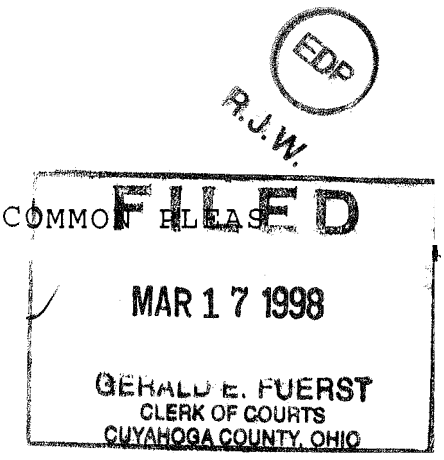
State of Ohio,)
County of Cuyahoga.)



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IN THE COURT OF COMMON PLEAS

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JANET L. PORACH, Administratrix of the Estate of JOHN G. PORACH, JR.,	)	
Plaintiff,	)	
vs.	)	Case No. 316045
	)	Judge Calabrese
LORENZO S. LALLI, M.D.,	)	
Defendant.	)	

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DEPOSITION OF BARRY ALLAN EFFRON, M.D.
Tuesday, December 2, 1997

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The deposition of BARRY ALLAN EFFRON, M.D., a witness, called for examination by the Plaintiff, under the Ohio Rules of Civil Procedure, taken before me, Barbara A. Oser, a Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice and/or stipulations of counsel, at University Hospitals of Cleveland, Lakeside Hospital, 11100 Euclid Avenue, Cleveland, Ohio, commencing at 4:00 p.m., the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiff:

Howard D. Mishkind, Esq.
Jeanne M. Tosti, Esq.
Becker & Mishkind Co., L.P.A.
Skylight Office Tower
1660 West Second Street
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241-2600

On behalf of the Defendant:

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

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(Thereupon, Plaintiff's Deposition Exhibit 1 was marked for purposes of identification.)

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BARRY ALLAN EFFRON, M.D.

a witness, called for examination by the Plaintiff, under the Rules, having been first duly sworn, as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION

BY MR. MISHKIND:

Q. Would you state your name for the record?

A. Barry A. Effron.

Q. Dr. Effron, my name is Howard Mishkind. We met for the first time moments before the deposition began. I represent the estate of John Porach, and I'm going to be asking you a series of questions concerning the opinions that you hold in this case, okay?

A. Yes.

Q. I want to leave this deposition having obtained all of the opinions and the bases for those opinions so that when you take the stand at the time of this trial, I don't hear anything for

the very first time. So my job and my effort will be to elicit all opinions that you have and the substance and subject matter supporting those opinions, okay?

A. Yes.

Q. Before we get into that, I have Plaintiff's Deposition Exhibit 1, which is a three-page document. For the record, would you identify what that is, please?

A. That's a curriculum vitae.

Q. How current is that, please?

A. It's my current CV.

Q. Are there any additions that would be needed to be made to bring it up to December 2, 1997 standards?

A. No.

Q. You have five publications?

A. Yes.

Q. Do you have any articles that have been submitted for publication?

A. No.

Q. Are you working on any publications currently?

A. No.

Q. Do any of these publications have any

relevance to the issues, as you understand them, in the John Porach case?

A. No.

Q. In a moment I'm going to talk to you about the material that you have in front of you, which contains multiple depositions and records. But I want to ask you first whether there is any information that has been removed from your file today prior to coming into this conference room?

A. No.

Q. Have you received any correspondence from Mr. Rispo with regard to any of the testimony that's taken place thus far other than just the deposition transcripts?

A. Cover letters with information, enclosed is a package of depositions.

Q. Have you received any summaries prepared by Mr. Rispo or from someone from his office relative to the testimony?

A. Yes.

Q. Where are those summaries?

A. Some of them are in this office and some are at home.

Q. When you say this office, do you mean on this floor?

A. On this floor.
Q. Is there a reason that you don't have those in this conference room with you now?
A. No.
Q. I presume you reviewed those summaries?
A. At some point.
Q. And you took that information into account in the totality of the information that you've been provided in this case?
A. Undoubtedly.
Q. Not necessarily relying entirely on that, but taking into account in, ultimately, arriving at your opinions?
A. I've read them all. So I assume that whatever information was in those summaries was processed and analyzed,
Q. If it's not a problem, I would like you to get the additional material that you have here. We'll go off the record for a minute or two, okay?
A. Oh, sure,
(Thereupon, a discussion was had off the record.)
Q. For the record, you have provided a memo, which is a summary prepared by Mr. Rispo of the deposition testimony of Dr. Botti, and a memo

prepared by Mr. Rispo, which is the testimony of Dr. David Effron; is that correct?

A. That's correct.

Q. Have you received any other similar memos from Mr. Rispo?

A. I believe I have, but they're not in my office here and I can't recall if they were summaries of physician experts or of other depositions.

Q. Would those be at your home?

A. Yes, if they're in my possession at all.

Q. I presume you received various cover letters from Mr. Rispo as well?

A. Correct.

Q. Some of those cover letters were after you had prepared your September 2, 1997 letter, correct?

A. They could well be.

Q. Do you recall receiving a letter from Mr. Rispo similar to a letter that I'm going to show you dated September 26 that was addressed to Dr. Janiak? I would just ask you to take a look at this letter and tell me whether you received a similar letter with similar questions.

A. Certainly. I don't believe that I saw

anything with this manner of detail, no.
Q. What else do you believe exists, either at this office or at home, that's been provided to you concerning the Porach case that you don't have with you physically right now?
A. Nothing to my recollection other than, like I said, cover letters and a copy of my own statement for fees.
Q. The cover letters, were they just enclosed, please, find particular documents, or were there questions contained within those cover letters?
A, I couldn't be certain. Most of them, as I recall, had lists of enclosures.
Q. While we're on the point of your billing, you generated your report in September of 1997. And in looking at some of the documents from your notebook with faxes along the top, it looked like a lot of information was forwarded to you sometime in just the month before you prepared your report. Is that an accurate statement?
A. Some of the physician expert reports were not provided to me at the time of my initial report.
Q. When were you initially retained in connection with this case?

A. Perhaps June of 1997.
Q. Have you to this day read the depositions of Dawn DeWitt or Jaclyn DeWitt?
A. I've read the deposition of Jaclyn DeWitt.
Q. And who is Jaclyn DeWitt?
A. As I understand it, she is Mr. Porach's stepdaughter.
Q. You read that deposition subsequent to preparing your report, correct?
A. I can't be certain.
Q. The reason I say that is because you didn't reference that in your report. So I conclude since you did reference what you had reviewed that you didn't have it. Is that a --
A. That would be a fair assumption.
Q. Did you just review Jaclyn DeWitt's deposition recently?
A. Within the past week.
Q. Did that provide you with additional information that you did not previously have?
A. It provided me with additional information regarding her recollection of phone conversations that transpired. So in that respect, there was additional information provided.'
Q. And which phone conversations did you

obtain additional information that are described by Jaclyn?

A. I believe it was the second of Mr. Porach's phone calls to Dr. Lalli's office.

Q. Tell me what other depositions you have been provided or other information you've been provided since your September 2, 1997 report.

A. I would need to look at that report and see what I had commented upon. I think I can answer that question now.

Q. Okay.

A. Various physicians' depositions, including those of Drs. Botti, Selwyn, Hoffman and David Effron, were reviewed subsequent to the preparation of that report, as well as the deposition of Jaclyn Porach.

Q. You don't mention the autopsy in your report. Did you have that at the time that you prepared your letter of September 2?

A. I can't be certain.

Q. Have you since reviewed it, whether you had it at the time of your report or obtained it since?

A. I've subsequently reviewed the autopsy.

Q. And have you reviewed the deposition of

Dr. Hoffman?

A. Yes.

Q. Do you find any inconsistencies between the testimony of Dr. Hoffman and the autopsy?

A. No, not specifically. I'm not expert at pathologic interpretation of myocardial infarction.

Q. So you certainly aren't intending to give any testimony at the time of the trial that would relate to the pathologic interpretation of the myocardium based upon the autopsy slides or the coronary arteries based upon the autopsy slides?

A. That's correct, I do not intend to provide that type of testimony.

Q. And the reason being that you're not qualified; someone such as Dr. Hoffman is much more qualified to provide opinions regarding the significance of the findings on the coronary slides and on the myocardial slides?

A. That's correct to the slides. I could provide interpretive discussion related to the overall clinical picture, but not related to the pathologic findings, per se.

Q. And you would certainly agree that the pathologic findings are important when one is

looking to date a particular event when the unfortunate and result of that event is death?

A Yes

Q Let me go back before we jump into the substance and ask you a few additional questions In reviewing your CV, I see that you are board certified in internal medicine?

A Yes.

Q You're also Board certified in c ardiology?

A. Yes.

Q. And that was in 1985?

A That's correct.

Q You have served as an expert witness in medical malpractice cases in the past, correct?

A What's correct

Q How many years have you been doing this type of work?

A. Since approximately 1987 or 1988

Q Have you at any time over the past ten years provided your services through any type of an expert search firm?

A. No.

Q. Tell me what percentage of your reviews in medical malpractice cases, Doctor, are for the defense of a doctor as opposed to in support of

a plaintiff.

A. In previous years I would have said approximately half for each side. It's perhaps a bit more for the defense in the last two years.

Q. When you say the last two years a bit more for the defense, can you give me a reasonable estimate as to where we fall now?

A. I've done fewer cases in the last few years because of time. Probably 60/40 or two thirds for defense just based upon my recollection.

Q. How many cases in the last two years have you reviewed?

A. In one way or another, perhaps ten.

Q. Was the number larger before 1996?

A. The time commitment may have been greater because some of the cases were protracted and progressed over many years.

Q. I'm using the number of ten cases and making an assumption that you review approximately five cases a year over the past two years. Is that a fair conclusion?

A. That would be fair.

Q. I don't want to put words in your mouth. If I'm using a figure that's more or less than what is the truth, you tell me, okay?

A. Five cases per year in the last two years seems about what I can recall.
Q. And before 1996 would you be reviewing more than five cases per year?
A. Not many more than that. Less than ten, but perhaps more than five.
Q. From 1987 up through 1996, would you be averaging somewhere between five and ten cases a year?
A. No, I didn't get asked to review very many cases during the first several years that I provided expert testimony. But in the early 1990s, as many as seven to ten cases per year.
Q. Currently how many cases do you have that you're serving as an expert where you're reviewing medical records?
A. This and one other.
Q. Is that other case with the Weston, Hurd law firm as well?
A. No.
Q. What law firm?
A. I have not opened the file. It was mailed to me and it's a plaintiff's case and it's from a firm in North Carolina.
Q. Doctor, in fact, you have gone on record

indicating that you prefer not to testify in Cleveland against a physician; isn't that a fact?

plaintiff's expert since 1987?

A. In court?

Q. Either in deposition or at court, whichever is easier for you.

A. I think it would be very hard for me to recall. Since 1987, not including file reviews, less than ten. But that's my best estimate.

