The State of Ohio)
Lorain County

IN THE COURT OF COMMON PLEAS

BARBARA WILEY, EXECUTRIX of)
the Estate of Michael Wiley)

Plaintiff,) Case No. 98 CV 121938

vs.)

DAVID A. BRANCH, D.O.,) Judge: Edward M. Zaleski
et al.)

Defendant.)

Deposition of DAVID A. BRANCH, D.O., a witness taken before MARILYN D. CRISTI, Notary Public within and for the State of Ohio in this cause on MONDAY, the 15th day of FEBRUARY, 1999 at THE HUNTINGTON BUILDING, SUITE 2010, Cuyahoga County, Ohio at 10:29 a.m. Pursuant to notice sent to counsel, this deposition was tape recorded by Legal Electronic Recording, Inc.

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APPEARANCES

MATTHEW P. MORIARTY, ESQ.
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Pepper Pike, Ohio
For the Plaintiff

JOHN S. CHAPMAN, ESQ.
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WILLIAM MEADOWS, ESQ.
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DAVID W. NEEL, ESQ.
ERIEVIEW TOWER
20TH FLOOR
Cleveland, Ohio
For the Defendant

P-R-O-C-E-E-D-I-N-G-S

David A. Branch, D.O. of lawful age, a witness herein having first been duly sworn as hereinafter certified, deposes and says as follows:

DEPOSITION OF DAVID A. BRANCH, D.O.
BY MR. MORIARTY:
Q State your full name please.
A David Allen Branch.
Q Dr. Branch, my name is Matt Moriarty. I'm one of the lawyers for the plaintiff in this case. Have you ever had your deposition taken before?
A Yes, I have.
Q Okay. Let me just give you a quick reminder, although I'm sure your counsel has told you what this is all about, and ask you some questions today. We'll be a few hours. If any -- if at any time you do not understand my question, let me know and I'll make it clear to you, okay?
A All right.
Q If you need to take a break for whatever reason, let me know. We can do that, all right?
A Okay.
Q And you have to keep your voice up so that we can all hear you. There's a fan going that tends to drown

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out some sound. And if you could do that, I'd appreciate it, all right?
A All right.
BY MR. MORIARTY: And just for the record this is the discovery deposition of Dr. Branch and the time and place having finally been agreed upon after some notices were sent out.
Q What's your current residence address, sir?
A 524 Rockwood Court, Avon Lake, Ohio.
Q What's the zip code there?
A 34012.
Q How long have you lived there?
A About four years, I believe.
Q Who do you live with?
A My wife and children.
Q Does your wife work outside the home?
A No. she doesn't.
Q How many children do you have?
A Six.
Q What is the range of their ages?
A Fourteen (14) weeks and twenty two (22) years.
Q Congratulations. And what's -- how old are you?
A Forty five (45).
Q What's your date of birth?

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A Let me check -- yeah, I'm forty live (45) --do the calculation again. 12-27-53.
Q And your social security number?
A 370-60-7023.
Q Do you have a CV with you?
A I do not.
Q Do you have one either at your office or in your computer somewhere'?
A I have one on my computer, but it crashed last week so I'll probably have to re-do it.
Q When you --
BY MR. MEADOWS: If I have one. I'll provide that to you.
BY MR. MORIARTY: That's fine.
Q Well, when the computer crashed, is the data recoverable or is it all lost?
A Actually it wasn't the computer that crashed. the monitor went out.
Q Okay.
A And it's an old monitor, so I'm not sure that I can --
Q All right.
A — even--
Q Well when you re-do it, or if you recover the data, if you could send the CV to your lawyer and he'll

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send it to me, I'd appreciate it, okay? Do you have an office?
A No.
Q All right. Where'd you do your -- where were you born and raised, first of all?
A Born in Howell, Michigan and raised down in Apollo, Michigan which is a small farming community
Q Okay. Did you graduate from college?
A Correct.
Q Where?
A Holy Cross College in Worcester, Massachusetts.
Q What year did you graduate'?
A 1976.
Q Did you go straight to medical school after that"
A No, I did not.
Q What'd you do after college'?
A For about the first year I worked with mentally handicapped adults in residential sightings, sort of like group homes.
Q Where was that?
A That was nominally in Plymouth. Massachusetts, near Plymouth.
Q Had you applied to medical school right away?
A I applied my junior year to medical school.
Q Okay. Where did you end up going to medical

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A I went to Des Moines College of Osteopathic Medicine and Surgery.
Q When did you graduate from there?
A 1981.
Q In the course of study in medical school, was there a specific class in emergency medicine?
A No, there was not.
Q Do you have any military service?
A No.
Q Was there anything in particular that influenced your decision to become a doctor ofosteopathic medicine as opposed to an MD or allopathic or whatever it is?
A Nor particularly, no.
Q Where'd you do your internship?
A At Lakeview Osteopathic Hospital in Battle Creek, Michigan.
Q Was it a general rotating internship?
A Correct.
Q Was it one year?
A Correct.
Q Did you do a residency after that'?
A After that I fulfilled my public health service commitment for the United States Government in Colstrip. Montana.

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Q How come you had a U.S. public service health commitment?
A The government paid for two years of my medical school.
Q Where were you in Montana?
A Colstrip, Montana.
Q Is it on an Indian reservation or just in a smaller town'?
A Smaller town.
Q And after your public health service was finished. did you do a residency?
A I did.
Q Where?
A At York Memorial Hospital in York, Pennsylvania
Q For how many years was the residency?
A Two years.
Q And any particular specialty?
A Emergency medicine.
Q Who was the program director?
A Dr. Edward Sarmai.
Q Do you know how to spell his last name?
A S-A-R-M-A-I, I think.
Q Have you done any fellowships?
A No, I have not.
Q In what states are you licensed to practice

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medicine?
A Michigan and Ohio.
Q Did you have to get a Montana license while you were out there?
A Yes, I did.
Q Did you let that lapse?
A I did.
Q It wasn't revoked for any reason?
A No.
BY MR. MEADOWS: Objection.
Q Are you board certified?
A Iam.
Q By which board?
A By the American College of Osteopathic Emergency Physicians.
Q What do you have to do to get board certified with that entity?
A It's a three process procedure. There's a written test. If you pass that, then you take the oral exam. If you pass that, then there's a part where they come out and observe you practice medicine for a day.
Q Foroneday?
A Foroneday.
Q I assume you passed the written exam?
A Correct.

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Q On the first try?
A Yes.
Q I assume you passed the oral exam?
A I did.
Q On the first try?
A No.
Q How many times did you take the oral exam?
A I believe, three.
Q The last phase where they observe you, is that -- is that a pass-fail situation?
A I believe so.
Q Okay. Do you -- did you have to go through that more than once?
A No.
Q And when did you become board certified?
A I believe, 1990.
Q Were there study -- written study materials published to help you prepare for your board exams?
A I mean there's things on the market you can buy.
Q Okay, did you buy any sort of study manuals to prepare for your board exam?
A There was one I think I bought to help get more familiar with the oral exam.
Q Was it on substantive areas of medicine or just something to help you through the mechanics of an oral

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exam?
A More the mechanics of the oral exam.
Q Are you eligible to become a member of the American College of Emergency Physicians?
A I think so. I don't know why I wouldn't be. I've never actually checked into it.
Q Do you keep up to date in your continuing medical education?
A Ido.
Q And I assume that is substantially -- all or substantially all of it is in emergency room medical courses?
A I guess, yes.
Q When you go to these CME classes, is the evaluation of chest pain in emergency room patients frequently one of the subjects?
A Yes.
Q Do you keep some sort of list and record of the CME courses that you attend?
A I assume I do. I must somewhere, yeah, recoeds.
Q Do you personally do that or do you have a secretary who might do that for you?
A For the AOA actually keeps track for me. The American Osteopathic Association credits are all sent it to them, and they send me updates every now and

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then.
Q Do you save the course materials from the CME courses that you attend?
A Not with great regularity, no.
Q Sometimes you do?
A Right.
Q Do you remember the last time prior to the summer of 1997 when you went to a CME course that would have included the evaluation of patients with chest pain?
A Not offhand, no.
Q Are you a member of any professional groups or societies for emergency room physicians?
A I'm a member of the American College of Osteopathic Emergency Physicians.
Q What does that organization do?
A Well they put on seminars and monitor emergency care issues.
Q Did you have to qualify to become a member of that organization?
A I think you -- I think you have to do a residency or be board certified to be a member. I'm not sure.
Q You do any teaching?
A We have residents that occasionally are -- interns occasionally that rotate through the emergency department at Fisher Titus, and when they're in the

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department, I'll do some teaching.
Q They are not emergency room residents?
A No they are not.
Q They're residents in some other sub-specialty that happen to be rotating through ER?
A Correct.
Q Does -- do you work at any other hospital beside, Fisher-Titus?
A At the present time, no.
Q Does that have a residency program in cardiology?
A No. it does not
Q And I assume it does not have a residency program in emergency medicine,
A Correct.
Q Are you on the -- listed as a professor on the faculty of any medical school?
A No.
Q Have you taught at continuing medical education seminars?
A No.
Q Have you lectured any emergency room group on any subject'?
A No.
Q Published any articles in the area of emergency medicine?

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A No.
Q What's the name of your emergency room group'?
A Norwalk Emergency Services
Q I-low many physicians are employed by that group'!
A Well. there's three shareholders. How many physicians we hire. I'm not sure if1 can give you a specific answer.
Q Okay, well let's start --
A They come and go, I don't know.
Q Well, let's start with the three shareholders.
A All right.
Q Who are they?
A Chris Brickman and Mike Murray and myself.
Q And do you know whether you actually employ other emergency room physicians?
A I under -- I believe we consider them employees.
Q Do you ever bring emergency room physicians in who may be considered independent contractors or locum tenens?
A There is one or two that may be. They have independent contract status.
Q Does the group have any affiliations with hospitals other than Fisher-Titus?
A Some of the doctors in the group do, but the group itself, Norwalk Emergency Services, doesn't.

