IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO
CASE NO. 393909

TARA C. KINTER,
Administratrix of the Estate of
SUTTON I. KINTER, 111, etc,

Plaintiff,

vs.

JAMES E. BIANCHI, M.D., et al,

Defendants.
_____/

VIDEOTAPED
DEPOSITION OF: JAY FALK, M.D.

TAKEN BY: The Plaintiff

DATE: November 15, 2000

TIME: 1:43 p.m. to 3:17 p.m.

LOCATION: 86 West Underwood Street
Suite 200
Orlando, Florida

REPORTED BY: REBECCA L. FELLA,
Notary Public, State of Florida at Large

A P P E A R A N C E S:

WILLIAM M. GREENE, ESQUIRE

Greene, McQuillan & Eisen Co., L.P.A.
1801 Bond Court Building
1300 East Ninth Street
Cleveland, Ohio 44114
(216) 687-0900
On behalf of the Plaintiff

MARC W. GROEDEL, ESQUIRE

Reminger & Reminger Co., L.P.A.
113 St. Clair Avenue
Cleveland, Ohio 44114
(216) 687-1311
On behalf of the Defendants James E. Bianchi, M.D., and Emergency Professional Services.

GEORGE M. MOSCARINO, ESQUIRE

Moscarino & Treu, LLP
1422 Euclid Avenue, Suite 630
Cleveland, Ohio 44115
(216) 621-1000
On behalf of the Defendant Lakewood Hospital

ALSO PRESENT: Patrick Uribasterra, Videographer

I N D E X

JAY FALK, M.D.

E X H I B I T S

(None marked)

P R O C E E D I N G S

THEREUPON:

VIDEOGRAPHER: The date is November 15th of 2000. This is the deposition of Jay Falk, M.D., taken in the matter of Kinter versus Bianchi, M.D., et al. The time now is 1:43 p.m. Will Counsel please introduce themselves?

MR. GREENE: My name is Bill Greene. I represent the Plaintiff.

MR. GROEDEL: My name is Marc Groedel. I represent Dr. Bianchi.

MR. MOSCARINO: George Moscarino. I represent Lakewood Hospital.

VIDEOGRAPHER: And will the Court Reporter please swear in the Witness?

JAY FALK, M.D.

having been first duly sworn to tell the truth, the whole truth and nothing but the truth, testified as follows:

DIRECT EXAMINATION

BY MR. GREENE:

Q. Dr. Falk, my name is Bill Greene, I represent the Plaintiff in this case. I'm going to ask you questions, You've been deposed on a number of occasions prior to this, I assume.

A. Yes.
Q. Is that correct?
A. Yes.
Q. So you know the rules. If I ask you anything that you don't understand or you want me to rephrase it, tell me and I'll rephrase it and hopefully make it more understandable. Fair enough?
A. Yes.
Q. You wrote a report dated August 21st, 2000, in this case, correct?
A. Yes.
Q. Have you looked at that today?
A. Yes.
Q. Have you read any other material by -- by way of deposition testimony after you wrote this report?
A. You mean were there depositions I received after I issued the report --
Q. That's what I mean.
A. -- between now and then? No.
Q. So you didn't -- you haven't read the deposition of Sutton Kinter's mother?
A. Well, I'll have to check actually. I'm not sure, to tell you the truth.
Q. Okay.

A. What is her name?
Q. Janice Kinter.
A. Not Janice Orndorff?
Q. No.
A. Then I don't believe I read that dep.
Q. Okay. And nurse Fox, did you read her deposition?
MR. MOSCARINO: Who is nurse Fox?
THE WITNESS: No.
MR. GROEDEL: Toth, did you mean?
BY MR. GREENE:
Q. Faye -- Faye Fox. You -- you've added -- you --
A. Faye Toth I read.
Q. -- mentioned Faye Fox's name in -- in your report --
MR. GROEDEL: Toth.
BY MR. GREENE:
Q. -- but it's Toth now. But she did sign it Fox.
A. I --
Q. You actually picked it up in your report and mentioned the name Fox, don't you --
A. I'd have to look at the report.
Q. -- in your report?

A. I understand what you're -- saying

Q. Right.

A. -- and I did read her deposition --

Q. Okay.

A. -- if her name is Faye Toth in -- in the deposition.

Q. Okay. You did read it?

A. Yes.

Q. Okay. You're an emergency room doctor?

A. Yes.

Q. You're from Brooklyn?

A. Correct.

Q. You look at about maybe forty, fifty malpractices cases a year?

A. Something like that.

Q. About seventy-five percent for the defense, ball park?

A. Not quite that many. Probably more sixty, forty.

Q. You're about four hundred and fifty dollars an hour for your fees?

A. For depositions.

Q. Right. You wrote a chapter on chest pain for the Cantelli book?

A. Tintinalli.

Q. For the Tintinalli book?
A. Yes.
Q. And you have special interest in chest pain, don't you --
A. Yes.
Q. __ chest discomfort?
A. Yes.
Q. Now, you wrote a report in this case which is three pages long; is that correct?
A. I didn't count the pages, but if you say it's three pages, I accept --
Q. The last page I see says page three on it.
A. Well, then it would be three pages long.
Q. Okay. Are you board certified in cardiology?
A. No.
Q. Are you board certified in cardiac pathology?
A. No.
Q. Did you read the reports of Plaintiff's expert cardiologist and cardiac -- and cardiologist and pathologist, those two reports, Factor --
A. Factor and --
Q. -- Joel Kahn?
A. Yes.

Q. Doctor, after you analyzed all of the material that you read and processed it through your experience and training, you wrote in the last paragraph that you believe that a prudent emergency physician would have wanted to have an EKG done.

In substance, is that what you wrote?

A. That's exactly what I wrote.

Q. Why is that?

A. Well, I think that there are a number of reasons, but I think that in -- in patients with a -- a near syncopal event, that one of the considerations would be a dysrhythmia. There are a number of conditions, like congenital heart blocks and things like that, that can present in younger people that may be picked up on an electrocardiogram.

And I think that in general, it's -- it's a readily available, easy to perform test, and so just, you know, the prudent thing to do is -- is to get one. I think most -- most emergency physicians would like to have one in -- in these kinds of cases.

Q. Now, you would agree that the priority for emergency room physicians must always be to rule out life threatening conditions.

Do you agree with that?

A. I think as a general principle that that is

the case, yes.

Q. And you've read Dr. Bianchi's deposition?

A. Yes, I have.

Q. And you know he was worried that the chest discomfort the patient talked about could have represented a cardiac condition.

Do you remember that testimony?

A. Not specifically.

Q. All right. Let's check Dr. Bianchi's deposition, page eighty-three.

You don't recall him being -- being concerned that this might have been a cardiac problem, the chest pain he was -- he was discussing?

A. I'm sorry, I -- I wasn't listening.

Q. On page eighty-three of his deposition, he's asked, you wanted to do a cardiac test on this patient, you wanted to rule out something that was life threatening, correct. And then he's asked on -- on -- on nineteen about cardiac syncope, and he says it's dangerous. And he also says later on in his deposition that he wanted the workup to see if there was a -- a lethal arrythmia pattern, but he wasn't able to because the patient didn't allow them to.

Do you recall the substance of that deposition?

A. Yes.

Q. Okay. Let me back up for one second. If the patient -- if the doctor is worried that chest discomfort that a patient talked about may represent a cardiac syncope, then you'd want to do an EKG, among maybe other things, but certainly you'd want to do an EKG; is that correct?

A. I'm sorry, I -- can you repeat the --

Q. If you were concerned about cardiac syncope --

A. I'm not --

Q. -- if you think maybe the patient's near fainting spell was cardiac in nature, that would be the reason why you would want to do an EKG. You want to check his heart out.

Is that fair to say?

A. I guess I'm having trouble with the term cardiac syncope. I'm not sure I know what you mean.

Q. You've never heard the term cardiac syncope?

A. Well, I'm not sure what you mean by it.

Q. Well, I mean syncope -- I mean, I can go back to the literature now and read you the definition if you want to. We can go to your literature and read your definition, but your -- I think your -- you review for the Annals of Internal Medicine?

A. I review for many journals, yes.
Q. All right. But that's one of them, isn't it?
A. The Annals of Emergency Medicine, you mean?
Q. No, the Annals of Internal Medicine. Isn't that on your -- your curriculum vitae as one of the journals that you review for, sir?
A. I don't believe I've reviewed for the Annals of Internal Medicine. I'm not -- I'm not sure,
Q. Really?
A. Yes.
Q. Okay. Well, let's go off the Record for a second.
A. I review for a lot of journals.
VIDEOGRAPHER: The time now is 1:50 p.m. We're off the Record.
(Discussion off the record.)
VIDEOGRAPHER: The time now is 1:51 p.m., and we're back on the Record.
BY MR. GREENE:
Q. I stand corrected. You review for a journal called Annals of Emergency Medicine; is that correct?
A. Yes, um-hum.
Q. So when I was asking on page eighty-three of Dr. Bianchi's deposition, I used the term cardiac

syncope.

That's a new term to you? You don't -- you don't --

A. Well, I think --

Q. __ recognize that as being --

A. I think I know what you mean by it, but you know, even -- even a simple faint, you know, the pathophysiology involves the heart to a certain extent. That's why it's now called neurocardiogenic syncope. So to differentiate out cardiac syncope, I assume you mean that it's a syncopal episode that is primarily caused by a heart condition as opposed to, you know, the heart being involved as in neurocardiogenic syncope.