Q. And let's talk about since 1987, how many times have you -- strike that. Would that ten include times that you've testified in deposition as well as in court, the totality of that situation?

A. Yes.
Q. Let's convert now over to the defense side. You've testified more as an expert witness either in deposition or at trial as a defense expert, correct?
A. Well, you're breaking this down into cases that go beyond the review stage.
Q. Yes, sir.
A. And I'm not certain that the 50/50 breakdown I can come up with. I think it's probably closer to equal among cases that have gone to discovery deposition and trial.
Q. Again, I want to understand what you're testifying to today. You're telling me that you've testified less than ten times as a plaintiff's expert in a combination of at depositions and at trial, correct?
A. In what time frame?
Q. Since 1987.
A. In Cleveland?
Q. No, I'm talking about all cases.
A. My responses were based upon your initial question about in Cleveland.
Q. I switched over to another question and perhaps I didn't segway in appropriately for you.

But I'm talking about since 1987, whether it's a Cleveland case or outside of Cleveland, how many times have you actually testified as an expert for a plaintiff?

A. Dozens.

Q. Dozens?

A. Dozens. Over a dozen.

Q. And that less than ten would be Cleveland cases?

A. Yes.

Q. And in the last two years, you have not testified in a case as a plaintiff's expert in Cleveland?

A. I couldn't under oath answer that. I just simply can't recall. I know that I have not been in the courtroom more than a very few times during this entire period of time.

Q. And with regard to your preference not to serve as an expert witness against one of your colleagues in the Cleveland area, can we agree that as of 1997 you would prefer not to serve as a plaintiff's expert if the case happens to be a local case?

A. I might accept a file that involved a plaintiff's attorney, but I would prefer to review

the file and identify the physicians involved and my relationship with those physicians because of my leadership role in cardiology here at University Hospitals and my relationship with many physicians around the city.

Q. And, again, just so I can cut straight to the chase, because of that, isn't it a fact that you have stated to other attorneys that your preference is not to serve as a plaintiff's expert against a local physician in the Cleveland area?

A. Yes, that's my preference, but not exclusively my response.

Q. When were you last deposed?

A. It could have been many months ago. I honestly can't recall. It has not been recently

Q. When are you scheduled to testify next?

A. There's nothing scheduled.

Q. What was the subject matter of the case that you testified in most recently within the last several months?

A. I cannot recall.

Q. This work as an expert witness, what percentage of your professional time does this take up?

A. Perhaps two percent.

Q. What's your charge, Doctor, for review of medical records?
A. $250 an hour.
Q. How about for testifying at deposition?
A. The same.
Q. And at trial?
A. The same, a half day minimum.
Q. Can you tell me when was the last time you testified at trial?
A. I testified at trial in a case that was tried here in Cleveland, and I was initially a defendant in the case. I was dropped from the case but was retained to review a stress test that I had interpreted.
Q. What was the name of the plaintiff in that case?
A. Peacock, P-E-A-C-0-C-K.
Q. And you were a named defendant in that case at one time?
A. At one time. It was re-filed without my name on the case.
Q. Did you then serve as an expert witness in the re-filed matter?
A. As I understand, I was not actually an expert witness but was retained to comment upon

reports that were generated by me that were material to the case.

Q. Other than the Peacock case, have you been named as a defendant previously?

A. No.

Q. That's the one and only time?

A. That's the one and only time.

Q. Who do you maintain your professional liability insurance with?

A. Well, I'm an employee of a corporation, and the corporation maintains it or had maintained it with PIE.

Q. Have you ever been insured through Frontier Insurance Company?

A. Not to the best of my knowledge.

Q. Have you worked with Mr. Rispo before?

A. No.

Q. Have you worked with any attorneys at Weston, Hurd before?

A. I may have, but I don't believe so.

Q. Tell me what your understanding is to how Mr. Rispo made contact with you.

A. I received an unsolicited letter from Mr. Rispo and/or a legal assistant.

Q. What did that letter say?

A. I believe the letter asked if I would be interested in reviewing records in reference to a case, and then it was followed up with a phone call when I probably did not respond to the initial letter.

Q. I don't have any cover letters or any correspondence in any of the material here other than the two summaries of the depositions. So what was the assignment, as you understood it, that Mr. Rispo requested you to perform?

A. There was a very small amount of medical records that he asked that I review with reference to medical malpractice.

Q. And he was requesting that you provide opinions relative to certain issues?

A. I don't know if the issues were defined, but I imagine that they were discussed at the time of the phone conversation.

Q. Have you reviewed any medical literature, Doctor, in connection with the preparation of your report?

A. Not in the context of this case, no.

Q. Have you reviewed any medical literature since the time of your report and prior to beginning this deposition that would relate in any

way to the subject matter of this case?
A. I'm certain that I have reviewed literature that relates to the treatment of heart attacks, but not specifically with reference to this case, no.
Q. You're certainly familiar with the term standard of care, are you not?
A. I am in a general sense familiar with that term, yes.
Q. What is your definition of acceptable standard of care for a physician?
A. As I understand it, it's a community or really a nationwide-based standard that is a threshold or a minimal level of community-accepted competence.
Q. Who establishes the standard of care?
A. I believe that it is a consensus of the physicians in practice, and it's -- the standard of care is not defined by an organizing body but is defined by the community of practitioners.
Q. With regard to the triage of a patient that calls a doctor's office with complaints that are potentially consistent with a cardiac condition, is the standard of care different if that call is made to a family practitioner's office as opposed

to an internist's office or a cardiologist's office?

A. No, the standard of care with respect to how the phone call should be triaged should be similar.

Q. Obviously, how that patient is treated if, in fact, there's an index of suspicion that that patient has a coronary event going on, that may differ depending upon whether it's a cardiologist's office or an internist's office; would you agree with that?

A. Yes.

Q. So can we certainly agree that in the Porach case we have to start from the proposition that whether this was a cardiologist's office that was called or a primary care doctor's office or an internist's office that there is a standard of care that applies with regard to what is reasonably acceptable concerning the triaging of that patient?

A. Yes.

Q. And certainly for a patient that is a known patient of an office, there is a level of information that the doctor's office has that is of assistance to that office in triaging the

patient as opposed to someone that calls in never having had any contact with that office; would you agree with that?

A. Most certainly.

Q. And certainly if this is an existing patient that has a prior medical history known to the office, that kind of information needs to be taken into account in triaging the patient's symptoms; would you agree with that statement?

A. In most cases, depending upon the nature of the symptoms.

Q. Do you intend to offer any opinions in this case at the trial as to Mr. Porach's life expectancy had he been treated for an acute myocardial infarction on October 14, 1994 and survived that event?

A. I didn't offer an opinion in my report, but I would be prepared to provide one, if asked.

Q. Was that the subject of the assignment, as you understood it, from Mr. Rispo?

A. I'm uncertain if that was included in any written requests. But I'm familiar with the natural history of coronary disease and would be competent to comment on that subject.

Q. And as I'm sitting here right now, can we

agree that your report of September 2, 1997 does not in any way address what John Porach's life expectancy would have been had he survived the acute myocardial infarction?

A. That is correct.

Q. Nor does your report address any issues concerning what degree of morbidity, if any, he would have had had he survived the acute myocardial infarction?

A. That's correct.

MR. MISHKIND: Do you intend to ask him questions concerning mortality and morbidity at the time of the trial?

MR. RISPO: Yes.

MR. MISHKIND: Notwithstanding the fact that it's not addressed in the report?

MR. RISPO: That's correct.

MR. MISHKIND: I am going to on the record object to the Doctor providing any such opinion testimony because it isn't provided in the report and I think that it's a subject matter that needs to be provided in the report. And without waiving my objection, however, since I'm

here and I don't want to come back in the event that some judge rules that I'm wrong and you're right, I'm going to question him without prejudicing my objection to his providing that testimony.

MR. RISPO: I think that's fine, but I also think it's obvious that you have the opportunity to inquire.

MR. MISHKIND: I know. But there are rules under Cuyahoga County's local rules that specify certain requirements before an expert can provide such opinions, and I would take the position that he has not done so up to December 2. And for that reason, my objection stands. But in any event, we'll save the verbiage for a later battle.

MR. RISPO: Fine.

BY MR. MISHKIND:

Q. I'm going to hold off on asking you specifics on that, but knowing now that you are going to, I'll get to it at the appropriate time in my questioning.

Can you cite me to any studies or literature that identify the life expectancy following survival after an acute myocardial infarction?

A. There's extensive literature in that regard. Studies of patients receiving conventional therapy versus thrombolytic therapy are widespread in the literature, and five-, ten- and twenty-year survival after heart attack has been well studied.

Q. Can you cite me to any particular lead articles that you're aware of that you consider to be good studies on the topic of survivability or survival after an acute MI?

A. I wouldn't be able to cite for you now a specific study, but the totality of studies would be summarized in a variety of standard textbooks of medicine.

Q. Which standard textbooks are you referring to that those studies would be summarized in?

A. Including Braunwald's, B-R-A-U-N-W-A-L-D, Textbook of Cardiovascular Diseases and the textbook from the Mayo Clinic.

Q. Do you consider those to be well-respected cardiac texts?

A. They're widely utilized by many cardiologists, including myself, as summaries of the medical literature.

Q. And with regard to the studies summarized in either or both of those texts relative to the survivability or the survival rates following acute MI, do you agree with the summarization in those two texts based upon the studies that have been done?

A. I couldn't state that I agree or disagree until I've had a chance to specifically reread those referenced subjects. But I would assume that the chapters were well written, carefully referenced and carefully analyzed.

Q. As you sit here right now, you have no basis to say that the summaries contained in either of those texts are at issue with what you understand to be the long-term life expectancy following acute MIs?

A. No, sir.

Q. Have you written any other letters to Mr. Rispo other than the September 2, '97 letter?

A. A statement of services.

Q. That's important. Other than that statement?

A. No.
Q. Do you know what the total tab is up to today?
A. The attorney reminded me that the statement has not been paid. I don't know. I don't recall.
Q. Mr. Rispo reminded you that he hasn't paid the bill yet?
A. As we discussed the issue this afternoon, yes. It may not have been paid. I don't recall one way or the other.
Q. You don't recall one way or another whether it's been paid?
A. Correct,
Q. Do you recall one way or another what the amount of that bill is?
A. I believe it only summarized the work that went into the preparation of this report, and it would be perhaps two or three hours of time.
Q. And how much time after September 2, 1997 have you put in?
A. Probably six hours.
Q. Additional?
A. Additional.
Q. So a total of eight or nine hours?
A. Probably, not including this deposition

Q. Other than the opinions concerning morbidity and mortality that we will talk about, are there any other opinions that you understand you will be asked to opine at trial other than what's contained in your report?

A. I have no knowledge of any other areas of opinion.

Q. And as you sit here right now, do you hold any other opinions other than those which are contained in your report and those which relate to postinfarction morbidity and mortality?

A. I'm sure there are other opinions. I just wouldn't know what areas may be questioned.

Q. Does your report, in your opinion, summarize what you believe to be the pertinent issues, aside from morbidity and mortality, that you intend to offer at the trial of this matter?

