 would reflect the information that was obtained from the</p>	<p style="text-align: right;">Page 41</p> <p>1 and the order to initiate Heparin was written by me.</p> <p>2 Q. When you talk about the initial order, what</p> <p>3 order are you referring to?</p> <p>4 A. I'm sorry?</p> <p>5 Q. When you referenced the initial order, you</p> <p>6 said that was written by you, what --</p> <p>7 MR. TABER: He said admission order.</p> <p>8 BY MS. SEVEYRN:</p> <p>9 Q. Oh, admission order, excuse me, I'm sorry.</p> <p>10 Which is the order relative to the administration of</p> <p>11 Heparin?</p> <p>12 A. The one circled, number one.</p> <p>13 Q. And that's in your handwriting?</p> <p>14 A. Yes, ma'am.</p> <p>15 Q. We'll get to that. What about 2 and 3 is that</p> <p>16 in your handwriting as well?</p> <p>17 A. Yes, ma'am.</p> <p>18 Q. Down below that, are I believe a number of</p> <p>19 medications, is that your handwriting?</p> <p>20 A. No, ma'am.</p> <p>21 Q. Anything else on the chart that's in your</p> <p>22 handwriting?</p> <p>23 A. I think the CT at 19:34 and number sign, the</p> <p>24 pound sign 29022.</p> <p>25 Q. What does that number reference, Number 29 --</p>

<p style="text-align: right;">Page 42</p> <p>1 A. 022?</p> <p>2 Q. 022?</p> <p>3 A. A dictation number.</p> <p>4 Q. So other than what's on this document the</p> <p>5 Emergency Department Ledger and what's contained in</p> <p>6 Dr. Cudnik's history, which is Exhibit 4, there's</p> <p>7 nothing else you can reference -- or is there anything</p> <p>8 else that you can reference that would contain</p> <p>9 information that you obtained from the patient, during</p> <p>10 that initial conversation?</p> <p>11 A. The question again?</p> <p>12 Q. Sure. You've pointed out two documents that</p> <p>13 would have information that you obtained or was obtained</p> <p>14 from the patient, initially after he arrived at</p> <p>15 Cleveland Clinic.</p> <p>16 A. Yes, ma'am.</p> <p>17 Q. The first was the history of Dr. Cudnik as</p> <p>18 contained in the Emergency Department Report, Exhibit 4;</p> <p>19 do you recall that?</p> <p>20 A. Yes.</p> <p>21 Q. The second was information contained in the</p> <p>22 Emergency Department Ledger that you've just gone over,</p> <p>23 Exhibit 2 --</p> <p>24 A. Yes, ma'am.</p> <p>25 Q. Other than what's in these two documents, if</p>	<p style="text-align: right;">Page 44</p> <p>1 you know, like a blast of information about the patient;</p> <p>2 57 year old white male, complaining of shortness of</p> <p>3 breath, and what may have been done to relieve it, what</p> <p>4 they would normally do. For example, I.V.</p> <p>5 initiate, oxygen administered, patient no better,</p> <p>6 patient worse, patient stable, information along those</p> <p>7 lines.</p> <p>8 Q. What treatment had already been provided to</p> <p>9 Mr. Stansbury prior to his admission to Cleveland</p> <p>10 Clinic?</p> <p>11 A. He had I.V.s established. He had oxygen</p> <p>12 given.</p> <p>13 Q. Do you remember where the I.V.s were</p> <p>14 established?</p> <p>15 A. I'd have to go back to the records and look to</p> <p>16 see who established what I.V.</p> <p>17 Q. Would you have that information from the Life</p> <p>18 Flight documents we've already looked at, and marked as</p> <p>19 Exhibit 1?</p> <p>20 A. I'd need to look at it. It's usually</p> <p>21 indicated on their report, but I don't specifically see</p> <p>22 the I.V. although they reference I.V. infusion of some</p> <p>23 fluid.</p> <p>24 Q. All right. So that reference would suggest to</p> <p>25 you that I.V.s were established?</p>
<p style="text-align: right;">Page 43</p> <p>1 there is anything else that you can reference in the</p> <p>2 chart that would contain information that you obtained</p> <p>3 or that was obtained from the patient initially.</p> <p>4 A. The question is, is there anything -- any</p> <p>5 other source of information?</p> <p>6 Q. Sure.</p> <p>7 A. That was available to me at that time?</p> <p>8 Q. No, after -- strike that. Is there any other</p> <p>9 source of information or documentation that was</p> <p>10 generated as a result of that initial dialog or</p> <p>11 interview with the patient?</p> <p>12 A. Oh, no, ma'am, not that I can see.</p> <p>13 Q. What information did you obtain after</p> <p>14 Mr. Stansbury's admission to the Clinic as to what</p> <p>15 treatment had already been rendered to him?</p> <p>16 A. I was informed that he had had a repair of the</p> <p>17 aortic root and that was pretty much what I recall,</p> <p>18 regarding his most recent surgery.</p> <p>19 Q. What about treatment that had already been</p> <p>20 rendered by the E.M.S. personnel, or the Life Flight</p> <p>21 team?</p> <p>22 A. That would have been on the run sheets or that</p> <p>23 would have been conveyed as a verbal report to nursing,</p> <p>24 and then subsequently to myself. And also the units, as</p> <p>25 they bring the patients in they would give a little bit,</p>	<p style="text-align: right;">Page 45</p> <p>1 A. Yes, ma'am.</p> <p>2 MR. TABER: I.V. or I.V.s?</p> <p>3 MS. SEVERYN: I.V.s.</p> <p>4 MR. TABER: Let's be clear.</p> <p>5 THE WITNESS: The Aurora Fire</p> <p>6 Department specifically references an 18</p> <p>7 to 20 gage I.V. left hand, and right hand.</p> <p>8 So two I.V.s were initiated.</p> <p>9 BY MS. SEVERYN:</p> <p>10 Q. What are the locations of the I.V.s?</p> <p>11 A. Left hand, right hand.</p> <p>12 (Thereupon, an off the record discussion was held.)</p> <p>13 Q. Back on the record. Other than the fact that</p> <p>14 oxygen was given and I.V.s established, is there</p> <p>15 anything else that was done by way of treatment?</p> <p>16 A. He was given 200 cc's of fluid by Metro Life</p> <p>17 Flight.</p> <p>18 Q. What information was given by Mr. Stansbury</p> <p>19 himself regarding what brought him to the hospital and</p> <p>20 to the attention of E.M.S. that day?</p> <p>21 A. I recall him telling me that he had</p> <p>22 experienced some severe shortness of breath and some</p> <p>23 chest pain.</p> <p>24 Q. When you obtained this history or after you</p> <p>25 obtained this history, what did you do after that?</p>

<p style="text-align: right;">Page 46</p> <p>1 A. Once I finished obtaining the history and</p> <p>2 examining him, I requested the labs that I wanted drawn</p> <p>3 on Mr. Stansbury and the test to be performed.</p> <p>4 Q. Let's talk about the examination that you</p> <p>5 performed. What did you do by way of examination?</p> <p>6 A. Inspected him, palpation and auscultation. I</p> <p>7 looked at him, I looked at his extremities, his face,</p> <p>8 his color, assessed how well he was answering questions,</p> <p>9 examined his neck, his chest, his abdomen, his</p> <p>10 extremities.</p> <p>11 Q. Were there any abnormal findings on</p> <p>12 examination?</p> <p>13 A. Nothing that was grossly abnormal.</p> <p>14 Q. After you completed the examination on the</p> <p>15 patient, you indicated that you had some labs drawn; is</p> <p>16 that correct?</p> <p>17 A. Yes, ma'am.</p> <p>18 Q. You ordered labs. What do you order by the</p> <p>19 way of laboratory results or tests?</p> <p>20 A. I'd have to refer to the chart to be</p> <p>21 specific.</p> <p>22 Q. Absolutely, please do so.</p> <p>23 A. Cardiac Troponin, a brain natriuretic</p> <p>24 N-A-T-R-I-U-R-E-T-I-C, peptide. A C.B.C., Chem.8,</p> <p>25 PT/PTT, and EKG, a chest x-ray, a blood gas, and a CAT</p>	<p style="text-align: right;">Page 48</p> <p>1 infection like a pneumonia.</p> <p>2 Q. Okay.</p> <p>3 A. The clotting, the PT/PTT to ensure that his</p> <p>4 clotting parameters were normal. The chemistries are to</p> <p>5 make sure that his renal function was normal, nothing</p> <p>6 out of the normal there, and since a CAT scan would be</p> <p>7 required for other reasons, make sure that his</p> <p>8 creatinine, that is the renal function, make sure that</p> <p>9 was normal.</p> <p>10 His blood gas was to see how much oxygen he had in</p> <p>11 his blood, the EKG was to see if he was having obvious</p> <p>12 signs of a myocardial infarction.</p> <p>13 The chest x-ray was to see was there anything</p> <p>14 abnormal as far as the operative site, was there an</p> <p>15 abscess in that area, was there a mass, a pleural</p> <p>16 effusion, unilateral, bilateral, did he have pneumonia</p> <p>17 with a sub-harmonic effusion, did he have a</p> <p>18 pneumothorax?</p> <p>19 Q. And that would be from the blood gas?</p> <p>20 A. No, the chest X-ray.</p> <p>21 Q. The chest x-ray, okay.</p> <p>22 A. But the blood gases would also reflect</p> <p>23 somewhat if he had a very large pleural effusion, he</p> <p>24 may not have as much oxygen as one would expect him to</p> <p>25 have.</p>
<p style="text-align: right;">Page 47</p> <p>1 scan and a D-dimer.</p> <p>2 Q. What were you considering by way of a</p> <p>3 differential diagnosis at that time?</p> <p>4 A. Well, with the chest pain and shortness of</p> <p>5 breath I would think of a pneumothorax, a myocardial</p> <p>6 infarction, cardiac tamponade, because of the type of</p> <p>7 surgery he supposedly had, a pulmonary embolism,</p> <p>8 pneumonia, pleural effusion, an abscess, and a slew of</p> <p>9 other things.</p> <p>10 Q. Were you considering all of these at the time</p> <p>11 you saw Mr. Stansbury in emergency, and at the time you</p> <p>12 ordered these tests?</p> <p>13 A. Yes, ma'am.</p> <p>14 Q. Going through each of the tests, can you tell</p> <p>15 why the tests were ordered and what information you</p> <p>16 expected to get back that would assist you in reaching a</p> <p>17 diagnosis as to the ideology of the patient's problems?</p> <p>18 A. Well, name a lab or a test, and I'll --</p> <p>19 Q. Sure. You went down the list of tests and you</p> <p>20 were referring to something, can we do it that way? For</p> <p>21 instance, I think you started with Troponin --</p> <p>22 A. Troponin, that's just to see if he had a heart</p> <p>23 attack.</p> <p>24 Q. Okay.</p> <p>25 A. The C.B.C. would be to see if he has an</p>	<p style="text-align: right;">Page 49</p> <p>1 And finally the CAT scan to basically confirm any</p> <p>2 abnormality, or better define any abnormality you see on</p> <p>3 the chest x-ray, because some things are there but you</p> <p>4 really can't see or appreciate well on a chest x-ray.</p> <p>5 Q. Would you indicate for us, Doctor, what the</p> <p>6 results were of these tests and when the results came</p> <p>7 in?</p> <p>8 A. At 18:00 hours his Troponin was recorded here</p> <p>9 as negative. His BNP is registered as I think 189 --</p> <p>10 187 which would be normal under these circumstances.</p> <p>11 Q. What time was that?</p> <p>12 A. At 18:00 hours. His blood gas, it says here</p> <p>13 17:50, between 17:50 and 18:07 hours, his blood gas came</p> <p>14 back and his oxygen supply was changed from four liters</p> <p>15 to a 50 percent Venturi mask.</p> <p>16 Those are the only lab results I see on this</p> <p>17 document here on this page.</p> <p>18 Q. When you referenced the page, what page --</p> <p>19 what is the number of the page you're referencing?</p> <p>20 A. You'd have to show --</p> <p>21 Q. Okay, it's not stamped.</p> <p>22 A. The Emergency Department Ledger, if you have a</p> <p>23 copy of that. The page right after that one.</p> <p>24 MR. TABER: It should be 0046, probably</p> <p>25 in your set.</p>

<p style="text-align: right;">Page 50</p> <p>1 MS. SEVERYN: Donna, could you go ahead 2 and mark this document, I think we are at 14. 3 (Thereupon, Exhibit Number 14 was marked for 4 identification) 5 BY MS. SEVERYN: 6 Q. Doctor, directing your attention to what's 7 been marked as Plaintiff's Exhibit 14, is that document 8 that you just referred to and read the results for, the 9 Troponin, the BNP, and the blood gases? 10 A. Yes, ma'am. 11 Q. With regard to other tests that were ordered, 12 can you tell us what the results of those tests were? 13 A. I don't know what time they were made 14 available, but as I recall the chest x-ray was normal -- 15 MR. TABER: Which one do you want to do 16 first? 17 MS. SEVERYN: Whatever the Doctor is 18 comfortable with. 19 THE WITNESS: The chest x-ray. That was 20 read, by Dr. Belhobek, B-E-L-H-O-B-E-K. 21 BY MS SEVERYN: 22 Q. Is there a time referenced on the report? 23 A. On the bottom it says finalized on 01/25/03, 24 7:44 p.m. 25 Q. Okay, what about the remaining tests? The</p>	<p style="text-align: right;">Page 52</p> <p>1 aneurysm repair? 2 A. Right. 3 Q. What affect would the fact that he had surgery 4 have on this result? 5 A. It would falsely elevate the result. 6 Q. So is it fair to say that this test result, 7 the D-dimer didn't really give you any useful 8 information in treating this patient? 9 A. Right. 10 Q. What other test results came in and what were 11 the results? 12 A. His hemoglobin was 9 and 28. 13 Q. What does that result suggest to you? 14 A. It suggests that he had a surgery. 15 Q. Again, was there anything about that result 16 that would any way assist you to figure out what was 17 going on with Mr. Stansbury? 18 A. No. His blood gas. 19 Q. What was the result of that? 20 A. He had a PO2 of 59, a pH of 7.48 on four 21 liters of nasal cannula. 22 Q. Is that a normal or abnormal result? 23 A. That's an abnormal result. 24 Q. What information would that have conveyed to 25 you regarding this patient's condition?</p>
<p style="text-align: right;">Page 51</p> <p>1 C.B.C. the Chem.8 -- 2 A. I don't know what time those were made 3 available. I'd have to look through and find the 4 results. 5 The D-dimer was valued at 10,940, but I don't know 6 what time that was made available. 7 Q. What does that result mean to you? 8 A. It's a fibrin and split product, suggestive of 9 a clotting process going on and a degradation process 10 going on. 11 Q. Would you consider that result abnormal? 12 A. Markedly. 13 MR. TABER: For this patient? 14 THE WITNESS: No, not for this patient, 15 but as far as your normal value, it would be 16 abnormal. 17 BY MS. SEVERYN: 18 Q. So it's markedly abnormal for -- 19 A. For you it would be markedly abnormal. 20 Q. And why is it not markedly abnormal or why was 21 it not markedly abnormal for Mr. Stansbury? 22 A. Well, it would not be markedly abnormal for 23 Mr. Stansbury because he had had surgery. 24 Q. All right. How would the surgery that he had 25 -- and I take it that you're referring to the aortic</p>	<p style="text-align: right;">Page 53</p> <p>1 A. That he was hypoxic. 2 Q. And does that suggest to you a lack of oxygen? 3 A. Yes, ma'am. 4 Q. Does it help you to determine the cause of his 5 problems that day? 6 A. No, ma'am. 7 Q. What other test results came back? 8 A. His -- let's see his Chem.8, I'm sorry KP-7. 9 Q. All right. And what is the result of that? 10 A. It shows his creatinine was 1, B.U.N. was 17, 11 potassium was low normal, 3.9. 12 Q. Are those findings in any way abnormal? 13 A. Not really. 14 Q. So was there anything about this test or the 15 results that in any way assisted you, in again 16 determining what was going on with Mr. Stansbury that 17 day? 18 A. No, ma'am. 19 Q. With regard to any of the other tests that 20 were ordered, was there any information on any of those 21 other tests that you obtained that in any way helped you 22 either determine what was going on with this patient, or 23 rule out for certain some of the problems that you had 24 been considering? 25 MR. TABER: Well, you can answer if you</p>

<p style="text-align: right;">Page 54</p> <p>1 want, but the form is defective. I'm not 2 clear what other tests you're referring to. 3 BY MS. SEVERYN: 4 Q. Well, any of the other tests that we haven't 5 talked about. I mean there was -- let's make it global 6 then. Out of the tests that you ordered, which of these 7 tests, and the results that came back, actually helped 8 you either come up with a diagnosis, or rule out some of 9 the differential diagnoses you had been considering? 10 A. Well the EKG did not show that he was having a 11 heart attack. The chest x-ray was interpreted as clear, 12 so the hypoxia demonstrated on his blood gas was not due 13 to a pneumonia, that we could see any way, pleural 14 effusion, or pneumothorax. 15 Q. All right. By the time you got the EKG you -- 16 is it fair to say you were able to rule out a heart 17 attack? 18 A. Well, with some certainty, yes. 19 Q. And once you had the results of the chest 20 x-ray, is it fair to say you were able to rule out 21 pneumonia, pleural effusion -- and what else? 22 A. Pneumothorax. 23 Q. You were able to basically rule out all three 24 of those once that chest x-ray came in; is that correct? 25 A. Yes, ma'am.</p>	<p style="text-align: right;">Page 56</p> <p>1 A. That's the one test that would have confirmed 2 the chest x-ray and help make a diagnosis. 3 Q. And I believe you've already told us that you 4 ordered a CT scan initially, it was one of the tests 5 that you ordered shortly after speaking with and 6 examining Mr. Stansbury? 7 A. Yes, ma'am. 8 Q. What does the standard of care require with 9 respect to the time in which a CT scan is performed, if 10 it's being performed through the emergency room? 11 A. I would imagine that's a local type of 12 phenomenon. 13 Q. What does that mean? 14 A. Well, if you have an emergency department in I 15 would imagine the upper peninsula, and you have a volume 16 of maybe 6,000 patients a year, I would anticipate you 17 should be able to get a CAT scan almost immediately. If 18 you're in a large teaching urban center, it would 19 probably take longer to obtain your CAT scan, depending 20 on the number of patients presenting that day, the 21 traffic in the E.D. the number of critical patients 22 upstairs, and the physicians who need to utilize that 23 resource for whatever reason. 24 Q. Let's talk about the Cleveland Clinic 25 Foundation then. Would you describe that then as a</p>
<p style="text-align: right;">Page 55</p> <p>1 Q. What other test results helped you to either 2 come up with a diagnosis or to rule out one of the 3 differential diagnoses you'd been considering? 4 A. At this point the thing that he -- the thing 5 that was missing was a CAT scan of his chest. 6 Q. And what -- strike that. What information 7 were you anticipating you would obtain from the CAT 8 scan? 9 A. Well, it would confirm that the x-ray was 10 indeed interpreted correctly and that let us look -- it 11 would indicate whether he had a pulmonary embolism or 12 not. 13 Q. And of course a P.E. is one of the things 14 that you had been considering on the differential 15 diagnosis? 16 A. Yes. 17 Q. And certainly it would have been one of the 18 things you'd been considering, especially from the 19 history, you had a patient that was 12 days post-op; 20 correct? 21 A. Yes, one of the things you would need to 22 consider. 23 Q. Other than the CT scan, are there any of these 24 tests that you've already told us about that would have 25 given you any information relative to the P.E.?</p>	<p style="text-align: right;">Page 57</p> <p>1 large urban hospital? 2 A. Yes, ma'am. 3 Q. Do you have an opinion as to the time frame, 4 that is mandated by the standard of care, in which to 5 obtain a CT scan for an emergency-room patient suspected 6 of a pulmonary embolism? 7 MR. TABER: Objection, over broad. Go 8 ahead. 9 THE WITNESS: I do not -- I'm not certain 10 what you're referring to. 11 BY MS. SEVERYN: 12 Q. I'm referring to this patient, Mr. Stansbury. 13 Let's assume that we're going back to the date of 14 January 25, 2003, which is the date of the treatment 15 that was rendered to him -- 16 A. Yes. 17 Q. -- at the Cleveland Clinic Foundation. 18 A. Right. 19 Q. Going back to that time and that hospital, 20 what was the standard of care, in your opinion, Doctor, 21 to a reasonable degree of medical certainty, as to how 22 quickly a CT scan should have been performed on that 23 patient. 24 MR. TABER: Same objection. 25 MS. HENRY: Join --</p>

<p style="text-align: right;">Page 58</p> <p>1 THE WITNESS: Well, we try to obtain the</p> <p>2 CT scan as soon as it's possible.</p> <p>3 BY MS. SEVERYN:</p> <p>4 Q. Going back to the Life Flight in this case, I</p> <p>5 think we can all agree that the patient was life</p> <p>6 flighted in by the Metro Life Flight Service; correct?</p> <p>7 A. Yes.</p> <p>8 Q. And is it fair to say that when he was life</p> <p>9 flighted there was information conveyed that the patient</p> <p>10 needed emergency care?</p> <p>11 MR. TABER: Objection.</p> <p>12 THE WITNESS: Well, one would assume</p> <p>13 if a patient is being life flighted that he</p> <p>14 is in need of emergency care.</p> <p>15 BY MS. SEVERYN:</p> <p>16 Q. Let me direct your attention to what's already</p> <p>17 been marked and identified as Exhibit 1. You had</p> <p>18 indicated on the record that you believe you had seen a</p> <p>19 third of those documents, which is CCF 0248. Can you</p> <p>20 read for you us in the middle of that page reason for</p> <p>21 critical care transfer?</p> <p>22 A. "To prevent patient's health being placed in</p> <p>23 serious jeopardy. To prevent serious impairment to</p> <p>24 bodily functions. To prevent serious disfunction being</p> <p>25 caused to any bodily organ or part".</p>	<p style="text-align: right;">Page 60</p> <p>1 chart, the vital signs were stable also.</p> <p>2 Q. Would you tell us from the record at</p> <p>3 approximately what time the CT scan was performed on</p> <p>4 Mr. Stansbury at the Clinic?</p> <p>5 A. I cannot tell you what time it was performed.</p> <p>6 I can only tell you when he left the department to</p> <p>7 obtain to have a CAT scan performed, and what time he</p> <p>8 returned from CAT scan.</p> <p>9 Q. Okay, Doctor, let me direct your attention to</p> <p>10 what has been premarked as Plaintiff's Exhibit 8. Is</p> <p>11 that the document that you're referring to?</p> <p>12 A. Yes, ma'am.</p> <p>13 Q. All right. So what time did Mr. Stansbury</p> <p>14 leave to go for a CAT scan?</p> <p>15 A. 19:27.</p> <p>16 Q. When did he come back?</p> <p>17 A. 20:15.</p> <p>18 Q. Now. One thing that's curious about that</p> <p>19 there's still a reference at 19:35; correct?</p> <p>20 A. Yes.</p> <p>21 Q. What does that reference mean to you?</p> <p>22 A. That his Heplock number 20 in the left was</p> <p>23 located in the upper forearm.</p> <p>24 Q. What is that H-L?</p> <p>25 A. Heplock.</p>
<p style="text-align: right;">Page 59</p> <p>1 Q. And what does it say below that at Section 1?</p> <p>2 A. "Needs emergent definitive cardiac care.</p> <p>3 Needs emergent operative care".</p> <p>4 MR. TABER: Just so the record is clear,</p> <p>5 the court reporter should have that in quotes,</p> <p>6 because he was reading off a piece of paper</p> <p>7 that he was asked to read.</p> <p>8 What page is that again?</p> <p>9 THE WITNESS: That's CCF 0248. And this</p> <p>10 is a Physician Certification for Transport</p> <p>11 Report, but I don't know -- Ginny --</p> <p>12 G-I-N-N-Y, G-U-J-R-A-L.</p> <p>13 BY MS. SEVERYN:</p> <p>14 Q. Would you agree, Dr. Aponte, that</p> <p>15 Mr. Stansbury needed emergency care when he was</p> <p>16 transported to the Cleveland Clinic Foundation?</p> <p>17 A. Well, I came to that conclusion once I saw the</p> <p>18 patient myself.</p> <p>19 Q. Okay. How would you characterize the nature</p> <p>20 of his condition? Was he in severe distress? Was he</p> <p>21 stable? Was he critical?</p> <p>22 A. Well, when I saw him myself he appeared to be</p> <p>23 stable. He was not hypoxic. He was able to speak in</p> <p>24 full sentences. He was able to hold a conversation with</p> <p>25 me. And if I recall correctly, I'd have to refer to the</p>	<p style="text-align: right;">Page 61</p> <p>1 Q. What is a Heplock?</p> <p>2 A. That is an intravenous catheter that's placed</p> <p>3 on a patient for vascular access.</p> <p>4 Q. Based upon the fact that there's that</p> <p>5 reference at 19:35, does that suggest to you that the</p> <p>6 patient is still in Room 17 at that time?</p> <p>7 A. No, ma'am.</p> <p>8 Q. All right, it does not?</p> <p>9 A. No. It just tells me that that's the time</p> <p>10 that they recorded that entry.</p> <p>11 Q. Does that entry suggest to you that an I.V.</p> <p>12 was placed on the patient?</p> <p>13 A. Not necessarily.</p> <p>14 Q. Okay. Do you have any information as to</p> <p>15 whether or not this patient was -- strike that.</p> <p>16 Did you read the deposition of Mrs. Stansbury in</p> <p>17 this case?</p> <p>18 A. No, ma'am.</p> <p>19 Q. Are you aware that according to her</p> <p>20 deposition, Mr. Stansbury was taken to CT and brought</p> <p>21 back immediately because the I.V. was misplaced for</p> <p>22 purposes of the CT scan?</p> <p>23 MR. TABER: Objection.</p> <p>24 THE WITNESS: No, I was not aware of</p> <p>25 that.</p>

1 BY MS. SEVERYN:

2 Q. You were at the Clinic for what, approximately
3 nine years?

4 A. Approximately.

5 Q. Was there a requirement as to the placement of
6 an I.V. for a CT scan of the nature that Mr. Stansbury
7 had?

8 A. What I'm familiar with is that the -- the I.V.
9 or the Heplock should be close to I think the elbow, but
10 you would have to talk to radiology about that.