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Q Does Norwalk Emergency Services have an exclusive contract to provide the emergency services at Fisher-Titus medical center?
A I believe it does.
Q Does Norwalk Emergency Services employ physicians' assistants?
A We started within the last year.
Q Does it employ any other type of medical personnel, not secretarial personnel, but medical personnel?
A Not that I'maware of.
Q Now you finished medical school in 1981. I'm sorry, when did you finish your residency?
A I think it was December 3 Ist, 1956.
Q What did you do after that?
A I worked for six months at York Memorial as an attending physician.
Q The same hospital where you had done your residency?
A Correct.
Q And then after that what did you do?
A I worked at Elyria Memorial Hospital until I started in Norwalk, and I think that was in '92 I made the switch.
Q All right, so some time in the middle of '87 you

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moved to Lorain County?
A Correct.
Q And you started working at Elyria Memorial Hospital here in Lorain County?
A Correct.
Q All right. And, I'm sorry, for how long did you work ai Elyria Memorial?
A Well, until. I believe, the end of '92.
Q All right. What was the name of the emergency room goup with which you were affiliated during your tenure at Elyria Memorial?
A Acute Care Specialists.
Q Do you know who the head of that group was at that rime?
A There was a group of five that had controlling interest in the goup, Dr. Meg Paul, Dr. Bedall, a Dr. Sullivan. and I can't recall the other two.
Q Do you have privileges at any hospital other than Fisher-Titus?
A Not at the present time.
Q Ever served in – excuse me, ever served as an expert witness in any type of case?
A Yes, I have.
Q First of all, were they all medical negligence cases?

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A No.
Q How many cases – in how many cases have you been an expert witness?
A Total, you know, maybe six or eight.
Q Let's take -- let's separate out the medical negligence cases. What were the oilier cases about"
A Child abuse and there was one assault case and a rape case.
Q The cases that you just mentioned, I assume that those were patients for whom you were a treating physician?
A That's correct.
Q And these assault cases, rape cases, child abuse cases. arose out of some events that led those people to the emergency room and your care. Is that fair?
A Well. one of them was in Montana when I was out there.
Q Okay.
A It wasn't in the emergency room.
Q Okay, all right. Now the other cases were -- they were medical negligence cases?
A Correct.
Q Were you the expert for the plaintiff or for the defendant?
A They were all for the defendant.

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Q Do you remember the names of any ofthose cases?
A No.
Q Are any of them currently open, active cases?
A I don't believe so.
Q Do you remember the names of the defense lawyers who retained you?
A No.
Q Do you remember the names of any of the defense law firms?
A No.
Q Do you remember where the cases were actually located? Were they all in Ohio?
A Yes, I think they were all in Ohio.
Q Did you give deposition testimony in any of those cases?
A I don't believe so.
Q Do you know whether you authored written reports in any of those cases?
A I'm sure I did in at least three of them.
Q Do you keep a record of the names of the cases that you've been involved in?
A No.
Q Would you keep some sort of accounting record that would reflect the payments that you would have received from defense law firms?

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A It might be in my tax files. I don't know.
Q Did any of the cases involve the evaluation of a patient with chest pain?
A No. Well, I take that back. There was -- there was one.
Q How long ago was that case?
A I was working in Elyria at the time. Quite a while.
Q Have you ever been asked by a plaintiffs lawyer to review a case and act as an expert?
A Yes.
Q Did you review the case?
A Yes.
Q Have you ever been sued in a medical negligence case before?
BY MR. MEADOWS: Objection. Show a continuing objection.
BY MR. MORIARTY. That's tine.
Q Go ahead.
A Yes.
Q How many times?
A Five times, I think.
Q Were any of them in Montana?
A No.
Q Were any of them in Pennsylvania?

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A No.
Q Ever practiced in any other state?
A No.
Q Uhm --
A Other than maybe as a student.
Q Okay.
A I think I did work in Massachusetts and Florida as a student.
Q Well would it be safe to assume that all five of the cases were filed in Ohio?
A Correct.
Q Do you know how many of them were tiled in Lorain County?
A I think, three of them.
Q And in what counties were the other ones?
A I believe, Huron.
Q Huron County?
A I think.
Q Did any of them have to do with the evaluation of a patient who had chest pain?
A One of them.
Q What was the name of the plaintiff in that case?
A I think his last name was Taylor.
Q Could you spell that, please?
A T-A-Y-L-0-R

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Q In what county was that filed?
A I believe, Lorain.
Q Was your deposition taken in that case?
A No.
Q Do you remember the name of the plaintiffs lawyer?
A No.
Q Do you remember the name of the lawyer who represented you?
A No.
Q How long ago was it?
A I think it was '91, '92.
Q Give me a thumbnail sketch about what the other four or so cases were about.
A There was a –
Q Wait, I don't mean to cut you off, but let me clarify something. The case we're here about, Mike Wiley's visit to the emergency room, is this included in the five?
A *Yes*, it is.
Q Okay. Tell me what the other three cases are about -- or were about?
A There was a lady who was seen in the emergency department a few times and admitted to the hospital, had pneumonia, was put on a ventilator, and then

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seventeen (17) to twenty (20) days after she was admitted to the hospital, she was taken off the ventilator, and that day or the next day she experienced respiratory arrest and had to go back on the ventilator, but before she got reintubated she had some brain damage.
Q Okay.
BY MR. MEADOWS: Let me interject. To the extent that any of the law suits are currently pending, I want you to limit your answer to just the basic allegation without getting into the facts of the defense of the case.
Q Are there any other cases pending?
A There's two other cases pending.
Q Okay. Do you know who the plaintiffs' lawyers are in either of those other cases?
A I'd have -- not offhand, no.
Q Okay. Then let's move on. I don't want to ask you about those other pending cases. That's fine. Ever been the subject of any medical disciplinary proceedings?
A No.
BY MR. MEADOWS: Objection.
Q Ever had your privileges at any hospital revoked?

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BY MR. MEADOWS: Objection.
A No.
Q Or suspended?
A No.
Q Does Norwalk Emergency Service have a corporate office somewhere'?
A Well, I think that they list Dr. Brickman's home as the corporate office or headquarters.
Q Do you know where he lives?
A Sylvania, Ohio. I don't know the exact address offhand, no.
Q Okay. Now let me briefly limit my questions to a time frame of July 1997. To the best of your knowledge were there any sort of signs in the emergency room at Fisher-Titus Medical Center announcing that Norwalk Emergency Service was the group that ran that emergency room?
A I don't think -- not that I'm aware of.
Q To the best of your knowledge. were patients or their families told in words or substance that while this is the Fisher-Titus Medical Center, this emergency room group runs the medical aspects of this emergency room?
BY MR. MEADOWS: Objection.
A I believe that when they register, registrating or

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admitting personnel inform them of the fact that there is a group and that they will be sending separate bills.
Q Okay. Do you wear a lab --- traditional white lab coat when you're working in the ER?
A Generally.
Q Other than Dr. Branch, what does it say on it?
A Emergency medicine.
Q Do you have an ID badge?
A Yes.
Q Does the ID badge say Fisher-Titus Medical Center?
A I'm not aware. I'm not sure. I'd have to look at it again.
Q Okay. Do you have it with you?
A No, not my lab coat
Q Are the emergency room nurses employees of Fisher-Titus Medical Center?
A Yes, they are.
Q Who is the chairman of the department of emergency medicine at Fisher-Titus?
A Dr. Thomas.
Q He's one of your co-shareholders or -
A He had an option to join, but he declined.
Q Okay.
A He's an employee.

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Q He's an employee of what, the hospital?
A Of the group. The corporation.
Q Oh, I'm sorry. Okay. So despite the fact that he is the chairman of the department, he is not a shareholder with you in the goup. Is that correct?
A Correct.
Q Okay. Does Fisher-Titus have any sort of an observation unit affiliated -- I'm sorry, let me rephrase that. Do they have an observation unit at Fisher-Titus Medical Center that you can use if necessary?
A They do.
Q All right. So as an emergency room physician you do not necessarily have to choose between a technical full hospital admission or a discharge. Is that true?
A Correct.
Q What is the unit called, this observation unit?
A Observation unit.
Q Is it part of the emergency department?
A Actually it's a general bed. It's just a bookkeeping entry, I believe, on their admitting notes and their billing.
Q Where is it located?
A Where there's a bed available in the hospital.
Q If a patient -- let me -- let me ask you this a

different way. If you decide to put a patient in the observation unit, what do you call it? An admission?
A **An** observation admission.
Q Okay. You have the authority to order such an observation admission?
A I -- I can't admit anyone to observation unit or otherwise. I have to work through one of the attendings who has admitting privileges.
Q So, for example, hypothetically, if you had a patient whom you suspected may be having either unstable angina or an acute myocardial infarction, you would have the option of doing an observation admission'? Is that true?
A Correct.
Q But if you were to do that, would you have to consult with the cardiologist?
A I'd have to consult either with the patient's doctor or the doctor on call for internal medicine.
Q All right. Does Fisher-Titus have cardiologists on staff!
A Yes.
Q Is there always one on the call list?
A We don't list the cardiologists on the call list.
Q Why not?
A You'd have to check with the hospital on their

policy, but we have an internal medicine. There's a cardiologist on call for North Ohio Heart, which is affiliated with Fisher-Titus.
Q That's the group out of Lorain?
A Correct.
Q Or based in Lorain, I should say. Okay, I'm a little confused. Who creates the call list?
A I'm not sure.
Q Does the emergency room group create the call list'?
A No.
Q Does the emergency room group have input into the creation of the call list?
4 I'm sure we have some, yes.
Q Internal medicine is a category on the call list?
A Correct.
Q Orthopedic surgery is a category on the call list?
A Correct.
Q Is cardiology a category on the call list?
A *No.*
Q Hypothetically, had you wanted to admit Mike Wiley to the observation unit or to the hospital itself, would you have worked through the internal medicine person on call?
A I would have called down that one first.

Carsio0064 NOT ON THE CALL LIST.