A. Yes, I believe so

MR. RISPO: Understand that he will be in a position to rebut any opinions that have been offered by the plaintiff's experts at the time of trial.

MR. MISHKIND: And I will elicit questions during the deposition relative

to the discovery depositions, but that's fine.

Q. Do you know Dr. Lalli?

A. No.

Q. Have you ever met him?

A. No.

Q. Have you ever talked to him?

A, Not to the best of my knowledge.

Q. Have you ever been to his office?

A. No, sir.

Q. Have you ever talked to or met Janice Schoch?

A. Not to the best of my knowledge.

Q. There is a history in the emergency room record. You reviewed that record, correct?

A. That's correct, but I'd like to turn to it.

Q. I'm going to read into the record the sentence in the history that I'm going to question you about. It starts out with the patient is a 44-year-old white male who complains of chest pain or complained of chest pain all day today. He went to see his physician, Dr. Lalli, and while in his office, he collapsed. The office called the ER. And then there's a continuation.

First, did I read that little part of the history in an accurate manner?

A. Yes.

Q. Do you know Dr. Gershman?

A. No.

Q. Have you talked to Dr. Gershman?

A. No.

Q. What is your understanding from your review in this case as to Dr. Gershman's involvement, and specifically how did he get summoned, who did he have contact with based upon the information that you have reviewed in this case?

A. To the best of my knowledge, and, I believe, it was Dr. Gershman, he arrived on scene in the doctor's office. I believe that he was called by the doctor or the office staff during the resuscitation attempt in the physician's office because the physician's office was adjacent to the hospital. And the emergency room would be receiving the patient shortly but no other emergency physicians were on scene, and, I believe, he physically responded.

Q. It's your understanding, is it not, that when he came to Dr. Lalli's office, Dr. Lalli and Janice Schoch were the only medical personnel that

were there with Mr. Porach?
A. Yes, because I believe that the EMS team arrived shortly thereafter.
Q. To your knowledge, did Dr. Gershman have any contact with Mrs. Porach from what you have reviewed in this case?
A. I wouldn't be able to recall. I imagine that he had no contact with her.
Q. In fact, from your review of the emergency room records and Mrs. Porach's deposition, is there any evidence to suggest that Dr. Gershman did have any contact with Mrs. Porach?
A. Not that I can recall.
Q. From your review in this case, is there any evidence that Dr. Gershman had any contact with Jaclyn DeWitt, the stepdaughter?
A. Well, Dr. Gershman arrived in the office, and it's conceivable that he interacted with the stepdaughter in some manner. But I wouldn't know that one way or the other.
Q. Well, from reviewing the stepdaughter's deposition and Janice Schoch's deposition, were you able to arrive at any conclusion that would permit you to say that Jaclyn DeWitt had any contact with Dr. Gershman?

A. No, I believe not.
Q. Can we agree that an emergency room doctor or any doctor that is treating a patient, whether it's in an emergency circumstance or an urgent circumstance, attempts to obtain a history relative to the patient's condition?
A. Absolutely.
Q. That's part of being a doctor, isn't it?
A. It's essential to instituting treatment.
Q. And there is a history that Dr. Gershman obtained in this case, is there not, relative to the onset of symptoms?
A. Well, this history is obtained after the patient's demise, but this is the doctor's knowledge of what the history was.
Q. How do you know it was obtained after his demise?
A. It was recorded after his demise.
Q. And the providers of this information based upon what you have reviewed would be who?
A. I would have no specific idea. The initial providers would be either the doctor, Dr. Lalli, and/or the office assistant and perhaps other people who arrived on the scene in the emergency room.

Q. Is it your understanding that this history would have been obtained by Dr. Gershman, in all likelihood, prior to the patient's demise but recorded sometime shortly after his demise?

A. That would be an assumption. I, quite honestly, am not in a position to know whether Dr. Gershman, indeed, asked about history. I think that a reasonably prudent physician would at least obtain a rudimentary history during the resuscitation. But I would have no knowledge of whether he did or not.

Q. If, in fact, the emergency room doctor obtained the history of the patient complaining of chest pain all day, that would certainly be inconsistent with the sworn testimony given by Janice Schoch in her deposition, would it not?

A. Yes.

Q. Do you have any reason to believe Janice Schoch over Dr. Gershman?

A. I have no reason to believe one or the other. I just know that Janice Schoch apparently spoke to the deceased.

Q. But as you sit here now, you're not in a position to say whether you believe Dr. Gershman or you believe Janice Schoch over Dr. Gershman;

you acknowledge that with regard to the emergency room doctor and the defendant's employee that there is an inherent inconsistency concerning the history of the patient's chest pain?

A. Yes.

Q. If a patient calls a doctor's office and does not have a prior cardiac history but is calling because he or she is ill, not for a regular scheduled appointment but for an ill visit, if you will, is it routine to do an EKG on an ill patient?

A. No.

Q. What symptoms must exist in that history taking in order to warrant performing an EKG on a sick patient?

A. Symptoms could include any of a myriad of symptoms referable to the heart, such as symptoms of heart attack, heart failure, inflammation of the heart or irregularities of the heartbeat.

Q. Would it be standard practice to order an EKG on a patient whose symptoms are consistent with a flu?

A. It might be if there were additional symptoms that could suggest the possibility of cardiac pathology because, of course, some

symptoms of flu can overlap symptoms of heart attack.

Q. Is it within the standard of care, Doctor, in your professional opinion, for an EKG to be ordered on a patient by a nonmedical person?

A. I'm not certain. In a sense, in our own office, EKGs are often done on patients prior to the physician actually seeing the patient.

So in that respect, the EKG is performed by technical personnel before the physician has evaluated the patient. But, of course, our patients are referred to us for cardiac evaluation.

Q. Right. So that's a distinguishable feature. What I'm really getting at is in a situation where the patient is not being referred for a cardiac evaluation but is presumably coming into the doctor's office for noncardiac reasons, is it acceptable or within the standard of care for an EKG to be ordered and performed on a patient without a physician actually making that order of performance?

A. I can't specifically comment on that. I'm uncertain. I believe that it may well be common practice for office staff to obtain EKGs prior to

a physician actually presenting in the patient's room. I believe that that is pretty routine. On the other hand, I would not, generally, expect office staff to make cardiac diagnoses.

Q. In this case, Doctor, do you have any explanation for why Janice Schoch took it upon herself without getting an order from Dr. Lalli, without talking with Dr. Lalli, without reviewing any symptoms on the patient with Dr. Lalli to perform an EKG on a patient that did not have a known cardiac history?

A. No.

Q. Doctor, can we agree that under normal circumstances, whether it's in a primary care physician's office or an internist's office or a cardiologist's office, if a patient is coming into the doctor's office with complaints that before an EKG is going to be performed on a patient that the physician that is going to see that patient should be made aware of the symptoms in order to justify the performance of the electrocardiogram?

MR. RISPO: Justify to whom?

MR. MISHKIND: In order to justify --

MR. RISPO: The insurance

company?

MR. MISHKIND: No, in order to justify from a safe and reasonable assistant doing the EKG.

MR. RISPO: Are you assuming there's a risk to performing an EKG?

MR. MISHKIND: Ron, if that's an objection, it's noted. But I would like to have the Doctor answer the question. You and I can chat at another time.

Q. *Go* ahead.

THE WITNESS: I'm going to have you read the question to me.

(Thereupon, record read.)

MR. RISPO: Objection to the use of the term justify because it's too vague and ambiguous.

Q. *Go* ahead, Doctor.

A. No.

Q. You don't agree with that?

A. I don't agree.

Q. Tell me why.

A. I think in many offices, if not most offices, a considerable amount of triage and evaluation is performed by office staff, whether

they be formally medically trained nurses or medical assistants or informally trained medical assistants.

I know that in our office it's quite common that an ECG is obtained prior to the physician entering the room when patients come in for scheduled or unscheduled appointments because in our office if a patient comes in for an unscheduled appointment, it's certain that the physician will require an ECG and our office staff performs it.

Q. And, again, in your office you're seeing patients that have cardiac histories?

A. Almost exclusively.

Q. Can we agree that before an EKG is performed by an office staff that there should be a history elicited that would prompt the necessity of doing an EKG?

A. Yes, unless the ECG were being obtained as part of a routine physical examination.

Q. And we can certainly agree that in Mr. Porach's situation there's no evidence that the ECG was being done as part of a routine physical examination, correct?

A. That's correct.

Q. This was being done first without Dr. Lalli's knowledge, correct?
A. There's no evidence that he was informed prior to the ECG being obtained.
Q. And this was based upon some decision-making process that Janice Schoch took upon herself, correct?
A. To the best of my knowledge, that's correct.
Q. Again, your knowledge is based upon all of the information that has been provided to you by the attorney that represents Dr. Lalli, correct?
A. That's correct.
Q. So if you had any information that would cause you to say something different, you would tell me, wouldn't you?
A. Yes.
Q. Is your practice exclusively here at University Hospitals or do you have an office outside the hospital?
A. Several offices outside the hospital.
Q. You're over at 1611 South Green?
A. That's correct.
Q. And where else?
A. At Landerbrook.

Q. How do you break down your time between the three offices?
A. I spend about 22 scheduled hours in out-patient cardiology, and of that, perhaps half is at Landerbrook, 30 percent is at University Hospitals and 15 to 20 percent is at University Suburban Health Center.
Q. What percentage of your patient population are cardiac patients?
A. Virtually all of my patients either have or someone suspects they have some form of cardiac abnormality.
Q. In order to comply with the standard of care in your two offices, do you have certain protocol that you expect your nurses and secretaries to follow in terms of triaging incoming calls?
A. The calls to my practice are actually triaged by my secretary here at University Hospitals, so that all of my patient calls are routed to this office.
Q. Your secretary, tell me about her background.
A. She has an undergraduate degree, to the best of my knowledge, and is a medical secretary.

Q. Does she have certain standing orders from you in terms of what questions to ask of patients when they call in and what steps to take with regard to information provided by patients?
A. There's nothing in writing.
Q. Well, I'm not suggesting that it's in writing. But is there a protocol that she has been instructed to follow when patients call in?
A. She, generally, records the message. If I happen to be in the office, which is infrequently, she may not record it in writing but transfer the call to me. Most messages are recorded on a message pad, and she has been instructed and does find me by phone or page if a patient calls in with a complaint of chest pain.
Q. And why is that?
A. Because she's not trained to evaluate whether the chest pain is serious or not, and that requires my direct assessment by phone or otherwise with the patient.
Q. Is she trained to ask questions to get a greater history on the level of discomfort or the nature of the chest pain?
A. No.
Q. She's directed to get that information to

you as soon as humanly possible?
A. She's directed to record the patient's complaints, as they describe them, in a careful manner. And for patients that complain of chest pain, she is to pass on the message to me expeditiously. Whether that's seconds or minutes depends a bit on my physical presence and availability.
Q. And you believe that to be the standard of care with regard to the triage by a nonmedically trained individual?
A. Yes.
Q. Is she instructed to advise the patient to call 911 if the patient has chest pain and you are not immediately available?
A. She has not been so instructed because either myself or a colleague is, generally, immediately available. But in a situation where contact was not possible, that would be her instructions.
Q. Can we agree that if contact cannot be made with you or one of your colleagues as expeditiously as possible that the standard of care of a nonmedically trained individual would require instruction to that patient to call 911?