Q. Okay. That was one of the reasons that Dr. Bianchi said he wanted to do an EKG?

A. Well, as I said, yes, that arrhythmia would be one of the considerations, and that would be the primary cause for syncope that was -- that was resulting from a primarily cardiac problem, although there are others.

Q. I understand.

A. Left atrial myxomas can cause syncope. There's a lot of strange things.

Q. But there can be cardiac causes. Cardiac

arrythmia, for example.

A. Arrythmia would be the major one, yes.

Q. And that's what Dr. Bianchi wanted to do an EKG for, among other reasons?

A. Yes.

Q. Now, Dr. Bianchi received a complaint from Mr. Kinter of chest discomfort.

Are you familiar with that?

A. Yes.

Q. And I believe you say in your article that that is a common term for chest pain. used by patients, discomfort?

A. I -- I wouldn't make a big distinction between the two.

Q. Now, it's important when a physician -- emergency room physician gets a report of discomfort in the chest or chest pain to take an appropriate history, is it not, Doctor?

A. Yes.

Q. And among the things you want to take a history for is where the pain was located?

A. Yes.

Q. How long the pain lasted for?

A. Yes.

Q. If it was the first time they had the pain

or they had had the pain on other occasions?

A. Yes.

Q. If the pain -- if the pain was -- when the pain went away?

A. Yes.

Q. And those are all standard questions that are very important to ask?

A. They would be important questions.

Q. Right. And -- and you would be critical of a doctor who didn't ask those kinds of questions in the face of -- of complaints from a patient about chest pain?

A. Well, I think in general my answer to that question would be correct; however, I think, again, that one needs to put it in the context of -- of the particular patient.

Q. A patient coming into your emergency room --

A. In other words --

Q. -- with chest pain --

A, In other words --

Q. -- and says Doctor, I've had -- been having chest pain --

A. Right. Exactly.

Q. -- you would ask him questions?

A. Yes. Rut again, the questions I would ask a

twenty-six-year-old that has no risk factors for coronary artery disease might be different than a fifty-six-year-old with multiple risk factors.

Q. Well, Doctor, you'd still want to know where the pain was, wouldn't you?

A. Well, I think -- yes. I -- I said yes. I -- I think you would.

Q. I'm talking about the twenty-six-year-old. Duration of pain?

A. All of those things would be helpful, yes.

Q. Okay. As a matter of fact, you've been critical on Direct or in depositions of doctors seeing patients with chest pain who didn't take a good history, haven't you?

A. Yes.

Q. In this case, is there anywhere either in Dr. Bianchi's chart or even in his deposition testimony where he notes the location of the chest pain?

MR. GROEDEL: Objection to your reference of the deposition testimony.

But you can answer the question. Go ahead.

BY MR. GREENE:

Q. Well, if you just want, let's do it two ways. Let's confine it. Is there anywhere in

Dr. Bianchi's chart where he charts what the duration of the chest pain was?

A. No.

Q. Is there anywhere in Dr. Bianchi's chart where he charts where the location of the chest pain was, where in the chest the pain was?

A. Other than the chest, no.

Q. Is there anywhere in his chart where he notes when the chest pain ended?

A. Well, it -- it says that -- at the time that he wrote his note that the -- the discomfort that he had had earlier was gone and that now he feels fine, so --

Q. So sometime between two and a half hours earlier when it started and two and a half hours later when he was interviewing him, the chest pain went away, but you can't tell me when in that two and a half hours it went away?

A, That's as close as you can get from his note, correct.

Q. Would you agree with me that the note is -- has a -- has a deficient history in that it -- it doesn't list when the pain started and where the pain was and when the pain ended?

A. Yes.

Q. And as far as him asking those -- those questions, you would be critical of him for not asking the questions?

MR. GROEPEL: Objection.

You can answer.

THE WITNESS: Again, I think that the relevance of the answers has to be put into the context of the patient. In other words, if you're considering that this patient may be at risk for having coronary artery disease and therefore you're worried about miocardia1 ischemia as a potential cause of this patient's pain symptoms, then those features might be helpful in delineating that.

If your assessment is that this patient is really not at risk for having coronary artery disease, which, by the way, turns out to be the correct assessment because he had clean coronaries on his autopsy, then I think the -- the details of those features become less germane.

Yes, I would be critical because for form sake and the way we like to do things, the most complete way is the best way, but whether or not they would have relevance in terms of decision making in this particular patient, I think it's

very unlikely,

BY MR. GREENE:

Q. Well, Doctor, I didn't mention the word coronary artery disease at all, but I did mention heart problem, and he was worried about him having a heart problem, wasn't he? That's why he wanted to do an EKG.

A. Well, I -- I think my interpretation of what he said was that he was worried about a rhythm disturbance, which is a completely separate issue to a certain extent than the chest pain and ischemic heart disease --

Q. All right.

A. -- which is extraordinarily rare in twenty-six-year-olds.

Q. Well, we'll get to that later, how rare it actually is. However, he was concerned enough about his heart to want to do an EKG?

A. Yes.

Q. And he didn't take any history of his chest pain, did he?

A. Well, we don't know what history he took, but what history he recorded is, as you've delineated --

Q. Well --

A. -- lacking in those details.

Q. Well, we know what history he had took because I asked him in his -- in his -- in his deposition early on to tell me everything that went on with that patient, and he never mentioned anything about asking him one question about the chest pain.

So we do know, don't we?

MR. GROEDEL: Objection.

You may answer.

THE WITNESS: Well, I guess that's your conclusion, yeah.

BY MR. GREENE:

Q. Well, you read his deposition, too. Did you conclude otherwise?

MR. GROEDEL: Objection.

THE WITNESS: Well, I -- I guess to me there's a difference between, you know, tell me what you did and you didn't mention that, and that for sure we know he didn't discuss it, but I'm willing to concede he didn't discuss it.

BY MR. GREENE:

Q. Okay. Now, you discuss vasospasm or Prinzmetal's angina in your report, do you not?

A. Yes.

Q. And in your article on chest pain, you have an entire section on variant angina, which is the same

thing, do you not?

A. You know, I'd have to look at it. Do you mind showing it to me?

Q. I do have your chest pain, and let me see if I have it right here in front of me. I think I do.

A. You do. I think you do.

Q. I'm handing you your report -- not your report but your article (tenders document to the Witness). And Jay Falk and O'Brien, and you have a paragraph on variant or Prinzmetal's angina, don't you?

A. Yeah.

Q. Okay. So whether it's a rare syndrome or not, you wanted emergency room doctors to be aware that people could die from vasospasms; is that correct?

A. I'm sorry, I wanted -- I want people to be aware --

Q. You wanted emergency room doctors to be aware of Prinzmetal's angina?

A. Yes.

Q. Now, in terms of -- did Dr. Bianchi come to a diagnosis of what the patient's problem was?

A. Yes.

Q. But were you also aware that Dr. Bianchi has testified that he was unable to make a diagnosis because the patient did not allow him to do a test he

wanted to do?

A. Yes.

Q. He felt it was -- he felt it was an important enough test that he testified he asked the patient three or four times to let him do the test, and this patient turned him down every time.

Do you remember that testimony?

A. Yes.

Q. Is syncope and near syncope, when you actually lose consciousness and when you almost lose -- lose consciousness, treated about the same by ER doctors?

A. Again, it depends. Similar, not necessarily exactly the same.

Q. And am I correct in saying that ordinarily chest pain is not a feature of vasovagal syncope?

A. Yeah, I -- I think that that -- that would be a fair statement, but I think that, again, there's some interpretation there. This patient had tingling in his hands. It sounds like he was fairly upset by the whole thing, so he may have been hyperventilating. A -- a sense of discomfort in the chest is not uncommon among people that are hyperventilating and feeling that way.

So I agree with you that chest pain, per se,

is certainly not part and parcel of vasovagal syncope; however, I think that some people who nearly pass out, who have tingling in their hands and are over breathing may feel a discomfort in their chest as well.

Q. But ordinarily, if you looked at an article on vasovagal syncope, you wouldn't find chest pain as one of the related features?

A. Right. I agree with that.

Q. Okay. And the -- you said he had tingling in the hands?

A. Yes.

Q. In actuality, what he reported was -- and we have very sparse reports of what the chest pain was, but it says tingling in both arms.

A. Yes.

Q. Is that what -- what it said, Doctor?

A. Yes.

Q. And as far as the character and nature of the -- of the chest pain and whether or not it would be associated with hyperventilation, since we have no description of what the pain was and how long it lasted and how intense it was and where it was makes it pretty hard for you to opine anything on that, doesn't it, Doctor?

A. Well, I think that that's a little bit over

stated. I mean, if you read Dr. Bianchi's note, he says he had some chest discomfort earlier but feels fine now. I think that, you know, to -- to then blow that up into how severe his chest pain was is -- is not really being fair.

I think that the implication is, the way 1 read this, is that the -- the discomfort is mild and it is not -- it does not appear to be a substantial complaint to Dr. Bianchi, at least that's how he -- he seems to be interpreting it as far as I can tell reading his note.

It would seem to me that an emergency physician who had a patient who had severe chest pain, that that would get a little bit more attention in his note.

Q. Where does he say in his note that the chest pain is mild?

A. Well, that's the point. Some discomfort, to me, I read that as not terribly severe. He had some discomfort, but he's kind of minimizing it in his note.

Q. Where does he say it's mild in the --

A. It doesn't. The word mild isn't there. I'm interpreting the -- the notion of some chest discomfort. I find it difficult to believe that an emergency physician who receives information from the

patient that he had severe pain in his chest is going to write a note that says some chest discomfort.