11 Q. Do you recall any time or instance where a
12 patient was returned from a CT because the Heplock was
13 not in the proper location and so they weren't able to
14 do the CT scan?

15 A. Not at this time.

16 Q. Do you know one way or another as to whether
17 that happened in this case?

18 A. I'm not aware of that happening in this case.

19 Q. Okay and is there anything curious to you that
20 there's an entry at 19:35 at Room 17 when the patient
21 left at 19:27 for the CAT scan?

22 A. Well it seems awkward, but whoever wrote it in
23 you'll have to talk to them about it. It doesn't mean
24 -- as I said, to me that just indicates the time when
25 they made an entry. It could be an afterthought, I

1 don't know.

2 Q. Could it also mean the patient was back in the
3 room and there was something that was being done with
4 regard to that Heplock?

5 A. It could mean anything you want it to mean I
6 would imagine.

7 Q. Do you recognize the initials at that entry?

8 A. No.

9 Q. You did indicate for us that the patient came
10 back from the CT scan at 20:15; correct?

11 A. That's what the record reflects, yes.

12 Q. When did you first learn the results of the CT
13 scan?

14 A. I have no independent recollection of that. I
15 mean I don't know exactly what time that was.

16 Q. Typically, how do you learn about the results
17 of a CT scan if those results are abnormal?

18 A. Several modalities, when the patient returns,
19 the transporting personnel can inform us, the
20 radiologist may, if it's slow enough, he may be able to
21 call us and give us an idea as to what he saw and what
22 he's going to be transcribing, you know, interpretation
23 and that's basically those two methods.

24 Q. Is it fair to say that at some point you did
25 obtain the results of the CT scan in this case?

1 A. Yes, ma'am.

2 Q. Let me direct your attention, Doctor, to what
3 has been marked as Plaintiff's Exhibit 7. Can you
4 identify that document for the record?

5 A. Deposition Exhibit Number 7, CCF 0305.

6 Q. What is that document?

7 A. This is the result of a CT chest with
8 contrast.

9 Q. Is this the report from the CT scan that we're
10 talking about?

11 A. Yes, ma'am.

12 Q. There's a number -- excuse me, a time up on
13 top, just above that line 7:58 p.m.; do you see that?

14 A. Yes, ma'am.

15 Q. Do you have any information as to what that
16 time references?

17 A. No. I don't know if that's when the test was
18 started or when it was completed.

19 Q. All right. So you don't know one way or the
20 other what the time specifically refers to?

21 A. Right.

22 Q. But we do know that he was back in Room 17 at
23 20:15?

24 A. Yes.

25 Q. And at least according to one of the entries

1 we know he left at 19:27?

2 A. Yes.

3 Q. All right. And we know you received
4 information about this CT scan; correct?

5 A. Yes.

6 Q. But we don't know how or when?

7 A. I know it was verbal.

8 Q. Okay.

9 A. But I don't know if it was telephonically or
10 the radiologist or the nursing personnel coming back
11 saying yes, they read it out as a positive CT.

12 Q. When you say positive CT, you mean it's
13 abnormal?

14 A. Yes, ma'am.

15 Q. What is abnormal about the CT?

16 A. There are -- I'm quoting. "There are large
17 thrombi within the right pulmonary artery, and the
18 proximal branches of both lower lobes pulmonary
19 arteries. They are probably new since the prior
20 examination of 1/16/03. Ill defined filling defects
21 within the inferior vena cava cannot be excluded. There
22 are small thrombi with the left upper lobe pulmonary
23 artery branches. The patient is status post median
24 sternotomy. There has been improvement of the chest
25 wall subcutaneous emphysema. There is a persistent

<p style="text-align: right;">Page 66</p> <p>1 small pericardial effusion/pericardial thickening with 2 fluid seen surrounding the ascending aorta with probably 3 a graft within the ascending aorta. I suggest clinical 4 correlation. There is very small residual amount of air 5 within the mediastinum. There is no definitive 6 abnormality involving the lungs, although this somewhat 7 limited examination due to motion artifact. A small 8 sebaceous cyst is seen in the upper posterior right 9 chest wall". 10 Q. All right. Is it fair to say that the CT scan 11 was positive for pulmonary emboli? 12 A. Yes, ma'am. 13 Q. Do you recall if you at any time reviewed the 14 results of the CT scan that was done on January 16th? 15 A. No, ma'am. 16 Q. Do you know if any information was conveyed to 17 either nursing or the radiologist regarding the prior 18 result on January 16th? 19 A. I cannot recall at this time. 20 Q. What did this report tell you? 21 A. That Mr. Stansbury had bilateral pulmonary 22 embolism. 23 Q. And again, is it fair to say that they were 24 large or at least some of those were large emboli? 25 A. Well, it was interpreted as large thrombi</p>	<p style="text-align: right;">Page 68</p> <p>1 Q. At the Cleveland Clinic at 17:33. 2 A. Right. 3 Q. All right, and this CT scan we had the patient 4 arriving back to the room at 20:15? 5 A. Right. 6 Q. We have the patient leaving -- well, we don't 7 know for sure when he left, but there is a reference in 8 the CT at I believe 7:58, that time reference we talked 9 about in Exhibit 7. 10 MR. TABER: What -- 11 MS. SEVERYN: I said there's just a time 12 reference in that Exhibit 7 as to 7:58. 13 MR. TABER: Oh, right. 14 THE WITNESS: Meaning what? 15 MS. SEVERYN: We don't know what it is. 16 MR. TABER: That's -- sorry. 17 MS. SEVERYN: That's okay. 18 BY MS. SEVERYN: 19 Q. Do you have a professional opinion, a medical 20 opinion based to reasonable degree of medical certainty, 21 as to whether or not the CT scan was performed in a 22 timely fashion in this case? 23 A. It was performed in a timely fashion in this 24 case, and in general, I would say this is -- this -- 25 anywhere this was performed in a timely fashion.</p>
<p style="text-align: right;">Page 67</p> <p>1 within the right pulmonary artery. 2 Q. I know you indicated -- strike that. You 3 recall the information about this CT was communicated to 4 you verbally or orally, but you don't recall if it was 5 from the radiologist or nursing; is that correct? 6 A. Yes. 7 Q. It would have been one or the other typically? 8 A. Yes. 9 Q. Again, you were at the Clinic for 10 approximately nine years, if the radiology department is 11 interpreting a positive CT like the one at issue here, 12 do they typically pick up the telephone and call you 13 with regard to those results? 14 A. Yes. 15 Q. But you don't know if that's what happened in 16 this case? 17 A. It's -- I don't recall. 18 Q. All right. Now, if we go back to the 19 information regarding the timing, I believe you 20 indicated early on that the patient was admitted to 21 Cleveland Clinic Foundation at 17:33? 22 A. I'm sorry, say that again? He was admitted to 23 where? 24 Q. Excuse me, received. 25 A. Oh, yeah.</p>	<p style="text-align: right;">Page 69</p> <p>1 Q. Is it fair to say that any order for testing 2 through emergency is being done on a STAT basis? 3 A. It's safe to say that, yes. 4 Q. And that would be a true statement? 5 A. I think that's the medical health care system 6 as I know it in this Country, that would be a safe 7 assumption in just about any hospital that I've ever 8 been to. 9 Q. Okay, and it certainly would be a true 10 statement as to the Cleveland Clinic Foundation? 11 A. Yes, ma'am. 12 Q. When the test results came back from the CT 13 scan, what did you do to initiate treatment? 14 A. Once we obtained the test results we contacted 15 cardiothoracic surgery and cardiology and informed them 16 of the results. At that point in time they requested 17 that I initiate a treatment with Heparin, which was I 18 wrote the order, and I wrote the admission order. 19 MS. HENRY: What did you say? I wrote 20 the order and what else? 21 THE WITNESS: The admission order. 22 MS. HENRY: Thank you. 23 MS. SEVERYN: Off the record. 24 (Thereupon, an off the record discussion was held.) 25 BY MS. SEVERYN:</p>

<p style="text-align: right;">Page 70</p> <p>1 Q. Back on the record. Doctor, directing your 2 attention to what has been previously marked and 3 identified as Exhibit 4, do you see that document? 4 A. Yes, ma'am. 5 Q. What is that document? 6 A. This is the transcription of the Emergency 7 Department Report. 8 Q. Who prepared this document? 9 A. Michael Cudnik, MD, C-U-D-N-I-K. 10 Q. Who was Michael Cudnik, MD, on 11 January 25, 2003? 12 A. He was a resident from MetroHealth Medical 13 Center who was rotating through the emergency department 14 at the Cleveland Clinic Foundation and was present in 15 taking care of the patient with me. 16 Q. I think you've stated that Dr. Cudnik actually 17 prepared the report? 18 A. He dictated this report. 19 Q. And I do note at the top that it was 20 authenticated by you? 21 A. Yes, ma'am. 22 Q. And what does authenticated mean? 23 A. That means that I read the report and signed 24 the report. 25 Q. Essentially, that means you agreed to it, you</p>	<p style="text-align: right;">Page 72</p> <p>1 his labs were obtained and sent off, and as the labs 2 were made available he would interpret them and inform 3 me if there was anything grossly abnormal, given the 4 circumstances of this patient. 5 Q. Do you recall having discussions with 6 Dr. Cudnik about Mr. Stansbury that evening? 7 A. Yes. 8 Q. What are your recollections about that? 9 A. Well, after we had evaluated him we discussed 10 the differential diagnosis and the approach to the 11 patient. At that point in time, I asked him to contact 12 cardiology and cardiothoracic surgery to inform them 13 that this patient was in the department and within our 14 institution and for them to offer us any information or 15 any advice as we evaluated this patient. 16 Q. Actually, that brings me to my next question. 17 Let me direct your attention to that Exhibit 7 that's in 18 front of you -- did I say -- Exhibit 4, excuse me. 19 A. Yes. 20 Q. If you would turn to the second page, there's 21 a reference there about two thirds down the page, the 22 patient will be signed out to Doctor -- is it Disch? 23 A. Disch. 24 Q. Who is Dr. Disch? 25 A. He's a resident -- he was a resident rotating</p>
<p style="text-align: right;">Page 71</p> <p>1 agreed with its contents? 2 A. Yes, ma'am. 3 Q. Let's talk a little bit about Dr. Cudnik's 4 role in the treatment of Mr. Stansbury on 5 January 25, 2003. What was Dr. Cudnik's role as a 6 resident in the treatment of Mr. Stansbury? 7 A. He was the resident who was assisting in the 8 managing of the patient. 9 Q. Was the overall responsibility for the care 10 and treatment of Mr. Stansbury at all times upon you? 11 A. Yes, ma'am. 12 Q. Okay. So you were essentially supervising 13 Dr. Cudnik? 14 A. Yes, ma'am. 15 Q. So when you say that Dr. Cudnik was 16 responsible for assisting in the management of 17 this patient you're talking -- you're not putting him on 18 par with you, in terms of responsibility with you in 19 terms of management? 20 A. Right. 21 Q. What treatment did Dr. Cudnik render to 22 Mr. Stansbury during that emergency visit on 23 January 25, 2003? 24 A. He would check on the patient's periodical, 25 ensure that I.V. O2 monitor were initiated, that</p>	<p style="text-align: right;">Page 73</p> <p>1 through the department of emergency medicine of the 2 Cleveland Clinic Foundation. 3 Q. What does that entry mean to you? 4 A. That means with respect to this patient to 5 expect Dr. Disch to report back to me on the condition 6 of the patient or the labs obtained, et cetera. 7 Q. What was Dr. Cudnik's role after this patient 8 was assigned to Dr. Disch? 9 A. He was no longer involved with the care. 10 Q. Do you recall speaking with Dr. Disch on 11 January 25, 2003 about this patient? 12 A. Yes. 13 Q. At what point in the care, if you can recall, 14 did Dr. Cudnik end his involvement and Dr. Disch begin 15 his involvement in Mr. Stansbury's care? 16 A. That would be approximately 19:00 hours, 17 because that's the time when they would change shifts. 18 Q. All right. So going back to that second page 19 of Exhibit 4, there's also a reference that cardiology 20 and cardiothoracic surgery were consulted; do you see 21 that? 22 A. Yes, ma'am. 23 Q. Do you have a recollection as to who actually 24 consulted cardiology and cardiothoracic? 25 A. That would have been Michael Cudnik, Dr.</p>

<p style="text-align: right;">Page 74</p> <p>1 Cudnik.</p> <p>2 Q. Did you personally ever speak with either the</p> <p>3 cardiologist that was consulted or the cardiothoracic</p> <p>4 specialist that was consulted?</p> <p>5 A. Yes.</p> <p>6 Q. At what point did you speak with either of</p> <p>7 them?</p> <p>8 A. That I cannot recall.</p> <p>9 Q. Which one did you speak with?</p> <p>10 A. I would imagine both. I don't have a specific</p> <p>11 recollection, but I know that I had spoken with them.</p> <p>12 Q. Is there any note that you would have made in</p> <p>13 the chart with regard to those conversations?</p> <p>14 A. No, ma'am.</p> <p>15 Q. So you don't have any specific recollection of</p> <p>16 speaking to the cardiologist or the cardiothoracic</p> <p>17 specialist in this case?</p> <p>18 MR. TABER: Objection --</p> <p>19 THE WITNESS: I just told you the direct</p> <p>20 opposite. I did speak with them, I just don't</p> <p>21 have a specific time that I can tell you I</p> <p>22 spoke with them.</p> <p>23 BY MS. SEVERYN:</p> <p>24 Q. All right. So you do have an independent</p> <p>25 recollection of having spoken with both specialists?</p>	<p style="text-align: right;">Page 76</p> <p>1 cardiothoracic surgery and cardiology contacted and have</p> <p>2 them made aware of who this person was, and that he was</p> <p>3 here, and what the situation was that we were facing.</p> <p>4 Q. All right, let me --</p> <p>5 A. They may have called back again, if I put out</p> <p>6 a call like that and the resident is unavailable, I'm</p> <p>7 more than happy to pick up the phone and help a</p> <p>8 resident out by talking to the consultant, giving them</p> <p>9 the gist of what's going on and just take it from there.</p> <p>10 Q. All right. In this particular case, do you</p> <p>11 know who initially contacted cardiology and or</p> <p>12 cardiothoracic?</p> <p>13 A. Well, what do you mean by who specifically?</p> <p>14 We usually just ask the secretary to consult the</p> <p>15 service. So for the physician or to the secretary who</p> <p>16 was sitting down, because no matter who -- I could have</p> <p>17 told a nurse to contact services and they would have</p> <p>18 relayed that information to the secretarial services and</p> <p>19 that consult would have been put forward.</p> <p>20 Q. Typically, how do you do it?</p> <p>21 A. Exactly as I just described it. I can ask a</p> <p>22 nurse. I can ask a technician. I could tell the</p> <p>23 secretary. I can ask the resident. I can ask anyone</p> <p>24 there, because basically it's a group effort, a group</p> <p>25 function to obtain what we need for the patient.</p>
<p style="text-align: right;">Page 75</p> <p>1 A. I have an independent recollection that I</p> <p>2 spoke with them, because I had asked them to be</p> <p>3 contacted. And I recall being on the phone and</p> <p>4 discussing Mr. Stansbury with someone, but when that</p> <p>5 occurred I cannot tell you.</p> <p>6 Q. All right. This recollection that you have of</p> <p>7 being on the phone and speaking with someone, do you</p> <p>8 have a recollection as to whom you spoke with?</p> <p>9 A. No.</p> <p>10 Q. So you spoke with someone, is that a one</p> <p>11 someone or multiple someones?</p> <p>12 A. I can't tell.</p> <p>13 Q. Going back to my question, do you have any</p> <p>14 independent recollection as to whether you spoke at any</p> <p>15 time with a cardiologist that was consulted about</p> <p>16 Mr. Stansbury?</p> <p>17 MR. TABER: Objection --</p> <p>18 THE WITNESS: You'll have to define</p> <p>19 independent recollection, because I recall</p> <p>20 speaking to actually several people about</p> <p>21 Mr. Stansbury. Who they were, and what we</p> <p>22 talked about, I can't tell you exactly.</p> <p>23 BY MS. SEVERYN:</p> <p>24 Q. All right.</p> <p>25 A. But I know it was my intention to have</p>	<p style="text-align: right;">Page 77</p> <p>1 Q. All right. And you're going to ask someone to</p> <p>2 do what?</p> <p>3 A. Contact cardiothoracic, whoever is on call for</p> <p>4 cardiothoracic and cardiology service.</p> <p>5 Q. In this case do you know who initially spoke</p> <p>6 with either cardiology or cardiothoracic?</p> <p>7 A. It may have been me, it may have been Michael,</p> <p>8 I don't know.</p> <p>9 Q. But you don't know?</p> <p>10 A. No.</p> <p>11 Q. All right. And again, when I'm talking about</p> <p>12 independent recollection, I'm talking about your memory</p> <p>13 versus your reliance on a document; okay?</p> <p>14 A. Right, okay.</p> <p>15 Q. Do you have any knowledge as to what</p> <p>16 information was conveyed to cardiology about the</p> <p>17 patient?</p> <p>18 A. If I had spoken with them that this is a</p> <p>19 patient who was life flighted in, had this aortic repair</p> <p>20 and is complaining of chest pain and shortness of</p> <p>21 breath.</p> <p>22 Q. Did you have any knowledge at the time that</p> <p>23 the patient came in as to when that aortic repair had</p> <p>24 taken place?</p> <p>25 A. My understanding was that it was about a week</p>

<p style="text-align: right;">Page 78</p> <p>1 earlier.</p> <p>2 Q. Do you have any knowledge as to what</p> <p>3 information was conveyed to cardiothoracic about this</p> <p>4 patient?</p> <p>5 A. If I had spoken with them, I would have told</p> <p>6 them that this was a patient who had this procedure, who</p> <p>7 presented to the E.D. complaining of chest pain and</p> <p>8 shortness of breath.</p> <p>9 Q. But again, we don't know who initially</p> <p>10 contacted them or --</p> <p>11 A. Right.</p> <p>12 Q. -- how they were contacted?</p> <p>13 A. Well, we know how they were contacted, the</p> <p>14 secretarial support was asked to generate a consult.</p> <p>15 Q. All right, so it always starts there?</p> <p>16 A. Right.</p> <p>17 Q. There is a reference on Page 2 of Exhibit 4,</p> <p>18 following what we've already looked at, cardiothoracic</p> <p>19 wished to be called when patient returned from a CT of</p> <p>20 the chest, and before Heparin was to be started on the</p> <p>21 patient. Do you see that note?</p> <p>22 A. Yes, ma'am.</p> <p>23 Q. Do you recall whether this information was</p> <p>24 conveyed to you at any time during your treatment of</p> <p>25 this patient on January 25, 2003?</p>	<p style="text-align: right;">Page 80</p> <p>1 indication.</p> <p>2 Q. What's the contraindication that you're</p> <p>3 referencing?</p> <p>4 A. Well, usually major surgery, you try not to</p> <p>5 give lytics or an anticoagulate to someone who has had</p> <p>6 major surgery.</p> <p>7 Q. Assuming hypothetically that you had a patient</p> <p>8 come in with the same reported symptoms as</p> <p>9 Mr. Stansbury, the shortness of breath, the chest pain,</p> <p>10 but no history of having had a surgery at any immediate</p> <p>11 point in time, would your treatment of this patient have</p> <p>12 been any different under those circumstances?</p> <p>13 MR. TABER: Objection, hypothetical,</p> <p>14 contrary in facts and nothing to do with this</p> <p>15 case and totally irrelevant.</p> <p>16 MS. SEVERYN: You can go --</p> <p>17 THE WITNESS: Throw me a hint here, what</p> <p>18 do I do now?</p> <p>19 MS. SEVERYN: You answer.</p> <p>20 MR. TABER: Well, you don't have to</p> <p>21 answer. If that has anything to do with this</p> <p>22 case go ahead, but if it doesn't, I don't know</p> <p>23 why we're wasting time on a hypothetical</p> <p>24 that's clearly contrary to the facts by</p> <p>25 anyone's assertion. It's totally irrelevant</p>
<p style="text-align: right;">Page 79</p> <p>1 A. What information?</p> <p>2 Q. The information I just read, that</p> <p>3 cardiothoracic wished to be called when the patient</p> <p>4 returned from the CT scan and before Heparin was</p> <p>5 started?</p> <p>6 A. Yes, we knew that -- my global recollection</p> <p>7 in managing Mr. Stansbury was we have to wait to get</p> <p>8 the CAT scan result, and then contact the consultants</p> <p>9 again.</p> <p>10 Q. Do you know why cardiothoracic wanted to</p> <p>11 wait for the CT scan results prior to administering</p> <p>12 Heparin?</p> <p>13 MR. TABER: Go ahead.</p> <p>14 THE WITNESS: You would have to ask</p> <p>15 them, but I would assume that it was because</p> <p>16 of the nature of the surgery he had had a</p> <p>17 week earlier.</p> <p>18 BY MS. SEVERYN:</p> <p>19 Q. And based upon your professional opinion, what</p> <p>20 role would that surgery have with respect to whether or</p> <p>21 not he was Heparinized immediately or after CT scan</p> <p>22 results came in?</p> <p>23 Q. Again, I would assume it would be to justify</p> <p>24 the use of a drug on a patient who clearly has a</p> <p>25 contraindication and may be a life threatening</p>	<p style="text-align: right;">Page 81</p> <p>1 and need not be answered, but you can do</p> <p>2 whatever you want with it.</p> <p>3 THE WITNESS: I'll elect not to answer</p> <p>4 that question.</p> <p>5 BY MS. SEVERYN:</p> <p>6 Q. Why not?</p> <p>7 A. It's a hypothetical situation.</p> <p>8 Q. You are permitted to answer hypothetical</p> <p>9 questions, Doctor.</p> <p>10 MR. TABER: Based on the case, yes, based</p> <p>11 on some other case, no.</p> <p>12 THE WITNESS: Right, my understanding was</p> <p>13 I'm here to answer questions about what</p> <p>14 happened this evening and what we did as --</p> <p>15 I'm here to answer questions regarding what</p> <p>16 actually did happen, not theoretically</p> <p>17 what could have happened or a hypothetical</p> <p>18 situation.</p> <p>19 BY MS. SEVERYN:</p> <p>20 Q. Well, you wanted cardiothoracic involved,</p> <p>21 Doctor, why?</p> <p>22 A. Because this was a person who had had a major</p> <p>23 surgery.</p> <p>24 Q. So that fact played a role in your treatment</p> <p>25 of the patient?</p>

<p style="text-align: right;">Page 82</p> <p>1 A. Yes, ma'am.</p> <p>2 Q. Now, you've already talked earlier about,</p> <p>3 again a recollection of having spoken with someone on</p> <p>4 the telephone that you think may or may not be</p> <p>5 cardiology or cardiothoracic?</p> <p>6 A. Yes, ma'am.</p> <p>7 Q. What do you remember about what was discussed</p> <p>8 during that telephone conversation?</p> <p>9 A. Specifically, I cannot tell you, I remember I</p> <p>10 could quote him saying these things. I just know my</p> <p>11 impression on my interactions with these services.</p> <p>12 Q. All right, and what are your impressions?</p> <p>13 A. The impression was obtain the CT and then</p> <p>14 contact the service. They will decide if and when he</p> <p>15 was to be treated with Heparin.</p> <p>16 Q. Do you have any recollection of contacting the</p> <p>17 cardiothoracic specialist after the CT scan results were</p> <p>18 obtained?</p> <p>19 A. I do not recall specially speaking with him,</p> <p>20 but I have a global impression that I had spoken with</p> <p>21 them, and that decision afterwards was to go ahead and</p> <p>22 Heparinize him, but I'm not certain.</p> <p>23 Q. All right.</p> <p>24 A. I just know that the key element there was</p> <p>25 obtain the CAT scan, confirm the pulmonary embolism to</p>	<p style="text-align: right;">Page 84</p> <p>1 THE WITNESS: I'm sorry.</p> <p>2 MR. TABER: The first part I think he's</p> <p>3 answered three or four times. The second part,</p> <p>4 go ahead. I think you should clarify.</p> <p>5 THE WITNESS: Say that again, I'm</p> <p>6 sorry.</p> <p>7 BY MS. SEVERYN:</p> <p>8 Q. I'm truly not trying to trick you. I'm having</p> <p>9 a hard time understanding your recollection, from a</p> <p>10 global impression, from yes I remember. So as I</p> <p>11 understood your testimony cardiothoracic wished to be</p> <p>12 called after the CT scan. You don't have any</p> <p>13 independent recollection of talking to them, but you</p> <p>14 have this global impression that you did?</p> <p>15 A. Uh-huh.</p> <p>16 Q. Is that a fair characterization --</p> <p>17 A. Yes.</p> <p>18 MR. TABER: -- what he says, let's move</p> <p>19 on to the second part.</p> <p>20 MS. SEVERYN: I will when I understand</p> <p>21 it, thank you, Counselor.</p> <p>22 MR. TABER: Well, I will instruct him not</p> <p>23 to answer, because he has answered it more</p> <p>24 than once which is all he's required to do.</p> <p>25 It's been at least four times. I don't mean</p>
<p style="text-align: right;">Page 83</p> <p>1 justify the use of this medication, that information was</p> <p>2 relayed and a decision was made by the appropriate</p> <p>3 services. And at that point in time, I wrote the order</p> <p>4 for the Heparin to be administered, and for the patient</p> <p>5 to be admitted to the cardiology services.</p> <p>6 Q. In your opinion, Doctor, what is the risk to</p> <p>7 the patient if Heparin is administered 12 days post-op?</p> <p>8 A. Depending on the type of surgery that you</p> <p>9 have. A major surgery you may have some complications</p> <p>10 such as bleeding, surgical anastomosis.</p> <p>11 Q. Is it fair to say that a pulmonary embolism is</p> <p>12 also a life threatening -- or is a life threatening</p> <p>13 event?</p> <p>14 A. Yes, ma'am.</p> <p>15 Q. I believe we've already marked and identified</p> <p>16 Exhibit 2. You indicated that that order, that Number 1</p> <p>17 order, to administer Heparin is in your handwriting;</p> <p>18 correct?</p> <p>19 A. Yes, ma'am.</p> <p>20 Q. So I think you've mentioned you don't recall</p> <p>21 specifically speaking with cardiothoracic, but the order</p> <p>22 to initiate Heparin came from you?</p> <p>23 MR. TABER: Objection --</p> <p>24 THE WITNESS: No, specifically --</p> <p>25 MR. TABER: Hold on.</p>	<p style="text-align: right;">Page 85</p> <p>1 to interrupt, but he will not answer the same</p> <p>2 question five times, please go ahead.</p> <p>3 BY MS. SEVERYN:</p> <p>4 Q. From whatever source it is, the order to</p> <p>5 initiate Heparin is in your handwriting; is that</p> <p>6 correct?</p> <p>7 A. Yes, ma'am.</p> <p>8 Q. When was the Heparin first administered?</p> <p>9 A. I have to refer to this document here. At</p> <p>10 20:30 hours. "Patient came back at 20:15, vital signs</p> <p>11 were obtained two minutes later and at 20:30 hours</p> <p>12 Heparin was started per order".</p> <p>13 Q. What document are you referring to?</p> <p>14 A. The Continuing Care Form.</p> <p>15 MS. HENRY: Is that Exhibit 8?</p> <p>16 MS. SEVERYN: Yes, it is. I think</p> <p>17 we've already marked that as Exhibit 8.</p> <p>18 THE WITNESS: This is it.</p> <p>19 BY MS. SEVERYN:</p> <p>20 Q. Just if you would confirm that Exhibit 8 is in</p> <p>21 fact the document that you're referring to?</p> <p>22 A. Exhibit 8 is.</p> <p>23 Q. I'm reading here, Heparin started per order.</p> <p>24 There is a reference after that to cardiology. What do</p> <p>25 you understand that reference to cardiology to mean?</p>

Page 86

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

Page 87

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

Page 88

1 already formed that were documented in the CT scan
 2 report?
 3 A. To my knowledge they would not.
 4 Q. Why would a patient who has been confirmed for
 5 a pulmonary emboli, what are the treatment options for
 6 that patient?
 7 MR. TABER: Objection, over broad.
 8 THE WITNESS: With respect to what?
 9 By MS. SEVERYN:
 10 Q. Treating the patient to address the pulmonary
 11 emboli that had already formed, what are the treatment
 12 options?
 13 MR. TABER: Same objection, over broad.
 14 THE WITNESS: Well, okay, if you're
 15 talking about treating a patient with
 16 pulmonary embolism that have already formed,
 17 you treat them with Heparin.
 18 BY MS. SEVERYN:
 19 Q. But you've indicated Heparin does not effect
 20 in any way, treat the clots that have already formed?
 21 A. Right.
 22 Q. What can we do by way of treatment as to the
 23 clots that are already in place?
 24 MR. TABER: Objection, over broad.
 25 Are we talking about this guy?