A. If the patient were complaining specifically of chest pain, I believe it would.
Q. In your experience, Doctor, have patients that are experiencing chest pain, that is, of cardiac nature, whether it's an actual infarct or anginal pain, have they used different terms to describe chest pain?
A. There are many terms that have been used by patients to describe symptoms, which, ultimately, prove to be heart attack.
Q. In your experience over the years that you've been doing this, what are some of the different terms that patients have used to describe either preinfarction, angina or actual myocardial infarct chest pain?
A. Soreness, ache, pressure, heaviness, sharp pain, squeezing.
Q. Whose responsibility is it to determine whether or not those various terms are, in fact, cardiac in nature or perhaps consistent with some other less emergent or urgent condition?
A. A trained medical professional.
Q. Would you agree that the standard of care requires when those type of symptoms are described that those symptoms be conveyed to the trained

medical person as expeditiously as possible?
A. A bit would depend upon the totality of the complaints. If one were to mention sharp pain, for example, along with a myriad of other symptoms, I think that that would be a different level of concern than somebody who might complain of chest pressure and shortness of breath. But there's really no way that an untrained person could identify that, in large part.
Q. Can we agree that under any circumstance nine hours from the time that a patient describes symptoms that may be cardiac in nature to pass, in other words, nine hours before that information is brought to a medically trained individual where the patient calls on two occasions during that nine-hour period, that that would not be in keeping with what you understand to be the standard of care for a medical doctor's office?
MR. RISPO: I'm not sure that question is clear, Howard.
Q. Doctor, do you understand?
A. It's a little unclear in that I wasn't certain whether you were supposing this case or whether this was a hypothetical structure.
Q. I'm saying to you in a situation where a

patient calls up and describes aching in the chest and those symptoms of achiness in the chest are not conveyed to the medically trained individual for at least nine hours and that patient calls back during the day and provides further information about chest pain and, in fact, uses the magic words chest pain as opposed to the less artful words that you hear in your practice and those symptoms during that entire myriad of nine hours are not conveyed to the medically trained and responsible individual. Can we agree, Doctor, so that I can try to move this along expeditiously, that that would not be in compliance with accepted standards of care?

MR. RISPO: Objection for the record.

Go ahead.

A. Yes, if the complaints included chest pain.

Q. What about if the complaints started out with achiness in the chest; is that something that should be conveyed to the responsible medical person for his or her evaluation in a period of time of less than nine hours?

MR. RISPO: Same objection.

A. In that case I would like to identify the

totality of the complaints because that is of some concern to me. That achiness in the chest may be a manifestation of lots of issues, and I would want to know what else the person was complaining of. But if the only complaint was, for example, achiness in the chest, I believe that should be conveyed promptly to a trained medical professional.

Q. What is your understanding as to Mr. Porach's complaints in the morning if you exclude the information from the emergency room doctor but take into account all other sources?

A. It's a bit hard to follow because there are conflicting reports, and I've tried but not very successfully tried to create a time line in my mind for the complaints.

But, I believe, in the morning the complaints included aching in the chest, numbness in the arms and legs and, I believe, diarrhea and some other complaints.

Q. What were the other complaints, Doctor?

A. I can't recall. There were a number of --

Q. Let me help you out a bit, and you can tell me whether these are some of the symptoms that were described based upon the information in the

depositions.
A. Okay.
Q. And, obviously, you weren't there when Janice Schoch talked to Mr. Porach, so you're taking into account a number of different sources of information concerning what Mr. Porach's symptoms were in that morning, correct?
A. That's correct.
Q. Would you include in those symptoms heartburn?
A. Yes.
Q. Would you include in those symptoms having complained of having cold sweats?
A. I'm not certain if that was conveyed to the medical receptionist, but I know that there was testimony that the patient, indeed, complained of cold sweats. So I would include that in the discussion of his symptoms.
Q. Difficulty breathing?
A. My recollection is that the difficulty breathing was not in the first phone call but in the second phone call according to some testimony.
Q. According to Janice Schoch, correct?
A. I'd have to review her deposition to be precise about that.

Q. Well, let's take into account what reasonably you understand to have been described during the morning conversation and reasonably what Mr. Porach was experiencing based upon having woken up in the morning and his symptoms prior to that call.

Having experienced heartburn, achiness in the chest and arms, the tingling in the arms and the legs, the diarrhea and the cold sweats, if you just take those symptoms into account and assuming those were communicated to the receptionist, are those symptoms the type of information that should be communicated to the responsible medical person?

MR. RISPO: Let me Just object €or the record.

A. I believe, in general, yes, because those symptoms are new for the patient, acute and represent a constellation of symptoms, which could be either a minor illness or something more serious.

Q. Let's talk about differential diagnoses for a moment. First define for me what that term means.

A. The term means a series of potential

diagnoses, some more and some less likely that are utilized to exclude and include illnesses.

Q. With the symptoms that we've just described before in the morning, tell me what the differential diagnosis from most serious down to somewhat serious would include, and we'll eliminate the un-serious situations.

A. Most serious might be acute aortic dissection. Another serious diagnosis would be myocardial infarction or heart attack. Another serious diagnosis could be a blood clot or a pulmonary embolism, pneumonia, acute abdominal process, such as infection or cholecystitis. And less serious would be viral pneumonia or viral gastroenteritis, et cetera.

Q. Can any of those conditions be ruled out over the telephone?

A. No.

Q. Can any of those conditions be ruled out or further evaluated by someone that is not a nurse or a physician?

A. No.

Q. Would you agree that the standard of care requires and required back in 1994 that a patient with those symptoms be evaluated as promptly as

possible at an appropriate medical facility?
A. Depending upon the relative emphasis of the patient on these symptoms, I could certainly agree with you that a timely evaluation is required, and as to the specific timeliness, it might depend upon how intense were some symptoms versus others.
Q. Who evaluates those symptoms in terms of how intense they are and how prompt that evaluation needs to be?
A. Generally, the physician, but I certainly expect, in a general sense, other nonmedical personnel to help with that evaluation in that as physicians we certainly can't respond to every phone call immediately.
Q. But certainly the ultimate responsibility for evaluating the seriousness and how quickly that evaluation needs to be made is one that must be made by the physician, correct?
A. To the best of my understanding, that's correct.
Q. Doctor, in this case do you know of any reason why Dr. Lalli could not have been interrupted at some time during the morning of October 14 to have talked to Mr. Porach or to have called Mr. Porach back to review any of his

morning symptoms?

A. I know of no reason why he couldn't have been interrupted

Q. And can we agree, Doctor, that Dr. Lalli should have either been notified in the morning of the symptoms that Mr. Porach had or interrupted at the time that the telephone call came in to Janice Schoch?

MR. RISPO: I'll object because of the assumptions *of* the complaints that you described.

Go ahead.

A. If, indeed, the complaints by Mr. Porach to the office included the symptoms that you enumerated, I believe that that should have been transmitted to the physician.

Q. And just to carry that further, failure to communicate those symptoms to the physician in the morning during that telephone call would be a violation of the standard of care, correct?

MR. RISPO: Same objection.

a. The standard of care issues are difficult for me to identify for a non-physician as compared to those of a physician.

So I'm not entirely certain what defines

the standard of care as relates to the timeliness of message transmittal. I'm not aware of any published guidelines, for example. I'm strictly commenting on what's reasonable and based upon my own experience.

Q. Let's talk about that for a moment. We can agree that frequently standards of care are not defined based upon anything published?

A. That's correct, as I discussed earlier.

Q. As you educated me earlier on. And certainly the standard of care is based upon what is reasonably prudent and acceptable in a particular internist's office or a particular primary care physician's office?

A. Yes.

Q. And you consider yourself to be a reasonable and prudent practitioner, correct?

A. Indeed.

Q. So, therefore, when we identify what the standard of care is in a medical office, basically what we're talking about is what type of system reasonably and prudently should be in effect in order to triage incoming patients' calls, correct?

A. Yes.

Q. And if, in fact, John Porach provided

the complaints that 1 described before to you to Dr. Lalli's office and they were not conveyed to Dr. Lalli at that time or shortly after getting off the telephone, we can certainly agree, can we not, Doctor, that that would not, in your opinion, be considered reasonable and prudent practice for a medical office?

MR. RISPO: Objection because of what was included and excluded in the constellation of complaints.

A. Based upon your assumptions, I think that that would not be good and proper medical care.

Q. Doctor, what information are you assuming Janice Schoch received during the morning telephone call?

A. I'd have to review her deposition. But as I recall from the deposition, there were issues of aching all over, including the chest, and complaints of arm and leg numbness.

Q. You saw the insurance form as well that was filled out shortly after Mr. Porach's death, didn't you?

A. I did see an insurance form, and I am referring to it at present.

Q. That insurance form, which is signed by

Dr. Lalli in the matter of a month after the death, confirms as well that he had aching in the chest and shoulders, which had been reported to his receptionist, correct?

A. That's what the insurance form under reason states.

Q. Do you have any reason to believe that report of achiness in the chest and shoulders occurred at any time other than in the morning?

A. The timing of the complaints is hard for me to sort out. I would really need to think that through and review the depositions to be certain of my response.

Q. I want you to assume that the testimony in this case, if Mr. Rispo's clients testify as they did at deposition, will be that that statement in the insurance form relates to the conversation that occurred in the morning of October 14.

With that in mind and if you exclude any other symptoms and just assume that John Porach just said he had aching in the chest and shoulders and didn't describe any more symptoms, what, if anything, was required of Janice Schoch in order to comply with the standard of care?

MR. RISPO: I object again. If

you would like to refer to Janice's transcript, which the Doctor has previously reviewed, I suggest you refer to Page 8.

MR. MISHKIND: Well, he can refer to any portion of the deposition.

Q. I'm not expecting that you have everything memorized, Doctor. Call upon whatever you need, independent of Mr. Rispo, and tell me based upon the information that you reasonably had or that she reasonably claims she had what was expected of her.

A. The complaint of aching all over sticks in my mind as one of the complaints. And, I think, that's a very difficult question to answer if the complaint is only aching in the chest and shoulders. There are a myriad of symptoms, such as arthritis and inflammatory disease of the muscles and dozens of other complaints, which could reasonably be reported by a patient as aching in the shoulders or aching all over. And I think that it's hard not to separate the known outcome in this case from the initial question in the sense that we already know what these complaints were, ultimately, related to.

If I look back at all of the messages that I receive through the course of a week or a month, there are many people that complain of pain in the neck or the chest or the shoulders or the stomach or the arm, and they're not all emergencies.

Q. Doctor, I understand.

A. So it's complicated.

Q. And we're looking at this prospectively; in other words, we're looking at it at the time that the events occurred and evaluating what should have been done at that point forward as opposed to retrospectively, correct? Would you agree with that?

