THE STATE OF OHIO,)
) SS: JAMES R. WILLIAMS, J.
COUNTY OF SUMMIT.)

IN THE COURT OF COMMON PLEAS

JENNIFER M. JACOB, INDIVIDUALLY AND AS EXECUTRIX OF THE ESTATE OF AMY A. STANLEY,	)	
Plaintiffs,	)	
v.	)	Case No. CV 95 051742
AKRON CITY HOSPITAL, et al.,	)	
Defendants.	)	

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Videotaped deposition of UGO GALLO, M.D., taken by the Plaintiffs as if upon cross-examination before Angela R. Zanghi, a Stenographic Reporter and Notary Public within and for the State of Ohio, at the law offices of Buckingham, Doolittle & Burroughs, 50 South Main Street, Akron, Ohio, on Monday, the 29th day of January, 1996 commencing at 10:00 a.m., pursuant to notice and agreement of counsel.

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that this deposition may be taken in stenotypy by Angela R. Zanghi, that her stenotype notes may be subsequently transcribed in the absence of the witness; and that all requirements of the Ohio Rules of Civil Procedure with regard to notice of time and place of taking this deposition are waived.

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I N D E X

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UGO E. GALLO, M.D.,

a Defendant herein, called by the Plaintiffs for the purpose of cross-examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposes and says as follows:

MR. CZACK: Let the record reflect this is the videotaped discovery deposition of Dr. -- Is it pronounced Ugo --

THE WITNESS: Correct.

MR. CZACK: -- Gallo, a Defendant in the case of Jennifer Jacob, Executrix, versus Akron City Hospital. This deposition's being taken by notice.

CROSS-EXAMINATION

BY MR. CZACK:

Q. Doctor, would you give the Court Reporter your full name and spell your last name.

A. Ugo Enesto Gallo, G-a-1-1-0.

Q. And what's your current business address, Doctor?

A. 525 East Market Street, Akron, Ohio, Department of Emergency Medicine, I believe it to be the City Campus. It previously was on both campuses.

Q. Okay. What's your date of birth, Doctor?

A. 10/31/1959.
Q. Doctor, I represent the Estate of Amy Stanley. I'm going to be asking you some questions here today.

A couple of rules I want to establish right now so that everybody is clear. It's important you answer out loud so that the Court Reporter can take down what your response is. Okay?
A. Okay.
Q. If you don't understand the question I ask, tell me that so I can repeat it and make it clear for you. Fair enough?
A. Fair.
Q. If you don't know an answer to a question, don't feel you have to answer every single question. If you don't know, feel free to explain why you don't know of just the fact that you do not know the answer. Okay?
A. Okay.
Q. If there -- At any time during the deposition you feel like there's something you want to change or add to a previous answer that you gave, feel free to stop me, we can go back and talk about that area. All right?
A. Yes.
Q. Now, have you ever been deposed before?

A. Yes.
Q. How many occasions?
A. Two prior.
Q. All right. Do you recall approximately the time that those depositions were taken, what year?
MR. SCHOBERT: To the best of your knowledge. Let me have a line of objection to anything that may refer to any previous litigation if he was involved. If that's okay, Mike.
MR. CZACK: That's fine.
MR. STRONG: All right. Go ahead. To the best of your knowledge, Doctor, just tell him what you remember.
A. I think in 1993 and December of 1995.
Q. (BY MR. CZACK) December of '95?
A. Correct.
Q. Okay, Were you defendants in those cases or were you a witness?
A. First one I'm not sure what I was classified as.
MR. SCHOBERT: I think you were actually a witness. That's my recollection.
A. Then I was defendant.
Q. (BY MR. CZACK) The one in December of '95 you are a

defendant?
A. Right.
Q. Do you recall is that case here in Summit County, filed in Summit County?
A. Yes.
Q. Does it relate to your services at Akron City Hospital?
A. Yes.
Q. Doctor, what did you review in preparation for your deposition today?
A. The medical records.
Q. Okay. That would be the December 6th, 1993 Emergency Room admission of Amy Stanley?
A. The visit that Dr. -- December, yeah, 26th, 1993.
Q. Okay. Have you reviewed any other medical records in this case or regarding Amy Stanley?
A. Just briefly reviewed the subsequent visit with Jeff.
Q. Okay. The one where she came in two days later, December 8th of '93?
A. Correct.
Q. All right. Did you look at the death certificate and autopsy?
A. Yes.
Q. All right. Anything else you've looked at other

than what you've told me here today in terms of medical records?

A. No.

Q. Are there any other papers, or records, reports, or summaries that you've reviewed in preparation for this deposition today?

MR. SCHOBERT: I'm going to object to the extent of any work product information I have presented to him. Doctor, is there any -- other than medical records and anything that I have provided to you, is there anything else you've reviewed?

A. No.

Q. (BY MR. CZACK) Okay. You have -- And I don't want you to tell me what it is -- You have looked at something, though, that Mr. Schobert has provided you?

A. That's correct.

Q. All right. Did you review any periodicals, or treatises, or medical books in preparation for this deposition?

A. No.

Q. Doctor, are you married or single?

A. Married.

Q. All right. Tell me about your educational

background.

A. Starting from college?

Q. College, sure.

A. Went to Ohio Northern University September of 1977 and graduated in July of 1982 with a Bachelor of Science in Chemistry. In August of that same year I had a Bachelor of Science in Pharmacy. Then matriculated to The University of Cincinnati College of Medicine. Graduated in June of 1986. Started my residency in emergency medicine at Akron City Hospital and completed that training in 1989 and was asked to stay on as teaching staff at Akron City Hospital.

Q. That would have been in 1989?

A. Correct. July lst, 1989.

Q. We have -- Mr. Schobert has provided us with a copy of your CV. There's -- It's a three-page document, is that correct, Doctor?

A. Correct.

Q. Okay. Is this CV current in terms of appointments, trainings, certifications, or is there anything you feel that you want to add to this orally here today?

MR. SCHOBERT: Take a moment, as we explained it may have been a couple of years old. It's my mistake.

A. I do have -- Let's see. Let's go page by page. How's that? I am now as far as current appointments, I'm an associate professor of emergency medicine. I guess as attending physician Department of Emergency Medicine would be SUMMA Health System would be correct, both campuses, City Hospital and St. Thomas.

Q. (BY MR. CZACK) Okay.

A. I am Board Certified. It was December, I don't remember what year, if it was '93. I don't really recall.

Q. Your Board certification?

A. Board Certified.

Q. Okay.

A. I'm no longer on the Trauma Committee as of January -- January 1995. I am presently, though, on the Respiratory Committee at the hospital.

Q. Akron City or both?

A. SUMMA Health Systems.

Q. Okay.

A. I guess it's no longer called Summit County Medical Society. It's now called, I guess, Greater Akron Medical an -- I don't know the exact name. It was changed. And I am no longer a member of the American Medical Association.

Q. Doctor, can you find out for me when your -- you became Board Certified and let Mr. Schobert know?

A. Yes.

MR. CZACK: Can you mark this as Plaintiffs' Exhibit No. 2, please, for the record.

(Plaintiffs' Deposition Exhibit 2 marked for identification.)

MR. SCHOBERT: Is there anything else while she's doing that?

Q. (BY MR. CZACK) One second. You got to wait until she's ready.

A. Sorry. I've given lectures at other hospitals, national lectures that aren't on here. I could get you those dates. I thought this would be my -- This is actually my very first CV. The second one I thought was on file. This is not it.

Q. Okay. You have another CV that you have on file?

A. Yes. It would be with Dr. Wilson, our department chairman.

Q. Okay.

A. Again, that's like at best two-years old.

Q. Okay. Could you get me that one that would have some of these --

A. Lectures and that?

Q. Correct.
A. Sure, I'd be glad to.
Q. Who are you current employed with, Doctor?
A. Excuse me, Mr. Czack. I don't mean to interrupt you. It says on the fax six, I guess, pages. Six. So I guess maybe it didn't all come over.
Q. Okay.

MR. SCHOBERT: We will provide you, Mike, with anything and if there's any follow-up questions maybe we can do it by written form. If nothing else, I mean, I think he has given you the essence of this -- You've given him where you've been professionally, your professional education and all that?

THE WITNESS: Correct.

MR. SCHOBERT: So any additional materials might be lectures and that type of thing?

THE WITNESS: Correct.

MR. CZACK: That's fine.

MR. SCHOBERT: I'll provide that to you. If there is a problem let me know.

MR. CZACK: Lectures, you know, publishings, and then that date that we

talked about. Okay?

MR. SCHOBERT: We'll get that for you.

Q. (BY MR. CZACK) You're currently employed where, Doctor, or who are you employed by?

A. SUMMA Emergency Associates.

Q. And how long have you been employed by SUMMA Emergency Associates?

A. That's a new entity as of January of this year.

Q. As of January of '96?

A. Correct.

Q. All right. Who were you employed by prior to January of '96?

A. Akron Emergency Physicians Associates, Inc.

Q. And how long were you employed by them?

A. Since July 1, 1989.

Q. And that's who you were employed by when you rendered treatment to Amy Stanley in this case, correct?

A. That's correct.

Q. Are you a partner or were you a partner of Akron Emergency Physicians, or a shareholder?

MR. SCHOBERT: In 1993?

MR. CZACK: 1993.