Page 89

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

<p style="text-align: right;">Page 90</p> <p>1 A. What location for example?</p> <p>2 Q. Strike that. At some point in time</p> <p>3 Mr. Stansbury went into respiratory distress; correct?</p> <p>4 A. Yes.</p> <p>5 Q. Tell us what information you have about that,</p> <p>6 when did it first occur?</p> <p>7 A. According to Deposition Exhibit 8, at 20:46</p> <p>8 about 16 minutes after he got his Heparin he was</p> <p>9 complaining of severe shortness of breath, cardiology</p> <p>10 and myself were at the bedside. His pulse-ox went down</p> <p>11 to 95 on 50 percent Venturi mask. Thereafter two</p> <p>12 minutes later it was noted to have audible wheezing and</p> <p>13 his respiratory rate increased to 44 breaths per</p> <p>14 minute. His pulse-ox decreased to 83 percent on a non</p> <p>15 re-breather mask. Blood pressure was 195 over 88 and</p> <p>16 his heart rate was 113.</p> <p>17 Q. All right. I think you indicated that you</p> <p>18 were present at this time as well as cardiology?</p> <p>19 A. Yes.</p> <p>20 Q. What was done for Mr. Stansbury by way of</p> <p>21 treatment after the onset of respiratory distress?</p> <p>22 A. According to this Deposition Exhibit 8, at</p> <p>23 20:56 after re-assessing, the patient was intubated with</p> <p>24 an 8.0 endotracheal tube.</p> <p>25 Q. Can we go off the record, I need a two minute</p>	<p style="text-align: right;">Page 92</p> <p>1 Q. Who actually intubated this patient?</p> <p>2 A. I did.</p> <p>3 Q. You put the endotracheal tube in place?</p> <p>4 A. Yes, ma'am. Now, again I don't specifically</p> <p>5 recall doing that, but that's something that I would</p> <p>6 have done.</p> <p>7 Q. You wouldn't have had cardiology do it, or one</p> <p>8 of the residents on hand?</p> <p>9 A. No. I think at that time Paul and I were the</p> <p>10 only ones in the room.</p> <p>11 Q. Now, you indicated the intubation was done in</p> <p>12 part because the patient was unresponsive. What do you</p> <p>13 mean when you say unresponsive?</p> <p>14 A. He was not breathing on his own.</p> <p>15 Q. Was he still conscious?</p> <p>16 A. I don't think so.</p> <p>17 Q. Was there a point in time after the onset of</p> <p>18 respiratory distress when a code was called?</p> <p>19 A. Probably within minutes.</p> <p>20 Q. And I think this Exhibit 8 references the type</p> <p>21 of endotracheal tube that was put in place?</p> <p>22 A. Well, the size, 8.0. He was a large person.</p> <p>23 Q. Okay. What does the standard of care require</p> <p>24 to ensure that an intubation has been properly</p> <p>25 performed?</p>
<p style="text-align: right;">Page 91</p> <p>1 break.</p> <p>2 (Thereupon, there was a short recess in the</p> <p>3 proceedings.)</p> <p>4 Back on the record. At the point in time when</p> <p>5 Mr. Stansbury went into the respiratory distress, and I</p> <p>6 think you already told us you were at hand and so was</p> <p>7 cardiology?</p> <p>8 A. Yes.</p> <p>9 Q. Both of you were bedside. Who was in charge</p> <p>10 of Mr. Stansbury's care between you and the</p> <p>11 cardiologist?</p> <p>12 A. I was.</p> <p>13 Q. Right before the break, you had referred to</p> <p>14 Exhibit 8, and was answering my question regarding what</p> <p>15 treatment was initiated in response to the respiratory</p> <p>16 distress, and I believe you had indicated that 20:56 the</p> <p>17 patient was intubated; is that correct?</p> <p>18 A. Yes, ma'am.</p> <p>19 Q. What is the purpose of intubation?</p> <p>20 A. Well, the patient had become unresponsive so</p> <p>21 you have to maintain a patient's airway, you have to</p> <p>22 take control of the patient's airway. So you do that by</p> <p>23 intubating the patient, that is putting a tube into</p> <p>24 their throat, into their lungs, so that you can</p> <p>25 oxygenate the patient.</p>	<p style="text-align: right;">Page 93</p> <p>1 A. You would listen to both sides of his chest.</p> <p>2 You would look to make sure that the chest wall is</p> <p>3 rising bilaterally. You would auscultate, listen to</p> <p>4 both sides of his chest. You would look to ensure that</p> <p>5 there's a fogging of the tube. You would auscultate his</p> <p>6 epigastric region to see if there's air traveling into</p> <p>7 the stomach. You would obtain a chest x-ray after</p> <p>8 you've intubated them, and my practice has always been</p> <p>9 to the End-Tidal CO2 detector.</p> <p>10 Q. Was a chest x-ray obtained in this case?</p> <p>11 A. I don't recall.</p> <p>12 Q. Would that be typically documented somewhere</p> <p>13 in the chart?</p> <p>14 A. It would be, but I don't see anything here.</p> <p>15 Q. Would there be a report or any documentation</p> <p>16 that was generated if a chest x-ray had been done?</p> <p>17 A. It should be written down in the nurse's note</p> <p>18 and it should be Em-STAT documentation that a post</p> <p>19 intubation chest x-ray was obtained, but in his case not</p> <p>20 necessary.</p> <p>21 Q. Why not?</p> <p>22 A. I told you about a slew of things you can do</p> <p>23 to confirm it, but one of the most important is an</p> <p>24 End-Tidal Co2 detector.</p> <p>25 Q. Okay. So was a CO2 detector used in this case?</p>

<p style="text-align: right;">Page 94</p> <p>1 A. Yes. Here it says positive color change to 2 purple with CO2 detector. 3 Q. All right. What does that mean, color change? 4 A. They're yellow, and if you've intubated the 5 patient appropriately they'll change to a purple color. 6 If you're in the stomach it will stay yellow. 7 Q. Do you know the type of CO2 detector that was 8 used at the Clinic on January 25, 2003? 9 A. It's the -- the one that's the quantitative 10 type. I'm sorry the qualitative type. 11 Q. What do you mean when you say that? 12 A. It indicates a color change. They have 13 another one that will actually measure CO2 for you. 14 Q. Are there different types of CO2 detectors 15 that measure or reflect a color change? 16 A. There probably are. 17 Q. Again, your information is that the CO2 is 18 going to be yellow and if the patient is properly 19 intubated -- 20 A. -- then it will change color. 21 Q. To purple? 22 A. Yes. 23 Q. If the intubation is successful? 24 A. Yes, right. 25 Q. Are you able to describe the type of CO2</p>	<p style="text-align: right;">Page 96</p> <p>1 Q. What does that mean to you? 2 A. That means that he's got electrical activity 3 but is not generating a pulse. 4 Q. Did you do anything by way of treatment in 5 response to that? 6 A. Yes, we gave him some Epinephrine and some 7 Atropine. 8 Q. What did you give him and when? 9 A. There was one amp of Atropine given at 20:57. 10 Q. How much was given? 11 A. One amp, roughly one milligram. 12 Q. Let me direct your attention to what's been 13 premarked as Exhibit 10, can you identify that 14 document? 15 A. It's the C.P.R. Data Sheet and Emergency 16 Medical Response. 17 A. Is that one of the documents that you were 18 referring to? 19 A. Yes, ma'am. 20 Q. Where on that document does it indicate the 21 medication given? 22 A. Where it says Atropine along the top. 23 Q. Okay. 24 A. Rather at the junction between the top and 25 middle third.</p>
<p style="text-align: right;">Page 95</p> <p>1 detector that was used at the Clinic? 2 A. It's one that I've seen frequently. It's 3 clear plastic with a flat surface on top and the central 4 area is yellow. 5 Q. Are there different CO2 detectors where the 6 color change is varied? 7 A. There may be, I don't know. 8 Q. Do you use a CO2 detector now at Holmes 9 Hospital where you presently work? 10 A. Yes. 11 Q. Does that also work -- 12 A. Same one 13 Q. -- qualitative basis? 14 A. Yes. 15 Q. All right. So it is normally yellow in color, 16 and if proper intubation, that color change on the CO2 17 is to purple? 18 A. Yes. 19 Q. What else was done for Mr. Stansbury by way of 20 treatment in response to that respiratory distress? 21 A. Well, at that point in time, once you intubate 22 a patient you have to -- and resuscitate them we saw 23 that there was electrical activity on the monitor, but 24 we could not feel a pulse. So we -- well, I decided 25 he's in pulseless electrical activity.</p>	<p style="text-align: right;">Page 97</p> <p>1 Q. Okay. 2 A. The time, heart rate, and lists medications. 3 Q. So the Atropine was given at 20:57? 4 A. Yes, ma'am. 5 Q. And you said one amp is equivalent to one 6 milligram? 7 A. Yes, ma'am. 8 Q. What else was administered by way of treatment? 9 A. Epinephrine. 10 Q. What dosage was administered? 11 A. He again received one amp. 12 Q. And what was the time? 13 A. At 20:59. 14 Q. Anything else? 15 A. He was given another dose of Atropine. 16 Q. What time was that? 17 A. At 21:02. 18 Q. So about seven -- no, five minutes later? 19 A. Yes. 20 Q. Any other medications -- 21 MR. TABER: Just past the arrest -- you 22 forgot one at the time of intubation as well. 23 THE WITNESS: Well, no -- yes, those 24 are listed on Exhibit Number 2. 25 BY MS. SEVERYN:</p>

<p style="text-align: right;">Page 98</p> <p>1 Q. What medications were administered during 2 intubation? 3 A. Etomidate 30 milligrams and Lidocaine and 4 Suxamethonium. 5 Q. What is the purpose of these medications 6 during the intubation process? 7 A. It's to allow us to relax the patient so that 8 we can intubate them. 9 Q. Specifically what part of the body is being 10 relaxed? 11 A. The larynx. 12 Q. Did the patient respond to the administration 13 of the Epinephrine and the Atropine? 14 A. No, he did not. 15 Q. Did you administer any other medications in 16 addition to the two doses of Atropine and the dose of 17 Epinephrine? 18 A. He received Activase. 19 Q. Where is that noted? 20 A. That's on part of Exhibit 10 page, number 2, 21 lower right hand corner, and also on Exhibit Number 2, 22 middle of right-hand column, TPA 50 milligram bolus I.V. 23 then 50 milligram drip I.V. over two hours. 24 Q. What is Activase? 25 A. It's a thrombolytic agent in what they call a</p>	<p style="text-align: right;">Page 100</p> <p>1 activity. 2 Q. We've talked about the fact after respiratory 3 distress the patient was intubated and certain 4 medications were administered, was there anything else 5 that was done by way of treatment? 6 A. C.P.R. 7 Q. Who administered that? 8 A. I'm sure I gave the order, but who actually 9 was pressing on his chest that would depend of the type 10 of personnel that we had available. 11 Q. Where is there a reference -- okay, I take 12 that back. That Exhibit 10 references the C.P.R.; 13 correct, under significant event? 14 A. Where are you? 15 Q. I'm on page 2 of that document, Exhibit 10, 16 Significant Events column? 17 A. Right. 18 Q. Looking at the top of that page, is it 19 accurate to state that the C.P.R. was started at 20:56 20 as noted? 21 A. Yes, ma'am. 22 Q. Did the patient ever recover from the 23 deteriorating condition, the respiratory distress? 24 A. No, ma'am. 25 Q. What was the time that the patient expired?</p>
<p style="text-align: right;">Page 99</p> <p>1 clot buster. 2 Q. So that was administered I take it in response 3 to the pulmonary emboli that were noted on the scan? 4 A. No, that was administered to his clinical 5 condition deteriorating. 6 Q. Okay, to the respiratory distress? 7 A. The respiratory distress, his becoming 8 cyanotic, unresponsive, requiring intubation. 9 Q. Other than these medications that you've 10 listed, the Activase, the Epinephrine, and the Atropine, 11 were there any other medications that were administered 12 after the patient went into respiratory distress? 13 A. At this time I'd have to say no. 14 Q. There's a references on that Exhibit, under 15 the rhythm section, P.E.A., what does the P.E.A. 16 reference? 17 A. Pulseless Electrical Activity. 18 Q. All right, and that's what you had described 19 for us? 20 A. Right. 21 Q. Electrical activity but no pulse? 22 A. Right. 23 Q. There's also a reference below that to 24 asystole, what does that mean? 25 A. That means that now he has no electrical</p>	<p style="text-align: right;">Page 101</p> <p>1 A. It's noted here, 21:16 hours. 2 Q. Is there any record that would reflect 3 everyone who was present during the respiratory distress? 4 A. I would not know. 5 Q. Do you have a recollection as to who was 6 present during the respiratory distress? 7 A. I know I was there, and I know cardiology was 8 there, and I know other people were there. Again, like 9 a global sense of other bodies present, but I don't know 10 specifically. I don't recall specifically who was there. 11 Q. So as we sit here today, you don't have a 12 recollection of the nursing staff that was present? 13 A. Right. 14 Q. Who was the cardiologist who consulted in this 15 case? 16 A. Paul Showenhausen. (phonetic spelling) 17 Q. Let me direct your attention to what has been 18 premarked as Exhibit 6. Can you identify that document 19 for the record? 20 A. Deposition Exhibit Number 6, Consult Document. 21 Q. Is that the cardiologist consultation? 22 A. Yes, ma'am. 23 Q. Is there anything significant about the 24 findings in this case? 25 A. With respect to what?</p>

<p style="text-align: right;">Page 102</p> <p>1 Q. Anything significant with respect to either</p> <p>2 condition or treatment of the patient?</p> <p>3 MR. TABER: Objection, over broad.</p> <p>4 THE WITNESS: No. I'm not trying to</p> <p>5 be obtuse, I'm just not sure --</p> <p>6 BY MS. SEVERYN:</p> <p>7 Q. There is a portion at the bottom A/P, does</p> <p>8 that typically stand for assessment slash plan?</p> <p>9 A. Yes, ma'am.</p> <p>10 Q. What was the assessment of the cardiologist,</p> <p>11 according to your review of this document?</p> <p>12 A. "Post-op aortic root replacement and shortness</p> <p>13 of breath secondary to P.E., question mark".</p> <p>14 Q. What is your understanding, if you have one,</p> <p>15 as to the initial note of a post-op aortic root</p> <p>16 replacement?</p> <p>17 A. What is my understanding of the?</p> <p>18 Q. Of that entry on this consult note?</p> <p>19 A. Just what it says, this is a patient who is</p> <p>20 post-op aortic root replacement.</p> <p>21 Q. Okay. Do you have any knowledge or</p> <p>22 information as to what the cardiologist's plan of</p> <p>23 treatment was in this case?</p> <p>24 MR. TABER: Objection.</p> <p>25 THE WITNESS: Yeah, at what point in</p>	<p style="text-align: right;">Page 104</p> <p>1 Q. Okay, and at some point after cardiology</p> <p>2 performs the consult, I would assume they communicate</p> <p>3 their findings?</p> <p>4 A. Yes.</p> <p>5 Q. Now that you've looked at the consult book --</p> <p>6 the consultant document, the entry by the cardiologist,</p> <p>7 does that in any way refresh your recollection as to</p> <p>8 what information was conveyed to you by cardiology in</p> <p>9 that phone conversation that you recall?</p> <p>10 A. No, not really.</p> <p>11 Q. Is it fair to say that after this consult, at</p> <p>12 least from the cardiologist's note down below at Number</p> <p>13 2, there was still a consideration that the shortness of</p> <p>14 breath may be secondary to a pulmonary emboli or</p> <p>15 embolism?</p> <p>16 A. Yes.</p> <p>17 MR. TABER: Off the record.</p> <p>18 (Thereupon an off the record discussion was held.)</p> <p>19 BY MS. SEVERYN:</p> <p>20 Q. On the record. Doctor, let me direct your</p> <p>21 attention to what's been premarked as Exhibit 13, can</p> <p>22 you identify this document?</p> <p>23 A. Exhibit 13 it looks like a printed sheet from</p> <p>24 Em-STAT system.</p> <p>25 Q. What is that, the Em-STAT system?</p>
<p style="text-align: right;">Page 103</p> <p>1 time? He's got a lot of things down here.</p> <p>2 BY MS. SEVERYN:</p> <p>3 Q. Can you tell from this Exhibit 6 when the</p> <p>4 cardiology consult occurred?</p> <p>5 A. Not from this document.</p> <p>6 Q. Is there any other --</p> <p>7 A. Oh, no it says patient is in CT. So that</p> <p>8 means I guess sometime 19 something, 19:00 hours</p> <p>9 somewhere around there. Probably when he came down to</p> <p>10 see the patient.</p> <p>11 Q. Where is your reference that you're noting</p> <p>12 that patient is in CT?</p> <p>13 A. I'll have to look --</p> <p>14 Q. Oh, on top.</p> <p>15 A. Oh, you mean on his document?</p> <p>16 Q. On his document.</p> <p>17 A. Right up on top.</p> <p>18 Q. Okay, I got you. Is the information contained</p> <p>19 in this consult, is that information that you recall</p> <p>20 being communicated to you by cardiology during the</p> <p>21 course of your treatment of Mr. Stansbury?</p> <p>22 A. What information are you referring to?</p> <p>23 Q. Well, you asked early on for a consult with</p> <p>24 cardiology?</p> <p>25 A. Right.</p>	<p style="text-align: right;">Page 105</p> <p>1 A. It's a computerized patient documentation</p> <p>2 program.</p> <p>3 Q. There are some names here Wayne Kupetz, RN; do</p> <p>4 you see that?</p> <p>5 A. Kupetz, K-U-P-E-T-Z, RN.</p> <p>6 Q. Melissa Wysocky? That's Melissa two S's</p> <p>7 W-Y-S-O-C-K-Y, RN. Mike Cudnik, MD, yourself. Are</p> <p>8 these all individuals that would have had a role in</p> <p>9 caring for Mr. Stansbury?</p> <p>10 A. Yes, ma'am.</p> <p>11 Q. Seeing this document, does it in any way</p> <p>12 refresh your recollection as to who was present during</p> <p>13 the respiratory distress?</p> <p>14 A. No, not really. Not really in that even if I</p> <p>15 was again globally aware of who actually was there, once</p> <p>16 something like this happens, you become so focused on</p> <p>17 the individual that it's almost like having antegrade</p> <p>18 amnesia, you forget about everything that just happened</p> <p>19 and you're all of a sudden -- it means nothing literally</p> <p>20 exists in the world, except for this person and you.</p> <p>21 I mean someone could be right by your side for</p> <p>22 two hours doing things with you, and someone will ask</p> <p>23 you, and you'll tell them I think it was this person.</p> <p>24 Why? That's the last person I remember seeing. Things</p> <p>25 like that.</p>

Page 106

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

Page 107

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

Page 108

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

Page 109

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

<p style="text-align: right;">Page 110</p> <p>1 Q. Now that we've actually spent quite some time 2 talking about the treatment of Mr. Stansbury on 3 January 25, 2003, does that in any way refresh your 4 recollection as to the identity of the cardiothoracic 5 specialist that was consulted in this case? 6 A. No, ma'am. 7 Q. Do you recall at what point in your treatment 8 of Mr. Stansbury on January 25, 2003, the focus of the 9 differential diagnosis if you will, turned to a 10 potential embolism? 11 A. Say that again? 12 Q. Sure. At what point in your treatment of 13 Mr. Stansbury, on that E.R. admission, did your focus 14 turn to a P.E. as opposed to some of the other 15 differential diagnoses you were considering? 16 MR. TABER: Objection, over broad. 17 Go ahead. 18 THE WITNESS: Definitely once I had 19 the CT results. 20 BY MS. SEVERYN: 21 Q. Once you had obtained the EKG result and the 22 chest x-ray, other than the CT scan, what other results 23 helped you to remove some of those differential 24 diagnoses or eliminate them? 25 MR. TABER: Objection, over broad, vague.</p>	<p style="text-align: right;">Page 112</p> <p>1 else is there. 2 BY MS. SEVERYN: 3 Q. Do pulmonary emboli ever show up on -- 4 A. No. 5 Q. So there's nothing unusual about the fact that 6 it didn't show up here? 7 A. No, but it points out the fact that you could 8 have bad things there that don't show up on a chest 9 x-ray. 10 Q. What other possible diagnoses were you 11 considering or that were left, after you were able to at 12 least get information that would suggest that you're 13 ruling out a myocardial infarction, the pneumonia, the 14 pleural effusion, the pneumothorax, other than the P.E. 15 what else were you considering? 16 A. You could still have a pneumonia, it just 17 doesn't show up because of let's say dehydration and you 18 could have something behind -- you could have something 19 involving the heart itself. 20 For example, he could be having cardiac tamponade, 21 you just don't appreciate it because this is an AP of 22 the chest and the heart may look large, but it may be 23 larger than it really should be. You really don't know 24 that, you're just assuming that it's large because of 25 the type of chest x-ray that you're getting.</p>
<p style="text-align: right;">Page 111</p> <p>1 THE WITNESS: I'm not sure I understand 2 your question. 3 BY MS. SEVERYN: 4 Q. Sure. Let me try it again. Your testimony 5 earlier, my recollection is that the EKG assisted you to 6 rule out myocardial infarction, heart attack; right? 7 A. Uh-huh. 8 Q. That's a yes? 9 A. Yes, ma'am. 10 Q. And the CT -- excuse me, the chest x-ray 11 helped you to rule out, because it was clear, pneumonia, 12 pleural effusion, pneumothorax? 13 MR. TABER: Objection, asked and answered. 14 THE WITNESS: I said that the chest x-ray 15 looked clear, but the CT would be definitive, 16 because there are a lot of things that you 17 don't see on a chest x-ray that are actually 18 there. For example, the chest x-ray was 19 interpreted as normal, but there was a 20 pericardial effusion, there was a pleural 21 effusion. There were massive pulmonary emboli 22 that never showed up, and pneumonia could 23 still be present, but not seen. A CAT scan 24 would help and definitively tell me that the 25 chest x-ray was read correctly, and whatever</p>	<p style="text-align: right;">Page 113</p> <p>1 But a CAT scan will show you that there is 2 pericardial effusion in there. Is there something 3 behind like a pneumonia, what we call a retrocardiac 4 pneumonia. You cannot -- usually you get a PA and 5 lateral of the chest so that you can look at the back 6 part -- yeah, the back part of the -- the area behind 7 the heart, and sometimes you'll see a low-lying 8 pneumonia that otherwise you'll look at the AP of the 9 chest, and you don't see it there. This was, would also 10 -- the CT would let us know if there was something 11 there, is this a pneumonia or is this a pulmonary 12 embolism. 13 Q. Was Dr. Disch present during the respiratory 14 distress? 15 A. He may have been but I don't recall seeing 16 anyone at that time except Mr. Stansbury. 17 Q. Did you speak with anyone else that was 18 present at the hospital that evening about 19 Mr. Stansbury, other than the patient himself, 20 family members, anyone else? 21 A. I spoke to his wife and like I said, she 22 didn't have any reaction at all. And I guess when, you 23 know, probably collectively looked at him and may have 24 discussed it amongst ourselves. Let's say other 25 physicians, other residents, nurses, you know, just as a</p>