Q Under what circumstances do you call Northern Ohio Heart Group?
A Well, if it's one of their patients, then we'll call them, or if the internal medicine requests a cardiology consult.
Q So in the case of Mr. Wiley, since he did -- assuming he didn't have a cardiologist, you would have worhed through the internal medicine specialists as opposed to calling a cardiologist directly Is that correct"
A Correct.
Q When a patient is admitted to the observation unit, who does the observing?
A *You* mean who's in charge?
Q *Yes.*
A It would be the admitting physician.
Q You are not -- as an emergency room physician if you initiate an admission to the observation unit you do not participate in the observation?
A Correct.
Q I assume that there are -- they have some nurses who assist in that observation?
A Correct.
Q Is there a time parameter, a minimum and maximum amount of time in which a patient can be in the

observation unit?
A I think the requirement is if they're in there less than twenty four (24) hours.
Q Do you keep a medical library at your home or at the hospital?
A We have a few medical books available at the hospital.
Q Do you personally keep one?
A I have a library at home. Mostly they're medical books from my training.
Q Back when you did your training, which I assume you mean your residency. Is that correct'?
A Correct.
Q Did you buy any emergency room tests?
A Yes.
Q Did you buy whichever one you wanted or did they recommend one or two'?
A Well, we were pretty much -- we could buy what we wanted.
Q Which ones did you buy?
BY MR. MEADOWS: Objection.
A I bought a copy of Tinilly's and was given a copy of May's, and I believe I bought a copy of Rosen's.
Q Was the first one that you mentioned Tintinelli's?
A Correct.

Q Second one was May's and the last one was Rosen Is that correct?
A Correct.
Q Have you purchased more recent editions of those books over the years?
A I recently bought a new edition of Tintinelli within the last six months.
Q Okay. If you wanted to consult a more recent edition of -- withdraw that question.
Do you know what edition of Rosen you own?
A I think it's the first edition.
Q If you wanted to consult a more recent edition, would you have the ability to do that through a -- either a hospital library or an emergency room library at the hospital?
A Hospital in the emergency department we have a more recent issue ofthose.
Q Does that group buy emergency room texts that it keeps collectively in the emergency department?
A I'm not aware that we've bought any books.
Q Well, you have a little emergency room library in the emergency department.
A Right.
Q Who is responsible for buying those books?
A I think the library, the hospital library.

Q Who in your goup decides which books to buy'?
BY MR. MEADOWS: For the library at the hospital?
BY MR. MORIARTY: Yes. I'm sorry.
BY MR. MEADOWS: I'm going to object because it assumes that they do -- I think he said the hospital does it. Go ahead.
A They probably -- it would probably be Dr. Thomas as chairman.
Q And what books do they have there at the hospital in the emergency medicine library ?
A Well, I don't if they have an emergency medicine library -- in the emergency department, we have a small collection of books.
Q Okay
A We have three volumes of Rosen and Tintinelli and Facts and Compansons, PDR. We nave Neilson's Pediatric and we have a series of toxicology books
Q Do you keep any cardiology textbooks?
A I don't think there's any cardiology textbooks there.
Q Do you from time to time refer to Tintinelli's book?
A Occasionally.

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Q Do you from time to time refer to Rosen's book'?
A Occasionally.
Q Do you generally refer them -- I'm sorry, do you generally refer to them because you find them to be reliable sources in emergency medicine?
BY MR. MEADOWS. Objection.
A I use them to sort of refresh my memory in various more obscure diseases.
Q But do you do that because you generally find them to be reliable reference material?
A Well, I mean they're usually dated because medicine is progressing rapidly.
Q Given the time parameters for publication, do you think they're reliable reference manuals?
A In some areas.
Q Subscribe to any journals'?
A No.
Q Does the group subscribe to any journals?
A Not that I'm aware of.
Q Does the -- do you personally receive journals?
A Yes.
Q Even though you don't subscribe to them?
A Yes.
Q Which emergency room journals do you receive?
A Emergency Medicine, Emergency News. Those are the

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only ones that are emergency.
Q Do you read them?
A Yes.
Q Do you review the Annals of Emergency Medicine?
A Not with great regularity, no.
Q I'm not sure if I asked you this before, but does either the group subscribe or does the hospital subscribe to emergency medicine journals that go to the hospital?
A I'm not -- I don't know.
Q Okay, so for example, is The Annals of Emergency Medicine available for you to review?
A Not that I'm aware of.
Q Your board -- your board certification entity, does it have any guidelines or protocols for the management of emergency room patients with various complaints?
A Not that I'm aware of, no.
Q Do you know whether the American College of Emergency Physicians has guidelines or protocols?
BY MR. MEADOWS: Objection.
A Not that I'm aware of.
Q Do you know whether the emergency department at Fisher-Titus Medical Center has guidelines or protocols for the management of emergency room patients?

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A No, they don't
Q They do not?
A They do not
Q Has the department collected or adopted guidelines that may have been published by someone else?
BYMR MEADOWS Objection
A No
Q Are you familiar with the Amencan College of Cardiology Guidelines for management of patients complaining of chest pains?
BYMR MEADOWS Objection
A I haven't read them recently, no
Q Have you read them in the past?
A Sometime ago
Q Under what circumstances would you have read them?
A I'm not sure I understand
Q Well, why did you read them? Did somebodv hand them to you or were you just curious or what?
A I think they were at a seminar
Q Have you ever heard of the Chest Pain Study Group?
A No
Q Do vou know whether the Amencan Medical Association has any protocols regarding the management of patients with chest pain7
BY MR MEADOWS Objection

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A Not aware.
Q Do you keep any sort of folders, some people arc pack rats, they keep articles and what not. Do you keep any sort of research folders on any topics of emergency medicine?
A Not really, no.
Q I assume that prior to July of 1997 you'd had occasion to see and examine patients who complained of chest pain?
A Correct.
Q It probably happens just about every day in your practice as an emergency room physician'?
A Right.
Q You do work full time, I assume?
A Yes.
Q Do you have any idea of the percentage of patients that you've evaluated for complaints of chest pain at Fisher-Titus Medical Center whom you have admitted?
A No, I don't.
Q Does chest pain have an ICD code number?
A I don't know.
Q Do you have any sense for the percentage of times when you have a patient complaining of chest pain that you consult the internal medicine specialist?
BY MR. MEADOWS: Objection.

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A No I don't.
Q You consider yourself to be an espert in cardiovascular medicine?
BY MR. MEADOWS: In the confines of an emergency room?
BY MR. MORIARTY: Well, let's take it the way I've stated it first, and then we'll narrow it down.
A I'm not sure I understand what you're asking.
Q Do vou consider yourself to be an expert in cardiovascular medicine?
BY MR. MEADOWS: Objection to form.
A From an emergency medicine standpoint, yes.
Q Okay. Well, would you agree that emergency room doctors, somewhat by the nature of the practice, are generalists?
A They have a broad general background in medicine
Q Okay. Do you believe that a cardiologist is in a better position to differentiate between chest pain from ischemia, versus non-ischemic chest pain?
BY MR. MEADOWS: Objection.
A In the emergency department setting?
Q In any setting.
A In the emergency department setting, I don't think there's any advantage to being a cardiologist.

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Q Okay. Why not?
A Well, it's basically a clinical assessment.
Q Okay. When you are in doubt about a diagnosis for an emergency room patient who presents with chest pain, do you consult the internal medicine specialist?
A Well, if I cannot explain their chest pain, then. yes.
Q Okay. Well basically, if a patient has ischemic chest pain, whether it's from unstable angina or an acute myocardial infarction, if that patient is sent home rather than admitted and treated. that can have some pretty serious consequences. Would you agree with me?
A I'll agree.
Q Okay. Do you get any sense of the degree of confidence that you need to have in your diagnosis before you end up consulting an internal medicine specialist or a cardiologist?
BY MR. MEADOWS. Objection to form -- I'm not sure what you mean.
A I don't quite understand what you're asking.
Q That's tine. Usually there's very little that is certain in medicine. Would you agree with me?
BY MR. MEADOWS: Objection.
A The facts usually is pretty certain.

Q Okay. When it comes to the diagnosis of chest pain, the origin of chest pain in the emergency room. is it lhighly unusual that something would be certain?
BY MR. MEADOWS: Objection.
A No, if they have -- if they have changes on their electrocardiogram, it's pretty definitive.
Q Okay. Well, if the patient -- if there was a possibility that a patient was having ischemic chest pain, just a possibility, would you consult with the internal medicine specialist under those circumstances?
BY MR. MEADOWS: At what point in the process? Immediately, before doing any tests?
BY MR. MORIARTY Before discharge from the emergency room.
A If I felt that the problem was ischemic, I would definitely consult with someone.
Q -- in your experience as either a physician or having been through medical legal matters, do you recognize any distinction between the terms possibility and probability?
A I'm not sure I understand what you're asking.
Q Well if -- if you were standing there evaluating a patient in the emergency room who had chest pain --
A Mm-hmm.

Q -- and the patient had been there for a while, and you had run some tests, and you weren't sure, but you thought it was likely or probable that that patient had ischemic chest pain, would you consult an internal medicine specialist or a cardiologist?
A If I thought it was likely they had ischemic chest pain, yes.
Q Okay. Under the same scenario, if you thought that it was unlikely, but possible, would you still consult an internist or a cardiologist?
BY MR. MEADOWS: Objection to form.
A If I thought that there was -- I guess I'd have to -- I'm not sure if I understand yet what you're asking.
Q Okay. Well, if you thought, for example, if you were able to divine percentages in your evaluation of a patient, and you thought there was a ten percent chance that a particular patient was having ischemic chest pain, but a ninety percent chance that it was from some other origin, would you consult an internal medicine specialist under those circumstances?
A Yes.
Q What about a five percent chance?
A Probably, yes.
Q You would probably consult with the specialist?
A Correct.