A. I had voting shares.

Q. (BY MR. CZACK) All right. You had that in 1993?

A. Correct.
Q. Now, in 1993 Akron Emergency Physicians Associates, part of that group -- or that group staffed the Emergency Room Department at Akron City, is that correct?
A. That's correct.
Q. Did any other entity, or corporation, or group provide Emergency Room physicians to Akron City at that time?
A. No.
Q. Did Akron City -- Other than residents, did Akron City have attending physicians that staffed that Emergency Department?
A. No.
Q. And you still are staffing the -- This new entity is still staffing Akron City, correct, the Emergency Department?
A. Correct.
Q. Now, you say you do some teaching, Doctor. That is where at, Northeastern Ohio University?
A. Correct.
Q. And what courses do you teach there?
A. We're a training program at Akron City Hospital. I have residency in emergency medicine. We give didactic lectures during the year to the residents.

It's not necessarily at the med school. We're an affiliate with the med school. I have an appointment through that affiliation.

Q. How long have you been an instructor?

A. 1993 or 4. '94. June of '94.

Q. All right. Now, you've told me about a case in which you were just deposed in December of '95 which you're a party defendant.

Were you ever a party to a lawsuit prior to that that you're aware?

MR. SCHOBERT: Objection. Again, note my continuing objection to all prior lawsuits.

A. No.

Q. (BY MR. CZACK) Do you know Dr. Colette Willins?

A. Yes.

Q. All right. How do you know her, Doctor?

A. She's a resident at Akron City Hospital.

Q. And I understand she was present on the evening of December 6th, morning of December 7th, 1993?

A. That's correct.

Q. Did Colette Willins actually see and examine Amy Stanley that evening?

A. Yes, she did.

Q. Were you ever with Colette Willins when she

physically examined and spoke to Amy Stanley?
A. The initial history and physical, no.
Q. At some point later in the evening you were in the room together with her?
A. Yes.
Q. On how many occasions.
A. Once.
Q. All right. And how long would the two of you have been in there together minute-wise? And I understand it's an approximation.
A. Five to ten minutes.
Q. Did any other physician examine or see Amy Stanley that evening other than yourself and Dr. Willins?
A. No.
Q. Can you -- Do you know how long Colette Willins took the initial history and examination of Amy Stanley the time you were not in there?
A. It was a typical intern --
MR. SCHOBERT: Well, answer his question specifically first. Do you know a specific amount of time?
A. I would say ten to fifteen minutes.
Q. (BY MR. CZACK) Okay. And that would have been prior to the time that you and her saw her together, correct?

A. Yes.
Q. Had you ever worked with Colette Willins prior to that evening?
A. I may have worked one or two shifts prior.
Q. You're not sure?
A. I don't remember. Specifically in the Emergency Department with her under my guidance, maybe once or twice. I had interactions with her when she was on family practice and other services when I called her down to the Emergency Department for consultations or other admissions prior to that.
Q. Okay. You did not know Colette Willins other than the professional relationship within the hospital?
A. Correct.
Q. How do the residents in training there work in the Emergency Department at least back in December of '93?
A. I'm not sure what you're asking.
Q. What was Colette Willins' job that evening?
A. We're a teaching institution. Her job is to see patients, make an initial assessment by taking a history and physical, come back to the attending who is responsible for that particular side or resident depending on the time of the day, and discuss that case then with the attending. And after that

discussion to determine whether an emergency exists and basically teachings on what you should think of, being is this an emergency, you know, a patient who comes for evaluation.

And then my responsibility is to go and see the patient and make sure the assessment that the resident or intern took is, indeed, accurate as far as what she told me.

Q. Okay. Do you have any independent recollection of this process going on that evening outside of what's in the medical records? By process I mean the process of the resident seeing the patient, you and her discussing, doing the teaching part, then you going and doing the actual assessment yourself.

A. Do I have any --

Q. Any independent recollection outside the medical records.

A. I know it occurred. Is that what you mean?

Q. Well, do you have -- Do you have in your mind a memory or recollection of what occurred that evening without looking at the medical records?

A. 1 know I talked to her. I know I went into the room and saw the patient. I know I came back and made notes on the chart and we discussed the patient's presentation, and I remember those things.

Q. Okay. Do you recall that evening, Doctor, if it was an extremely slow evening, a slow evening, an average evening, busy, or extremely busy for the Emergency Department?
A. No, I do not.
Q. Do you recall what time Amy Stanley came into the hospital that night?
A. I know it had to be after 11:00 since that's when my shift started.
Q. Your shift started at 11:00?
A. About 2300 if I remember correctly.
Q. And you were scheduled to work until what time?
A. 8:00 a.m.
Q. The following morning?
A. Correct.
Q. From the 11:00 p.m. to 8:00 a.m. shift the next morning were there any other attending physicians on duty that evening?
A. At that time, yes.
a. Who would that have been?
A. The only one I know for sure is Dr. Weigand since his name is on the demographic information. Other than that, I don't have any independent recollection.
Q. Okay. The fact that Dr. Weigand's name is on there,

does that indicate he would have been there that evening?

A. He was working the medical side from 3:00 p.m. until 1:00 a.m. or 12:00 midnight.

Q. Okay. I'm sorry, I didn't hear the first. He was working where?

A. Basically because his name's on the chart the way it's designated he was working the blue side.

Q. Okay.

A. And our shifts would go from 7:00 a.m. to 4:00 p.m. This being December, most likely that shift went from 3:00 p.m. to midnight. It may have been until 1:00 a.m. but I don't recall it.

Q. Okay. You're talking about the shift that Dr. Weigand was on?

A. Correct.

Q. You mentioned he worked on the blue side. Can you explain that to me.

A. That would be the major medical side.

Q. And. you would have -- What was your side called?

A. Mine basically would have been the back hall and to help out if there is an area that was seeing, you know, a disproportionate amount of patients on one side.

Q. Would you switch back and forth different weeks?

would you be on the blue side some weeks and he would be on the other side?

A. Correct.

Q. Do you know who came in for Dr. Weigand after he left after midnight on the blue side?

A. That was me.

Q. That was you?

A. (Indicating.)

Q. Is there any way we can tell whether that was a busy night or slow night from the chart?

A. No.

Q. Is there any other records or in the Emergency Department log that's kept that lists how many patients came in that particular evening that we can measure that against?

A. There is a log.

Q. Where's that log maintained, do you know?

A. Being that this is a couple years, I have no idea. I know for the first month or two they're kept behind the nurses' station. Other than that, I don't know where they're kept.

Q. Okay. So this particular evening you were there and Dr. Willins was there. Was Dr. Willins assigned to work specifically with you or would she rotate through the Emergency Room?

A. Specifically with me.

Q. All right. Did you have any other residents that worked specifically with you that evening?

A. No.

Q. Do we know what night of the week this was, Doctor?

A. Not just by looking, no.

Q. Okay. Are there certain nights of the week that are busier than others in the Emergency Department, generally? I understand that's not a hard and fast rule. But generally are there some nights that are more busy --

A. I would say the first weekend in every month.

Q. How about full moons, is that true that hospitals get busier during full moons? Have you noticed that?

A. It seems that way. I don't know.

Q. There's no scientific reason why?

A. I think they actually had a publication on that. I think it is just coincidental or luck.

Q. Now, Dr. Willins had just begun, it's my understanding, in the Emergency Department rotation in December. Does she meet with you before she begins work in that department so that --

A. She would have met either with the residency director at that time or one of the chief residents to be oriented to the department and the process

that goes on in the department.

If that would have been my first shift with her, I would have, you know, said basically this is how I do things and would like things done.

Q. Okay. You would have sat down with her and explained that --

A. Correct.

Q. -- if not that night then -- then one of the prior nights in December?

A. Correct.

Q. And ultimately, as I understand it, you as the attending physician in the Emergency Department has responsibility for the care of the patient, correct?

A. Correct.

Q. Have you ever been -- And I have to ask this. Have you ever been suspended from the practice of medicine, Doctor?

MR. SCHOBERT: Objection. Go ahead,, Doctor.

A. No.

Q. (BY MR. CZACK) Have you ever had your privileges suspended from any institution?

MR. SCHOBERT: Objection.

A. No.

Q. (BY MR. CZACK) When did you first learn that Amy

Stanley died?

MR. SCHOBERT: To the extent that there's any protected activity at the hospital that might have resulted in his knowledge, I've instructed him not to talk about that. I don't know whether you can answer.

MR. CZACK: I guess generally let me -- And you can object if you feel the need to.

MR. SCHOBERT: Well, yeah. I mean, there are certain things I just won't let him answer because it's protected, and certain activities always result in review and certain unfortunate outcomes always result in review regardless of whether everything was done appropriately or not. That is protected. To the extent that that occurred I won't let him answer questions about those activities. But if you can answer generally when you first learned of her death, give him a time frame.

A. Probably several months after.

Q. (BY MR. CZACK) After December of '93?

A. Correct.

Q. Okay. And again, without getting into some of the things that occurred, was this something in passing somebody told you or was it something more formal that -- that occurred that made you aware of that?

MR. SCHOBERT: You can answer that.

A. More formal.

Q. (BY MR. CZACK) Dr. Willins has testified that you told her that you and her might be hearing from lawyers about Amy Stanley dying. Do you recall that?

A. I received a 180-day letter.

Q. Okay.

A. When I received that letter I went to the computer system of her transcribed dictations and looked up that patient's name and the date that I saw -- saw her and I made a note to see if I saw the patient independently or if I did see the patient with a resident. Since I did see it with Dr. Willins, I informed her that I did receive this note and that she should not discuss this case and if any discussions she has should be with the attorneys of the hospital.

Q. Okay. So actually your first notice of this lady dying is, what, the more formal notice you told me about or the 180-day letter?