<p style="text-align: right;">Page 114</p> <p>1 post significant event type of round-robin. But</p> <p>2 specifically, what we said, who said what, I couldn't</p> <p>3 really say.</p> <p>4 Q. Did you review the deposition transcript of</p> <p>5 Michael Chrisman?</p> <p>6 A. No, ma'am.</p> <p>7 Q. Did you ever speak with anyone at the hospital</p> <p>8 that evening that you understood to be the paramedic</p> <p>9 that had responded to the home of Mr. Stansbury</p> <p>10 initially that afternoon?</p> <p>11 A. If he was the paramedic from the Metro Life</p> <p>12 Flight?</p> <p>13 Q. No. They would have been with the Aurora</p> <p>14 E.M.S.</p> <p>15 A. If I spoke with that person that would have</p> <p>16 been telephonically, because there was no other way for</p> <p>17 us to really communicate.</p> <p>18 Q. But you don't have any recollection today of</p> <p>19 having any such conversation; correct?</p> <p>20 A. Right.</p> <p>21 Q. Going back to the intubation, you indicated</p> <p>22 typically you would check for breath sounds --</p> <p>23 A. Uh-huh.</p> <p>24 Q. -- use the CO2 detector --</p> <p>25 A. Yes, ma'am.</p>	<p style="text-align: right;">Page 116</p> <p>1 A. They're there to assist in performing the</p> <p>2 resuscitation.</p> <p>3 Q. When you talk about assisting, what types of</p> <p>4 assistance are you referring to?</p> <p>5 A. Various types of assistance.</p> <p>6 Q. Is there typically a nurse or member of the</p> <p>7 nursing staff, who charts what is happening and what is</p> <p>8 occurring by way of treatment during the respiratory</p> <p>9 distress and or code?</p> <p>10 A. There usually is one person assigned to</p> <p>11 document the events of a code.</p> <p>12 Q. Can you tell from the records in this, who</p> <p>13 would have done the documentation in this matter?</p> <p>14 A. Not by looking at signatures or initials.</p> <p>15 Wait a minute, I'm sorry, there's a recording nurse,</p> <p>16 Kristina Vaji.</p> <p>17 Q. Vaji?</p> <p>18 A. I think so.</p> <p>19 Q. And you're referring to Exhibit Number?</p> <p>20 A. Exhibit Number 10.</p> <p>21 Q. And that's the recording nurse?</p> <p>22 A. Right.</p> <p>23 Q. Do you know nurse Vaji?</p> <p>24 A. I remember her, yes.</p> <p>25 Q. Any reason to believe she was not charting</p>
<p style="text-align: right;">Page 115</p> <p>1 Q. -- in assisting in the process to ensure the</p> <p>2 intubation was done correctly. Do you recall following</p> <p>3 your typical protocol to ensure that the intubation was</p> <p>4 proper in this case?</p> <p>5 A. I would usually request that an End-Tidal CO2</p> <p>6 detector be attached to ensure that there is color</p> <p>7 change.</p> <p>8 Q. What does the standard of care require in your</p> <p>9 opinion, Doctor, to a reasonable degree of medical</p> <p>10 certainty, regarding your obligation to chart the</p> <p>11 intubation process?</p> <p>12 MR. TABER: Objection.</p> <p>13 THE WITNESS: I'm not sure what you mean</p> <p>14 by that. I mean usually if I'm intubating</p> <p>15 someone I will request my medication, I would</p> <p>16 perform the procedure, ensure that the</p> <p>17 intubation was appropriate and successfully</p> <p>18 completed, and just mention that the patient</p> <p>19 was intubated.</p> <p>20 BY MS. SEVERYN:</p> <p>21 Q. Do you typically make any chart entry anywhere</p> <p>22 in the patient's chart with respect to that intubation?</p> <p>23 A. Typically, no.</p> <p>24 Q. What is the role of the nursing staff in a</p> <p>25 respiratory distress situation?</p>	<p style="text-align: right;">Page 117</p> <p>1 accurately in this case?</p> <p>2 A. No, she's a good nurse and she -- a good nurse</p> <p>3 in that patient care is primary concern.</p> <p>4 Q. When we talk about the administration of</p> <p>5 A.C.L.S. medication, do you know what we're referring</p> <p>6 to?</p> <p>7 A. Not specifically.</p> <p>8 Q. That doesn't have any medical significance to</p> <p>9 you?</p> <p>10 A. No, it tells me that there's probably a code</p> <p>11 situation and medications are required.</p> <p>12 Q. What does the standard of care mandate</p> <p>13 regarding treatment -- the administration of medicine</p> <p>14 treatment during a code?</p> <p>15 MR. TABER: Objection, over broad.</p> <p>16 THE WITNESS: I'm not sure --</p> <p>17 BY MS. SEVERYN:</p> <p>18 Q. Let's assume, hypothetically, that we have a</p> <p>19 code situation where there are -- there's electrical</p> <p>20 activity but no pulse, during that phase of the code,</p> <p>21 what is the standard of care regarding the</p> <p>22 administration of medicine?</p> <p>23 MR. TABER: Objection, over broad not</p> <p>24 about this case.</p> <p>25 MS. SEVERYN: I'm asking a general</p>

<p style="text-align: right;">Page 118</p> <p>1 question.</p> <p>2 MR. TABER: I know, and that's why I</p> <p>3 objected. Go ahead if you can.</p> <p>4 THE WITNESS: If you request medication</p> <p>5 you administer it.</p> <p>6 BY MS. SEVERYN:</p> <p>7 Q. All right. If we have a patient such as</p> <p>8 Mr. Stansbury who has electrical activity but no pulse,</p> <p>9 what does the standard of care require as to the type of</p> <p>10 medication and the dosage of medication that needs to be</p> <p>11 administered under those circumstances?</p> <p>12 A. Oh, well I think I understand what you're</p> <p>13 saying now. Medications that you would use would be</p> <p>14 Atropine and Epinephrine.</p> <p>15 Q. What is the dosage that you would use?</p> <p>16 A. One milligram.</p> <p>17 Q. How frequently would you use them?</p> <p>18 A. One every five minutes or as needed depending</p> <p>19 on their effectiveness.</p> <p>20 Q. Is that true for both of them, once every five</p> <p>21 minutes or as needed?</p> <p>22 A. No, the Atropine you may only need once.</p> <p>23 Q. All right, then let's take them one at a</p> <p>24 time. What does the standard care require, regarding how</p> <p>25 much and how frequently you want to administer the</p>	<p style="text-align: right;">Page 120</p> <p>1 Q. What is the Epinephrine designed to do in a</p> <p>2 code situation?</p> <p>3 A. Well, it's designed to help the heart</p> <p>4 reestablish mechanical activity, theoretical.</p> <p>5 Q. Again, as an emergency room physician what</p> <p>6 factors do you typically consider when determining</p> <p>7 whether or not to administer additional doses of the</p> <p>8 Epinephrine under a code situation?</p> <p>9 A. In Mr. Stansbury's case how is the patient</p> <p>10 responding at that point in time.</p> <p>11 Q. Again, let's assume after five minutes there's</p> <p>12 no response?</p> <p>13 A. You may wish to repeat it, you may wish to not</p> <p>14 repeat it.</p> <p>15 Q. What are the considerations as to whether to</p> <p>16 repeat, to not to repeat?</p> <p>17 A. Again, the patient's clinical condition.</p> <p>18 Q. Again, assuming nothing's changed?</p> <p>19 A. You may wish to repeat it, you may not wish to</p> <p>20 repeat it.</p> <p>21 Q. What clinical considerations would help you in</p> <p>22 determining whether or not you wish to repeat or not?</p> <p>23 A. If he had a pulse.</p> <p>24 Q. What if he did?</p> <p>25 A. If he had a pulse then you would observe him</p>
<p style="text-align: right;">Page 119</p> <p>1 Atropine --</p> <p>2 A. The Atropine --</p> <p>3 Q. -- in a situation where there's electrical</p> <p>4 activity but no pulse?</p> <p>5 A. Okay, the Atropine you should administer no</p> <p>6 more than two milligrams.</p> <p>7 Q. During what period of time?</p> <p>8 A. During any period of time.</p> <p>9 Q. What about the Epinephrine?</p> <p>10 A. The Epinephrine you can administer as often as</p> <p>11 you wish to continue coding the person with pulseless</p> <p>12 electrical activity.</p> <p>13 Q. As often as you want?</p> <p>14 A. Once every five minutes.</p> <p>15 Q. Once you've administered a first dose of</p> <p>16 Epinephrine, again the situation being that the patient</p> <p>17 has electrical activity no pulses, what events or what</p> <p>18 would determine whether or not a second dose is</p> <p>19 administered?</p> <p>20 A. Well, patient's response, and basically how</p> <p>21 long the person's been in that condition.</p> <p>22 Q. What if after five minutes there is no change</p> <p>23 in the patient's condition?</p> <p>24 A. Well, at that point you can repeat it again if</p> <p>25 you wish.</p>	<p style="text-align: right;">Page 121</p> <p>1 at that point in time to see how he's doing, what his</p> <p>2 blood pressure is.</p> <p>3 Q. What if he didn't have pulse?</p> <p>4 A. If he didn't have a pulse, as I said before</p> <p>5 not to be redundant, but you can give him another dose</p> <p>6 or you can just continue with your C.P.R. it's not</p> <p>7 really -- at that point in time, it's not going to make</p> <p>8 much of a difference.</p> <p>9 Q. Would you agree that in the United States at</p> <p>10 least in the metropolitan areas that there is one</p> <p>11 standard of care?</p> <p>12 A. There can be one standard of care --</p> <p>13 Q. Okay.</p> <p>14 MR. TABER: Object, that's a legal</p> <p>15 question, not a medical question, but you</p> <p>16 can go ahead.</p> <p>17 THE WITNESS: Well, it depends on how</p> <p>18 you interpret that.</p> <p>19 BY MS. SEVERYN:</p> <p>20 Q. Well, do you believe you're held to the same</p> <p>21 standard of care here at the Holmes Hospital as you were</p> <p>22 at the Cleveland Clinic Foundation?</p> <p>23 MR. TABER: Objection, that's a legal</p> <p>24 term, you can answer if you want, but it's not</p> <p>25 a question --</p>

<p style="text-align: right;">Page 122</p> <p>1 THE WITNESS: I would practice 2 medicine the same here as I would there, 3 except for modifying local factors. 4 BY MS. SEVERYN: 5 Q. Okay. 6 A. Whatever they may be. 7 Q. What types of things do you mean to include in 8 that local factors? 9 A. Too numerous to elaborate. It depends on the 10 actual situation as you see it. Certain protocols are 11 generated to give you a guideline, but they're not 12 absolute. They're simply a guideline and clinical 13 discretion overrides those guidelines at any given time. 14 Q. Dr. Aponte, do you believe to a reasonable 15 degree of medical certainty, that you met the standard 16 of care in your treatment of Mr. Stansbury in this case? 17 A. Yes, ma'am. 18 Q. Do you have any criticisms with respect to any 19 of the treatment that was rendered at the Cleveland 20 Clinic Foundation with respect to Mr. Stansbury on 21 January 25, 2003? 22 MS. KINKOPF: I'm going to object to that. 23 THE WITNESS: On the day that I saw him? 24 BY MS. SEVERYN: 25 Q. Yes.</p>	<p style="text-align: right;">Page 124</p> <p>1 A. Cardiology. 2 Q. All right. So in your opinion, it would have 3 been their decision as to whether or not a filter would 4 have been placed? 5 A. Yes, ma'am. 6 Q. Typically, is the filter placed through 7 radiology? 8 A. To the best of my knowledge, yes. 9 Q. Are you aware that there are medications that 10 can be given to counteract the effects of Heparin if for 11 any reason it becomes necessary to do so? 12 A. Yes, ma'am. 13 Q. What are some of these medications? 14 A. Vitamin K Protamine. 15 Q. Do you have an opinion as to how quickly 16 Heparin begins to have an effect, after it's first 17 administered? 18 A. No, ma'am. 19 Q. Doctor, do you know whether the circumstances 20 surrounding Mr. Stansbury's demise, were ever considered 21 by any peer-review committee by the hospital? 22 MR. TABER: Objection -- 23 MS. KINKOPF: Objection -- 24 MR. TABER: I instruct you not to answer 25 that. It's privileged pursuant to Ohio law,</p>
<p style="text-align: right;">Page 123</p> <p>1 A. I have no objections to the medical care that 2 he received on the day of his visit on the 25th of 3 January, 2003. 4 Q. Have you ever had or been in a situation where 5 a filter was placed by radiology to prevent a blood clot 6 from migrating? 7 A. Well, when I was doing my residency and when I 8 was doing my internship, perivena cava filter. 9 Q. Were you ever in a situation at the Cleveland 10 Clinic Foundation where a radiologist would call you 11 with reports of a P.E. and where it was your 12 determination that a filter be placed? 13 A. No, ma'am. 14 Q. Would you typically consult with someone 15 before placing a filter? 16 A. Yes, ma'am. 17 Q. Who would you consult with, typically? 18 A. I was consult with the admitting service. 19 Q. What do you mean admitting service? 20 A. Well, I function in the Emergency Department, 21 and if a patient needs something like a filter, that's 22 to be determined and implemented by the admitting 23 service. 24 Q. In the case of Mr. Stansbury who was the 25 admitting service?</p>	<p style="text-align: right;">Page 125</p> <p>1 not admissible in lawsuits, that's not 2 relevant. 3 MS. HENRY: Join in the objection. 4 MS. SEVERYN: I'll withdraw the question, 5 thank you. 6 MS. SEVERYN: 7 Q. Did you speak with any -- strike that. Other 8 than your attorney, is there anyone else that you spoke 9 with about this case since these events occurred on 10 January 25, 2003? 11 A. No, ma'am. 12 Q. Do you have any criticisms as to the treatment 13 administered by the Aurora E.M.S. personnel? 14 A. No, ma'am. 15 Q. Do you have any criticisms of the treatment 16 administered by the Metro Life Flight personnel? 17 A. No, ma'am. 18 Q. You were a physician at the Cleveland Clinic 19 again for a period of time from what, '95 to 2004, 20 roughly? 21 A. Uh-huh. 22 Q. If a physician issues discharge orders, and 23 for whatever reason those orders are not communicated to 24 the patient or placed on the discharge sheet, typically 25 whose responsibility is that?</p>

<p style="text-align: right;">Page 126</p> <p>1 A. I wouldn't know. I don't function -- that's</p> <p>2 not part of my function.</p> <p>3 Q. In that capacity?</p> <p>4 A. Right.</p> <p>5 Q. Do you have any knowledge or information about</p> <p>6 any telephone calls to the Clinic by either</p> <p>7 Mr. Stansbury or his widow, after the discharge, after</p> <p>8 the aneurysm repair, but before the emergency room</p> <p>9 admission that we're talking about today?</p> <p>10 A. Not that I can recall at this time.</p> <p>11 Q. Doctor, let me direct your attention to what's</p> <p>12 been marked as Exhibit 12. Can you identify that</p> <p>13 document?</p> <p>14 A. It's a Deposition Exhibit Number 12, Chart</p> <p>15 Fact Cleveland Clinic Foundation Deficiency Slip, Friday</p> <p>16 April 4, 2003 10:07 a.m.</p> <p>17 Q. Do you recall receiving that document?</p> <p>18 A. No, ma'am.</p> <p>19 Q. So that's not something to your knowledge</p> <p>20 generated to you?</p> <p>21 A. No, ma'am.</p> <p>22 Q. After having read the document, do you have</p> <p>23 any understanding as what it's designed to do?</p> <p>24 A. This document?</p> <p>25 Q. Yes.</p>	<p style="text-align: right;">Page 128</p> <p>1 may have been a phone call after the fact, where someone</p> <p>2 had asked me some questions about it, but that's the</p> <p>3 only thing I could really recall regarding that question.</p> <p>4 Q. Doctor, do you have an opinion as to whether</p> <p>5 any of the treatment rendered by the physicians and</p> <p>6 staff of Cleveland Clinic Foundation at all times</p> <p>7 adhered to the applicable standard of care in treating</p> <p>8 Mr. Stansbury?</p> <p>9 A. I think that they did adhere to the standard</p> <p>10 of care.</p> <p>11 MS. SEVERYN: I don't have questions</p> <p>12 at this time, Doctor. You do have an</p> <p>13 opportunity --</p> <p>14 MS. HENRY: I have some questions.</p> <p>15 CROSS-EXAMINATION</p> <p>16 BY MS. HENRY:</p> <p>17 Q. Dr. Aponte, my name is Deirdre Henry I</p> <p>18 represent Dr. Cudnik. You were the Attending emergency</p> <p>19 room physician; correct?</p> <p>20 A. Yes.</p> <p>21 Q. Explain to us what Attending means?</p> <p>22 Q. Attending is a fully trained, residency</p> <p>23 trained board certified physician, considered to be</p> <p>24 competent in the practice of emergency medicine to the</p> <p>25 point that he may at least be considered capable of</p>
<p style="text-align: right;">Page 127</p> <p>1 A. It's designed to inform me that there's a</p> <p>2 deficiency in one of my charts and the expiration</p> <p>3 summary.</p> <p>4 Q. Do you know what the deficiency that's being</p> <p>5 referenced is?</p> <p>6 A. I would imagine I'm just guessing an</p> <p>7 expiration summary.</p> <p>8 Q. Off the record.</p> <p>9 (Thereupon, as off the record discussion was held.)</p> <p>10 Dr. Aponte, were you ever provided with a copy of</p> <p>11 interrogatories in this case?</p> <p>12 MR. TABER: No.</p> <p>13 MS. SEVERYN: Off the record.</p> <p>14 (Thereupon, an off the record discussion was held.)</p> <p>15 BY MS. SEVERYN:</p> <p>16 Q. Dr. Aponte, have you reviewed any records or</p> <p>17 documents, other than those that you've described for us</p> <p>18 today? Portions of the emergency chart as well as the</p> <p>19 Life Flight, what you call the run sheet for E.M.S. as</p> <p>20 well as Dr. Krofina's deposition?</p> <p>21 A. No, those are the only documents that I've</p> <p>22 reviewed in preparing for this deposition.</p> <p>23 Q. Did you ever speak with Dr. Krofina about his</p> <p>24 patient Mr. Stansbury?</p> <p>25 A. Off the top of my head I would say, no. There</p>	<p style="text-align: right;">Page 129</p> <p>1 supervising physicians in training of the same specialty.</p> <p>2 Q. Dr. Cudnik was a resident physician rotating</p> <p>3 through the emergency at the Cleveland Clinic; correct?</p> <p>4 A. Yes, ma'am.</p> <p>5 Q. You were the supervisor supervising</p> <p>6 Dr. Cudnik's interactions with Mr. Stansbury; correct?</p> <p>7 A. Yes, ma'am.</p> <p>8 Q. And part of what Dr. Cudnik was learning at</p> <p>9 the Cleveland Clinic was evaluation of patients and how</p> <p>10 to make decisions on differentials, that sort of thing;</p> <p>11 correct?</p> <p>12 A. Yes, ma'am.</p> <p>13 Q. As the Attending, you were the physician</p> <p>14 ultimately responsible for Mr. Stansbury's care?</p> <p>15 A. Yes, ma'am.</p> <p>16 Q. You were the physician who was responsible</p> <p>17 once you made the original assessment of him, to</p> <p>18 determine what was in the differential diagnosis and</p> <p>19 what needed to be done to come to a final diagnosis;</p> <p>20 correct?</p> <p>21 A. Yes, ma'am, but that's always done in</p> <p>22 consultation with a resident because you can always</p> <p>23 learn something.</p> <p>24 Q. All right. But you were the one who was</p> <p>25 making the final decision?</p>

<p style="text-align: right;">Page 130</p> <p>1 A. Yes, ma'am.</p> <p>2 Q. You would be discussing it with the resident</p> <p>3 as part of the education process?</p> <p>4 A. Yes, ma'am.</p> <p>5 Q. You would have been the physician who was</p> <p>6 responsible for deciding what tests were to be done?</p> <p>7 A. Yes, ma'am.</p> <p>8 Q. And you explained to us the tests that you</p> <p>9 requested and why they were requested and the results;</p> <p>10 correct?</p> <p>11 A. Yes, ma'am.</p> <p>12 MS. KINKOPF: Excuse me, this is Lauren</p> <p>13 Kinkopf, I'm having a hard time hearing the</p> <p>14 questions, would it be possible to speak up a</p> <p>15 little bit?</p> <p>16 MS. HENRY: I can speak up.</p> <p>17 MS. KINKOPF: Thank you.</p> <p>18 BY MS. HENRY:</p> <p>19 Q. You would also be as the Attending, the</p> <p>20 physician who would make the decision as to what</p> <p>21 consultations you wanted made in this case?</p> <p>22 A. Yes, ma'am.</p> <p>23 Q. Now it's my understanding that Dr. Cudnik was</p> <p>24 with you when you initially met Mr. Stansbury?</p> <p>25 A. Yes, ma'am.</p>	<p style="text-align: right;">Page 132</p> <p>1 A. To the best of my recollection, yes.</p> <p>2 Q. The decision as to what care was to be</p> <p>3 rendered to Mr. Stansbury along the way, until the time</p> <p>4 that the CT result came back, was ultimately your</p> <p>5 decision; correct?</p> <p>6 A. Yes, ma'am.</p> <p>7 Q. The decision as to if and when Heparin was</p> <p>8 going to be administered I understand was a decision</p> <p>9 that was going to be made in conjunction with</p> <p>10 cardiothoracic surgery -- or cardiology rather?</p> <p>11 A. Yes, ma'am.</p> <p>12 Q. Once the results of the CT came back in,</p> <p>13 consultation with cardiology, the decision was made to</p> <p>14 give the Heparin?</p> <p>15 A. Yes, ma'am.</p> <p>16 Q. And you were the one who ultimately gave the</p> <p>17 order for the Heparin -- the starting of the Heparin;</p> <p>18 correct?</p> <p>19 A. Yes, ma'am.</p> <p>20 Q. Based on what you recall about this case,</p> <p>21 Dr. Cudnik did what you asked him to do and what was</p> <p>22 asked of him; correct?</p> <p>23 A. Yes, ma'am.</p> <p>24 Q. Do you have any criticisms of Dr. Cudnik?</p> <p>25 A. No, ma'am.</p>
<p style="text-align: right;">Page 131</p> <p>1 Q. And you said that you saw him as he was being</p> <p>2 brought down the hallway and you watched them bring him</p> <p>3 into the room; correct?</p> <p>4 A. Into the room, yes.</p> <p>5 Q. Who is the they, that were bringing him into</p> <p>6 the room?</p> <p>7 A. The paramedics, Metro Life.</p> <p>8 Q. Once he's brought into the room by Metro Life,</p> <p>9 then you assume the care of the patient?</p> <p>10 A. Yes, ma'am.</p> <p>11 Q. So the information that is reflected in the</p> <p>12 dictated notes by Dr. Cudnik is information that you</p> <p>13 were aware of?</p> <p>14 A. Yes, ma'am.</p> <p>15 Q. During the time of the care of the patient?</p> <p>16 A. Yes, ma'am.</p> <p>17 Q. If there was any additional information that</p> <p>18 you required, you would have taken whatever steps was</p> <p>19 necessary to obtain it; correct?</p> <p>20 A. Yes, ma'am.</p> <p>21 Q. Now, I think you said that Dr. Cudnik would</p> <p>22 communicate with you as test results were obtained?</p> <p>23 A. Yes, ma'am.</p> <p>24 Q. Did he communicate with you the test results</p> <p>25 as they were obtained in a timely manner?</p>	<p style="text-align: right;">Page 133</p> <p>1 Q. Do you believe that Dr. Cudnik met the</p> <p>2 standard of care for the role that he played in the</p> <p>3 emergency room, as it relates to Mr. Stansbury on</p> <p>4 January 25, 2003?</p> <p>5 A. Yes, I do.</p> <p>6 MS. HENRY: Thank you.</p> <p>7 MS. SEVERYN: No follow-up questions</p> <p>8 MR. TABER: We will not waive signature.</p> <p>9 Any questions on the phone?</p> <p>10 MS. KINKOPF: No.</p> <p>11 MR. TABER: Okay, we will not waive</p> <p>12 signature. And on the record, for the record,</p> <p>13 as we have discussed, although that does not</p> <p>14 necessarily need to be identified, Dr. Aponte</p> <p>15 is expected to testify both as a fact witness,</p> <p>16 and automatically because he is a physician as</p> <p>17 an expert witness as to his own care and</p> <p>18 involvement and as he testified today in great</p> <p>19 detail.</p> <p>20 Accordingly, under the local rule and</p> <p>21 decisions of the Eighth District, he is not</p> <p>22 required to issue an expert report. But I</p> <p>23 want it made clear that this is the one and</p> <p>24 only opportunity to ask him questions in any</p> <p>25 of those capacities, and I invite any further</p>

