State of Ohio,)
) ss:
County of Cuyahoga.)

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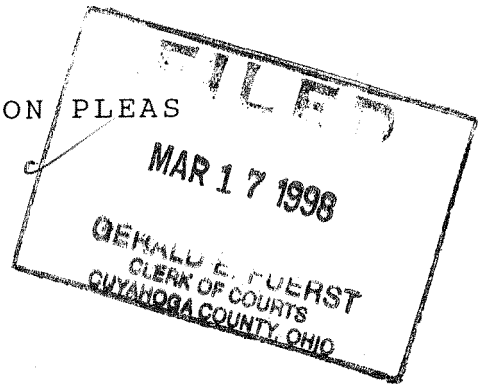
IN THE COURT OF COMMON PLEAS



JANET L. PORACH, ADMINISTRATRIX OF THE ESTATE OF JOHN G. PORACH, JR.,

Plaintiffs,

vs.

LORENZO S. LALLI, M.D.,

Defendant.

Case No. 316045

Judge Calabrese

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DEPOSITION OF CARL A. CULLEY, M.D.

Monday, November 10th, 1997

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The deposition of CARL A. CULLEY, a witness herein, called by counsel on behalf of the Plaintiff, for examination under the Ohio Rules of Civil Procedure, taken before me, Terry D. Gimmellie, RMR, a Registered Professional Reporter and a Notary Public in and for the State of Ohio, by notice or agreement of counsel, at the Lakewood Medical Arts Building, 16215 Madison Avenue, Lakewood, Ohio, commencing at 7:00 p.m. on the day and date as set forth above.

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APPEARANCES:

For the Plaintiffs:

HOWARD D. MISHKIND, ESQ.,
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For the Defendant:

RONALD A. RISPO, ESQ.,
Weston, Hurd, Fallon, Paisley & Howley
2500 Terminal Tower
Cleveland, Ohio 44114

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CARL A. CULLEY, M.D.

a Witness herein, called by counsel on behalf of the Plaintiff, for examination under the Ohio Rules of Civil Procedure, having been first duly sworn, as hereinafter certified was deposed and said as follows:

CROSS-EXAMINATION

BY MR. MISHKIND:

Q. Doctor, my name is Howard Mishkind, And I represent the estate of John Porach as I'm sure you well know. I'm going to be asking you some questions concerning the opinions that you hold in this case.

The purpose of my deposition is to understand the basis for your opinions and the extent of the opinions that you have in this case and those opinions that you intend to provide when this case goes to trial next month, okay?

A. That's fine.

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(Plaintiffs' Exhibit No. 1 marked for purposes of identification.)

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BY MR. MISHKIND:

Q. This one is a one-page document which has your name across the top, and above it, the words "curriculum vitae." I presume that this is, in fact, your resume, of sorts.

A. Yes. The only difference on that is that about a month or two ago, I resigned my position at Fairview Hospital. Other than that, it would be current.

Q. In reviewing your CV, I do not detect any professional writings. Have you done anything that has been published?

A. No.

Q. I also do not see anything relative to any teaching responsibilities or assignments.

Do you do any teaching in any medical schools?

A. Not in any medical schools. We do a rotation on the hospital service at the main Cleveland Clinic Hospital, and there are residents and interns who could round with us there, but they're not formal teaching assignments.

Q. We'll talk about your affiliation with the Cleveland Clinic in a moment, but you are not a professor at any of the medical schools?

A. Correct.

Q. And have not been a professor or an associate professor or assistant during your career, have you?

A. Correct.

Q. Your letter written to Mr. Rispo has the Cleveland Clinic Foundation across the top of it. That is a relatively recent affiliation for you?

A. Yes, as of June of last year.

Q. And, what is your position, or your affiliation with the Cleveland Clinic?

A. Associate staff member in the division of regional medicine.

Q. You are an employee of the Cleveland Clinic?

A. Yes.

Q. Now, your letter was written on the Cleveland Clinic stationery. Is the income that you earn from serving as an expert, does that go to the Cleveland Clinic or does that go to you personally?

A. That depends on when the income is generated. If I were to take time out of my regularly scheduled hours to provide testimony

of this type, then that income would go to the Cleveland Clinic.

If I do it outside of those regular hours, then it would come to me directly.

Q. So for example, our 7:00 dep this evening, this is income that you're earning?

A. Yes.

Q. Before the Cleveland Clinic affiliation, June of '96, you were associated with Innova Corporation?

A. Yes.

Q. And what was your affiliation with Innova Corporation?

A. We were also salaried employees of Innova, in this office, the same one that we're at now. As primary care internal medicine, the same as we are now.

Q. Who are you affiliated with in this office, what other doctors?

A. Dr. Robert Wagar, Dr. Robert Colacarro and Dr. Manuel Valera were all with me in Lakewood Medical Associates. We all came together in Innova, and we all came to together with the Cleveland Clinic.

Since we joined the clinic, we also have

Dr. Jeffrey Christian and Dr. Ruthanne Muniak who work in this building.

Q. Do you spend any time at the main campus of the Cleveland Clinic?

A. I do on a hospital service for about two weeks out of each year, roughly, depending on the circumstances. I do not actually see patients in the outpatient clinic downtown.

Q. You mentioned in correcting your resume that the position that you held that's reflected on the resume that's with Fairview General Hospital is no longer valid?

A. Correct.

Q. When did that terminate?

A. About a month or two ago.

Q. Do you have hospital privileges at any other hospitals other than the Cleveland Clinic Foundation?

A. Yes, at Lakewood.

Q. Do you have an area that you specialize in within the area of internal medicine?

A. No.

Q. How would you describe your practice?

A. Primary care, internal medicine.

Q. I take it in the area of primary care,

you have from time to time the occasion to diagnose and treat patients with coronary artery disease?

A. Yes.

Q What percentage of your patient population that you treat currently has some degree of coronary artery disease for which you follow?

A Well, I don't have any exact figure I would say between 10 and 20 percent

Q The letter that you wrote to Mr Riggo dated August 19th, 1997, do you have that in front of you?

A Yes

Q Have you written any other reports to Mr Riggo in connection with this case?

A No.

Q Did you prepare any draft of that report that you reviewed and perhaps made corrections to before finalizing that particular report?

A No.

Q Did you review your report with Mr Riggo before sending it to him?

A I don't remember doing that, no

Q In your letter of August 19th, you

identified having received a copy of the complaint, a copy of Dr. Lalli's deposition, the deposition of Janet Porach, the deposition of Janice Schoh. And I'm going to refer to her as the receptionist because I will mispronounce her name periodically, or call her Janet, or Janice, as Mr. Rispo and I have bilaterally done during this case.

So, I'll probably err on just saying the receptionist, so you and I know who we are talking about. And the report of Dr. Hoffman. That's the information that's identified in your letter?

A. Yes.

Q. And you have that information, I see, in one stack off to the side of your desk.

Is that the extent of the information that you were provided at the time that you wrote your report?

A. That's correct.

Q. And I see that there is some additional information that you have, and we are going to talk about that in a moment in another stack. But in reviewing that information, I don't see that you have, at anytime been provided the

depositions of John Porach's stepchildren; is that correct?

A. That's correct.

Q. Do you know the names of the stepchildren?

A. No.

Q. Do you know how many stepchildren there are?

A. No.

Q. Do you know how many stepchildren were living at the home with John Porach and his wife at the time that he was ill on October 14th, 1994?

A. No.

Q. Do you know how many children John Porach had?

A. Not off the top of my head, no.

Q. Do you know how many children John Porach had from his marriage to Janet Porach?

A. No.

Q. Do you know how many times John Porach had been married?

A. I don't remember that.

Q. I also note in reviewing the material that you have that you don't have a deposition

transcript of a woman by the name of Mary Narey; is that correct?

A. Yes, correct.

Q. Do you know who Mary Nary is?

A. No.

Q. And have you ever seen any type of a summary, or, in fact, seen a deposition of Mary Nary, that you for some reason no longer have with you?

A. Not that I recall.

Q. Were you provided with the autopsy for John Porach?

A. Yes.

Q. Do you have a copy of the autopsy?

A. Yes, I do.

Q. That's one of the items that you received subsequent to your report?

A. Yes.

Q. At the time that you prepared your report, you didn't have that, correct?

A. Probably not, unless I forgot to mention it in that first paragraph, but I don't believe that I did.

Q. What about the Fairview General Hospital records?

A. Unless they're included in one of the other records from Dr. Lalli's office, I don't believe that I would have had that as a separate item.

There is only a copy of the emergency room report from the time when he had arrested which is Dr. Lalli's office record. But I have no separate record that I remember.

Q. Has there been any information that you requested from Mr. Rispo that you've not been provided?

A. No.

Q. Do you think that in order to fairly and objectively to review this case that you should have reviewed the Fairview General Hospital records as well as the autopsy prior to rendering opinions in this case?

A. No. I don't see how that would have changed my opinion.

Q. Do you know the emergency room doctor that prepared that note that you just referenced?

A. By name, but not personally.

Q. You used to work out at Fairview General Hospital so you would you know him by that

name from that connection?

A. Yes.

Q. Since your report, what additional information have you been provided other than the autopsy that you just referenced?

A. I have the deposition of Dr. Botti, Dr. Hoffman, Dr. Selwyn and a summary of the deposition of Dr. Effron who apparently his deposition was not available prior to the time this was mailed to me.

Q. And you reviewed all of that information in connection with today's deposition?

A. Yes.

Q. There is 23 documents in here. One is a summary of the deposition of Dr. Botti and a summary of the deposition testimony of Dr. Effron, and both of these documents you reviewed prior to today's deposition?

A. Yes.

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(Plaintiffs' Exhibit Nos. 2 and 3 were marked for purposes of identification.)

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BY MR. MISHKIND:

Q. Exhibit 2 is the deposition summary that

Mr. Rispo provided you on Dr. Botti?

