IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

JANET L. PORACH, ADMINISTRATRIX, etc.,)
Plaintiff,)
-vs-) JUDGE CALABRESE
) CASE NO. 316045
LORENZO S. LALLI, M.D.,)
Defendant.)

- - - -

Deposition of ROBERT E. BOTTI, SR., M.D., taken as if upon cross-examination before Susan M. Cebron, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Robert E. Botti, Sr., M.D., 24701 North Lakeland Boulevard, Euclid, Ohio, at 10:30 a.m. on Thursday, September 18, 1997, pursuant to notice and/or stipulations of counsel, on behalf of the Defendant in this cause.

- - - -

MEHLER & HAGESTROM
Court Reporters
1750 Midland Building
Cleveland, Ohio 44115
216.621.4984
FAX 621.0050
800.822.0650

APPEARANCES:

Howard D. Mishkind, Esq.
Becker & Mishkind
Suite 660 Skylight Office Tower
1660 West 2nd Street
Cleveland, Ohio 44113
(216) 241-2600,

On behalf of the Plaintiff;

Ronald A. Rispo, Esq.
Weston, Hurd, Fallon, Paisley & Howley
2500 Terminal Tower
Cleveland, Ohio 44113
(216) 241-6602,

On behalf of the Defendant.

ROBERT E. BOTTI, SR., M.D., of lawful age, called by the Defendant for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF ROBERT E. BOTTI, SR., M.D.

BY MR. RISPO:

Q. Doctor, my name is Ron Rispo. I represent Dr. Lorenzo Lalli in this matter. I am here to ask you a number of questions. If at any point along the way the question is not clear, we would all prefer that you stop and have me clarify it or repeat it, is that clear?

A. That's clear.

Q. Okay. Doctor, I will skip the usual as far as credentials are concerned. We all know that you are board certified, is that right, in cardiology?

A. No, I am not board certified. I am board certified in internal medicine and I am board eligible in cardiology.

Q. I do want one preliminary, however, to be taken care of so there is no surprises later on. What is your standard hourly rate for deposition?

A. $200.00 an hour.
Q. And is it different for trial purposes?
A. No.
Q. Okay.

MR. MISHKIND: Off the record.

- - - -

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

- - - -

Q. Moving on, doctor, you have been requested to consult in this matter on behalf of the Porach family. You have consulted on many other cases from time to time, haven't you?
A. Yes.
Q. How often or how frequently do you consult on matters that go to court?
A. Well, I think infrequently because most of them are probably settled before they get to court.
Q. Backing up then, how often do you consult on matters that involve claims of medical malpractice?
A. Oh, I would say probably about six a year, something like that.
Q. Okay. And do you testify exclusively on one side or the other?

A. No, I do not.
Q. About 50/50?
A. No. It would be predominantly for the defense. Probably 80/20, I would say.
Q. Have you personally authored any publications that deal with the topics of diagnosis of myocardial infarction?
A. I think the answer is yes. It depends on how you want to interpret some of the studies that were done. We did some studies on old people with myocardial infarction, and we did some studies on certain electrocardiographic abnormalities and myocardial infarctions, but I have not looked at these things recently to see if it is perfectly germane.

Can I get a copy of my CV?

MR. MISHKIND: Do you want his CV?

MR. RISPO: I would.

Q. While we are waiting for that, can I ask you what articles -- I'm sorry -- what references you would consider authoritative on the subject of this case that you reviewed for the Porach family?
A. I didn't review any articles for this case.

Q. If you were to consult any references, I know you have the body of medical information committed to memory, but if you were to refer to authoritative sources on the diagnosis of myocardial infarction, signs and symptoms, what sources would you refer to?

MR. MISHKIND: Objection.

A. Can I answer?

MR. MISHKIND: Yes. My objection is only for the record based upon not only the form of the question, but --

A. I think the number one textbook is Braunwald's Textbook of Cardiology.

I have the CV now. Can I just look it over for a second.

Q. Take your time.

A. There is an article on acute myocardial infarction, which is not germane to this case. It has to do with certain electrographic criteria, which this patient didn't have. So it is not germane to this case.

Q. It sounds to me that it might be interesting and something I might like to read.

A. The title is Significance of Isolated Left Anterior Hemiblock and Left Axis Deviation

During Acute Myocardial Infarction. It's Number 25 in the list of publications.

Q. Okay.

A. And then I have one on Acute Myocardial Infarction in the Elderly, which, again, is reference Number 30, but that is not germane to this case

And I think those are the only two that are really even remotely related to this.

Q. Okay. Perhaps we could make copies of this later.

A. Fine.

Q. Getting back to references then, you said Braunwald's?

A. B-r-a-u-n-w-a-1-d. It's called Heart Disease, A Textbook of Cardiovascular Medicine. The Fifth Edition is the most current one.

Q. Any others that you would routinely refer to?

A. Well, there's a volume that comes along with it, it's called Cardiovascular Therapeutics, A Companion to Braunwald's Heart Disease, and the editor of that is Smith.

Q. Do you have occasion from time to time to refer to Robbins Text Pathologic Basis of Disease?

A. No.

Q. Or --

MR. MISHKIND: Give me the name of that, Ron, please, Pathologic Basis of --

MR. RISPO: Of Disease.

Q. Or Coronary Care edited by Dr. Gary Francis?

A. No.

Q. Or Silent Myocardial Ischemia and Infarction by Peter Kohn?

A. I am familiar with his work and I read his articles.

Q. Or Clinical Cardiology by Lang?

A. No.

Q. Or Myocardial Infarction by Arie Goldberg?

A. I am familiar with that book, but I have not referred to it at all. I don't refer to it.

Q. Would you consider it authoritative?

MR. MISHKIND: Objection.

A. I have no opinion on that.

Q. Have you received copies of the office records of Dr. Lalli in connection with this case?

A. Yes.

Q. Have you had occasion to review the EKG's in that set of records?

A. Yes.

Q. Do you have two pages of tracings?

A. Yes, I have two tracings. One is complete and the other is incomplete.

Q. Okay. Let's get that straightened out right away because I noticed that myself.

MR. RISPO: Off the record.

- - - -

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

- - - -

(Thereupon, Defendant's Exhibit 1, Botti, two-sided document entitled Bipolar Limb Leads was marked for purposes of identification.)

(Thereupon, Defendant's Exhibit 2, Botti one-page document containing echocardiogram strips, was marked for purposes of identification.)

- - - -

MR. MISHKIND: Let me just indicate on the record that before any questioning is asked of the doctor, which I certainly have no problem with the questions being asked, but Exhibit 1 that Mr. Rispo just had marked is a two-sided

page of EKG strips.

This two-sided page, this is the first time that I have seen it, and notwithstanding having received the office records from Dr. Lalli, and I think the production of documents from you previously, I only had the one side, which has the one side of them, and I am not sure whether that is terribly relevant to the issues in the case, but I just want the record to reflect that.