Q. Well, when he comes up to the nurse who sees him just a few minutes prior to Dr. Bianchi, was he having chest pain?

A. Well, we don't know. The way -- it sounds to me, the way this is written, that he's complaining of some chest discomfort and numbness and tingling in both arms, you know, when it began. It's not clear to me that he was actually having it at the time, but it's possible.

Q. Okay. I mean, he -- this says that he's comp1aining?

A. Yes.

Q. And when you read it and wrote your report, you noted that --

A. Yes.

Q. -- that he was complaining of chest pain.

Would that have been relevant for the doctor to actually know that he had -- we know he had chest pain at the time he was having the bowel movement.

A. Yes.

Q. You reported that. Would it be relevant to know that he was having chest pain also, Doctor, just a few minutes prior to seeing you I was having chest

pain? Would you want to know that as his treating doctor?

A. Yes.

Q. Did Dr. Bianchi find that out?

A. Well, it's not clear to me what he knew about the timing of the pain in terms of when it -- when it came and went. He knows that he had had it earlier, and it indicates that he's not having it at the time that he examines him. And we've already discussed and I've conceded that the duration of the pain, from when it started to when it stopped, is unclear from the record.

Q. And Dr. Bianchi, who wants to have a test that he thinks is important to rule out a life threatening cardiac arrythmia --

MR. GROEDEL: Objection.

MR. GREENE: That's what he testified to. All right. If you want me to go into his testimony, I will, but I think that -- I think that we've established earlier, Doctor, that you recall that.

BY MR. GREENE:

Q. He asked the patient three or four times to do a test that he thinks is necessary to rule out a life threatening problem.

Do you recall that?

A. Yes.

Q. And the patient turns him down.

Do you recall that?

A. Yes.

Q. Do you recall that Dr. Bianchi described the patient as being cooperative and friendly?

A. Do I recall that?

a. Yes, do you recall that?

A. Yes, I do, um-hum.

Q. And do you recognize that if an emergency room physician, because you -- because you train emergency room physicians, don't you, Doctor?

A. Yes, I do.

Q. Do you recognize that if an emergency room physician feels that he has to do a test to rule out a life threatening problem and he has a patient that is reluctant to undergo the test, that the doctor has some obligation to try to talk the patient into the test?

A. Yes.

Q. And he has an obligation to make a good faith effort to try to talk him into the test?

A. Yes.

Q. He has an obligation to, like, say more than four times in a row, I want to do an EKG; he'd have to

tell him, for example, why he wants to do it?

A. I think an explanation of the rationale for doing any test is part and parcel of what physicians should do with patients.

Q. And he knows he had a patient that just had a near syncopal event when he was having blood drawn, so he might be a little reluctant to undergo another test.

Is that fair to say?

A, I'm not sure I understand what you're saying.

Q. Well, you know by history Dr. Bianchi knew that this whole thing started when they went to draw blood from him for his pre-employment physical.

A. Right.

Q. So you know the patient might -- might have been a little reluctant to undergo any other test and would need some explanation as to why he needed the test.

Is that fair to say?

A, Well, I would think he was very reluctant to undergo further tests. He refused them.

Q. Well, the only -- okay. The only evidence we have that he refused the test was Dr. Bianchi's testimony and some -- and some testimony about a

conversation from some people in the hospital legal department.

Is that fair to say?

A. Yes.

Q. But going back, Dr. Bianchi -- you're -- are you familiar with the doctrine -- and I'm sure you are -- in -- in emergency medicine and in medicine of informed assent?

A. Yes.

Q. Okay. In order for a patient to be charged with the responsibility of turning down a test, the test has to be explained to him and the doctor has to let him know why he wants to do it and why it's important and what's involved in the test.

Is that fair to say?

A. Yes.

Q. Do you know if Dr. Bianchi ever did that?

A. Well, I -- we know that Dr. Bianchi wanted to do the cardiogram. We know that he had a working relationship with the patient. As you just mentioned, he described him as cooperative,

Q. Friendly and cooperative.

A. And -- and so --

Q. Well, let me back up, I'll -- I'll make it easier. I'll withdraw the question.

Did Dr. Bianchi ever explain to the patient that this EKG was noninvasive and involved no pain?

A. I would not know the exact details of that, but I think that it's common knowledge that EKGs involve no pain.

Q. Well, do you know that -- that this patient had never had an EKG in his life?

A. Well, most people haven't had an EKG, but I think if you took a survey of people around the room and asked them do you think an EKG hurts, they would all say no.

Q. It's pretty interesting that you'd say that, because I don't think that's exactly true, but we'll -- we'll decide that later on.

Whether that's true or not true, you've never read any -- any studies on that, have you; that's just your opinion?

A. Yes.

Q. Okay. Do you know, though, if Dr. Bianchi ever told him in substance than an EKG is a -- a noninvasive test that involves no pain?

A. I don't know for certain that he used those words.

Q. Okay, Do you know if he used the words in substance and told him that, in substance told him that

this is not invasive and doesn't involve any pain?

A. I -- I don't know.

Q. Okay. Now, do you have his deposition in front of you?

A. Yes.

Q. On page sixty-seven, line seven, correct me if I'm wrong --

A. Just a moment, please.

Q. Read on with me. I'll give you all the time you want to look at it.

A. Okay.

Q. Question, did you ever tell him in substance that an EKG is a noninvasive test and involves no pain; answer, I don't believe so.

Did I read that correctly?

A. Yes.

Q. All right. Did he ever ask him if he had had an EKG before this, a -- a prior EKG? Did he ever ask him that?

A. He didn't recall.

Q. Did he ever tell him, most importantly, that he wanted to do an EKG, in substance, because he wanted to rule out something that might be life threatening? Did he ever tell him that?

A. Well, I don't think he did tell him that,

but you know, I think, again, there's a proportionality issue here in terms of what his real index of suspicion is and -- and why he's doing it --

Q. The question is --

MR. GROEDEL: Let him --

MR. GREENE: -- very direct. I only asked you, did he ever tell him that.

MR. GROEDEL: Well, let him -- let him answer the question the way he wants to answer it.

MR. GREENE: Well, he wants to answer a question that I haven't asked.

BY MR. GREENE:

Q. I'll -- I'll tell you what, Doctor. 1'11 make you an agreement. We can -- if you answer what I ask you, then I'll let you make any statement you want afterwards.

A. Well, I'm not making a statement. I'm answering the question you asked me.

Q. Do you know if he ever told him in substance that he wanted to do a test to rule out something that might be life threatening?

A. Well, I'm trying to answer the question. I -- I think that, you know, one of the questions that you asked him was the same question that you're asking me -- I'm just looking at his deposition -- which is

the next question you asked him. And, you know, he said that he -- he was conveying to the patient that -- that he felt he was going to be fine and that it's common for people to faint.

This is a guy that's very upset. He's embarrassed. He's on his first day of work. He nearly passed out. He's making a scene. His co-workers had to bring him to the emergency room. And Dr. Bianchi's assessment is that he's had a vasovagal syncope reaction, which is a very benign condition, and that is overwhelmingly the most likely thing.

So for him to tell him, well, you know, I just want to do this EKG because you might die I think is disproportional to the way he really felt about it. And so I don't think he did tell him that he wanted to do a test to make sure he doesn't die. I think he said, look --

Q. That's not what I asked him. I asked him, did you ever explain to him in substance you wanted to do this test because you wanted to rule out something that was -- that might be life threatening, and he said no.

A. Right.

Q. But he wanted him -- he felt strongly enough that he mentioned it three or four times that he wanted

to do this test. He kept on -- according to Dr. Bianchi, he kept on coming back and asking him that. So he must have had an index of some suspicion that there was a problem that he wanted to rule out.

Is that fair to say?

MR. GROEDEL: Objection.

You may answer.

THE WITNESS: Well, I think the problem he was trying to rule out was that he'd be in this position today where, God forbid, something did happen, that he'd be criticized for not having the EKG, but I think he felt that it was --

BY MR. GREENE:

Q. Really?

A. -- overwhelmingly likely --

Q. Do you really think that? You think that was his testimony?

A, -- that the test would be normal,

Q. You think that was his thinking then, that I want to save myself from getting --

A. Well, I think in emergency medicine --

Q. Can I finish? I wanted to save myself --

A. Well, if you let me finish, I'll let you finish.

Q. -- from getting a hey, knuckle head call.

Do you know what a hey, knuckle head call is?

A. No.

Q. You don't? Do you remember having your deposition taken in a chest pain case where you were the plaintiff's expert, Doctor, about -- exactly eleven months ago today, Kelvy? Do you remember that --

A. Not exactly.

Q. -- deposition?

A. I'm sure you'll refresh my memory.

Q. Macelvy (ph). Macelvy. And that's where I got the hey, knuckle head description. You said, no doctor wants to get a hey, knuckle head call. Hey, knuckle head, you know the patient that you saw yesterday who had chest pain, well, he died at a hospital and you didn't even do an EKG on him,

Do you remember that testimony at all?

A. Not exactly.

MR. GREENE: All right. Let's go off the Record for one second,

VIDEOGRAPHER: The time now is 2:15 p.m. We're off the Record.

(Discussion off the record.)

VIDEOGRAPHER: The time now is 2:17 p.m. We're back on the Record.

BY MR. GREENE:

Q. I'm reading here from a transcript I'm going to show you to see if it refreshes your recollection. Lenona Macelvy and Jacob Macelvy versus, among others, Emergency Medical Group, Dr. Linda Rhine, Dr. Raj Paul, Dr. Hammond, state court in Georgia.