<div>Page 134</div> <div>1 questions that may be necessary. Although, I</div> <div>2 think we've been extremely thorough today.</div> <div>3 MS. SEVERYN: I'm actually thinking about</div> <div>4 your invitation.</div> <div>5 MR. TABER: I don't want any second</div> <div>6 guessing --</div> <div>7 MS. KINKOPFL: I'm sorry, could you</div> <div>8 repeat that, I didn't get all of that?</div> <div>9 MR. TABER: Sorry, I said I don't want</div> <div>10 there to be any misunderstanding as to what it</div> <div>11 means to be a hybrid fact/expert Doc</div> <div>12 testifying. That there is only one</div> <div>13 deposition in our County, and I just wanted to</div> <div>14 be clear on that point.</div> <div>15 MS. SEVERYN: And I am clear on that. My</div> <div>16 only question was whether or not I wanted to</div> <div>17 ask any further standard of care questions,</div> <div>18 and I don't. I think we are done.</div> <div>19 (Thereupon, the deposition was concluded at 1:59</div> <div>20 p.m.)</div> <div>21</div> <div>22</div> <div>23</div> <div>24</div> <div>25</div>	<div>Page 136</div> <div>1 ERRATA SHEET (dmd)</div> <div>2 IN RE:</div> <div>3 DEPOSITION OF: JOSEF APONTE, MD TAKEN: 9/22/05</div> <div>4 Do Not Write On Transcript - Enter Changes Here</div> <div>5 PAGE LINE CHANGE REASON</div> <div>6</div> <div>7</div> <div>8</div> <div>9</div> <div>10</div> <div>11</div> <div>12</div> <div>13</div> <div>14</div> <div>15</div> <div>16</div> <div>17</div> <div>18</div> <div>19</div> <div>20 Please forward the original signed errata sheet to</div> <div>21 this office so that copies may be distributed to all</div> <div>22 parties.</div> <div>23 Under penalty of perjury, I declare that I have</div> <div>24 read my deposition and that it is true and correct</div> <div>25 subject to any changes in form or substance entered here.</div> <div>Date: _____ SIGNATURE OF DEPONENT: _____</div>
<div>Page 135</div> <div>1</div> <div>2 CERTIFICATE</div> <div>3</div> <div>4 THE STATE OF FLORIDA</div> <div>5 COUNTY OF BREVARD</div> <div>6 I hereby certify that I have read the foregoing</div> <div>7 deposition by me given, and that the statements</div> <div>8 contained herein are true and correct to the best of my</div> <div>9 knowledge and belief, with the exception of any</div> <div>10 corrections or notations made on the errata sheet, if</div> <div>11 one was executed.</div> <div>12</div> <div>13 Dated this _____ day of _____, 2005.</div> <div>14</div> <div>15 _____</div> <div>16 JOSEF APONTE, MD</div> <div>17</div> <div>18</div> <div>19</div> <div>20</div> <div>21</div> <div>22</div> <div>23</div> <div>24</div> <div>25</div>	<div>Page 137</div> <div>1 STATE OF FLORIDA)</div> <div>2 COUNTY OF BREVARD)</div> <div>3</div> <div>4 CERTIFICATE OF OATH</div> <div>5 I, the undersigned authority, certify that the</div> <div>6 witness personally appeared before me and was duly sworn.</div> <div>7</div> <div>8 Dated this _____ day of _____, 2005.</div> <div>9</div> <div>10</div> <div>11 _____</div> <div>12 DONNA D'ALESSANDRO</div> <div>13 Notary Public, State of Florida</div> <div>14 My Commission No. DD 220006</div> <div>15 My Commission Expires 06/21/2007</div> <div>16</div> <div>17</div> <div>18</div> <div>19</div> <div>20</div> <div>21</div> <div>22</div> <div>23</div> <div>24</div> <div>25</div>

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 Aponie, 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 Aponie, MD

A														
<p>abdomen 46:9</p> <p>able 29:14 31:25 36:14 36:20 54:16,20,23 56:17 59:23,24 62:13 63:20 94:25 112:11</p> <p>abnormal 46:11,13 48:14 51:11,16,18,19 51:20,21,22 52:22,23 53:12 63:17 65:13,15 72:3</p> <p>abnormality 49:2,2 66:6</p> <p>above-referred 139:7</p> <p>abscess 47:8 48:15</p> <p>absolute 122:12</p> <p>Absolutely 19:7 46:22</p> <p>Academy 22:10</p> <p>access 61:3</p> <p>accurate 100:19</p> <p>accurately 117:1</p> <p>achieved 9:20</p> <p>action 138:12,12</p> <p>Activase 98:18,24 99:10</p> <p>active 12:16</p> <p>active-duty 11:11</p> <p>activity 95:23,25 96:2 99:17,21 100:1 117:20 118:8 119:4 119:12,17 120:4</p> <p>actual 23:20 122:10</p> <p>acute 22:4</p> <p>addition 98:16</p> <p>additional 120:7 131:17</p> <p>address 87:18,20 88:10</p> <p>adhere 128:9</p> <p>adhered 128:7</p> <p>administer 83:17 98:15 118:5,25 119:5,10 120:7</p> <p>administered 5:3 44:5 83:4,7 85:8 87:1,5,6 97:8,10 98:1 99:2,4 99:11 100:4,7 118:11 119:15,19 124:17 125:13,16 132:8</p> <p>administering 79:11</p> <p>administration 41:10 87:24 98:12 117:4,13 117:22</p> <p>administrative 109:17</p> <p>Administrator 1:4</p> <p>admissible 125:1</p> <p>admission 32:17,20,22 32:23 33:5 40:25 41:7,9 43:14 44:9</p>	<p>69:18,21 110:13 126:9</p> <p>admitted 31:7 32:14 33:3,18,20,20 67:20 67:22 83:5</p> <p>admitting 123:18,19,22 123:25</p> <p>advance 7:5</p> <p>advancement 18:4</p> <p>advice 72:15</p> <p>affect 52:3</p> <p>affiliated 19:18,23 20:6 20:13 21:11</p> <p>affirmed 4:9</p> <p>aforementioned 138:5</p> <p>afternoon 114:10</p> <p>afterthought 62:25</p> <p>agent 98:25</p> <p>agree 58:5 59:14 108:8 121:9</p> <p>agreed 70:25 71:1 139:9</p> <p>ahead 5:23 27:15 37:6 50:1 57:8 79:13 80:22 82:21 84:4 85:2 110:17 118:3 121:16</p> <p>air 66:4 93:6</p> <p>airway 91:21,22</p> <p>alive 108:25</p> <p>allow 98:7</p> <p>ambulatory 14:8</p> <p>America 24:3</p> <p>American 22:10</p> <p>amnesia 105:18</p> <p>amount 66:4</p> <p>amp 96:9,11 97:5,11</p> <p>anastomosis 83:10</p> <p>ANDRESS 2:16</p> <p>and/or 138:14</p> <p>aneurysm 26:8 27:12 52:1 126:8</p> <p>answer 5:22 53:25 80:19,21 81:3,8,13 81:15 84:23 85:1 121:24 124:24</p> <p>answered 35:8 37:5 81:1 84:3,23 111:13</p> <p>answering 46:8 91:14</p> <p>answers 5:10</p> <p>antegrade 105:17</p> <p>anticipate 56:16</p> <p>anticipating 55:7</p> <p>anticoagulate 80:5</p> <p>anybody 34:19 36:2</p> <p>anyone's 80:25</p> <p>aorta 66:2,3</p> <p>aortic 26:8 43:17 51:25 77:19,23 102:12,15</p>	<p>102:20</p> <p>AP 112:21 113:8</p> <p>apart 6:20 40:6</p> <p>apologize 27:24</p> <p>Aponte 1:8,13 2:21 4:8 4:13,15 59:14 122:14 127:10,16 128:17 133:14 135:14 136:2 139:2,25</p> <p>APPEARANCES 2:1</p> <p>appeared 59:22 137:6</p> <p>APPEARING 2:14</p> <p>applicable 128:7</p> <p>apply 138:14</p> <p>appointment 20:19</p> <p>appointments 19:9,11 19:21 20:3</p> <p>appreciate 24:7 49:4 112:21</p> <p>approach 72:10</p> <p>appropriate 83:2 115:17</p> <p>appropriately 94:5</p> <p>approximately 4:21 17:24 60:3 62:2,4 67:10 73:16 106:12</p> <p>April 126:16</p> <p>area 48:15 95:4 113:6</p> <p>areas 121:10</p> <p>Army 11:12,13,15,17 11:18 12:8,15,20,23 14:17 15:16,21 16:1</p> <p>arrest 97:21</p> <p>arrival 7:1</p> <p>arrived 7:18 31:8 32:2 32:3 35:1 42:14</p> <p>arriving 7:19 68:4</p> <p>arteries 65:19</p> <p>artery 65:17,23 67:1</p> <p>artfully 28:2</p> <p>articles 21:22 22:1</p> <p>artifact 66:7</p> <p>ascending 66:2,3</p> <p>asked 5:19 34:1 59:7 72:11 75:2 78:14 103:23 111:13 128:2 132:21,22</p> <p>asking 5:25 8:1 17:15 23:10 24:6 25:22 28:1 109:23 117:25</p> <p>aspect 21:8 23:5</p> <p>aspects 6:19</p> <p>assertion 80:25</p> <p>assess 35:23</p> <p>assessed 46:8</p> <p>assessment 40:11 102:8 102:10 129:17</p> <p>assigned 14:23,25 15:7 35:4 73:8 116:10</p>	<p>assist 47:16 52:16 116:1</p> <p>assistance 116:4,5</p> <p>assistant 18:5</p> <p>assisted 53:15 111:5</p> <p>assisting 71:7,16 115:1 116:3</p> <p>associated 22:8 38:5</p> <p>association 22:12</p> <p>associations 22:9</p> <p>assume 5:23 57:13 58:12 79:15,23 86:13 104:2 117:18 120:11 131:9</p> <p>assuming 36:13 80:7 112:24 120:18</p> <p>assumption 69:7</p> <p>asystole 99:24</p> <p>Atropine 96:7,9,22 97:3,15 98:13,16 99:10 118:14,22 119:1,2,5</p> <p>attached 13:3 26:20 27:3 28:12 115:6</p> <p>attack 47:23 54:11,17 111:6</p> <p>attended 11:5</p> <p>Attending 8:16,23 106:19 128:18,21,22 129:13 130:19</p> <p>attention 29:9,18 39:14 40:16 45:20 50:6 58:16 60:9 64:2 70:2 72:17 96:12 101:17 104:21 106:1 126:11</p> <p>attorney 125:8 138:10 138:11 139:17</p> <p>atypical 107:15</p> <p>audible 90:12</p> <p>Aurora 30:24,25 45:5 114:13 125:13</p> <p>auscultate 93:3,5</p> <p>auscultation 46:6</p> <p>authenticated 70:20,22</p> <p>authoritative 22:23 23:3</p> <p>authority 137:5</p> <p>authorized 138:5</p> <p>autolysing 89:11,13</p> <p>automatically 133:16</p> <p>autopsy 108:12 109:12 109:20,23</p> <p>available 6:3 24:8 31:11 36:12 43:7 50:14 51:3,6 72:2 100:10</p> <p>Avenue 2:10 139:4</p> <p>aware 9:13 25:20 26:10 26:12,14 61:19,24</p>	<p>62:18 76:2 105:15 124:9 131:13</p> <p>awkward 62:22</p> <p>A-P-O-N-T-E 4:16</p> <p>A-U-R-O-R-A 30:24</p> <p>A.C.L.S 21:1 117:5</p> <p>a.m 1:15 126:16</p> <p>A.T.L.S 20:24</p> <p>A/P 102:7</p> <p>A1A 1:17</p> <tr> <th data-bbox="115 491 386 534">B</th><th data-bbox="394 491 665 534"></th><th data-bbox="673 491 945 534"></th><th data-bbox="953 491 1224 534"></th><th data-bbox="1232 491 1503 534"></th></tr> <tr> <td data-bbox="115 534 386 1970"></td><td data-bbox="394 534 665 1970"></td><td data-bbox="673 534 945 1970"></td><td data-bbox="953 534 1224 1970"></td><td data-bbox="1232 534 1503 1970"> <p>B 3:1</p> <p>back 6:1 7:15 27:19,20 31:6 34:1 44:15 45:13 47:16 49:14 53:7 54:7 57:13,19 58:4 60:16 61:21 63:2,10 64:22 65:10 67:18 68:4 69:12 70:1 73:5,18 75:13 76:5 85:10 91:4 100:12 113:5,6 114:21 132:4,12</p> <p>background 8:8 11:5</p> <p>bad 112:8</p> <p>based 24:4 36:23 38:22 61:4 68:20 79:19 81:10,10 132:20</p> <p>basically 5:9 15:5 20:20,21 39:12 49:1 54:23 63:23 76:24 109:1 119:20</p> <p>basis 69:2 95:13</p> <p>battalion 13:4</p> <p>Beaumont 12:15,19,20 12:23</p> <p>becoming 10:19 99:7</p> <p>bedside 20:20 86:1 90:10 91:9</p> <p>beginning 11:5 29:25</p> <p>begins 124:16</p> <p>Behalf 2:2,7</p> <p>Belhobek 50:20</p> <p>belief 135:7</p> <p>believe 26:9 27:1,25 29:19 40:5 41:18 56:3 58:18 67:19 68:8 83:15 91:16 116:25 121:20 122:14 133:1</p> <p>belonged 15:4</p> <p>benefit 87:8,9</p> <p>benefits 87:8</p> <p>best 37:15 124:8 132:1 135:7</p> <p>better 44:5 49:2</p> <p>bilateral 48:16 66:21 108:5</p> </td></tr>	B									<p>B 3:1</p> <p>back 6:1 7:15 27:19,20 31:6 34:1 44:15 45:13 47:16 49:14 53:7 54:7 57:13,19 58:4 60:16 61:21 63:2,10 64:22 65:10 67:18 68:4 69:12 70:1 73:5,18 75:13 76:5 85:10 91:4 100:12 113:5,6 114:21 132:4,12</p> <p>background 8:8 11:5</p> <p>bad 112:8</p> <p>based 24:4 36:23 38:22 61:4 68:20 79:19 81:10,10 132:20</p> <p>basically 5:9 15:5 20:20,21 39:12 49:1 54:23 63:23 76:24 109:1 119:20</p> <p>basis 69:2 95:13</p> <p>battalion 13:4</p> <p>Beaumont 12:15,19,20 12:23</p> <p>becoming 10:19 99:7</p> <p>bedside 20:20 86:1 90:10 91:9</p> <p>beginning 11:5 29:25</p> <p>begins 124:16</p> <p>Behalf 2:2,7</p> <p>Belhobek 50:20</p> <p>belief 135:7</p> <p>believe 26:9 27:1,25 29:19 40:5 41:18 56:3 58:18 67:19 68:8 83:15 91:16 116:25 121:20 122:14 133:1</p> <p>belonged 15:4</p> <p>benefit 87:8,9</p> <p>benefits 87:8</p> <p>best 37:15 124:8 132:1 135:7</p> <p>better 44:5 49:2</p> <p>bilateral 48:16 66:21 108:5</p>
B														
				<p>B 3:1</p> <p>back 6:1 7:15 27:19,20 31:6 34:1 44:15 45:13 47:16 49:14 53:7 54:7 57:13,19 58:4 60:16 61:21 63:2,10 64:22 65:10 67:18 68:4 69:12 70:1 73:5,18 75:13 76:5 85:10 91:4 100:12 113:5,6 114:21 132:4,12</p> <p>background 8:8 11:5</p> <p>bad 112:8</p> <p>based 24:4 36:23 38:22 61:4 68:20 79:19 81:10,10 132:20</p> <p>basically 5:9 15:5 20:20,21 39:12 49:1 54:23 63:23 76:24 109:1 119:20</p> <p>basis 69:2 95:13</p> <p>battalion 13:4</p> <p>Beaumont 12:15,19,20 12:23</p> <p>becoming 10:19 99:7</p> <p>bedside 20:20 86:1 90:10 91:9</p> <p>beginning 11:5 29:25</p> <p>begins 124:16</p> <p>Behalf 2:2,7</p> <p>Belhobek 50:20</p> <p>belief 135:7</p> <p>believe 26:9 27:1,25 29:19 40:5 41:18 56:3 58:18 67:19 68:8 83:15 91:16 116:25 121:20 122:14 133:1</p> <p>belonged 15:4</p> <p>benefit 87:8,9</p> <p>benefits 87:8</p> <p>best 37:15 124:8 132:1 135:7</p> <p>better 44:5 49:2</p> <p>bilateral 48:16 66:21 108:5</p>										

bilaterally 93:3 bit 5:2 12:2 18:10 43:25 71:3 130:15 blank 139:18 blast 44:1 bleeding 83:10 Bliss 12:25 blood 46:25 48:10,11 48:19,22 49:12,13 50:9 52:18 54:12 90:15 121:2 123:5 BNP 49:9 50:9 board 9:17,19,20,25 10:2,4,8,12,19,22,25 11:1 15:2 128:23 bodies 101:9 bodily 58:24,25 body 22:17 89:9 98:9 bolus 98:22 bone 22:4 book 21:2,5 23:6 104:5 bottom 30:7 32:8 33:8 50:23 102:7 139:18 Bragg 14:3,12,25 15:1 brain 46:23 branches 65:18,23 break 89:18,25 91:1,13 breath 7:3,3,24 34:13 44:3 45:22 47:5 77:21 78:8 80:9 90:9 102:13 104:14 114:22 breathing 92:14 breaths 90:13 BREVARD 135:4 137:2 138:3 briefly 11:4 brigade 13:5 bring 8:4 43:25 131:2 bringing 34:12 131:5 brings 72:16 broad 22:24 57:7 88:7 88:13,24 102:3 110:16,25 117:15,23 Brooksville 16:17,18 16:23 17:12 brought 7:22 18:3 34:9 35:2,12,13 36:6 45:19 61:20 131:2,8 Building 2:9 139:3 buster 99:1 B-E-L-H-O-B-E-K 50:20 B.U.N 53:10 <hr/> C <hr/> C 135:1,1 call 6:24 7:5,8,10 31:1 34:12,14 63:21 67:12	76:6 77:3 98:25 113:3 123:10 127:19 128:1 called 16:7 76:5 78:19 79:3 84:12 92:18 calls 126:6 cannula 52:21 capable 128:25 capacities 133:25 capacity 8:15,22 12:10 13:6,9 14:9 16:9 19:18 22:18 126:3 cardiac 46:23 47:6 59:2 112:20 cardiologist 74:3,16 75:15 91:11 101:14 101:21 102:10 104:6 cardiologist's 102:22 104:12 cardiology 69:15 72:12 73:19,24 76:1,11 77:4,6,16 82:5 83:5 85:24,25 86:1,4,5,11 90:9,18 91:7 92:7 101:7 103:4,20,24 104:1,8 107:5 124:1 132:10,13 cardiothoracic 69:15 72:12 73:20,24 74:3 74:16 76:1,12 77:3,4 77:6 78:3,18 79:3,10 81:20 82:5,17 83:21 84:11 86:4,6,12,22 86:24 107:4 110:4 132:10 care 3:6,13,21 14:8 34:6 56:8 57:4,20 58:10,14,21 59:2,3 59:15 69:5 70:15 71:9 73:9,13,15 85:14 89:9 91:10 92:23 106:18 108:2 115:8 117:3,12,21 118:9,24 121:11,12 121:21 122:16 123:1 128:7,10 129:14 131:9,15 132:2 133:2 133:17 134:17 career 17:18 18:4,24 19:8 20:2 caring 105:9 Carolina 14:5 case 1:2 19:6 20:6,10 58:4 61:17 62:17,18 63:25 67:16 68:22,24 74:17 76:10 77:5 80:15,22 81:10,11 93:10,19,25 101:15 101:24 102:23	108:12 110:5 115:4 117:1,24 120:9 122:16 123:24 125:9 127:11 130:21 132:20 CAT 46:25 48:6 49:1 55:5,7 56:17,19 60:7 60:8,14 62:21 79:8 82:25 111:23 113:1 catheter 61:2 cause 4:3 53:4 caused 58:25 cava 65:21 123:8 CCF 29:20 30:8,10,10 30:11,11 39:17 58:19 59:9 64:5 cc's 45:16 center 2:17 8:21 12:15 12:20,24 16:6 17:13 17:22 18:20 19:16,17 29:16 56:18 70:13 central 17:13,23 95:3 certain 10:21 30:4,10 53:23 57:9 82:22 100:3 106:19 122:10 certainly 36:20 55:17 69:9 certainty 54:18 57:21 68:20 115:10 122:15 certificate 108:1 137:4 138:1 certification 9:21 59:10 138:13 certified 9:17,19,25 10:2,4,13,20 15:2 128:23 certify 135:6 137:5 138:4,8,10 certifying 138:15 cetera 28:14 39:4 73:6 89:15 chair 22:20 Chairman 15:8 19:14 chance 8:4 39:3 change 19:3 38:12 73:17 94:1,3,5,12,15 94:20 95:6,16 115:7 119:22 136:5 139:13 changed 49:14 120:18 changes 136:3,23 139:12,14 chapter 21:4 chapters 20:25 characterization 84:16 characterize 59:19 charge 91:9 chart 6:21 25:24 27:12 28:16 39:6 40:9 41:21 43:2 46:20	60:1 74:13 93:13 107:12,25 115:10,21 115:22 126:14 127:18 charting 116:25 charts 116:7 127:2 check 71:24 114:22 checklist 109:18 cheeks 7:20,20 chemistries 48:4 Chem.8 46:24 51:1 53:8 chest 45:23 46:9,25 47:4 48:13,20,21 49:3,4 50:14,19 54:11,19,24 55:5 56:2 64:7 65:24 66:9 77:20 78:7,20 80:9 93:1,2,4,7,10,16,19 100:9 110:22 111:10 111:14,17,18,25 112:8,22,25 113:5,9 children 22:5 Chrisman 114:5 circled 40:24 41:12 circumstances 35:22 36:11 49:10 72:4 80:12 118:11 124:19 citing 139:13 City 16:3 civilian 12:10 clarification 28:20 clarify 84:4 89:2 Claus 7:21 clear 5:1,13 45:4 54:2 54:11 59:4 95:3 111:11,15 133:23 134:14,15 clearly 24:7 79:24 80:24 Clerk 139:17 Cleveland 1:8 2:10,13 2:17,17 3:5,6,8,9,10 3:12,13,14,16,17,19 3:20,21 8:12 18:12 18:14,20 19:1 20:4 21:11 25:24 27:12 31:9,12 32:3 33:9 39:18 42:15 44:9 56:24 57:17 59:16 67:21 68:1 69:10 70:14 73:2 121:22 122:19 123:9 125:18 126:15 128:6 129:3,9 139:4,5 Clinic 1:8 3:5,6,8,9,10 3:12,13,14,16,17,19 3:20,21 8:12 18:12 18:14,16,21 19:1,4	19:13 20:4 21:6 25:15,19 26:9,19 27:12 31:9,13 32:3 33:9,24 34:9 35:1 38:8 39:18 42:15 43:14 44:10 56:24 57:17 59:16 60:4 62:2 67:9,21 68:1 69:10 70:14 73:2 94:8 95:1 106:6 107:1,11,16,19 109:14 121:22 122:20 123:10 125:18 126:6,15 128:6 129:3,9 139:5 clinical 20:21 66:3 99:4 120:17,21 122:12 Clinics 24:3 Clinic's 25:4,7,24 28:16 close 62:9 closer 12:3 clot 99:1 123:5 clots 87:11,14,15,18,25 88:20,23 89:6,8,11 89:17 clotting 48:3,4 51:9 code 92:18 116:9,11 117:10,14,19,20 120:2,8 codes 21:4,5 coding 119:11 collectively 16:13 113:23 College 11:7 color 46:8 94:1,3,5,12 94:15,20 95:6,15,16 115:6 column 98:22 100:16 come 17:7 18:19 54:8 55:2 60:16 80:8 129:19 comfortable 50:18 coming 6:14 7:13 34:15 65:10 commenced 138:9 Commission 137:12,13 138:21,21 committee 22:19 124:21 COMMON 1:1 communicate 35:23 36:14 104:2 114:17 131:22,24 communicated 36:15 67:3 103:20 125:23 communicating 108:18 Community 15:16 16:22 17:2
--	---	--	--	--