MR. RISPO: The side that you have is the opposite of the side that I have. Only after I discovered the problem that I found these were available and I apologize to both of you for that inadvertence, but it was a clerical mistake on our part.

Q. Doctor, you have had a chance to review both Exhibits 1 and 2 now?

A. Correct.

Q. If you require any further time to review those, feel free to do so. 1 suspect that you won't though, however, and we will proceed.

Let me also ask if you have had the opportunity to review the transcripts of the

depositions of Mrs. Porach and her daughter, daughters?

A. Mrs. Porach is Janet?

Q. Janet, correct, and her daughter would be Jaclyn DeWitt.

A. The answer is yes.

Q. Okay. Good. Based upon your knowledge of the file, doctor, what is your understanding and recollection of the symptoms as reported of the patient John Porach in the morning prior to his death?

A. I would have to review the --

Q. I won't ask you to do that. I thought maybe you might have it noted.

A. If I remember -- well, I better review it because he had a lot of symptoms.

In general, he had generalized aches and pains throughout his body, including his chest. He was feeling poorly. I believe he had diarrhea that morning. I can't remember, he may or may not have had shortness of breath on that morning. I really can't remember that.

I don't know where that is all documented by way of -- those are the symptoms I remember, although I'm not sure that that's all inclusive.

MR. MISHKIND: Doctor, if you want to look at Page 22 of Mrs. Porach's depo, I don't know whether you want --

A. Okay. According to Mrs. Porach's deposition, he was in a cold sweat and he was short of breath, he felt like he couldn't breathe. His stomach was upset. That's all I see here.

Q. Okay. Is that the information that you had and upon which you based your opinion as stated in your report of June 2nd?

MR. MISHKIND: Well, let me object. You asked him about the daughter's deposition and the wife's. He has only referred to the wife's deposition. He has not referred -- in response to your question he did not refer to the daughter's testimony at this point, and he had the daughter's deposition. So I don't want the record to be misconstrued.

A. The answer to your question is no, though, because I had a number of depositions and I had the visits in the office, Dr. Lalli's office, I had the emergency room records, and I had a statement of a life insurance statement by the physician.

So my opinion was based upon all of those records.

Q. The totality?

A. Correct.

Q. But what I am asking for in particular is the complaints of symptoms and signs, and as to that I believe the primary source of that information is in the transcripts that I referred to earlier, Janet Porach and her stepdaughter, Jaclyn DeWitt. If I am not correct in that I --

A. Well, also in the deposition that the receptionist gave.

Q. Of course.

A. She talked about a number of symptoms in there, too. That's Janice Schoch, is that correct?

Q. Yes. And you did have that available to you?

A. And I had that available, too, and I think in there she talked about what she thought were a lot of the symptoms that he called in about.

MR. MISHKIND: Page 9, doctor.

A. Well, Page 8, for example, has aching in the chest and shoulders, okay? And then on Page 9 he had aching all over, including his chest. So that's based upon the totality of those records as far as the symptoms go, okay?

Q. Okay. Let's take it in chronological step-by-step analysis then, if we might.

Janet would be the first witness, if I'm not mistaken, who would have knowledge and provide us with the signs and symptoms in the morning prior to her departure for work on the morning of October 14th, and I would ask you based upon her report whether you believe -- if you believe that John Porach had a myocardial infarction in the morning?

A. Now, I don't quite understand your question. What do you want me to assume?

Q. Okay. Let me maybe put a little more framework on this.

MR. MISHKIND: You need to be more helpful with your question.

Q. As I understand the testimony, the first report of symptoms came somewhere around 5:00 in the morning?

A. Correct.

Q. And the first witness to those was Jan, Janet Porach, and her knowledge was limited to the period between 5:00 in the morning and 7:00 or 7:30 when she left for work, and so if I may segment for the purpose of our question and ask

you based upon the symptoms that she reported then, which I think you recorded earlier as diarrhea, tingling in the arms and legs, feeling poorly, aches and pains throughout his body, if that's a correct summary --

A. Cold sweat and couldn't breathe, also.

Q. Okay. Assuming those were the symptoms as reported by Janet, then during that period between 5:00 a.m. and 7:30 do you have an opinion whether John Porach had an MI that morning?

A. Just based upon those symptoms, not subsequently what happened?

Q. Yes.

A. The opinion is I couldn't tell.

Q. If you had to base an opinion based on those symptoms, what would be within your differential?

A. Acute myocardial infarction or heart attack, pneumonia, with this viral symptomatology, it could be viral infection, pulmonary embolism, that's the main ones I could think of.

Q. Okay. When you say viral infection, would that include the flu?

A. Yes, but it would not include the flu alone

because you would have to assume that he had pneumonia as part of the flu like syndrome, because the business of being short of breath is not typical of flu symptoms unless there is pneumonia or something to cause shortness of breath, okay?

Q. Okay. Fine. But MI would be among those differentials?

A. Correct.

Q. And of the symptoms that would lead you to a differential of MI, which of them would be consistent with an MI?

A. All of them.

Q Moving forward then to the next point in time when we have evidence, I believe there was a phone conversation reported in the deposition of Jan Schoch between John Porach and Jan Schoch, and at that point he provided another description of his symptoms. Can you recall what those symptoms were at that time?

A Aching in the chest and shoulders.

MR. MISHKIND: And, again, this is based upon Jan Schoch's testimony.

MR. RISPO: I believe she's the only one that has testimony at that time.

MR. MISHKIND: Right. Or the only one that has testimony or heard statements made by him at that time, which is 9:30 to 10:30 in the morning. You're right.

A. Aching in the chest and shoulders and, actually, aching all over.

Q. And I believe that she asked him if he had chest pain as such and he said no?

A. I didn't understand that. Excuse me. I don't understand that question. Aching in the chest is chest pain. He said he had aching in the chest. That's chest pain.

MR. MISHKIND: I think what he is asking is that what Jan said he told her in her testimony, if he said he had chest pain.

