In The Matter Of:

Doc. 159

BARBARA GRASGREEN v.
MERIDIA HILLCREST HOSPITAL

JAMES GOLDSTEIN, M.D.
June 1, 1995

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IN THE COURT OF COMMON PLEAS OF
CUYAHOGA COUNTY, OHIO

BARBARA D. GRASGREEN,
etc., et al.,
Plaintiffs,
-vs- Judge Griffin
Case No. 263268
MERIDIA HILLCREST
HOSPITAL, et al.,
Defendants,

The deposition of James A. Goldstein, M.D., a witness in the above-entitled cause, taken before Joan E. Martin, CSR-0111, a Notary Public in and for Oakland County, Michigan, (acting in Oakland County, Michigan), at 3601 W. Thirteen Mile Road, Royal Oak, Michigan, on the 1st day of June, 1995, commencing at 2:20 p.m., pursuant to the Michigan Court Rules.

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APPEARANCES:

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Appearing on behalf of the Plaintiffs.

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Royal Oak, Michigan
June 1st, 1995
About 2:20 p.m.

MR. SCOTT: Doctor, my name is John Scott, again. I represent Dr. Chentow in this case.

EXAMINATION BY MR. SCOTT:

Q: Have you had your deposition taken before?
A: Yes.
Q: Let me have an understanding of what your experience is in testifying in depositions and in reviewing malpractice cases. Have you reviewed malpractice cases prior to this one?
A: Yes.
Q: When did you first begin reviewing malpractice cases?
A: Approximately 1984.
Q: Have you reviewed any cases for Plaintiff counsel before this one?
A: No.
Q: Have you reviewed any cases for attorneys in Cleveland before this one?
A: Not that I recall.
Q: Have you testified in Ohio?
A: No.

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Q: About how many cases do you have pending that you are reviewing?
A: Three.
Q: In the last 12 months or a years time about how many cases do you review?
A: Three to five a year.
Q: When I say review, I mean by that an attorney sends to you information and asks your opinion as to whether the care met departed from the standards. Is that what you mean as well?
A: Yes.
Q: How long have you been reviewing cases at that approximate number per year, three to five per year, has that been ongoing since roughly '84?
A: No, I think really only the past four or five years where I have had three to five cases per year roll by.
Q: Have you testified out of the state of Michigan?
A: Yes.
Q: What percentage of these cases that you have been involved with take you outside of the state?
MR. ZUCKER: John, the doctor has only been in Michigan for eight months.

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MR. SCOTT: All right.
A: I was in Missouri from 1986 up to until last August and I would say all but one case that I ever reviewed with the exception of one or two while I was residing in Missouri.
Q: Can you estimate for me the number of depositions that you give in a years time?
A: I have only given a total of six or seven depositions ever, and they all are in the past four or five years.
Q: And those cases - strike that. Have any of those cases ever dealt with the issue of TPA?
A: Yes.
Q: How many cases would you say?
A: One. One directly and I dealt with a number of cases that have dealt with acute myocardial infarction or chest pain syndrome where questions about thrombolytic therapy was the central issue involved with the case.
Q: Was that case in Missouri?
A: No. Illinois.
Q: When was that case, approximately?
A: Four years ago.
Q: What was the issue in that case?

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A: I have to try to recollect the exact details. I was actually reviewing the case for the Defendant physician who administered thrombolytic therapy to a patient who was a good candidate for thrombolytic therapy. The physician was there - it was her job to evaluate the patient and make the right decision to give the thrombolytic a try and the patient suffered a fatal intercerebral hemorrhage. I think that case was dropped by the Plaintiff.
Q: Did you give a deposition in that case?
A: Yes.
Q: Do you remember the case name?
A: No.
Q: Or the case attorney?
A: There's a consortium in Illinois that handles that sort of thing.
Q: When you say consortium, what do you mean by that?
A: Physicians interinsurance exchange or some global group that insures many of the physicians in Illinois. I don't remember the specific law firm. It was more under the umbrella, this insurance consortium that covers liabilities insurance for physicians.
Q: Do any of your publications deal with TPA?

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A: Yes.
Q: Can you identify them for me? I have a copy here if you like.
MR. ZUCKER: There's a number of them, grants and publications?
A: Are you interested just in the publications?
Q: (BY MR. SCOTT) Correct.
A: You say TPA, can I include thrombolysis?
Q: Sure.
A: You want just the TPA versus chest pain and acute myocardial infarction?
Q: Yes.
A: Reference number 29 is the one that most directly deals with thrombolytic therapy. It is an experimental study looking at the advantages of direct angioplasty for acute myocardial infarction versus thrombolysis.
It was a study of both TPA and streptokinase. Then a lot of the other publications that deal with ischemic and infarction talk about management of myocardial infarction, which includes the use of thrombolytic drugs. There are seven or eight publications that have portions of them that deal specifically with thrombolysis. Do you want me

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to list those, too?
Q: You have listed number 29. Are you able to identify those others?
A: Yes.
Q: Okay.
A: Number 12 is Determinants of Hemodynamic Compromise With Severe Right Ventricular Infarction. Number 13 is Pathophysiology of Hemodynamically Severe Right Ventricular Infarction.
Actually number 19 is a very relevant reference. It is Coronary Angiography With a Novel Mobile Radiographic Imaging System, which refers to a unique system I developed to do angiography at bedside particularly in patients who have been given a thrombolytic drug to try to see whether the arteries are open or not.
Number 22, Determinants of the Recovery of Right Ventricular Performance Following Experimental Chronic Right Coronary Artery Occlusion, deals with that issue. Number 28, Effects of Reperfusion on Ischemic Right Ventricular Dysfunction: Disparate Mechanisms of Benefit Related to Duration of Ischemia. Both those latter two deal with a response the right heart to collusion and then reperfusion,

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which is opening up the blood vessel, therefore is direct relevance in discussions of thrombolytic drugs.

Q: Thank you, Doctor.

Have you published any materials in connection with the life expectancy of patients having a condition similar to the patient in this case?

A: Similar. Much of the data on mortality comes not only from the literature on myocardial infarction, which would deal with many of the references that I just described, but a lot of the – one of the major determinants, if not the major determinant, of survival is the magnitude of damage to the left ventrical and impairment of its ejection fraction, which when it's severe leads to heart failure.

It is an area that I have been focused on for the past four years as director of heart failure and cardiac transplant service. Just as an example, reference number 14, entitled Treatment of Congestive Heart Failure by Afterload Reduction, discusses the natural history of congestive heart failure, which is most commonly a result of a damage from heart attacks and discusses the life span particularly related to depression of the left

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ventricular performance.

Q: Have you testified in connection with life expectancy?

A: Yes.

Q: When was the last time?

A: In Arkansas.

Q: Approximately how long ago?

A: Within the past six months.

Q: What was that case name?

THE WITNESS: Is it kosher for me to give out privileged and confidential information?

MR. ZUCKER: No, no. It is okay.

A: The name of the case –

MR. ZUCKER: It wasn't a patient, was it, a patient of yours?

A: No.

Actually it was a deposition, not the trial.

Q: (BY MR. SCOTT) That's all right.

A: The case is in Arkansas, but I gave the deposition in Missouri. Maybe I gave it here. Sometime within the past six months. But the case is in Arkansas. The name is Lamondry.

Q: Do you have a record of it here in your

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office?

MR. ZUCKER: Of his deposition?

Q: (BY MR. SCOTT) Or of the person who asked you for the deposition or for whom you gave the deposition?

A: I am sure a record exits.

MR. ZUCKER: John, I will agree to get you copies of anything that you want from the doctor if he can get it.

Q: (BY MR. SCOTT) In that case, were you testifying on behalf of the doctor or the patient?

A: Plaintiff.

Q: Have you ever testified in connection with the role of a house physician or a house doctor or a house officer?

A: Not that I recall.

Q: I assume that you have not written on that subject; is that fair to say?

A: No.

Q: I am right in that?

A: I have not written on the subject.

Q: Do you have any involvement in the selection of house officers at this institution?

A: I will. I have only been here for eight

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months. In fact, one of my roles I was recently appointed as the Director of Education for the house staff and the medical students at this institution in cardiovascular training, and at all other institutions where I have been a faculty member I participated in the selection of house staff and cardiology fellows. For that matter and I am sure I will here participate in the fellow selection. When it comes time to the nest round for house staff selection I will be in that as well.

Q: When you say house staff, does that include house doctors?

A: House staff particularly refers to interns and residents who are in training in a formal program at a teaching institution such as this.

In their role as house officers or house staff they are here at night admitting patients and taking care of emergencies. So they are serving the role of house officers as well.

Q: The interns and residents do?

A: And sometimes fellows as well.

Q: Do you have house doctors, aside from interns, residents and fellows, with whom you work?

A: At this institution?

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Q: Right.
A: Do you mean who were hired specifically just to be here at night to take care of patients unrelated to their own personal patients?
Q: Yes.
A: No.
Q: When you were in St. Louis at the university there, did you have house physicians practicing with you?
A: Actually, they were both there at Barnes Hospital and here we have physicians who are hired as house physicians, but they all come from the house staff. They are interns, they are residents, and fellows who moonlight covering patients. We have some patients on the teaching service who the interns and residents have primary responsibility for and respond to emergencies and we also have house physicians who are, in our institution here and at my prior institution, who hire from within the teaching program and are paid extra to moonlight to cover. So I guess in a sense they are house physicians.
Q: Do those interns and residents come from a program involving cardiology or the study of cardiology?