Do you remember this case at all?

A. Yes.

Q. You were the plaintiff's expert?

A. Yes.

Q. And did you say -- isn't this your language, if I'm going to send you home and you potentially have a high risk thing, I'm going to make absolutely sure I detail my findings, my thinking, so that, God forbid, you were to drop dead, I would have an answer to people who -- who are asking me, well, knuckle head, how come you sent him home? Did I read that correctly?

A. Yes.

Q. Okay. If --

A* But --

Q. If Dr. -- if Dr. Bianchi was so concerned, as you testified, to ask him three or four times --

A@ No. You --

Q. -- to get an EKG because he was -- he was worried about being questioned later on and the patient

turned him down every time, can you tell me why when the patient left he dictated a note, which you have in front of you -- you have his note in front of you, Doctor?

A. Yes.

Q. Does he mention anywhere in that note that he offered the patient an EKG even one time and the patient turned him down?

A. No, he doesn't mention that until his addendum the next day.

Q. But you --

A. Can I respond to -- to --

Q. Doctor, you're going to come to trial, and you can respond to anything. But now you're on Cross Examination, and you'll have time -- you'll have time to do whatever you want.

MR. GROEDEL: Okay. Well, I -- I will move to --

MR. GREENE: Marc will ask you --

MR. GROEDEL: I will --

MR. GREENE: -- whatever he wants to ask you and you can testify, but I'd like my questions answered, respectfully.

MR. GROEDEL: Okay. I will -- I will move to strike the question and answer because this is

not Cross Examination, but you can --

MR. GREENE: If it's not Cross Examination, it's news to me.

MR. GROEDEL: Well, take a look at Ohio Civil Rule 26-B and you'll see it's not --

MR. GREENE: Let me go on,

MR. GROEDEL: -- Cross Examination.

MR. GREENE: Your objection is noted. And I'll --

MR. GROEDEL: Well--

MR. GREENE: -- finish my questioning, and if the judge feels that I can't ask -- that I can't Cross Examine, I'll have to directly examine your expert, which is, to me, pretty silly.

MR. GROEDEL: Well, I don't think you're letting him answer the question fully, Bill.

BY MR. GREENE:

Q. Doctor, I want to turn to another part in this examination, and that is, assume that Mr. -- that -- that -- excuse me, that Sonny, Sonny Kinter, was kept on a cardiac monitor at the hospital,

Would you expect that if he had another cardiac arrythmia or a cardiac arrythmia that that would show up on the monitor?

A. If you're asking me if someone is on a

cardiac monitor and they have an arrythmia will it show up on the monitor, yes.

Q. Okay. Mr. Kinter had, in the last two and a half hours prior to Dr. Bianchi seeing him, almost fainted twice and then had at least one, if not two, episodes of chest pain.

Is that fair to say?

A. Yes.

Q. Would that be the kind of patient that you might want to monitor for -- for awhile to -- to see if he either had, A, another syncopal episode, or B, another cardiac episode where he has chest pain?

A. Well, I think not necessarily, because there were very plausible explanations for both episodes. One, of course, was the original blood drawing, Even people watching television know that tough cops faint when they have their blood drawn or they see autopsies on Quincy. So he had a very plausible explanation for the first episode.

And then the second episode, which happened shortly thereafter, was him straining at stool, which is another very well known etiologic cause of slowing of the heart rate and -- and a vasovagal syncope. so -- so no, I don't think that just the -- just the very fact that there were two episodes in the prior two

and a half hours obligates a monitoring period.

Q. The question I asked you was, he not only had two episodes of syncope, but he also had at least one, and maybe two, episodes of chest pain.

A. Well, again --

Q. Would that concern you or not --

A. Well --

Q. -- as an emergency room physician?

A. -- again, it depends on what your interpretation of the chest pain is and what the nature of it and all of the things that we don't necessarily know about.

Q. And the interpretation of the chest pain. and what it was and how worrisome the chest pain -- pain was would rely upon finding out about the chest pain, right?

A. If you --

Q. You would have to find out about it first, don't you?

A. Yes. I think more details --

Q. All right,

A. -- would be necessary.

Q. And Dr. Bianchi --

A. But again, I think --

Q. And Dr. Bianchi --

MR. GROEDEL: Wait. Wait. Can you let him finish his answer, Bill? I don't --

MR. GREENE: Yeah. That -- that was an episode where I definitely interrupted YOU, and I'm sorry. Do you have anything else you want to say?

THE WITNESS: That's very gracious of you, Counsel.

BY MR. GREENE:

Q. Thank you. I try and be gracious.

A. Yes. I -- I think that in the -- again, in the -- you know, it's -- it's easy to divide these things into little compartments and then harp on what one ought to do given this compartment versus that compartment, but I think that when you look back at the whole case and you're talking about a twenty-six-year-old with no risk -- no risk factors for having underlying coronary artery disease who has a clear, justifiable reason to have a near fainting episode and then has a little bit of discomfort in -- in the chest associated with it, by implication, because it's not harped on as -- as an issue, then I think that it's completely acceptable to believe that this entire episode is a vasovagal episode. It's the most common by far. It's way the most likely

explanation of this.

Q. Doctor, where in the literature can I find chest pain as a feature of vasovagal syncope?

A. Again, we -- we have discussed --

Q. Can you name me any place?

A. No. We've discussed this already, and I think that it's -- it's not -- chest pain in and of itself is not characteristic of vasovagal syncope, and we've discussed that.

Q. So we have somebody with a feature that doesn't fit the diagnosis.

Fair to say?

A. Not necessarily. Again, we will quibble over the details of it, but I would contend that someone who has -- has nearly fainted, is hyperventilating, has tingling in his arms and a little bit of mild chest discomfort is completely consistent with that, if that's the way it was.

Q. There --

A. Now, if he has crushing chest pain --

Q. Well, we don't --

A. -- that lasts for two and a half hours, then I agree with you, but I don't believe that if he had those things, that the -- the outcome would have been this. I think it would have been different.

Q. The outcome?

A. Yes. I think that if, as you're implying --

Q. Well, let me strike that.

A. -- the patient had a major episode of two and a half hours' worth of crushing chest pain, that this is not the record we would see, nor would that have been the behavior on the part of Dr. Bianchi.

Q. I didn't imply he had two and a half hours of crushing chest pain. I implied the record shows that he had chest pain at the time of his bowel movement as an associated feature of his syncope, and he also had chest pain when he went to the ER room several hours later. Whether one lasted fifteen minutes and the other lasted ten minutes, I don't know. Nobody knows.

And why don't we know, Doctor?

A. Because it's not in the records.

Q. No one took an adequate history.

Fair -- fair to say?

A. Yes. I've conceded that,

Q. Okay. You do agree, however, that if the patient had an EKG, since he was asymptomatic at the time Dr. Bianchi saw him, an EKG would probably be negative.

Isn't that what you wrote?

A. Yes.

Q. Okay. But if you were doing an EKG for the purpose of ruling out a cardiac arrythmia, you'd want to do the EKG when the patient was symptomatic, wouldn't you?

A. Well, I mean, ideally whenever we're trying to diagnosis rhythm disturbances, you would like to have the patient to have the disturbance when you're doing the tracing. Unfortunately, you can't command the patient to have the problem at the time that you're monitoring them, which is why we use things like halter monitors and event monitors to pick them up.

Q. Sometimes you keep the patients around for a while in a step-down unit or some other unit and just monitor them for a couple of hours before letting them go home.

You do that, don't you, Doctor?

A. Actually, I don't do that very often, but it -- it is a strategy, yes.

Q. Sometimes it's a strategy to get a little consult from a cardiologist if you're concerned?

A. Yes.

Q. And sometimes it's a strategy if you have a patient who is not letting you take a test you want to take to have someone else talk to them, like his wife

or maybe his co-workər; isn't that corrəct?

A. Well, thərə arə all kinds of stratəgiəs to coərce pəoplə intə -- intə doing things.

Q. Də yəu knəw what stratəgy Dr. Bianchi usəd?

A. Nə.

Q. Də yəw knəw Dr. Bianchi?

A. No.

Q. Havə yəu əwər təstifiəd fər Mr. Grəədəl's law firm?

A. I know that I've reviewed at least one other matter for their firm, but I'm not sure that it went to deposition.

Q. You didn't read the mother's deposition, but let us say that the patient, Sonny Kinter, went home and was still having chest pain, started having chest pain again.

Would that -- had he been monitored at that time and then -- this was within thirty minutes of Dr. Bianchi saying good bye to him -- had he been on a monitor at that time, I -- I believe your testimony is that it would have been positive?

MR. GROEDEL: Objection.

You may answer.

THE WITNESS: Well, that's not what I said. I said -- you're -- you're əquating chest

discomfort or chest pain with arrythmia, and -- and I have no way of knowing whether or not he would have an arrythmia with that chest pain.

BY MR. GREENE:

Q. Well --

A. And that's the only thing a monitor --

Q. Right. Well --

A. -- would pick up is an arrythmia.

Q. -- if a patient has -- is having coronary artery spasm at the time of his EKG, is that going to show up on an EKG?

A. A twelve-lead EKG, yes.

Q. Okay. Well, that's what you use, don't you, in the ER room, twelve-lead EKG?

A. Not for monitoring. That's what you use --

Q. I understand, though, and if you did an EKG at that time.

A* Yes, if --

Q. Okay. If he says I'm in pain, I'm having pain, you do an EKG?

A. Yes.

Q. All right, And I believe you testified at length in the Macelvy deposition, but I'm going to ask you this. There's a big difference between in-hospital cardiac arrest and out-of-hospital cardiac arrest.