A. Yes.

Q. And Exhibit 3 is the summary of the testimony of Dr. Effron that Mr. Rispo provided you?

A. Yes.

Q. Have you read those deposition transcripts?

A. Yes, I have.

Q. Did you make any notes when you read those depositions?

A. No.

Q. Did you make any notes at all in the deposition transcripts?

A. No.

Q. Do you have any notes on computer from anything that you've read?

A. No, just the report itself.

Q. So aside from the report from August, you've read over three depositions and been provided with two summaries of other depositions and an autopsy report, but have not made any other notes, or written any other letters or reports in connection with the additional information; is that correct?

A. That's correct.

Q. Have you been provided with any other reports, or been shown any other reports from any other experts in this case?

A. No.

Q. Are you aware of the fact that there are some additional experts in this case that have provided opinions other than the people that we've talked about thus far?

A. No.

Q. Have we now covered everything in Carl Culley's mind that has been provided to him relative to the death of Jack Porach?

A. Yes, I believe so.

Q. Doctor, I want to talk a little bit about your experience in doing this kind of work.

You have served as an expert witness in the past, correct?

A. Yes.

Q. Have you worked with Mr. Rispo on any cases before?

A. I believe one other case.

Q. Is that a case that you're currently working with him on, or is it a closed case, to your knowledge?

A. I believe it's currently open.
Q. What is the name of the patient or the name of the doctor in that case?
A. I wouldn't really know off the top of my head.
Q. Is that a case that you have prepared a report and sent that to Mr. Rispo like you did in the Porach case?
A. I believe so, yes.
Q. Have you been deposed in that case?
A. No.
Q. Other than the one current case that you're working with with Mr. Rispo, have you ever worked with him before?
A. No.
Q. Did the case that you're working on with Mr. Rispo that you don't remember the name of, did that case precede the Porach case or come after Porach?
A. I don't remember.
Q. Do you know how it is Mr. Rispo got your name?
A. No.
Q. Have you worked with any other attorneys in the Weston, Hurd law firm?

A I don't remember any off the top of my head

Q What about Steve Walters? Does that name ring a bell?

A I don't think so

Q Pierre Penny?

A I don't think so

Q You've worked with other law firms other than Groston. Hurd is an expert witness, correct?

A. Yes.

Q You have done a bit of work with the Reading and Reminger law firm as an expert witness defending doctors, correct?

A. Yes.

Q How many times have you testified for a doctor at the request of either Mr Sadzak or Mr Fineran or Mr Scott?

A I wouldn't be able to give you an exact number, but among the partners of that firm, I probably have done one about 20 cases. I would presume

Q In fact, you're currently working with that law firm as an expert witness on several cases, correct?

A. Yes.

Q. What other defense firms are you currently working with as an expert witness where you have testified or are anticipating testifying?

A. Arter & Hadden, and Quandt, Giffels & Buck.

Q. Any others?

A. I'm not too good at names, but.

Q. You are doing fine thus far.

A. I did one case, I think for Jacobson, Maynard. And another case for a firm in the Akron/Canton area, but I can't remember their name.

Q. Buckingham, DooLittle?

A. Yes, that sounds familiar.

Q. Have you done more than one case for the Arter & Hadden firm?

A. Yes.

Q. How many cases?

A. At least two, maybe three. I can't remember exactly.

Q. What about Quandt, Giffels & Buck?

A. Several cases. I can't remember the exact number.

Q. During a given year, how many cases, medical malpractice cases do you review on average?

A. It varies from year to year. Probably on average, 10.

Q. Doctor, is it fair to say that in terms of the testifying that you have done in medical malpractice cases that you have served exclusively as an expert witness on behalf of either a doctor or a hospital that has been named in a medical malpractice case?

A. Of those that I have agreed to testify for, yes, they've all been in the defense.

I have reviewed cases for the plaintiff, but did not accept those cases.

And I did do one case which was not malpractice, it was a criminal case for fraud in which I testified against the physician.

Q. And just so the record is clear, you did review, I think, the case for was it Dennis Lansdowne from the Spangenberg law firm?

A. Yes.

Q. And you found that there was no merit to that case. The doctor did not violate the standard of care. So you indicated that you

were unwilling to serve as an expert in that case?

A. Correct.

Q. So anytime that you have testified, it's been 100 percent defending a doctor where a claim has been asserted against him or a hospital where a claim has been asserted against it?

A. Except for that one fraud case, yes, which is not a malpractice case.

Q. I'm talking about medical malpractice cases.

A. Correct.

Q. Do you provide your expert testimony through any medical malpractice service companies?

A. No.

Q. Have you ever advertised?

A. No.

Q. When were you last deposed? When did you last give deposition testimony?

A. About a month ago.

Q. And are you scheduled to give a deposition in the near future?

A. Yes.

Q. When is that?

A. Actually, I have one this Friday.

Q. Even though I would suspect that the numbers vary from time to time, on the average, just like we talked about the 10 cases a year that you review, on average, how frequently during a given week or a given month do you give testimony?

A. Well, it would be less than that -- I shouldn't say that. Sometimes there is more than one deposition in a given case, but some there is no deposition. So it probably comes out even. I would guess you are talking about on the average less than one a month, probably.

Q. What case is it that you are scheduled to give a deposition in on Friday?

A. I would have to refer to my note. That's a case called Boyd versus University Hospital.

Q. You are an expert for University Hospital in that case?

A. Yes.

Q. And who is the lawyer that you are working with on that case?

A. Chris Troyee.

Q. Have you ever testified as an expert in this case where the issue involved the diagnosis and treatment of a patient with coronary artery disease?

A. Yes.

Q. I don't have to ask you when you were testifying on behalf of the defendant or the patient, because that's been sort of taken care of in my previous question, but was that a death case?

A. Yes.

Q. What was the name of that case?

A. I don't remember.

Q. Was there an issue as to whether or not the Doctor or the hospital promptly recognized and treated the patient's symptoms?

A. Yes.

Q. And you were of the opinion that they did treat the patient's symptoms promptly?

A. Well, I'm sure that the terms, although I don't remember the details of it, I'm sure that the terms would have been that they appropriately satisfied the problem regardless of the unfortunate outcome in this case.

Q. And you recognize that there are certain

circumstances where no matter how good the care is, sometimes patients die?

A. Correct.

Q. You also recognize that there are circumstances where with prompt recognition of symptoms and prompt initiation of treatment, fatal events, such as fatal arrhythmias can be prevented?

A. Yes.

Q. Before we move off of the topic of your experience as an expert witness, I'm going to ask you about your experience as a defendant.

Have you ever been named as a defendant in a medical malpractice case?

A. Yes.

Q. On how many occasions, please?

A. Three.

Q. Are any of those cases currently pending?

A. No.

Q. What was the subject matter of those cases?

A. The first case was a situation where a patient had an allergic reaction to an eye drop.

The second case was a patient who had an

attack of vestibular neuritis, two months later had a stroke.

And the third case was a patient who had a chronic leukemia condition who underwent an orthopaedic surgical procedure and suffered a myocardial infarction after it.

Q. What were the names of those patients starting with the allergic reaction?

A. I don't remember that. That was a long time ago. That was about 18 years ago.

Q. What about the vestibular neuritis?

A. I don't remember that name either. Again, that was a long time ago. That was probably about 12 years ago.

Q. And the leukemia?

A. That patient's name was Clayton Derthick.

Q. Spell the last name, please.

A. D-E-R-T-H-I-C-K.

Q. I'm sorry, I-C-K?

A. Right.

Q. Who do you maintain your professional liability insurance with right now, the Cleveland clinic?

A. Yes, self-insured.

Q. Before your affiliation with the

Cleveland Clinic?

A. It was with Pico.

Q. Do you know Dr. Lalli?

A. No.

Q. Have you ever talked to Dr. Lalli?

A. I don't believe so. I know his name, but I don't believe I ever socialized with him.

Q. When you say you know his name, through what circles?

A. Well, I believe he is on the staff at Fairview, and I believe also at Lakewood.

Q. Two hospitals that up until very recently -- actually you still -- do you still have privileges at Fairview?

A. No, we resigned the privileges at Fairview. We still have privileges at Lakewood.

Q. So the time that you accepted this assignment you had privileges at both Fairview and Lakewood Hospitals?

A. Yes.

Q. Do you know the receptionist for Dr. Lalli?

A. No.

Q. Have you talked to her?

A. No.

Q. Dr. Hoffman from University Hospital, the pathology expert, do you know Bob Hoffman?

A. No.

Q. Do you know Dr. Robert Botti?

A. No.

Q. What about Dr. Jeffrey Selwyn?

A. No.

Q. Do you know Dr. Bruce Janiak?

A. No.

Q. Do you know Dr. Barry Effron?

A. No.

Q. What am I being charged today, Doctor, for this deposition?

A. $200 an hour.

Q. What are you charging Mr. Rispo to testify at trial next month?

A. $200 an hour.

Q. What do you charge for review of records?

A. $200 an hour.

Q. Have you done any research at all in the medical literature prior to preparing your report?

A. No.

Q. Have you done any research in medical

literature prior to today's deposition?

A. No.

Q. Would you please list for me the textbooks within the area of internal medicine that you go to from time to time for information?

A. Scientific American medicine, Harrison's Internal Medicine and Cecil's.

Q. In effect, Doctor, you considered Harrison's to be one of the leading textbooks in the area of internal medicine?

A. Yes.

Q. Well-respected source of information on areas of internal medicine?

A. Yes.

Q. Something that you consider to be authoritative in the area of internal medicine?

A. It depends how you define "authoritative."

Q. How do you define it?

A. I would define it as a standard reference sources, peer-reviewed and written by an established authority.

Q. And is that what you consider Harrison's

to be?

A. Yes.

Q. If you needed reliable information on a diagnosis and treatment of a patient with symptoms that could be related to coronary artery disease, or could represent acute myocardial infarction, where would you look for reliable information on those topics, either coronary artery disease or manifestations of an acute myocardial infarction?