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A: The interns and residents, they are in internal medicine. Cardiology fellows do.
Q: Are there any particular qualifications that you require of the house staff in this institution - are you aware of the qualifications required of them?
MR. ZUCKER: In general or in a specific area?
Q: (BY MR. SCOTT) I am really talking about house physicians and I suspect you are not.
A: I think when I use the term house physician, as I understand you to imply in your question, you are speaking of a physician who is in the hospital at night to respond eo whatever responsibilities have been articulated in their job description, who are doing that as a service that they are being paid for as opposed to a part of a formal training program.
So house staff, interns and residents is part of their formal training program every third or fourth night are on-call and they take admissions and they respond to emergencies. They get a salary for being an intern or resident, but they don't get any extra money for being on-call.
Yet in many institutions, including this one and including others I have been at, there

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were also opportunities for those physicians to moonlight. Some will do it in the emergency room, some will do it at other hospitals, but many will do it inhouse where they would cover certain services, certain patients and respond to whatever their needs would be.
So they were house physicians and, of course, their qualifications generally would be that they would be at a certain level of training within their house staff program and, obviously, would have met the qualifications to be in that training program, either internal medicine or cardiology OF both.
Q: Can you approximate for me the number of times that you have actually testified in court?
A: Twice.
MR. ZUCKER: May I interrupt, John?
MR. SCOTT: Sure.
MR. ZUCKER: Your question prior to the last question was that the doctor's knowledge of the qualifications of the house officer. Do you want to get back there now that you have established what he means by house officer?
MR. SCOTT: No, no.

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MR. ZUCKER: You don't care eo know the answer?
MR. SCOTT: I care to know the answer. I thought I was given the sum of that answer.
MR. ZUCKER: As to the qualifications?
Q: (BY MR. SCOTT) And have both of those occasions been in Missouri?
A: No. One was in Oregon and one was in Arkansas.
Q: Are you teaching at this time, Doctor?
A: Yes.
Q: Will you tell me what you teach? What is the program? Describe the program that you are in.
A: I am the Director of the Coronary Care Unit here at William Beaumont Hospital. I also have a lot of other activities and responsibilities; heart failure and cardiac transplantation and catheterization laboratory.
And I mentioned I am Director of the Cardiovascular Teaching Program for the medical students and house staff. We have our own training program here at this institution, our own interns and residents in training and internal medicine. It's a

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certified program. We have our own fellowship program in cardiology, in fact, a world renown one. We also have medical students who rotate through here on a very regular basis both from the University of Michigan as well as Wayne State University.

And in my various capacities I am involved on a daily basis teaching in the coronary care unit, in my office across the way, cath lab, bedside consultation, formal didactic conferences, et cetera.

Q: In the cases that you have reviewed, approximately what percentage have been on behalf of the plaintiff and for the defendant?

A: Let's see, 65 percent plaintiff, 35 percent defendant.

Q: How was it that you were contacted in this case?

A: I was trying to sort that out with Mr. Zucker. He called me and he can't recall how he got my name and I don't think I really knew.

Q: What are your fees for review?

A: For the review of the records *$375* an hour.

Q: And deposition?

A: Five hundred dollars an hour.

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Q: Testimony in court?

A: Depends.

Q: On what?

A: Depends on where the extent of travel, how much time.

Q: Do you have a set fee or an hourly basis?

A: Not really. I haven't testified that many times to elicit a fee.

Q: Will you tell me what you have reviewed in this case?

A: I have reviewed records provided to me by Mr. Zucker. They include a compendium with most of the records, I assume, from the hospitalization of the patient at Meridia Hospital.

MR. ZUCKER: May I interupt?

MR. SCOTT: Sure.

MR. ZUCKER: Bid you review everything that I sent you to some extent or another?

A: Yes.

Q: (BY MR. SCOTT) The letter to you of January 23, 1995, lists 20 sets of records. Did you review each of those items?

A: I reviewed most of it.

Q: Did you conduct any medical research in

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connection with your opinions here?

A: No.

Q: Or any medical search of the literature?

A: No.

Q: Consult with anybody?

A: No.

MR. ZUCKER: Did you do any review relative to life expectancy, confer with any charts or tables?

A: Do you mean with respect to both questions other than my ongoing review of the literature medicine over the past 20 years, nothing specific to this case. It is areas that I am familiar and an expert in.

Q: **(BY** MR. **SCOTT)** I am sorry. What was the last part?

A: These are all areas that I am not only familiar with but expert in.

Q: What areas are you talking about?

A: The acute myocardial infarction, thrombolytic therapy, heart failure.

Q: Are you going to give an opinion in this case as to this patient's life expectancy?

A: If asked.

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Q: What is your opinion? Do you have an opinion at this time?

A: Do you want to phrase that as a specific question in term of at what point, before he came into the hospital, before treatment, after treatment.

Q: At the time that he came into the hospital.

A: Before he received any treatment?

Q: TPA treatment do you mean?

A: You ask the question and I will try to answer it as best I can.

Q: Before he received any TPA treatment.

A: I can give you an opinion based on data available. It's clear from reviewing the records that this patient had had a prior myocardial infarction and had had some damage to the left ventricle. That we know from a review of the records. I believe it was **1986.**

At that time, whatever that date was, he had a scan that looked at his left ventricular function. That was 1986 where he had an ejection fraction of 35 percent, which I think at least provides some information, at lease at that time. It's the only concrete information that we had that he had some damage, not end stage damage, but some.

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Prom that, at least base an opinion, there is data to ballpark in the general population what life expectancies may be, depending on the level of impaired function of the left ventricle.

Q: Are you able to quantitate the damage in '86?

A: Well, based on that scan?

Q: The ejection fraction?

A: The ejection fraction normally ought to be about 50 or 55 percent or above. We know from heart failure studies that when the ejection fraction is less than 30 percent, that the survival rate over three years is limited, and that anywhere from 50 to 70 percent of the patient's will be dead over three years.

Q: When you say these studies, will you reference them for me what you are taking about? For example, you just referenced a study that suggests that when the fraction gets below 30 percent, some 50 to 75 percent of those patients will die within three years, if I understand correctly.

A: That's correct.

Q: Where does that informtion come from?

A: The medical literature.

Q: All right. Can you cite for me the

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literature that you are taking about?

A: Yes.

Q: Go ahead. Would you.

A: There's numerous studies. I can cite some of the most important. There is a first trial that looked at that was, particularly with respect to drugs that could then improve that somewhat, was that VA cooperative trial.

The second big study was called the consensus trial. There have been many, many other trials in addition to that that have found – but those are probably the two most often quoted.

Q: Are those references cited in the literature that you had published about that subject?

A: Yes, I am almost certain they are, if not I would be happy to provide them to you.

Q: Do you have an opinion in this case as to the likely life expectancy of this patient prior to treatment with TPA?

A: I can give you opinions in the sense of describing things that we know. I can also describe things we don't know. I think that is the best you can do in this case.

We know prior to this most recent

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admission, during which he died, that he had a heart attack and he had some damage. It wasn't at the level of below 30 percent where he was at the highest potential mortality. We don't know what happened in the interim.

Q: I was going to ask you about that. Is it likely that the patient worsened in some respect since '86?

A: Impossible to know. Some patients get better even without interventions like angioplasty to open the artery, collateral blood flow and other healing forces may allow the ventricle to improve spontaneously.

Q: Let me just pause with you for a moment. I don't mean to interrupt. I just need to follow with you, if I can.

Those patients who become better, are they generally patients who are younger than this patient?

A: Not necessarily.

Q: What are the factors that go into predicting if a patient will become better over the passage of time?

A: It relates to the amount of initial

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irreversible damage, and that's an issue in this case, because when the ejection fraction was done, it could have been early in the course of the infarction and some of the damage seemed, in fact, to be what we call stunned or hibernating muscle which could have completely recovered, to the extent irreversible damage, the location of the damage in term of what portion of the heart, whether there are narrowings in other arteries, the progression of the hardening of the artery process. Many, many factors can contribute.

Q: Do you describe those also in your publications that you have given in your CV?

A: Many of them.

Q: In this instance are you able to take each one of those factors and say how it relates in this case, for example, the extent of damage I take it that you don't really – that no one can really say as of '86; is that what you are saying?

A: We can state what we know from the one scan done and everything else is speculation. Now it could educated speculation. The fact that he survived as long as he did from the first heart attack makes it extremely unlikely that he experienced progressive

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deterioration.
Furthermore, if he experienced
progressive deterioration, he most likely would have
developed symptoms of heart failure, none of which I
have been made aware of in my review of the records.
So it's less likely that he had major deterioration.
Whether or not he had improvement is hard to know.
We never knew his coronary anatomy
and how many other blood vessels were blocked. There
was never any repeat evaluation. So anything else at
this point is just guesswork.
Q: You do you have any opinion as to whether he
did improve or not from '86?
A: No, other than what I have already stated.
MR. ZUCKER: Do you mean his
ejection fraction?
MR. SCOTT: Right.
A: Other than what I have already stated.
Q: (BY MR. **SCOTT)** What would be the parameters
of improvement besides ejection fraction? How does
one say if there has been improvement?
A: Well, it can be one of symptoms. If a
patient is having symptoms and those resolve, it can
be one of exercise capacity and how that resolves.