A. She asked him if he had pain in his chest and he said no.

Q. But he did say aching in the chest?

A. Which is the chest pain.

Q. Well, that's the differential that Mr. Porach made, he distinguished between aching and chest pain?

A. He is a layperson, that's a very --

Q. I understand.

A. Well, I think that she differentiated between the aching and the chest pain because she was the one that asked him whether he had chest pain. He didn't volunteer he had chest pain. She specifically asked him. He volunteered that he had aching in the chest and shoulders.
Q. I am not arguing. I am just trying to get established what evidence we have on the subject.
A. Okay.
Q. Let me ask a similar question then on the basis of those symptoms plus the prior information, which we have already established through Jan Porach, do you have an opinion as to whether Mr. Porach was suffering from an acute MI at that time, at 9:30 in the morning?
A. I still can't be absolutely sure, but my emphasis would be more towards a myocardial infarction among those differential diagnoses.
Q. Okay. Would you still have the other differential diagnoses in the picture or would you eliminate any?
A. They would still be in the picture. Now, that's based upon what is written down here. That is not based upon as if I were going to talk to him

and elicit more of a history.
Q. I understand. We are strained or restrained by what information we have.
A. Okay. Fine.
Q. Then as I recall there was little in the way of any clear report until around 3:15 in the afternoon, at which time the stepdaughter, Jaclyn DeWitt, provided testimony as well as Jan Schoch, as to her father's symptoms. Do you have a recollection of what that testimony was and those symptoms were?
A. Well, I will refer to the deposition, rather than to try to just remember.
MR. MISHKIND: Are you talking about Jackie DeWitt now?
A. Yes. It says Jaclyn Porach, but that's an error, right?
MR. MISHKIND: Right.
A. That's who we are talking about.
MR. MISHKIND: Doctor, just from a quick reference, look to Page 10, Jaclyn DeWitt.
A. Yes. He has had chest pains and he couldn't move his arms and he had trouble breathing.
Q. I will ask you the same questions at this

point. Do you have an opinion as to whether he was suffering from an MI, acute MI at that time?

A. I still can't be absolutely sure, but I would even think more of it at that time.

Q. Would you still have the other differential diagnoses surviving then?

A. Yes.

Q. But then we have, I think the next solid piece of evidence is the EKG studies that we have marked as Exhibits 1 and 2. Assuming those EKG studies were performed at 17:39, although the strip says 16:39, I think the difference had to do with daylight saving time or something --

A. You're referring to Defendant's Exhibit 2, you are correct. I have two EKG here?

Q. Right. And the one that I am referring to, the only one recorded as to time is 17:39, is that right?

A. 16:39.

MR. MISHKIND: Off the record.

- - - -

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

- - - -

Q. Based upon that EKG strip, doctor, or the two of

them taken together, assuming they were both recorded at the same time and of the same patient, do you have an opinion as to whether the patient, John Porach, was suffering from an acute MI at the time of those strips?

A. Yes.

MR. MISHKIND: He has answered the question yes. I wanted to know whether he was to take into account the history that preceded it or --

Q. Let's take them in steps.

A. Okay.

Q. Can you tell, do you have an opinion based on the EKG strips alone whether he was suffering from an acute MI?

A. Yes, I have an opinion.

Q. What is your opinion?

A. My opinion is that the electrocardiogram is consistent with an anterioseptal infarct, age undetermined, but consistent with an acute myocardial infarction.

Q. Well, maybe we can breakdown a little further, what is your -- what do you mean when you refer to an acute versus a remote?

A. Acute refers to the fact that there would be ST

segment elevations, which we term injury current, and these are present on this electrocardiogram.

Q. Can you identify which leads or slides indicated an elevated ST segment?

A. V-2, V-3, V-4 definitely.

Q. May I come around and read over with you?

A. Sure. Do you want me to demonstrate it for you?

Q. If you would be kind enough, because I am still learning on the subject.

MR. MISHKIND: You are too modest.

A. You have to take what the baseline is. The baseline is between the end of the T wave and the beginning of the P wave and T wave. So there is the baseline. The PR interval is between the Q wave and the QRS and you can see that it is on the same level as the baseline.

This is the ST segment. You can see by the card that I have here that that is not on the baseline. It is elevated. It is higher than the baseline.

So, therefore, that is ST elevation. That's in V-2.

Q. V-2, the same on V-3?
A. V-3 is the same and V-4 is the same.
Q. Okay. Assuming --
A. But, let me also point out to you that on Exhibit 1, if you look at the electrocardiograms, that those ST elevations are not present.

So on the old electrocardiogram done in 19, whenever, 1990 I think this is, isn't it?

Q. I don't know, frankly, when that prior one was.
A. The other electrocardiogram previous --

MR. MISHKIND: It has a date of, it looks like June 25, 1990.

A. That's right. The other electrocardiogram does not have that.
Q. That's the baseline EKG?
A. That's the only other -- I don't know if that is the baseline. That's the only electrocardiogram I have to compare. But the ST elevations were not present on that electrocardiogram.
Q. That means that the MI occurred sometime between January of 1990 and October 14th of 1994?
A. That's correct.
Q. You did say that the age would be classified and indeterminate?

A. Yes, because --
Q. Go ahead.
A. I was going to ask you to explain what you mean by that.
Well, because sometimes when you have an acute anterioseptal infarct and the patient has recovered from the acute anterioseptal infarct, you can be left with an electrocardiogram that looks like Exhibit 2.
Q. So then the Exhibit 2 EKG is consistent with a remote EKG -- I'm sorry -- a remote acute MI -- remote MI?
A. Well, it's just what I said. The interpretation is that this is an anterioseptal infarct, age undetermined, which means that it could be acute, it could be subacute or it could be old.
Q. It could be old or remote?
A. Correct.
Q. And if it is indeterminate, are you saying it could be anytime between January -- June 20th --
MR. MISHKIND: June 25, 1990.
Q. -- June 25th of 1990 and October 14th of 1994?
A. Correct.
Q. I think you also said that it's consistent with an acute MI?

A. Correct.
Q. Is it diagnostic of an acute MI?
A. No.
Q. And it's not diagnostic because why?
A. Because of the reason I just gave you. It's consistent if you have a patient who has an anterioseptal infarct and who recovers, you can have an EKG that looks like this, okay?
Q. If you had an acute MI in progress, would you expect to find a higher elevation of the ST segment?
A. It's common, but this is still consistent with it. It depends upon how long the infarct has been there. Sometimes these things change very rapidly.

MR. RISPO: I am going to have marked here as an exhibit for purposes of our discussion Exhibit 3.

- - - -

(Thereupon, Defendant's Exhibit 3, Botti, document entitled Evolutionary Changes Following Blood Flow Obstruction, was marked for purposes of identification.)

And ask you to take a moment to review that

chart showing evolutionary changes following blood flow obstructions.

MR. MISHKIND: Can you for the record indicate what the source of that is? You were afraid I was going to ask you that.

MR. RISPO: Off the record.

- - - -

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

- - - -

Q. The exhibit before you shows progression from baseline to hours following blood flow obstruction to hours to days and so on and days to weeks and weeks to months.

If we were looking at an acute MI in progress, would we not see something closer to the image under letter B?

A. Not necessarily. Unfortunately this is an idealized scheme that doesn't hold up in clinical medicine.

Q. Well, when you say not necessarily, I guess my question should be more refined. Is what you see in letter B more typical or more common than not?

A. No. I would think it would be more diagnostic. In other words, if you had something that looked like that, then you would say the electrocardiogram shows an acute infarct and you can be sure of that. But, unfortunately, life is not as simple as this diagram.

Q. Okay. In your experience, you see a lot of cardiology patients, don't you?

A. Correct.

Q. In your experience, what percentage of cases present in the form as you would describe in letter B?

A. I really can't answer that. I can't give you a percentage.

Q. Would it be fair to say that more often than not an EKG will be closer to the images in letter B then it would be in our Exhibit 2?