A. Oh, I think either of those three textbooks.

Q. Do you consider the other two, by your definition to be authoritative texts?

A. Yes.

Q. You also subscribe to, I believe, the Annals of Internal Medicine and JAMA?

A. I don't subscribe to Annals of Internal Medicine. I see it from time to time?

JAMA is something that I receive regularly.

Q. And do those journals, at least JAMA, do they frequently have up-to-date information on the diagnosis and treatment of patients with

acute myocardial infarction?

A From time to time, yes.

Q. Doctor, can we agree that patients that are fortunate enough to reach a coronary care unit during evolving myocardial infarction have a substantial lower mortality than those patients that are not directed to a coronary care unit or an emergency room?

A. Yes.

Q. Can we further agree that cardiac arrest can be prevented by early therapy aimed specifically at the prevention of life-threatening dysarrhythmias?

A. Well, that would have to be qualified. There are times that that could be prevented. But actually the purpose of the coronary care unit is to intervene as promptly as possible once an arrhythmia occurs. It's rare actually that an arrhythmia can be prevented in that respect.

Q. Well, if you get a patient into a hospital when he has an evolving acute MI, what is the goal of the therapeutic intervention at that point?

A The goal of the therapeutic intervention

is try to reestablish blood supply, if possible. And if not possible, to at least try to improve the physiologic status of the heart so that it minimizes the damage.

Q. And if a patient is in appropriate coronary care unit during an evolving MI and is hemodynamically stable when he arrives in the coronary care unit, what is your understanding as to the percentage of patients that still die, that still evolve with heart attacks and suffer cardiac arrests, notwithstanding prompt immediate medical intervention?

A. I don't know an exact figure, but the majority of them would certainly survive.

Q. Can we agree that when we look at statistics in terms of sudden cardiac death or cardiac arrest and the statistics about patients, whether they're young or old that die of cardiac arrest, those are patients to a great majority, or the larger percentage, that do not make it to an emergency room or a coronary care unit for appropriate intervention?

A. Could you restate that? I sort of missed

the beginning of your question.

Q. Not a problem. Let me just mention to you, from time to time, very rarely do I state a question that just seems to keep on going on and on.

But if I do, tell me, like you just did, and I will restate it.

A. Okay.

Q. Most patients that die of sudden cardiac death or cardiac arrest are patients that for whatever reason are not seen promptly enough at a medical facility that has a coronary care unit. Would you agree with that statement?

A. Yes.

Q. The majority of patients that are fortunate enough to get to a coronary care unit and are under monitoring with appropriate intervention, the majority of those patients that arrive with an evolving MI that are hemodynamically stable at the time of presentation survive?

A. Yes.

Q. What caused John's cardiac arrest in your opinion, John Porach?

A. Well, he most likely had ventricular

fibrillation.

Q. What caused the V-fib?

A. I believe it was cardiac ischemia.

Q. And what caused the cardiac ischemia?

A. A thrombus in his left anterior descending artery.

Q. You have Dr. Hoffman's report, and you have Dr. Hoffman's deposition, correct?

A. Yes.

Q. Do you have any reason to dispute his findings and his explanation concerning the coronary arteries, specifically the left anterior descending and the myocardium?

A. Well, I'm not a pathologist, so I wouldn't be able to argue with him one way or the other about that.

Q. So certainly, at the time of trial, you will defer to Dr. Hoffman with regard to the findings as explained by him relative to the myocardium and the coronary arteries?

A. Well, I would certainly defer to a pathologist. Whether I would defer to him specifically, you know, with contrary advice from another pathologist is a different question. But I wouldn't dispute the issue of

the microscope's slides with a pathologist.

Q. Okay. And even though you're not a pathologist, and I appreciate you not trying to venture into an area that you're not qualified to venture into, but do you find anything intellectually unacceptable to you relative to his findings and conclusions as expressed in his deposition?

A. No. The only thing that I would have hoped in that report was if they could have narrowed down the time frame more precisely. It was left quite wide open as to exactly what the definition of quote, "a few hours" meant.

Now, I really have no idea whether that is something that can be resolved by a pathologist, but I believe that was the one issue which I would have hoped could have been clarified somewhat better.

Q. Well, when you read Dr. Hoffman's deposition, that clarified it for you, didn't it?

A. Well, not really. He was still really quite vague about the time. Again, I don't if it's possible to be any more precise than that.

But I think that left a very wide time frame open, and that whole time frame is within the time frame of this particular question in this case.

So in that respect, I don't think that it shed too much light on the situation as it presented here.

Q. What is your understanding as to Dr. Hoffman's testimony as to the injury to the myocardium, the timing on that?

A. Well, in his deposition he said that he thought a few hours could really extend anywhere longer than minutes and shorter than days. And so that leaves a pretty wide range of time.

As I said, it includes an entire limit during this entire case.

Q. It's your understanding in reviewing Dr. Hoffman's testimony that he indicates that the changes that occur to the myocardium -- I'm not talking about to the coronary arteries; I'm talking about to the actually myocardium -- occurred in what time period?

A. Well, the phrase he used in his report was "a few hours."

Q. I'm talking about his dep which was taken more recently than his report. And Mr. Rispo had an opportunity to have him clarify and refine what I meant. What was his explanation at the time of his deposition?

A. In his deposition I remember him saying specifically that it was longer than minutes and shorter than days. I believe he said that several times.

Q. That's the myocardium?

A. I believe so, yes.

Q. Do you recall Dr. Hoffman indicating that the myocardium can be timed much better than a thrombus can be timed in terms of the injury caused to the myocardium as opposed to the injury caused by thrombus to the coronary artery?

A. Yes, sir.

Q. And. Do you recall Dr. Hoffman indicating in his testimony that if changes that occurred in the myocardium occurred between four to six hours prior to the death of the patient?

A. Well, I may be confusing several of the depositions. As you said earlier, there were

three depositions of the plaintiff's witnesses that I reviewed, and I can't really, off the top of my head, pinpoint one to the other. All three of them seem to be fairly vague about the time period.

Q. Okay. Well, I submit to you, his testimony is anything but vague relative to his opinion on the myocardium. If.

I submit to you that Dr. Hoffman is the only one that testified specifically concerning the changes to the myocardium, because Dr. Hoffman is the only one really qualified to do so, and his testimony indicates that the changes to the myocardium are in the at least four to six-hour range based upon the findings in terms of the muscle fibers, and the edema and the separation of muscle fibers and all of that pathologic explanation that was given at the time of his deposition, certainly you wouldn't have any basis to dispute that, would you?

A. No, I wouldn't.

Q. How many heart attacks do you think John Porach suffered on October 14th?

A. That's hard to say. I view it as a

continuum, to tell you the truth.

Q. So you wouldn't dispute Dr. Hoffman's testimony where he said that he sees only evidence of one heart attack occurring in the distribution of the left anterior descending artery?

A. No, I wouldn't dispute that.

Q. Okay. And when you say an evolving or a continuum, is that the word you used?

A. Yes.

Q. When do you think his heart attack started?

A. Well, as I said, this is a difficult thing to define. And believe me, I sympathize when it's difficult for the other witnesses to narrow it down more specifically, but the reason why I'm using that term is because the symptoms of unstable angina certainly mimic those of a full-blown myocardial infarction.

And the definition that distinguishes it would be when there is actual myocardial death, which is what an infarction is, but there is a continuum of symptoms related to that ischemia that progressed from the unstable angina condition to a full-blown

myocardial infarction with necrosis.

It's quite honestly very difficult to pinpoint when you cross that threshold.

Q. Let me ask you this: If you accept the pathologic evidence that we have in the case that the injury to the myocardium was in the range of four to six hours prior to his death, and just to be real simple, we use 6:00 as his death, so if we take it back to at least noon to 2:00 p.m. as being the earliest period of time where there is actual evidence of injury to the myocardium, what may have preceded that may have been angina, or sometime between the angina and when we see injury to the myocardium, a heart attack occurred, correct?

A. Yes.

Q. Okay. Do you have any evidence to suggest that the heart attack occurred any earlier than the morning of October 14th, 1994?

A. No.

Q. What is your definition of sudden cardiac death? Because God knows I've seen enough definitions as I have been doing my reading in this case. But I want to know what

Dr. Culley's definition is.

A. My definition would be instantaneous death where someone literally falls over dead.

Q. With no precursor of symptomatology?

A. Well, not necessarily. Sudden death means that you just suddenly die. But there may or may not have been symptomatology prior to that.

Q. By definition, does sudden cardiac death include patients that have had evolving MI that have symptomatology, either that precedes the MI of angina, then actual ischemic pain associated with the MI for hours before they suddenly fall over dead?

A. I'm sure that is a matter of some controversy as to the exact definition of it. Personally, I would say anyone who appears to be stable and then suddenly dies is a sudden death. But as you can imagine there are a variety of symptoms that people may or may not have prior to that time which makes it confusing.

Q. If John Porach had chest pain, shortness of breath for a 10 to 12-hour period, and then had a fatal arrhythmia in the doctor's office

in the late afternoon and dropped over and died, does that meet your definition of sudden cardiac death?

A. Yes. If he were a stable, alert, talking, individual who appeared to be all right and then suddenly died, I would call it a sudden cardiac death, yes.

Q. That really has nothing to do, however, with whether or not treatment earlier in the day, assuming he had chest pain and shortness of breath, whether treatment earlier in the day would or would not have altered the outcome that we know occurred later in the day, correct?

A. You mean whether or not I would call it sudden cardiac death?

Q. Right.

A. Well, I would still use that terminology, yes. But I think there are those who would say that if someone were recognized to have a cardiac event and were under active treatment for some period of time, then died, they probably would not call that a sudden cardiac death.

Q. Really. So we don't get hung up with

sometimes can confuse the jury, the fact that John Porach fell over dead in the doctor's office, may or may not fit yours or other doctors' definition's of sudden cardiac death.

What's really at issue is what were his symptoms earlier in the day, and would intervention earlier in the day have prevented his death. Maybe yes, maybe no, depending upon which set of facts are believed in this case; is that a fair statement?