Do you agree with that -- in terms of mortality?

A, Well, it turns out that if you take -- if you take all the cumbers, the -- the answer is probably not, but for -- but for people with acute coronary syndromes, if you're in a monitored setting at the time of the event, absolutely there's a huge difference.

Q. So, for example, in Sonny Kinter's case, if he had had his cardiac arrest not at home in the bathroom where he's wedged into door, but in the hospital when he's on a monitor, the outcome would have probably been different.

Would you agree with that?

A. Absolutely.

Q. He would have lived?

A. Well, I don't know if he would have lived, but he -- he certainly would have had a much better shot at living, yes.

Q. Well, the -- I think you quoted statistics that survivability of in-hospital cardiac arrest is something like ninety-three percent?

A. That's probably -- that's probably successful defibrillation, but not -- not survival. But I -- I'm not arguing the point. There's no question that he likely --

Q. He would have been much better off in a hospital?

A. Well, he likely would have survived.

Q. Okay. And do you have expertise in the treatment and outcome of young people who have Prinzmetal's angina?

A. No.

Q. Okay. So you're not going to be offering any testimony about that?

A. No.

Q. Okay. You were aware from reading Dr. Factor's report that he found evidence of myocardial necrosis that was at least four to six hours old?

A. Yes.

Q. And you don't think that an EKG that was done six hours prior to death would have -- would have been abnormal in spite of that finding?

A. That's correct.

Q. So you would disagree with Dr. Factor on that?

A. Yes.

Q. And with Dr. Kahn on that?

A. Yes.

Q. Okay. I know that you have an interest in

emergency cardiac care, correct?

A. Yes.

Q. Do you have an expertise in cardiac pathology?

A. I'm not a pathologist,

Q. Okay. You don't hold yourself out as being a heart specialist in the medical community, do you, Doctor?

A. No.

Q. Okay. Do you know why it is that Dr. Bianchi would be concerned enough to offer a patient a test three or four times but then when the patient leaves never put that in the chart until after he dies, not put it in his note?

MR. GROEDEL: Objection.

You may answer.

THE WITNESS: No.

BY MR. GREENE:

Q. As a matter of fact, when you or any of your associates have a similar situation, you're careful to put it in the chart, aren't you?

A. We all do our best to document as best we can.

Q. But you teach your residents and you teach your students that if a patient turns down a test that

you think is important and is going to leave the hospital, to put it in the chart?

A. Yes.

Q. That's acceptable standard practice, isn't it?

A. I think so.

Q. Okay. So why Dr. Bianchi chose to tell a story after the patient died he didn't tell when the patient was alive and leaving his ER room is something you're not going to testify about because you don't know the answer?

MR. GROEDEL: Objection.

THE WITNESS: Correct.

BY MR. GREENE:

Q. So whether Dr. Bianchi asked him one time casually and didn't fight him on it or whether he asked him three or four times is something you don't know?

A. Right. I -- I can only take him at his word and -- and what he's documented in the record and what he's sworn to in testimony. If he's -- if he's lying about it, I have no way of knowing that or no opinion. I mean, that's not -- I don't believe that to be the role of the expert to decide that,

Q. I agree. But when -- when Sonny Kinter went home and talked to his mother, who is a nurse, and the

mother testified that she had to explain to him what an EKG was in detail because he had no idea, would that tend to indicate that it was not explained to him by Dr. Bianchi if that's true?

MR. GROEDEL: Objection.

THE WITNESS: Well, I suppose if when he got home he had no idea what the test was, then by implication no one had explained it to him.

BY MR. GREENE:

Q. Okay. And part of the standard of care is to not only offer a patient a test but to explain to him why you want it in case he turns it down, explain to him why -- why you want to do it so he can make an informed assent or informed consent.

That's only fair, isn't it, Doctor?

A. I think we've been through this a number of times.

Q. Okay. Do you know how long Dr. Bianchi spent with this patient?

A. I -- my understanding was somewhere around fifteen, twenty minutes maybe.

Q. Do you know how much of that time was spent in discussing whether or not to do an EKG?

A. I certainly do not.

Q. Have you had patients turn down EKGs?

A, Yes.

Q. On how many occasions?

A. It happens.

Q. On how many occasions do you recall that happening?

A. I have no idea.

Q. How do you do with talking them into it?

A, I'm -- I bat close to a thousand.

Q. I mean, let's go through it because I -- I don't know.

It doesn't hurt, right?

A. Right.

Q. It's pretty quick?

A. Yes.

Q. And were you aware that this patient had been told by two separate people at Lakewood Hospital that they were going to pay the bill?

A. Yes.

MR. GREENE: Let's go off the Record for a second.

VIDEOGRAPHER: Time now is 2:33 p.m. We're off the Record.

(Discussion off the record.)

VIDEOGRAPHER: Time now is 2:34 p.m. We're back on the Record.

BY MR. GREENE:

Q. Dr. Falk, do you own a copy of Braunwald -- Braunwald Heart Book?

A. Yes, I do.

Q. How about Hurst's, The Heart, do you have a copy of that, too?

A. Yes.

Q. That's a standard, acceptable reference book in the area of the heart?

A. Yes.

Q. And your testimony is that variant angina is -- is uncommon, correct?

MR. GROEDEL: Generally or with a twenty-six-year-old?

MR. GREENE: We'll go into the age group.

MR. GROEDEL: Okay.

BY MR. GREENE:

Q. But it's uncommon?

A. Well, it's --

Q. It's not a tricky question. I mean, it says in Hurst's it's -- it's uncommon. I'm just --

A. Yeah.

Q. -- trying to move this along.

A. It's uncommon, and -- and you see it in young people especially when there are reasons to -- to

see it. Like, cocaine would be the most prevalent reason in our society that we see it.

Q. Okay. But we know he wasn't on coke --

A. Exactly.

Q. -- because he had been tested that very day for that.

A. Well, it makes it -- so my point is that it makes it even less likely that he would have this.

Q. But do you know if Dr. Bianchi ever had the result of that test in his hand?

A. Well, but I think that it was clear that he wasn't a cocaine freak,

Q. You can tell that by just talking to people?

A. Well --

Q. I mean, watching baseball players, I don't know that to be a fact.

A. Well, that's a whole different --

Q. All right.

A. -- issue.

Q. However, sudden death in variant angina patients is very common?

A. Well, in patients with established diagnoses of variant angina that have recurrent episodes of spasm it's not uncommon, yes.

Q. Okay.

A. But if you wanted -- but if -- but, you know, we don't know that he -- prospectively, we didn't know that he has that diagnosis, so if you want to take the incidents of sudden death in the population of young people that faint when they give blood, you know, it's like one in a million.

Q. Okay. Then add people who have multiple syncopal events with chest pain.

A. Well, first of all, he never passed out, so multiple near syncopal events.

Q. Well, near syncopal events with chest pain recurring, is that still one in a million, Doctor, and if it is, where is a study that tells me that?

A. Right. Well, there is no study, but it's -- it's clearly not common.

Q. And yet Dr. Kahn says every cardiologist has patients who have variant angina?

A. Yes.

Q. Okay. So it's nothing you've not heard about.

You even talked about it in your chapter?

A. Yes.

Q. The syncope, though, isn't the syncope -- isn't chest pain with syncope, doesn't that provide a clue that you may be involved with variant angina?

A. Well, you know, again, we've -- we've danced around this, you know, three or four times now, and I've stated --

MR. MOSCARINO: I'm sorry. Go ahead.

THE WITNESS: That's okay. You know, I've stated my opinion about it and --

BY MR. GREENE:

Q. Well, I'm going to Cross Examine you on it then, Doc, because in -- in Hurst's -- and I'll show it to you -- they talk about variant angina being uncommon and that the symptoms are not usually remarkable, but they say -- and tell me if I read this wrong -- syncope, presumably due to ischemia-induced ventricular arrythmia to the arterial ventricular block during -- during rest angina is a useful diagnostic tool, I think I messed that one word up, arterial.

A. Atrial.

Q. Atrial ventricular.

They do say that, don't they, useful tool, useful clue?

A. Yes. But again, you know, you -- you're taking that out of context, and if you're trying to apply that to this case, it -- it really doesn't apply because that -- what that implies is somebody is simply sitting there, develops chest pain and passes out, but

that's not at all what happened in this case.

What happened in this case is, the guy went to get blood drawn and nearly fainted, and then he went to have a bowel movement and nearly fainted again. And during those episodes, there was some issue of chest discomfort. That is a very different presentation to, a guy, for no apparent reason, is sitting there, develops chest pain and passes out.

Q. Do you know, Doctor, if he had the chest pain prior to passing out or had the chest pain when he awoke? Do you know that?

A. Well, A, he never passed out.

Q. Prior to getting --

A, But B, it's --

Q. That's the question. Do you know that?

A. It's -- it's not clear from the record.

Q. And it's not clear because there was not an adequate history taken, right?

MR. GROEDEL: Objection.

THE WITNESS: Well, but we do know that the two precipitating events to his episodes were the blood drawing and the squeezing at stool. That is clear from the record.,

BY MR. GREENE:

Q. Okay. When he had the chest pain squeezing

the stool, did he have it prior to feeling faint or after he felt faint?

A. I don't know.

Q. It wasn't asked, right? It wasn't asked?

A. Right.

Q. It wasn't answered, right?

A. That's correct.

Q. Okay. Did he have -- did he have chest pain for fifteen, twenty minutes after he no longer was dizzy? Do you know that?