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One thing in this patient's favor
is that we know in patients who got substantial
impairment of the left ventricular function, those who
survived the first year or two tend to have selected
themselves out as having the best prognosis.
We know that from the end stage
heart failure population. Although, those with
ejection fraction of less than 30 percent have a high
mortality. Even with that population he wasn't in
that, But even within that population there is a
subset that survives beyond a year and they seem to do
relatively well compared to the others.
So the fact that he survived more
than a year after his initial infarction is another
point in his favor, but, again, these are all kinds of
circumstantial pieces of information and without
actually having a study, an echocardiogram or a
nuclear study or a catheterization, where you can
actually have the information in your hand and say,
there it is, this is quantitative data. There is no
way you can just speculate,
Q: Without that data it would be speculation in
your view as to whether he improved? Did I state that
correctly?

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A: Yes. In terms of whether his left
ventricular function improved, yes.
Q: What brought the patient into the hospital,
Doctor?
A: He had chest pain.
Q: What was the etiology in your mind – in your
opinion, if you are able to give one?
A: It is problem that it was due to ischemic
heart disease, hardening of the arteries.
Q: Did this patient have an MI shortly before
this admission or during his admission or are you not
able to give any opinion?
A: As far as I could tell from my review of the
records there was never any proof by myocardial
enzymes that he actually had what we call myonecrosis
or infarction. That really would be the ultimate
defining piece of data.
Q: Does that mean that he might have or he might
not have, but we cannot say?
A: If my records are complete, I could not find
any evidence that he had abnormal myocardial e q m e s ,
and he did not have a myocardial infarction.
Q: Is it, then, your opinion to medical
certainty that he did not have an **MI** when he came into

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the hospital or during his stay or are you not able to
go that far?
A: Is that the same question? I am sorry. Is
that the same question?
Q: I think it is the same question.
A: As far as I can –
Q: What I think your answer was you saw no proof
of it and I just wanted to make certain that – I just
wanted to know one way or the other whether that means
he did not or whether your really cannot say for
certain.
A: Well, there are really only two absolute
pieces of data that confirm a myocardial infarction in
a certain time frame. You can have an old myocardial
infarction. It will show up on the
electrocardiogram. You can have an acute myocardial
infarction, in which case you can prove – infarction
means death of tissue.
When heart muscle dies, it releases
a piece of muscle enzymes, we call, that you can
measure in the blood. If you catch the chest pain
syndrome in the right time frame, you will see an
elevation of these e q m e s in the blood so-called CK
enzymes.

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In somebody who presents with acute chest pain, as he did, we get multiple determinations of these enzymes, and if they rise, and if the portion that represents the heart is elevated, then we can say that there has been damage, irreversible damage, a necrosis or an infarction.

What I am saying is that as far as the records I reviewed, I couldn't find any evidence that that had happened.

Q: Is it possible that he had an infarction and that the damage had been done before he came in or that somehow the infarction began at a time when you no longer drew enzymes.

A: It's possible, less likely, but possible. The other way to prove it would have been to have an autopsy to look for evidence of fresh infarction of heart muscle tissue itself.

Q: Does that same analysis apply to the day after he was admitted when he re-experienced chest pain shortly prior to TPA, at the time TPA was given?

A: Yes. The same tests have to be done to prove the presence or absence of infarction.

Q: Does the ischemic pain suggest that the patient was becoming worse over the years from '86?

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MR. ZUCKER: Would you repeat that question.

Q: (BY MR. SCOT") Sure. Does the attack of ischemic pain - I think on the 20th - in any event, shortly prior to the time he was admitted, does that suggest that the patient was, that his coronary artery disease was progressing over the years?

A: First of all, I am not clear that they have really proven that his chest pain was from his heart, because the central issue in this case - because when he was admitted - there are a lot of things that cause chest pain.

Although given his history of a prior heart attack, it certainly is the highest on your lists of differential diagnoses that this is heart pain, ischemic pain. Because his initial electrocardiogram showed abnormalities that were essentially unchanged from his prior heart attack in 1986. Just because he came in with chest pain, doesn't mean that it was necessarily ischemic pain.

So if he had had new EKG changes that were characteristic of ischemia, I would say, yes, he had ischemia. If he had documented infarction by elevated enzymes, I would say, yes, he had ischemic pain. I think he probably was having ischemic pain, but I don't know that for sure.

But then to answer your question does the development of ischemic pain, if that's what he was having, some years after a prior heart attack with an interval in between without having chest pain, does that mean that his hardening of the arteries is getting worse, and the answer is almost certainly.

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Q: Any way to quantitate that or is that just pure speculation?

A: There are ways to quantitate it. We don't have any way to quantitate it in this case, but there are many ways to quantitate it.

Q: We were talking about whether you have an opinion to a reasonable degree of medical certainty as to this patient's life expectancy. I am not certain that we had come down on that question.

We talked about what goes into it. I am not saying that you ought to have an opinion. I am just wondering if you do and, if so, could you tell me.

A: I have an opinion, but I think within the frame work of your question, can I answer it with a degree of medical certainty, I am not so sure I can do

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that because of the absence of any modern data relevant to this patient's demise.

I am really basing it on what happened several years prior when he had his initial heart attack and really what his status was when he died, which would have been relevant to his future survival is unknown. So the opinions are based on speculation as I have articulated. I can't give you an opinion with any medical certainty as to what his survival would have been.

Q: Even without that degree, within your speculation, so to speak, do you have a time frame in mind?

MR. ZUCKER: I would put an objection on the record, John, for obvious reasons. Go ahead and answer the question, Doctor, if you can.

A: Yes. Again, with all the limitations and conditions that I put on it -

Q: (BY MR. SCOTT) If it's just too speculative, if you just don't ascribe any weight to it then that's fine.

A: Then let's leave it.

Q: Okay.

What information would you have

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liked to have - I think we have gone over that just a little bit - but to assess whether and the extent to which this patient worsened since '86?

MR. ZUCKER: Did you understand the question?

A: Yes, I think so.

MR. ZUCKER: I am going to put an objection on the record to that question. Go ahead.

A: If I understand what you are getting at, the key piece of information is to know how well the pump is pumping and you can obtain that information from an echocardiogram or nuclear studies. And biologically with young patients most modern cardiologists would perform a coronary angiogram to get information on how many arteries were narrowed, how severe the narrowings are, how much muscle was supplied by those narrowings.

Depending on those findings, in addition a stress test with or without a profusion study would give information on the flow limitation to muscle that is still alive, a combination of that information about the muscle and the vessels and the flow and how much is dead or alive really allows you to not only have some idea of what is in store for the

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patient for the future, but then also guides you for therapy.

Q: *(BY* MR. SCOTT) Are you able to give an opinion to a reasonable medical certainty as to any of those factors in this case?

A: NO.

Q: Where a patient has a 35 ejection fraction, is that patient likely to improve with the ejection fraction?

MR. ZUCKER: Over years?

MR. SCOTT: Yes.

A: Likely, meaning more probably than not.

Q: (BY MR. SCOTT) Sure.

A: Not more probably than not.

Q: Is that patient likely to worsen then?

A: Some do, some don't. Again, not more probably than not. There are many different courses in it. It depends on a lot of factors that I articulated in term of location and how much of that was really irreversible narrowings in other blood vessels, development of collaterals, changes that develop over time like blood pressure, diet, medicines, many factors.

Q: Do you expect that as of time this patient

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entered the hospital his ejection fraction was less than 30, or 30 or less?

A: No.

Q: No opinion one way or the other, no way to say one way or the other?

A: I expect it's not. He did not have symptoms of congestive heart failure. He did not have physical exam findings of congestive heart failure. There was no evidence that I am aware of by physical exam **or** by the chest x-ray that he had enlargement of the heart or congestive heart failure.

So all those are strongly against his ejection fraction of being less than 30 percent.

Q: Is there information that, or studies that would suggest the life expectancy of this patient as he appeared in **'86** with an ejection fraction of 35?

A: I am sorry?

Q: Can one go back to **1986** and take this man's ejection fraction and place this man in a category at that point in time as to his life expectancy?

MR. PUCKER: In other words, those studies that the doctor is referring to above and beyond the **30** percent ejection fraction, Arthur Grasgreen in 1986, 35 percent ejection fraction at

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that time what this life expectancy; do you have an opinion?

Q: (BY MR. SCOTT) Are you able to say based upon that information alone or the information that we know about the fellow in '86?

A: No. Other than to say obviously he did reasonably well. He certainly survived until - the date of his admission is May of **'93.** So that's seven years, which does say something with regard to lack of progression.

Q: Will you tell me your understanding of the nurse's request that was made to Dr. Chentow I believe on May 21st - in any event, the same evening that the patient was given TPA?

MR. ZUCKER: Do you understand that question?

A: Yes. My understanding is that that Dr. Chentow in his role as house physician was called to evaluate an EKG in a patient who was having acute chest pain.

MR. ZUCKER: Was that your question?

MR. SCQTT: I think so.

Q: (BY MR. SCOTT) Essentially, I am asking you,

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Doctor, what your understanding is as to why Dr. Chentow was called.