competent 128:24 complaining 7:2 34:12 44:2 77:20 78:7 90:9 complete 12:21 15:17 106:13 completed 10:24 12:18 13:24 14:11 17:17 46:14 64:18 115:18 138:9 complications 83:9 comprises 10:9 computerized 105:1 concern 117:3 concluded 134:19 conclusion 59:17 condition 28:14 34:6 52:25 59:20 73:5 99:5 100:23 102:2 119:21,23 120:17 confirm 49:1 55:9 82:25 85:20 93:23 confirmed 56:1 88:4 confused 25:17 confusing 37:23 confusion 26:16 38:7 38:15 congestive 22:7 conjunction 132:9 connected 138:11 connection 20:3 37:12 37:18 conscious 92:15 consider 22:23 23:3 51:11 55:22 120:6 consideration 104:13 considerations 120:15 120:21 considered 124:20 128:23,25 considering 47:2,10 53:24 54:9 55:3,14 55:18 110:15 112:11 112:15 consult 3:10 76:14,19 78:14 101:20 102:18 103:4,19,23 104:2,5 104:11 123:14,17,18 consultant 76:8 104:6 consultants 79:8 consultation 101:21 129:22 132:13 consultations 130:21 consulted 73:20,24 74:3,4 75:15 101:14 110:5 contact 29:2 39:5 72:11 76:17 77:3 79:8 82:14 contacted 69:14 75:3	76:1,11 78:10,12,13 86:11,12,12 107:5 contacting 82:16 contain 42:8 43:2 contained 42:5,18,21 103:18 135:7 contents 71:1 continue 119:11 121:6 continued 12:9 15:20 Continuing 3:13 85:14 contraindication 79:25 80:2 contrary 80:14,24 contrast 64:8 control 91:22 138:14 conversation 37:22,23 38:17 39:8 40:11 42:10 59:24 82:8 104:9 108:20,23 109:15 114:19 conversations 74:13 conveyed 34:11,20 43:23 52:24 58:9 66:16 77:16 78:3,24 104:8 109:22 copies 31:18 136:20 copy 8:4 28:7,15,16 31:17 49:23 127:10 corner 29:19 98:21 coroner's 108:1 correct 10:10 29:7,21 30:20 31:23 34:23 46:16 54:24 55:20 58:6 60:19 63:10 65:4 67:5 83:18 85:6 90:3 91:17 100:13 114:19 128:19 129:3 129:6,11,20 130:10 131:3,19 132:5,18,22 135:7 136:22 138:6 corrections 135:8 139:12 correctly 6:16 55:10 59:25 111:25 115:2 correlation 66:4 counsel 138:11,11 139:10 Counselor 84:21 counteract 124:10 country 14:19 69:6 County 1:1 134:13 135:4 137:2 138:3 couple 6:1 course 18:23 19:8 20:24 24:18 55:13 103:21 courses 20:22 21:11 court 1:1 4:1 5:5,13 13:16 30:23 59:5	139:15,17 cover 30:4 Co2 93:9,24,25 94:2,7 94:13,14,17,25 95:5 95:8,16 114:24 115:5 CPR 3:16 creatinine 48:8 53:10 critical 56:21 58:21 59:21 criticisms 122:18 125:12,15 132:24 CROSS 2:20 CROSS-EXAMINA... 128:15 CT 3:12 41:23 55:23 56:4,9 57:5,22 58:2 60:3 61:20,22 62:6 62:12,14 63:10,12,17 63:25 64:7,9 65:4,11 65:12,15 66:10,14 67:3,11 68:3,8,21 69:12 78:19 79:4,11 79:21 82:13,17 84:12 88:1 103:7,12 110:19 110:22 111:10,15 113:10 132:4,12 CT's 89:10 Cudnik 1:9 39:11 40:3 40:6 42:17 70:9,10 70:16 71:13,15,21 72:6 73:14,25 74:1 105:7 129:2,8 130:23 131:12,21 132:21,24 133:1 Cudnik's 39:24 42:6 71:3,5 73:7 129:6 curious 60:18 62:19 current 23:9,15 currently 8:20 9:1 customarily 23:11 CUYAHOGA 1:1 cyanotic 99:8 cyst 66:8 C-U-D-N-I-K 70:9 C.B.C 46:24 47:25 51:1 C.E.O 17:6 C.P.R 96:15 100:6,12 100:19 121:6 C.V 8:5 c/o 139:2	Dated 135:10 137:7 138:16 day 6:15 45:20 53:5,17 56:20 122:23 123:2 135:10 137:7 138:16 days 55:19 83:7 DD 137:12 138:21 Dean 1:5 6:7 Deans 37:19 death 108:2 Deceased 1:5 December 18:17 decide 82:14 decided 95:24 deciding 130:6 decision 19:5 40:24 82:21 83:2 124:3 129:25 130:20 132:2 132:5,7,8,13 decisions 129:10 133:21 declare 136:22 decreased 90:14 defective 54:1 defects 65:20 Defendants 1:10 2:7 deficiency 3:19 126:15 127:2,4 define 49:2 75:18 defined 65:20 Definitely 110:18 definitive 59:2 66:5 111:15 definitively 111:24 deformities 22:4 degradation 51:9 degree 57:21 68:20 115:9 122:15 dehydration 112:17 Deirdre 2:12 128:17 demise 124:20 demonstrated 54:12 department 6:15,25 8:16 14:8 15:10 19:14,24,24 20:16 31:1 33:10 39:18 40:15,21 42:5,18,22 45:6 49:22 56:14 60:6 67:10 70:7,13 72:13 73:1 107:20,23 123:20 depend 100:9 depending 56:19 83:8 118:18 depends 36:11 38:11 121:17 122:9 depo 25:23 DEPONENT 136:24 deposition 1:13,22 4:1	4:5,19 5:2 24:24 26:2 26:21 27:4,8 28:6,8 30:15 31:5 39:17 61:16,20 64:5 90:7 90:22 101:20 114:4 126:14 127:20,22 134:13,19 135:6 136:2,22 138:6,7,8,9 139:7,8,12,16,22 depositions 4:24 describe 20:18 56:25 94:25 described 76:21 99:18 127:17 description 3:2 7:2 designed 120:1,3 126:23 127:1 detail 133:19 detector 93:9,24,25 94:2,7 95:1,8 114:24 115:6 detectors 94:14 95:5 deteriorating 99:5 100:23 determination 123:12 determine 53:4,22 119:18 129:18 determined 123:22 determining 53:16 120:6,22 devoted 21:7 diagnoses 54:9 55:3 110:15,24 112:10 diagnosis 47:3,17 54:8 55:2,15 56:2 72:10 110:9 129:18,19 dialog 43:10 Dice 15:1 dictate 107:12,23 dictated 25:9 40:7 70:18 106:5,14 107:2 107:10 131:12 dictation 28:7 42:3 died 108:15 109:2 difference 33:3,17 121:8 different 80:12 86:10 94:14 95:5 differential 47:3 54:9 55:3,14 72:10 110:9 110:15,23 129:18 differentials 129:10 digress 8:8 direct 2:20 4:11 29:9 29:18 39:14 40:16 58:16 60:9 64:2 72:17 74:19 96:12 101:17 104:20 106:1 126:11 138:14
---	--	--	---	--

directing 50:6 70:1 direction 138:14 director 18:5 Disch 72:22,23,24 73:5 73:8,10,14 113:13 discharge 3:14,17 11:25 16:1 28:13,14 106:4 107:2,9,14 108:4 125:22,24 126:7 discharged 11:23 discretion 122:13 discussed 72:9 82:7 113:24 133:13 discussing 75:4 130:2 discussion 36:25 39:21 40:4,13 45:12 69:24 104:18 106:10 127:9 127:14 discussions 72:5 disfunction 58:24 distress 59:20 90:3,21 91:5,16 92:18 95:20 99:6,7,12 100:3,23 101:3,6 105:13 113:14 115:25 116:9 distributed 136:20 District 133:21 division 13:5 dmd 136:1 Doc 134:11 Doctor 8:4 27:22 29:15 30:6 40:18 49:5 50:6 50:17 57:20 60:9 64:2 70:1 72:22 81:9 81:21 83:6 104:20 115:9 124:19 126:11 128:4,12 doctors 86:10 document 3:3,9,10,20 28:18 30:5 31:14,15 31:22 32:1 33:7,15 33:22 38:24 39:16 40:14,20,21 42:4 49:17 50:2,7 60:11 64:4,6 70:3,5,8 77:13 85:9,13,21 86:17 96:14,20 100:15 101:18,20 102:11 103:5,15,16 104:6,22 105:11 106:2,8 107:13 116:11 126:13,17,22,24 documentation 31:7 43:9 93:15,18 105:1 116:13 documented 88:1 93:12 documents 21:25 24:23 29:11,14,19 30:2	31:10,11 34:5 42:12 42:25 44:18 58:19 96:17 127:17,21 dog 16:21 doing 92:5 105:22 121:1 123:7,8 Donna 1:21 4:1 50:1 137:11 138:4,20 139:21 dosage 97:10 118:10,15 dose 86:2,25 97:15 98:16 119:15,18 121:5 doses 98:16 120:7 dots 13:17 Dr 4:13 19:14 26:2,5 26:20 27:2,4 28:7,9 39:11,24 40:3,6 42:6 42:17 50:20 59:14 70:16 71:3,5,13,15 71:21 72:6,24 73:5,7 73:8,10,14,14,25 106:15 113:13 122:14 127:10,16,20 127:23 128:17 129:2 129:6,8 130:23 131:12,21 132:21,24 133:1,14 drawn 46:2,15 drip 98:23 drug 79:24 Dr.Cudnik 128:18 due 54:12 66:7 duly 4:9 137:6 138:5 duty 12:16 14:11 86:15 86:18 D'Alessandro 1:21 4:1 137:11 138:4,20 139:21 D-A-R-N-A-L-L 15:16 D-dimer 47:1 51:5 52:7	111:12,20,21 112:14 113:2 effusion/pericardial 66:1 Eighth 133:21 either 16:12 36:9 53:22 54:8 55:1 66:17 74:2 74:6 77:6 102:1 109:16 126:6 EKG 46:25 48:11 54:10,15 110:21 111:5 El 16:3,12 elaborate 122:9 elbow 62:9 elect 81:3 electrical 95:23,25 96:2 99:17,21,25 117:19 118:8 119:3,12,17 element 82:24 elevate 52:5 eligible 10:22,22,25 11:2 eliminate 110:24 ELLIS 2:9 139:3 Elyria 18:2,3,7,8,11 emboli 66:11,24 88:5 88:11 89:17,21,25 99:3 104:14 108:5 111:21 112:3 embolism 21:18,23 23:21 47:7 55:11 57:6 66:22 82:25 83:11 88:16 104:15 110:10 113:12 emergency 3:16 6:14 6:25 7:18 8:17,18,24 9:21 10:1 11:18 12:9 13:10 14:16,21 15:2 16:9 17:18 19:25 20:2 21:17 22:10,22 23:2,6,12,23,24,25 24:1,4,5 25:1,13,19 25:25 32:24 33:10 39:18 40:14,20 42:5 42:18,22 47:11 49:22 56:10,14 58:10,14 59:15 69:2 70:6,13 71:22 73:1 86:20 96:15 120:5 123:20 126:8 127:18 128:18 128:24 129:3 133:3 emergency-room 57:5 emergent 59:2,3 Emmerman 19:14 emphysema 65:25 employed 8:12,20 employee 138:11 employment 20:1	Em-STAT 3:20 25:11 28:6 31:13 93:18 104:24,25 endotracheal 90:24 92:3,21 End-Tidal 93:9,24 115:5 ensure 48:3 71:25 92:24 93:4 115:1,3,6 115:16 Enter 136:3 entered 136:23 entire 20:24 21:2 entries 64:25 entry 61:10,11 62:20 62:25 63:7 73:3 102:18 104:6 115:21 epigastric 93:6 Epinephrine 96:6 97:9 98:13,17 99:10 118:14 119:9,10,16 120:1,8 equivalent 97:5 er 13:22 28:3 errata 135:8 136:1,20 139:11,12,14 especially 55:18 Esquire 1:22 2:4,8,12 2:15,15 139:2,22 essentially 70:25 71:12 established 44:11,14,16 44:25 45:14 Estate 1:4 et 28:14 39:4 73:6 89:14 Etomidate 98:3 Euclid 2:10 139:4 Europe 12:17 13:2 evaluated 72:9,15 evaluation 129:9 evening 24:18 25:3 26:13 31:6 72:6 81:14 113:18 114:8 event 83:13 100:13 114:1 events 100:16 107:24 116:11 119:17 125:9 Evidence 24:3 exactly 17:8 63:15 75:22 76:21 examination 4:11 10:9 46:4,5,12,14 65:20 66:7 examinations 9:23 examined 4:9 46:9 examining 8:2 36:10 46:2 56:6 example 20:23 44:4 90:1 111:18 112:20	exams 10:17 exception 135:7 exchange 36:1 excited 27:25 excluded 65:21 excuse 22:1 32:2,12,13 41:9 64:12 67:24 72:18 111:10 130:12 executed 135:8 Exhibit 29:10 31:17,23 33:12 39:15,17 40:8 40:17 42:6,18,23 44:19 50:3,7 58:17 60:10 64:3,5 68:9,12 70:3 72:17,18 73:19 78:17 83:16 85:15,17 85:20,22 87:2 90:7 90:22 91:14 92:20 96:13 97:24 98:20,21 99:14 100:12,15 101:18,20 103:3 104:21,23 106:2 107:13 116:19,20 126:12,14 Exhibits 4:5 exists 105:20 expect 33:14,23 48:24 73:5 expected 7:12 47:16 133:15 experienced 7:23 45:22 expert 133:17,22 expiration 3:14,17 106:4 107:2,6,9,14 108:4 127:2,7 expired 100:25 106:14 108:5,24 expires 106:6 107:10 137:13 138:21 Explain 128:21 explained 130:8 explaining 108:23 extending 87:12 extensive 25:8 extent 6:1 20:8 extremely 134:2 extremities 46:7,10 E-P-P-I-N-G-E-N 13:18 E.D 3:5,6,8,10,13,21 56:21 78:7 E.M.S 29:5 43:20 45:20 114:14 125:13 127:19 E.R 24:4 110:13
F				
F 135:1 face 46:7				

facility 15:15 19:18 facing 76:3 fact 24:20 25:21 45:13 52:3 61:4 81:24 85:21 100:2 112:5,7 126:15 128:1 133:15 factors 120:6 122:3,8 facts 80:14,24 fact/expert 134:11 fading 12:4 failure 22:7 fair 17:16 36:23 37:10 38:22 52:6 54:16,20 58:8 63:24 66:10,23 69:1 83:11 84:16 87:13,17 104:11 FALLON 2:12 falsely 52:5 familiar 62:8 family 113:20 far 9:13 48:14 51:15 fashion 68:22,23,25 Federal 13:18 feel 95:24 felt 87:7 fibrin 51:8 89:14 figure 52:16 filed 139:17 filling 65:20 filter 123:5,8,12,15,21 124:3,6 final 129:19,25 finalized 50:23 finally 49:1 financially 138:12 find 33:23 51:3 139:11 findings 46:11 53:12 101:24 104:3 finish 39:3 finished 46:1 Fire 30:25 45:5 first 5:3,12 10:2 22:15 34:7,25 35:6,18 37:4 42:17 50:16 63:12 84:2 85:8 90:6 119:15 124:16 138:5 five 23:17 85:2 97:18 118:18,20 119:14,22 120:11 FL 1:17 139:19 flat 95:3 Flight 3:3 7:9,13 25:2 29:7,17,17 30:17 36:3,5,9,25 37:12,18 38:1,5,24 43:20 44:18 45:17 58:4,6 114:12 125:16 127:19 flighted 6:25 58:6,9,13	77:19 Flight's 37:1 Floor 2:17 Florida 1:21 4:3 9:2,14 16:17,23 135:3 137:1 137:12 138:2,4,20 fluid 44:23 45:16 66:2 focus 110:8,13 focused 105:16 fogging 93:5 follow 89:10 following 14:13 78:18 115:2 139:10 follows 4:10 follow-up 133:7 forearm 60:23 foregoing 135:6 138:6 138:13 forget 105:18 forgot 97:22 form 54:1 85:14 108:2 136:23 formal 22:16 formation 87:14 formed 87:18 88:1,11 88:16,20 89:17,22 formulated 40:24 Fort 12:25 14:3,12,14 14:15,25 15:7,12,23 forth 138:8 forward 76:19 136:20 forwarded 139:17 Foundation 1:8 8:13 18:14 19:2 20:4 21:12 31:9,13 32:4 33:9 39:18 56:25 57:17 59:16 67:21 69:10 70:14 73:2 121:22 122:20 123:10 126:15 128:6 139:6 four 49:14 52:20 84:3 84:25 frame 57:3 Frank 22:6 free 14:19 frequently 95:2 118:17 118:25 Friday 126:15 friends 19:3 front 28:18 72:18 full 4:14 6:17 59:24 fully 128:22 function 48:5,8 76:25 86:7 109:2 123:20 126:1,2 functioned 12:16 13:1 functions 58:24 furnished 139:10	further 133:25 134:17 138:8,10 <hr/> G gage 45:7 gas 46:25 48:10,19 49:12,13 52:18 54:12 gases 48:22 50:9 gather 32:1 general 13:12 14:7,12 68:24 89:6 117:25 generate 78:14 generated 43:10 93:16 122:11 126:20 generating 96:3 Georgia 14:4 17:13,14 17:23 19:22 20:11 Germany 13:18,25 gesture 5:15 gestures 5:11 getting 6:24 29:1 89:13 112:25 Ginny 59:11 gist 39:12 76:9 give 5:10 21:10,20 43:25 52:7 63:21 80:5 96:8 121:5 122:11 132:14 given 4:19 24:25 25:2,9 44:12 45:14,16,18 55:25 72:3 87:7 96:9 96:10,21 97:3,15 122:13 124:10 135:6 gives 13:21 giving 76:8 global 37:21 54:5 79:6 82:20 84:10,14 101:9 globally 105:15 go 5:23 6:1 12:11 16:16 17:12 18:1,11 27:15 37:6 44:15 50:1 57:7 60:14 67:18 79:13 80:16,22 82:21 84:4 85:2 89:15 90:25 110:17 118:3 121:16 Goeppingen 13:15 going 5:1,23,25 8:7 14:18 17:7 23:15 31:6 34:1 36:13 38:12 47:14 51:9,10 52:17 53:16,22 57:13 57:19 58:4 63:22 73:18 75:13 76:9 77:1 94:18 114:21 121:7 122:22 132:8,9 good 9:14 17:9 117:2,2 graduate 11:8 graduated 11:6 graft 66:3	grand 17:3 great 133:18 grossly 46:13 72:3 group 76:24,24 growing 87:12,14 guess 103:8 107:3 113:22 guessing 127:6 134:6 guideline 122:11,12 guidelines 122:13 Gulf 16:25 17:1 guy 88:25 89:1 guys 12:2 G-I-N-N-Y 59:12 G-O 13:17 G-U-J-R-A-L 59:12 <hr/> H H 3:1 4:15,17 habitually 23:10 24:10 hair 6:17,17 7:20 hallway 131:2 hand 40:23 45:7,7,11 45:11 91:6 92:8 98:21 handwriting 40:22 41:13,16,19,22 83:17 85:5 handwritten 40:10 happen 81:16 107:24 happened 7:17 16:1 19:6 62:17 67:15 81:14,17 105:18 happening 62:18 116:7 happens 105:16 happy 5:20 76:7 hard 84:9 130:13 Harold 1:5 6:7 24:16 37:19 head 5:11 6:17 26:7 127:25 health 58:22 69:5 hearing 130:13 heart 22:7 47:22 54:11 54:16 90:16 97:2 111:6 112:19,22 113:7 120:3 held 39:21 40:13 45:12 69:24 104:18 106:10 121:20 127:9,14 help 53:4 56:2 76:7 111:24 120:3,21 helped 53:21 54:7 55:1 110:23 111:11 hemoglobin 52:12 Henrich 4:18 Henry 2:12,22 39:20 57:25 69:19,22 85:15 125:3 128:14,16,17	130:16,18 133:6 Heparin 41:1,11 69:17 78:20 79:4,12 82:15 83:4,7,17,22 85:5,8 85:12,23 86:2,25 87:4,10,13,17,24 88:17,19 89:7,7 90:8 124:10,16 132:7,14 132:17,17 Heparinize 82:22 Heparinized 79:21 87:8 Heplock 60:22,25 61:1 62:9,12 63:4 hereinabove 138:8,9 Highway 1:17 Hills 16:7,13 hint 80:17 history 39:11,23,24 42:6,17 45:24,25 46:1 55:19 80:10 hold 59:24 83:25 Holmes 8:21 18:19 95:8 121:21 home 114:9 honorable 11:25 Hood 14:14,15 15:7,13 15:23 hopefully 87:11 horse's 36:17 hospital 7:6 14:24,25 15:16 16:7,22 17:2,5 18:7 32:23 33:21 35:7 45:19 57:1,19 69:7 86:17 95:9 113:18 114:7 121:21 124:21 hospitals 16:4,5 hot 16:21 Hotel 1:16 hours 32:5 49:8,12,13 73:16 85:10,11 98:23 101:1 103:8 105:22 HOWLEY 2:12 hundreds 28:17 Huntington 2:9 139:3 HURD 2:12 husband 108:15,24 109:2 hybrid 134:11 hyper-stimulation 22:5 hypothetical 80:13,23 81:7,8,17 hypothetically 80:7 117:18 hypoxia 54:12 hypoxic 53:1 59:23 H-L 60:24 H-O-L-M-E-S 8:21
---	---	---	---	--

<p>I</p> <p>idea 38:19 63:21 86:9</p> <p>identification 4:6 50:4</p> <p>identified 40:8,17 58:17 70:3 83:15 133:14</p> <p>identify 29:12,14 39:15 64:4 96:13 101:18 104:22 106:2,20 126:12</p> <p>identity 110:4</p> <p>ideology 47:17</p> <p>Ill 65:20</p> <p>image 7:21</p> <p>imagine 56:11,15 63:6 74:10 127:6</p> <p>immediate 80:10</p> <p>immediately 11:11 35:19 39:5 56:17 61:21 79:21</p> <p>impact 87:25</p> <p>impairment 58:23</p> <p>implemented 123:22</p> <p>important 5:9 93:23</p> <p>impression 37:22 82:11 82:13,20 84:10,14</p> <p>impressions 82:12</p> <p>improvement 65:24</p> <p>include 20:22 21:4 122:7</p> <p>included 40:7</p> <p>INCORVAIA 2:4</p> <p>increased 90:13</p> <p>Independence 2:5</p> <p>independent 6:2,10 7:16 26:18 27:10 34:2,3 36:24 63:14 74:24 75:1,14,19 77:12 84:13</p> <p>independently 6:20</p> <p>indicate 49:5 55:11 63:9 96:20</p> <p>indicated 12:18 44:21 46:15 58:18 67:2,20 83:16 88:19 90:17 91:16 92:11 114:21</p> <p>indicates 28:24 62:24 94:12</p> <p>indicating 28:13</p> <p>indication 80:1</p> <p>individual 1:4 105:17</p> <p>individuals 105:8</p> <p>infarction 47:6 48:12 111:6 112:13</p> <p>infection 48:1</p> <p>inferior 65:21</p> <p>inform 63:19 72:2,12 127:1</p>	<p>informal 22:15</p> <p>information 24:23 25:25 26:12,19 27:3 31:25 32:6 33:23 34:8,10,10 37:21 39:7,13,25 40:10 42:9,13,21 43:2,5,9 43:13 44:1,6,17 45:18 47:15 52:8,24 53:20 55:6,25 58:9 61:14 64:15 65:4 66:16 67:3,19 72:14 76:18 77:16 78:3,23 79:1,2 83:1 86:19 90:5 94:17 102:22 103:18,19,22 104:8 109:22 112:12 126:5 131:11,12,17</p> <p>informed 43:16 69:15</p> <p>infusion 44:22</p> <p>initial 4:15 29:2 39:8 40:3,10 41:2,5 42:10 43:10 102:15</p> <p>initially 42:14 43:3 56:4 76:11 77:5 78:9 114:10 130:24</p> <p>initials 63:7 116:14</p> <p>initiate 41:1 44:5 69:13 69:17 83:22 85:5</p> <p>initiated 45:8 71:25 91:15</p> <p>inspect 35:22</p> <p>Inspected 46:6</p> <p>instance 47:21 62:11</p> <p>institution 72:14</p> <p>instruct 84:22 124:24</p> <p>instructions 139:10</p> <p>intention 75:25</p> <p>interactions 82:11 129:6</p> <p>interested 138:12</p> <p>internal 17:6</p> <p>internship 10:23 12:11 12:16,19,21 13:12 123:8</p> <p>interpret 5:15 72:2 121:18</p> <p>interpretation 36:18 63:22</p> <p>interpreted 54:11 55:10 66:25 111:19</p> <p>interpreting 67:11</p> <p>interrogatories 127:11</p> <p>interrupt 85:1</p> <p>interview 43:11</p> <p>intravenous 61:2</p> <p>intubate 95:21 98:8</p> <p>intubated 90:23 91:17 92:1 93:8 94:4,19</p>	<p>100:3 115:19</p> <p>intubating 91:23 115:14</p> <p>intubation 91:19 92:11 92:24 93:19 94:23 95:16 97:22 98:2,6 99:8 114:21 115:2,3 115:11,17,22</p> <p>invitation 134:4</p> <p>invite 133:25</p> <p>involve 17:18 19:6 25:8 29:5 37:25</p> <p>involved 73:9 81:20</p> <p>involvement 73:14,15 133:18</p> <p>involving 66:6 112:19</p> <p>irrelevant 80:15,25</p> <p>issue 67:11 133:22</p> <p>issues 17:8 24:20 125:22</p> <p>L.V 44:4,16,22,22 45:2 45:7 61:11,21 62:6,8 71:25 98:22,23</p> <p>L.V.s 44:11,13,25 45:2 45:3,8,10,14</p> <p>J</p> <p>January 8:9 18:18 25:13,19 26:1,10,13 57:14 66:14,18 70:11 71:5,23 73:11 78:25 86:21 94:8 106:18 110:3,8 122:21 123:3 125:10 133:4</p> <p>jeopardy 58:23</p> <p>JIM 2:15</p> <p>job 5:14</p> <p>Join 57:25 125:3</p> <p>Josef 1:8,13 2:21 4:8 4:15 135:14 136:2 139:2,25</p> <p>Journal 24:4</p> <p>journals 24:2,5</p> <p>judge 5:5</p> <p>junction 96:24</p> <p>jury 5:5</p> <p>justify 79:23 83:1</p> <p>J-O-S-E-F 4:15</p> <p>K</p> <p>K 124:14</p> <p>keep 5:12 12:5 17:15 32:13 87:11</p> <p>key 82:24</p> <p>kilogram 87:3,3</p> <p>kind 6:17 18:9</p> <p>Kinkopf 2:15 106:11 122:22 124:23 130:12,13,17 133:10</p>	<p>KINKOPFL 134:7</p> <p>knew 7:11 19:4 79:6</p> <p>know 4:24 5:20 12:1,2 17:15 28:2,16 29:22 30:21 44:1 50:13 51:2,5 59:11 62:16 63:1,15,22 64:17,19 64:22 65:1,3,6,7,9 66:16 67:2,15 68:7 68:15 69:6 74:11 75:25 76:11 77:5,8,9 78:9,13 79:10 80:22 82:10,24 86:10,19 89:21 94:7 95:7 101:4,7,7,8,9 106:16 106:25 107:7,8 112:23 113:10,23,25 116:23 117:5 118:2 124:19 126:1 127:4</p> <p>knowing 106:24</p> <p>knowledge 77:15,22 78:2 86:3,23 88:3 102:21 106:23 109:21 124:8 126:5 126:19 135:7</p> <p>known 13:19</p> <p>KP-7 53:8</p> <p>Kristina 116:16</p> <p>Krofina 1:9 26:2 127:23</p> <p>Krofina's 26:20 27:4 28:7 127:20</p> <p>Kupetz 105:3,5</p> <p>K-U-P-E-T-Z 105:5</p> <p>L</p> <p>lab 47:18 49:16</p> <p>laboratory 46:19</p> <p>labs 8:2 46:2,15,18 72:1,1 73:6</p> <p>lack 53:2</p> <p>large 4:3 6:16 48:23 56:18 57:1 65:16 66:24,24,25 92:22 112:22,24 138:4</p> <p>larger 112:23</p> <p>larynx 98:11</p> <p>lateral 113:5</p> <p>latitude 16:25</p> <p>Lauren 2:15 106:11 130:12</p> <p>law 2:4 124:25</p> <p>lawsuits 125:1</p> <p>lay 20:18</p> <p>learn 63:12,16 129:23</p> <p>learning 129:8</p> <p>leave 17:4 19:1 60:14</p> <p>leaving 68:6</p> <p>lecture 21:19,20</p>	<p>lectured 21:16</p> <p>lectures 20:22,25 21:10</p> <p>Ledger 3:5 33:10 40:15 40:21 42:5,22 49:22</p> <p>left 12:8 18:20 32:24 45:7,11 60:6,22 62:21 65:1,22 68:7 112:11</p> <p>legal 17:8 121:14,23</p> <p>letter 139:18</p> <p>let's 8:8 14:2 23:17,19 31:14 45:4 46:4 53:8 54:5 56:24 57:13 71:3 84:18 89:1 112:17 113:24 117:18 118:23 120:11</p> <p>license 9:10,13</p> <p>licensed 9:1,4,7</p> <p>Lidocaine 98:3</p> <p>life 3:3 6:25 7:9,13 25:2 29:7,16,17 30:16 36:3,5,8,25 37:1,12 37:17 38:1,5,24 43:20 44:17 45:16 58:4,5,6,8,13 77:19 79:25 83:12,12 114:11 125:16 127:19 131:7,8</p> <p>limited 66:7</p> <p>line 12:17 13:1,2,3,7,24 64:13 136:5 139:13</p> <p>lines 44:7</p> <p>list 47:19</p> <p>listed 97:24 99:10</p> <p>listen 93:1,3</p> <p>lists 97:2</p> <p>literally 105:19</p> <p>literature 21:22 23:9 23:15 24:8,17</p> <p>liters 49:14 52:21</p> <p>little 5:2 12:2,3,4 18:10 43:25 71:3 130:15</p> <p>LLC 1:22</p> <p>LLP 2:9,12 139:3</p> <p>lobe 65:22</p> <p>lobes 65:18</p> <p>local 25:1 56:11 122:3 122:8 133:20</p> <p>located 60:23</p> <p>location 62:13 89:25 90:1</p> <p>locations 45:10</p> <p>long 11:13 13:6 14:9 15:12 16:12 17:1,22 18:8,16 22:11 119:21</p> <p>longer 56:19 73:9 108:24</p> <p>look 23:14,15 24:2,20</p>
---	---	---	--	---