Q I don't want to take every number down to zero, but how low an index of suspicion would you have to have and still consult with a specialist?
BY MR. MEADOWS: I'm going to object. Could you repeat that? I'm not sure I caught it.
Q Sure, that's fine. As I said earlier, if you don't understand my question, I'm happy to rephrase it If you had a four percent belief that the patient was having ischemic chest pain, but a ninety-six percent chance they weren't, do you consult with a specialist?
BY MR. MEADOWS: I'm going to object cause I'm not sure it's fair to the witness to be making such fine distinctions between -- he already said that if -- even if there was a five percent he would, and now you want him to distinguish between five and four, and I imagine you're going to take it one step further and say three, two, one. And I just don't know if it's fair to the witness to suggest to him that those distinctions are appropriate.
BY MR. MORIARTY: He'll tell me if it isn't fair, but in fairness to both of

you, my original question was whether you had some sense of how confident you had to be and in order to get the answer to my question, I've had lo translate it into numbers.
A I'd have to be highly confident.
Q Highly confident that it was nut --
A Ischemic.
Q -- ischemic. And how do you -- how do you as an emergency room physician determine that?
A Well, if there's a -- if there's a clinical presentation that suggests that it's not ischemic, and none of the tests support ischemia or injury, then I become highly confident.
Q Okay. And do you believe that the -- withdraw that question.
Have you heard the phrase standard of care?
A *Yes*, I have.
Q Tell me what you understand that phrase to mean, so that we're on the same wave length here.
A Well, I have legal training. It's a legal phrase. It has no realm in the medical practice. I mean, we never heard it in medical school.
Q Okay.
A I only hear it from lawyers.

Q Okay, and you tell me what you understand it to mean.
A The standard of care is when a regional or ordinary physician would -- how a reasonable or ordinary physician would perform.
Q Tell me about your legal training.
A I went to law school part-time at Cleveland State Marshall School of Law and became licensed in law in January of '96.
Q When did you start at Cleveland State?
A Hmm. I think 1990, '91.
Q When you were working at Elyria Memorial Hospital?
A Correct. Correct.
Q And you were -- did you work as an emergency room physician by day and go to school at night?
A Well, because I was an independent contractor at Elyria Memorial, I worked out hours that I was available to work, and they would either pick me for those hours or they wouldn't.
Q Okay, but you graduated from Cleveland Marshall College of Law?
A Correct.
Q And you are licensed to practice law in the State of Ohio'?
A Correct.

Q When did you pass the bar exam'?
A I took, I think, the written, the three day test, in July of '95. And they had instituted the ethical portion that I had neglected to get my paperwork in on time, so I think I took that in November or the fall of '95. Sometime in the fall of '95. And then I received notice sometime in December that I passed all the parts and that I could be sworn in.
Q Have you practiced law at all?
A Some, yes.
Q Okay, tell me what kind of law you have practiced?
A Family law and contract law.
Q When you say family law, what do you mean by that?
A I've done some child custody cases. some dissolution. Mostly child custody
Q How much of your time, your professional time, do you devote to emergency medicine as opposed to the practice of law'?
A Probably ninety nine percent (99%).
Q Emergency medicine?
A Yes.
Q Do you have any affiliation with any law firm?
A No.
Q And when you engage in your law practice, do you have a law office or --

A I practice out of my house.
Q Okay Do you have letterhead and all that kind of stuff for a law practice'?
A Right. With computers you can do pretty much anything.
Q All right. Took torts in law school?
A I did.
Q Do you subscribe to any -- are you a member of the Ohio State Bar Association?
A I believe I am.
Q Do you subscribe to any legal journals?
A Just what the Ohio State Bar Association convey in the Cleveland -- and then I guess I am on WestLaw and I get their monthly updates -- I don't know if you consider that a journal or not.
Q So you get the weekly, what we call OBAR, the little green --
A Yes.
Q -- magazine. Do you read the cases pertaining to medical negligence law suits?
A Not with great regularity.
Q Did you say you were a member of the Cleveland Bar Association?
A Correct.
Q So you get the Cleveland Bar Journal?

A Yes.
Q Member of any committees?
A No.
Q Are you a member of anything like the American Society of Law and Medicine?
A No.
Q *Are* you a member of any sort of medical legal organization?
A No.
Q All right, let me get back to what I was about to ask you about -- I was asking about these percentages and when you would consult a specialist. If you have some doubt about the diagnosis, does the standard of care require that you consult with either an internist or a cardiologist?
BY MR. MEADOWS: Objection.
BY MR. NEEL: Objection.
A I don't -- I mean,you're talking legalese again, and as a doctor I don't think that the standard of care really enters into it -- patient care is ail we're concerned about.
Q Well, the standard -- there is a standard of care that you have to subscribe to in caring for patients, is there not?
A Well, we try to practice good medicine, but we

don't think of it in terms of standard of care. As I said before, that's a legal concept.
Q If there is any doubt in your mind as to a diagnosis on a patient with chest pain, does -- does the reasonable and prudent physician consult with the specialist on call?
A I would.
Q Does the reasonable and prudent physician do that?
A Well, I have to think I'm reasonable and prudent, so I guess so.
Q You may be more than reasonable and prudent, that's why I asked.
A Uhm, --
BY MR. MEADOWS: You're asking about a specific diagnosis or any diagnosis in general?
BY MR. MORIARTY Well, I'm talking about -- still talking about a patient that comes in complaining of chest pain.
Q If you have some doubt as to whether that's ischemic or not, consistent with what I've already asked you, would the reasonable prudent physician consult with a specialist?
A Do you want me to set the standard of care here?
Q No, I want you'to tell me what the standard of

care requires.
A Well, 1 can't answer that because I told you what I would do. But whether I meet the standard or above the standard is -- is a legal call.
Q Do you like to think you act within the standard?
A Yes, I like to think that. And as you nieiitioned. I may be above the standard.
Q If there is some doubt about the diagnosis regarding a patient who complains ofchest pain, would you personally admit that person to the observation unit?
A I would try to arrange that. That's correct.
Q Ifyou admit a patient complaining ofchest pain. either to the observation unit or to the hospital itself or you effectuate that type of consultation. do you find out about it later if it turns out to be nor ischemic chest pain?
A No, we do not.
Q Have you ever personally been admonished, warned, et cetera, for excessive calls to the consultants regarding patients with chest pain?
A No.
BY MR. MEADOWS: Show an objection to the extent it calls for peer review of answers.

Q Speaking of peer review, was Mike Wiley's -- I don't want to know the content of any peer review, the date of it, who was present, anything -- and a simple yes or a no will do. Was Mike Wiley's case peer reviewed?
BY MR. MEADOWS: Objection.
A Not to my knowledge.
Q Do you have independent recollection of seeing Mike Wiley in the emergency room on July 16, 19977
A Do I recall the event or --
Q Yes, sir.
A Not specifically.
Q You are -- for your testimony, you're relying on the medical records?
A Heavily, right.
Q Exclusively?
A I have some vague recollection is all -- a few things.
Q If I asked you to describe what he looked like, could you do that?
A Well, other than I recall a lot of tattoos, I'm not sure I could specifically identify him.
Q Okay. When did you learn that Mike died on July 21st?
A When I received notice of a suit.

Q Did you review anything to prepare for your deposition today?
A Basically the chart.
Q When you say the chart, you're speaking of the emergency room records from Fisher-Titus Medical Center'?
A Correct.
Q Regarding Mike Wiley?
A Correct.
Q Did you review any other medical records?
A I believe I was able to review the autopsy report.
Q Any other medical records that you recall?
A No.
Q Did you read any medical literature?
A For this – preparing for today?
Q *Yes*, sir.
A No.
Q Did you read any medical literature after you got notice ofthe suit -- did you go consult anything on your own?
BY MR. MEADOWS: For purposes ofthis case *or* just in his normal course?
BY MR. MORIARTY: For purposes of this case.
A No.

Q Did you watch any video tapes to prepare yourself for a deposition today?
A No.
Q Do you believe that you are familiar with the signs and symptoms of unstable angina?
A Yes.
Q Can you please tell me what you can recall off the top of your head would be signs and symptoms of unstable angina?
A Chest pain, some sort of pain or discomfort in the chest. Sometimes shortness of breath. Sometimes diaphoresis or sweating. Sometimes dizziness or light-headedness. Sometimes nausea.
Q Anything else you can think of!
A Those would be the main ones.
Q Are there risk factors for unstable angina?
A Well, there's risk factors for heart disease. I'm not sure they're separated out.
Q Okay. Are they basically the same?
A I would say so, yes.
Q What are some of those risk factors?
A Age, sex, smoking, hypertension, elevated cholesterol or lipids, activity or lack thereof, and family history. Family history. I guess that would cover most of the major ones.