A. The more formal.
Q. All right. But you didn't go to Dr. Willins until you got this 180-day letter, is that -- or at least you didn't have this conversation with her until then?
A. Correct.
Q. Did Dr. Willins say anything to you when you told her this?
A. If she did I do not recall what she said.
Q. You don't recall what she said?
A. Correct.
Q. Where did this conversation take place, if you remember?
A. In the hospital probably in a private place. Specifically where, I do not recall.
Q. Doctor, I'm going to show you what's been marked as Plaintiffs' Exhibit No. 1. And this is --
A. I have a copy.
Q. Right. I've given you a copy of it. The reason I'm using my records here is because I've numbered the pages down in the right-hand corner.
A. These are numbered as well.
Q. Right. And that's the Xerox copy that Mr. Schobert provided us with. So when we refer to these records we'll use the little number in the right-hand

corner, at least I will to make it easier for you and everybody else.

A. Okay.

Q. Have you talked to Colette Willins in 1996 or late 1995?

MR. SCHOBERT: About this case or in general?

Q. (BY MR. CZACK) About this case, correct. About this case.

A. No.

Q. Have you read her partial deposition that was taken a couple of weeks ago?

A. I did not have an opportunity to review it.

Q. Have you discussed Amy Stanley -- Amy Stanley's December 6th, 1993 admission with Colette Willins other than the time you met with her about the 180-day letters or other than the date of December 6th '93?

A. You mean her visits and not the admission, right? No.

Q. I'm sorry. Not the admission date. The Emergency Room visit.

Prior to December 6 '93 you never saw Amy Stanley as a patient?

A. Not to my knowledge.

Q. And you've not looked at any other medical records of Amy Stanley since this lawsuit was instituted, I think you said that earlier, other than the December 8th records and the autopsy?

MR. SCHOBERT: Other than what you already told him you looked at, have you looked at anything else?

A. No.

Q. (BY MR. CZACK) Doctor, are there any written Emergency Department guidelines or standards that are published by any medical groups or organizations that are relevant to the facts of this case?

MR. SCHOBERT: Objection. Go ahead.

A. I'm not sure what you're asking.

Q. (BY MR. CZACK) Okay. With regard to chest pain evaluation, are there Emergency Room guidelines or standards that are published?

MR. SCHOBERT: Objection.

Q. (BY MR. CZACK) If you're aware of them.

A. There's, I mean -- There's a lot of standards published by, you know, journals. I mean, different colleges have, you know, guidelines.

Q. Okay. Any of the Boards that you are certified by or the committees that you are on, do any -- are you aware of any of those?

MR. SCHOBERT: Well, maybe you can break that down into two questions, first of all. I mean, are you asking whether, first of all, any Boards -- he's told you he's certified by the American Board of Emergency Room Physicians.

MR. CZACK: Okay.

MR. SCHOBERT: They have the Board certification.

A. There is a large, you know, I guess outline of what you should do with someone who has chest pain or other, you know, symptoms.

Q. (BY MR. CZACK) Okay. I wasn't trying to trick you. That's all I was trying to ask you. There is a -- something they publish. Do you know what the formal name of that is?

A. No, I do not.

Q. Have you ever read those standards or those guidelines before?

A. Yes, I have.

Q. Would you have a copy of those anywhere in your office?

A. No.

Q. And those are published by or put out by the --

A. American College of Emergency Room Physicians.

Q. Do you regularly subscribe to any emergency medicine journals or manuals?
A. Yes.
Q. Which ones?
A. Annals Of Emergency Medicine, North American Clinics Of Emergency Medicine, JAMA. There is a quarterly, I don't remember, I guess Emergency Medicine Topics.
Q. Okay.
A. I believe that's the name of it.
Q. Are there any texts that you regularly refer to in your practice of emergency medicine?
A. Being a teaching hospital, the two texts that are used as references are Tinelly's Textbook Of Emergency Medicine.
Q. How do you spell --
A. I don't know.
Q. Tinelly's?
A. Tinelly. And the other is The Textbook By Rosen.
Q. And these are used in your -- your teaching?
A. These are references.
Q. Do you have these in your office?
A. Correct.
Q. The night of December 6th, 1993 and morning December 7th of '93 did you speak to anybody else from Amy Stanley's family that -- that you recall?

A. No, I did not.
Q. So with regard to this Emergency Room visit, the only person you spoke to concerning this patient was the patient herself?
A. And Dr. Willins.
Q. All right. Do you know any members of Amy Stanley's family outside of -- outside your professional practice?
A. Professional practice, no.
Q. Okay. Have you ever come in contact with any of Amy Stanley's family members at any time?
A. Yes.
Q. Okay. When was that?
A. Last year.
Q. All right. And under what circumstances did that occur?
A. They came in as a patient.
Q. Okay. Do you know who that was?
A. No. I don't remember -- All I know is I found out that she was related after I went into the room.
Q. Okay. How did you find that out?
A. She asked that another physician examine her.
Q. Okay. And there was no other conversations between the two of you after that?
A. No.

Q. Okay. Looking at the exhibit you have in front of you, Doctor, Plaintiffs' Exhibit No. 1. When you first when in to see Amy Stanley which pages of that chart would you have had present already? Which of those pages would you have had in front of you?

A. Page No. 1, Page No. 3, Page No. 4, Page No. 5, Page No. 6. That's all.

Q. Okay. And pages -- Page 1 would have been completed at that time when you had it in the chart?

A. Possibly.

Q. Okay. Do you recall in this case whether it was or wasn't?

A. No, I do not.

Q. All right. Is it normally completed by the time you see the patient?

MR. SCHOBERT: Only if you know.

A. I'd say a majority.

Q. (BY MR. CZACK) All right. Page 3, the authorization page, normally you've got some signature from the patient by the time you see the patient?

A. I believe that's the back of Page 4.

Q. Okay. And then 4, 5, and 6, those would have been partially completed by the time you saw the patient?

A. What do you mean by completed?

Q. Well, all the writing we see on them now, would all of that writing have been there the first time you saw Amy Stanley that evening?
A. No.
Q. Okay. Tell me what entries you have physically made in the record, handwritten entries have you made.
A. On Page 5 where it has under reassessment, that is my handwriting.
Q. Right next to reassessment there?
A. Correct.
Q. All right. Where else do we see your writing in -- in Plaintiffs' Exhibit No. 1?
A. My signature on that same page.
Q. Okay.
A. And my signature on Page 9.
Q. Okay. Tell me what Pages 7, 8, and 9 are. Those are, what, transcribed --
A. That's a transcribed dictation that was performed by Dr. Willins.
Q. And what does all that information evidence?
MR. SCHOBERT: Objection.
Q. (BY MR. CZACK) What is that information?
A. That's the history and physical and other information that would be pertinent to a patient's visit to the Emergency Department.

Q. Okay. Let -- Let me ask you this, Doctor. The information that's in that transcribed dictation, Pages 7, 8, and 9, is that something that's prepared with information that's acquired only by Dr. Willins or is that information -- or is that transcription a compilation of information from you and Dr. Willins?

A. That would be mainly information from Dr. Willins. If there was -- I had done a dictation there would have been a, you know, note to that effect.

Q. Okay. So this mainly came from Dr. Willins' examination and review of the patient?

A. Correct.

Q. The information that's contained in this transcription, though, is something Dr. Willins would have shared with you at some point when you and her met before discharging the patient?

A. This dictation was not transcribed prior to her discharge.

Q. Right. I understand that. But the information that's contained therein that Dr. Willins had, she would have shared that with you before discharging the patient, correct?

A. Excuse me. Correct.

Q. All right. Have you looked at the Stow Fire Department records, Doctor? Have you seen those?

A. No.

MR. CZACK: Do you have a copy of those, Jeff, because I don't?

MR. SCHOBERT: Here.

Q. (BY MR. CZACK) Take a moment to look at those, Doctor, if you would.

A. Okay.

(Witness reviews documents.)

A. Okay.

Q. Have you ever seen that record before?

A. No.

Q. All right. And that record that you're looking at is the Stow -- I'm sorry, what's the caption on top?

A. Stow Fire Department Emergency Medical Service Report.

Q. And what's the date on that, if it's on there?

MR. SCHOBERT: I think it's up here in the corner.

A. 12/6/93.

Q. (BY MR. CZACK) And that's for patient Amy Stanley?

A. Correct.

Q. Did that record ever become a part of Amy Stanley's chart at the Akron City Emergency Room as far as you know?

A. It never was.

Q. Okay. And as far as you're aware or -- Strike that.

You've never seen that before today?

A. Other than Jeff informing --

Q. Other than when you -- Right.

A. -- me before this morning.

MR. SCHOBERT: We went over that today.

Q. (BY MR. CZACK) Okay. So you've never seen that before today?

A. No.

Q. Does the fire department record from the local rescue squads and EMT units normally become a part of the hospital emergency patient chart?

A. This here?

Q. Normally. I guess generally I'm asking general procedure.

A. If the patient would not have been transported this would not become part of the medical record.

Q. In this case because the patient was not transported it is not a part of the record?

A. Correct.

Q. Okay. Doctor, do you know -- And I asked Dr. Willins this -- the page -- first page of Plaintiffs' Exhibit No. 1, you've been in the

Emergency Room there for awhile at Akron City, do you know who takes that information? Is that a triage nurse that takes that information and types it in the chart or is that a clerk or could that be either one in certain situations?

A. This specific information --

Q. Yes.

A. -- would be a clerk.

Q. Does that person have any medical training whatsoever?

A. Other than maybe, you know, medical terminology, I don't believe so.

Q. All right. And that would also include the information contained on Page 2, is that accurate?

MR. SCHOBERT: That it's done by this clerk individually?

Q. (BY MR. CZACK) Done by a clerk person or registration person.

A. I guess the only thing as far as diagnosis or chief complaint, that may be information that she obtained from the chart that would be marked Page 4.

Q. Okay. Now --

MR. SCHOBERT: I think it's a question. Did you answer his question about whether this particular page --

A. Again, here it says diagnosis.

MR. SCHOBERT: All right.