A. I -- I don't know for sure.

Q. It wasn't asked, was it?

A. Correct.

Q. Doctor, as far as how rare -- you're not testifying that variant angina or Prinzmetal's angina in an unheard of phenomena, are you?

A. Obviously it's not unheard of since we've all heard of it.

Q. Have you read studies on variant angina?

A, Yes.

Q. Did you read any in preparation for this deposition?

A. Actually, I just read this -- just that case report and review of the literature that I found very quickly a few days ago.

Q. Okay. I wonder if I could take a look at it.

A. Sure (tenders document to Counsel).

MR. GREEN: Can we go off the Record, please?

VIDEOGRAPHER: The time now is 2:40 p.m., and we're off the Record.

(Discussion off the record.)

VIDEOGRAPHER: The time now 2:41 p.m. We're back on the Record.

BY MR. GREENE:

Q. Doctor, you -- you looked at an article that appeared -- I don't know if I've got the publication here or not. I just have your library name, but you read it.

And am I right in saying that your article says there's an excellent long-term outcome of treated VAP, variant angina, with eighty to -- eighty-nine to ninety percent overall survival at five years?

A. Yes.

Q. Okay. Did you read the study from the Cleveland Clinic where they had a hundred and one variant angina patients, the youngest being twenty years old?

A. No.

Q. Would you like to read it?

A. Yes, if I see it.

Q. Okay, I'll -- I'll leave you with it because you're going to testify at trial. I thought you'd be interested in seeing it.

A. Thank you.

Q. Okay. Do you know we've had two high school football players die of heart attacks in Cleveland in the last couple of weeks? Would that be a rare event?

A. Are you sure they died --

MR. GROEDEL: Objection.

THE WITNESS: I'm not sure I know what YOU mean by a heart attack, but okay.

BY MR. GREENE:

Q. They died of heart-related reasons.

A. Well, that's not -- that is rare, yes. I mean, if you -- if you look at the number of high school football players there are and -- and the number that drop dead, it's very small, but it happens. It happens to lots of athletes.

Q. Your criticism in Macelvy of Dr. Hammond was, quote, Dr. Hammond, in my view, clearly did not ask the appropriate questions, and I think her written chart does not reflect a thoughtful history.

Do you recall saying that?

A. Yes.

Q. Does Sonny's chart reveal a thoughtful history of his chest pain?

A. No. It reveals a thoughtful history of the episodes with the chest pain being minimized in the -- in the record as a -- as --

Q. Actually, the only thing he says about the chest pain at all is that he had some?

A. Right, Exactly. So the implication being that in his discussion with the patient, that -- that that was not a significant, prominent feature of the episode would be how I would read that.

a. And you -- in his discussion with the patient, did he ask the patient how severe the pain was?

A, Well, again, we've discussed --

Q. He didn't ask him any --

A. -- this and that we don't know the --

Q. -- any question --

A. I don't know the answer to those questions.

Q. He didn't ask him, as far as you know by the chart and by his deposition testimony, he didn't ask him any of those questions that you consider important to ask in chest pain patients?

MR. GROEDEL: Objection --

THE WITNESS: Right.

MR. GROEDEL: -- with respect to your reference to the deposition.

BY MR. GREENED:

Q. You did read his deposition, did you not?

A. Yes, I did.

Q. Okay.

MR. GROEDEL: We're just not sure that your history was the same history that he took.

BY MR. GREENE:

Q. How long -- now, Doctor, do you think retrospectively that this patient had two different disorders? Do you think he had vasovagal syncope and just happened to have Prinzmetal's angina at the same time and the two are not related? Is that what you think?

A. No. I think in retrospect that the likelihood is that his -- that he did have a vasovagal episode and that, in retrospect, I think that he probably associated with that vasovagal episode had some coronary spasm. That's how I would interpret that.

Q. so I -- so I am clear as to terms, do you think that the reason for his faints had to do with his coronary spasm?

A. No.

Q. Okay. So you think he had -- he had two vasovagal episodes and just happened to have Prinzmetal's angina and die at the same time, but they're not related? That's what I was asking.

A. No, that's --

Q. You think that's unrelated?

A. That isn't what I said. I --

Q. How is the spasm related to the near faints?

A, I think that it was precipitated by those episodes. If you -- you know, if you look at the -- the pathophysiology of what can precipitate spasm, one of the -- the well known causes is hyperventilation. In fact, there's a thing called the hyperventilation test, which in this article is -- is more specific than ergonovine testing for -- for coronary artery spasm.

So patients that -- that hyperventilate and have -- happen to have Prinzmetal's angina as an underlying thing can precipitate an episode, And that would be my -- my hypothesis would be that he had this vasovagal reaction to the blood drawing and then the bowel movement. During those episodes, he hyperventilated, which causes the tingling in his arms and precipitated these episodes of spasm.

Q. Would it also cause his chest pain?

A. Well, the spasm would have caused the chest pain then, I suppose, yes.

Q. All right. Doctor, you've written that when anybody comes in with acute chest pain, the possibility of acute myocardial ischemia must always be considered?

A. Yes.

Q. And you also wrote that patients complaining of -- of acute chest pain should -- shall be triaged, correct?

A. Shall be what?

Q. Triaged,

A. Triaged.

Q. Triaged, Excuse my pronunciation. Triaged.

A. Yes.

Q. Okay. And you've also written that basically any adult that has chest pain needs a chest x-ray and an EKG?

A. In general I would agree with that.

Q. Did he get a chest x-ray?

A. No.

Q. Did he get an EKG?

A. No.

Q. You've also written in the Macelvy case and you testified the amount of history I can get from the chart is clearly inadequate.

Did you write -- did you say that in the Macelvy case?

A. I might have, I don't have the deposition in front of me, as you do. I'm -- if -- if you've written it down, then I assume that that would be something I said. It sounds like something I would say.

MR. GREENE: Okay. Let's go off the Record for a minute.

VIDEOGRAPHER: The time now is 2:47 p.m., and we're off the Record.

(Discussion off the record.)

VIDEOGRAPHER: The time is 2:48 p.m. We're back on the Record.

BY MR. GREENE:

Q. Doctor, assuming that Dr. Bianchi had -- had the patient stick around awhile, was observed, and the patient had chest pain while under the observation period. Let's say the patient even had his cardiac arrest while under the Observation period,

To a reasonable probability, he would have been resuscitated in the hospital, correct, successfully?

A. Yes.

Q. He would probably have no heart damage?

A. Well, that's a little bit more difficult to -- to know, but he -- he may not have.

Q. Well, in the Macelvy case, she had unstable angina, and you felt if she was resuscitated from a heart attack, she wouldn't have any heart damage.

Why would he be any different?

A. I -- 1 don't believe that's what I would have said in the Macelvy case. If you can find that for me. That she'd have no heart damage I think would be a little bit over stated. If --

MR. GREENE: Let's go off the Record and I'll look for it, see if I'm right. If I'm wrong, I apologize.

THE WITNESS: Just keep in mind that I don't review the Annals of Internal Medicine.

BY MR. GREENE:

Q. Doctor, yes, I said Annals of Internal Medicine. And I think you look at six or seven publications, and one of them is not the Annals of Internal Medicine --

A. Correct.

Q. __ although as I recall, you are board certified in intern medicine as well?

A. Yes, I am.

Q. So that might have been something that you

would look at. At any rate, I think I -- I'm reading this right. So I think that, yeah, the overwhelming probability is if you had unstable angina and you're admitted to a coronary care unit, the overwhelming probability -- probability is that you will survive, but whether you will survive without any muscle damage or some muscle damage depends on a wide variety of factors, which you talked about. At the bottom of the page, you said, I think it's very unlikely she would have had any muscle damage or any cardiac arrest.

A. Well, that isn't the question you asked me. The question you asked me was that if he had a cardiac arrest and was -- was resuscitated, would he have no heart damage, and I said I don't know about no heart damage. And you said, well, I testified in this case that if somebody arrested and was resuscitated they would have no heart damage, and that is clearly not what I said.

Q. You said if someone has unstable angina and has -- and is in the coronary care unit, the overwhelming probability is you will survive, and I read you --

A. Right.

Q. -- the first part because you were talking about surviving a heart attack.

A. But that wasn't the question you asked me. You asked me would there be any heart muscle damage, and that isn't what we're talking about in -- in those two patients.

Q. So you found this unstable angina patient we were talking about having a heart attack and not having any damage because their -- their heart is -- let's say myocardial infarct. Let's say a sudden cardiac death. Cardiac arrythmia stops your heart.

How long does it have to be stopped before there is muscle damage?

A, It's very hard to know.

Q. Okay.

A. It depends on the coronary anatomy, the quality and timing of the resuscitation. These patients -- these patients often will bump their enzymes, and clearly they've had some muscle damage once they've arrested,

Q. Okay.

A. How much is very variable,

Q. What was the reason -- YOU do -- you -- you have testified that if Mr. Kinter had had a cardiac arrest, he would have been resuscitated if he was in the hospital successfully, correct?

A. I think that that's more likely than not.

Q. And do you know what the clinical outcome of these patients are that are treated medically?

A. Well, those -- those data don't really speak to the people who have arrested. They're -- they're talking about the whole population of people who are treated. And I've conceded and you've established that in general, this disease carries a very benign prognosis in long-term survival, and I agree with that.

Q. Once it's identified? Once it's identified?

A. Yes.

MR. GREENE: Okay. Off the Record for a second.

VIDEOGRAPHER: Time now is 2:52 p.m. We're off the Record.