A Yes

Q And we're going to talk about those facts, and I want to find out what your opinion is in terms of what should have been done at given point.

But sudden cardiac death really is irrelevant if, in fact, there were things that should have been done earlier in the day because you already told me that the best place for a man to be with an evolving I is in the hospital, being observed and treated, as opposed to driving in a car or sitting at home waiting for medical advice or appointments to be made.

A Well, if I understand your question

correctly, I would agree that whether or not we label this a sudden cardiac death, according to one person or another's criteria, I don't believe that that would be the issue on which I would judge negligence in this case.

Q. Fair enough. The office that you have now in terms of your personnel, has it changed at all since you become affiliated with the Cleveland Clinic?

A. Yes.

Q. How has it changed?

A. Well, there are some new people here. Actually, most of my staff has been with me for a number of years. One person has transferred to the clinic office out in Westlake. But by and large, my general staff is the same that it's been.

Q. How many staff members, nondoctors do you have in the office?

A. I have never actually added it up. We have a bunch of people who are part time, so we have several people who are just here, you know, for a few hours a week or so. We probably have about 20 people all together.

Q. Do you have particular individuals or individuals that are charged with triage?

A. Yes.

Q. Do you have a phone triage system?

A. We have a registered nurse who does triage for us now. We did not prior to belonging to the clinic.

Q. Before the clinic affiliation, who handled your telephone triage?

A. We have both LPN and nursing assistants who would handle those calls depending on who was available to do it.

Q. So you have always had either as current an RN and before LPN or nursing assistants that would handle the triage of telephone calls?

A. Well, of course, a receptionist answers the phone in the first place. So if you want to include that in the definition of triage, if that were determined to be a question that didn't just involve making an appointment, then, yes, it would be passed on to one of those other people.

Q. Well, if the individuals called in and indicated that they had certain symptoms, and

the patient described the symptoms, and the patient wanted to be seen for those symptoms, how would that be handled in your office?

A. Well, there is no one set formula for that. That all depends on how things are presented. Most people who would call -- I mean, if they don't give us their symptoms, we ask for their symptoms, at least, so we could have something written on the day sheet so we know what they are there for.

Q. Who is the "we"?

A. Anyone handling the phone call whether it be the receptionist or triage person.

Q. And how does the receptionist know what questions to ask?

A. Well, she doesn't except in the most general terms.

Q. Okay. But obviously a diagnosis or recommendation relative to steps that are going to be taken aren't going to be made based upon a receptionist's general --

A. No, not a diagnosis.

Q. So if a patient calls up and gives vague symptoms which could be consistent with one or a number of different conditions, has it been

you're practice to have that receptionist turn the telephone call over to the nurse's aide or to the LPN in the ward?

A Well, again, there is no set protocol to that It depends how urgently it is presented to the person There are other things, too If you're talking to someone on the phone and they obviously seem to be short of breath while they talk to them on the phone, obviously, that was some concern

But there isn't a set protocol for that as far as questioning the patient about this or that or the other symptom.

Q Well, what's the receptionist supposed to do? I'll give you an example People call to a law firm and they think that the receptionist somehow is indoctrinated with a kind of legal knowledge I presume people call a doctor's office, they think whoever picks up the phone has some medical knowledge and that may or may not be true, but I have a certain protocol where I tell the receptionist what she is to do with that telephone call so that someone is not handled inappropriately

I presume in a medical office, that the

receptionist has certain instructions that she is to follow with regard to a call that may have some vague symptomatology described, and the patient is either looking for advice or looking to be seen for the condition.

A. Well, again, there is no set protocol for it, but it really depends on how the patient responds to that scenario. Because in general, the receptionist is there to give people appointments. So if she were to say, "We have an appointment for you at 3:00 in the afternoon," and the patient says, "I don't think I can wait that long," then that would be turned over to a triage person to determine if it were a more urgent situation.

Of course, if someone had obvious problems like they were gasping for breath on the phone, or said that they had severe chest pain or something like that, the receptionist would say, just call the rescue squad before she talked to anybody.

But most of the time, if it weren't that clear-cut, she would then turn that over to a triage person.

Q. So if it's obvious, the receptionist can

say call 911. If it's less obvious, they turn it over to a triage person?

A. Yes.

Q. If the receptionist indicates that, "We do not have any appointment right now, but I will get back in touch with you and get you in," does the receptionist, in your opinion, in an internal medicine practice, have responsibility to get back to that patient?

A. Well, if, indeed, she promised that she would get back to the patient, I believe she has a responsibility to get back to the patient.

Q. All right.

A. Ordinarily, what we would do is to offer that person the next available appointment which maybe it wouldn't be until the next day or something, but it would be unusual not to say here is an appointment.

Q. And if the patient expresses symptoms that the receptionist doesn't feel are obvious, the gasping of air that you described before, and if the receptionist doesn't turn that over to triage, but the patient wants to be seen and there is nothing available, and

hypothetically the receptionist says, "I will get back to you, we have nothing open right now but I will get back to you" and doesn't indicate anything other than that, that "I will have to get back in touch with you," and she doesn't callback, is that, in your opinion, below the standard of care?

MR. RISPO: Let me object to the hypothetical. Because it depends on the symptoms that are presented on the original question, the original contact.

BY MR. MISHXIND:

Q. Go ahead, Doctor.

A. Well, I don't see that as actually a standard of care question. I mean that's really more a courtesy question; if you promise you are going to call someone, then you should call them.

But the standard of care really is a different question.

Q. What is your definition of the standard of care, Doctor?

A. Well, that depends who we're talking about.

Q. We are talking about an internal medicine

practice that is run by both nurses as well as other people that a doctor entrusts to handle contact with his or her patients. What's the standard of care when someone calls in with a set of symptoms that may either be obvious, less obvious, or obscure, what's to be done?

MR. RISPO: Objection to the form of the question.

THE WITNESS: Well, the standard of care as far as that goes is to try to be as accommodating to the patient as possible. In other words, to try to arrange as timely a visit as is logistically possible.

BY MR. MISHKIND:

Q. So you would certainly agree that if a patient calls wanting to be seen and expresses that he has achiness in the chest and the arms, and the receptionist indicates that the doctor does not have an appointment, that they're booked, but indicates that she would get back in touch with him, and the receptionist does not call back, that would not be in keeping with accepted standards of practice?

A. Well, to clarify that situation, the key

determinant in this kind of scenario is the urgency with which the patient presents those symptoms

For instance, if someone were looked up for several weeks ahead of time and the receptionist said, 'I don't have anything available for two weeks ' then it becomes contingent upon the patient to make some other remark that they need to be seen earlier than that

Q. But that's not what we're talking about here

We're talking about a situation where that day the calendar appeared to be full, but there was no indication that it was weeks and there was an indication, at least based upon the testimony, the committed testimony that she said she would get back to John Pollock that day, and she didn't, would you agree that if that's the case, and he's described achiness in the chest and the arms and wants to be seen, and she indicates that she will get back in touch with him and she doesn't get back, that that would not be in keeping with accepted standards of practice?

A. Well, in this particular scenario, my understanding was that Dr. Lalli was not going to be back in the office until something like 2 o'clock in the afternoon. And the receptionist was not going to be able to present that case to him until he got back at 2 o'clock in the afternoon at the earliest.

Q. Did the receptionist tell Mr. Porach that that would be the case?

A. Well, I don't remember specifically that a particular time was placed on it, but I believe it was left very vague. And, for instance, in my own practice, someone could write me a note in the morning, and I may be so busy that I don't have a chance to look at that later in the afternoon or even at the end of the day.

So the way that I judge those things is the urgency with which it's presented.

Q. Well, let's take that scenario that the doctor is going to be out of the office until 2 o'clock. Would it be acceptable under those circumstances with the same description that I gave before where the doctor reappears at 2 o'clock, and still there is no contact

between the receptionist and the doctor about the patient's calling that morning, no discussion with the doctor about whether the patient should come in or should be seen elsewhere? And, in fact, the receptionist never does call back the patient. Never does consult with the doctor about the patient's call from the morning, in your professional opinion, Dr. Culley, would that be below the standard of care?

A. Again, in this particular case, my understanding of the timing involved in this was that Dr. Lalli was not going to be back in the office until about 2 o'clock or so. And that Mr. Porach's daughter picked up the phone and called around 3:00 or 3:30 in the afternoon. So that period of time, an hour, hour and a half of time between Dr. Lalli arriving in the office and getting a second telephone call does not seem to be a standard of care issue.

Q. An hour to an hour and a half when one has an evolving MI could be the difference between life and death, can't it?

MR. RISPO: Objection,

hypothetical.

THE WITNESS: It could be, of course. The issue is, hypothetically, how things are presented and whether the patient describes the patient with certain urgency.

I believe the patient, if the patient is having a significant problem in his own mind, and calls in the morning and says that he would like to be seen, and the receptionist leaves it very vague about when this is going to be arranged, I believe that it is the patient's responsibility to say, "No, I'm really having a problem here. I can't wait until the afternoon to find out if I'm going to be seen."

Short of that information, I don't know how one could make a decision about it.

BY MR. MISHKIND:

Q. What about a situation where a telephone call comes in between 9:30 and 10:30 and the patient calls asking to be seen, the patient doesn't know whether or not his symptoms are serious or not because the patient has never experienced this before. Let's take that scenario. I presume that you have patients

that experienced for the first time a set of symptoms, and they are seen by you. Sometimes those symptoms are very benign. Other times those symptoms prove to be very serious, correct?

A. Yes.

Q. And it's you, the doctor, with your training and experience that has to evaluate whether or not those symptoms are benign or when they really represent the precursor of a very serious condition, correct?

A. Yes.

Q. It's not for the patient to diagnose his condition, correct?

A. It's not for the patient to diagnose his condition, but it is up to the patients to put some kind of urgency onto it.

I mean, if that weren't the case, then even making that initial telephone call wouldn't be a requisite feature.