A. I'm not sure where they got that. I'm not sure if that's the final diagnosis or is that the, you know, pretreatment. That I don't know.

Q. (BY MR. CZACK) Okay. We're talking about high blood pressure/chest pains?

A. Correct.

Q. Do you recall in this case when you saw Amy Stanley whether that information was in there when you saw her chart; high blood pressure/chest pains?

A. I do not recall.

Q. Okay. Seeing that we now know that Amy Stanley was not brought in by the fire department, do you know how she -- she came in that evening, Doctor?

A. She came in by private vehicle by herself.

Q. Okay. Can you tell me what the term differential diagnoses means?

A. My interpretation of that would be possibilities o different diagnostic entities that may be possible based on the patient's presenting symptoms.

Q. Do you as an Emergency Department physician use this differential diagnoses principle?

A. I'm not sure what you mean by principle.

Q. Well, you just defined what it is. Is it used in

the Emergency Department?
A. Yes.
Q. Okay. It's something you teach or when you did do instruction?
A. Yes.
Q. Something you would talk about with students?
A. And residents.
Q. Have you ever heard of the term index of suspicion in medicine?
MR. SCHOBERT: Objection. Go ahead.
A. Yes.
Q. (BY MR. CZACK) Okay. What does that mean to you?
A. A likelihood or possibility or probability of something occurring.
Q. Now, at 2340 Dr. Willins ordered 75 milligrams of Vistaril and a pulse oximeter reading. Were you consulted before those orders were made, Doctor?
A. Yes.
Q. And did you concur in those things being done?
A. I concurred with the pulse Ox. The Vistaril being administered was my suggestion.
Q. And before this patient was discharged you were consulted and you discussed the discharge instructions, correct?
A. Correct.

Q. Did you concur with the discharge orders and the treatment that was given in this case?
A. Yes.
Q. Why did you suggest Vistaril be given, Doctor?
A. This patient's major complaint was she could not relax. Vistaril is a mild medication for anxiolytic complaints.
Q. Do you give that often in the Emergency Room, is that something you give --
A. No.
Q. By the time this patient was discharged did the Vistaril accomplish what it was intended to accomplish?
A. Without looking at the records themselves, I believe they did.
Q. Please feel free at any time, Doctor, I don't want you to talk off the top of your head, feel free to stop and look at the record.
A. I believe so.
Q. You believe it did?
A. Correct.
Q. Okay. That's based on -- Did you find a particular note in the record that makes you believe that or is that just your recollection?
A. Partly my recollection and partly the fact that the

nurse did make 'a mention that the patient was still, you know, at the time of discharge complaining or voicing that she still felt anxious, and that's the other part of it.

Q. Okay. I guess maybe you didn't understand my question.

MR. SCHOBERT: I think there was some mix up. I'm confused.

Q. (BY MR. CZACK) The Vistaril is intended basically to -- for lay purposes, to calm her down?

A. Correct.

Q. All right. Did it calm her down the way you intended it to at the time of discharge?

A. I believe so for the reasons that I stated earlier.

Q. For the reasons you just stated. All right.

Why did Dr. Willins order the pulse oximeter?

A. Because the triage note is that the patient complained of shortness of breath. She did not voice this complaint to myself nor Dr. Willins in our questioning. And just to confirm that she was not hypoxic a pulse Ox was ordered.

Q. Could Vistaril lower one's blood pressure?

A. It potentially can.

Q. All right. The dictated portions, Pages 7, 8, and 9, are those dictated in every case, Doctor, at

Akron City Hospital?

A. Yes.

Q. Do you have any handwritten notes concerning Amy Stanley that -- that are outside the chart?

A. Outside of this exhibit?

Q. Right.

A. No.

Q. I'm talking about the evening you saw her notes.

A. No.

Q. And as I understand it, these notes on Page 7, 8, and 9 were transcribed after the patient was -- was discharged from the hospital. Is that correct?

A. Correct.

Q. Who types that up, Doctor, do you know?

A. Personnel hired by the hospital for transcription.

Q. And it's important, I presume, that these summaries are -- are accurate?

A. I would say that would be safe to assume.

Q. Okay. Who's responsible, if anybody, to proofread these summaries for accuracy?

A. It would be me.

Q. And did you proofread these summaries after they were prepared?

A. Yes.

Q. We've talked about the pages that you have made

entries in this record, Doctor. Can you please read for me on Page 5 your -- your reassessment of the patient.

A. It would be my assessment of the patient. "Patient with pressured speech complains of jaw pain secondary to dental work today. Developed chest pain after vomiting this evening. Apparently did not eat until dinnertime. Negative" -- I can't read mine. It's not a good copy.

MR. SCHOBERT: Mine isn't much better.

A. "Negative pain. Cold sweats. Positive smoking history of one pack per day now down to one pack per week. As far as negative history of coronary artery disease."

Q. And then there are some numbers there to the right?

A. Which I do not know what those mean.

Q. Okay. Those are not your entries?

A. Correct.

Q. Now, when was this reassessment made in terms o -- of the timing of her --

A. This assessment would have been made after Dr. Willins made her initial assessment, discussed the case with me, then we went back and after I examined the patient would have come back out to the work area, talked some more and I would have made this

quick note.

Q. Okay. So after Dr. Willins saw the patient herself these notes here are when you went back in to see the patient yourself?

A. Correct.

Q. We don't know the time of these notes, though, correct? There's no time entered in anywhere that we can tell what time it is?

A. That's correct.

Q. At some point you and Dr. Willins formulated or thought about a diagnosis of this patient?

A. Correct.

Q. When would that have occurred, Doctor, in terms of these --

A. A preliminary working diagnosis after I discussed the case with Dr. Willins after her findings. The final impression would have been determined after I saw the patient and examined her.

Q. Okay. What was the preliminary working diagnosis that you and Dr. Willins considered?

A. All of them?

Q. Every single one of them, yes.

A. Being it's a teaching hospital, I mean, with this person coming in and the fact she is a resident and is supposed to be taught and learn from this, I

presented it more than one way. You can look at what is it's presentation from a life-threatening versus nonlife-threatening, cardiac versus noncardiac etiology of her complaints.

Q. That's how you presented it to her?

A. Correct. I said when someone comes in with these complaints there are things you should think of.

Q. Okay.

A. And our job is to determine is it life-threatening versus nonlife-threatening. Of the life-threatening, the chest discomforts or whatever, and then use it as a small mini-lecture topic to discuss.

Q. Okay. And chest discomfort's important because there is always a possibility that could be a catastrophe?

A. The patient never really described chest discomfort. She complained of intrascapular pain and shoulder pain.

Q. We'll get into that in a second. So you gave a sort of a mini-discussion or lecture with Dr. Willins?

A. True.

Q. What was the working diagnosis that you and her came up with at that time?

A. Based on the most probable cause would have been a viral illness, gastroenteritis, esophageal spasm,

hiatal hernia, biliary disease including cholelithiasis, cholelithostitis, pancreatitis based on the signs, symptoms, and history taken -- took -- taken by her and then myself.

Q. Now, this working diagnosis was made when, before you saw the patient or after you also saw the patient?

A. It was expanded after I saw the patient.

Q. Right. So this working diagnosis you just gave me was part of a discussion between you and Dr. Willins before you made your assessment?

A. Correct.

Q. All right. And how is it that you recall these diagnoses? Is this something you just remember from this patient --

A. Something --

Q. I'm sorry?

A. It's common. A good Emergency physician would think of those things.

Q. Okay. Did you think of those things then or --

A. Yes.

Q. -- did you think of those now that you've looked at the record?

A. I thought of them at that time.

Q. All right. But they're not entered anywhere in the

record, correct?

A. Correct.

Q. All right. And did you consider anything of cardiac origin at that time?

A. It was considered.

Q. Okay. So that would have also been part of your working diagnosis you just gave me?

A. As far as a probable, no. It was a possibility.

Q. All right. Well, none of these were probable at that time, can we assume that? They were all possibilities until you worked further with the patient?

A. That would be fine.

Q. Okay. Then after this -- this working list, and that's what a differential diagnosis list is sort of, isn't it? Just so I understand.

A. Basically you have a patient coming in with symptoms, based on those symptoms what is remote, what is possible, what is probable.

Q. Okay. All right. So then after you and Dr. Willins had discussed this at some point then you go in and see the patient yourself?

A. Correct.

Q. By yourself. Can you tell me, Doctor, what you consider to be some of the primary coronary artery

risk factors?

A. Family history of coronary artery disease, it's debated whether it's someone of age less than 60 or greater than 60. Smoking history, diabetes, hypertension, hypercholesterolia, and whether the patient themself have a history of coronary disease.

Q. And the first thing you said age less than 60 or more than 60. What distinction does that have?

A. Some people will say that it doesn't make a difference if the person's older or younger than 60 as far as that being a risk factor. Some people say that it should be somewhat remote as far as family member that has cardiac disease at a younger age is of significance.

Q. Okay. Being in the Emergency Department for six years I'm sure you've seen a gamut of complaints and illnesses and quote unquote, emergencies. What are the most common, and this is just your opinion, the most common causes of chest pain that you've seen in the Emergency Room?

MR. SCHOBERT: Objection. Go ahead, Doctor.

A. Musculoskeletal, pulmonary processes, bronchitis, pneumonia, pleurisy. I think those would be the most common if you went by diagnoses.