Q Okay. And are there tests that you can run in the emergency room to help you evaluate whether a patient complaining of chest pain may or may not have unstable angina?
A Yes.
Q And what sort of tests would those be?
A Electrocardiogram.
Q Do you call that an ECG or an EKG?
A Our hospital -- it tends to be referred to as a EKG.
Q Okay, go ahead.
A Chest x-ray, blood tests. The patients respond to various therapies.
Q Okay. Would you include cardiac enzymes within the sub-group of blood tests?
A Yes.
Q And what is the standard of care for the treatment of a patient in whom you suspect unstable angina in the emergency room?
A The patient I suspect unstable angina?
Q Yes, sir.
A Would be to stabilize the patient. I would -- by placing them on some oxygen, monitor, starting an IV, and if it's unstable angina or I think it's unstable angina, I'd probably start him on nitros, possibly

blood-thinning medication
Q And then consult with an internist or cardiologist7
A Correct
BY MR MEADOWS May I ask for a clarification7 Are you talking about after he's done -- the tests that you just described or if it's part of his suspicion, amongst other things, at the outset of his work-up? Essentially your question was clear in terms of --
A Well, I thought he was talking basically about someone who I thought had unstable angina and someone who I clinically suspect has unstable angina that's what I would do
Q If the patient comes in complaining of chest pain and your initial differential diagnosis includes unstable angina, you would run some of the tests that you've already mentioned to me -
A Correct
Q -- and depending on the outcome of those tests you -- if you still suspected that it might be unstable angina. you would consult the specialist
A Correct
Q Can you have unstable angina that manifests itself

as a sudden prolonged episode of chest pain. but docs not show EKG or enzyme evidence of an infarction'?
A Well. by definition, angina is non-infarction, so yes.
Q Can acute myocardial infarction manifest the same way? And by that I mean a sudden prolonged episode of chest pain, but without EKG or enzyme changes consistent with infarction?
A Well, the initial EKG may or may not be normal. Usually there is some change in the EKG over time. The initial blood test may or may not be abnormal.
Q But over time it may become abnormal'?
A If they've had an infarction, the blood test will become abnormal or overtime.
Q What do you consider to be the range of normal for blood pressure?
A Well, diastolic would probably be below eighty-five (85) or eighty (80) millimeters of mercury, and systolic probably below a hundred and forty (140) to a hundred and sixty (160), although I understand they've changed those numbers and they may be slightly lower. I think ideally they like to see systolic below a hundred and forty (140) and diastolic about eighty (80) present day treatment protocols for hypertension.
Q And what about for pulse? What would you consider

a normal range for a pulse to be?
A Sixty (60) to a hundred (100).
Q Are cardiac enzymes more sensitive when you test them serially?
A Some of them are, yes.
Q Which -- which are?
A Well, there's a window for them to rise. Myoglobin which we test for -- was testing for -- sixty (60) or ninety-seven (97) is sensitive very early on. CKMB sort of becomes the next sensitive one and then the troponin I takes the longest to rise and remains elevated the longest.
Q But they are -- these cardiac enzymes are most sensitive when tested several times over the course of a certain hour or period of time. Is that correct?
BY MR. MEADOWS: Are you grouping them all together?
A As a group, yes.
Q Okay. Are you aware of any textbooks that advocate serial testing of the cardiac enzymes for patients who complain of chest pain in the emergency room?
BY MR. MEADOWS: Objection.
A I'm not aware of what the textbooks are advocating on that specifically.

Q Are you aware of any journal articles or published studies that indicate that the enzymes are more sensitive when tested serially?
A There may be some, but I'm not specifically aware of them.
BY MR. MEADOWS: Show an objection.
Q In your opinion, does the standard of care require that cardiac enzymes be tested serially for patients complaining of chest pain in the emergency room?
BY MR. MEADOWS: Objection.
A No, I don't -- I don't believe that's the standard of care. no.
Q Why not?
A Cause we admit or see dozens of people with complaints of chest pain that clinically we don't feel is cardiac, and that it would be unwise to spend all that time and money doing serial enzymes on someone that you don't think has cardiac disease.
Q Okay. Let me ask you specifically about a couple of the enzymes. To do your knowledge what is the on set of elevation for the CK?
A CK?
Q Yes.
A Not the CKMV?
Q Correct.

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A Well. probably four to six hours.
Q And what about for the CKMB? What's the --
A Probably about the same.
Q I-lm-hmm. And do you know when the CK is -- I'm sorry, let me rephrase that,
When to your knowledge does the CK peak?
A It's been a while since I reviewed that. I would -- I would estimate around twelve (12) hours.
Q Have you seen lab manuals or any studies to indicate that it's twelve (12) to twenty-four (24) hours?
A I don't recall offhand.
Q Okay. Do you know when the CKMB peaks?
A I thought I was talking about the CKMB.
Q No, I was asking you for CK and then CKMB.
A I think it's around twelve (12) hours.
Q Okay. In Mike Wiley's visit to the emergency room, you only ordered one set of cardiac enzymes. Is that correct?
A Correct.
Q Why?
A Because I was looking specifically at the myoglobin.
Q I've had marked the EMS sheet as Exhibit 1 and the medical chart from the emergency room visit as Exhibit

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2. Do you have those in front of you?
A I do.
Q According to my copy of the chart, Exhibit 2, his myoglobin was twenty-nine (29) when it was tested. Is that correct?
A Correct.
Q And what is it about a myoglobin of twenty-nine (29) that was reported at twenty after four that indicated to you that there was no need to repeat this cardiac panel.
A Well, myoglobin is supposed to rise fairly rapidly in about two hours, but it's not very specific for the heart, and so elevated myoglobin is a fairly good screening test or an excellent screening test to rule out myocardial infarction, but if it's elevated, it doesn't mean it is a myocardial infarction. So if it's normal two hours after onset of chest pain, it -- it's highly strong evidence that there's not been a myocardial infarction.
Q Are you finished with your answer?
A Yes.
Q Does the myoglobin rule out myocardial infarction completely?
A If it's normal two hours after the onset -- if it's normal two hours after the onset of chest pain.

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Q Then it does rule it out?
A Pretty much a hundred percent accurate in ruling it out
Q Well, when you say pretty much a hundred percent, --
A I'd have to maybe review some of the newer literature, but the literature that when I started using the myocardial test in our emergency departments, basically at that time it was my understanding that if it was normal two hours after the onset of pain, then you've rule out a myocardial infarction
Q Does a normal myoglobin two to four hours after the onset of chest pain rule out unstable angina?
A No
Q Do any ot the cardiac enzymes, even if normal, rule out unstable angina?
A No
Q When it comes to actually ruling out either acute myocardial infarction or unstable angina, would you agree that you cannot do that just based on a history?
A Pardon7
Q When it comes to ruling out either an acute myocardia infarction or unstable angina, would you agree with me that you cannot do that based only on the patient's history?

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A No, I disagree strongly. I do that daily.
Q Do you think that you can rule in and rule out myocardial infarction and unstable angina based only on an EKG?
A No.
Q Is it true that initial EKG's are only somewhere between twenty-five (25) and fifty percent (50%) accurate in diagnosing patients who have ischemic chest pain?
A He initially could use -- that's correct.
Q I'm going to ask you some questions about these medical records. First, as far as Exhibit 1 is concerned, would you have had a copy of the EMS run sheet available to you to look at while you were taking care of Mike Wiley?
A It's difficult to say. A lot of times they're tilled out later and then put with the chart.
Q Do you remember whether or not you had that to review in this case?
A I don't recall.
Q Do you routinely review them when you look at --
A Well, when they're available, I'll take a look at them, yes.
Q Okay. Now, doctor. we don't have these bates stamped or anything with page numbers, so I'm looking

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at what for you is probably the third page in. It's the handwritten notes.
A Allright.
Q Do you see which one I'm holding up?
A My second.
Q Okay. First of all, up at the top -- I'm sorry, could I have the EMS run sheet for a second. On this sheet the vital signs recorded were initially a pulse of a hundred and twelve (112). That would be abnormally high, would it not?
A Correct.
Q And the blood pressure, if I'm reading this correctly, was two hundred and twenty (220) over a hundred and twenty (120). That would be abnormally high, would it not?
A It's elevated.
Q It would qualify as hypertense just for that one blood pressure?
A Yes.
Q Now let's get back to Exhibit 2. The blood pressure towards the top here, was this recorded by a nurse?
A Yes.
Q Do you know whether the emergency department -- I'm s o ~whether the hospital employed any

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physicians' assistants in the emergency department'?
A Not that I'm aware of.
Q So what we're talking about when we're talking about the medical personnel who attended to Mike Wiley, it would have been you as the physician. Is that correct?
A Correct.
Q Do you know whether any other physician saw Mike?
A Not that I'm aware of, or recall.
Q And nurses from the hospital. Is that right?
A Correct.
Q What about respiratory therapists'?
A Well, they would have done the EKG.
Q Okay. And what about -- there were no physicians' assistants to your knowledge.
A (NO VERBAL RESPONSE)
Q Any other -- that's a no?
A That's a no. I'm sorry.
Q Okay, any other medical personnel to your knowledge?
A Not that I can recall.
Q The blood pressure of a hundred and seventy (170) over a hundred (100) seems to be recorded at the top here. Is that still considered elevated!
A Yes.

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Q Is that top section under nursing notes, was that written by the nurses to your knowledge?
A Yes, to my knowledge.
Q Do you know which nurse?
A Well, it's signed over here, C. Liinbaugh, so I assume that she wrote it although they do a lot of team nursing, so --
Q Do you know that nurse?
A Yes.
Q Does she still work there?
A Yes.
Q Do you know whether or not you read her nursing note when you took care of Mike Wiley?
A I know I read it eventually. When I --whether I read it before or after I saw the patient, I don't recall. When they're coming by ambulance. a lot of time I see them before the nurses have the capability to write their notes.
Q When you say you read it eventually, you mean that day?
A Yes.
Q Do you also get oral report from the EMS squad?
A Yes.
Q You personally?
A Well. they call in on the radio. I usually don't

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answer the phone or the radio. It's usually taken by a nurse.
Q Do you get all the reports from your emergency room nurses?
A Yes.
Q Now below that section of nursing notes under physical exam, would you agree with me that the handwriting looks different than it does up at the top?
A It changes.
Q Do you know who wrote that?
A There's a couple lines there that are the -- still the nurses, but then the rest of that is mine.
Q So under physical exam, some of this writing is yours?
A Yes.
Q What about the orders? Whose handwriting is that?
A It looks like it's mine.
Q In your notes that you wrote, it says, for example, chest x-ray, per ER doc, EKG per ER doc. Why is it written per ER doc?
A Because I was the one that read them.
Q But that's the way you indicate that –
A Right.
Q -- as opposed to saying me or I?
A Right.