A. What do you mean by more often than not?

Q. Well, more than half of the patients you see in acute MI having EKG strips done within hours of the acute MI, would they not have --

A. In other words, 50 percent, 51 percent you are talking about?

Q. Yes.

A. I think the answer would be yes.

Q. And would it be closer to 75 percent, actually?
A. I can't answer that. I don't know the answer to that question.
Q. How many patients do you have in your practice on average come in with an MI?
A. I can't even answer that. I have been in practice, you know, for 40 years now. So I have seen a lot of MI's, but --
Q. Broadening the question not restricted to people coming into your office, but those that you have seen, let's say, in an emergency room or at any facility.
A. Okay. You can also add onto the fact that when I was chief of cardiology at University Hospitals we used to have conferences all the time. We would read all the EKG's there and we would read EKG's now where we are.

So we see an awful lot of patients, actually EKG's sometimes without the patients who have myocardial infarcts.

Q. Well, broadening the question to encompass all of your readings of EKG's, patients in acute MI, would you say it would be fair to say that 75 percent or more of them would have a picture more closely approximating the image at Section

B of Exhibit 3?

A. No.

Q. So it would be somewhere between 51 and 75 percent?

A. I don't want to be pinned down because I have never looked at the percentage wise, but there are infarcts and there are infarcts. Some people have what we call minor infarcts, what we call nontransmural infarcts, and almost none of them, in fact, none of them have ST elevations like in B.

Q. Okay.

A. So that if you look at the number of nontransmural infarcts, you probably are lucky if you have 50 percent of the patients who have what looks like B, if you are just using the term infarction.

Q. Okay. Fair enough. Then let me ask the inverse question. Based upon your experience in all cases, whether in or outside the hospital, in your office or otherwise, what percentage of your patients would have an acute MI as opposed to indeterminate, as you have diagnosed or determined otherwise, and still have EKG tracings such as you have seen and described in

Exhibit 2?

A. I can't give you a precise percentage, but this is not uncommon. The EKG's that look like Defendant's Exhibit 2 is not uncommon to have in a patient who presents with an acute myocardial infarction.

Q. Let's take it the next step. Taking in toto account the EKG and the physical symptoms that we have reviewed from morning to afternoon --

A. Right.

MR. MISHKIND: From all sources?

Q. From all sources and all data that you have available to you with one exception, and that is the pathology studies by Dr. Hoffman?

A. Without any blood studies, also.

Q. And without blood studies, but we don't have those in any event, do we?

A. No.

Q. But leaving out for the moment Dr. Hoffman's study, but based upon the symptoms, all of them during the day, and the EKG studies, when, if at all, in your opinion, did Mr. Porach commence having his MI?

A. With the initial onset of his symptoms.

Q. And that would be at 5:00 in the morning?

A. Correct.
Q. Based again on all the information available to you, you're aware, I assume, that Mrs. Porach has testified that her husband reported an easing of the symptoms, that he was feeling better before she left for work?
A. Correct.
Q. What, in your opinion, was the cause of his or the reason why he experienced an improvement in his symptoms?
A. I don't know.
Q. Would it be a spontaneous clearing or resolution of the thrombus?
A. I don't think so.
Q. Can you have an easing of symptoms which would come about because of a spontaneous clearing of the thrombus?
A. Yes.
Q. So that his symptoms are consistent with spontaneous clearing of the thrombus?
A. I don't think so.
Q. Why not?
A. Because if you had spontaneous clearing of the thrombus I would expect the symptoms to not get better, but to disappear entirely, and as far as

I can tell from looking at the records, his symptoms never disappeared entirely.

Q. So your view of it is that they improved somewhat, but don't disappear and, therefore, what was happening in the meantime?

A. I don't know the answer to that question. I don't think we have the answer to that question.

Q. Would you call this case, assuming that your opinion is correct, that he had the MI in the morning at 5:00 a.m. --

A. Correct, I think that's when the thrombus formed and obstructed the vessel, about 5:00 in the morning.

Q. Would you call this an acute MI?

A. Yes.

Q. Is it your opinion that the -- well, let me ask it differently.

We know that after the EKG studies were taken the patient went to the washroom and collapsed in the doctor's office, you're aware of that, aren't you?

A. Yes.

Q. Okay. Taking that additional factor into account, do you have an opinion as to whether he had a secondary MI?

A. Yes, I have an opinion.
Q. What is that opinion?
A. The opinion is most likely he did not, but I can not be sure that he did not. It is, one of the complications in acute myocardial infarction is ventricular fibrillation without another MI.

On the other hand, he could have had another MI and had ventricular fibrillation. So I cannot say for sure whether he had another one or not, but it is not necessary to envoke that to explain his cardiac arrest.

Q. Now, let's take into account the pathology studies by Dr. Hoffman.
A. Yes.
Q. I believe Dr. Hoffman gave an opinion to the effect that, in his view, the MI occurred within a few hours before death.

MR. MISHKIND: His words were just hours, I think.

MR. RISPO: Well, that's the second page.

Q. On the first page he refers to the lesion could not have been more than a few hours old, and I assume he is referring too old from death, although he could have meant old from the time

when he examined it.

MR. MISHKIND: Obviously I can't -- I am not going to respond because I don't know what Dr. Hoffman says.

MR. RISPO: Whatever the record shows, that's what he said.

Q. You have seen that report, have you, doctor?

A. Yes.

Q. Taking that into account, do you have an opinion as to when the MI occurred?

A. Yes.

Q. What is your opinion?

A. The same, that it occurred at the onset of the symptoms.

Q. At 5:00 in the morning?

A. Correct.

Q. Taking this study from Dr. Hoffman into account, is it equally as likely that he suffered a second MI in the period of time after the EKG study that was done at 5:30?

A. No.

Q. And why do you say that?

A. Because he only had, he had complete obstruction of the left anterior descending, he had the infarct and distribution in the left anterior

descending, and he had no infarct or anything to suggest infarction in any other part of the heart.

So, therefore, on the basis of the autopsy, it is most consistent with a single myocardial infarction.

Q. If it is a single myocardial infarction, then do you disagree with Dr. Hoffman's conclusion that the lesion could not be more than a few hours old?

A. Well, I don't know what he means by a few. I agree, my definition of a few in this case would be six to 12 hours, something like that, and I think that fits exactly with what went on clinically. I think the autopsy is consistent with my analysis of the case and when the infarction occurred.

The patient complained at about 3:15 or 3:30 of a change in his symptoms, greater severity. He now complained, according to his stepdaughter, of shortness of breath, he couldn't move his arms, and chest pain.

If he had an increasing severity at 3:30, is it not more likely that he had another MI at 3:30 in the afternoon?