25:14 29:11 33:8 36:8,12 44:15,20 51:3 55:10 93:2,4 103:13 112:22 113:5 113:8 looked 26:2 29:3 44:18 46:7,7 78:18 104:5 111:15 113:23 looking 31:12 87:2 100:18 116:14 looks 104:23 losing 12:1 lot 17:5 24:5,7 26:16 28:1 103:1 111:16 low 53:11 lower 29:18 40:23 65:18 98:21 lower-left-hand 32:7 low-lying 113:7 lungs 66:6 89:22 91:24 Lykes 16:21,21 17:1 lytics 80:5 L-Y-K-E-S 16:21	18:22,25 19:10 21:13 21:24 22:2,21 24:19 24:22 25:6 26:14 32:10,19 33:4,13,16 34:24 40:2,19 41:14 41:17,20 42:16,24 43:12 45:1 46:17 47:13 50:10 53:3,6 53:18 54:25 56:7 57:2 60:12 61:7,18 64:1,11,14 65:14 66:12,15 69:11 70:4 70:21 71:2,11,14 73:22 74:14 78:22 82:1,6 83:14,19 85:7 91:18 92:4 96:19 97:4,7 100:21,24 101:22 102:9 105:10 108:7,13,16,19 109:25 110:6 111:9 114:6,25 122:17 123:13,16 124:5,12 124:18 125:11,14,17 126:18,21 129:4,7,12 129:15,21 130:1,4,7 130:11,22,25 131:10 131:14,16,20,23 132:6,11,15,19,23,25 MD 1:8,9,13 2:21 70:9,10 105:7 106:22 135:14 136:2 139:2 139:25 mean 38:11 51:7 54:5 56:13 60:21 62:23 63:2,5,5,15 65:12 70:22 73:3 76:13 84:25 85:25 87:20 92:13 94:3,11 96:1 99:24 103:15 105:21 106:7 115:13,14 122:7 123:19 Meaning 68:14 means 5:15 9:19 20:18 70:23,25 73:4 96:2 99:25 103:8 105:19 128:21 134:11 138:14 meant 10:6 measure 94:13,15 mechanical 120:4 median 65:23 mediastinum 66:5 medical 3:16 6:20 8:21 11:6,7 12:15,20,23 13:13 14:7,12 16:6 17:6,13,22 18:5,20 19:12,15,17,22 20:5 20:9,13,14 25:3,4,7 25:12 29:16 40:24	57:21 68:19,20 69:5 70:12 87:25 96:16 107:24 115:9 117:8 121:15 122:15 123:1 medication 28:13 83:1 96:21 115:15 117:5 118:4,10,10 medications 41:19 97:2 97:20 98:1,5,15 99:9 99:11 100:4 117:11 118:13 124:9,13 medicine 8:17,18 9:2,7 9:10,14,22 10:1,21 11:18,20 12:9 13:10 14:16,22 15:2 16:9 17:18 19:25 20:2 21:17 22:10,22 23:3 23:6,12,23,24,25 24:1,4,5 73:1 117:13 117:22 122:2 128:24 mega 21:4 Melbourne 1:17 18:19 Melissa 105:6,6 member 22:9,11,20 116:6 members 22:17 113:20 Memorial 18:7 memory 6:12 7:16 77:12 mention 115:18 mentioned 13:1 16:8 27:1 83:20 met 106:21 122:15 130:24 133:1 methods 63:23 Metro 3:3 20:7,8 25:2 25:2 29:17 36:15 37:1 38:24 45:16 58:6 114:11 125:16 131:7,8 MetroHealth 19:15,15 19:16 29:16 70:12 metropolitan 121:10 Michael 1:9 70:9,10 73:25 77:7 114:5 middle 4:15 58:20 96:25 98:22 migrating 123:6 Mike 105:7 military 11:12 milligram 96:11 97:6 98:22,23 118:16 milligrams 98:3 119:6 mine 5:22 minute 8:8 90:14,25 116:15 minutes 8:7 35:16 85:11 90:8,12 92:19 97:18 118:18,21	119:14,22 120:11 misplaced 61:21 missing 55:5 misunderstanding 134:10 modalities 63:18 modifying 122:3 monitor 71:25 95:23 months 16:14 17:3 21:15 motion 66:7 mouth 36:17 move 84:18 multiple 31:18 75:11 89:21 Myers 2:15 12:1 106:11 myocardial 47:5 48:12 111:6 112:13 MYRA 2:4	normally 35:21 44:4 95:15 North 1:17 14:5 24:3 Notary 1:21 4:2 137:12 138:4,20 notations 135:8 note 70:19 74:12 78:21 93:17 102:15,18 104:12 noted 33:15 90:12 98:19 99:3 100:20 101:1 106:19 139:12 139:14 notes 25:10 131:12 138:7 nothing's 120:18 notice 139:7 notified 108:1 noting 103:11 number 3:2 23:13 24:8 30:7 39:17 41:12,18 41:23,25,25 42:3 49:19 50:3 56:20,21 60:22 64:5,12 83:16 97:24 98:20,21 101:20 104:12 116:19,20 126:14 139:13 numbers 29:23 NUMBER:CV-05-55... 1:2 numerous 122:9 nurse 76:17,22 116:6 116:15,21,23 117:2,2 nurses 113:25 nurse's 93:17 nursing 25:10 34:11,17 34:21 43:23 65:10 66:17 67:5 101:12 109:17 115:24 116:7 N-A-T-R-I-U-R-E-T... 46:24
M			N	O
Macon 17:14 19:22 20:11,23 madam 35:12 maintain 91:21 major 15:1 80:4,6 81:22 83:9 making 40:24 89:15,15 129:25 male 6:17 7:20 44:2 manage 38:13 management 23:19 71:16,19 managing 71:8 79:7 86:5 mandate 117:12 mandated 57:4 manner 131:25 mark 1:9 50:2 102:13 marked 29:10 40:8 44:18 50:3,7 58:17 64:3 70:2 83:15 85:17 126:12 markedly 51:12,18,19 51:20,21,22 mask 49:15 90:11,15 mass 48:15 massive 111:21 matter 76:16 116:13 139:7 ma'am 4:20 6:5 8:6,14 8:19,25 9:3,6,9,12,16 9:18 10:11,15 11:16 11:19,22,24 12:13 15:7,22,25 17:19,21			N 2:19 name 4:14 14:3,24 20:14 47:18 128:17 139:18 names 105:3 nasal 52:21 natriuretic 46:23 nature 59:19 62:6 79:16 necessarily 61:13 133:14 necessary 5:21 93:20 124:11 131:19 134:1 139:8 neck 46:9 need 5:12 12:2 34:4 44:20 55:21 56:22 58:14 76:25 81:1 90:25 106:9 109:19 118:22 133:14 needed 58:10 59:15 118:18,21 129:19 needs 59:2,3 118:10 123:21 negative 49:9 never 111:22 new 11:7 65:19 87:15 news 109:3 night 7:17 nine 62:3 67:10 NINTH 2:16 nod 5:15 nods 5:10 non 90:14 normal 48:4,5,6,9 49:10 50:14 51:15 52:22 53:11 111:19	oath 5:3,4 137:4 object 121:14 122:22 objected 118:3 objection 22:24 26:22 57:7,24 58:11 61:23 74:18 75:17 80:13 83:23 87:19 88:7,13 88:24 102:3,24 107:17 109:4 110:16 110:25 111:13 115:12 117:15,23 121:23 124:22,23 125:3 objections 123:1 obligation 115:10

<p>observe 109:6 120:25 obtain 43:13 55:7 56:19 57:5 58:1 60:7 63:25 76:25 82:13,25 93:7 131:19 obtained 39:7,11,13,25 42:9,13,13 43:2,3 45:24,25 53:21 69:14 72:1 73:6 82:18 85:11 93:10,19 110:21 131:22,25 obtaining 46:1 obtuse 102:5 obvious 48:11 obviously 6:1 10:12 occasion 21:10 24:17 occasions 4:21,22 occur 90:6 occurred 35:18 75:5 103:4 125:9 occurring 116:8 Oceanfront 1:16 oddly 19:13 offer 72:14 office 1:22 108:1 136:20 officer 12:17 13:2,2,3,7 13:13,25 14:7,12 22:19 OFFICES 2:4 Oh 2:5,10,13,17 40:5 41:9 43:12 67:25 68:13 103:7,14,15 118:12 139:4 Ohio 1:1 9:5,14 18:2 19:12 20:4 124:25 okay 5:16 6:4,12 7:25 20:15 23:10 24:13 25:16,22 26:3 27:7 27:25 28:11,22 29:13 36:1,20 38:3 40:11 47:24 48:2,21 49:21 50:25 59:19 60:9 61:14 62:19 65:8 68:17 69:9 71:12 77:13,14 86:1 87:13 87:17 88:14 89:2,5 92:23 93:25 96:23 97:1 99:6 100:11 102:21 103:18 104:1 107:7,22 119:5 121:13 122:5 133:11 old 44:2 once 7:18 10:17,24 21:15 39:4 46:1 54:19,24 59:17 69:14 84:24 95:21 105:15 110:18,21 118:20,22 119:14,15 129:17</p>	<p>131:8 132:12 139:13 ones 92:10 onset 90:21 92:17 operative 26:4,21 27:2 27:10 28:9 48:14 59:3 opinion 57:3,20 68:19 68:20 79:19 83:6 115:9 124:2,15 128:4 opportunity 128:13 133:24 opposed 110:14 opposite 74:20 options 88:5,12 oral 5:9 9:22 10:9,18 orally 67:4 order 10:12 33:5 40:25 41:1,2,3,5,7,9,10 46:18 69:1,18,18,20 69:21 83:3,16,17,21 85:4,12,23 100:8 132:17 ordered 46:18 47:12,15 50:11 53:20 54:6 56:4,5 ordering 8:2 139:17 orders 125:22,23 organ 58:25 organization 22:15,19 original 129:17 136:20 139:16 Orlando 1:22 139:19 outside 107:19 ovarian 22:5 overall 71:9 overrides 122:13 oxygen 44:5,11 45:14 48:10,24 49:14 53:2 oxygenate 91:25 O2 71:25 O246 29:20</p> <hr/> <p style="text-align: center;">P</p> <hr/> <p>PA 113:4 packet 109:18 page 3:5,7,11,12,13,15 3:18,19,20,22 31:19 49:17,18,18,19,23 58:20 59:8 72:20,21 73:18 78:17 98:20 100:15,18 136:5 139:11,13 pages 3:4,8,9,16 28:17 138:6 139:14 PAGE(S) 3:2 pain 45:23 47:4 77:20 78:7 80:9 PAISLEY 2:12 palpation 46:6</p>	<p>paper 22:4,5 59:6 papers 22:6 par 71:18 paramedic 114:8,11 paramedics 131:7 parameters 48:4 part 27:3 58:25 84:2,3 84:19 92:12 98:9,20 107:3,24 113:6,6 126:2 129:8 130:3 particular 6:13 23:11 76:10 parties 136:21 138:11 party 138:11 Paso 16:3,12 passing 108:18 patient 6:7,13 7:6,18 23:20 24:16 30:18 32:9,11,12 33:19,20 34:2,7,12,15 35:16 35:20,23,23 36:2,6,9 36:10,13,18 38:13 40:1,11 42:9,14 43:3 43:11 44:1,5,6,6 46:15 51:13,14 52:8 53:22 55:19 57:5,12 57:23 58:5,9,13 59:18 61:3,6,12,15 62:12,20 63:2,9,18 65:23 67:20 68:3,6 70:15 71:8,17 72:4 72:11,13,15,22 73:4 73:6,7,11 76:25 77:17,19,23 78:4,6 78:19,21,25 79:3,24 80:7,11 81:25 83:4,7 85:10 86:6 87:5,6,7,9 88:4,6,10,15 89:10 89:16,20 90:23 91:17 91:20,23,25 92:1,12 94:5,18 95:22 98:7 98:12 99:12 100:3,22 100:25 102:2,19 103:7,10,12 105:1 106:6,14 107:10 113:19 115:18 117:3 118:7 119:16 120:9 123:21 125:24 127:24 131:9,15 patients 43:25 56:16,20 56:21 129:9 patient's 47:17 52:25 58:22 71:24 91:21,22 107:5,24 115:22 119:20,23 120:17 Paul 92:9 101:16 Peacock 22:6 peer-review 124:21 penalty 136:22</p>	<p>peninsula 56:15 people 24:1 75:20 101:8 peptide 46:24 percent 21:9 49:15 90:11,14 perform 115:16 performed 8:3 26:15 46:3,5 56:9,10 57:22 60:3,5,7 68:21,23,25 92:25 109:12,20 performing 116:1 performs 104:2 pericardial 66:1 111:20 113:2 period 10:21 119:7,8 125:19 periodical 71:24 perivena 123:8 perjury 136:22 permitted 81:8 persistent 65:25 person 76:2 81:22 92:22 105:20,23,24 108:17 114:15 116:10 119:11 personally 34:16,19 38:25 40:9 74:2 137:6 personnel 7:9 36:25 37:12,18 43:20 63:19 65:10 100:10 109:18 125:13,16 person's 119:21 Peter 106:21 pH 52:20 phase 117:20 phenomenon 56:12 phone 1:23 12:3 75:3,7 76:7 104:9 128:1 133:9 phonetic 101:16 physically 35:22 physician 8:24 11:15 13:3 16:10 20:2 37:25 59:10 76:15 108:2 120:5 125:18 125:22 128:19,23 129:2,13,16 130:5,20 133:16 physicians 56:22 113:25 128:5 129:1 pick 67:12 76:7 piece 28:13 59:6 pink 7:20,20 place 17:9 77:24 88:23 89:18 92:3,21 138:8 placed 58:22 61:2,12 123:5,12 124:4,6</p>	<p>125:24 placement 62:5 placing 123:15 Plaintiffs 1:6 2:2 Plaintiff's 29:10 31:23 33:12 39:15 40:8 50:7 60:10 64:3 plan 102:8,22 plastic 22:4 95:3 played 81:24 133:2 PLEAS 1:1 please 4:13 5:20 46:22 85:2 89:2 136:20 139:7,10 pleural 47:8 48:15,23 54:13,21 111:12,20 112:14 pneumonia 47:8 48:1 48:16 54:13,21 111:11,22 112:13,16 113:3,4,8,11 pneumothorax 47:5 48:18 54:14,22 111:12 112:14 point 17:10 25:23 34:3 38:18 55:4 63:24 69:16 72:11 73:13 74:6 80:11 83:3 90:2 91:4 92:17 95:21 102:25 104:1 110:7 110:12 119:24 120:10 121:1,7 128:25 134:14 pointed 42:12 points 112:7 portion 10:9,16 21:6 25:9 27:20 40:9 102:7 portions 25:24 40:20 40:21 127:18 positive 65:11,12 66:11 67:11 94:1 possibility 108:9 possible 58:2 112:10 130:14 possibly 38:4 post 65:23 93:18 114:1 posterior 66:8 post-op 55:19 83:7 102:12,15,20 potassium 53:11 potential 110:10 pound 41:24 PO2 52:20 practice 9:1,4,7,10,14 10:20 11:18 93:8 122:1 128:24 practicing 11:20 18:6 premarked 4:5 31:16</p>
--	--	--	---	---

33:12 39:15 60:10 96:13 101:18 104:21 106:2 preparation 24:24 25:22 30:14 31:5 prepared 70:8,17 107:10 preparing 127:22 present 39:4 40:3 70:14 86:4 90:18 101:3,6,9,12 105:12 111:23 113:13,18 presented 78:7 presenting 56:20 presently 22:8,9 95:9 pressing 100:9 pressure 90:15 121:2 pretty 6:15 43:17 prevent 58:22,23,24 87:14 123:5 prevents 87:13 previously 70:2 139:9 primary 108:2 117:3 print 28:7 31:12 printed 25:10 104:23 prior 25:15,23 30:2 34:15 36:1,9 37:2 38:24 39:2 44:9 65:19 66:17 79:11 privileged 124:25 probably 15:3 49:24 56:19 65:19 66:2 92:19 94:16 103:9 113:23 117:10 problem 35:24 problems 17:6 47:17 53:5,23 procedure 78:6 115:16 proceedings 91:3 process 5:2 51:9,9 98:6 115:1,11 130:3 product 51:8 products 89:14 profession 14:1 professional 17:18 18:24 19:8 21:7 68:19 79:19 program 12:12 15:8,12 19:19 105:2 proper 62:13 95:16 115:4 properly 92:24 94:18 Protamine 124:14 protocol 115:3 protocols 122:10 provided 24:25 27:5 28:6 44:8 127:10 proximal 65:18 Prudential 19:15	PT/PTT 46:25 48:3 Public 1:21 4:2 137:12 138:4,20 publish 21:22 published 21:25 22:3 pulmonary 21:17,23 23:20 47:7 55:11 57:6 65:17,18,22 66:11,21 67:1 82:25 83:11 88:5,10,16 99:3 104:14 108:5 111:21 112:3 113:11 pulse 95:24 96:3 99:21 117:20 118:8 119:4 120:23,25 121:3,4 pulseless 95:25 99:17 119:11 pulses 119:17 pulse-ox 90:10,14 purple 94:2,5,21 95:17 purpose 91:19 98:5 purposes 61:22 pursuant 124:25 put 76:5,19 92:3,21 putting 71:17 91:23 P.E 55:13,25 102:13 110:14 112:14 123:11 P.E.A 99:15,15 p.m 1:15 50:24 64:13 106:12 134:20	radiologist 63:20 65:10 66:17 67:5 123:10 radiology 62:10 67:10 123:5 124:7 Radision 1:16 rate 90:13,16 97:2 reaching 47:16 reaction 109:7,8 113:22 read 23:22 24:3 27:18 27:20 50:8,20 58:20 59:7 61:16 65:11 70:23 79:2 106:7 111:25 126:22 135:6 136:22 139:10,12,13 139:16 readily 36:12 reading 39:1 59:6 85:23 really 38:13 49:4 52:7 53:13 104:10 105:14 105:14 112:23,23 114:3,17 121:7 128:3 reason 28:15 56:23 58:20 116:25 124:11 125:23 136:5 reasonable 57:21 68:20 115:9 122:14 139:16 reasons 5:12 48:7 reassigned 14:2,3,14 recall 6:16,18,19 7:4 21:21 31:2 36:4 37:6 37:16 38:2,6,16 39:1 42:19 43:17 45:21 50:14 59:25 62:11 66:13,19 67:3,4,17 72:5 73:10,13 74:8 75:3,19 78:23 82:19 83:20 92:5 93:11 101:10 103:19 104:9 108:23 109:10 110:7 113:15 115:2 126:10 126:17 128:3 132:20 recalled 107:15 receive 33:19 34:16 received 7:5,8,10,11 32:9,11,12,16,21 33:2,17,19 34:11,15 35:7 65:3 67:24 97:11 98:18 123:2 receiving 35:16 126:17 recess 91:2 recognize 63:7 recognized 22:17 recollection 6:2,10 7:17 26:18 27:11 34:2,3 35:11 36:24 37:1,11,15,20,24 38:4,14,19,23 63:14	73:23 74:11,15,25 75:1,6,8,14,19 77:12 79:6 82:3,16 84:9,13 86:3 101:5,12 104:7 105:12 109:7 110:4 111:5 114:18 132:1 recollections 72:8 recommendation 15:6 record 3:6,13,21 4:14 5:1,13 27:20 29:12 30:6 33:11 39:16,20 39:21 40:12,13 45:12 45:13 58:18 59:4 60:2 63:11 64:4 69:23,24 70:1 90:25 91:4 101:2,19 104:17 104:18,20 106:3,10 127:8,9,13,14 133:12 133:12 recorded 49:8 61:10 recording 116:15,21 records 6:3 25:3,5,7,12 25:14 28:3 36:8 37:2 44:15 86:21 107:25 116:12 127:16 recover 100:22 REDIRECT 2:20 redundant 121:5 reestablish 120:4 refer 6:3 24:10,17 30:6 34:4 35:11 46:20 59:25 85:9 reference 41:25 42:7,8 43:1 44:22,24 60:19 60:21 61:5 68:7,8,12 72:21 73:19 78:17 85:24,25 99:16,23 100:11 103:11 referenced 41:5 49:18 50:22 86:11 127:5 references 45:6 64:16 92:20 99:14 100:12 referencing 49:19 80:3 referred 24:9 50:8 91:13 referring 29:22 31:15 31:22 33:7 34:14 39:24 40:18 41:3 47:20 51:25 54:2 57:10,12 60:11 85:13 85:21 96:18 103:22 116:4,19 117:5 refers 64:20 reflect 39:11,12,25 40:22 48:22 86:18,21 94:15 101:2 reflected 131:11 reflects 39:7 63:11 108:4	refresh 35:11 104:7 105:12 110:3 regard 34:8 50:11 53:19 63:4 67:13 74:13 regarding 28:3,9 32:1 43:18 45:19 52:25 66:17 67:19 81:15 91:14 106:14 115:10 117:13,21 118:24 128:3 region 93:6 Regional 8:21 18:20 registered 49:9 relates 133:3 relation 16:23 35:1,6 107:1 relative 26:19 27:12 41:10 55:25 138:11 relax 98:7 relaxed 98:10 relayed 76:18 83:2 relevant 125:2 reliance 77:13 relieve 44:3 relocate 19:5 remaining 15:24 50:25 remember 6:23 7:1,19 7:22 8:1 14:3 20:14 22:14 37:17 38:3 44:13 82:7,9 84:10 105:24 108:20 116:24 remembered 6:14,24 108:22 remove 110:23 renal 48:5,8 render 71:21 rendered 34:6 43:15,20 57:15 122:19 128:5 132:3 repair 26:9,19 27:13 43:16 52:1 77:19,23 126:8 repeat 5:21 10:18 119:24 120:13,14,16 120:16,19,20,22 134:8 repeating 4:23,25 rephrase 5:21 replaced 106:11 replacement 102:12,16 102:20 report 3:8,12 26:4,21 27:2,10 28:9 39:4,19 39:23 42:18 43:23 44:21 50:22 59:11 64:9 66:20 70:7,17 70:18,23,24 73:5
---	---	---	---	--