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Q Can you translate the orders that you wrote, please?
A Dawn – over here?
Q Yes, sir, on that same page we're talking about
A There was a order for Mylanta, Donnatol to be given orally An order for some ibuprofen to be given orally, and then some sublingual nitro was ordered at a later time
Q Was the nitro only ordered and given once?
A Correct
Q What was the purpose for the mylanta and dynatol?
A He had reported some nausea
Q Is that what you would call a GI cocktail?
A Correct
Q Does a GI cocktail routinely include morphine'
A Not when I give it, no
Q How come you did not give this patient morphine in the emergency room?
A Because I didn't feel it was indicated
Q Why didn't you feel it was indicated?
A Because my initial physical exam and history led me to believe that this was muscle skeletal pain and I dont treat muscle skeletal pain with morphine
Q Let's go to the next page which for me looks like that

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A Sure.
Q Do you have the same page there?
A Yeah.
Q It appears to me that the nursing note box towards the top of that page is simply a carbon of the nurse's notes from the prior page.
A Correct.
Q And then are these notes down here in the reassessment section, are those all nurses' notes?
A Correct.
Q Does your hand writing appear anywhere in that section?
A No.
Q Would you have -- did you read -- let me rephrase that.
Did you read these notes while you were taking care of the patient'?
A I don't recall offhand. I particularly do. A lot of times the nurses just tell me what they wrote before they write it.
Q Do you have any specific recollection of that in this case?
A Of being told or reading them'?
Q Eitherone.
A No.

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Q So you're just telling me whar your routine is? Is that correct?
A Correct.
Q When do you initially form your first differential diagnosis on a patient in the emergency room?
A When I do my initial history and physical.
Q Okay, well, is it just based on history or do you include the physical?
A Well, I include physical.
Q Do you remember -- I'm som. First of all, do you use a differential diagnosis system in evaluating patients?
A yes.
Q Do you specifically remember what your differential diagnosis was on Mike Wiley when you did your history and physical exam?
A Well, I thought most likely he had --
Q Well, wait a minute. I don't mean to cut you off. Do you specifically remember what your differential was?
A Specifically remember?
Q Yeah.
A No.
Q Okay, based on your now having re-read your notes, the history notes, the physical notes, and then your

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approach, what you did to evaluate. most likely what was your differential diagnosis'?
A Well, high on the list was muscle skeletal pain. but he had risk factors for heart disease that I was going to need to evaluate and make sure I wasn't being prejudiced by my physical findings. and problems with the lungs, such as pneumo thorax was also a consideration.
Q Did you consider pulmonary embolism at all?
A I didn't think that was very high. No I don't think I did, in this case.
Q Well, was acute myocardial infarction in your differential?
A Yes.
Q Was unstable angina in your differential?
A Yes. I was just initially of classifying them as heart problems.
Q What was it about the history and physical that put musculoskeletal pain at the top of the list?
A Well, he was sweating quite a hit, diaphoretic. It was a hot July day. He was doing physical activity. So that -- that could actually be consistent with either muscle or heart problems. But the physical exam – he had strongly reproducible symptoms on physical exam were palpation of the chest and the movements of

the chest. So muscle skeletal seemed much more likely than heart, but he did have risk factors, so I need io evaluate him from that aspect.
Q When you've got a patient who comes in sweating, complaining ofchest pain, but it is the middle of a hot July day, presumably it is hot, how do you differentiate between diaphoresis and exertion or sweating'?
A There is no way to really differentiate that.
Q Okay. So in the condition that Mike was brought into the emergency room, you would have to consider that he may have been having diaphoresis?
A Although it could have been from a cardiac event, I would have suspected that he would have maintained his diaphoresis, whereas the nurses' notes are that he was warm and dry or arrival other than for a wet shirt where the ambulance had put an ice bag on him.
Q Are men at higher risk for acute myocardial infarction or unstable angina?
A In the forty (40) age group, yes.
Q To the best of your knowledge, did you ever call Dr. Resseger, R-E-S-S-E-G-E-R?
A Not that I recall and if had of I would have sure made a note of it.
Q Is chest pain developing with physical exertion

suggest ischemia?
A It can.
Q Do you have any note that indicates when his chest pain started in relationship to when he started shoveling?
A You mean how long he'd been shoveling?
Q Yes, sir.
A No.
Q Do you have any notes in your chart from either you or the nurses that indicate how long it was from the onset of chest pain until he was evaluated in the emergency room?
A My understanding, if I recall the chart correctly, was the onset of pain was approximately one – 1:00 p.m.
Q Can you point out to me in the chart where that indicates that?
A I think that would be my note here where I got approximately 1:00 p.m. under past/medical/social.
Q You're talking about the first page I started asking you about.
A Yes.
Q PMH social and --
A Right.
Q – then there's an approximate 1:00 p.m.?

A 1:00 p.m Yes
Q And your testimony is that's an indication of when the chest pains started?
A It's important for us to know the onset of pain, so that we know if we're going to use thrombolytics, and I must have asked him that, I would assume, very early, and I would have made a note there so that I could recall it later for dictation or any decision-making thoughts down the line So that would have been an important thing for me to jot down and not to --
Q But that's what you believe that particular notation refers to?
A Yes
Q Are you sure of that?
A I am as sure as I can get
BY *MR* MEADOWS We've been at it for an hour and a half At a good point, can we take about five minutes just for a short bathroom break?
BY MR MORIARTY Yeah, let me see -- well might as well do it right now This is as good a time as any
(OFF THE RECORD)
BY MR MORIARTY
Q Doctor, when you've got patients who come in who

do have musculoskeletal pain. do they usually have blood pressures of two hundred and twenty (220) over a hundred and twenty (120) or later in this case for Mike a hundred and seventy (170) over a hundred (100)?
A This gentleman had been exercising, in essence, shoveling, and your blood pressure tends to go up as you're active.
Q Okay. And does it tend to stay up?
A Well, it came down significantly by the time he came to the hospital.
Q But was still hypertense or any range that would be considered hypertense.
A He was in a range that does not require immediate treatment.
Q Was it in a range though that you would have to consider at least in evaluating the overall condition of the patient?
A Many patients come to the ER and just by the fact that they're there, their blood pressure is up. So at this level, it was not a major concern.
Q Did his blood pressure ever go into what you consider to be a normal range?
A It continued to come down. I believe there's a record in the nurses' notes of a hundred and fifty (150) over ninety-six (96) at one point, and a hundred

and forty-eight (148) over ninety-two (92) at another point.
Q What I'd like to know, however, is whether it came down to what you consider to be a normal range?
A It was never in the normal range, but it was not at a level that required immediate treatment.
Q Smoking is a risk factor for heart disease, is it not?
A That's correct.
Q At the end of the first paragraph of your typewritten emergency room record. the history of the present illness, there's a comment about a slight cough occasionally productive of some yellow sputum. Do you see that comment?
A Correct.
Q Was that significant to you at all in evaluating this patient?
A Not particular, no, not in the end.
Q A couple sentences before that it says he is beginning to feel better and the pain had markedly decreased with actually no intervention or therapy other than the application of ice water to his shirt. Do you see that?
A Correct.
Q That is not actually true, is it?

A I'm not sure I understand.
Q Well the EMS group did more than apply ice water to his shirt.
A They started an IV and probably placed him on some oxygen.
Q By nasal cannula?
A Correct.
Q So there was some more therapy than ice water, correct?
A That's correct.
Q By the time you saw Mike Wiley, did he already have an IV in place in the emergency room?
A I believe so from the EMS chart.
Q Did he continue to be on oxygen therapy?
A The nurses started him on or continued him on some oxygen therapy.
Q When you question a patient who has chest pain, do you suggest terms to the patient?
A I try not to.
Q After they've given you their original description, do you suggest terms?
A I try to use their terms.
Q So the burning term would have been Mike Wiley's'?
A I would assume so.
Q To your knowledge has that term in and of itself

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been studied with relation to the incidents of patients who have either acute myocardial infarction or unstable angina'?
A A study of the use of the word burning'?
Q Yes, sir.
A I'm not aware of any.
Q I think you may have said this before, but shortness of breath would be a sign or symptom of acute myocardial infarction, would it not?
A It could be.
Q Would it also be a sign or symptom of unstable angina?
A Could be.
Q Do you recall anything else about Mike Wiley's chest pain other than as recorded and your typewritten emergency room record?
A Not offhand, I guess.
Q From what you have recorded here, would you consider the pain to have been substernal?
A Id have to read my notes. I couldn't comment on that. I have a feeling that it's not, but I couldn't say specifically from what I've charted.
Q Would that be important to know?
A My chart that is chest pain's reproducible, so I tend to think it was more lateral, but I haven't

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charted anything specific to that.
Q You didn't actually use the word reproducible in your record, did you?
A Yes, I did -- I think, let me check. Yeah, clinical impression. It does appear to be reproducible on palpation to the chest wall so I feel this most likely is chest wall pain.
Q Where is that?
A Clinical impression.
Q Okay. Does the reproducibility of the pain rule out acute myocardial infarction?
A Well, it could have two processes going on, I suppose, yes.
Q Does it rule out unstable angina?
A It makes it less likely.
Q But it doesn't rule it out?
A No.
Q Do you know whether the patient got the Mylanta and Donnatol before your physical exam?
A It looked like he had got it after my physical exam cause the nurses' notes, if I read their notes correctly, Dr. Branch -- it says notify.
Q Is there any note of when you did your history and physical?
A Usually they -- nurses note when I go in.

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Sometimes I'll note on the chart. if it's available to me when I'm doing my history physical. There's a place for history time. Many times I do fill that out.
Q Is it filled out in this case?
A No. I can't say when I did the history physical. I would assume that I did it before I ordered the Mylanta and Donatol.
Q Okay. Did you read the EKG itself or just rely on a computer reading?
A I read the EKG myself
Q And based on your review of the EKG, an acute myocardial infarction was unlikely?
A There was no evidence on the initial EKG of a myocardia infarction.
Q Okay. And there was no evidence in your opinion of an – of an acute myocardial infarction on the second EKG?
A That's correct.
Q So you told me earlier that the initial EKG is only twenty-five (25) to fifty percent (50%) accurate. When you put a second one on top of it within an hour to two hour span of time, how much more accurate is it for ruling out an acute myocardial infarction?
A I can't give you the statistic, but it does go up significantly.