I mean I should go out into the community and just ask people going up and down the street whether they have certain symptoms that might be serious.

The patient has to make some

determination in his own mind about the need for medical care, whether it's urgent or not urgent.

And then when he makes the telephone call, somehow that has to be expressed to the person who is going to schedule the visit.

Q. The fact that the patient called the doctor's office, doesn't that indicate to you that there is a concern on the part of the patient as to how he's feeling?

A. Sure. But I get things on my schedule, and it always amazes me, quite honestly, people will call up and say that they're having a severe headache. And there will be appointments open that very day, but they will schedule an appointment for next week sometime.

Q. But I'm going to take John Porach's situation. Here is a man who doesn't have any prior history of coronary symptoms and calls the morning that he dies and gives symptoms that he doesn't, during that telephone call, have any reason to know are symptoms in all probability of an evolving MI.

He makes the call to the doctor's office.

Let's just take that scenario. That's a good move on the patient's part, isn't it, to pick up the phone and call the doctor's office?

A. Yes.

Q. And to bring information to the doctor's attention as to what his symptoms are. That's another good call, correct? Another good fact, I should say?

A. Well, again to clarify that. Most appointments that are made for me, the facts are not brought to my attention in the sense that the receptionist comes up to me and says, "I'm scheduling a visit with Mrs. Smith today because she has a headache." Most of the time it just appears on my schedule; Mrs. Smith, headache.

She wouldn't necessarily come to me and present the whole telephone call to me unless, as I said earlier, there was something about the urgency of it that the patient presented to make it think that it was anything more than a routine headache.

Q. There are situations, are there not, Doctor, in your office, where after some type

of triage is done by the nurse's aide, the LPN, or the RN, that recommendations are made to the patient that, "I think you should come in and be seen by the doctor," or "I think you should *go* **to** the emergency room and have an X-ray or have some blood work done"?

A. Yes.

Q. Okay. And the patient may call up, not having a clue as to what his or her symptoms are, but once they're described and additional information is obtained, your office, based upon the protocol that you establish, may make certain recommendations of the patient to come on in or to *go* to the emergency room, correct?

A. Yes.

Q. And it certainly is the responsibility of the internist's office whether it's the doctor himself, or through people that he trains, to make that assessment as to whether or not this is the patient that should be seen immediately, or a patient that can be referred to the emergency room, or a patient that doesn't need to be seen at all on that particular day, correct?

A. Well, again, it's a matter **of** degree.

Because naturally there is no way that you are going to train a receptionist to do the same kind of diagnostic evaluation that a physician does.

Q. Sure.

A. By logical necessity, can only be in the most vague terms, and that's why I stress the point about the patient having some feedback in that situation because if the patient, himself, perceives the patient to be of a more urgent nature, and for some reason or the other, the receptionist is not getting the message, then the patient has to say that. Otherwise, the receptionist has no way to evaluate it otherwise.

Q. The receptionist or the person that's receiving the call at the doctor's office must have a basic understanding of what type of symptoms, or what type of conditions are going to be called into your office in order to know what to do with the telephone call. Would you agree with that?

A. Well, you know, in a practice like ours, for instance, we have to code everything. Everything has to have a number on it. I'm

sure you are familiar with that.

Q. Sure.

A. Because we don't want to keep looking in the book for those code numbers for the most common things that we do. We keep a separate list of that. We have over 2,000 diagnostic codes on that list alone. So people literally will call us for virtually anything.

And there is absolutely no way that we could have a protocol for a receptionist that would allow them to go through the diagnostic evaluation for thousands and thousands of different diagnoses. It just can't be done.

Q. So if a patient happens to be in a medical practice that the doctor doesn't, for whatever reason, have an RN, an LPN, or a nurses' aide working for him and chooses to have a receptionist who has been trained through the years handling the telephone calls and doing the triage, is it your testimony that it's incumbent upon the patient alone to express an urgency as opposed to a responsibility on the part of the person receiving the telephone call to determine what steps need to be made?

A. Well, I think that in general terms that's correct. If the receptionist gives a patient a particular scenario, and the patient in his own mind feels that his problem is more urgent than that, then he has to say, "I believe I need to be seen sooner" or "would you ask the doctor about it," or "do you think I should go *to* the emergency room," or something else.

In other words, if the receptionist isn't getting the message over the telephone that the patient feels she should be getting, then the patient has to say that.

Q. How is the patient to know whether or not the receptionist is getting the message if the receptionist says, "I'll have to get back in touch with you" and doesn't tell the patient anything about the doctor being out of the office, even though the doctor was in the office that morning, doesn't say anything about the particulars, just says, "I'll have to get back in touch with you," how can the patient know, how can the patient read the receptionist's mind to know what her understanding is of the degree of urgency?

A. I guess that's exactly the point. Neither the patient nor the receptionist can read the other one's mind.

Q. Okay. It has to be communicated verbally. It can't even be communicated the way you and I are right now because I can look at you, and I can see the gestures you make, and I can see the expression on your face, and I can work that into my decision about what's going on.

When you are talking on the telephone, all you can judge is the way the person's voice sounds and what they're saying, and that's obviously an imperfect means of communication.

So if I'm sitting there having chest pain and shortness of breath and the receptionist is saying, I'll get back to you later, then it's up to me to say, "No, I'm really having a problem right now, I can't wait."

What is your understanding of the training that the receptionist had in Dr. Lalli's office?

A. My understanding is that she had been a receptionist for something like 30 years.

That she actually had no formal courses in medical assisting.

Q. Did she know how to interpret an EKG?

A. No.

Q. If a patient calls up a doctor's office and says I want to come in for an EKG, would you find that to be an unusual request on the part of the patient that does not have any prior coronary history?

A. No, that's not an unusual request, actually.

Q. In this case, what is your understanding as to the telephone call in the afternoon as to what John Porach told the receptionist?

A. Well, I don't think we'll ever know what he told the receptionist.

Q. What set of facts have you relied upon for purposes of your review of this case in connection with the afternoon contact?

A. Well, just what was said in the deposition from the receptionist, and was it the daughter? I can't remember. It was either the daughter or someone else relaying the daughter's interpretation of what he was saying at that point.

My understanding was that the daughter picked up the phone, made the call, handed it to Mr. Porach and apparently was there somewhere nearby while the conversation was going on.

Q. But you have not read the stepdaughter's deposition?

A. No.

Q. Okay. And what is your understanding from whatever source -- and I believe the only source that you would have as having read the deposition of Mrs. Porach, the deposition of Dr. Lalli and the deposition of Janet Schoh, what is your understanding of what John Porach said in that conversation with Janet in the afternoon?

A. Off the top of my head, I don't specifically remember the wording or what was accorded to that.

Q. If John Porach said that he had chest pain, shortness of breath and was having difficulty lifting his arms, would you agree that those symptoms would be, by anyone's assessments, whether their nurse or receptionist or an LPN, those are symptoms

that are serious, potentially serious symptoms?

MR. **RISPO:** Let the record reflect an objection on my part to the hypothetical facts assumed.

THE WITNESS: Just the way you stated it, I would say that's correct.

BY MR. MISHKIND:

Q. And while that may not necessarily be indicative of a heart attack, certainly, on a differential, heart attack has to be right up there when someone describes chest pain, shortness of breath and difficulty lifting their arm, would you agree with that?

A. Yes.

Q. And if those symptoms were communicated to your office, what would you expect your office to **do** in response to such a telephone call regardless of how urgent the patient describes them, just calls up and says, "I have got shortness of breath, I'm having difficulty breathing, and **I** am having difficulty lifting my arm," what, under those circumstances would you expect your office to **do?**

MR. RISPO: Same objection for the record.

MR. MISHKIND: That's fine.

THE WITNESS: Under those circumstances, I would expect my receptionist to either tell the patient directly to call the rescue squad and go to the emergency room or the receptionist would at least give that to the triage nurse for her to make a determination about it.

BY MR. MISHKIND:

Q. And would you expect, unless some information substantially different was gathered by the triage nurse, that the triage nurse would then indicate, "Call 911 and get yourself to the hospital ASAP"?

A. Yes. Again, allowing for exceptions. There are, in medicine, as I'm sure you've probably heard, exceptions to every rule.

If a patient is laughingly telling you this on the telephone, naturally you determine it differently than if somebody is obviously short of breath while telling you that. There is everything in between.

Q. If the patient is obviously short of

breath and indicates even in a nonurgent matter, just a matter of fact, that they were calling back again, they have shortness of breath, chest pain and difficulty lifting their arm, under those circumstances, can we agree that the standard of care would require that some immediate triage of those symptoms be done and the patient be advised to call 911?

MR. RISPO: Same objection.

THE WITNESS: Yes. Again, there are exceptions to that rule. They wouldn't pertain in this case. In general terms, I would say yes.

BY MR. MISHKIND:

Q. And, again, if that set of facts was conveyed, and the person on the other end of the phone, whether it's your office or Dr. Lalli's office, or any primary care office that receives that call, with those symptoms relayed, and they do not advise the patient to dial 911 for emergency medical care, can we agree that with that hypothetical set of facts being relayed that that would be a violation of the standard of care?

MR. RISPO: Same objection for the record.

THE WITNESS: Given that scenario, I would agree with you, yes.

BY MR. MISHKIND:

Q. And why would those symptoms mandate that emergency medical care be provided?

A. Well, those are pretty typical symptoms, and I think that the general population is aware of those kinds of symptoms. And, of course, someone needs to be urgently evaluated because that is a potentially life-threatening problem.

Q. When you have a patient that has an MI, and you ask them what their symptoms are, to the extent that they can speak at that time, do you always get the same description terms from the patient in terms of what the pain felt like?

A. No, not always. There is nothing in medicine that's always.

Q. And, in fact, isn't there a wide range of words that people use to describe the pain that they're experiencing at the time of a heart attack?

A. Yes.

Q. And, in fact, not only is there a wide range of terms used, but the actual physiological response of the body to the ischemic event varies from patient to patient?