A: My understanding is that the nurse recognized that he had a patient in coronary care unit with history of ischemic heart disease, who was having recurrent chest pain, who had been admitted to rule out myocardial infarction, who was having recurrent chest pain, and had an EKG that, I assume, disturbed the nurse, who called the house physician to evaluate this patient who was having recurrent chest pain to look at the EKG.

Q: Is it your understanding that Dr. Chentow was called to evaluate the patient or is it your understanding that Dr. Chentow was asked by the nurse to read the EKG for the nurse?

A: My understanding is that Dr. Chentow is the house physician and the fundamental rule, if not the primary rule, of a house physician at every institution that I ever worked in, and I think Dr. Chentow himself admitted in his deposition that the primary role is to respond to emergencies.

Chest pain is potentially an emergency. Chest pain in a patient in a coronary care unit is a potential emergency. So looking at an

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eletrocardiogram - we don't admit electrocardiograms, take care of electrocardiograms. We take care of patients. We use electrocardiograms to help us assess patients who are having problems.

So Dr. Chentow was house physician. He was called to assess a patient, not an electrocardiogram. He may have been given an electrocardiogram as the first introduction to the patient, but no matter what that electrocardiogram showed, his job was to assess the patient, not the electrocardiogram.

Q: Is it your understanding that the nurse had called or paged Dr. Van Dyke as of the time Dr. Chentow was asked to read the EKG?

A: I don't know what the timing of page of Dr. Van Dyke was relative to the page of arrival or discussion with Dr. Chentow.

Q: Is it important in assessing the care rendered by Dr. Chentow as to whether the nurse was in contact or attempting to reach Dr. Van Dyke at the time that Dr. Chentow is called?

A: It depends.

Q: Go ahead, Doctor.

A: If the house physician is called to evaluate

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an EKG in a patient who has whatever problem and his doctor is down stairs and is going to be up in two minutes and the EKG is normal and the patient is doing fine, that might be one circumstance.

If the patient is having chest pain and the electrocardiogram is strikingly abnormal, it is the job of the house physician, any physician, even just walking by not the house physician, any physician who is asked to be involved in the case when there is an emergency - and chest pain is an emergency, and chest pain with an abnormal electrocardiogram is an emergency - to assess is this something that I need to deal with and to what level do I need to deal with this.

That is something we decide day in and day out for all kinds of problems, whether it is a common cold or cardiac arrest, what is my role in this case, what is my responsibility as a physician be it contractual or ethically. Ethically and contractually actually for house physician, when he's called to evaluate a patient with chest pain, it is to assess, what is the patient's status this second.

I am here. I am in this room. I am here to evaluate this patient's EKG and therefore

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the patient. I look at the EKG. Even if the EKG was normal, I want to know how is this patient doing. And I don't ask the nurse what the vital signs are and how the patient looks. That's my job. I am a doctor.

Patients don't come into hospitals to be taken care of by nurses, although nurses are wonderful and incredible, they come in to be taken care of by doctors; to assess the case, to assess the patient, review relevant records, salient and relevant to the particular issue they are dealing with and then make a decision as to what role they need to play.

If the patient is totally stable and the EKG is unimpressive and the patient is fine and their physician is arriving and going to be there in two minutes, say, fine, I am going to be down the hall. If Dr. so-and-so doesn't arrive in a few minutes and you need me, call me. Or, gee, if Dr. Van Dyke hasn't called back and this patient is having chest pain and has an abnormal electrocardiogram, I've got to examine the patient, I've got to review the records, I need to talk to Dr. Van Dyke and he is not available, I need to start to treat this patient.

Now, tell me what the question was.

Q: Well, if the nurse is in touch with Dr. Van

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Dyke or is about to be in touch with Dr. Van Dyke and Dr. Chentow and the nurse has told Dr. Chentow that he has placed a call to Dr. Van Dyke and expects the return call, does that make a difference in the duties that you ascribe to Dr. Chentow?

MR. ZUCKER: Object to the question. You can answer.

A: Could you rephrase that or say it again.

Q: (BY MR. SCOTT) Does it make a difference in what you expect of Dr. Chentow if Dr. Van Dyke either is on the phone or is called within moments of the EKG?

A: I am not sure I can answer that question in a direct fashion, not to be coy about it, but the house physician's role is to assume the care of a patient who is having an emergency until and unless they are relieved of that responsibility by the attending physician.

Q: If the attending physician is on the telephone with the nurse, does that make a difference to you?

A: If the attending physician is on the phone, then why bother to call Dr. Chentow or if the attending physician is on the phone and says Dr.

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Chentow is not needed, then that is a different situation.

Q: Let me ask you this: The assessment you wanted Dr. Chentow to make I understand, I think, in this instance is there any information that was not properly assessed by the nurse in terms of the patient's clinical status?

MR. ZUCKER: Object. Could you be more specific. Do you understand the question?

MR. SCOTT: Sure.

MR. ZUCKER: If he understands the question, I will let him answer it. Do you understand the question?

MR. SCOTT: Let me be more specific.

Q: (BY MR. **SCOTT)** The patient's vital signs, the patient's extent of pain, patient's complaints, any other assessments that you would have like to have made, is there anything - any of those, to your knowledge, that were not properly assessed by the nurse and given to Dr. Van Dyke?

MR. ZUCKER: Object to the form of the question. Go ahead.

A: I am not sure how complete of an assessment

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the nurse made. I wasn't focused on much detail on the nurse's role. But I think what is really crucial here is that those are not nursing responsibilities. Those are physician responsibilities.

Certainly the nurse should make an initial assessment while they are waiting for the physician to arrive. And if this is a hospital that doesn't have house physicians, they should call the emergency room physician or any other attending physician in the hospital to respond to an emergency just as you would with a cardiac arrest, and get a hold of the individual patient's attending physician. This patient needed a physician. That's the problem in this whole case.

Q: (BY MR. SCOTT) When Dr. Van Dyke was called, that is, when he was on the phone, regardless of what precise time that was, does that constitute the patient at that point having a physician, in your words?

MR. ZUCKER: Object to the form of the question.

Q: (BY MR. SCOTT) Do you understand what I mean?

A: I understand it. I think it's - if that is

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a definition of having a physician, it is a pathetic definition of a having a physician.

Q: **All** right. I understand.

Going back to my prior question - let me put that question in a different way. Was there information that should have been communicated to Dr. Van Dyke about the patient's vital signs, about his extent of pain, about his complaints, that you believe was not communicated?

A: Yes. What should have been communicated is a full assessment by a physician.

Q: What would that be?

A: A salient history, physical exam and a review of the relevant medical records.

Q: Now, the history, presumably, would be known to the patient's attending cardiologist, would it not?

A: Hopefully it would, although if someone was covering it might not. I think the issue is that when you are called for an emergency and you are the first physician there, you don't know whether somebody else is going to be there to take over for you physically in 30 seconds, three hours or never.

And your responsibility is to assume the responsibility for that patient until you

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have been relieved by that individual's attending physician. So in that regard, you need to act as a physician, which means to get as much informtion in the time frame as you can to be able to begin to manage that patient to help them, which means a focused history, physical exam, and a review of records pertinent to the problem and within the time frame of an emergency to make decisions to do the right things.

Q: Was there treatment that should have been given before Dr. Van Dyke was called?

MR. ZUCKER: Was there any treatment other than TPA that should have been administered?

MR. SCOTT: No. Let me go back.

Q: (BY MR. SCOTT) Before Dr. Van Dyke was called and within the time frame where Dr. Chentow is asked by the nurse to look at the EKG is there some treatment that you believe Dr. Chentow should have given to this patient?

A: My understanding is the patient was already on aspirin, heparin and nitroglycerin. I would have to review the records to see whether the patient was on a beta blocker or calcium channel blocker.

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Q: If the patient were not, what would be your answer then?

A: Depending on the doses of the medicines, and I don't have those in my mind, I would have to review and I would be happy to do that if you would like to me to, to see whether further adjustments of the medicines that the patient was already on, such as nitroglycerin, would have been appropriate, whether administration of other drugs would have been appropriate.

I think the key thing that Dr. Chentow could have done would have been not only to examine the patient, but to bother to look at the medical records and the old EKG to see that the patient had a prior myocardial infarction in 1986, to see that the patient had a prior EKG on his admission, and the EKG he was having when Dr. Chentow was called really was unchanged from the prior one and that this was not an acute myocardial infarction.

Q: Do I understand correctly that to your knowledge at this time there was no treatment that Dr. Chentow should have given to the patient?

MR. ZUCKER: Object. That is not what he said. He said he was there to evaluate whether to increase the medication that he was already taking among other things.

Q: (BY MR. SCOTT) I am not going to argue with you certainly, because you are the expert, but I just want to know if you believe if Dr. Chentow should have gone in and given X, Y and Z of treatment.

A: I would have to go back into the records and look at some specific aspects of the nurse's notes, look at the vital signs and the medication chart to see whether at that precise time there were any additional medicines that should have been adjusted or initiated.

Q: Doctor, I think we ought to do that as a matter of fact, because if that will be your opinion at trial, then I need to know.

MR. ZUCKER: I just want to raise this point, John, that the treatment rendered between – the treatment rendered between the time of the TPA working backwards to when Dr. Chentow came in is not an issue in this case. It's the TPA, the administration of the TPA.