A. We're trying to evaluate it prospectively with the knowledge that we have the final outcome available to us, which is very difficult to sort cut.

Q. Well, you said that achiness in the chest and shoulders can be reasonably consistent with a number of different things, arthritis, et cetera. Can aching in the chest reasonably be consistent with a cardiac event as well?

A. It can be.

Q. And if achiness in the chest and shoulders is described to a receptionist, a nonmedical

individual, can we agree that the evaluation of those symptoms in terms of the urgency of medical evaluation and medical treatment or the non-urgency is something that should be made by a medically trained individual?

A. Yes, I would agree with that statement.

MR. RISPO: I would like to object again. She asked do you have chest pain. You're excluding very important information, which was solicited and requested and received in that first telephone conversation.

MR. MISHKIND: Ron, why don't you go ahead and say that because she then asked whether or not he had chest pain. Is that what you're looking for?

MR. RISPO: Well, that's precisely the point. You're trying to examine the Doctor and obtain an opinion by excluding some of the most important information. You've asked it five or six times and you're trying to get the Doctor to exclude all the facts.

MR. MISHKIND: No, I'm not.

MR. RISPO: Well, then why don't

you include the facts.

MR. MISHKIND: Mr. Rispo, are you done?

MR. RISPO: Yes, I am.

MR. MISHKIND: Because I'm going to sit back and remain silent for as long as I need to until you're done testifying or asking this Doctor questions on direct examination. And I'm going to take my --

MR. RISPO: My point has been taken.

MR. MISHKIND: I'm going to do a discovery deposition as if upon cross-examination of your witness. I'm going to ask him the questions that I want to, and I'm not going to sit here and have you belabor the issue as to whether or not I'm including or excluding information on the record. There's a time and place for that. Now is not the time.

MR. RISPO: But you are being unfair to the witness.

MR. MISHKIND: No, I'm not. You are being unprofessional in your conduct,

and I'm going to move on. If you want to make any further comments, do it at your own expense. I'm taking this Doctor's deposition.

BY MR. MISHKIND:

Q. Doctor, let me just ask you this so that I can keep Mr. Rispo in line. If a patient says he has aching in the chest and a nonmedically trained person says do you have pain in the chest and the patient says no, can we agree that there is some inherent inconsistency between that statement?

A. Yes, because patients often use the word pain for very sharp, exquisite pain, and the pain of heart attack is not exactly sharp and exquisite.

Q. So can we agree that if simply Janice Schoch, as Mr. Rispo has so eloquently added in the deposition, asked the patient whether or not he had pain in the chest in response to the patient's complaints of aching in the chest and shoulders that that does not exclude from consideration cardiac origin for his complaints?

A. That's correct.

Q. Can we agree then that there still is a requirement in order to comply with the standard

of care that there be evaluation as to whether or not those symptoms of achiness in the chest are a serious condition that requires immediate as opposed to non-urgent evaluation by the physician?

MR. RISPO: By whom?

MR. MISHKIND: By the physician.

MR. RISPO: By the physician as opposed to the receptionist?

MR. MISHKIND: Sure.

A. If one were only concentrating on the aching in the chest, but, obviously, one elicits more than one symptom, generally, from patients. So I think that the summation of all the symptoms is what I'd have to utilize to make that distinction.

Q. Was there any evaluation made by Dr. Lalli of achiness in the chest in the face of a patient saying he didn't have chest pain?

A. No, there was none.

Q. Should there have been an evaluation made by Dr. Lalli?

A. Ideally, a trained medical professional could elicit a variety of symptoms from the patient to help identify whether there was an

acute or less acute problem.
Q. Would it have been important for Janice Schoch to have brought that information to Dr. Lalli's attention?
A. Clearly, in hindsight, it was extremely important.
Q. Well, at the time when you have inherent inconsistencies between I've got achiness in the chest and shoulders and yet in the same sentence says I don't have chest pain, is that the type of information that should be in a reasonable time period brought to the doctor's attention for his or her evaluation?
A. Yes. I'm not quite certain, in my own mind, what that reasonable time frame is. But to a general question, I'd say yes.
MR. RISPO: Can I interrupt just a second?
MR. MISHKIND: Yes.
(Thereupon, a discussion was had off the record.)
Q. Do you have an opinion in this case as to how promptly Janice Schoch should have brought the information that she claims she had to the doctor's attention?

MR. RISPO: After the morning call or when?

MR. MISHKIND: I'm talking about the morning call.

A. I have not formulated that opinion.

Q. My purpose of taking your deposition today is to find out whether or not you're going to testify as to any opinions one way or another, but I don't want to hear at the time of trial that you're going to provide an opinion different than I have not formulated one. Can I move on and accept that?

A. I believe so.

Q. Okay. What was John Porach's prior medical history?

A. He was in good health. I understand that he had been treated for gout.

Q. Any other, shall we say, risk factors for coronary artery disease?

A. There was some discussion that his weight was above ideal body weight.

Q. What was his weight?

A. I couldn't recall. I'm thinking around 220 pounds, but I'd have to check.

Q. He was a past cigarette smoker?

A. Correct.
Q. His history of cigarette smoking in terms of the length of time and the number that he smoked, was that a risk factor?
A. Yes.
Q. His weight, was that a risk factor?
A. I would consider obesity to be a risk factor if it's greater than 20 percent above ideal body weight, and I'm really in no position to be certain that he was obese.
Q. How tall was he?
A. I recollect around six feet tall, but I could be wrong.
Q. So if he was greater than 20 percent above his ideal body weight, then his weight would be a risk factor?
A. Yes.
Q. In fact, some of the studies that have been coming out now have been concentrating more on obesity and the effects that obesity has on various health concerns, including diabetes and ultimate coronary artery disease, correct?
A. That's correct.
Q. Was his hyperlipidemia also a risk factor for coronary artery disease?

A. Yes.
Q. In a patient that has a number of risk factors for coronary artery disease, should the index of suspicion when a patient is calling up and is being triaged by someone be increased with regard to the potential that those symptoms are of a cardiac nature as opposed to arthritis and benign symptoms?
A. Only in a very general sense because cardiac disease can, of course, occur in people with no or few risk factors. And so as not to exclude the possibility of cardiac disease from people with only a few risk factors, in general, the index of suspicion should be high in anyone with reasonable complaints.
Q. Did you detect that there was any index of suspicion on the part of Janice Schoch that his symptoms were potentially cardiac in nature in the morning of October 14, 1994?
A. No,
Q. Would you agree with his medical history and with the history given by him and the response that he gave to the doctor of not having chest pain but yet having achiness in the chest --
MR. RISPO: To the doctor or the

receptionist?

MR. MISHKIND: I'm sorry. Well taken. To the receptionist.

Q. -- that there should have been an index of suspicion that his symptoms were potentially cardiac in nature?

A. It's hard to say without really hearing the symptoms firsthand. But based upon the records, I think that there was some cause for suspicion that this was cardiac, but not predominant cause.

Q. Nonetheless, if there is cause for concern or cause for an index of concern that the symptoms are potentially cardiac in nature, that cause for concern needs to be communicated and evaluated by a physician, correct?

A. Should be evaluated by a physician, in general.

Q. And specific in this case, based upon his medical history and based upon the symptoms that Janice Schoch admits she had and not including anything else but just Janet Schoch's testimony, was that cause for suspicion communicated to Dr. Lalli in what you believe to be a reasonable and acceptable manner?

A. It was, ultimately, communicated only late

in the day.

Q. When you take into account the fact that the patient called back up at 3:00 to 3:30 in the afternoon, not having heard back from the doctor's office, was that cause for suspicion communicated in a reasonable and prudent manner in your professional opinion, Dr. Effron?

A. I am somewhat uncertain because, again, I don't know precisely what was conveyed, and I know that that was conveyed by the patient to the receptionist. I know that no information was conveyed to the physician.

And, again, with the benefit of hindsight and knowing the ultimate outcome, I think it would have been appropriate to convey that information to a physician.

Q. And I appreciate that. But when one is evaluating a patient and is evaluating the level of concern or the index of suspicion, that evaluation must take into account potentially life-threatening conditions, i.e., cardiac conditions, correct?

A. When one is evaluating what condition?

Q. When one is evaluating symptoms that potentially are cardiac in nature and one has an

index of suspicion or cause for concern that the symptoms are consistent with a coronary condition, the -- strike that. I'll rephrase that. It was going to come out garbled, anyway.

Do you have an opinion, Doctor, in this case as to when John Porach suffered the thrombotic occlusion of his left anterior descending artery?

A. Yes.

Q. What's your opinion?

A. In the early morning hours of the day of his death.

Q. What time?

A. There's a continuum of onset of heart attack, and heart attack is rarely timed within seconds or minutes. But early morning hours perhaps at the time that he was awakened with symptoms at 5:00 a.m.

Q. Actually, I think, the records indicate about ten minutes of 6:00 is when he awakened, got his wife up. So 5:30, 6:00 is when you believe there may have been the commencement of the thrombotic occlusion?

A. Yes.

Q. And there was then a continuum of events

that -- continuum of occlusion that occurred?
A. It's uncertain whether the occlusion was complete at the onset and whether it remained complete or whether it was partial at the onset, became complete and then perhaps even what we call recanalized.
But, nonetheless, I think it's fair to say that in retrospect and having reviewed the case and knowing the autopsy results and the presentation that this man's heart attack began around 6:00 a.m. on the day of his death.
Q. Is it also reasonable to conclude that early in that time period some of his symptoms may have been preinfarction angina?
A. That's quite possible.
Q. Do you have an opinion in this case as to how many infarcts Mr. Porach experienced?
A. I believe that he had one heart attack.
Q. And certainly there's no evidence pathologically or otherwise to suggest that he had more than one, is there?
A. I believe that he had one infarct.
Q. That's sort of a way of saying there isn't any other evidence that there's more than one?
A. Correct.

Q. Fair enough. Doctor, as you stated in your report, you would agree that John Porach's complaints were not recognized by Dr. Lalli's office as being cardiac in nature, correct?
A. Yes.
Q. If they were recognized as being cardiac in nature, what, in your professional opinion, should have been done in the morning of October 14, 1994 in order to comply with the standard of care?
A. He should have been directed to contact the emergency rescue system and obtained immediate transportation to an emergency room equipped for handling acute myocardial infarction.
Q. Where do you have hospital privileges?
A. University Hospitals.
Q. Have you ever had hospital privileges at Southwest?
A. No.
Q. Are you familiar at all with any **of** the cardiothoracic surgeons out at Southwest?
A. Southwest has heart surgery?
Q. Well --
A. I'm not certain that Southwest has heart surgery; if they do, **I** am not quite familiar with the surgeons.