A. Correct.

Q. So that I would presume, in your experience, you have heard patients describe their chest pain as crushing pain?

A. Yes.

Q. As stabbing pain?

A. Yes.

Q. As aching pain?

A. Yes.

Q. As pain pain?

A. Yes.

Q. Just regular garden variety pain?

A. Yes.

Q. If a patient says that they have aching in the chest and in the arms, is that a symptom that could be consistent with an acute MI?

A. Yes.

Q. Do you always have shortness of breath that accompanies the achiness or the symptoms

in the chest area or does that vary from patient to patient?

A. That can vary.

Q. If a patient is complaining of aching in the chest and in the arms and it determined based upon additional questioning of that patient that the patient also has experienced shortness of breath within a very recent period of time before the complaint of chest pain, nausea, heartburn, tingling and numbness in the hands and the legs as well as diarrhea, what potential diagnoses would you consider with that umbrella of symptoms?

MR. RISPO: Objection to the hypothetical, but go ahead.

THE WITNESS: Well, that particular range of symptoms covers a lot of territory.

BY MR. MISHKIND:

Q. Sure. Tell me from the most serious in your differential to the least serious if the patient presents with that description.

A. Well, someone could have a pulmonary embolus. They could have some catastrophic abdominal event. They could have abdominal

aortic aneurysm. They could have a ruptured disk. They could have a myocardial infarction. They could have cholecystitis.

They could have a lot of benign processes as well. They could have simple constipation. They could have gastroenteritis.

There are dozens and dozens of different things within that wide of range of symptoms.

Q. If the patient presents a description of an achiness in the chest and in the arms, and based upon questioning the additional symptoms that I described are elicited, should that patient be evaluated on an emergent or urgent basis?

MR. RISPO: Objection again to the hypothetical.

MR. MISHKIND: That's fine.

THE WITNESS: Well, the same thing that we went through earlier would apply. It depends on how the patient presents that, and the urgency that the patient puts on those symptoms.

BY MR. MISHXIND:

Q. So again, you're putting the onus on the patient, as opposed to the doctor or the

doctor's office to elicit through additional questioning that information?

A Sure because as I just said, those kinds of symptoms cowork such a wide range of territory that it could literally be something like a vulnerary embolus where the person could die within minutes, all the way to a gastroenteritis that is going to go away by itself even if they don't see the doctor

Q Let's assume that John Porach had had the actual MI sometime between 5:30 and 7:00 a.m. that morning and had been referred to an emergency room for evaluation in the morning, and that referral had occurred some time between 9:30 and 10:30 a.m.

In your professional opinion, doctor, knowing what we know in terms of his death, and knowing what we know in terms of the findings on autopsy, would John Porach have been seen in the emergency room within the window of opportunities for the initiation of thrombolytic therapy?

A Yes, sir.

Q And had he been seen in that morning with the referral occurring sometime between 9:30

and 10:30, based upon a heart attack occurring sometime between 5:30 and 7:00 a.m., would he more likely than not have survived?

A. I think in those terms he more than likely would have survived, yes.

Q. If he had had an EKG done in the morning, with a referral taking place someplace between 9:30 and 10:30, for him to go to an emergency room, and an EKG had been done immediately upon presentation to a local emergency room, knowing what we know in terms of the autopsy findings, the coronary arteries, the myocardium, would he likely have shown changes on the EKG consistent with an acute myocardial infarction?

A. Probably not.

Q. Why is that?

A. It's not likely that his electrocardiogram earlier in the day would have been any more abnormal than it was later in the day. If anything, there are progressive changes that occur over the course of hours to a day that would have been more substantial. So I think in probabilities, they would have to say his electrocardiogram

would have been less diagnostic than it was at the time that the one was taken -- when was it, 5:30 in the afternoon?

Q. Would he likely have been given thrombolytic therapy in the morning?

A. That would depend on other factors such as cardiac enzymes.

Q. Okay. And, again, knowing that the heart attack probably started sometime around 5:30 to 7:00 and it may be a little bit earlier, it may be a little bit later, but certainly in the 10 to 12-hour range prior to his demise based upon the evidence that the jury is going to have in this case to consider, is it likely that cardiac enzymes, drawn between, let's say, 10:30 and 12:00, would have been abnormally elevated indicative of an acute infarct?

A. Actually, they probably would not have been elevated at that stage.

If we are going with what you said earlier, which was that five to six hours prior to the time of his death that he suffered the infarct, then there would have been no enzyme elevations prior to that time.

Q. We're saying four to six hours before his death there is injury on pathology to the myocardium?

A. Yes.

Q. But the thrombotic event occurred, and the evolving heart attack started earlier that morning between 5:30 and 7:00, so he presents within a period of three to five hours following the onset?

A. Well, the cardiac enzymes do not go up until you actually have necrosis

Q Okay

A. So you would have to have an actual infarct. If you have unstable angina, you may have a thrombus there, and you may have symptoms, but you will not have enzyme elevation because you don't get enzyme elevation until there is actual necrosis. And necrosis means that there is actual cardiac death

Or to clarify that, there is death of some myocardial fibers, not necessarily the person drops over dead. There has to be tissue death for enzyme elevation to occur.

Q What is your opinion in this case? What

will be your opinion at the trial of this matter as to what likely would have been done had he been seen in the emergency room before 12 noon on October 14th?

A. Well, if we accept the pathology interpretation from Dr. Hoffman, which, again, I'm not going to comment on, if we were to accept that, then I would piece that together and say that he had unstable angina starting from when he woke up in the morning, and that he then, perhaps, did go on to have an actual infarction sometime in the middle of the afternoon.

But that had he presented to the emergency room earlier in the day at 9:30 or 10, whenever the other telephone call was made, he would have been evaluated in the emergency room, but he would not have had diagnostic EKG or enzyme changes.

Q. All right. Let's assume that you're scenario is correct and the call was made sometime between 9:30 and 10:30. So he is seen at the emergency room sometime between those hours and a half-hour to an hour later, and it was evaluated in an emergency room and

he had unstable angina, but no clear-cut evidence on EKG, or on cardiac enzymes of an acute MI, what would have been the standard protocol in terms of treating that man with those symptoms?

MR. RISPO: Before you answer, could you please read that back, because I think I missed something.

(Record read.)

THE WITNESS: Presuming it was recognized as a potential unstable angina situation, that person would have been admitted to the hospital, placed on some type of monitoring device, probably started on heparin infusion and nitroglycerin infusion and then had serial electrocardiogram and enzyme studies done.

Q. And can we agree that with that admission and with monitoring, with heparin to prevent the further propagation of the thrombus, that more likely than not, he would have avoided the fatal event that occurred later that afternoon?

A. I think under that scenario as you presented it, I would say that's a true

scenario.

Q. Certainly we've talked about this before, but the best place to be when you're having a heart attack is in a medical facility qualified to handle your condition?

A. Yes.

Q. And can we agree that in retrospect, John Porach's complaint, that we know to be at the very least achiness in the chest and in the arms in the morning, were probably cardiac in nature?

A. Retrospectively which, of course, is always much easier than prospectively, yes, I would agree with that.

Q. Yes. And I am not questioning whether at this point whether they should have been recognized for more than that. But when we look at it retrospectively, those symptoms were likely signs, whether they were of an evolving MI, or signs of unstable angina, which were the precursor to his ischemic events, they were coronary in nature?

A. Yes.

Q. When they should have been appreciated as such, either at that time, or based upon

additional questions, obviously, you take issue with that in the morning based upon the receptionist's responsibility?

A. Yes. And I think that's the crux of this whole case in my opinion.

Q. I understand. And it's really a question of who is believed in terms of what his symptoms were that morning and what was demonstrated, because as you told me, if his symptoms were appreciated to be more serious than what the receptionist believes them to have been communicated, you certainly would acknowledge to the jury that this man should have been directed to a hospital, evaluated at a hospital, and more likely than not would be alive today?

A. If he had presented those classic symptoms, yes.

Q. Well, even if they weren't classic, if there was enough index of suspicion that either the receptionist got Dr. Lalli on the phone, or the receptionist on her own told him to go to the emergency room, more likely than not, he would be alive today?

MR. RISPO: Objection to "index

of suspicion," but go ahead.

THE WITNESS: Well, not to make it too complicated, but these are just the way medical things are, but even Dr. Lalli on the telephone may not have been able to make a more specific diagnosis.

Naturally, he can ask more pertinent questions about it, but he's still totally dependent on how the patient presents those symptoms to him over the phone. He is not able to read anybody's mind better than the receptionist.

Q. Presumably Dr. Lalli is more skilled in trained in asking appropriate questions in follow up to information provided by the patient, correct?

A. Correct.

Q. So that the patient may give some information not knowing what is important to tell the doctor, it's the doctor's then responsibility to ask additional questions to elicit information to put that history together, correct?

A. Well, again, not to make things too complicated, it's the responsibilities of both

parties to communicate with each other. Certainly a doctor has a higher level of responsibility in that respect than the receptionist would.

Q And the history is an important component of a diagnosis, correct?

A. It's very important. That's why I emphasized the communication between both parties.

Q. Sure. So that there are responsibilities going both ways, but the ultimate analysis, when it comes to the history-taking, it's the doctor that's trained to know what questions to ask. The patient must be open and provide what information he or she can provide, but the doctor has the ultimate responsibility to ask the appropriate questions, correct?

A. Well, again, not to make it too complicated either.

Q. That's okay.

A. But the patient is the one who always has the ultimate decision-making capacity, because there are circumstances where people come in with what I believe are classic symptoms. I say, you are having a heart attack you should

go to the hospital. And they just don't want to believe me and refuse to follow that advice.

So I mean, it's the doctor's responsibility in that circumstance to ask the appropriate questions to make some determination about how to dispose of that case.

But the ultimate responsibility is always the patient's because a doctor actually only gives opinions.

Q. Okay. John Porach called in the morning to the doctor's office, correct?

A. Yes.

Q. John Porach called back to the doctor's office in the afternoon when he didn't hear back from the receptionist, correct?