We are not criticizing – my understanding is the doctor is not criticizing Dr. Chentow's administration of medication and so forth,

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because he didn't treat the patient. He didn't walk in and physically treat the patient so why are you asking this.

He just told you that the problem was that he didn't come in and treat the patient and you want to ask him questions about whether other things should have been done by Dr. Chentow. Is that my understanding?

MR. SCOTT: I just want to know every opinion and criticism that this doctor will have.

A: I wasn't going to bring it up if you weren't.

MR. SCOTT: That's fine.

MR. ZUCKER: Go for it.

Q: (BY MR. SCOTT) My understanding then – may we simply say –

MR. ZUCKER: Off the record.

(Discussion held off the record).

Q: (BY MR. SCOTT) I am just wondering, for example, if you are going to testify at trial that when Dr. Chentow came to see this patient, he should have given the patient some particular medication or some particular treatment?

MR. ZUCKER: He's testified as to

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what treatment. He said he should have gone in there, reviewed the chart.

MR. SCOTT: I view that differently than treatment.

Q: (BY MR. SCOTT) I understand review the chart. I am talking about treatment with medication, for example, OF some other therapy.

A: Just to reiterate what I said before, I would have to go back into the records and review that specific time to see what medications he was on, the doses, what the vital signs recordings were at that time to make an opinion as to whether anything different should have been done at that moment therapeutically.

Q: May I ask you to do that some point in time?

MR. ZUCKER: I will agree to that.

Q: (BY MR. SCOTT) Now, Doctor, is it your understanding that Dr. Chentow was qualified to treat coronary patients?

A: Yes, on a certain level.

Q: Tell me at what level?

A: I should back up and say I don't have, in my mind, Dr. Chentow's background, but I assume he was not a board certified or trained cardiologist, but he

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was a house physician.

Any licensed physician ought to be able to handle the basic emergency of a chest pain, an acute myocardial infarction on a certain level. I wouldn't expect him to be able to do a cardiac catheterization.

Q: Would you expect him to be able to administer TPA?

A: Yes.

MR. ZUCKER: Do you mean to prescribe TPA?

MR. SCOTT: Yes.

A: Yes.

Q: (BY MR. SCOTT) Why do you say so?

A: TPA is probably most widely given by physicians who are working in primary care settings, emergency rooms. Those are not necessarily emergency room trained specialists.

There are most frequently around this country still folks who have background in primary care and no further specialty training other than that.

For any physician who is going to serve in the responsibility as a house physician and

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going to respond to emergencies, of which chest pain is an extremely common one and acute myocardial infarction is an extremely common one, ought to be qualified to make a decision regarding the indications, benefits and risks of administrating thrombolytic therapy for acute myocardial infarction.

Q: Is that a subject matter that would require keeping current on the literature?

A: Obviously the more current you are in the literature, the more knowledgeable, but it's a basic level of knowledge that a modern physician should possess.

Q: If in fact a doctor does not possess that information, does not treat with TPA, do those facts in and of themselves mean that that doctor is not qualified to be a house physician?

MR. ZUCKER: Object. Irrelevant. Go ahead.

Q: (BY MR. **SCOTT)** You may answer.

A: For adult medicine, yes. If it was a house physician taking care of a pediatric ward, perhaps not. If he was an obstetrician who was covering an obstetrical ward, perhaps not, but they would have a house physician who covered general medicine available

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who could respond.

So, yes, a house physician who has general medical responsibilities for adult medicine is responding to emergencies such as pulmonary edema, **as** Dr. Chentow listed in his deposition as a primary responsibility as a type **of** emergency response to myocardial infarction falls in the same category.

In fact, pulmonary edema is a fairly common complication of myocardial infarction so, yes.

Q: In the world of house physician standards and requirements of house physicians by community hospitals, are you familiar with what a hospital requires and what the standards of care require for the qualifications of a house physician?

MR. ZUCKER: Object to form. Go ahead.

A: I think you would have to specify which hospital you are referring to or if you are referring to published national criteria.

Q: (BY MR. **SCOTT)** Let's take this hospital, I mean in this instance, are you familiar with that hospital and its departments and sizes and requirements for house physicians?

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A: I don't know what their requirements and regulations are.
Q: What about published standards?
A: I am not aware of whether there are published standards for that particular issue.
Q: When we are talking about published standards, are there published standards that require a house physician to be able to administer TPA and be able to take care of coronary patients, to your knowledge?
A: I don't know.
Q: You would assume that the attending doctor, the attending cardiologist, and his covering cardiologist would be familiar with the patient's medical records as well; is that fair to say?
A: I would assume that the attending cardiologist should be familiar with the patient's history. To what extent the covering cardiologist is aware of the details is going to vary depending on many factors.
Q: The EMG of 1986, are you aware as to whether that is contained - was contained in the chart at the time?
MR. ZUCKER: In what chart, his

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hospital chart, or the chart from that administration that I received copies of or that you received copies of? Which chart are you referring to?
MR. SCOTT: The chart available in the medical - the coronary intensive care unit at the time that Dr. Chentow responded.
A: I don't know what was in the chart at that time.
Q: (BY MR. SCOTT) Would you expect the '86 EKG to be there?
MR. ZUCKER: Object.
A: I would expect that there would be a notation as to whether or not the EKG changes that were seen at any trace, whether new or old, whether that was the hard copy of the EKG that was in the chart, whether you had to go search for it, whether you had to call and have it FAX'd, which we do all the time when we have somebody come in for an EKG and we don't know whether the changes are new or old. We search.
We ask, have you ever had an EKG before, have you had a heart attack, have you had a catheterhation, have you ever had surgery, have you had EKGs, when and where, and we search for them in our own hospital. We call up and have them FAX'd to

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make comparisons.
So noting whether or not changes are new or old is critical. Each point in time when a physician is reviewing an EKG and sees abnormalities, the first question must be with respect to the ischemic heart disease, are these changes new or old and do I have a prior trace to know whether these are new or old or what their vintage is.
Q: (BY MR. SCOTT) So you would expect the chart to contain either the EKG or a statement as to its content, that is, the EKG of 1986, as of the time that Dr. Chentow was called to see the patient?
MR. ZUCKER: Or the fact that he had a heart attack in 1986, isn't that what you said, among other things? A reference to a previous heart attack, is that your question initially?
MR. SCOTT: No.
A: At each point where: there's an EKG and there's changes, it should be related to whether there were prior changes and whether those changes are new. Again, whether or not the hard copy is in the chart may be optimal but less critical.
Q: (BY MR. SCOTT) What physical examination would you have expected Dr. Chentow to perform when he

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was called? I thought you had mentioned that you wanted the doctor to do a history and look at the medical records and to do a physical examination?
A: Do you want me to go through the specific steps or just the general focus?
Q: Generally first.
A: As I stated before, in situations like this one does a thorough, but focused physical exam. So it would have been looking at the general appearance, whether the patient had abnormal mental status, whether the patient was short of breath, what level pain the patient was having, would have examined the vital signs carefully himself, not relying on rumor.
Q: Rumor you said?
A: Rumor or word of mouth or what is written down on the chart. It is the physician's responsibility to look at the patient, to measure the blood pressure or look and see if it is on a monitor, to either measure the pulse rate or look at it on the monitor at that time to measure the respiratory rate, to then examine, particularly with respect to cardiovascular abnormalities, looking at how the pump is doing, is the skin warm and pink with good flow or is it clammy and cool and bluish.

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Q: Is that what you mean by looking at how the pump is doing?
A: That is one reflection of it on physical exam. By listening to the lungs to see whether they are dry or not, whether there is evidence of fluid, to look at the neck veins as a reflection of feeling pressure on the right side of the heart, to feel the pulses in the carotid to get a feel for how severely the pump may be impaired, to feel the chest wall to see how enlarged the chambers may be, to listen to the heart tones to see whether there are abnormalities that reflect problem relating to heart attacks new and old and those sorts of things.
Q: As to all those items is there any reason you have to believe that that information was not properly communicated to Dr. Van Dyke by the nurse?
A: That is not the kind of assessment that a nurse is trained nor expected to do. It is a physician's job both to perform the examination and to communicate, which is another major issue in this case, quite frankly. This whole issue of – excuse me for using the term rumor, but let's say indirect communication.
I mean this patient had chest pain,

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got a potent clot dissolving drug and was never seen by a physician during the time of this episode of recurrent chest pain.
Q: Now, I want to only – I don't mean to interrupt.
A: As far as I know.
Q: I understand. I don't want to interrupt you, but I want to speak only prior to the TPA administration.
A: I am sorry. Ask the question again.
Q: I am referring only prior to the time period only prior to the TPA administration.
A: Then focus the question again for me. I am sorry.
Q: Is there any reason for you to believe these factors which you identified in the physical examination including all the vital signs, the appearance of the patient, the skin and the way the pump was working, any reason for you to believe that those factors, that information was not properly given and correctly given to Dr. Van Dyke by the nurse?
A: Well, I am convinced that that information wasn't properly communicated because it wasn't obtained by a physician.