(Discussion off the record.)

VIDEOGRAPHER: Time is 2:52 p.m. We're back on the Record.

BY MR. GREENE:

Q. Doctor, do you have any opinion of what the myocardial necrosis that Dr. Factor found that was at least four to six hours old was from?

A. Well, can I -- can I just look at his report for a moment?

Q. Yeah.

MR. GREENE: Let's go off the Record while

the doctor reads the report.

VIDEOGRAPHER: The time is 2:53 p.m. We're off the Record.

(Discussion off the record.)

VIDEOGRAPHER: Time now is 2:54 p.m. We're back on the Record.

BY MR. GREENE:

Q. Dr. Factor finds evidence of myocardial necrosis at least four to six hours old.

Do you know what that represents?

A. Do I know what it represents?

Q. Yes. How did he get it?

A. Well, yes, I -- I think that it's from diffuse coronary spasm because it's -- it's small areas throughout both the right and the left ventricle, so it -- it involves a -- a widely distributed geographic area, but it's not like a transmural myocardial infarction where it's localized and very severe in one spot. It's more diffuse, And there's fibrosis throughout also, which to me indicates that this probably has happened before.

Q. In -- in lieu of that, accepting that as being correct, is it still your opinion that an EKG taken in the emergency room by Dr. Bianchi would have been negative?

A. Yes.

Q. Okay.

A. Yes, because, you know, the -- the -- this -- the EKG is very good at picking up injury pattern and ischemia, especially when it's localized to certain sections of the heart, like the anterior wall, the posterior wall. But this implies to me that this is very diffuse but not -- not uniform in its distribution.

So, you know, I think that it's -- it's unlikely that you're going to see that on -- on an EKG, and especially during the time when he's pain free, which is when Dr. Bianchi would have had the opportunity to -- to take the EKG is when he already didn't have any pain.

Q. Do you know if the -- there would have been any abnormalities at all?

Are -- are you saying the EKG would have been entirely normal?

A. I think that's the most likely outcome.

Q. And as soon as he has symptoms, then it would be abnormal if taken while he was symptomatic, to a probability?

A. Well, again, the classic discussion about variant angina is that during episodes of pain, most of

the time that's how you make the diagnosis. There is ST elevation during the pain which goes away --

Q. so --

A. -- excuse me, when there's no pain. But there is a subset of patients -- there are a subset of patients --

Q. Right.

A. -- with variant angina that have pain and no EKG changes, but usually --

Q. Where is --

A. -- they tend to have them.

Q. There is a huge subset of patients that have EKG changes while not having pain with variant angina, isn't there?

A. I -- I think that's not common, no.

Q. Okay. Well, we'll get to that.

A. That's not my understanding.

Q. I'll have to pull a study out I have, because I think it says opposite, but I'll -- I'll do that just prior to the -- to the deposition ending so we can keep -- we can go along,

So are you saying if the triage nurse had put an EKG on him when he was complaining of pain in the emergency room when he first came in, it likely would have been positive?

MR. MOSCARINO: I'll object to that's what the triage nurse is saying the patient had at the time because that's -- that's inconsistent with her deposition testimony.

MR. GREENE: Well, it's very consistent. She testified what she wrote.

BY MR. GREENE:

Q. Assuming -- assuming that Mr. Kinter had pain while he was being examined in the ER room by the nurse and that she did an EKG on him while he was in pain, it likely would have been positive, according to your testimony.

Fair to say?

A. Well, I --

MR. MOSCARINO: Objection to the according to her testimony, because her testimony is that he was feeling better and he wanted to go home.

MR. GROEDEL: I'll join in the objection.

You can answer.

MR. GREENE: I'll -- I'll rephrase it, George.

BY MR. GREENE:

Q. Assuming that the nurse's note is correct -- and I'll read you the note. The note reads, complains of -- of some chest discomfort and numbness, and then

puts the time down as 4:31, and tingling in -- in both arms.

There, if that's true, he's symptomatic right in the emergency room, correct?

A, If -- if that's what that means. If he's symptomatic -- I think your question is, if he was symptomatic, indeed, when he walked into triage and she would have slapped a twelve-lead EKG on him immediately at that time, would it have been positive --

Q. No, that's not what I'm asking.

A. Oh, okay.

Q. I'm not talking about slapping it on. I'm saying doing it while he's in pain, because your -- your testimony is, while he's in pain and having the numbness and the tingling, if he has an EKG done at that time, it's likely positive,

A. Well, it's much more likely that it would be positive than when his symptoms resolve. There -- there are a subset of patients in whom it would not be positive, as we've just discussed.

Q. More probable than not?

A. Yes, I think more likely than not --

Q. Okay.

A. -- it would have been.

Q. Do you know what the hospital protocol is

for chest pain patients having EKGs? Did you read the hospital protocol?

A. I think in general, most hospitals, it's very similar, that the -- that the nurses triage them with a high priority to get back to a room and that the nurses in general will be allowed to go ahead and get electrocardiograms on patients they feel it's indicated in.

Q. Now, you also write in your article that one of the causes of chest pain is anxiety.

Do you recall that?

A. Yes.

Q. So when Mr. Kinter went home and asked his mother -- let's assume he asked his -- his mother, the doctor told me I'm too young to have a heart attack, that's not true, though,

He's not too young to have a heart attack, is he?

A. Well, I think the -- he's -- no, he's not too young to have a heart attack, but the -- the number -- heart attacks in general, when people say a heart attack, what they're referring to is a myocardial infarction resulting from coronary artery disease. And I think that although it's -- it's -- you know, twenty-six, it can happen, it's very, very unusual to

see acute myocardial infarctions from coronary artery disease in twenty-six-year-olds.

You can get it from vasculitis. You can get it from a -- a myocardial band that traps a coronary vessel. You can get it from Prinzmetal's. These are all very rare events.

Q. But he's not too young to have a cardiac event. That advice he's too young to have a cardiac event isn't true?

MR. GROEDEL: Objection.

BY MR. GREENE:

Q. You can be that age and -- and have a cardiac event?

A. Well, now you just changed the question from heart attack to cardiac event.

Q. Well, you -- you've educated me that there are various ways to get a cardiac event that don't have anything to do with arterial sclerotic blockages; for example, spasm.

He's not too young for that, is he, Doctor?

A. No.

Q. But his mother indicating to him that maybe it's anxiety is a good guess.

It's a possibility, right?

A. Well, people with what we call panic attacks

all -- also do get chest discomfort, which is what I was saying before in relation to a guy who is upset about nearly passing out and over breathing, and they get this discomfort. And people with panic attacks get that discomfort as well, yes.

Q. Doctor, the chapter that comes right after yours in the Tintinalli book is on syncope, by Dr. Wilson.

Do you know Dr. Wilson, Andrew Wilson?

A. Let me -- let me just take a look at his name for a second.

Q. Sure (tenders document to the Witness).

A. Actually, I do -- I do not know him.

Q. Okay. That's -- you wrote the prior chapter on chest pain?, correct?

A. Yes.

Q. Do you have anywhere in your chapter where you relate chest pain to syncope?

A. No.

Q. Is there anywhere in the syncope chapter where it says that syncope can appear with chest pain?

A. I don't know. I haven't read that chapter,

Q. Please take a look (tenders document to Witness).

A. I'm sorry, what was your question?

Q. Is there anywhere in the syncope chapter where it discusses chest pain being a feature of syncope?

A. Well, I'd have to read the whole chapter to answer that question. I -- I don't know the answer to your question.

a. Well, you're reading it now,

A. Well, I think I'm looking it over,

MR. GROEDEL: Come on.

MR. GREENE: It's a short chapter. It's a couple of pages.

MR. GROEDEL: No, No.

MR. GREENE: Well, let's go off the Record and I'll read it to him.

MR. GROEDEL: No, no, no, no. We're not doing that. Come on. I mean --

NR. GREENE: I'm going to be --

MR. GROEDEL: -- do you want to point something out to him in there?

MR. GREENE: Well, there's nothing in there about syncope.

MR. GROEDEL: Well, if you want to make that representation to him -- I mean, we're not going to sit here and read book chapters --

MR. GREENE: Okay.

MR. GROEDEL: __ for you, Bill. Come on. That's ridiculous.

MR. GREENE: Okay. I agree. Let's go back on the Record. Are we on the Record?

VIDEOGRAPHER: We're on the Record.

BY MR. GREENE:

Q. All right. Well, Doctor, in your cursory check of this, did you see anything there about chest pain and syncope?

A. It's a very cursory check. No, I don't.

Q. Okay. And yet syncope with angina -- syncope with angina is a feature of Prinzmetal's angina, having syncope, is it not?

A. Yes, Again, we've -- we've, I think, been through this --

Q. Okay.

A. -- that if you're sitting there and you develop chest pain and then pass out, then that is very suggestive that the myocardial ischemia created the -- the problem.

Q. Let me hand you an article from the American Journal of Cardiology (tenders document to the Witness).

Are you familiar with that journal at all?

A. Yes.

Q. All right. This is from the Cleveland Clinic, Department of Cardiology, where they have thirty patients with angina with normal coronary arteries. Okay. You're -- you're welcome to editorialize if I'm not reading this right. It starts off by saying cardiologists commonly encounter patients with angina-like chest pains and normal or near normal coronary arteriograms,

A. Okay.

Q. That would be our patient here, would it not?

A. Well, that -- that could be patients with variant angina, but it could also be patients that have non-cardiac causes of their chest pain as well,

Q. Of these patients, these thirty patients, how many had -- these are all patients with chest pain and normal coronary arteries.