A. Yes.

Q. John Porach then drove to the doctor's office, if you believe the testimony, that he was told to come to the doctor's office to be seen, correct?

A. Yes.

Q. John Porach followed the advice of the doctor's office with regard to coming in to be

seen, correct?

A. Yes.

Q. Is there any indication that John Porach did not comply with the instructions that were given to him by Dr. Lalli's office?

A. No. And I didn't mean to imply that in my answer to that question. I was only trying to elaborate on the situation of communication between the two parties.

Q. Okay.

A. And the way the patient interpreted. But I would not say Mr. Porach refused to follow advice, no.

Q. And there are situations where patients do not comply with recommendations and advice of a doctor. And under those circumstances, if bad things happen, then they have only themselves to blame, correct?

A. Correct.

Q. There is no evidence in this case that John Porach did not comply with the advice and the recommendations given to him by Dr. Lalli's office, is there?

A. No.

Q. Now, in the afternoon if John Porach had

been advised to go to an emergency room at 3:00 to 3:30 with symptoms communicated to the doctor's office of shortness of breath, chest pain, difficulty raising his arms, do you have an opinion to a reasonable degree of probability, if seen within a short period of time after that telephone call, whether or not John Porach would have survived?

MR. RISPO: Objection to the assumptions in the hypothetical as not grounded upon the evidence. But go ahead.

THE WITNESS: You are talking about the phone call at 3:00 or 3:30 in the afternoon?

BY MR. MISHKIND:

Q. Right, exactly.

A. Yes, I would agree with that.

Q. That had those symptoms been communicated, number one, we can agree that he should have been told to call 911 for emergency care, correct?

A. Yes.

Q. And would it also have been acceptable to tell him to go ahead and drive to the emergency room, or would you believe that the

standard of care would have mandated call 911 and get an ambulance there?

A. I would say that 911 -- and the only thing acceptable short of that is if the person had a relative or someone right there with him who could get him in the car and get him there in five minutes.

Q. So if discussing with the person you learn that you had people that were under age in the house with you that couldn't even drive the car, then could we agree that the mandate would be call 911?

A. Yes.

Q. And assuming reasonable response by ambulance service in the city that Mr. Porach lived in, is it your opinion that more likely than not, he would have survived?

MR. RISPO: Objection to the foundation of the hypothetical. Go ahead.

THE WITNESS: Given that scenario, I would agree with that, yes.

BY MR. MISHKIND:

Q. Now, at that particular point, had he been seen in an emergency room after the 3:00 to 3:30 call, would he have been within the

window for thrombolytic therapy or outside of the window for thrombolytic therapy?

A. Well, that's a difficult question because of that inability to pinpoint the actual time of the myocardial infarction. That would be a difficult call because if someone thought that it had started at 5:00 or 5:30 in the morning when his symptoms first started, he would have been outside that window.

Q. And even though someone is outside of the window though, that doesn't mean that they're not salvageable from the standpoint of saving their life?

A. That's true. It restricts your choice of available therapies, but there are still other things that could potentially be done.

Q. And I presume it's your opinion that he would have been taken to a catheter lab for a catheterization in the afternoon?

A. Well, that's a very complicated question which involves pieces of information that we don't have like the enzymes and the actual EKG recording at that time and so on. So, I think it would be very difficult for anyone to say specifically about what would have been done.

Q. Just so I understand what you would testify to to a given hypothetical fact pattern in the afternoon, as Howard Mishkind has described it, the best that you would be able to say to the jury is that more likely than not, if that fact pattern that you you've described Mr. Mishkind is believed, it's my opinion that Mr. Porach would have survived in the afternoon of October 14th, 1994?

A. Most likely, yes.

Q. As to exactly what the treatment would have been, whether it was thrombolytics or whether it would have been some type of intervention, cardiothoracic intervention that you're not going to comment upon, but you will, at least, acknowledge if my hypothetical is correct, that John Porach would be alive had he been seen based upon those symptoms in the afternoon?

MR. RISPO: You mean intervention other than thrombolytic?

MR. MISHKIND: Correct, yes, sir.

THE WITNESS: Within the 51 percent being a probability, yes.

BY MR. MISHKIND:

Q. Okay. At what point in the afternoon, prior to his V-fib do you believe the window of opportunity to save John Porach's life closed?

A. That's another difficult question to answer. But I think again looking retrospectively at that whole scenario that had been able to be evaluated in the hospital even within an hour of the time that he actually died, he probably would have been in that same category. At least potential interventions.

But that is a very difficult thing to answer on the basis of the information that we know.

Q. And just to be fair across the board, then if we assume a 6:00 death, if we say 4:30, beyond 4:30, or beyond maybe a quarter to five we start getting into less than that 50 percent likelihood that intervention would have made a difference?

A. I think so. Because again, we don't know exactly when the infarction occurred. Once the infarction occurs, and you cannot do something like thrombolytic therapy to

potentially revascularize that area, then the potential for the arrhythmia is there, and the potential for nonability to resuscitate is there. So that makes it very problematic.

Q. When you have a patient in the coronary care unit that's outside the period for thrombolytics, and you are giving them oxygen, you are giving them, perhaps, heparin, and you're monitoring them, you're in a much better position to see electrical disturbances that may be precursors to a fatal arrhythmia, correct?

A. Yes.

Q. And you are then presumably qualified in a position to initiate emergency medical treatment to either prevent that fatal arrhythmia or to reduce the likelihood of that fatal arrhythmia, correct?

A. Yes. That becomes much more problematic. There you are outside of the range of saying the probability. That's much more difficult to judge. And on the information that's available here, I don't know that anyone could give you a figure on that one.

Q. Okay. You mention in your report that

John's life expectancy, if he survived the acute myocardial infarction, that he would not have lived a normal life expectancy?

A Correct.

Q Had he received intervention within the windows that we're talking about from the morning to, say, a quarter of five in the afternoon, what reduction in life expectancy are you intending to opine at the time of trial that John Porach would have had?

A Well, I would not fix a specific number on it But I would say that in general terms, one expects coronary bypass surgery to last for about 10 years And this is a young man who has a lot of arteriosclerotic disease.

And obviously he has some other genetic factors that predispose him of having these problems, and I think it's very difficult to go beyond that 10-year window.

Q So your testimony is that there is going to be that John Porach would have died by the age of 55 had he survived this heart attack?

A If we had to put it in terms of probability, again that 51 percent, I think that's true There are certainly people who

survive longer, but on the average, you expect people with bypass surgery to go about 10 years before they have another coronary event

Q If he can not receive bypass surgery, but has been treated for cardiac problems and has survived, would his life expectancy have been longer?

A No Well, certainly, if he has not had any cardiac damage, his prognosis would be better once he has some electrical death of cardiac fibers, that cuts you in a whole series of other complicating factors that would shorten that considerably but for someone who has normal myocardium, who is revascularized, is going to have about 10-year result from that

Now, that's not to make it too difficult, either, but I mean one always hopes there will be other things in the future that would extend that but right now, that's about what one could expect

Q Are there any studies, or any medical literature that you could point me to that would support your opinion that if John Poroch had been seen in the morning, tropolytics

given, then subsequently, I presume, revascularized without substantial damage to the myocardium, that his life expectancy would only be 10 years at the age of 44?

A. Well, I can't quote you any specific literature. I'm just talking from general knowledge of the medical situation.

Q. Okay. But you're also acknowledging that the earlier he was seen in the day, the less damage the myocardium, the longer his life expectancy would have been?

A. Most likely, yes.

Q. Can you tell me with optimal treatment, had he received thrombolytics very early on in the progress of the heart attack, would little, if any, damage of the myocardium and subsequent revascularizing of the coronary artery that was occluded, what the best-case scenario would be in terms of his life expectancy?

A. The best-case scenario?

Q. Yes.

A. Well, I mean there are people who have had revascularization who have lived for 20 or more years, but that's not the average. So

when we are talking about probability, we could use that kind of figure.

Q. And, again, if we use a man 44 years old with his premorbid medical history, and then the myocardial infarction with little, if any, damage, permanent damage to the myocardium that's revascularized subsequently, what would be the life expectancy that you would expect for that 44-year-old man under those circumstances?

A. If he did have some damage?

Q. No. With little, if any, damage to the myocardium, because the intervention was prompt, thrombolytics were --

A. Well, one expects an interventional procedure like that to last about 10 years.

The reason is that the process that makes someone get arteriosclerosis in the first place doesn't go away once a bypass procedure or some other angioplasty was done.

So that underlying disease process that causes arteriosclerosis in the first place does not end just because you do a bypass. That continues on. And that's why you cannot presume that you get a bypass and you are good

for the rest of your life. Well, for the rest of your natural life.

Q. Now, you say it's good for 10 years. Does that mean that the patient, if that 10-year period comes along and the bypass then shuts down, that the patient is going to die at that point?

A. The patient will have some other disease related to arteriosclerosis. And if they're lucky, they'll have localized disease that might be able to be treated again.

But most people develop more diffuse coronary artery disease which is not able to be treated with a surgical method. And so there, you're relying on medical therapy, and there are all kind of other complications that occur, of course, under that circumstance.

Q. I just want to understand when you testify at trial next month, you're going to say that John Porach, under the scenario that the fact pattern that we believe occurred in this case, that I have asked you to assume had intervention been provided, the best-case scenario is that John would have lived 10 years and then more likely than not would be

dead at the age of 54?

A. No, not the best case. I'm saying the probability. The best case could be considerably longer than that. But again, these things are usually stated in terms of probabilities.

Q. So probably with appropriate intervention, he would have lived 10 years, but you cannot rule out, and certainly wouldn't say to Mrs. Porach that the best that would happen would be 10 years because you recognize that John, had he received appropriate treatment with minimal damage to the heart, could live 15, 20 years?

A. That's correct.

MR. RISPO: Objection to "could." Go ahead.