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Q: What was missing
A The physician at the bedside examining the patient.
Q: I understand your position. What information was missing?
A: The entire assessment; the history, the physical exam, review of the medical records, synthesis as to the assessment and the plan for the patient communicated physician to physician, that was what was missing.
Q: Doctor, have you seen, in your experience, where a nurse, maybe someone else in the hospital, asks a physician in passing what an EKG reflects?
A: Yes.
Q: And in those circumtances – strike that.
Have you also seen it where the EKG is from a patient who has a cardiac history and is in pain and where the nurse is asking the house physician to say what an EKG reflects?
A: Just as a, oh, by the by is this interesting or, gee, I need some help with this patient?
Q: No. More of an inquiry – more of a request as to what does this EKG say, what is contained in the EKG?

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MR. ZUCKER: Just to set the record straight, the question is do you know of any instances where a person who has a cardiac history, where a nurse asks a doctor walking by in the hospital to interpret an EKG, correct?
MR. SCOTT: Walking by isn't quite – let me put it this way.
MR. ZUCKER: Are you referring to the curb side consultation that Dr. Lach talks about in his report.
MR. SCOTT: Let me ask it that way.
MR. ZUCKER: All right.
Q: (BY MR. SCOTT) You have seen Dr. Lack's report where he talks about a curb side opinion, something like that? I mean have you seen that occur in your career?
A: I think that most sophisticated and wise physicians are extremely wary of curb side consultations precisely for the reasons I think you are driving at, which is if you are walking down a hallway and someone says, here, I've got something interesting to show you, isn't that fascinating to peak your interest and to educate you, yes, that is fine, but that is not what we are talking about here.

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physically possible, not to do it by indirect communication through a nurse, not to treat a patient by a protocol and not to then further assess the patient by a FAX machine.

Q: Doctor, you were called in this case in January of this year; is that correct?

A: Yes.

Q: You have a list here of documents that you reviewed. Included in the list was reports of two other experts retained by the Plaintiff. Did you see those?

A: Yes.

Q: Both of those individuals were cardiologists?

A: Yes.

Q: Do you know those individuals or either of them?

A: I know Dr. Ader.

Q: I am not talking about Dr. Ader.

Do you know Dr. Ader personally?

MR. ZUCKER: He wants to know about my esperts.

I want to ask what possible relevance does that have to anything that is happening here?

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I object. You can answer if you want.

Q: (BY MR. JACKSON) Do you know Dr. Ader?

A: Yes.

Q: How do you know Dr. Ader?

A: He was a fellow in the same cardiology program I trained at in 1978.

Q: You were fellows together in that program; is that it?

A: He was senior to me. I was in the research laboratory and he was a clinical fellow.

Q: Do you know Dr. Ader to be a good, qualified cardiologist?

A: I knew him superficially 17 years ago when he was just finishing his fellowship, so I would have no opinion as to how he practiced cardiology since he left his training.

Q: How was he at that time from your understanding?

A: Good.

Q: He was a competent physician?

A: Yes.

Q: You disagree with his opinions in this case?

A: Some of them.

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Q: Which ones?

MR. ZUCKER: Object. Let's get the report out and let's not try memory exercises here.

Q: (BY MR. JACKSON) You disagree with Dr. Ader's opinions as it relates to Dr. Van Dyke?

A: Yes.

Q: Now there are two other – in terms of the information that you reviewed in preparation for your opinions in this case, there were two reports.

MR. ZUCKER: Dr. Ross and Dr. Gore.

Q: (BY MR. JACKSON) In addition to Dr. Ader's, you reviewed a report of Dr. Joel Gore and one of Allan Ross?

MR. ZUCKER: Same objection.

Q: (BY MR. JACKSON) Do you recall reviewing those before rendering your opinion?

A: Yes.

Q: Which one are you looking at right now?

A: I have both of them in front of me.

Q: Which one is on top?

A: Dr. Gore.

Q: Dr. Gore, do you know him to be a board certified cardiologist?

A: Yes.

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Q: From what institution?

A: He is at the University of Massachusetts.

Q: Is that a good medical institution as far as you know?

A: Yes.

Q: Do you note in Dr. Gore's report an absence of any criticism of Dr. Van Dyke?

MR. ZUCKER: I still have a continuing objection to any questions regarding other Plaintiff's experts or not being called to testify at trial in this matter, and whose depositions have never been taken?

A: Could you ask the question again.

MR. JACKSON: Would you read that back for him, Miss.

(The requested portion of the record was read by the reporter).

A: No. In fact, I think there are very clear criticisms of Dr. Van Dyke.

Q: (BY MR. JACKSON) Where do you see Dr. Van Dyke's name mentioned?

A: I think it's simplied. If I can read throughout, I will quote the section.

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Q: Sure.
A: On page two of Dr. Gore's letter he states first paragraph of that page, in addition there was a deviation in the standard of care in the administration of thrombolytic therapy. The hospital's own guidelines relative to thrombolytic therapy indicate a number of relative contraindications to the administration of TPA. Thus, if indeed Mr. Grasgreen was having a heart attack, which he wasn't, then alternative forms of therapy should have been considered and he should not have received TPA.

I think therein lies one of the key issues in this case that this patient was not having a heart attack. If the attending physician had carried out his responsibilities to handle this case in the ways that I have already articulated, this patient never would have been given TPA.

So I agree with Dr. Gore that the patient was not having a heart attack, did not have an indication for TPA. It was Dr. Van Dyke's responsibility to make the decision to give TPA. He made the wrong decision, which contributed to this patient's demise.

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Q: Does Dr. Gore mention Dr. Van Dyke at all?
A: No.
Q: Does he mention Dr. Chentow?
MR. ZUCKER: By name?
MR. JACKSON: Yes.
A: Yes, on the second paragraph of that.
Q: (BY MR. JACKSON) Does he mention the hospital employees?
A: Yes.
Q: Let's go to Dr. Ross' letter. Dr. Ross is from what institution?
A: George Washington University.
Q: Is that a good medical institution in your opinion?
A: Yes.
Q: By the way, when is Dr. Gore's letter dated?
A: July 5th, *1994.*
Q: What about Dr. Ross' letter?
A: The same.
Q: Do you note an absence of any criticism of Dr. Van Dyke in Dr. Ross' letter?
MR. ZUCKER: Are you going to retain these people as experts in this case?
MR. JACKSON: Am I?

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MR. ZUCKER: Yes.
MR. JACKSON: No, I don't anticipate.
MR. ZUCKER: Is anybody doing a cross examination?
MR. JACKSON: Do I intend? Yes, you bet I do.
MR. ZUCKER: Of these doctors, Dr. Ross or Dr. Gore, is anybody else here going to be to questioning them?
MR. JACKSON: I don't know. I suppose that will depend upon what other people decide to do.
Q: (BY MR. JACKSON) Do you need that question repeated?
A: No. I think I remember it. I would answer it similarly to the other letter, which is - although Dr. Van Dyke is not named specifically.
Q: Does he name Dr. Chentow and hospital employees?
A: May I finish my answer?
Q: Let me ask you that and you can finish your answer. Does he mention - you noted that he didn't mention Dr. Van Dyke, but does he mention Dr. Chentow

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and hospital employees?
A: You have got kind of three questions on the table. If you could just restate it one at a time, I will be happy to tackle them one at a time.
Q: You wanted to make the point that he did not mention Dr. Van Dyke by name. Does he mention Dr. Chentow by name in his report?
A: I didn't want to make the point that he didn't mention him by name. I was trying to answer another question and use that as the introductory sentence.
Q: Does he mention Dr. Chentow by name in his report?
A: Yes.
Q: Does he mention the hospital employees by name in the report or references hospital employees?
A: He also mentions Dr. Van Dyke by name,
Q: Does he?
A: Yes.
Q: How so?
A: It's typed on the paper these.
Q: You just said he didn't mention his name,
MR. ZUCKER: He didn't mention him in what context?

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MR. JACKSON: We know what context we are taking about.
A: He has mentioned a lot of people in here.
Q: (BY MR. JACKSON) Doctor, as it relates to his opinions of inappropriate care he mentions Dr. Chentow by name, does he not?
A: Yes.
Q: And he refers specifically to the hospital employees, does he not?
A: He refers to attending Nurse Jordan.
Q: He makes no reference to Dr. Van Dyke by name, correct?
A: With regards to standard of care, no, he doesn't.
Q: Now you wanted to make some point that although he doesn't mention Dr. Van Dyke, you were going to say something and I got into the other names and what was that?
A: The original question you asked was is there anything in Dr. Ross' letter that has any comment with regard to departures of the standard of care by Dr. Van Dyke. I don't want to put words in your mouth, but I thought that was the question.
My answer was going to be similar

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to Dr. Ross' letter in that they both focus on one of the key issues, which is that this patient died from complication of TPA and that this patient should have never received TPA, because he was not having an acute myocardial infarction.
As I answered with respect to Dr. Ross' letter, if the attending physician had done his job properly, this patient should have never received TPA.
Q: Quote for me from Dr. Ross' letter where you see that he was critical of Dr. Van Dyke.
MR. ZUCKER: Object here for one second.
Doctor, I would advise you not to answer these questions, but I am really not your attorney and I can't do that. I will tell you that it is a total waste of time and that I wouldn't waste my time. I would let the court - if Mr. Jackson persists, I would let the court decide at later time whether or not you have to do these things relative to answering the questions or read for Mr. Jackson from these two letters.
Q: (BY MR. JACKSON) Let me make a suggestion to you, Doctor. He is wrong because these are materials