Q. Are you familiar with Dr. Sharma?
A. The name is familiar to me, and, I believe, I have had occasion to meet him.
Q. Do you know whether surgeons out at Southwest General Hospital have privileges to perform cardiac catheterizations?
A. They most certainly do. Cardiologists have privileges, not surgeons.
Q. Do you **know** whether Southwest General Hospital has an interventional cardiac cath lab?
A. I don't really have any personal knowledge of the facilities at that hospital.
Q. If Southwest General Hospital had an interventional cardiac cath lab back in 1994 and had physicians confident to perform within that interventional cardiac cath lab, explain to me what then does that permit Southwest General Hospital to do in connection with the treatment of a patient that presents in the course of an evolving acute myocardial infarction?
MR, RISPO: I object to your assumption,
Go ahead.
MR. MISHKIND: **I** will represent to you that that's the **God's** honest truth,

not just an assumption.
Q. But go ahead.
A. The care of patients with acute myocardial infarction might involve administration of intravenous thrombolytic therapy or might on occasion involve the urgent performance of cardiac catheterization and what we call direct balloon angioplasty, and those are options that are decided upon by the treating cardiologist.
Q. Do you know whether Southwest General Hospital had adequate facilities and personnel to perform angioplasty for patients suffering acute myocardial infarctions in October of 1994?
A. I'm not closely familiar with their capabilities, but I believe that that was a capability that was offered by that hospital.
Q. Is the long-term survival of patients that are fortunate enough to be timely recognized to be suffering from an acute MI and fortunate enough to arrive at a hospital within the window of opportunity for thrombolytics, is the life expectancy of those patients greater than those patients that arrive and are treated outside the window of opportunity for thrombolytics?
A. Early treatment results in improved

survival, and the timeliness of treatment has a major impact on survival. Patients that are treated with thrombolytic therapy as compared to those patients that don't receive thrombolytic therapy do better long term; therefore, their survival is enhanced.

Q. Is the modem of treatment limited to thrombolytics in a patient that arrives within the window of opportunity for the use of thrombolytics or does it oftentimes advance to angioplasty and under certain circumstances coronary artery bypass surgery?

A. Well, the treatment of acute myocardial infarction is, obviously, very complex, and it might involve any of a variety of modalities, including thrombolytic therapy. Patients might also receive aspirin, intravenous beta blockade, oxygen, Morphine, Nitroglycerin and other medical treatments.

Q. And all of those things that you've just described are with the purpose of preventing or limiting the amount of damage to the myocardium?

A. That's correct.

Q. And by preventing or limiting the amount of damage to the myocardium, you also prevent or

limit the likelihood of a fatal arrhythmia occurring?

A. That's correct.

Q. Can we agree that more likely than not if John Porach had been evaluated in an emergency room following his telephone call to the doctor's office within a reasonable period of time at Southwest General or a close emergency room that he would have survived?

MR. RISPO: Objection because of the timing.

Go ahead.

A. Well, I believe that if he had been hospitalized or had been seen in an acute care facility anytime prior to his arrest in the doctor's office that more probably than not he would have survived.

Q. Can we also agree that even if he had been seen late in the afternoon but had been in an appropriate coronary care unit or appropriately equipped emergency room at the point in time when he experienced the arrhythmia that more likely than not with prompt intervention he would have survived?

A. Correct. That was encompassed in my

previous response.
Q. So, obviously, the earlier you treat him before he becomes hemodynamically unstable and is experiencing an arrhythmia, the greater the probability is of survival, but even had he experienced an arrhythmia but had been in a hospital coronary care unit or a qualified emergency room, it's your opinion more likely than not he would have survived?
A. It's not certain that he would have survived, but more probably than not he would have survived.
Q. And you understand in law there's no requirement of certainty; more probably than not means greater than 50 percent?
A. Yes, I'm familiar with that.
Q. And that's why you answered that way?
A. Precisely.
Q. Thanks. What's your understanding as to what Janice Schoch told Mr. Porach in terms of follow-up that she intended to have with him that day?
MR. RISPO: At what time?
MR. MISHKIND: I'm talking about the telephone call in the morning.

Q. What did she tell John she was going to do by way of follow-up contact with him, if anything?
A. I believe she said that she was going to contact him later in the day with an appointment.
Q. And what is your understanding as to whether that contact that she said she would have with him would be for an appointment that day or another day?
A. Again, without reviewing her deposition, my understanding is that it was for that day.
Q. Would you agree that reasonable and prudent practice in a physician's office would require that when someone is told that they will be contacted for an appointment for that day that there be contact with that patient that's waiting to hear from the office?
MR. RISPO: Objection.
But go ahead.
A. Again, I'm not intimately familiar with the standards as they apply to prompt return of telephone calls. I just know that we do our best to return phone calls, and we have many hundreds of them to deal with on an average week and some get returns sooner than others. But we try to do

it prudently.
Q. But we're talking about in a situation where an office says I will call you back today, and, as you said, the understanding that you obtained was they would call back that day for an appointment that day. Reasonable and prudent practice, given those set of circumstances, would dictate that the office should call back, correct?
A. I believe so. I just can't comment on whether failure to **do** so represents malpractice.
Q. And, again, let's forget about that word malpractice. You agree with me that that's a reasonable and prudent practice that should be followed in the operation of an internist's office, correct?
A. To the best of one's ability. Sometimes it's simply not possible to do everything that comes across the desk in a day.
Q. Is there any indication that you can tell from Dr. Lalli's office or his appointment schedule that day or the number of patients that he had that there were any fire drills or any problems that would have prevented someone from getting back to John Porach?
A. No.

Q. Would you describe Dr. Lalli's practice as a busy internal medicine practice?
A. I would be unable to characterize it one way or the other to be honest with you.
Q. Can you tell me how many patients he had scheduled for that day?
A. More than a dozen and less than 50. I looked at the log briefly.
Q. In looking at the log briefly, you're limited to saying between more than 12 but less than 50?
A. Well, if I look at it again, I could probably count every name.
Q. Go ahead and look.
MR. RISPO: In what context?
MR. MISHKIND: I want to establish that this Doctor did not have a busy practice or certainly on that day did not have what Dr. Effron would consider to be a high volume of patients scheduled in his office.
MR. RISPO: Apart from the fact that he had a full schedule and no open appointments?
MR. MISHKIND: Well, you call

it a full schedule and no open appointments. I want Dr. Effron to look at the schedule that he has.

A. It might be faster if you find the schedule.

Q. I thought you said you had it.

A. I have seen it. I don't know if I have it. I don't see it right at the moment.

Q. Well, suffice it to say, he had patients scheduled. Do you know how many patients he had scheduled in the morning?

A. I would just like to look at the appointment book before answering. I don't think it would be fair to ask me to reconstruct that from memory.

Q. If Mr. Porach had been directed to the emergency room based upon the telephone call that occurred between 9:30 and 10:30 that morning and was seen at Southwest General Hospital and arrived in the morning of October 14 at one of those facilities, what would, if you know, the standard protocol have been in terms of working this patient up?

A. Had he arrived at what time?

Q. After the telephone call at 9:30 and, let's

say, had he arrived by 11:00 a.m., no later.
A. I imagine that he would have had his vital signs obtained. He would have had an EKG obtained. He would have had routine blood chemistries, including cardiac enzymes obtained. He would have probably had a chest x-ray obtained, a white blood cell count and further studies pending review of those initial screening evaluations.
Q. What interventions would he have likely been provided pending the outcome of the cardiac enzymes and a review of the EKG?
A. Prior to any of those?
Q. Yes.
A. He probably would have received supplemental oxygen,
Q. What about any type of pain medication?
A. Unlikely until the diagnosis was more firmly established.
Q. Do you have an opinion as to what the EKG likely would have shown had it been done during this time period?
A. I have an opinion based strictly upon my prior training and experience and not based upon any other evidence that it would have shown

changes consistent with acute myocardial infarction.

Q. And had an EKG been done in the morning on John Porach arriving sometime before 11:00 a.m. with EKG findings consistent with an acute myocardial infarction, what would the standard of care have been in 1994 with regard to the next step **of** medical intervention?

A. The patient would have been diagnosed with acute myocardial infarction, and the next step would have been to call a cardiologist to see the patient. The cardiologist would have administered medication, including beta blockade, Heparin, Nitroglycerin and decided among various re-perfusion items, including thrombolytic therapy or a primary angioplasty.

Q. Given the onset of symptoms between 5:30 and 6:00 a.m. in 1994, when, in your professional opinion, would the window of opportunity for the administration of thrombolytics have closed?

A. There's no hard and fast rule or there wasn't in 1994. But, in general, community practice was to administer thrombolytic therapy within six hours of the onset of symptoms.

Q. When you say there's no hard and fast rule,

it could be a little bit less than six hours, it could be a little more than six hours?

A. Not less; more perhaps. Some physicians might have administered thrombolytic therapy at somewhat more than six hours. But there would be no reason not to administer it at less than six hours.

Q. At what point in time in 1994 was there thought that administration of thrombolytics postinfarction raises greater risk to the patient than the benefits of attempting to re-perfuse with thrombolytics?

A. I'm not aware of that.

Q. Are there risks if one is given thrombolytics at ten, twelve or fourteen hours after an infarct?

A. The risks are that complications from bleeding could occur, and there are very occasional patients that develop severe bleeding into the area of heart attack and so-called hemorrhagic infarction. But studies have subsequently shown that the benefits, indeed, outweigh the risks, even at more than six hours.

Q. In John Porach's case, again, if he had been directed to an emergency room and had been

evaluated by a cardiologist, is it your opinion more likely than not had that evaluation been concluded prior to 1:00 that thrombolytic therapy would have been part of the modality of treatment?

A. I would be more confident about saying 12:00 noon.

Q. Now, had thrombolytic therapy been administered before 12:00 noon, more likely than not John Porach would have survived, correct?

A. Yes, I've testified to that.

Q. And John Porach more likely than not would be alive today, correct?

A. That's correct.

Q. Would John Porach more likely than not have been evaluated for further treatment of his coronary artery disease after he had recovered from the acute myocardial infarction?

A. Yes.

Q. More likely than not would John have been a candidate for angioplasty?

A. That's uncertain. It would depend upon his course following recovery from heart attack and perhaps the results of an exercise stress test.

Q. The fact that John was in otherwise good health before he suffered the acute myocardial

infarction, does that bode well for his likelihood of survival following his acute myocardial infarction?

A. Well, it's natural that if somebody had other illnesses that those illnesses would compromise their long-term health.

Q. And, in fact, the studies that perhaps you're familiar with that are summarized in the texts talk about the premorbid condition and the age of the patient when they experience an acute MI in terms of their life expectancy, do they not?

A. That's a given.

Q. It may be given, it may be obvious. But we can certainly agree that that's part of the statistical analysis, how old the patient was and what kind of preinfarction condition they were in?

A. Correct.

Q. And the healthier, the more active the patient was before the infarct, the longer the survivability is, correct?

A. Well, it largely depends upon the extent of damage caused by the heart attack. But, clearly, if the patient had another limiting illness, then that would be factored into the overall assessment of what their life span would be. And if they did

not have such limiting illnesses, that would not be part of the equation.

Q. Did John Porach have any other underlying limiting conditions that would have impacted his life expectancy?

A. He had cardiac risk factors, which, of course, impacted upon the possibility of coronary artery disease. But, to my knowledge, he had no other serious chronic medical illnesses.