BY MR. MISHKIND:

Q. People that have intervention by way of coronary artery bypass grafting of the type that likely John would have received, had he survived, are able to return to a relatively normal existence during the period that the bypass is patent, would you agree with that?

A. Depending on what kind of work they did

before, but most people, yes
Q He worked at the county treasurer's office, not in a [illegible] type of occupation, had he undergone successful cardiac care to the left anterior descending, do you see any reason why he could not have returned to his employment in that capacity
A Well, of course, he would have required more than one graft but had he gotten appropriate bypass surgery, yes, he most likely could have gone back to that same occupation.
Q. How many grafts would he likely have needed?
A Well, again, that's [illegible]. He would need at least two
Q Would you defer to a cardiologist with regard to the degree of recommended grafting?
A Yes
Q But generally speaking, as an internist you are familiar enough with what patients are likely to need even though you are not the one that's calling the shots?
A Correct.
Q Let's assume that you're correct that it

would have been two areas that would have been bypassed. Under those circumstances are patients able to, in addition to working, are they able to, with moderation to their diet and other activity, are they able to enjoy a relatively normal existence so long as the grafts remain patent and open?

A. Yes.

Q. And would you have any reason to believe that John would not have enjoyed a relatively normal life during the time that it was open with diet, moderation, exercise, and perhaps weight loss, as part of the routine? Would that be a fair statement?

A. Well, not to make it too complicated.

Q. Go ahead. Make it complicated.

A. But the reason that I'm saying that he would not have normal life expectancy is that this is a young man who's got advanced arteriosclerosis, so he's got some kind of genetic problem that predisposes him to having this difficulty, and that's not going to go away.

So even if you bypass him, he is going to develop arteriosclerosis in those other

vessels. That's the reason why I'm shortening his life span.

So, it really doesn't actually matter as far as the scenario that you presented. He still has a shortened life span because of that.

Q. That EKG, you say, all the way normal is not classic for acute infarct. Tell me what you meant by that.

A. Well, he does not have the typical ST segment elevation on that EKG that one usually sees.

Q. And would you have needed a larger elevation in the ST section for it to be the typical?

A. Yes.

Q. How many different leads did he have ST elevations in?

A. I would have to look at it again. If you would like me to do that.

Q. Sure, very quickly if you would.

A. As I look at this, and, of course, this is a xerox copy of the electrocardiogram, but he has mild ST segment elevation in two leads here.

Q. Which leads are you looking at?
A. V II and V 111.
Q. What about V IV?
A. That's a hard one to call.
Q. Would you agree that there is some elevation in V IV although less than what you see in V II and V III?
A. Not what I would call significant, no.
Q. But even though it's not significant, there is some elevation?
A. Well, even that's hard to tell because you have to take into account the slope of the line that you use as the base line, and that's an upgoing slope as it is, so it's hard to judge.
Q. Are those EKG findings -- could those EKG findings be consistent with both an acute as well as a remote infarct?

MR. RISPO: Objection to "could."

THE WITNESS: They could be, yes.

BY MR. MISHKIND:

Q. Can we agree that in order to arrive at a diagnosis on a patient as to whether or not they are experiencing, or have experienced an

acute infarct, or a remote infarct, that you would need more than that EKG; you would need to know the clinical picture of the patient?

A. You would need to know the clinical picture. You would need to know enzyme studies and whatever else you can get your hands on to make that determination, sure.

Q. Was this a standard or a half-standard EKG?

A. This is a standard in DIM leads and half-standards in the chest leads.

Q. So the elevations you see in the chest leads you need to double them?

A. Yes.

Q. When you double those, we have findings that are consistent with the type of ST elevation you would see in acute MI, don't we?

A. They are still not what we consider to be classic.

Q. But certainly more consistent with an acute MI than if this was a standard EKG, correct?

A. You mean if it was one that had standard elevations in the recording, in the chest leads, yes, that's true.

Q. Yes. In your report you say at no time was chest pain described. For purposes of that statement in your report, you are accepting the testimony of Janet and are excluding the testimony of the Porach family, correct?

A. Well, the description that I took from the wife's deposition was that he was aching all over including, you know, arms, legs, everything. So I mean that naturally includes his chest.

But naturally when you are interpreting that symptom, you have to take it in the context of aching all over.

So in that respect, there is so mention of aching in the chest. But in the context of aching all over, it's a different story.

Q. Well, if you had something from the receptionist where she acknowledged that he complained of achiness, specifically in the chest and the arms, not just aching all over, would you give that more credence?

A. From the receptionist?

Q. Yes.

A. Well, quite honestly, I don't know how

anyone could recollect exactly what they said, what is it now, three years after the fact.

Q. What if you had something that was prepared shortly after the death that reflected achiness in the chest and the arms by the receptionist that wasn't based upon her testimony two or three years afterwards, but it was a statement made by her in terms of what John Porach said the morning of his telephone call, would you give that more credence?

A. Well, that would have been more credence, of course. But the difficulty with these situations is that one is always influenced by knowing what the event was.

And that's the whole crux of these kinds of cases is that after the fact, it's easy to look back and say, oh, yeah, he was complaining about chest pain.

In reality, what he had talked about before was aching all over. But when you know the guy had a heart attack, then you tend to focus on those specific symptoms. That makes it difficult to evaluate anyone's testimony about it.

Q. If that EKG had been presented to you and you realized that this was a half-standard EKG in terms of the chest leads, and you had evidence that the patient had experienced shortness of breath, chest pain that day before the EKG was taken, what impression would you have arrived at in terms of the significance of that EKG?

A. Well, it certainly is an abnormal EKG. I mean, given those symptoms you are describing, that looking at this EKG would tell me that this is a person who needs additional cardiac evaluations.

Q. With those symptoms, with the EKG, knowing it's a half-standard, would it be more consistent with some acute coronary event going on?

A. Well, it certainly could be consistent with an acute coronary event. But it would not be a diagnostic EKG in the sense of saying, oh, yes, now it is definitely an acute event. The EKG is still a nondiagnostic EKG.

Q. You wouldn't jump to the opposite conclusion to say this is a remote or an old infarct, if you knew at the time that you were

looking at that EKG that the patient had been experiencing chest pain, that the EKG with the chest leads was a half-standard, you would either conclude that this was an acute event, or perhaps not write down any type of diagnosis on the EKG?

MR. RISPO: Objection. If you understand the question. Go ahead.

BY MR. MISHKIND:

Q. What would you have done with that scenario given the fact that you have got this EKG, you know that the patient has had chest pain, shortness of breath?

A. I would assume that he had acute symptoms and do some other studies to look into it, yes.

Q. And if this patient happened to have dropped over dead in your office, God forbid, and you're then looking at this EKG after you know that the patient has collapsed in your office, would that even be more reason to think that those findings, especially with the chest leads being half-standard, that those findings were consistent with an acute event as opposed to a remote or an old infarct?

A. I would think so yes.

Q. Do you have any explanation for why Dr. Lalli in this case, when he looked at the EKG after John Porach had collapsed in his office, why he wrote down remote or old infarct?

A. I really don't know. I quite honestly don't know why he would even bother to interpret the EKG because my understanding was that he never even saw the EKG before the patient arrested. So who knows what one does under the stress of those kinds of circumstances. No, I don't know why he wrote that on there.

Q. And certainly you would differ with his interpretation given the fact of when he's looking at that EKG knowing what he knew at that particular point?

MR. RISPO: With the benefits of hindsight.

BY MR. MISHKIND:

Q. Not with the benefit of hindsight. He saw this man. He read this EKG after the man had collapsed and died, essentially died --

MR. RISPO: Howard --

MR. MISKIND: Let me finish my question

MR RISPO: The issue in this case, you know, I would say I know, is what the appropriate reading would have been before the Ramirez

Let's not get too carried away with this hindsight attribution of some kind of motivation You're going way far afield

MR MISHKIND: Well, if I may, I would all say a tendency of misinterpreting things, or carrying it too far

But my question to Dr. Collins, and it's my last question, my second last question to you is if this patient had collapsed in your office, and before the code had an AED and you looked at the AED that was here after his collapse, and you looked at the chest leads, can we infer that you would have indicated on that that the findings were consistent with an acute event as opposed to a recent or an old infarct?

MR RISPO: Objection The question is irrelevant to the issue in this case.

THE WITNESS: Well, I'll answer that by telling you how I was taught to interpret EKG's, which is one that one should have all of the available information and then ignore it.

In other words, the EKG is supposed to stand on its own regardless of what other clinical facts there are.

And that's how one is to interpret an EKG. There are a variety of schools about how to do that, but that's how I was told to.

BY MR. MISHKIND:

Q. What would you have marked down on the EKG?

A. I would have read it was abnormal electrocardiogram with anterior changes consistent with ischemia, age unknown.

Q. Doctor, I asked you a lot of questions relative to your statement that you have in your report.

I also asked you a lot of questions on areas that touch on areas in this case and areas specifically addressed in your report.

But I want to make sure before I conclude, have we covered the opinions that

you hold in this case and the bases for those opinions that you hold in this case?

A. Yes, I believe we have. I would reserve the right to answer whatever questions come up during the course of the trial.

But within what I would anticipate coming up, yes, I believe we covered the ground.

Q. And as you sit here right now, do you know have any areas that you anticipate being asked, or opinions that you hold at this point, beyond those which we have already covered this evening?

A. Not that I am aware of, no.

Q. I would only ask that to the extent that if you review any additional information, or arrive at any additional opinions beyond those which we have discussed, that you let Mr. Rispo know so that I have an opportunity to question you before you take the stand.

But with that, I have no further questions, and I thank you.

(Deposition concluded at 9:30 p.m.)

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Carl A. Culley, M.D.

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C E R T I F I C A T E

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

I, Terry D. Gimmellie, RMR, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, CARL A. CULLEY, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified, and was completed without adjournment.

I do further certify that I am not a relative, employee or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 30th day of November, 1997.

T. Gimmellie

Terry D. Gimmellie, RMR, Notary Public
in and for the State of Ohio.
My commission expires November 7, 2001.

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