How many of them had syncope with their angina?

A. I don't know. I've never seen that article.

Q. Well, the article, I'm going to point to you in table one, ten patients.

Am I reading that correctly, Doctor, syncope with angina, ten patients?

MR. GROEDEL: Objection.

You can answer.

BY MR. GREENE:

Q. A third of the population?

A. Right.

Q. And the age group of this population was as young -- let me give you the age group. There were people in this age group as young as thirty. Actually, it ranges from thirty-six to sixty-five. The age of patient at the onset of symptoms ranges from thirty-six to sixty-five.

Am I reading that correctly?

MR. GROEDEL: Objection.

You can answer.

THE WITNESS: Do we really need my expertise to know if you're reading it correctly?

BY MR. GREENE:

Q. Well, I want the jury to know that I'm not misrepresenting it.

A. Yes, those patients were the age you're saying.

Q. Okay. Can you give me another test where they have people with vasovagal -- with what you say this patient had, vasovagal syncope with chest pain, what percentage of people who have vasovagal syncope present with chest pain, any studies do you know of?

A. No.

Q. Between now and trial,,would you look so you can tell the jury?

MR. GROEDEL: Objection,

No, Bill, we're -- we're not going to do your research for you.

MR. GREENE: You won't research that?

MR. GROEDEL: Well,,if we do,,it will be between myself and Dr. Falk.

MR. GREENE: Okay. I just want to go on the Record that I'm asking you, because I'm going to ask you at trial, did you check and see any studies of vasovagal syncope where they have chest pain as a feature.

And you don't have to look if you don't want to, but I'm going to ask you the question, and I want the jury to know that.

MR. GROEDEL: Could we have a copy of that article you presented him with?

MR. GREENE: Sure. Could we go off the Record?

VIDEOGRAPHER: The time now is 3:07 p.m., and we're off the Record.

(Discussion off the record.)

VIDEOGRAPHER: The time now is 3:08 p.m.,

and we're back on the Record.

BY MR. GREENE:

Q. Doctor, I -- I referenced a Cleveland Clinic study a little earlier, and I said I would bring it out, so I'm going to bring it out. This is a study that appeared in the Journal -- American Journal of Cardiology.

Is that a journal that you're familiar with?

A. Yes.

Q. Okay. There they had a group of forty-three patients with variant angina -- angina with normal coronary arteries and sixty-five patients who had abnormal coronary arteries, defined as more than fifty percent stenosis in the arteries. And the only thing I -- the only point I was -- was making, Cleveland, Ohio, we have a hundred and eight patients with variant angina.

It's not that rare a syndrome, is it?

MR. GROEDEL: Objection.

THE WITNESS: Well, it's -- Cleveland is a big town. A hundred and eight patients is a small percentage of the population. But we've already established that it's not rare, but it's not terribly common, especially in

twenty-six-year-olds.

BY MR. GREENE:

Q. Well, there's a spectrum of patients who are in their twenties and thirties?

A. Yeah. It happens.

Q. Okay. And it happens enough that you actually had it in your article?

A. Well, sure.

MR. GREENE: Okay. Off the Record. I may be done. Let me just see.

THE WITNESS: May I see that article for a moment while you're looking at that?

MR. GREENE: I'll get it. I'll let you snake a copy of it.

THE WITNESS: I'd just like to see it right now for a minute.

MR. GREENE: Okay.

VIDEOGRAPHER: The time is 3:12 p.m. We're off the Record.

(Discussion off the record.)

VIDEOGRAPHER: The time now is 3:14 p.m. We're back on the Record.

BY MR. GREENE:

Q. In your report, you state, there is an implication that Mr. Kinter felt he had no health

insurance coverage and feared a large bill for tests he felt were not needed.

Where did you get that from?

A. I got it from some of the deposition testimony. I can't remember exactly which person. I believe that's where that came from.

Q. But actually the deposition testimony, and we talked about it earlier, was that he was told by two different people that the bill was being paid by Lakewood Hospital?

A. Right, that -- but that he was concerned about it and that they tried to reassure him.

Q. How long does it take to do an EKG?

A. Five minutes.

Q. You write that -- and I started your deposition off with this -- you write that you believed -- believe a prudent emergency physician would have wanted to have the EKG done, correct?

A. Yes.

Q. And you write if that, indeed, was the case and the patient refused, then Dr. Bianchi did not fall below the standard of care in not having been able to convince the patient to have one performed.

You wrote that, too, didn't you?

A. Yes.

Q. If Dr. Bianchi did not make an adequate, good faith effort to get the patient to get this heart test, this EKG, that would have been beneath the standard of care?

A. Yes.

Q. Now, Dr. Bianchi has testified that he was called the next day and that he was part of a conference call, he believed, with his superior, the man that -- that runs the emergency medicine group that he belongs to, and the hospital president, chief executive officer, Dr. Prime, I believe his name was.

Do you recall that?

A. Yes.

Q. And that he was asked if he was aware that the patient he had seen the night before had died of a cardiac arrest at another hospital.

Do you recall the substance of that also?

A. Yes.

Q. And that he was asked, because they -- they could see from his tests that he didn't order an EKG, he was asked if he ordered an EKG or not,

Do you recall that?

A. Yes.

Q. And then he went down to the hospital on his day off and made another note, a note discussing

conversations with the -- with the patient about EKG on three or four different occasions and the patient turning it down,

You're familiar with that testimony?

A. Yes.

Q. And that he wrote about conversations and about turning down -- down tests that he wrote no where in his original note,

A. Yes.

Q. You're familiar with that?

A. Um-hum.

Q. You're also familiar that a nurse, the discharge nurse, also came in that day, after Dr. Bianchi came in, and wrote another note after the patient had already died discussing how the patient was fine when he left.

Are you familiar with that?

A. Yes.

Q. Does any of that trouble you?

MR. GROEDEL: Objection.

You can answer.

MR. MOSCARINO: Object to the form.

THE WITNESS: No.

MR. GREENE: No? Thank you. I don't have any further questions.

COURT REPORTER: I'm sorry, I didn't hear the answer.

MR. GREENE: The answer is no. And I don't have any further questions.

MR. MOSCARINO: I have a couple of questions --

MR. GROEDEL: Okay.

MR. MOSCARINO: -- very briefly.

(Discussion off the record.)

MR. MOSCWRINO: Dr. Falk, real briefly, my name is George Moscarino. We met Just before the deposition, I represent Lakewood Hospital,

CROSS EXAMINATION

BY MR. MOSCARINO:

Q. In your three-page report, there's no criticisms of the hospital personnel, that being the nursing staff; is that right?

A, Correct.

Q. When we go to trial of this case, then you will not be issuing any opinions that the nursing staff was below the standard of care; is that correct'?

A. That's correct.

(Discussion off the record.)

BY MR. MOSCARINO:

Q. So you agree with the Plaintiff's expert,

Dr. Unger, when he testified just a few weeks ago that the nursing staff complied with the standard of care, correct?

A. Yes.

MR. MOSCARINO: Okay, Thanks.

VIDEOGRAPHER: The time now is 3:17 p.m. We're off the Record. This concludes the video deposition.

(Deposition concluded at 3:17 p.m.)

CERTIFICATE OF OATH

STATE OF FLORIDA)

COUNTY OF ORANGE)

I, REBECCA L. FELLA, being a Notary Public, State of Florida at Large, do hereby certify that JAY FALK, M.D., personally appeared before me and was duly sworn.

Witness my hand and official seal this 27th day of November, 2000.

Rebecca Fella

Court Reporter
Notary Public, State of FL
Notary Comm. No. CC-968031
Comm, Expires: 10/01/04

C E R T I F I C A T E

STATE OF FLORIDA)
COUNTY OF ORANGE)

I, REBECCA L. FELLA, certify that I was authorized to and did stenographically report the foregoing proceedings, that a review of the transcript was requested, and that the transcript is a true and complete record of my stenographic notes,

I further certify that I am not a relative, employee, or attorney, or counsel of any of the parties, nor am I a relative or employee or any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

DATED this 27th day of November, 2000,

Rebecca Fella
REBECCA L. FELLA

Accurate Orlando Reporters
105 E. Robinson Street, Suite 300
Orlando, Florida 32801
(407) 246-0046 Fax (407) 246-8084

November 27, 2000

Marc W. Groedel, Esquire
Reminger & Reminger ***Co., LPA***
113 St. Clair Avenue
Cleveland, Ohio 44114

IN RE: Kinter vs. Bianchi
Deposition of Jay Falk, M.D.

Dear Mr. Groedel,

Enclosed please find your copy of the deposition of Jay Falk, M.D., which was taken in the above-styled cause on November 15, 2000. Also attached is the Errata Sheet to be completed by the deponent when reading your copy of the deposition.

After the witness has completed these forms, please return them to our office for inclusion in the original transcript.

If the reading and signing has not been completed prior to December 27, 2000, we shall conclude that the reading and signing of the transcript has been waived and we will forward the original transcript to the ordering attorney without further notice.

Your prompt attention to this matter is appreciated.

Sincerely,

Rebecca Fella

Rebecca L. Fella

E R R A T A S H E E T

DO NOT WRITE ON TRANSCRIPT - ENTER CHANGES HERE

IN RE: Kinter vs. Bianchi

Page	Line	Correction	Reason

Under penalties of perjury, I declare that I have read my deposition in this matter taken on November 15, 2000, and that it is true and correct, subject to any changes in form or substance entered above.

DATE

JAY FALK, M.D.