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which were sent to you and which you reviewed, not only did you review them and read them, I note that in your review of them you very carefully underlined a number of passages in all of these documents; is that a fair statement?
MR. ZUCKER: You don't know that I didn't do that before he saw the records.
Q: (BY MR. JACKSON) Did you do that underlining?
A: Yes.
MR. ZUCKER: I underlined as well.
Q: (BY MR. JACKSON) That is your underlining?
MR. ZUCKER: Go ahead and tell him why I am wrong.
Q: (BY MR. JACKSON) Am I correct, Doctor?
A: Yes.
Q: So you reviewed these not only just reading them, but you underlined passages in both of those letters; is that true?
A: That's correct.
Q: Now if he suggests to you not to answer these questions, he is wrong, because you do have to answer these questions. Now whether or not these questions -

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MR. ZUCKER: You were going eo tell him why.
Q: (BY MR. JACKSON) - these questions come out at an appropriate time in court and it is for the judge to decide. It is not for any one of us here to tell you as an expert in the case not to answer the question. So I would suggest to you not to do that because that would not be appropriate and these were materials which you reviewed and reviewed in some detail. So these are in fact appropriate questions which I think you have to answer.
MR. ZUCKER: Excuse me.
MR. JACKSON: No. We are wasting a lot of time.
MR. ZUCKER: Go ahead. Follow his advice and answer the questions. He's paying you.
A: My response would be that I am the expert in cardiology and the legal stuff you guys need to settle.
Q: (BY MR. JACKSON) Exactly.
A: Why don't you guys decide what you want me to answer. If you want me to answer, I will be happy to tackle it as best I can.
MR. ZUCKER: Go ahead and answer

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his questions.
Q: (BY MR. JACKSON) Quote from Dr. Ross' letter, if you would, where you believe he criticizes Dr. Van Dyke's care of this patient.
A: Indirectly?
Q: However you imply or read it, Doctor, because he doesn't do it directly, does he
A: No.
Q: Nor did Dr. Gore directly?
A: No.
Q: So where do you read into Dr. Ross' letter that he criticizes Dr. Van Dyke?
A: The next to last paragraph says, a strongest argument against thrombolytic therapy, however, was that the electrocardiograph indications for giving the patient TPA did not exist. Furthermore, the electrocardiograms on his final admission were essentially unchanged from acute tracings at the time of his 1986 myocardial infarction, hence, should have been interpreted as most compatible with an old left ventricular aneurysm.
And that really is the essential issue that I articulated with regard to the other letter and I also addressed in my comments.

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Q: Why do you suppose that Dr. Gore acting as the Plaintiff's exper in his review of the case as well as Dr. Ross acting as the Plaintiff's expert in the review of the case didn't criticize Dr. Van Dyke?
A: You would have to ask them.
Q: What is your understanding of that?
MR. ZUCKER: Object. And you really don't have to answer this question, but that is up to you.
A: I think you would have to ask him.
Q: (BY MR. JACKSON) Do you have any understanding of why they didn't criticize Dr. Van Dyke?
A: You would have ask them.
Q: I am not asking them.
A: I don't know.
Q: You don't know?
A: I don't know. You would have to ask them.
Q: Were you asked to specifically focus on Dr. Van Dyke in your review of this case?
A: I was asked to review the case, period.
Q: Did it strike you as unusual or odd that two other cardiology experts did not criticize Dr. Van Dyke directly?

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MR. ZUCKER: Object.
A: I can't answer that question.
Q: (BY MR. JACKSON) Why?
A: I don't want to be –
MR. ZUCKER: Answer the question.
Answer the question.
A: My position was to review this case from my perspective and my opinion. They focused on the same basic arguments that I did that the fundamental issue here was a mistake in giving TPA for the reasons that I have articulated. I don't know what their full opinions are. I don't know if these letters express their full opinions.
If you had them sitting here answering these questions the same as you asked me, they might come out and criticbe Dr. Van Dyke as well. I suspect that they would, but again that is something you will have to ask them.
Q: Did it strike you as odd that they didn't mention Dr. Van Dyke by name in their reports?
A: I tried to answer that as best I could.
Q: The answer you gave me is the best you can do in that regard?
A: Yes.

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Q: Why were you sent those reports?
A: You have to ask Mr. Zucker.
Q: Of what significance did they have to you?
A: Just part of the record. I was sent many materials and I looked at everything that was sent to me.
Q: In what areas of medicine do you consider yourself to be an expert?
A: They guess it depends on how you define an expert.
Q: You used the term earlier in your examination that you were an expert in certain areas I think you said. So whatever definition you use of expert. What areas of medicine do you consider yourself to be an expert?
A: I am a board certified internist and I consider myself to be expert in internal medicine. I am a board certified cardiologist and consider myself to be even more expert in cardiology.
I have spent the past 15 years doing a lot of clinical and experimental research, writing and lecturing around the country, and in fact in many places around the world, on all aspects of heart disease, put particularly in the areas of

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myocardial infarction, heart failure, cardiac transplantation, many other areas in cardiology.
Q: Do you administer TPA?
A: Yes.
MR. ZUCKER: Do you mean diagnose? Is your question does he diagnose TPA or do the actual administration?
MR. JACKSON: TPA is not a diagnosis.
MR. ZUCKER: Does he prescribe TPA or does he administer it?
MR. JACKSON: He said yes.
A:: I both prescribe it and physically administer it. So the answer is yes, both.
Q: (BY MR. JACKSON) You do both?
A: I do both.
Q: Okay. If you had a patient such as Mr. Grasgreen, okay, assume that there were no contraindications to the administration of TPA and assume that you believed he was having an evolving myocardial infarction. Would the administration of TPA be appropriate for that individual?
A: Yes.
Q: How much do you intend to charge if you come

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to Cleveland?
A: I haven't really thought about it.
Q: What have you charged in the past when you go to court out of town?
A: Depending on the distance, the time involved, anywhere from *$4,000* a day and **up.**
Q: What is your max per day?
A: I have only done it twice.
Q: You charged *$4,000.* Did you charge more than that at some other time?
A: No, but it depends on the distance and the time involved with travel and the amount of time involved with discussions, and the amount of time spent at the trial itself.
Q: Is that *$4,000* per day plus your travel expenses?
A: Yes.
Q: What are your parameters beyond *$4,000* is what I am trying to understand. It is *4,000* to what?
A: No upper limit. Again, I haven't sat down or thought about it or negotiated.
Q: In the two times that you testified in court out of town, what did you charge, one was *4,000* or were they both 4,000?

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A: Those are ballpark figures. One was many years ago and I don't recall how long I spent and what I charged. The other one was more recently and I think it **took** me the better part of a day and-a-half or two days. I think the total charges came close to $10,000.
Q: Have you ever been sued?
A: No.
Q: You are not going to render an opinion as to Mr. Grasgreen's life expectancy, correct?
MR. ZUCKER: Objection. He stated if he was asked to, he would. That's exactly what he said.
Q: (BY MR. JACKSON) Let me ask it **this** way: Do you have an opinion as to Mr. Gmsgreen's life expectancy, an opinion to a reasonable degree of medical certainty?
MR. SCOTT: Object. He's answered that he does not have an opinion.
MR. JACKSON: That's what I thought he said. That is what I am trying to clear up.
Q: (BY MR. JACKSON) You did not have such an opinion?
A: No, not to a reasonable degree of medical

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certainty.
MR. ZUCKER: Would - well, go ahead.
MR. JACKSON: Thank you.
MR. ZUCKER: Do you want me to ask him the follow-up question?
MR. JACKSON: No, because the follow-up question as to what his opinion would -
MR. ZUCKER: I thought he said that he had to do more research now that he knows he may be asked that question.
Q: (BY MR. JACKSON) Doctor, my understanding is, because I thought Mr. Scott inquired to some extent on this, there is no information that you could obtain now even if you chose to go out and look, because there are some variables here which can't be answered, for you to render an opinion as to life expectancy of Mr. Grasgreen? Did I understand that correctly? In other words, you do not have an opinion right now to a reasonable degree of medical certainty as to life expectancy?
A: That is correct.
Q: Even if you sat down and did research, there is no information that would assist you in reaching a

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reasonable degree of medical certainty as to life expectancy because there is certain information about his cardiac condition which is lost, which we will never know.

A: That's correct.

Q: Did I understand you to say that in terms of heart attack or MI, you talked about enzymes, and the **CM** enzymes had to be high – I am trying to recall what you said in that regard.

A: The CK enzymes are an indicator of actual destruction of heart muscle tissue.

Q: What is MB?

A: That is the subfraction of the enzyme that is specific for the heart.

Q: If those are elevated, that tells us what?

A: It tells you, depending on the total of the CK and the percentage of the MB and the specific range of normals for that laboratory, which vary somewhat from hospital to hospital depending on the techniques they use. When it's abnormal, that indicates that there has been some infarction.

Q: Infarction in lay terms is heart attack?

A: That's correct.

Q: Now would those values maintain a high level

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or I mean can they go up and then go back to a normal range and still indicate a heart attack or does that make any sense?

A: The pattern of time at which they rise and then decline depends on the pattern of the blockage that typically, if there is a total blockage, they rise within a certain number of hours and then go on and fall back to normal over several days, unless there are new occlusions that develop or the arteries are opening and closing. So there is a time frame that gives you information about what is happening.