88:2 93:15 133:22 138:6 reported 1:20 80:8 reporter 4:2 13:16 30:23 59:5 138:15 139:15 reporter's 5:14 138:1 reports 24:4 123:11 represent 128:18 reproduction 138:14 Republic 13:18 request 14:18,19,21 115:5,15 118:4 requested 46:2 69:16 86:14 130:9,9 require 56:8 92:23 115:8 118:9,24 required 48:7 84:24 117:11 131:18 133:22 requirement 62:5 requiring 99:8 residency 9:21 10:24 10:25 11:1 12:12 13:11 14:16,21 15:2 15:8,12,17 17:16,17 19:19 123:7 128:22 resident 70:12 71:6,7 72:25,25 76:6,8,23 129:2,22 130:2 residents 20:12 92:8 109:16 113:25 residual 66:4 resource 56:23 respect 23:19 38:11 56:9 73:4 79:20 88:8 101:25 102:1 109:11 115:22 122:18,20 respected 15:5 respiratory 90:3,13,21 91:5,15 92:18 95:20 99:6,7,12 100:2,23 101:3,6 105:13 113:13 115:25 116:8 respond 98:12 responded 114:9 responding 120:10 response 3:16 91:15 95:20 96:5,16 99:2 119:20 120:12 responsibility 71:9,18 125:25 responsible 20:20 71:16 108:17 129:14 129:16 130:6 rest 17:17 restrictions 10:19 result 43:10 51:7,11 52:4,5,6,13,15,19,22	52:23 53:9 64:7 66:18 79:8 110:21 132:4 results 46:19 49:6,6,16 50:8,12 51:4 52:10 52:11 53:7,15 54:7 54:19 55:1 63:12,16 63:17,25 66:14 67:13 69:12,14,16 79:11,22 82:17 110:19,22 130:9 131:22,24 132:12 resuscitate 95:22 resuscitation 116:2 retrocardiac 113:3 return 139:14,18 returned 60:8 62:12 78:19 79:4 returns 63:18 review 25:12 27:6,9 28:5 102:11 114:4 reviewed 24:24 25:24 26:18 28:2,17 38:24 66:13 127:16,22 reviewing 37:1 revoked 9:11 re-assessing 90:23 re-breather 90:15 re-certified 9:23 10:6 10:13 rhythm 99:15 right 7:12 11:3 12:18 14:11,15 20:1,11,17 24:6 27:9 28:3,4 29:1 29:3,4 30:12 31:4,22 31:25 32:11,17 34:14 34:22 35:15 37:24 40:23 44:24 45:7,11 49:23 51:24 52:2,9 53:9 54:15 57:18 60:13 61:8 64:19,21 65:3,17 66:8,10 67:1 67:18 68:2,3,5,13 71:20 73:18 74:24 75:6,24 76:4,10 77:1 77:11,14 78:11,15,16 81:12 82:12,23 86:16 88:21 89:14,20,22 90:17 91:13 94:3,24 95:15 98:21 99:18,20 99:22 100:17 101:13 103:17,25 105:21 111:6 114:20 116:22 118:7,23 124:2 126:4 129:24 right-hand 29:19 98:22 rising 93:3 risk 4:23,24 83:6 87:7 risks 89:16,24	RN 105:3,5,7 Road 2:5 Robinson 139:18 robust 6:16 7:19 Rockside 2:5 ROETZEL 2:16 role 71:4,5 73:7 79:20 81:24 105:8 106:18 115:24 133:2 room 7:1,18 8:24 25:25 32:24 35:2,3,4,20 56:10 61:6 62:20 63:3 64:22 68:4 92:10 108:22 120:5 126:8 128:19 131:3,4 131:6,8 133:3 root 43:17 102:12,15 102:20 Rosen's 23:22 rosy 7:20 rotating 70:13 72:25 129:2 roughly 96:11 125:20 round-robin 114:1 route 9:20 routine 35:25 routinely 107:15,19 rugged 21:1 rule 53:23 54:8,16,20 54:23 55:2 111:6,11 133:20 ruling 112:13 run 24:25 25:2 29:3 30:16 31:1,2 43:22 127:19	99:3 110:22 111:23 113:1 school 11:6 19:12,23 20:5,13,14 Schwartz's 23:23 sebaceous 66:8 second 5:13 16:7 37:6,7 42:21 72:20 73:18 84:3,19 119:18 134:5 secondary 102:13 104:14 secretarial 76:18 78:14 secretary 76:14,15,23 section 59:1 99:15 see 14:2 23:15 33:14 35:6 43:12 44:16,21 47:22,25 48:10,11,13 49:2,4,16 53:8 54:13 64:13 70:3 73:20 78:21 89:11 93:6,14 103:10 105:4 108:6 111:17 113:7,9 121:1 122:10 seeing 7:6 31:2 105:11 105:24 113:15 seen 26:20 27:11 30:2,9 30:14 58:18 66:2,8 86:20,23 95:2 111:23 sense 101:9 sent 72:1 sentences 59:24 separate 6:20 40:6 September 1:15 139:1 139:7 serial 89:10 serious 58:23,23,24 serve 13:6,9 14:9 15:21 served 22:18 service 11:11 33:21 58:6 76:15 77:4 82:14 106:20 107:4 123:18,19,23,25 services 1:22 76:17,18 82:11 83:3,5 139:22 set 49:25 138:8,9 seven 97:18 severe 7:24 45:22 59:20 90:9 Severyn 2:4,22 4:12 12:5,7 13:23 23:1 26:25 27:18,21 28:22 28:25 31:3 33:1 35:9 35:14 37:9 39:22 45:3,9 50:1,5,17,21 51:17 54:3 57:11 58:3,15 59:13 62:1 68:11,15,17,18 69:23 69:25 74:23 75:23 79:18 80:16,19 81:5	81:19 84:7,20 85:3 85:16,19 87:21,23 88:9,18 89:1,4,12 97:25 102:6 103:2 104:19 107:21 109:5 110:20 111:3 112:2 115:20 117:17,25 118:6 121:19 122:4 122:24 125:4,6 127:13,15 128:11 133:7 134:3,15 SEVEYRN 41:8 sheet 3:16 25:1,2 28:7 28:13 30:4,16,18 31:1,2 96:15 104:23 125:24 127:19 135:8 136:1,20 139:11,12 139:14 sheets 25:11 29:3 43:22 shifts 19:16 73:17 short 91:2 shorthand 138:7 shortly 56:5 shortness 7:3,3,23,24 34:13 44:2 45:22 47:4 77:20 78:8 80:9 90:9 102:12 104:13 show 49:20 54:10 112:3,6,8,17 113:1 showed 111:22 Showenhausen 101:16 shows 53:10 side 17:1 32:7 40:23 105:21 sides 93:1,4 Sierra 16:6,13 sign 41:23,24 108:1,3 139:8,14,16,18 signature 40:23 133:8 133:12 136:24 139:8 139:18,23 signatures 116:14 signed 70:23 72:22 136:20 significance 38:9 117:8 significant 100:13,16 101:23 102:1 114:1 signs 48:12 60:1 85:10 simply 28:2 122:12 sit 6:9 26:17 101:11 106:25 site 48:14 sitting 76:16 situation 36:12 76:3 81:7,18 115:25 117:11,19 119:3,16 120:2,8 122:10 123:4 123:9 six 16:14 22:6
--	--	--	---	---

S

size 92:22 slash 102:8 slew 23:8 47:8 93:22 Slip 3:19 126:15 slow 63:20 small 65:22 66:1,4,7 smaller 89:13,15 someones 75:11 somewhat 48:23 66:6 soon 58:2 sorry 10:6 13:16 27:17 30:23 41:4,9 53:8 67:22 68:16 84:1,6 94:10 116:15 134:7,9 sort 129:10 sound 13:22 sounds 114:22 source 43:5,9 85:4 speak 21:1 34:19 36:5 36:17,21 59:23 74:2 74:6,9,20 108:14 109:11 113:17 114:7 125:7 127:23 130:14 130:16 speaking 7:22 36:4,9 37:2,11,16,17,20,25 38:6,25 39:2 56:5 73:10 74:16 75:7,20 82:19 83:21 special 38:9 specialist 12:10 74:4,17 82:17 110:5 specialists 74:25 specially 82:19 specialty 8:18 9:24,25 129:1 specific 34:5 46:21 74:10,15,21 specifically 44:21 45:6 64:20 76:13 82:9 83:21,24 92:4 98:9 101:10,10 114:2 117:7 spell 4:13 spelling 101:16 spent 16:14 110:1 split 51:8 89:14 Splitting 89:14 spoke 37:13 38:20 39:24 74:22 75:2,8 75:10,14 77:5 113:21 114:15 125:8 spoken 36:2 38:4 74:11 74:25 77:18 78:5 82:3,20 106:21 spouse 109:15,22 stable 44:6 59:21,23 60:1 staff 15:11 17:6 19:17	101:12 115:24 116:7 128:6 stamp 32:8 33:8 stamped 29:20 49:21 stand 4:17 102:8 standard 56:8 57:4,20 92:23 115:8 117:12 117:21 118:9,24 121:11,12,21 122:15 128:7,9 133:2 134:17 standing 9:15 Stansbury 1:4,5 6:7,10 24:16 25:8,18 26:8 29:2 31:6,8 32:2,3 34:8,20,23 36:21 37:3,13,19 38:15,25 39:8,13 40:4 44:9 45:18 46:3 47:11 51:21,23 52:17 53:16 56:6 57:12 59:15 60:4,13 61:16,20 62:6 66:21 71:4,6,10 71:22 72:6 75:4,16 75:21 79:7 80:9 89:21 90:3,20 91:5 95:19 103:21 105:9 108:5,14 109:11 110:2,8,13 113:16,19 114:9 118:8 122:16 122:20 123:24 126:7 127:24 128:8 129:6 130:24 132:3 133:3 139:5 Stansbury's 24:21 25:15 43:14 73:15 91:10 106:18 120:9 124:20 129:14 start 87:22 started 47:21 64:18 78:20 79:5 85:12,23 100:19 starting 34:7 132:17 starts 78:15 STAT 69:2 state 1:21 4:2,13 9:2,5 9:8 19:12 20:4 100:19 135:3 137:1 137:12 138:2,4,20 stated 28:2 70:16 statement 69:4,10 108:8 statements 135:6 States 121:9 stationed 13:14 status 65:23 stay 94:6 stayed 16:3,8 stenotype 138:6 steps 131:18	sternotomy 65:24 stomach 93:7 94:6 Straight 16:25 Street 2:16 139:19 strike 11:17 43:8 55:6 61:15 67:2 90:2 125:7 students 20:9,12 21:3 studied 15:10 study 15:9 subcutaneous 65:25 subject 136:23 subsequently 9:22 43:24 substance 136:23 sub-harmonic 48:17 sub-set 28:21,23 successful 94:23 successfully 10:24 115:17 sudden 105:19 suggest 44:24 52:13 53:2 61:5,11 66:3 112:12 suggestive 51:8 suggests 52:14 Suite 1:16 2:5 139:19 summary 3:15,18 106:4 107:2,9,14 108:4 127:3,7 supervising 71:12 129:1,5 supervisor 129:5 supply 49:14 support 78:14 supposed 18:4 supposedly 47:7 sure 6:16 7:10 23:2,25 24:6 25:18 30:12 33:25 42:12 43:6 47:19 48:5,7,8 68:7 87:24 89:4 93:2 100:8 102:5 106:9 107:18 108:25 110:12 111:1,4 115:13 117:16 139:14 surface 95:3 surgery 19:24 26:9,15 28:9 38:7,16 43:18 47:7 51:23,24 52:3 52:14 69:15 72:12 73:20 76:1 79:16,20 80:4,6,10 81:23 83:8 83:9 132:10 surgical 20:15 83:10 surrounding 66:2 124:20 surviving 109:15,22	suspected 23:20 57:5 suspended 9:11 Suxamethonium 98:4 Suzanne 1:4 139:5 Svenson 26:5 Swenson 26:5 27:2 28:9 sworn 4:9 137:6 138:5 symptoms 80:8 syndrome 22:6 system 31:13 69:5 104:24,25 S's 105:6	teach 21:2,11 teaching 19:9,11,18,20 20:3,19,21,21 21:7 56:18 team 36:3,6 38:5 43:21 technically 14:23 18:18 technician 76:22 telephone 2:14 67:12 82:4,8 106:12 126:6 telephonically 65:9 114:16 tell 5:1 9:19 11:4 31:7 47:14 50:12 60:2,5,6 66:20 74:21 75:5,12 75:22 76:22 82:9 90:5 103:3 105:23 109:2 111:24 116:12 telling 7:23 45:21 tells 61:9 117:10 ten 17:3 22:13 tendency 36:16 term 121:24 Terminal 2:13 terms 13:25 20:1,18 22:19 38:3 71:18,19 test 46:3 47:18 52:6,10 53:7,14 55:1 56:1 64:17 69:12,14 131:22,24 testified 4:10 133:18 testify 133:15 138:5 testifying 5:5 134:12 testimony 84:11 111:4 testing 69:1 tests 8:3 46:19 47:12,14 47:15,19 49:6 50:11 50:12,25 53:19,21 54:2,4,6,7 55:24 56:4 130:6,8 Texas 12:25 14:14 text 23:6,8,11 24:10,17 Textbook 23:22,23,24 textbooks 23:13 24:1 texts 22:1,22,23 23:2 23:18 24:9,14 thank 69:22 84:21 125:5 130:17 133:6 theoretical 120:4 theoretically 81:16 thickening 66:1 thing 22:16 55:4,4 60:18 87:16 107:3 128:3 129:10 things 4:23,25 47:9 49:3 55:13,18,21 82:10 93:22 103:1 105:22,24 109:19 111:16 112:8 122:7 think 4:22 7:4 10:3,8
--	---	---	---	--

<p>10:18 14:10 16:6,8 16:14 17:3,11 18:9 18:15 20:6 22:14 26:4 28:12 29:2 30:5 30:22 32:24 35:8 39:10 41:23 47:5,21 49:9 50:2 58:5 62:9 69:5 70:16 82:4 83:20 84:2,4 85:16 90:17 91:6 92:9,16 92:20 105:23 109:1 109:17 116:18 118:12 128:9 131:21 134:2,18 thinking 134:3 third 32:7 58:19 96:25 thirds 72:21 thorough 134:2 thought 15:3 17:8 threatening 79:25 83:12,12 three 30:13 54:23 84:3 throat 91:24 thrombi 65:17,22 66:25 thrombolytic 98:25 Throw 80:17 Thursday 1:15 till 11:14 18:17 time 5:18 6:3 9:11 10:21 11:21 13:11,19 21:7 24:13 26:7 27:14,15 31:8 32:2,7 32:11,13,15,17,18,20 32:21,22 33:2,2,14 33:17,18,19,20 34:25 35:9 36:20 37:15,21 38:18,21 43:7 47:3 47:10,11 49:11 50:13 50:22 51:2,6 54:15 56:9 57:3,19 60:3,5,7 60:13 61:6,9 62:11 62:15,24 63:15 64:12 64:16,20 66:13,19 68:8,11 69:16 72:11 73:17 74:21 75:15 77:22 78:24 80:11,23 83:3 84:9 90:2,18 91:4 92:9,17 95:21 97:2,12,16,22 99:13 100:25 103:1 106:9 109:7 110:1 113:16 118:24 119:7,8 120:10 121:1,7 122:13 125:19 126:10 128:12 130:13 131:15 132:3 138:8 139:8,16 timed 33:6</p>	<p>timely 68:22,23,25 131:25 times 15:23 71:10 84:3 84:25 85:2 128:6 timing 67:19 Tintinalli's 23:24 today 5:8 6:9 25:22,23 30:3 101:11 106:25 114:18 126:9 127:18 133:18 134:2 told 4:25 10:8 36:19 55:24 56:3 74:19 76:17 78:5 91:6 93:22 107:5 top 26:7 64:13 70:19 95:3 96:22,24 100:18 103:14,17 127:25 topic 21:2,16,23 24:11 total 17:3 totally 80:15,25 touched 21:19 tough 18:9 Tower 2:13 TPA 98:22 traffic 56:21 trained 14:18 15:2 128:22,23 training 15:18 17:17 129:1 transcribing 63:22 transcript 114:4 136:3 138:13 139:9,13,14 transcription 70:6 138:6 transfer 58:21 transport 25:1 30:18 59:10 transported 59:16 transporting 36:15 63:19 traveling 93:6 treat 88:17,20 89:6,7 treated 25:18 82:15 treating 52:8 88:10,15 128:7 treatment 6:19 7:15 21:17 24:21 25:8,13 25:15 37:18 43:15,19 44:8 45:15 57:14 69:13,17 71:4,6,10 71:21 78:24 80:11 81:24 88:5,11,22 90:21 91:15 95:20 96:4 97:8 100:5 102:2,23 103:21 110:2,7,12 116:8 117:13,14 122:16,19 125:12,15 128:5 trick 27:22 84:8</p>	<p>Troponin 46:23 47:21 47:22 49:8 50:9 true 69:4,9 118:20 135:7 136:22 138:6 truly 84:8 139:20 truth 138:5 try 12:5 58:1 80:4 111:4 trying 27:22 84:8 102:4 tube 90:24 91:23 92:3 92:21 93:5 TUCKER 2:9 139:3 turn 23:7,8,14,18 72:20 110:14 turned 23:11 24:13 110:9 two 4:22 5:12 13:8,17 13:24 15:14,20,24 16:4 17:24 33:3 37:4 37:10 42:12,25 45:8 63:23 72:21 85:11 86:10 90:11,25 98:16 98:23 105:6,22 119:6 type 7:21 11:20 12:11 47:6 56:11 83:8 92:20 94:7,10,10,25 100:9 112:25 114:1 118:9 types 94:14 116:3,5 122:7 typical 115:3 typically 33:14,23 36:5 36:8 63:16 67:7,12 76:20 93:12 102:8 106:5,7 109:14 114:22 115:21,23 116:6 120:6 123:14 123:17 124:6 125:24</p> <hr/> <p style="text-align: center;">U</p> <hr/> <p>uh-huh 5:11 84:15 111:7 114:23 125:21 uh-uh 5:11 ultimately 129:14 132:4,16 umlaut 13:20 unavailable 76:6 unclear 5:20 undersigned 137:5 understand 5:6 6:6 8:9 84:20 85:25 111:1 118:12 132:8 understanding 27:24 38:15 77:25 81:12 84:9 87:4 102:14,17 109:21 126:23 130:23 understood 5:23 84:11 106:17 114:8</p>	<p>unilateral 48:16 unit 13:4 25:1 36:15 United 121:9 units 43:24 87:2,3 unresponsive 91:20 92:12,13 99:8 unusual 107:14 112:5 upper 56:15 60:23 65:22 66:8 upstairs 56:22 urban 56:18 57:1 use 30:18 79:24 83:1 95:8 114:24 118:13 118:15,17 useful 52:7 usually 10:23 44:20 76:14 80:4 86:6 106:13 107:12,23,25 109:17 113:4 115:5 115:14 116:10 utilize 56:22</p> <hr/> <p style="text-align: center;">V</p> <hr/> <p>vague 37:20,24 38:4 110:25 Vaji 116:16,17,23 value 51:15 valued 51:5 varied 95:6 Various 116:5 vascular 61:3 vena 65:21 Venturi 49:15 90:11 verbal 43:23 65:7 verbally 5:10 67:4 versus 77:13 86:4 139:5 visit 28:3 71:22 123:2 Vista 16:7,13 visually 35:22 vital 60:1 85:10 Vitamin 124:14 voice 12:5 volume 56:15 vs 1:7</p> <hr/> <p style="text-align: center;">W</p> <hr/> <p>wait 79:7,11 116:15 waiting 7:1 waive 133:8,11 139:8 139:17,23 wall 65:25 66:9 93:2 Walt 106:15,21 want 4:25 5:14 35:9 50:15 54:1 63:5 81:2 109:23 118:25 119:13 121:24 133:23 134:5,9 wanted 8:3 46:2 79:10</p>	<p>81:20 89:5 130:21 134:13,16 wasting 80:23 watched 35:13 131:2 wavy 6:17 way 19:5 33:2 45:15 46:5,19 47:2,20 52:16 53:12,15,21 54:13 62:16 64:19 86:6 88:20,22 90:20 95:19 96:4 97:8 100:5 104:7 105:11 107:14 110:3 114:16 116:8 132:3 Wayne 105:3 week 20:24 21:3 77:25 79:17 went 11:11 16:17 18:2 20:8 21:4 25:10 47:19 90:3,10 91:5 99:12 weren't 62:13 WEST 2:9 139:3 Western 20:6,10 WESTON 2:12 we'll 7:15 31:14 41:15 we're 6:6 8:10 57:13 64:9 80:23 117:5 126:9 we've 34:4 40:16 44:18 78:18 83:15 85:17 100:2 110:1 134:2 wheeled 35:20 wheezing 90:12 white 6:16,17 7:20 44:2 widow 126:7 wife 113:21 William 12:15,19,20,23 wish 108:2 109:20 119:11,25 120:13,13 120:19,19,22 139:12 139:17 wished 78:19 79:3 84:11 withdraw 125:4 witness 2:20 13:17,21 22:25 26:23 27:16 28:23,24 30:25 32:22 32:25 35:12 37:7 45:5 50:19 51:14 57:9 58:1,12 59:9 61:24 68:14 69:21 74:19 75:18 79:14 80:17 81:3,12 83:24 84:1,5 85:18 88:8,14 89:5 97:23 102:4,25 107:18 110:18 111:1 111:14 115:13 117:16 118:4 121:17</p>
---	--	---	---	---

122:1,23 133:15,17 137:6 138:5 words 10:20 35:10 work 14:17 16:20 19:16 95:9,11 worked 13:12 14:7 15:1 16:3,9 20:9,12 working 12:9 18:13 19:4 works 5:2 world 105:20 worse 44:6 wouldn't 86:19 92:7 126:1 write 136:3 139:13 writing 39:3 written 9:22 10:9 21:16 40:25,25 41:1,6 86:22,24 93:17 wrote 62:22 69:18,18 69:19 83:3 wrought 17:5 Wysocky 105:6 W-Y-S-O-C-K-Y 105:7	0250 29:20 30:11 0302 39:17 0305 64:5 06/21/2007 137:13 138:21	1982 12:22 1987 15:19 1989 11:23 16:2 1991 17:10 1993 10:3,5 1995 18:15	39 3:8	88 90:15 89 11:14
X	1	2	4	9
X 2:19 3:1 x-ray 46:25 48:13,20 48:21 49:3,4 50:14 50:19 54:11,20,24 55:9 56:2 93:7,10,16 93:19 110:22 111:10 111:14,17,18,25 112:9,25	1 3:3,5,7,11,12,13,15 3:18,19,20,22 4:5 29:10 44:19 53:10 58:17 59:1 83:16 1/16/03 65:20 1:15 106:12 1:59 1:15 134:19 10 3:16 96:13 98:20 100:12,15 116:20 10th 2:17 10,940 51:5 10:07 126:16 10:10 1:15 100 3:16 101 3:11 103 3:11 104 3:20 106 3:15 107 3:15 11 3:17 113 90:16 1150 2:9 139:3 116 3:16 12 3:19 21:3 22:14 55:19 83:7 126:12,14 126 3:19 128 2:22 13 3:20 4:5 31:17,23 104:21,23 13th 26:10 136 139:11 1375 2:16 14 3:21 50:2,3,7 15 21:3 16 90:8 16th 66:14,18 17 53:10 61:6 62:20 64:22 17:33 32:5 67:21 68:1 17:50 49:13,13 18 45:6 87:3 18:00 49:8,12 18:07 49:13 187 49:10 189 49:9 19 103:8 19:00 73:16 103:8 19:27 60:15 62:21 65:1 19:34 41:23 19:35 60:19 61:5 62:20 195 90:15 1981 11:9	2 3:5,8,9,16 33:12 40:17 41:15 42:23 78:17 83:16 87:2 97:24 98:20,21 100:15 104:13 20 21:9 45:7 60:22 20:15 60:17 63:10 64:23 68:4 85:10 20:30 85:10,11 20:46 90:7 20:56 90:23 91:16 100:19 20:57 96:9 97:3 20:59 97:13 200 45:16 139:18 2003 8:9 10:7 25:13,19 26:1,10,13 57:14 70:11 71:5,23 73:11 78:25 86:21 94:8 106:18 110:3,8 122:21 123:3 125:10 126:16 133:4 2004 18:18 125:19 2005 1:15 135:10 137:7 138:16 139:1,7 21:02 97:17 21:16 101:1 22 1:15 139:7 220006 137:12 138:21 25 8:9 25:13,19 26:1,13 57:14 70:11 71:5,23 73:11 78:25 86:21 94:8 106:18 110:3,8 122:21 125:10 133:4 25th 123:2 2500 2:13 27 139:1 28 52:12 29 3:4 41:25 29022 41:24	4 2:22 3:8 39:15,17 40:8 42:6,18 70:3 72:18 73:19 78:17 126:16 40 3:5 42 3:5,8 425 139:19 44 3:4 90:13 44113 2:13 44114 2:17 44115-1475 2:10 139:4 44131 2:5 46 29:25 30:12 47 30:13 48 30:13 49 30:13	9 3:14 52:12 106:2 107:13 9/22/05 136:2 90 3:13 92 3:13 925 2:10 139:4 95 90:11 125:19 96 3:16 97 3:5 98 3:5,16
Y			5	
yeah 26:23 28:23 67:25 102:25 113:6 year 10:4 11:8 12:21 14:10 15:17 18:10,13 44:2 56:16 years 6:1 13:8,24 15:14 15:20,24 17:25 22:13 22:14 23:17 62:3 67:10 yellow 94:4,6,18 95:4 95:15 York 11:7			5 3:4,9 50 3:22 29:25 30:13 49:15 90:11 98:22,23 5005 2:5 57 44:2 58 3:4 59 52:20	
0		3	6	
0046 49:24 01/25/03 50:23 022 42:1,2 0246 30:11 0247 29:20 30:8 0248 29:20 30:10 58:19 59:9 0249 29:20 30:10		3 3:6 41:15 3,9 53:11 30 98:3 31 3:20 3101 1:17 321,541,1082 1:24 32801 139:19 32940 1:17 33 3:5	6 3:10 101:18,20 103:3 6,000 56:16 60 3:13 600 2:5 64 3:12 68 3:12	
			7	
			7 3:12 64:3,5 68:9,12 72:17 7,48 52:20 7:44 50:24 7:58 64:13 68:8,12 70 3:8 72 3:8 758141 1:22 78 3:8	
			8	
			8 3:13 60:10 85:15,17 85:20,22 90:7,22 91:14 92:20 8,0 90:24 92:22 80 87:2 81 11:14 83 3:5 90:14 85 3:13 87 3:5 877,546,7676 1:23	