Q. If John Porach had been your patient and had been timely seen and evaluated and treated on October 14, 1994 and survived his heart attack because he had received thrombolytic therapy within the window of opportunity but then had follow-up coronary care with you, what would the regimen of treatment have been?

A. You're asking me for the long-term regimen subsequent to recovery from heart attack?

Q. Yes, sir.

A. A variety of medications and lifestyle changes.

Q. What kind of work did John Porach do?

A. I'm going to say a deputy treasurer for the state or the county.

Q. Go ahead and say it then.

A. I don't remember if it's the state or the county.

Q. No, you said you were going to say it. I'm saying go ahead and say it then. That was my attempt to humor, Doctor. You're correct. He worked for the county.

Any reason to believe that John Porach could not have returned as I think it was a cashier at the treasurer's office following his recovery from the heart attack?

A. More probably than not, he would have been rehabilitated to gainful employment.

Q. Now, in the afternoon on October 14, 1994, we can agree, can we not, Doctor, that if John Porach complained of chest pain and shortness of breath and if there was any legitimate reason for him not having been seen or evaluated prior to that time that, given the complaint by the patient of shortness and breath and chest pain, the standard of care which would be required of a reasonably prudent practitioner operating a medical practice would have been to direct that patient to call 911 immediately?

MR. RISPO: For a doctor or for the receptionist?

MR. MISHKIND: For Dr. Lalli's office that is equipped with a triage by a secretary that is not a nurse or a medically trained individual, just someone that's had on-the-job experience.

A. Yes. As I stated in my report, I believe that if the patient had complained of chest pressure and shortness of breath on that afternoon that it would be appropriate to refer him to emergency medical services.

Q. And, again, this is given the assumption that there was no reason prior to that time for him to be at a hospital being evaluated. But if we just take the point of time of 3:15, 3:30 and he complains of shortness of breath and chest pain and if there was not such instruction by Janice Schoch for him to call 911, that would be a violation of the standard of care, correct?

A. Yes, assuming that he, again, complained of chest pain and shortness of breath.

Q. If a patient calls up that has no cardiac history, coronary history before that has called once in the morning and then calls back again in the afternoon and that patient calls and asks,

hypothetically, to come into the office for an EKG, what under those circumstances do you believe reasonably and prudently should be done by the receptionist or the secretary that is fielding that telephone call?

A. I would make certain that the patient's complaints were recognized and that there was some discussion as to what the symptoms were that concerned the patient. And if there was then the descriptors of chest pain and shortness of breath, then that call should be referred immediately to the physician.

Q. Can we agree that it would be unusual for a patient that doesn't have a coronary history, that doesn't have complaints of chest pain or shortness of breath to call up a doctor's office and to request an opportunity to come into the doctor's office to have an EKG performed?

A. I would think that would be uncommon, although a number of my patients call and request EKGs for a variety of imagined or real complaints.

Q. Again, Doctor, that's because these patients are predominantly coronary patients of yours to begin with, correct?

A. Or think they have cardiac disease.

Q. John Porach wasn't a coronary patient nor did he think he had coronary disease, correct?
A. To the best of my understanding.
Q. Have you reviewed Dr. Botti's testimony?
A. I have reviewed his deposition and his witness report in some detail.
Q. And you know Dr. Botti, don't you?
A. Quite well.
Q. In fact, Dr. Botti trained you, didn't he?
A. That's correct.
Q. And you respect Dr. Botti, don't you?
A. Yes.
Q. As an internist and as a cardiologist, is he well respected in the Greater Cleveland area?
A. Extremely well respected.
Q. And certainly, €or the record, well respected by Dr. Barry Effron as well?
A. Indeed.
Q. I'll have that section printed up and given to Dr. Botti.

Are there any aspects of Dr. Botti's testimony or his opinion report that you take issue with?
A. There may be, and I will first review his report.

Q. Okay.
A. I have reviewed his report.
Q. Are there any areas of his report that you disagree with?
A. No.
Q. From your review of Dr. Botti's deposition, were there any areas of opinions that he expressed that you take issue with?
A. I'd have to review the deposition in detail.
Q. As you sit here now, you're not in a position to respond?
A. Correct.
Q. Do you agree with Dr. Botti's testimony where he indicates that if John had presented to the emergency room in the morning, he would have been given aspirin, would have been treated for pain and would likely, based upon what we know now, have been given TPA to dissolve the blood clot or had gone to a cath lab for acute cardiac catheterization with the idea of doing an emergency angioplasty?
A. I believe that's exactly what I had testified to previously.
Q. So certainly with regard to the

interventions in the morning as described by Dr. Botti, you and he agree?

A. Yes.

Q. With regards to the interventions in the afternoon, had John been sent to the hospital, assuming he complained of shortness of breath and chest pain, first, we've already established that the standard of care required that he be directed to call **911** and to be transported to a hospital. Had those symptoms been described, had he been seen at Southwest General Hospital within a half an hour or 45 minutes after making that telephone call to the doctor's office, would he more likely than not have been outside the window of opportunity for thrombolytics?

A. More likely than not.

Q. But still based upon what you said before, a consideration for thrombolytics would have at least been entertained depending upon the history elicited from the patient as to the onset of symptoms?

A. That's correct.

Q. In any event, if a judgment was made at that point not to administer thrombolytics, the treatment of choice would have been a heart cath

and then consideration as to whether or not angioplasty would be efficacious or make arrangements for a **CABG?**

THE WITNESS: You'll have to read that back.

(Thereupon, record read.)

Q. I'll rephrase it. If we're outside the window of opportunity for thrombolytics, a heart cath would have been --

A. No. If the infarct had been substantially completed, then initial therapy would largely be conservative with pain relief, beta blockade and treatment of recurrent symptoms, administration of Nitroglycerin.

A subsequent evaluation might involve cardiac catheterization and further treatment to be determined by the findings of catheterization.

Q. The idea though being in the afternoon with that medical intervention, more likely than not the fatal arrhythmia that occurred at 5:30, 6:00 would have been avoided, correct?

A. The chance of lethal arrhythmia may have been lessened. But, nonetheless, were it to have occurred, effective treatment could have been provided.

Q. But can you agree that the probability of him sustaining ventricular fibrillation would have been lessened had he been in a hospital at 4:00 receiving oxygen and other appropriate cardiac treatment?

A. I believe that's correct.

Q. And more likely than not, although we've established this a couple times, death from ventricular fibrillation or any other dysrhythmia more likely than not would have been avoided?

A. Yes.

Q. Now, Dr. Selwyn, do you know him?

A. No.

Q. What about Dr. David Effron, do you know him?

A. Yes.

Q. How do you know Dr. David Effron?

A. We share the same last name and we are distant cousins.

Q. Can you tell me with regard to Dr. Selwyn whether or not there are any aspects of his opinion report that you take issue with?

A. I take issue with it only in a few points. Again, I think that it's easy in hindsight to be certain as to what would have been done

previously. And as I reviewed the report, I found that it was I would say more critical of the office staff and the triage system than I believe is standard in an internist's office.

For example, I don't believe that clear a protocols and triage systems are standard in most internists' offices, although certainly that sounds ideal.

Q. Any other areas that you take issue with?

A. There are others, including the statement that the symptoms should have been immediately conveyed to Dr. Lalli. Again, I believe that in hindsight that's quite obvious. But immediacy of message transmission is hard to establish prospectively. It's just very, very difficult, and, obviously, physicians can't do everything immediately.

Q. Well, again, just so I'm clear, Doctor, with regard to your opinion, with the known medical history and with the patient conveying complaints of achiness in the chest and with the limited information that Janice Schoch received or attempted to receive from John Porach, how promptly should that information have been conveyed?

A. We talked about that earlier, and I wasn't in a position to really offer expert testimony on the exact length of time. I think that, clearly, it would have been in this patient's best interests that a physician reviewed that information promptly.

As to what represents malpractice, I believe, is difficult for me to state, and that's why I am being honest with you in stating that I don't know the exact time frame at which a message of this nature should be transmitted. It's just difficult to state.

Q. Define for me your use of the term promptly.

A. Hours, not days.

Q. And, again, because hours could mean the difference between someone living and someone dying, tell me in the face of those symptoms how prompt hours should be.

A. I can't put a number on it. A little bit depends upon the acuity of the complaint at the time and the doctor's availability and the reasonableness. I think ten minutes is far too short and six hours is probably too long. Between those time frames, I find it really quite hard to

be more conclusive.
Q. How prompt do you expect your nonmedically trained secretary to convey symptoms to you of a patient that calls in with achiness in the chest, recent onset of those symptoms?
A. My patients all have cardiac disease, for one. So it's a completely different spectrum of illness that I see.
Q. Given that though, how promptly?
A. Less than an hour.
Q. Anything else in Dr. Selwyn's --
A. I told you about the time. I really have to get back to work. I have an hour's worth of messages to return.
Q. And, Doctor, if we need to reconvene --
A. I think we have to do that. If it's going to be more than a few minutes, I'm going to quit.
Q. Well, I understand you have to get to see patients?
A. Right. They're in the intensive care unit.
Q. I'm not debating you nor am I arguing with you. And I'm asking you --
A. We talked about a time frame of 4:00 to 6:00, and I allowed that because I have patients in surgery and coming out of the operating room.

Q. Doctor, I need to find out what your opinions are and what especially Mr. Rispo is intending to have you --

MR. RISPO: We've been through that. He knows that.

A. I understand that. It's just if we can reconvene or spend no more than about ten minutes on this portion of the time.

Q. We can reconvene.

A. Well, we'll have to do that.

Q. Give me a couple minutes to talk to Ms. Tosti, and I may finish up with maybe just a few questions. It's not going to, by any means, be the end of it.

A. Okay.

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

Q. I think you were commenting on other areas of Dr. Selwyn. And what we can do, if you want, is we can bypass that at this point, and I can give you an opportunity to review that at the next session because I would like to find out what areas you take issue with with regard to the expert testimony. So maybe in preparing for the next round, you can concentrate, if you do some

additional review, on that thought process that will maybe help streamline it.

A. That would be fine.

Q. I want to just ask you a couple questions about John post-infarct. One question before that though. With regard to the efficacy of angioplasty post-infarct, is there a defined window of opportunity for the use of angioplasty following an acute MI?

A. No.

Q. You've seen the autopsy on John Porach?

A. Yes.

Q. Did he have multi-vessel c ronary artery disease?

A. The autopsy was not very clear in that regard actually. To the best of my recollection, I believe that there was a description of coronary artery disease, and the term that is utilized says that the coronary arteries demonstrate multifocal moderate to severe stenosing atherosclerosis.

Q. And as a cardiologist, as you look at the description and you're actually reading onto the second page as well, just tell me how you would quantify the level of coronary artery disease that he had, if you can.