A. No.
Q. How would you explain those symptoms as reported at 3:30 in the afternoon?
A. I can't -- well, I can explain them on the fact that as a result of the heart attack that the heart.muscle is not working properly, that the pressure within the left ventricle, the end-diastolic pressure was rising, that he was developing early manifestations of heart failure, which could cause him to have shortness of breath, and the fact that he would have changes in the pressure within the heart would change the amount of oxygen going to the heart muscle and could result in more pain on that basis.

I am giving you a physiological explanation. I really can't say for sure because we don't have those measurements, but this is what is known to happen in the progress of a patient with acute myocardial infarct.

From just an objective point of view it is known that a patient's pain can fluctuate and they can get these symptoms and you don't always have an explanation for them, but if I have to give you an explanation, that's the explanation

I would give.
Q. Is not an MI defined as a deprivation of oxygen to the heart muscle?
A. That's a partial explanation. That's not the complete definition.
Q. Resulting in death of tissue?
A. Correct.
Q. Okay. Is it not also a fact that when deprived of oxygen, the heart muscle will inevitably lose life, will die, necrose?
A. No, that's not absolutely true.
Q. You described moments ago your interpretation what occurred at 3:30 in the afternoon and among the description you gave a comment that there would be reduction in the oxygen flow to the heart muscle?
A. Further reduction.
Q. Further reduction, okay. When there is a further reduction for a significant period of time, will there not be pain?
A. Well, not necessarily. You may or may not know that probably one-sixth of patients with heart attacks never have any chest pain.
Q. I understand. But if you do have pain, is it not likely that you have lost further

oxygenation to the heart muscle?

A. Well, that's the explanation I gave. That's the explanation I gave, but that's an explanation. The proof of this is difficult to come by.

Q. If you do have the pain as described by the patient at 3:30 in the afternoon, would that not indicate that some of the heart muscle and tissue is dying?

A. Well, I think that's a fair statement, as long as the pain is prolonged like it was in this case.

Q. Okay. And if true, would that lend credence to the possibility that there was a second MI?

MR. MISHKIND: Objection.

A. No. Because what we mean by a second MI is that there would be another vessel obstructed, which would cause an MI.

If you have, the obstruction is complete and is still there and there is fluctuation of the pain based upon physiological changes going on, that is not a second MI by definition.

Q. I see. So if I understand your comment, you would not consider the second MI unless it involved a different vessel?

A. Well, it gets very complicated. In general

that's true, but that's not always true.

The way you would really define a second MI is that you would have blood tests would show, you have abnormal blood tests with the first MI, and then the blood test would get better and then there would be an episode of pain or something. You would do more blood tests and then the blood tests would become elevated, okay?

Q. I see.

A. So without those kind of data all I can say is that based on my experience with many patients of myocardial infarction following the blood test you do not have to envoke a second MI to explain this man's clinical course.

Q. Okay. Now I understand your earlier stated opinions better.

How long does an MI last in a typical case?

A. I don't understand your question.

Q. Well, how long would it normally take for the enzyme studies to show that the MI had ended before you would consider a second MI?

A. You are probably talking at least 12 to 36 hours, because you would have to -- there's a natural course of the enzyme. They go up and

they can continue to go up and then they start to come down, and I would think in 12 to 36 hours you would start to see the enzymes come down.

So that instead of coming down they started to go up again, then I would think you would be able to tell.

Q. Okay. I follow you.

What are the classic symptoms for an MI, doctor?

A. The classic symptoms, chest pain occurring in most patients in the substernal area. In a significant number of people over the heart, where the heart is, which is the left of the sternum, which we would call precordial, and then you can have, however, pain anywhere from the jaw down to the umbilicus and in any location, but the typical presentation is that of chest pain.

Q. Does it require radiation -- radiating pain?

A. It does not. It may radiate, but it does not necessarily have to.

Q. Does it require shortness of breath as well?

A. No.

Q. Is the chest pain diagnostic?

A. No.
Q. Is it severe?
A. Not necessarily. It can be, but not necessarily.

As we said before, you don't have to have any chest pain at all. So that's the least severe type of chest pain, if you don't have any.

Q. Would you agree that the EKG study that we have standing alone is not diagnostic of an acute MI in progress?
A. Yes.
Q. If John Porach had presented to the emergency room with this EKG study and the symptoms as previously reported, what would be the indicated course of treatment?
A. He would be admitted to the hospital and placed on the coronary care unit, and then I think he would be given aspirin immediately in the emergency room. He would have been treated for his pain, either with morphine or intravenous nitroglycerin or both, and then he would either have been taken to the cath lab for an acute emergency cardiac catheterization with the idea of doing an emergency angioplasty, or he would

have been given TPA or something like TPA to dissolve the blood clot.

Q. Do you have privileges at Southwest General Hospital?

A. I do not.

Q. Or at Fairview?

A. I do not.

Q. Do you know based upon your professional associations whether these facilities are available at the emergency rooms at Southwest General or at Fairview?

A. Which facilities?

Q. To do cardiac cath upon an emergency basis and angioplasty?

A. They are available at Fairview, but not at Southwest at the present time. I believe. In fact, I know that for sure. They don't have cardiac surgery, so they can't do cardiac surgery on an emergency basis.

Let me back off from that statement. Normally when you do an angioplasty you have to have cardiac surgery for backup. However, if you come to the conclusion that no matter what happens that you are not going to use cardiac surgery backup, under those rare circumstances

and only in a few places would one do angioplasty.

The reasoning would be this. The artery is completely blocked. If I go in there and open it up and it blocks again, I am no worse than I was before.

Most places don't have this type of reasoning. They have the reasoning that if you are going to do angioplasty you have to have cardiac surgery, even in case the artery backs up, under those limitations, and I don't know what the cardiologist's policy at Southwest is.

So I would say they have the ability to do TPA, but they do not do cardiac angioplasty with that one reservation. At Fairview they do have cardiac surgery and they do have the capacity to do angioplasty.

Q. If the patient presented with this EKG study, but without the symptoms as described by Jaclyn DeWitt, without complaints, in other words, of severe chest pain, radiating pain --

A. Then why was the electrocardiogram done?

Q. I am assuming now that it has been done.

A. But why was it done?

Q. Assume for the sake of this question that the

EKG study were done without the symptoms reported by the daughter, stepdaughter, Jaclyn --

MR. MISHKIND: The daughter what?

MR. RISPO: The stepdaughter.

MR. MISHKIND: I didn't catch what you said. Stepdaughter, okay.

Q. -- and the patient presented to an emergency room, would it be consistent with the standard of care to simply monitor the patient on a coronary care unit?

MR. MISHKIND: Let me just object because it assumes facts which are not in evidence, but --

MR. RISPO: We have a major dispute --

MR. MISHKIND: That's just my objection.

MR. RISPO: We have a major dispute what the facts are, but I am probing for the sake of discussion.