Q. Okay. And in an Emergency Department setting the history is important, is it not?
A. It's very important.
Q. And the different ways you can obtain history I presume are from -- obviously from the patient, talking to the patient?
A. Correct.
Q. Talking to if the patient's family is there and you need information from them the patient may not have you sometimes use that as -- as a source?
A. If it's needed.
Q. Okay. What about outside physicians, attending family physicians, do you ever use that as a source of history?
A. When it's felt that the attending physician would need to be contacted, the case would be discussed and at times the history -- there's history that he provides that would be helpful.
Q. Okay. What circumstances would you consider calling an attending physician?
A. Someone needs to be admitted, someone needs a follow-up within 24 hours.
Q. Is there a general guidelines or procedures, written guidelines or procedures at Akron City that deal with calling attending family doctors?

A. Not to my knowledge.
Q. What are the common signs and symptoms of a patient who's having an acute MI, Doctor?
A. Chest pain that is described as a pressure, tightness, heaviness, dull, aching discomfort.
Q. Where?
A. Classically it's thought to be retrosternal, behind the breast bone. Maybe associated with radiation to different parts, typically to the left side. As far as arm, inner aspect is classically taught. It could be referred anywhere.
Q. Any other areas that would radiate to classically?
A. Neck, jaw, shoulder. A person would complain of shortness of breath, nausea, occasionally vomiting, cold sweats.
Q. Anything else?
A. It could be anything. Pleuritic chest pain in someone over the age 70 occurs in two to three percent, depends on your age. I mean, there's all these -- all these possibilities.
Q. Okay. Is blood pressure a factor at all?
A. It's classically referenced in -- in books that the blood pressure may be elevated. My personal experience in treating many MIs, I would say it appears in maybe ten percent of the patients.

Q. How about anxiety?
A. That is one of the things that is listed towards the end.
Q. Okay. I think we can both agree that not all patients who are having an acute MI present with all of these complaints, can we agree to that?
A. I would agree to that.
Q. As an Emergency Department doctor what tests, studies, imaging modalities, whatever, are available to you to confirm or rule out an acute MI?
A. If they were indicated, you can order to rule out sometimes none of the tests that can be ordered, which can be an EKG, a blood count, enzymes, can be ordered but they don't always rule out a cardiac event.
Q. The EKG, electrocardiogram you're talking about?
A. Correct.
Q. So the main ones would be the EKG and the -- the enzymes?
A. Enzymes are really, you know, they're a test that can be done. But they do not rule in rule out and are not used in the decision making whether someone does or does not have an MI. It's based on their history and presentation.
Q. Okay. What is -- Explain to me what an

electrocardiogram is, Doctor.

A. It is an electrical tracing of the heart. Basically it's depending on where the electrodes are it's how those electrodes perceive the electrical activity of the heart.

Q. And how long does it take for that study to be completed on a patient?

A. If there's no complications, I would say probably 30 seconds.

Q. Okay. It's not invasive or painful to a patient?

A. No.

Q. Those were available in December of '93 at Akron City Hospital?

A. Yes.

Q. Were the nurses aware -- Nurses are aware that that study or that test is available, are they not?

A. Yes.

Q. What are the benefits of that test? What does -- What does it tell *you* if there's a positive reading or abnormal reading?

MR. SCHOBERT: Objection. Go ahead.

Q. (BY MR. CZACK) What can it show you, I guess?

A. It can show you if there's nothing wrong or felt to be nothing wrong. It may show nonspecific changes. It could show evidence of ischemia.

Q. As an attending doctor at -- attending Emergency Room doctor at Akron City in December of '93 did you have the power and authority to admit patients to the hospital?

A. I cannot admit patients.

Q. What's the procedure for having a patient admitted that you felt needed to be admitted?

A. I would discuss the case with that person's attending.

Q. All right. Suppose the patient didn't have an attending.

A. Depending on what their complaint is, you may make a referral to a specific specialty if that's what was needed, or based on zip code a patient can be referred to an internist.

Q. What if somebody needed to be admitted immediately and you couldn't get ahold of the attending, what's the procedure then?

A. Patients can always be stabilized and cared for in an Emergency Department.

Q. Okay. Before the admission is done?

A. Correct.

Q. Are there written rules and regulations that were in effect in December of '93 concerning Emergency Department physician's admission of patients and the

procedure you had to follow?

MR. SCHOBERT: Objection. Go ahead.

A. I don't understand the question.

Q. (BY MR. CZACK) The procedure you just talked about, what we just talked about very generally, are there written guidelines that you had to follow in --

A. I'm sure there is, but I don't know specifically.

Q. Okay. You went back in and assessed Amy Stanley at some point later after you had this discussion with Dr. Willins, and you've read for us into the record what your notes say. What happened after that then, Doctor? You came back out, you said you filled in the chart with the notes you read to us. What occurred from there?

A. I spoke with Dr. Willins and felt that her assessment was pretty much on line and I was in agreement with her assessment.

Q. Okay. Why don't we step back a second. What was Dr. Willins' assessment?

A. That the patient presented with the symptoms that she has documented and felt that her jaw pain was secondary to her dental work, felt that the nausea and vomiting was related to her having the dental procedure and the medication for that procedure. And that's about it in a nutshell.

Q. Now, you earlier told me about the differential diagnosis that you and Dr. Willins had put together. I didn't hear those as being part of that differential diagnosis; jaw pain secondary to dental work.
A. I said that was partial at that time.
Q. Okay. But those were part of that differential at that time?
A. What could be the cause.
MR. SCHOBERT: We're mixing up times. Are you talking about the later time or earlier time? You were referencing both.
Q. (BY MR. CZACK) Right. I'm talking -- Let me make it clear for you, Doctor. Earlier when you and Dr. Willins put together this working set of diagnoses where you gave me probably six or seven different things, was this something you and her arrived at or just you, the ones you read for me?
A. Both.
Q. Both of you.
A. I would have asked her and whatever she didn't fill in **I** would have filled in.
Q. Okay. **I** guess **I** was neglecting my duty. Let me go back. When you asked her initially the working diagnoses, what was her working diagnoses?

A. The jaw pain was related to the dental procedure.
Q. Okay.
A. The nausea and vomiting was possibly related to the dental procedure or a GI or viral component.
Q. All right.
A. That's it.
Q. Okay. And then you filled in all these other things you told me?
A. And more.
Q. And more. Is there anything else you can think of that you also filled in that you haven't told me?
A. Specifically?
Q. Yes.
A. The jaw pain, the differential could be -- could have been the dental work itself, could be that she has a problem with her jaw as far as the joint, the TMJ, that she had an otologic problem, could this represent pathology in the posterior pharynx, could this be an unusual presentation for heart.
Q. Okay. Now, we'll go ahead to where I was before. You now came back, entered your assessment in the chart and then met with Dr. Willins and discussed a final diagnosis, correct?
A. Correct.
Q. And it was at that time -- I think I cut you off

before -- that you said that you felt she was pretty much on with her assessment that she gave initially?

A. Correct.

Q. And that assessment would be noted on Page 9 of Plaintiffs' Exhibit 1?

MR. SCHOBERT: Use his with the page numbers.

A. Those are impressions.

Q. (BY MR. CZACK) Okay. Is that different than a diagnoses?

A. It's what our thought was and what is the most likely probable explanation for her presentation.

Q. Okay. Is there a difference between a diagnosis and an impression for purposes of this chart?

A. Yes.

Q. All right. Explain to me what the difference is.

A. Impression is my medical opinion of what the person's complaints add up to. A diagnosis, the way I would look at it is something that was used for -- I don't know what the right term is -- coding.

Q. I'm sorry what, coding?

A. Coding and that type of stuff.

Q. Not Codeine the medicine. Coding, c-o-d-i-n-g?

A. Correct.

Q. Okay.

A. This is an opinion, that's what it is, the impression. That's why it specifically states impression.

Q. All right Doesn't hold any less significance than the quote unquote diagnosis for medical purposes, does it?

A. I believe not.

Q. Okay And these impressions that were typed in here, that's something that Dr. Willins obviously would have dictated into her machine and would have been entered in there, but those are things that you and her both came up with and concurred with, correct?

A. I guess so.

Q. Well, you don't sound sure. I don't want you to guess. If --

A. I'm not sure if I used those exact words.

Q Which ones are you not sure about?

A. I don't know if I would have worded it exactly hypomania/bipolar disorder I -- I guess it's just a matter of wording I probably would have wording things a little differently

Q. How would you have worded it?

A. For No. 2?

Q. Well, for any of the ones that you're not sure of.

A I would have said --

MR SCHOENECK: I'll object. I don't know if he said he's not sure. He said he would have worded it differently. Go ahead, Doctor.

A. I would have said anxiety with -- secondary to hypomania with slash history of bipolar depressive disorder.

Q (By MR CZACK) Okay. Anything else in there you would --

A. I would have not used -- I would not have used the words chest pain because in the discussions that Dr. Willins and I had there is no mention that the person really had chest pain. She complained of heartburn.

Q Is there anywhere in the record that there's complaints of chest pain?

A Well, it has it on this demographic Page 1, Page 2, nurses notes, which is Page 6.

Q. Does it mention midsternal pain?

A. Says she had midsternal pain.

Q Okay. What's -- Where is that? What's the chest or behind the chest wall?

A Behind the chest wall.

Q Okay. So there were a couple references to chest

pain either at the time or -- or prior thereto her admission or her attending the Emergency Room?

A. Correct.

Q. Okay. What would you have said for No. 3 then if -- if you didn't agree with chest pain? What would you have called it?

A. I probably would have said nausea, vomiting, diarrhea secondary to gastroenteritis.

Q. Okay. Anything else in the impressions that you felt is not accurate of what you felt was --

A. I didn't say it wasn't accurate.

Q. I'm sorry.

A. I said I would have worded it differently.

Q. Worded it differently. Okay.

A. That's it.

Q. You have the power to change these impressions after you've gone through and read these? You said you're the one responsible for accuracy.