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Q But it does not rule out unstable angina. docs it?
A Well if you're having unstable angina, you're likely to have some non-specific changes on the EKG, but it doesn't rule it out.
Q Well, what percentage of patients who are having unstable angina will have EKG changes?
A I can't give you a percentage.
Q Let me batch all of the cardiac enzymes together, if I could for a moment Is it your testimony that based on all these cardiac enzymes. acute myocardial infarction was unlikely?
A I would say based on the myocardial -- the myoglobin enzyme, acute myocardial infarction was highly unlikely.
Q When you say highly unlikely, what do you mean?
A Nearing ninety-nine (99) to a hundred (100) percent assurance.
Q Okay. Given all the -- all or collectively all the cardiac enzymes, are any of the individual ones that you want to point out?
A (NO VERBAL RESPONSE)
Q Did they rule out unstable angina?
A No.
Q Did the cardiac enzymes as reported in the chart influence your decision either way on whether or not

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this patient had unstable angina?
A I think what influenced me most about this not being angina was his non-response to nitroglycerin.
Q Okay, we'll get to that. But the enzymes themselves didn't sway you either way on a decision of unstable angina in Mike Wiley's case.
A Correct.
Q According to the nurses' notes, when Mike Wiley came in, his pain level was a nine on a ten scale. Is that correct?
A Well, it's unclear to me whether that was the initial pain. I think I read that as the initial pain.
Q Would that be important to know?
A I suppose. He did improve by the time he got to the hospital, I believe his pain was a five.
Q Do you know when he went from a nine to a five in his level of pain?
A I couldn't say with certainty from the chart.
Q Is fire still severe chest pain?
A Well, severe is a subjective term, but it's the middle of the scale.
Q Well, if a – let me put it to you this way. Could a patient who was having an acute myocardial infarction have pain on a level of five'?
BY MR. MEADOWS: Objection.

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BY MR. CHAPMAN: Objection.
A **A** patient can have an acute myocardial infarction and not have any pain.
Q Okay. So the same would be true for unstable angina. A patient complaining of pain on a five level could be having unstable angina.
A Yeah.
Q Of what significance, if any, was the diminution of the pain from a nine to a five?
A That may indicate – be more evidence possibly of angina. because angina usually gets better with rest.
Q Okay. So the fact that he went from a nine to a five cenainly didn't rule out unstable angina?
A No.
Q In fact, it made unstable angina -- let me rephrase that. In fact, going from a nine to a five with rest and treatment would make you slightly more suspicious of unstable angina. Would it not?
A In the face of a normal EKG, it makes angina maybe a little ahead of a MI in the differenrial, but my strong clinical impression was still that this was muscle skeletal.
Q What was -- my reading of this chart indicates that he – his level of pain never dropped below a five. Is that the way you see this chart?

A Yeah, that would be correct.
Q What's the significance, if any, to you of the fact that he stayed at the level of five through the remainder of his emergency room stay?
A It's consistent with muscle pain.
Q Is it consistent with anything else?
A Well, I was concerned about angina, so I did give him a nitro sublingual, and all the indications were that he had not had a heart attack. So that, I says, well maybe this is angina, so I had the nurses give him a sublingual nitro, and I would suspect that that should alter -- it may not take it away, but should alter his sensation of pain if it's angina, but wouldn't affect muscle skeletal pain.
Q In what percentage of cases will sublingual nitro decrease ischemic chest pain from unstable angina?
A I couldn't give you a percentage. I mean my clinical experience -- if they have a normal EKG with no ischemic changes having suspected, should be a minor ischemic change that should rapidly respond.
Q Let me ask you this way. The fact that Michael Wiley's level of pain apparently did not decrease in response to the nitroglycerin, did that rule out unstable angina?
A It made it extremely unlikely, highly unlikely in

my mind, yes.
Q And what's highly unlikely in your mind again?
A Highly unlikely is highly unlikely.
Q You don't attach any particular percentage to that?
A You can if you like, but I'm not going to.
Q For how long was Mike Wiley in the emergency room after the sublingual nitro was given?
A Twenty-two (22) minutes.
Q Sublingual nitro has relatively rapid onset, doesn't it?
A That's correct.
Q Wouldn't it have been reasonable and prudent to repeat the administration of sublingual nitro when the initial dose did not change the pain at all?
A That would have been a clinical option, but I was highly impressed with his clinical presentation of muscle skeletal pain.
Q Have you seen instances in which, although an initial dose of sublingual nitro may not have affected a level of pain, a subsequent serial dose within thirty (30) minutes has?
A I can't recall any specific instances of that.
Q Is dosing several times with nitroglycerin -- nitroglycerin a more sensitive way to evaluate response

in the face of potential chest pain of ischemic origin?
BY MR MEADOWS Objection
A I'm not aware that it's more sensitive
Q Could be and you're just not aware of it?
A I'm not aware ot any studies that show that it's more sensitive
Q Could there be such studies, and you simply are not aware of them for some reason?
A There could be
Q Okay, let me go to the last page of your -- I'm sorry, I didn't -- at the bottom of the same page I was asking you about, where it says diagnosis Do you see that'
A Yes
Q And would you have had a differential diagnosis at that point7
A At that point I felt that it was inter left chest wall pain I guess this is where I think that it was not substernal because here I specifically write left chest wall
Q Okay, but would you have – would you have had a differential, which included more than just this diagnosis, at that point in the evaluation?
A At this point in the evaluation, I'm highly confident with this diagnosis

Q Okay. Acute left chest wall pain just describes a time of onset and a location, does it not?
A Correct.
Q And is it -- is it your testimony that your opinion at the time was that the cause of this was musculoskeletal?
A Correct.
Q In your opinion most likely during the shoveling, right?
A Correct.
Q How confident were you of that diagnosis?
A Highly confident.
Q And what does that mean?
BY MR. MEADOWS: Rather than highly confident?
BY MR. MORIARTY: Mm?
BY MR. MEADOWS: You've asked him that a few times, and I don't know if he can --
Q Can you tell -- I can't crawl into your head and understand what that means. Are you able to describe to me in any more detail what it means when you say highly confident?
BY MR. MEADOWS: If you can, do it. If you can't, tell him no.
A I can't.

Q Do you think you had a ninety percent (90%) confidence level at that time?
A I was highly confident.
Q You can't answer that question'?
A I'm not going to put a number on it.
Q And the reason you did not repeat the enzymes or consult an internist or a cardiologist was because that you were highly confident that this was musculoskeletal in origin?
A Correct.
Q In hindsight, knowing now what happened several days later, and having read the autopsy report, what in your opinion, to a reasonable degree of medical probability, was happening with Mike Wiley when he was in the emergency room on July 16th, 1997?
BY MR. MEADOWS: Objection.
A I have *no* opinion.
Q How come you don't have an opinion? You don't have enough information?
A That's correct.
Q What more information would you need to know?
A Follow-up medical records.
Q You mean of the four or five days between this emergency room and his death?
A When he was to see his family doctor.

BY MR. MEADOWS: I'm going to show an objection at this point because I had put out discovery requests myself several months ago, and it's my understanding to date I have not received such responses, although over the weekend I received a copy of responses that had been propounded on behalf of the hospital, So if there are any subsequent medical records or any medical records that would have fallen within the documents that I requested, I don't know that it's appropriate for you to question this witness on those at this time. I think there may even be some petty motions to that effect.
BY MR. MORIARTY: I'm not asking him about any specific medical records. I just want to know his opinion. If he doesn't have an opinion, he can tell me that, and then if he develops one later, then at least he can supplement it.
BY MR. MEADOWS: Okay.
Q Doctor, do you believe now, knowing that Mike Wiley died most likely of a heart attack several days

later, do you believe that it is at least possible that he was having unstable angina. when he was in your emergency room on July 16th?

BY MR. MEADOWS: Objection. The first part ofyour question states as a fact that he died ofa heart attack.

BY MR. MORIARTY: Okay, I'll rephrase the question.

Q When you read the autopsy. what did you conclude about the cause of his death?

A It was unclear.

Q Was heart attack, acute myocardial infarction, one of the potential causes?

BY MR. MEADOWS: Objection. He's not the pathologist --

A I'm not a pathologist, but the way I read that wasn't consistent with what a path report for acute myocardial infarction should show.

Q Was it a coronary death?

BY MR. MEADOWS: Objection of form -- I don't know what that means.

A I couldn't say.

Q All right. Did you dictate this discharge summary yourself, this emergency room note?

A Yes, I did.

Q Throughout this I've asked you about various risk factors. Before I sort of put those together, let me ask you, what was Mike Wiley's weight when he was evaluated in your emergency room?

A It's unclear.

Q Is it at least possible that weight can be, specifically overweight, can be a risk factor for heart disease?

A Correct.

Q Do you know whether or not he was overweight?

A He wasn't.

Q Why do you say that?

A I read the autopsy report.

Q Okay. Do you know whether or not the weight recorded in the autopsy is accurate?

A No.

Q Do you remember him being – I think the autopsy said like a hundred and twenty-six (126) pounds. Do you remember Mike Wiley being a skinny hundred and twenty-six (126) pounder?

A I don't remember him being overweight.

Q Okay. You don't remember either way?

A Well, I remember the tattoos on what I would consider probably a normal frame or a regular frame.

Q Okay. Well, if you have a male patient in his

forties who comes in complaining of a sudden onset of burning chest pain, and it came on with exertion, and he is a smoker -- be's got, at least by measurement in the ambulance and in the emergency room, elevated blood pressures and pulse rates, you would agree that acute myocardial infarction and unstable angina should have been in the differential diagnosis?

A They were.

Q You would agree that they should be?

A They should and were in the differential.

Q Okay. And some of the -- or all of the things that I mentioned are at least some risk factors for heart disease. Is that correct?

A Correct.

Q This page in the medical record, could you turn to it, please? Is this -- how many leads would have been connected to him to lead to this monitor strip?

A He has three, I think here.

Q This is not a twelve (12) lead EKG?

A Correct.

Q Was he under continuous twelve (12) lead EKG monitoring when he was in the emergency room?

A We don't have that capability.

Q And these printouts at the bottom, HR I assume is heart rate.