A. Well, you present a scenario, though, that is impossible. I mean, why did the patient go to the emergency room?

Q. Let's suppose he went in for a general checkup.

A. Okay. He came into the office and he is feeling perfectly well and he had an EKG like this?
Q. Right. And the doctor said, well, I would like you to go over to the emergency room. What would be -- let me ask it this way.

Would it be consistent with the standard of care to simply monitor his progress in the coronary care unit without doing, as you described it --
A. Oh, of course, under those circumstances you might not even put the patient in the hospital.
Q. You might even send him home?
A. Sure. You might -- you probably would want to give him some treatment of some sort in the way of medication. You might want to draw some blood tests just to be sure that nothing went on, you know, acutely. In other words, if you did blood tests on someone asymptomatic like this and they came back all normal, you would assume that this was old, but then you would also know that he had coronary disease and you would treat him for chronic coronary disease, and in our particular practice we would and in most cardiologists' practices would then either schedule him for a stress test or more likely

schedule him for an elective cardiac catherization.

Q. Would it be fair to conclude then from your previous answers, doctor, that the diagnostic evidence here is the report of symptoms of chest pain, shortness of breath radiating down his arm?

A. No, that's not true.

Q. Maybe I didn't put it the same way.

Would it be fair to say then that the medical evidence requiring the emergency care, including a cardiac cath and thrombo -- antithrombolytics and so forth would not be done unless there were the symptoms as he reported them?

A. That's correct.

Q. It wouldn't be done solely on EKG?

A. That's correct.

Q. And would you agree that if an MI were not in progress, a patient would not have the classic symptoms that were described by Jaclyn DeWitt, chest pain, radiating pain and shortness of breath?

A. I don't quite follow that question.

Q. If those physical symptoms were diagnostic and

the medical indication for emergency care, they are then diagnostic of an MI, acute MI in progress?

A. In conjunction with the electrocardiogram.

Q. Right. If John did not have the symptoms described by Jaclyn DeWitt, you wouldn't do the cardiac cath, you wouldn't administer antithrombolytic agents and you wouldn't do an angioplasty, we have agreed on that?

MR. MISHKIND: Objection. *Go* ahead.

A. Well, you mean back to the previous scenario where the man comes in and is asymptomatic and is perfectly well?

Q. Yes.

A. Sure. You have to make a diagnosis of an acute myocardial infarction before you treat it as acute myocardial infarction. In a man who comes in with an electrocardiogram like this in the absence of symptoms, who is feeling perfectly well, you cannot make the diagnosis of acute myocardial infarction and you would not treat him for acute myocardial infarction.

Now you might change your mind somewhere along the way if you were to draw a set of

enzymes, for example, and in spite of him being asymptomatic the enzymes were limited, then you may change your mild and say this really is a myocardial infarction despite the absence of symptoms. We are going to go ahead and do those things.

Q. Let me get at it a little differently.

What symptoms are diagnostic symptoms of ischemia?

A. Chest pain is the most significant.

Q. Are the symptoms the same for ischemia as they are for an acute MI?

A. The location of the pain is the same. The character of the pain can be the same, although it is unusual for -- are you talking about angina, is that what you are talking about?

Q. Yes.

A. You are talking about ischemia without infarction, which we will call angina.

Usually the pain is not as severe, but usually it is not severe. Usually you don't have associated symptoms like diaphoresis, sweating, nausea, vomiting, but you may.

So that if you were to do an epidemiological study, the patient with angina

has less severity of the pain, same location, doesn't have a character of pain like an elephant sitting on the chest, although there is a big overlap here, usually doesn't have associated symptoms and, of course, the pain is short-lived. That's the critical point of differentiation.

A patient with angina usually has pain that lasts just for a few minutes, definitely no longer than 15 or 30 minutes, and is -- and that's how you try to make a differential.

Q. I see. So that if the pain is passing in nature, it is more likely to be ischemia -- angina without MI?

A. Angina means there is no MI.

Q. Whereas if it is an acute MI in progress and it's been in progress since 5:00 in the morning, it is more probable that it would be continuous?

A. Correct.

Q. All day?

A. Well, it can be continual rather than continuous, but the episodes of pain would be prolonged and not short.

Q. How long is prolonged?

A. I said, 15 to 30 minutes or longer.

Q. More than 15 to 30 minutes?
A. Right.
Q. If he denied chest pain at 9:30 in the morning, would that rule out an all day long MI?
MR. MISHKIND: Objection. *Go* ahead, doctor.
A. I don't know what you mean by an all day long MI.
Q. Well, your opinion as stated was that he had the MI in the morning?
A. Right.
Q. And it hasn't ended by 3:15 or 3:30 in the afternoon?
A. You mean the chest pain associated with the myocardial infarction is not ended, is that what you mean? I don't know what you mean by the end. When you have a myocardial infarction there is a natural history of different aspects, there is a natural history of the chest pain, there is a natural history of what goes on pathologically, and these are not necessarily in common.

In other words, if you have chest pain that lasts for two hours and goes away, the chest pain is gone, but pathologically there is things

going on within the heart for up to I would say a week or 10 days afterwards there are changes going on in the heart.

Q. But with --

A. So I don't know what you mean by the end of the heart attack. Are you talking about the chest pain or what are you talking about?

Q. If the chest pain ends --

A. Correct.

Q. -- before 9:30 in the morning --

A. Correct. Okay.

Q. -- would that mean that the death of heart tissue had stopped?

MR. MISHKIND: Objection.

A. No.

MR. MISHKIND: Objection to the hypothetical.

A. Well, yes, I think by that time it would mean that the amount of heart tissue that was going to die has been established. Pathologically, for example, if the pain went away at 9:30 and it started at 5:30 and he were to all of a sudden die, you are lucky you see anything at all on pathology, okay?

And if he were to die 10 days later all you

would see would be scar tissue.
Q. Okay. I think I follow you.
- - - -
(Thereupon, a recess was had.)
- - - -
Q. Going back on the record, doctor, is it not unusual for a patient to have an MI and not have classic symptoms until 10 hours after the MI was in progress?
A. I would say it's unusual, yes.
Q. And if we were to accept the testimony that's available to us, the only information we have here, John Porach didn't have the classic symptoms until 3:30 in the afternoon?
A. Well, he had some of the classic -- well, I agree with that, yes.
Q. So then would it be fair to say that John Porach's experience was unusual?
MR. MISHKIND: Objection.
A. Well, I don't know what you mean by unusual. In our experience we see this all the time.
Q. It's not classic?
A. It is not classic, correct.
Q. Is this an example of what has been termed in some of the literature as sudden death syndrome?

MR. MISHKIND: Objection. I am not sure what literature you are referring to or --

MR. RISPO: I am not referring to anything specific, just in general.

A. Yes. He had sudden death, yes.

Q. And sudden death occurs among patients who had no prior pathological diagnosis and the statistics are relatively high indicating that those people die before they reach a hospital setting?