A. Right.

Q. Did you read these after they were dictated?

A. Yes.

Q. And you didn't feel the need to change them at that -- Why didn't you change them at that time?

A. Because at that time I -- the time of the review of this I knew that the patient had returned to the

hospital.

Q. Okay. When did you review these, Doctor?

A. The exact date, I don't recall.

Q. Okay. What does the fact that she returned to the hospital have to do with your review of the accuracy of that impression?

A. It is my impression from attending seminars that if you know there's an event that you shouldn't change it because that may be construed that you're trying to change, or hide, or cover up the facts.

Q. Okay. Nevertheless, this list of three impressions that were entered into this record is something that you and Dr. Willins had to discuss prior to her dictating that, correct?

A. The exact wording, no.

Q. Okay. Wow does that work between you and the resident? Do you write down exactly what you want the impression to say or is it just a verbal discussion?

A. Just a verbal discussion.

Q. Now, this lady had complaints -- You can refer to the record -- of inability to relax and anxiety, jaw pain, pressured speech, and I believe she was hypertensive, is this correct?

A. Hyperten -- Hypertension wasn't a complaint. That

was a finding.

Q. It was a finding.

A. Otherwise that would be correct.

Q. All right. I think at some point the nurse noted she complained of midsternal pain radiating to her back sometime prior to coming to the hospital?

A. Correct.

Q. Sweats, vomiting, and diarrhea?

A. Nurse notes says that she vomited her dinner and had diarrhea. There's no mention of sweats in the nurses notes.

Q. Okay. The nurses notes did mention, though, the vomiting and the midsternal chest pain, correct?

MR. SCHOBERT: Objection. Asked and answered. Go ahead, Doctor.

A. She vomited her dinner and had diarrhea. And that says, "States she had midsternal pain that radiated to her back." And then it goes on. "Patient denies sharp pain at present."

Q. (BY MR. CZACK) Anywhere in the record does this patient complain of sweats and shoulder discomfort?

MR. SCHOBERT: Take your time and go through the records.

MR. CZACK: Sure.

A. Sweats. And what **was** the other one, please?

Q. (BY MR. CZACK) Shoulder discomfort.
A. Fifth line of Page 7 has down -- makes a mention of some shoulder pain and farther down that same paragraph there's another mention of shoulder pain. As far as sweats, after she had vomited and had diarrhea she was noted to be sweating and hot and cold.
Q. Okay.
MR. SCHOBERT: Do you want to keep looking and make sure.
A. Okay.
MR. SCHOBERT: I think it goes on to talk about sweats.
A. "She no longer had any sweating or no longer felt hot or cold at the time of presentation." That would be the same paragraph.
Q. (BY MR. CZACK) Go ahead and read the next sentence, too, then, Doctor.
A. "At the present time the only thing she is complaining of is the fact she cannot relax, her shoulder is uncomfortable and her jaw hurts."
Q. How old was this patient?
A. Sixty-seven.
Q. Was she a smoker?
A. Yes.

Q. The things I just talked about, these symptoms or complaints or findings and what we saw in the record, are those not on that list of classic signs and symptoms of an acute MI you earlier talked about?

A. I think you have to look at the presentation of the patient and just not look at a list of symptoms or signs.

Q. Okay. I understand that. We can talk about that in a second.

But were those things not on that classic list that you told me about, yes or no?

MR. SCHOBERT: Objection.

A. Everything I said was classic.

Q. (BY MR. CZACK) Okay.

A. So there's a list.

Q. There's a list?

A. And symptoms, I would agree with that. Not that they're classic.

Q. Okay. But many of the things you mentioned as being in a descending order, part of those signs and symptoms this lady presented with, correct?

A. Correct.

Q. What was her blood pressure like throughout the Emergency Room visit, Doctor?

A. The first reading at triage was elevated 186/105, her last reading was 177/98.
Q. Is that a sharp drop in blood pressure?
A. No.
Q. Still elevated by the time she was discharged?
A. For her age it may be considered slightly elevated.
Q. Okay. Now, the diagnosis that was made, jaw pain secondary to dental work, what --
(Interruption in proceedings.)
Q. -- in your opinion, Doctor, what things were present in the record or present clinically that justified a diagnosis of jaw pain secondary to dental work?
A. Okay. She has down in the first paragraph says she was having jaw pain and goes, "Seems that her jaw pain developed when she had dental work done today. And soon after she got home from having dental work done the jaw pain started."
Q. Okay. Anything else that --
A. I have to read the whole thing. If you want to me read the whole thing to see if there are other mentions. But my note that I had read earlier said that the pain was related to the dental work today.
Q. Okay.
A. The nurses, I think, in her past history also wrote down that she had dental work done today.

MR. SCHOBERT: Go ahead. Just take your time. He's asking you based on what's in the record.

A. Under Treatment Plan, "Patient says she is experiencing jaw pain secondary to her dental work." I believe that's all.

Q. (BY MR. CZACK) Okay. So basically supporting this diagnosis is the fact that historically the pain began after her dental work?

A. Correct.

Q. Where in her jaw did she have this pain?

A. Independently as I recall it was on the left side.

Q. On the left side? Okay.

A. In the mandible.

Q. How was she describing that pain to you? Sharp? Dull? Throbbing?

A. It was a discomfort in the area that she had the work performed by her dentist.

Q. What kind of work did she have done?

A. I'm not sure if she had an extraction or actual root canal work. I know she had dental work. I don't know exactly which type. I don't recall.

Q. And for how many hours had that jaw pain been going on?

A. From the time she arrived home.

Q. Okay. But I mean, was her appointment at 9:00 in the morning or 7:00 at night?
A. I don't know.
Q. Did you feel that the type of work she told you she had done was consistent with the kind of pain she was having in the jaw?
A. Correct.
Q. Did anyone call her dentist at any time while she was in the Emergency Department?
A. No.
Q. Would it be important for you to know as an Emergency Department doctor that this patient had called her dentist earlier that evening to complain about the jaw pain and he told her that that was not consistent with the kind of work he did in her mouth and if it continued she should be seen in the Emergency Room? would that be important for you to know that?
A. Correct.
Q. All right. Did anybody ask the patient, Did you call your dentist?
A. I don't have any independent recall of that. And she didn't tell us that, either.
Q. All right. But if nobody asks her that and she doesn't offer it, nobody's going to get that

information, correct?

MR SCHOEPP: Objection.

A. Not necessarily

Q (BY MR CZACK) Well, if she doesn't offer that information and none of the physicians ask her that --

A. It's very customary when patients are sent in by their doctors that they inform us they were sent in by their doctors and that doctor, or dentist, whatever that person may be, would like a call

Q Okay But, again, if that doesn't occur and nobody asks her that question, that information is not going to come out, correct?

MR SCHOEPP: Objection.

A. Correct

Q (BY MR CZACK) Hypomania/bipolar disorder. Would you agree with this statement: Patients with bipolar disorder are often hypomanic just because they have bipolar disorder Do you agree with that statement?

A. They're not always hypomanic.

Q So you disagree with that statement?

A. I'm not sure what the statement says All I can say is bipolar is a psychiatric iagnosis To have that diagnosis, basically the patient has to have had a

manic episode one time in their life. And that's all it means.

Q. Okay. Bipolar disorder is a psychiatric diagnosis of -- Just give me a thumbnail definition of it.

A. Basically there's an episode during the person's lifetime that characteristically occurs in a person's early 20's to somewhere up in the thirty -- third decade where they have an episode where they're manic, meaning that they have had a hyperexcitable state. And not necessarily, but it may be associated with periods of depression, there may be cycles between episodes of depression and mania, and there may not.

Q. Do you have any special training or experience in this area?

A. Yes.

Q. Okay. Hypomania is --

A. Would be not a full-blown manic episode. It would be, you know, a degree or less of severe presentation.

Q. Okay. What kind of things do you do as an Emergency Room Department physician to confirm that somebody's having a manic episode?

A. It's a clinical.

Q. All right. What are the -- What signs and symptoms

are you looking for?

A. A person may have anything from lack of sleep, hyperexcitable state, hypersexuality, grandiosity, feeling in -- inepitent as far as even with the law that no one can basically touch them or harm them, spending sprees, and maybe intrusive, speech may be pressured, they may have a flight of ideas meaning that their brain is racing and really can't keep up pace with what's going on inside of their head.

Q. Okay.

A. Basically I think of it as a charged state or awareness.

Q. Clinically what signs and symptoms were there to support this diagnosis?

A. The patient had pressured speech, she felt that she just couldn't relax, she was pacing, which was not mentioned.

Q. I'm sorry, I didn't hear that.

A. She was pacing.

Q. That wasn't in the record, though?

A. Correct.

Q. This is something you remember independently?

A. Correct.

Q. Okay.

A. The fact that she's on Lithium, which is used for

the treatment of bipolar disorder.

Q. Anything else?

A. That's why I felt she was hypomanic.

Q. Is it important to know or would you want to know whether a patient had a history of prior hypomanic episode?

A. I'm not sure what you're asking or its relevance.

Q. Well, would you want to know if this patient has had an episode like this before?

A. Well, she said she's bipolar. So she -- that would be, you know, make me make the presumption that she had this before. And the fact --

Q. But she's had --

A. -- and the fact that she was on Lithium. I mean, you don't put someone on Lithium if they've never been manic.

Q. Okay. How long had she been taking Lithium?

A. I do not know.

Q. Had she had her Lithium prescription changed recently, or altered?

A. I do not know.

Q. Do you know the last time she had her blood levels checked by her doctor?

A. I do not know.

Q. Did you call her psychiatrist and ask any of those

questions?