A. It can't be done based upon the narrative that is seen here in the autopsy.
Q. Doctor, can we agree that while statistics talk about a large percentage of patients suffering sudden coronary death following acute myocardial infarction, the majority of patients that are fortunate enough to arrive at a coronary care unit or an emergency room survive the acute event?
A. Yes.
Q. So that when we hear about or perhaps even see statistics about all the patients suffering heart attacks and the number of people that drop dead outside of the hospital, that doesn't take into account that the majority of those patients that, for whatever reason, happen to be in the right place at the right time, the majority of them do survive, correct?
A. The mortality of myocardial infarction in the United States once hospitalized is approximately ten percent.
Q. What kind of morbidity do you believe to a reasonable degree of medical probability John Porach would have experienced had he been given thrombolytic therapy in the morning of October 14

and then had appropriate medical or surgical intervention for his coronary artery disease following recovery from the infarct?

A. The extent of coronary artery disease was not clearly identified, and so I can't be certain. I believe that he would have recover-d from his myocardial infarction and been treated in a conventional fashion and done well.

Q. So you don't believe that he would have had any significant morbidity that would have affected his enjoyment of life?

A. Well, most patients after recovery from heart attack have a good recovery and none to mild symptoms.

Q. Do you have any reason to believe that John Porach, in addition to returning to work, could not have returned to a quality of life that he had enjoyed previously with his wife and his children?

A. It's considerable speculation as to the extent of disease. But since I specialize in cardiac rehabilitation, I can state that many patients after heart attack recover to a greater degree of functioning or equal degree of functioning as previously.

Q. And specifically with regard to John, had

he been treated on October 14, can we agree more likely than not that he would have returned at least to the same or perhaps better quality of life posttreatment for this infarct?

A. He would have required ongoing medical supervision and medications, and he would have required certain lifestyle modifications to reach full rehabilitation potential.

Q. In 1994 what was the life expectancy of a 44-year-old white male?

A. I'm uncertain, but I could estimate it to be at perhaps 30 years.

Q. Do you have an opinion to a reasonable degree of medical probability as to whether John Porach's life expectancy, had he survived the acute myocardial infarction, would have been less than the average life expectancy that you have just stated?

A. I'm certain that would have been somewhat less than the average life expectancy because he had a chronic and incurable disease, that is, coronary atherosclerosis, which would require lifelong medical treatment and management. And despite our best treatment for coronary artery disease, long term there are further consequences,

including the development of subsequent heart attacks, heart failure and arrhythmias.

Having said that, it's probable that he would have survived in excess of ten years and perhaps in excess of fifteen years.

Q. Can you tell me when in excess of ten or in excess of fifteen years he would have died?

A. I couldn't state that because I have no way of knowing what the ultimate extent of his heart attack would have been, and the prognosis is entirely governed by the extent of damage to the heart muscle. It's unpredictable based upon the information that's been provided to me.

Q. Is it reasonable to conclude that had he been treated promptly and had good cardiac rehab and altered his diet, his lifestyle to complement that cardiac rehab that he more likely than not would have avoided subsequent infarcts?

A. I'm unable to say that because one would need to put a time frame on that. And, obviously, over the course of a lifetime, I think it would be more likely than not that he would sustain more infarctions. The natural history of coronary disease is that people that have coronary disease, ultimately, die of coronary disease.

Q. I will tell you that **Dr.** Botti has opined in his deposition that had John received appropriate medical care on October 14 and thereafter that more likely than not he would have lived to at least the age of **69**, so that he would have had, in his opinion, at least a 25-year life expectancy.

Do you have any reason to disagree with Dr. Botti, assuming survival and assuming good cardiac follow-up thereafter?

A. Again, based upon lots of data regarding the long-term survival of patients with heart attack, it really depends upon how much damage was done to the heart muscle and at what time he was treated and how extensive the heart attack was. Since we don't really know that, I think that it's impossible to speculate.

But I would have to state that a 25-year survival for someone with an anterior wall heart attack would be at the very upper limit of what I would consider a reasonable estimate.

Q. So a lot of his survival would really be dependent upon what went on day in and day out of his life during the next years in terms of his diet, his follow-up with medical care and somewhat

with regard to what God has planned for him?
A. And new discoveries by medical science.
Q. Fair enough. Are you going to testify that John Porach might have lived more than ten years had he survived?
A. I had not placed a number on his long-term survival formally.
Q. Is it your intent to opine that he would likely not have lived more than ten years, or is that not --
A. I wasn't asked to address that question specifically; if I am, I will think about it formally. And I am certain that I will not be able to state that more probably than not he would live 25 years. That I would disagree with.
Q. Well, can you tell me, as you're sitting here now, what more likely than not would have been a reasonable range of years that he would have lived enjoying life with his wife and children following his 44th year on this earth?
A. I would be very comfortable with the assessment of 15 years to 10 years, but it's a broad range and I --
Q. Fifteen years to ten years?
A. Ten to fifteen years or fifteen to ten is

an estimate that seems reasonable, given the anterior wall myocardial infarction and given the occlusion in the left anterior descending of his major coronary vessel.

Q. Do you believe that there are studies that would indicate that a 44-year-old man in otherwise good health with no other medical conditions that has an anterior wall infarct with the degree of thrombotic occlusion is limited in life expectancy to ten to fifteen years?

A. It depends upon the extent of heart attack. And if there was substantial damage to the heart muscle, ten to fifteen years might be an outside estimate. If there was no damage to the heart muscle, fifteen to twenty years might be an estimate. It's simply impossible to state with certainty.

Q. So that the earlier he was treated on that day and the less heart muscle damage, the longer his life expectancy?

A. That's correct.

MR. MISHKIND: Okay. We will adjourn at this point because I know you have other pressing matters.

THE WITNESS: Yes.

MR. MISHKIND: I will let Mr. Rispo know how much additional time. You know at least one area of inquiry concerning the other expert testimony?

THE WITNESS: Correct.

MR. MISHKIND: I thank you for your time.

THE WITNESS: Okay.

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(DEPOSITION ADJOURNED AT 7:00 P.M.)

- - -

CERTIFICATE

STATE OF OHIO,)
) SS:
COUNTY OF CUYAHOGA.)

I, Barbara A. Oser, a Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, BARRY ALLAN EFFRON, 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 by means of computer-aided transcription, and that the foregoing is a true and correct transcript of the testimony as 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 any 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 26th day of December, 1997.

Barbara A. Oser

Barbara A. Oser, RPR
Notary Public in and for
the State of Ohio.

My Commission expires November 5, 2002.

CURRICULUM VITAE

NAME: **BARRY ALLAN EFFRON**

SOCIAL SECURITY NO.: 283-44-6267

DATE OF BIRTH: June 7, 1953

HOME ADDRESS: 3990 Orangewood Drive
Orange Village, Ohio 44122
(216)5914445

BUSINESS ADDRESS: Department of Medicine
University Hospitals
11100 Euclid Avenue
Cleveland, OH 44106
(216)844-8951

EDUCATION:

1975	B.A.	Cornell University, Ithaca, NY (with distinction)
1978	M.D.	Ohio State University, Columbus, OH (cum laude)

Postdoctoral Training:

Internship & Residencies:

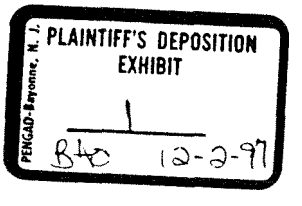
1978-79	Medical Intern, University Hospital, Columbus, OH
1979-80	Assistant Resident (Medicine), University Hospital, Columbus. OH
1980-81	Senior Resident (Medicine), University Hospitals, Cleveland, OH

Fellowships:

1981-83	Clinical Fellow, Division of Cardidogy, Case Western Reserve School of Medicine, University Hospitals, Cleveland, OH
1984-85	Post-Doctoral Research Fellow, American Heart Association, Department of Medicine, Cardidogy Section, University of Wisconsin Medical School

LICENSURE and CERTIFICATION:

1981	Diplomate, American Board of Internal Medicine
1982	Ohio License Registration No. 48155
1984	Wisconsin License Registration No. 26120
1985	Diplomate, American Board of Internal Medicine, subspecialty of Cardiovascular Disease



HOSPITAL and FACULTY APPOINTMENTS:

1983-84	Chief Resident in Medicine, University Hospitals, Cleveland, OH Instructor in Medicine, Case Western Reserve University, Cleveland, OH
1984-85	Clinical Instructor, University of Wisconsin Hospital and Clinics
1985-95	Assistant Professor of Medicine, Case Western Reserve University, Division of Cardidogy, University Hospitals, Cleveland, OH
1995-	Associate Professor of Medicine, Case Western Reserve University, School of Medicine, Cleveland, Ohio
1985-	Director, Lipid Disorders Clinic, University Hospitals Cleveland, OH
1988-	Director, EKG/Stress Laboratory, University Hospitals Cleveland, OH
1989-	Medical Director, Cardiac Rehabilitation Program, University Hospitals, Cleveland, OH
1995-	Associate Division Chief, Clinical Programs Division of Cardiology University Hospitals of Cleveland

AWARDS and HONORS:

1975	Phi Beta Kappa, Cornell University
1978	Alpha Omega Alpha, Ohio State University
1988	Certificate of Appreciation, American Heart Association

PROFESSIONAL SOCIETIES:

1983	American College of Physicians
1985-	American Heart Association, Council on Clinical Cardiology
1990-	Cleveland Lipid Club, Moderator

COMMITTEES:

1983 1985-89	Intern Selection Committee, Department of Medicine, University Hospitals of Cleveland
1986-	Homeostasis II Planning and Examination Committees, School of Medicine Case Western Reserve University

1986-87	Board of Trustees, University Physicians, Inc.
1987-90	Medical Education Committee, American Heart Association Northeast Ohio Affiliate
1987-89	Chair, Physicians Cholesterol Education Program Task Force
1987-94	Quality Assurance Committee, Department of Medicine, University Hospitals of Cleveland
1989-	Committee on Continuing Medical Education, Case Western Reserve University School of Medicine, Cleveland, OH Chair, 1990-present
1990-	Chair, Fellows' Evaluation Committee Division of Cardiology University Hospitals of Cleveland/VA Medical Center Cleveland, OH
1991-92	Faculty Benefits Subcommittee, Case Western Reserve University
1990-	Credentialing Committee, Department of Medicine, University Hospitals
1993-95	Clinical Practice Operating Committee, Department of Medicine Co-Chair, Operations Subcommittee

PUBLICATIONS:

Effron BA, Nellis SH, Uedtke AJ: Effects of coronary gardenhose on tissue vdumes in autoregulated hearts (abstr). Circulation 1985; 72:Suppl III:III 485.

Munger MA, **Effron BA:** Amoxapine cardiotoxicity. Ann Emerg Med 1988; 17:274-278.

Glasser SP, DiBianco R, Effron **BA,** et al. The efficacy and safety of Pravastatin in patients aged 60 to 85 years with low-density lipoprotein cholesterol >160 mg/dl. Am J Cardiol 1996; 77:83-85.

Lee JH, Challapalli S, Effron **BA,** Geha AS: Impact of an arrhythmia protocol on reducing length of stay for postoperative atrial fibrillation (abstr). Chest 1996; 110:23S.

Lee JH, Kim KH, vanHeeckeren DW, Murreil HK, Cmolik BL, Graber **R, Effron BA,** Geha AS: Cost analysis of early extubation after coronary bypass surgery. Surgery 1996; 120;611-9.