MR. MISHKIND: Objection.

A. Is this a question?

Q. Well, let me refer to some of the literature that I have had occasion to review.

MR. MISHKIND: Let me just indicate on the record that the literature you are about to refer to you already asked him about and he was not, either did not recognize it as authoritative or was not familiar with it, and I am just going to object. Taking it out of context and not applying it to the facts of this case is inappropriate.

But having said that, go ahead and

ask your question.

Q. Would you agree with the statement that sudden coronary death involves a rapidly progressing coronary lesion which plaque is disrupted and often results in a partial thrombus leading to regional myocardial ischemia that produces a fatal ventricular arrhythmia?

MR. MISHKIND: Objection.

A. I don't think that occurs in every case, no. I think that can occur, that is one of the scenarios for sudden cardiac death, but there are other scenarios in which there is no obstruction at all.

Q. And perhaps no symptoms at all until moments before death?

A. Correct.

Q. Okay. Would you --

A. Well, let me back off. You have to define what you mean by sudden cardiac death. Most people define sudden cardiac death as death occurring within six to 24-hours after the onset of symptoms.

This man had what I would call instant cardiac death, which is a subform of sudden cardiac death.

Q. Okay. Instant meaning that he had --
A. He died instantly.
Q. After the MI?
A. No. He just died, it means that he died instantly. I mean, he just dropped dead.

Well, actually, I will back off. No. I am wrong. He fits under the category of sudden cardiac death because he had symptoms for a number of hours beforehand. Instant cardiac death means he had no symptoms and he just drops dead.

Q. If he had no symptoms until he reached the bathroom in the doctor's office, that would be the type you described earlier where he died instantaneously?
A. Correct.
Q. And that is one form of sudden death?
A. Correct.
Q. And is it true or would you agree with the statement that roughly one and a half million individuals in the United States alone suffer from acute MI, just generally, annually?
A. I think it's less than that now, but it is in the category there. The problem is that patients who die instantly or suddenly without

actually objective symptoms are usually thrown into the category of having an MI, and I am not sure that that's necessarily true.

Q. So there may be some that died for other unrelated reasons?

A. Well, it is mainly coronary disease, but you can have ventricular fibrillation without myocardial infarction.

Q. Okay. Is it also true that of those approximate one and a half million annually in the United States who suffer from an acute MI, about only one-third are hospitalized?

A. Well, again, with the reservations that I said that assuming they had infarcts, yes.

Q. Of those who do suffer sudden death, is it true that a majority of those cases are cases in which they had an acute plaque change with minimal thrombus, which led directly to the fatal arrhythmia?

A. I am not familiar with the literature that would substantiate that. That sounds to me like somebody's theory. I do not -- I mean, I don't have any objection to it if the data show that, but I am not personally authoritative enough or have expertise to say whether that's true or

not.
Q. Would you agree with this statement that early recognition of acute myocardial infarcts by a pathologist is a difficult problem, particularly when death has occurred within minutes to a few hours after onset of the ischemic injury because diagnostic morphological changes lag behind the actual injury?
A. Yes. I already testified to that.
Q. And do you agree with the statement that myocardial infarcts less than six to 12 hours old are usually not apparent on gross examination?
A. On gross examination, yes, I would agree with that.
Q. I think you have already agreed with this statement, too, doctor, that patients admitted to the hospital to simply rule out myocardial infarction based upon a negative EKG often go on to infarction on follow-up?
A. I agree with that.
Q. Okay. The elevated ST changes that you identified in the strip identified as Exhibit 2, are they not more consistent with an MI more than days after -- days before this strip was

taken, a study was taken?

MR. MISHKIND: Objection.

A. Yes, they are more consistent, but, unfortunately, that is not diagnostic. They can occur within hours or actually minutes you can have evolution and changes like this, as proven in this case.

Q. Would it be fair to say then 10 percent of the cases of MI the initial symptoms are so mild that the diagnosis is not made until months later when an EKG study is finally taken?

MR. MISHKIND: Objection.

A. I think it's higher than that. I think it is higher than 10 percent.

Q. Is there such a thing as a false negative EKG?

A. Yes, you can have a myocardial infarction with a normal electrocardiogram, if that's the question.

Q. Would you consider Exhibit 2 an example of a false negative?

A. No.

Q. As far as --

MR. MISHKIND: Exhibit 2 was which, the -- okay. The one at 5:30?

MR. RISPO: Yes, on the 14th of

October of '94.

MR. MISHKIND: Go ahead.

Q. With respect to the chances of survival now, doctor, I would like to ask you statistically speaking, is it not true that with males in their mid-forties the statistics show that the chance of survival is significantly reduced among those males who have sudden myocardial infarctions?

A. As compared to what?

Q. Older patients who may have developed collateral circulation.

A. Well, I can't answer your question because I don't -- how do you know that they developed collateral circulation?

Q. Let me drop out that part of the question then and just say as compared to older patients.

A. No. It's just the opposite.

Q. It's your view that the younger patients have a higher chance of survival?

A. Correct.

Q. Given the circumstances of this case and the degree of coronary artery disease in question, do you have an opinion as to what his expected survival would be?

A. Yes.
Q. What would it be?
A. Well, it depends upon what the course of events would be. In other words, if he was able to have intervention that was successful, then his prognosis would be better than if he was not treated with modern day methods.
Q. I guess you are assuming that had there been prompt recognization assuming the symptoms, that's the probability of survival?
A. I understand that, but it depends upon what the course of events were. In other words, if he had a successful angioplasty and he had successful bypass surgery, his prognosis, of course, would be much better than if these interventions were unsuccessful.
Q. Assuming he had the best of care?
A. The best of care? I would assume that -- what was the question again?
Q. What would be his life expectancy?
A. I would think he probably would have like a --
Q. Keeping in mind --
A. He would likely have about a 25 year, 50 percent survival.
Q. 25 year being to age 70?

A. How old was he?

MR. MISHKIND: 44.

A. 69. He had a 50/50 chance of getting to be the age of 69.

Q. Did you take into account the fact that he had established now by reason of the pathology studies significant coronary artery disease?

A. Absolutely. That's what the basis is done on.

Q. And if he had not had the coronary artery disease as shown on the pathology studies, what would his normal life expectancy be?

A. I don't have those data.

Q. It would be significantly greater, wouldn't it?

A. What do you mean by significantly?

Q. 10 years longer?

A. I don't know the answer to that question. You would have to look it up in the life table and see what your life expectancy is at age 44.

Q. Is there a significant percentage of population, particularly among men, who deny their symptoms?

MR. MISHKIND: Objection. Go ahead.

A. Yes.

Q. And is that not, in fact, part of the main problem in diagnosing and rendering the

appropriate care to male patients?

MR. MISHKIND: Objection to the general nature of the question. *Go* ahead.

A. Yes.

Q. Standards of care now, doctor. Standards for board certified cardiologists are greater or higher than those for an internist, are they not?