A. No, I did not.

Q. Did you believe she was having a mild, moderate, or a severe manic episode?

A. Mild.

Q. Based on what?

A. The fact that she had the same symptoms and findings.

Q. I understand you've made that diagnosis based on these clinical findings and complaints that she was making.

The fact is, though, you really had no evidence that this bipolar disorder was not well controlled, did you?

MR. SCHOBERT: Objection.

A. Repeat the question.

Q. (BY MR. CZACK) Sure. You made your diagnosis based on the clinical findings that you had in front of you?

A. Correct.

Q. But the fact of the matter is, that you really had no evidence in front of you to show that this bipolar disorder that this lady had was not well controlled?

A. You're --

MR. SCHOBERT: Same objection.

A. You're asking me whether she was controlled or not controlled?

Q. (BY MR. CZACK) Yes.

A. And do I have evidence of that?

Q. Right.

A. I guess I can't answer the question the way you're wording it.

Q. Okay. Which part don't you understand?

A. Well, it's not a simple yes no answer.

Q. Okay.

A. I mean, it's --

Q. Let me ask you this. Did you have anything in the record there, anything independently in your mind that you recall today, that would indicate that her bipolar disorder was not well controlled?

MR. SCHOBERT: Objection.

A. Her presentation.

Q. (BY MR. CZACK) Okay. Because of her presentation you felt that her bipolar disorder was not well controlled?

A. She was having an episode which could be defined as hypomania. Whether it's because of, you know, her getting worse for whatever reason, I'm not sure I'm -- I don't understand. I'm not trying to be

evasive. I just -- I don't understand.
Q. I understand.
A. I don't understand what you're asking.
Q. Could this hypo -- How long do these episodes last? You said you have some --
A. Well, they could last -- They could be cyclical that they vary like a day or two or they could last months.
Q. Okay. And the fact is that this lady has been diagnosed with this psychiatric condition, the fact is she's been on Lithium for a period of years, you've made the assumption that at some point she had a manic episode that caused all this to be put in place?
A. I made the presumption.
Q. The presumption. Okay. Between the time that she was first diagnosed with that condition and time she came into the Emergency Room in December of '93 you don't know whether she ever had another manic episode between those 20 years, do you?
A. No.
Q. Could that condition that you diagnosed that evening, that manic episode you felt she was having, could somebody get worse?
A. Or better.

Q. Or better. We -- We don't know?
A. Correct.
Q. Did you feel it was safe to let her go home that night, the fact she was in a manic episode?
A. I wouldn't have let her go home if I didn't feel it was safe.
Q. Why did you feel -- How did you know it wouldn't get worse that evening?
A. You don't. You just have to base it on your, I guess, gestalt. I mean, she was not bad.
Q. Okay.
A. I mean, she had a doctor that she was told to follow up with. If she followed up with him and if he felt that she was, you know, out of control. Family members are the ones that usually will institute something unless they get so out of control that the law is involved.
Q. Wouldn't you normally call a person's doctor with a psychiatric condition like that that was in a manic episode?
A. Our job is to decide whether the person is safe or not safe to go home, or **is** a threat to themselves. I didn't feel she was a threat to herself. And it's not uncommon that patients are told to follow up with their doctors.

Q. Okay. So the answer is no, you didn't feel it necessary to call her psychiatrist that night?
A. Correct.
Q. Do you know who her psychiatrist was?
A. Independently at this time I don't recall.
Q. And the fact that she had family members there, you didn't go speak to her family members about this psychiatric condition?
A. I was unaware that she had family members present in -- at the hospital.
Q. Your third diagnosis, history -- I'm sorry, history of chest pain secondary to nausea and vomiting. What does that mean, Doctor? Explain to me what that diagnosis or impression means.
A. I don't know since I didn't dictate it. True, I signed it. But I can't speak for what Dr. Willins, you know, meant by that. If she would have said intrascapular or like I said, how I would have worded it, I could give you my interpretation of it, what my meaning is. I can't, you know, make an interpretation of what Dr. Willins specifically stated.
Q. And that is your signature down below there, correct?
A. As we discussed.

Q. Let's look at the chart. What kind of chest discomfort or chest symptoms was this lady having?

MR. SCHOBERT: Objection to the extent we've done some of that. Go ahead, Doctor.

A. It says, "After dinner she threw up. Had burning pain which she called heartburn in the sternal area, and her back seemed to hurt a little bit midscapular after vomiting." Is that what you're referring to? It's not called chest pain. It's --

Q. (BY MR. CZACK) I guess my question is, did anybody ask this lady --

A. I did.

MR. SCHOBERT: Let him ask his question.

A. Okay. I'm sorry.

Q. (BY MR. CZACK) Did anybody ask this lady how long that chest -- I guess we're disagreeing on whether the word pain was ever used. But the chest symptoms, did you ever ask her how long that lasted?

A. Yes.

Q. How long did it last?

A. From independent recollection, a couple of minutes.

Q. All right. So that's not in the record but you remember independently she told you it lasted a

couple of minutes?
A. Right.
Q. What was the intensity and character of that chest feeling that she was having?
A. A lot of times you ask those questions and patients cannot answer those questions. This is a summation, summary of what a patient is best able to tell you after asking and sometimes even giving adjectives to patients. A lot of times I know that is a very important question, but no matter what, you know, you may elicit -- try to elicit from a patient or even try to help by giving adjectives you still cannot get those answers.

So the fact that it's not here does not mean they were not asked. This is just a recollection or a documentation of a summary of what the patient described and we were able to get from that patient in her own words.

Q. Is that normally important information, though, when there are chest --
A. I said it was.
Q. I'm sorry?

MR. SCHOBERT: Let him finish his question.

Q. (BY MR. CZACK) Are those normally important things

to know when somebody has chest complaints; the intensity and the character of the pain?

A. Correct.

Q. And you don't note in your assessment how long that chest pain or that chest feelings lasted? That's something you remember independently?

A. Correct.

Q. Did you and Dr. Willins ever discuss or entertain the idea or thought that this chest pain may have been cardiac in origin?

A. Dr. Willins made her presentation. I went in and saw the person. Because if you look at the complaints as a constellation and all the things together, this may represent cardiac ischemia. So as I noted, I went in and made my assessment. The fact that she had localized the pain to where she had dental work, I felt that was safe to assume that. The fact that she had, you know, discomfort in my note I -- I just put shortly, all I put down is she had no chest pressure. But in my customary questions there's a lot more than just whether it was pressure. I asked tightness, heaviness. The fact that it's not documented does not mean it was not asked.

Q. Doesn't mean it was asked either, though, right?

A. That's my -- That is the way I practice medicine is I ask all these questions. This is not my dictation. I just made a quick note feeling that our conversation was regarding this discomfort I entrusted through my questioning. It wasn't that I did not ask those questions.

Q. Okay. And what did you tell me the cardiac consideration was in terms of your differential?

A. What are the cardiac considerations?

Q. Right. What -- What was the potential diagnosis you considered with Dr. Willins?

A. Could this be cardiac ischemia.

Q. Okay.

A. Angina.

Q. All right.

A. Could this be a myocardial infarction, could this represent pericarditis, could this -- as far as other things you think of could this represent a dissection of the great vessels.

Q. You considered these cardiac diagnoses. What did you do to rule out her complaints --

A. I took a history.

Q. Okay. And let me finish my question.

A. Okay. Sorry.

Q. What did you do to rule out the midsternal pain that

was radiating to her back, the elevated blood pressure, the anxiety, vomiting, and nausea, jaw pain, and shoulder discomfort? What did you do to rule out that there was something going on cardiac wise with those complaints?

MR. SCHOBERT: Objection.

Q. (BY MR. CZACK) Did you do anything?

MR. SCHOBERT: Go ahead, Doctor. Answer the question.

A. Basically you don't -- To determine whether to do tests or no tests is to take a history.

Q. (BY MR. CZACK) Okay.

A. The history was taken. Based on her presentation, the history that I took, the complaints that I was able to elicit from her, I felt that no tests were indicated.

Q. Okay. So by your history you felt that no tests you just said were indicated to rule out any cardiac problem?

A. As we stated earlier --

MR. SCHOBERT: Objection. Go ahead.

A. -- history and physical is basically your premise for obtaining tests or making your diagnosis.

Q. (BY MR. CZACK) What did you attribute -- What shoulder was bothering her?

A. It was intrascapular towards the left.
Q. She also had shoulder discomfort at a couple points. Do you remember which shoulder it was?
A. Left.
Q. All right. What did you attribute the shoulder discomfort to? We talked about jaw pain, dental work; anxiety, hypomania; and chest feelings or discomfort, nausea and vomiting. What was the shoulder discomfort that continued attributed to?
A. When one vomits the esophagus, you know, can cause pain referred to the shoulder. A hiatal hernia may refer pain to the shoulder. Intrascapular shoulder discomfort, with a gallbladder typically it's more on the right but it can be the left as well. Intrascapular on the left may be from pancreatitis, pericarditis can be thought of as well. As well as cardiac.
Q. What did you feel the left shoulder was being caused by that evening?
A. An esophageal etiology.
Q. Doctor, you're familiar with this chart. When this lady was discharged it notes that her condition had improved. Can you tell me all the improvements she made from the time she came in at 11:17 until the time she left at 12:35. If you need to look at

the chart, go ahead.