A Correct.

Q Respirate -- R-E-S-P, would that be his respiratory rate?

A Correct.

Q SPO2, is that is his pulse oximetry?

A Correct.

Q What's the hundred and forty (140) NBPs? I'm sorry, a hundred and forty (140) -- what is -- what's the category that says NBPs?

A Blood pressures, systolic --

Q Systolic and then NBP is diastolic?

A Diastolic.

Q And what -- then what's NBPM mean?

A Mean pressure.

Q Does that mean arterial pressure?

A You mean blood pressure, yeah.

Q Okay. Did you read the chest x-ray yourself?

A Yes, I did.

Q Was the radiologist's report available prior to discharge?

A No.

Q Go to the home going instructions, if you would please. Did you actually write these home going instructions?

A I did.

Q Please tell us what the instruction is regarding an appointment with his family doctor.

A It says call to arrange an appointment at his family doctor in two to four days for follow-up care.

Q So he was supposed to call his family doctor within two to four days?

A Well I expected him to call that day and set up an appointment for two to four days.

Q Is that what you told him, to call that day to set up an appointment within two to four days?

A Well, I don't recall which day of the week that was, but that would have been my standard discharge verbal instruction.

Q I'm sorry, you don't specifically recall what you talked with Mike Wiley or his wife about as far as when to place the call and when to see his doctor?

A Uh--

Q Do you specifically recall?

A I don't specifically recall. I know my general standard discharge verbal instructions.

Q In your opinion, did you comply with the standard of care when you treated Mike Wiley in the emergency room on July 16th?

A Yes, I did.

Q And why is that?

A Well. I met the -- I think I went beyond the ordinary proven position.

Q Why?

A I clinically felt this was muscle skeletal on my initial exam. I waited two and a half hours before even ordering the initial cardiac enzymes. That's giving him a chance to elevate. I did a second EKG shortly before he was discharged to make sure nothing had changed or developed, and I had given him some nitroglycerin looking for a response to angina which I didn't get. Clinically it still looked like be had muscle skeletal pain.

Q Is left chest wall pain a sign or symptom of ischemia?

A Could be.

Q What was it about Mike Wiley that led you to conclude that his diagnosis was musculoskeletal in origin?

A It was reproducible palpation of the chest wall and with movement to the chest wall, and none of the objective testing disproved or proved anything else. Nothing disproved my clinical impression.

Q Yeah, I don't mean to go over things that I asked you before, but it's difficult to sit here and remember what I've been over before sometimes, so excuse me.

Bear with me. And your lawyer will tell me if I'm repeating myselfanyway. If -- I think what you just told me is that left chest wall pain can be ischemic in origin, correct?
A Yes.
Q Okay. If left chest wall pain is reproducible on palpation or movement, does it diminish your suspicion that it is ischemic in origin?
A Correct.
Q Does it -- does it eliminate the possibility that it is ischemic in origin?
A Not a hundred percent (100%), no.
Q Can you put a percent on that?
A No.
Q So it diminishes the chances of it being ischemic by some unknown amount.
A Correct.
Q But leaves the possibility of it still being ischemic?
A Correct.
Q And then you said that it was reproducible with no objective evidence to prove otherwise. When you say objective evidence, ar you talking about the EKG, the enzymes --
A The chest x-ray and the therapeutic maneuvers.

Q And I'm sorry, the last one?
A Therapeutic maneuvers.
Q Such as?
A The administration of sublingual nitro.
Q Okay. The chest x-ray would not be expected to diagnose -- withdraw that.
A chest x-ray wouldn't be expected to rule in or rule out either way a heart attack or unstable angina, would it?
A Well, ifthey have pulmonary edema it suggests more of a heart origin.
Q Normally it wouldn't.
A Well, I see a fair amount of people with pulmonary edema from heart attacks.
Q Okay. In this case, the negative chest x-ray did not completely rule out heart attack *or* unstable angina, did it?
A Correct.
Q And the EKG did not rule out unstable angina?
A The second one, normal one, makes it highly unlikely.
Q It didn't rule it out, unstable angina, not myocardial infarction.
A Oh, I'm *sorry.* It decreases the probability.
Q Okay, but didn't rule it out. And the normal

range of the enzymes didn't rule out unstable angina.
A Correct.
BY MR. MEADOWS: Are you askingjust in isolation each of these tests?
BY MR. MORIARTY: Yes.
BY MR. MEADOWS: Not the -- to not decide everything else?
BY MR. MORIARTY: Yeah I got to go through them for my own mind.
BY MR. MEADOWS: Okay.
Q And the non-response to sublingual nitro didn't rule out unstable angina.
A It made it unlikely.
Q Okay. And what you're telling me, if I can just paraphrase, is that although individually these didn't rule out unstable angina or an acute myocardial infarction, collectively they made it unlikely?
A Highly unlikely.
Q Did they make it impossible?
BY MR. MEADOWS: Make what impossible? An infarct or unstable angina?
Q Collectively did these tests that we've been talking about, including the reproducibility on physical exam, make it impossible that Mike Wiley was having an acute myocardial infarction?

A I think they ruled out an MI.
Q Completely')
A Mm-hmm.
Q Yes?
A Yes.
Q And collectively these tests, including the non-response to sublingual nitro and the reproducibility of the pain, did it make unstable angina impossible?
A it made it highly unlikely.
Q Would you agree that at least in your own opinion, acute MI was ruled out more definitively than was unstable angina?
A I felt they were both essentially unlikely.
Q Well, EKGs and enzymes are not as accurate in the diagnosis of unstable angina, as they are for acute MI, correct?
A Correct.
Q So to that extent, that those were part of your assessment, even if it'sjust a little bit, unstable angina was not as definitively ruled out as acute MI in your mind in this case. Is that true?
BY MR. MEADOWS: Based on those two tests?
A On the clinical picture, I didn't think it was angina.

Q Clinical picture, meaning what?
A The reproducibility of his chest pain.
Q Was that an important factor in your mind?
A Yes.
Q Did you give any consideration to running an arterial blood gas?
A If his pulse ox was pretty good, ninety-seven percent (97%), not really, no.
Q If a patient is having unstable angina, are they going to be hypertense or hypotense?
A Difficult to say -- they probably would be more likely to be hypertensive - could be normotensive
Q If a patient has got unstable angina, should the symptoms be relieved by rest?
A Usually they're decreased.
Q Is shortness of breath precipitated by exertion an anginal equivalent?
A I'm not sure I understand what you're asking.
Q Do you know what I mean by an anginal equivalent?
A I'm not sure how you're using that, no.
Q Have you heard the term?
A Not really.
Q Are patients with unstable angina at risk for sudden cardiac death?
A I believe so, yes.

Q I'm almost done, doctor Just a couple more things Would you agree that ischemic pain lasting more than fifteen (15) minutes, which is not relieved by nitroglycerin or is accompanied bv diaphoresis or shortness of breath -- I'm sorry, diaphoresis or shortness of breath, suggest a diagnosis of acute MI?
A Put in the nght setting
Q Okay
A Those three and a twelve-year-old. I wouldn't -- twentv-vear-old -
Q Okay.
A There may be other explanations for all those symptoms.
Q Was there any particular downside to admitting to Mike Wiley to the observation unit at the Fisher-Titus Medical Center?
A What do you mean by downside?
Q Well, what would the harm have been to admit him to the observation unit or consult with the internist to at least consider that?
BY MR. MEADOWS: Objection.
A No harm.
BY MR. MORIARTY: Give me two minutes to consult with my colleague here, and we're close to being done or we are

done.
(OFF THE RECORD)
BY MR. MORIARTY:
Q In the circumstance where you've got a patient in the emergency room who's complaining of chest pain, and, you know, like Mike Wiley who has some risk factors, and MI and unstable angina are in the differential diagnosis, and in the course of evaluating the patient, you've whittled it down to what you are confident is musculoskeletal in origin, could you increase the confidence level of that diagnosis by keeping the patient longer and repeating the enzymes?
BY MR. MEADOWS: Objection. I'm not sure it's a proper hypothetical, and it truly is a hypothetical of sorts. With that, if you can answer, go ahead.
A In this case, I didn't feel anything would be gained by keeping him longer and repeating the enzymes.
Q I understand that you don't feel that in this case, but could you increase the – from a scientific standpoint, can you increase the confidence in the diagnosis if you do serial enzymes?
BY MR. MEADOWS: Objection.
A In ruling out the MI, but I felt confident that I'd ruled that out.

Q Can you increase the confidence in the diagnosis, if you administer nitro several more times?
A I'm not sure that it would have made -- I'm not sure that that would increase confidence level.
Q You can --you'd certainly agree that you can increase the confidence level in the diagnosis if you consult with an internist or a cardiologist who then evaluates the patient in a observation unit for some period of time. Would you not?
A If another doctor came in to evaluate the patient, but in most cases they're not – depending on when they're admitted, they're not evaluated for several hours.
Q I don't have anything else.
BY MR. NEEL:
Q I have one question, doctor. Do you have any criticism of the nurses or of Fisher-Titus Hospital in connection with this case?
A None.
BY MR. NEEL: Thank you.
BY MR. MEADOWS: We'll have him read it.
(END OF DEPOSITION)

I have read the foregoing page(s) 1 through 99 and note the following corrections:

PAGE	LINE	CORRECTION

DAVID A. BRANCH, D.O. DATE

99B0463

CERTIFICATE

The State of Ohio) ss
County of Cuyahoga)

I, MARC EPPLER, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the abovenamed DAVID A. BRANCH, O.O..was first duly sworn to testify the truth; that the testimony then given by him was videotape recorded and reduced to writing; that said deposition was taken and that it was completed without adjournment: that the foregoing is a true and correct transcript of the testimony given by the witness as aforesaid: that I am not a relative or counsel of either party or otherwise iiiterested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office in Cleveland, Ohio this 23rd day of MARCH, A.D., 1999.

MARC EPPLER
Notary Public - State of Ohio
my commission expires 10-4-2003