MR. MISHKIND: Recognizing that Dr. Botti is a board certified internist, not a board certified cardiologist?

A. It has nothing to do with me.

Q. I wasn't necessarily addressing your specialty, but I am asking about the difference between a board certified cardiologist in general as compared with an internist such as Dr. Lalli.

MR. MISHKIND: Objection.

A. There are no standards established. I think that as far as the standards of recognizing and screening or referring patients with myocardial infarction for appropriate care, I would say the standards are no different.

I think the standards may be different once the patient is diagnosed as having a myocardial infarction and then is brought into the hospital

for treatment, but the way we practice --
Q. In terms of diagnosis.
A. In terms of suspicion of diagnosis, I think the standards are the same.
Q. How about the standards of a board certified cardiologist on the one hand and a family practitioner or a general practitioner on the other?
A. I think the standards as far as suspecting myocardial infarction and referring them to the appropriate facility or physician for care are the same.
Q. How about the standard as compared between a board certified cardiologist and, let's say, a nurse?
A. I have no idea.
Q. Do you know what the standards are for a nurse?
MR. MISHKIND: I mean, object because there is no nurse involved in this case, but --
A. I have no idea what the standards are for a nurse.
Q. Do you have any knowledge of what the standards are for a nonmedically trained receptionist in a doctor's office?

A. As far as I know, there are no standards that are written down anyplace.
Q. You don't have an opinion, therefore, as to what the standards of care for a receptionist would be?
MR. MISHKIND: Objection.
A. Yes, I have an opinion
Q. You said they are not written down anywhere?
A. There are no standards written down for receptionists, as far as I know.
Q. And a few minutes ago you said you have no idea?
A. Well, because I run an office, I have an idea of how a receptionist should handle calls that come in referring to different complaints.
Q. Is this your personal opinion?
MR. MISHKIND: Objection.
A. All of this is my personal opinion.
Q. So it is not based upon a generally recognized standard of care?
MR. MISHKIND: Well, I am going to object to the form of the question.
A. Generalized recognized standard of care? Not that I know.
Q. You wouldn't hold a receptionist to the same standards that you would expect from your

colleagues, board certified internists or cardiologists?

MR. MISHKIND: Objection.

A. I find it difficult to answer the question. I don't know what you are referring to, making a diagnosis of a myocardial infarction or are you referring to whether they should call -- for example, if I get a call from a patient, the buck stops with me. I don't have to refer the patient anyplace else, but if my receptionist gets a call from the patient she should under certain circumstances refer the questions to me.

Q. I understand that, but you wouldn't expect her to diagnose the condition?

A. Absolutely not.

Q. Okay. Do you have any written standards or protocol for the receptionists in your office?

A. We do not.

Q. Are the receptionists in your offices all trained nurses?

A. No.

Q. Are the receptionists in your offices put through any special training?

A. No.

Q. What advice do you give or what training -- what

instruction do you give to your receptionists as to how they should handle a patient who calls in and asks for an appointment because he is having chest pain?

A. Those patients -- those calls are -- well, it depends upon, they take a history of the chest pain. If the chest pain is new with the patient, we get called immediately to talk to the patient.

Q. Okay. Do you have a standing order with any of your receptionists that if you are not available they should take other measures?

A. I am available.

Q. Assuming you are not available, say you are out of town.

A. Yes. They give it to one of my partners.

Q. Okay. How about -- is your office always staffed 24-hours a day?

A. We have a call service 24-hours a day.

Q. Do you leave any instructions with your call service?

A. They call immediately. The call service always calls immediately.

Q. Calls the physician?

A. The physician.

Q. They don't have a standing order to refer the patient immediately to the emergency room without calling you?
A. The call service or no one has that authority.
Q. In your opinion, does a patient bear some responsibility if he denies symptoms?
MR. MISHKIND: Objection. Are you talking about specifically in this case or are you speaking in general?
Q. I am talking about this case, but I am asking you to assume that for purposes of this case -- for purposes of this question that John Porach denied his symptoms for a period of nine or 10 hours.
MR. MISHKIND: Objection. That assumes facts which are not in evidence, but go ahead and answer the question.
A. Ask me the question again.
MR. MISHKIND: I am sorry for interrupting.
Q. The question is whether a patient in the position of John Porach, if it is true that he denied his symptoms for a period of nine or 10 hours between 5:00 in the morning and 3:00 in the afternoon, would bear some responsibility

for his ultimate demise?

MR. MISHKIND: Objection. Again, it does not assume facts in evidence.

A. The answer is no.

Q. Does a patient ever bear any responsibility for his ultimate demise?

A. Yes.

Q. And would he bear some responsibility if he denies his symptoms and doesn't report them?

A. No.

Q. Under what circumstances would he bear responsibility?

A. If he were instructed to do certain things and he didn't do them.

Q. You wouldn't blame the physician if the patient reports -- fails to report all of his symptoms, would you?

A. I would blame the physician if he didn't ask adequate questions to bring out the symptoms.

Q. And if he did ask the right questions and the patient denied those symptoms --

A. You are only do what you can, right.

Q. Then you can't blame the doctor?

A. Correct.

Q. If a patient had his acute MI at 5:00 in the

morning and did not call for emergency assistance, did not go to an emergency room immediately thereafter, waited around in his home for a period of nine hours, did not object when he could not get an immediate appointment at a doctor's office, denied or neglected to report his symptoms to members of his family until nine hours later and told the office receptionist on at least one occasion that he did not have chest pain, and if the patient drove past an emergency room at Southwest General Hospital on his way to the doctor's office, would you think that that patient bore some responsibility for his own death?

MR. MISHKIND: Let me just show an objection to the hypothetical. But go ahead and answer the question, doctor.

A. No.

MR. RISPO: I think I have concluded and I want to thank you very much for your patience, doctor. I am still learning.

MR. MISHKIND: I would like for the doctor when it is transcribed, even though it is not highly technical, I would

like the doctor to read it rather than waiving signature on this.

THE WITNESS: I would prefer to do it.

ROBERT E. BOTTI, SR., M.D.

C E R T I F I C A T E

The State of Ohio,) SS:
County of Cuyahoga.)

I, Susan M. Cebron, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named ROBERT E. BOTTI, SR., M.D., was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this _____ day of _____, A.D. 19 ___

_____
Susan M. Cebron, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires August 17, 1998

WITNESS INDEX

	PAGE
CROSS-EXAMINATION ROBERT E. BOTTI, SR., M.D. BY MR. RISPO.....	3

EXHIBIT INDEX

EXHIBIT	MARKED
Defendant's Exhibit 1, Botti, two-sided document entitled Bipolar Limb Leads.....	9
Defendant's Exhibit 2, Botti, one-page document containing echocardiogram strips.....	9
Defendant's Exhibit 3, Botti, document entitled Evolutionary Changes Following Blood Flow Obstruction.....	 25