A. Blood pressure improved.

Q. Okay.

A. She -- She was not as anxious.

Q. I'm sorry, she was what?

A. Not as anxious.

Q. As anxious?

A. Right. Or restless or whatever.

Q. Where is that noted that she's not as anxious or as restless?

A. It's not noted. You asked me what I recall.

Q. So independently you recall her restlessness got better?

A. Correct.

Q. Okay. *Go* ahead. What else improved when this lady was sent home?

A. That's all I recall.

Q. That's all?

A. Correct.

Q. If you look at Page 5 of the record, Doctor, Homegoing Instructions. Your signature is down below those, correct?

A. Correct.

Q. What does your signature indicate?

A. That I had seen that patient that day.

Q. Does it indicate anything else? I mean, is there any other reason you signed that -- that line there?
A. And that I would -- That that's my note above. Just to identify this is the patient I saw.
Q. Okay. The homegoing instructions there, that's not your writing, is it?
A. No, it is not.
Q. Who would have made those homegoing instructions as part of the order, you or --
A. Dr. Willins.
Q. -- Dr. Willins? Okay. Do you know who she was referring to, "Call your doctor for continued jaw pain"?
A. Dr. MacCallum.
Q. All right. And there's another note, "Return if chest pain with nausea, vomiting, or sweating lasting longer than 15 minutes." The -- You read those notes before they were told to the patient, did you not?
A. No.
Q. All right. So your signature doesn't indicate you would have seen those homegoing instructions?
A. Correct.
Q. Okay. Would you have discussed those homegoing dis -- instructions with Dr. Willins before she gave

them to the patient?
A. Yes.
Q. All right. And we see in there again the word chest pain?
A. Correct.
Q. Okay. What was the concern there with that homegoing instruction the way it reads in your mind?
A. If someone has chest pain that returns this may represent possibly cardiac or other etiology.
Q. And that's what this note was talking about?
A. Yes.
Q. Now, let's -- And we're almost through here. Let's talk about the treatment you gave this patient. She came in at almost midnight for jaw pain. She was still having jaw pain when you sent her home at 12:30. What did you give her on her way home to help her with the jaw pain?
A. I don't recall.
Q. Could you look at the record and see if anything was given to her to help her with the pain she had in her jaw?
A. She may have had a script written by another, you know, independent she had dealt with.
MR. SCHOBERT: Just check the chart.

Q. (BY MR. CZACK) Just whatever you -- What you gave her, Doctor, as far as treatment.
A. Nothing.
Q. Okay. The manic episode that you felt she was having. When she was discharged she was still very restless, anxious, pressured, constantly moving. What did you give her to help her with those problems?
MR. SCHOBERT: Objection. Go ahead.
A. As I stated, we give her Vistaril. And as I stated, that she had improved prior to her discharge.
Q. (BY MR. CZACK) With regard to what symptoms?
A. The restlessness and her activity.
Q. Would you say that the improvement from the Vistaril was significant, moderate, or very minor?
A. It was notable otherwise she wouldn't have been discharged.
Q. Okay. So you gave her the Vistaril. It made a notable improvement in her anxiety and restlessness. What else did you do to help her with that manic episode before you discharged her?
A. She was instructed to follow up with her physician and to have her medication -- make sure she takes her medicine, and have a -- have her checked out in that regard.

Q. Okay. What else did you do other than that?
A. Nothing.
Q. Did you expect this lady to be able to sleep that night?
A. Yes.
Q. No problems?
A. She would have some problems.
Q. Chest pain secondary to nausea and vomiting. You felt that was gastrointestinal in nature in your opinion?
A. As noted in there, she had the nausea and vomiting then the discomfort.
Q. Okay.
A. She didn't have the chest pain first.
Q. All right. Did you do anything or give her anything to alleviate those symptoms?
A. She had none of those symptoms when she presented to the Emergency Department.
Q. You told me earlier, Doctor, these diagnosis codes that are in -- in the chart you have nothing to do with, is that correct?
A. These numbers you mean?
Q. Right.
A. Correct.
Q. You don't even know who puts those in there?

A. That's correct.
Q. Do you know what those numbers stand for, do you know what those diagnoses are?
A. Probably an interpretation of what's written from a billing standpoint.
Q. Is that normally what it's supposed to be; they're supposed to reflect what the diagnoses or the impression is of the physician?
A. Correct.
Q. Would you agree -- Doctor, would you agree with me that as a general medical principle, early detection and treatment of a myocardial infarction is important for the welfare of a patient?
A. In a general statement, yes.
Q. Why?
MR. SCHOBERT: Objection. Go ahead, Doctor.
A. Basically you're trying to prevent further injury to the person or reduce the amount of injury that's already occurred.
Q. (BY MR. CZACK) And the fact is, on this particular evening an EKG or blood enzyme workup was never done, correct?
A. That's correct.
Q. Do you know Dr. Charles MacCallum?

A. Just professionally.
Q. I mean, have you met him before? You know who he is?
A. If I had been asked to pick him out in a lineup I may get that wrong. He may not like that answer.
Q. You met him before where, in the hospital or professional functions?
A. Hospital.
Q. Have you had a chance to speak to Dr. MacCallum about this case at all or about his patient?
A. No, I haven't.
Q. On Page 9, the last page, Doctor. I'm going to strike that. Actually Page 8. Second last page. There's a section there under Emergency Department Course DDx. What's does that stand for?
A. Differential diagnosis.
Q. All right. And is that line supposed to be used to put differential diagnoses in there?
A. It should have been.
Q. All right. Do you know why it wasn't in this case?
A. Some people comply and some people don't comply.
Q. Okay. Whose job is it to see that that's filled out?
A. The resident's.
Q. Okay. And ultimately is it your responsibility that

that is filled out before this thing is transcribed?
A. For transcription it would be impossible.
Q. Okay. How about after transcription, what are you supposed to do if it's not filled out?
A. I normally would have filled it in.
Q. Is there a reason why you didn't in this case?
A. Again, because this chart was in my box to be signed after I was aware that she came in and did not do well.
Q. Okay. Where would this chart have been when she came in on December 8th?
A. What part of the chart?
Q. Everything. I guess -- I guess my point is --
A. There's a flow system of paperwork that's very complex and cumbersome and I can't even try to describe where, you know, at what point it may have been or may not have been.
Q. Okay. When does everything come back together so it's all one record like we have here?
A. Sometimes two weeks later.
Q. Okay. And when it was in your box to sign two days later when she came back in what pages would have been in there?
MR. SCHOBERT: Objection.
A. I didn't say it was two days later. I said after

the fact that she -- It was after I knew that she had returned and did poorly. I didn't say it was two days.

Q. (BY MR. CZACK) All right. I guess my only question is, I'm just trying to understand logistically, when Mrs. Stanley was brought back in two days later would any part of this chart have been available for the physicians who saw her on December 8th?

A. If it's based on track record, probably not.

Q. Why?

A. It may not -- It may be somewhere in the system being put together.

Q. Okay. When she came in to the Emergency Room two days later and somebody -- would somebody be immediately aware that she had been in there two days ago?

A. Yes.

Q. And would it be feasible for them to be able to track down where these pages are?

A. They would have been able to get ahold of my dictation through the computer system since it was transcribed prior to that.

Q. Okay. So the sum and substance of what happened two days before when she was in to see you would have been available at some point to the physicians on

December 8th?
A. It may have been.
Q. Okay. Do you know in this case whether it was or wasn't?
A. I do not.
Q. Okay. If it wasn't what would the reason be, that it's going through this tracking system?
MR. STRONG: Objection. Speculation.
MR. SCHOBERT: Objection.
A. This copy, because of that. But there's other ways of getting it.
Q. (BY MR. CZACK) Okay. Would any of this information concerning the transcription be on a computer?
A. Yes.
Q. That would be the transcribed pages?
A. That would be the actual dictation.
Q. Okay. Did you understand all my questions here today, Doctor, for the most part?
A. For the most part.
MR. SCHOBERT: I'll object. Go ahead.
Q. (BY MR. CZACK) Is there anything you want to add or change in terms of prior answers to any of the questions?
MR. SCHOBERT: Again, reserving the right to review the transcript.

MR. CZACK: Sure.

MR. SCHOBERT: Doctor, if you can answer that question.

A. I have none really.

MR. CZACK: Okay. Can you give me just one minute just to look at my notes?

MR. SCHOBERT: Yeah. 1/11be happy to give you one minute. Is there anybody else that's going to be asking anything?

MR. EDMINISTER: Not I.

MR. SCHOBERT: Okay. It's all up to you.

(Discussion had off the record.)

Q. (BY MR. CZACK) Doctor, I have just one other question. I appreciate your cooperation here today.

It is your testimony that on the evening of December 6th, 1993, the morning of December 7th, 1993, you did not speak with any other member of Amy Stanley's family or anybody that was with her, is that correct?

A. I stated I was unaware there was anyone other than her since the chart marks down that she just came in by herself.

Q. Okay. So then therefore, you did not speak to anybody from her family, is that your testimony?

MR. SCHOBERT: Objection.

Q. Yes or no.

A. No. I didn't speak to anybody.

MR. CZACK: Okay. No further questions.

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(Deposition concluded at 12:00 p.m.)

I have read the foregoing transcript of my deposition taken on Monday, January 29th, 1996 from page 1 to page 95 and note the following corrections:

PAGE:	LINE:	CORRECTION:	REASON:

_____

UGO E. GALLO, M.D.

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

I, Angela R. Zanghi, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that UGO E. GALLO, M.D. was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth and nothing but the truth; that the deposition as above set forth was reduced to writing by me by means of Stenotype and was subsequently transcribed into typewriting by means of computer-aided transcription under my direction; that said deposition was taken at the time and place aforesaid pursuant to notice and agreement of counsel; and that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I hereunto set my hand and seal of office at Cleveland, Ohio, this 7th day of February, 1996.

Angela R. Zanghi, Notary Public
Within and for the State of Ohio
848 Terminal Tower
Cleveland, Ohio 44113

My Commission Expires: June 8, 1999.