Q: Now did I understand you to say that as it relates to this case you don't know whether Mr. Grasgreen in fact had a myocardial infarction at the hospital?

A: As far as I recollect from my review of the laboratory data I was never able to find any elevated enzymes to suggest that he had a documented heart attack.

Q: These are the records that you reviewed?

A: Yes.

Q: And there is a cardiac injury profile and apparently you had circled or someone circled some values here. Do those not indicate elevated CK-MB

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enzymes?

MR. ZUCKER: Increased enzymes doesn't necessarily mean heart attack.

MR. JACKSON: I thought he just said they did.

A: I think the reason – you will note this isn't flagged.

Q: **(BY** MR. JACKSON) Let me ask first: Do those not indicate in the lab values that there were elevated **CK-MB** e q m e s ?

A: They are borderline elevated. This is a level of rise that is not diagnostic. In other words, the total CK is not abnormal. The total CK is within the normal range and therefore a small elevation of the CK-MB does not necessarily indicate that this is a myocardial infarction.

Q: What does the index indicate?

A: The index is high, but the index has to be interpreted within the range of the total. When the total is not elevated – even a slightly increased index can be misleading. **So** it's possible this could represent some infarction, but it's not absolute.

Q: On those values there are two values, the first two values are for the 21st; is that correct?

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They are on the right-hand side.

A: Right.

Q: Those are elevated; am I correct?

A: The total CKs?

Q: No, sir. The MB fraction, which is specific to heart as I understood you to say.

MR. ZUCKER: CK-MB?

MR. JACKSON: Right.

A: The fiist one is not elevated. It's within the normal range. The second one is minimally elevated and the third one is back down to the normal level.

Q: I thought it said high, or is that the index?

A: That is the index.

Q: The second one is high, is that right, and that's a later one on the 21st, what is it, 11:01?

A: Yes.

Q: Apparently is the time?

A: Yes.

Q: Then those values on the 22nd go back to normal?

A: Yes. We are talking about very subtle changes, very subtle changes.

Q: According to the laboratories at Hillcrest

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Hospital, those are elevated?
A: Yes.
Q: You did not believe those to be indicative of myocardial infarction?
A: I think they could possibly represent myocardial infarction. They are in a range where you can't be sure.
Q: What information would you need to, in addition to those values, to be sure whether there was a myocardial infarction?
MR. ZUCKER: The question is how do you diagnose myocardial infarction.
Q: (BY MR. JACKSON) What else would you need?
A: A whole set of other parameters and a general clinical profile, a pattern of chest pain, a pattern of EKG changes, changes in wall motion, changes in clinical hemodynamic status, angiographic findings, all could be useful in these kinds of borderline cases.
This is a very common finding when you say, gee, chest pain, the patient has coronary disease, the CKs are borderline elevated. I don't what this is from, the skeletal muscle, which could be from the heart and we need other confirmatory

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evidence. Sometimes it is hard to know whether this was a tiny little bit of infarction.
For this degree of enzyme elevation it really doesn't matter. The critical issue is, is the pain coming from the heart, what is the pattern of narrowings and how do we treat it.
Q: You determine that with what, a catheterization?
A: Well, a combination of history, physical exam, non-evasive studies.
MR. ZUCKER: Excuse me.
(Discussion held off the record).
Q: (BY MR. JACKSON) As it relates to your board certification, Doctor, were you successful in those tests on the first attempt?
A: Yes.
Q: Have you ever been denied staff privileges or have they ever been revoked from or suspended from any hospital?
A: No.
(Discussion held off the record).
Q: (BY MR. JACKSON) Just a couple more, Doctor.
I have here what I understand to be your file as it relates to this case. Was there

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anything taken out of this file before the deposition or is this your complete file?
A: It's complete.
Q: I have a couple of questions here. I went through this earlier. There are some things I am unable to read. On the back of your – is a letter from Mr. Zucker dated January 23rd, 1995. There are a number of notes that you have written. Actually on the front of the second page also.
I would like copies of these. I don't think we need to mark this, but have your nurse or maybe give him your file and he can copy it and send it back to you. Timewise it might be the easiest thing to do.
A: That's fine with me.
Q: There are some small notes in here. There's one with your name on it. What is that note? That's your handwriting I take it?
MR. ZUCKER: Dr. Van Dyke's progress note on the 22nd regarding the nurse's notes on the 21st.
Q: (BY MR. JACKSON) What is the significance of that?
A: I don't remember. I would have to go search

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through the records to see why that was relevant.
Q: Since you received the initial materials which are listed in the letter from Mr. Zucker on the 23rd of January, have you reviewed any additional materials?
A: I don't think so.
Q: Here is a note. It's again in your handwriting?
A: Right.
Q: What is that?
A: That was the hand note regarding a recent conversation to prepare for this deposition, just what he would like me to – what he wanted me to review and in particular to focus on for the deposition.
It says review all depos in detail. Then I made a detailed note to myself, particularly the issue of he said/she said and who said what in terms of who was told what, what the communication was between Dr. Chentow and the nurse, what the communication was between the nurse and Dr. Van Dyke.
Q: As it relates in the hospital chart here, there's some yellow stickums and notes that you made, were those made in preparation for the deposition?

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A: I think they were predominantly made during my initial review. Then in preparation for this deposition I read through the materials again using my paginated marks and annotations. I don't think I made any new ones. Most of the notes and comments were made during my initial review.
Q: The little blue card here, would you read that for me and tell me what that is all about?
A: This card I think was some notes I made during my initial conversation with Mr. Zucker regarding the essence of the case as he communicated it.
Do you want me to read through it and interpret it?
Q: Yes, please.
A: Conference with Zucker, attorney. TPA, 74 year-old male, Chest pain, nitroglycerin.
ECG: Within normal limits. 18 hours later recurrent chest pain. House staff versus RN question disputes, question relieve with nitroglycerin, "new acute MI." Then nurse to m.d. on phone (covering in car.) Then a comment that says prior MI, continued hypertension coumadin, recurrent PE.
The other side it says tells nurse

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to start TPA then gets EKG FAX'd to home. No acute MI. Stop TPA. Later fatal intracranial hemorrhage. Then didn't check patient. RN didn't look in chart and then 1-19-95 one half hour discussion.
Q: That was the information apparently from the first conversation you had with Mr. Zucker about the case?
A: Correct.
Q: In your file here there's a copy of Dr. Ader's report. At the bottom there's some notes that you made. I wonder if you would read those in. Those were difficult to interpret.
A: It says, why not m.d. to m.d. communications. Question mark, how far away.
Q: Relative to what?
A: I think where Dr. Van Dyke was.
Q: Okay.
A: Question, how long to drive to hospital.
Q: Again, referencing Dr. Van Dyke?
A: Correct. Question, other attendings inhouse. Question, did he ask who read EKG, did he ask to speak an m.d.
Q: Did you answer those questions or were those answered for you in some fashion?

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A: I am sorry?
Q You posed questions as you reviewed Dr. Ader's report?
A: Yes.
Q Did your review or preparation for your deposition resolve those questions for you?
A: Some of them
Q: Which ones?
A: Whether there were other attendings in the house or at least other physicians in the house.
Q: What was the answer?
A: There were clearly other physicians in the house. Did he ask who read the EKG I think was unclear. Did he ask to speak an m.d. It seems that he didn't. How far away he was I don't know. How long a drive to the hospital I don't know.
Q: What is this note down here? I can't make that out.
A: It says agree.
MR. JACKSON: I don't need to mark all this, but I need copies.
MR. ZUCKER: I will take the file and make copies.
Q: (BY MR. JACKSON) Do you anticipate to appear

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live in this case?
A: If requested.
Q: Have you been requested to appear live?
A: Yes.
MR. ZUCKER: Do you have an airplane reservation for Tuesday, Doctor?
A: Yes.
MR. JACKSON: No further questions at this time.
RE-EXAMINATION BY MR. SCOTT:
Q: Doctor, would you mind looking at the EKGs that you referenced and just tell me if you see any changes of any kind as among the EKGs leading up to the one on May 21 and comparing it to the one of May 21 at about 5:50, I believe.
A: Could you restate the question with regard to the essence of how you want me to address that.
Q: Yes. I want to know whether you see any changes of any kind or discrepancy, any changes whatsoever, in the EKGs taken at admission and through, I believe it's May 21 at about 5:50 in the evening.
A: Can I pull this out and turn it side by side? It's hard to compare one with the other upside

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down.
MR. ZUCKER: Sure you can.
You are not asking about the '86?
MR. SCOTT: Not yet.
Q: (BY MR. SCOTT) Yes, if you wish to do it that way, that's fine, but I am most interested in the EKGs. I want a separate question as to the EKGs in the hospital upon admission and through the time of the EKG of May 21 at 5:50.
MR. ZUCKER: That's 7:17 in the morning. You want that one, yeah. And where is the admission.
A: They were out of order. I am looking first here on the 20th of May 1993, 2204, which I understand to be the initial EKG for that admission. The next one I have is the 2Pst of May at 7:17 in the morning and those essentially are the same.
Q: Do you see any changes, Doctor?
A: No significant changes in those two.
Q: What changes do you see?
A: No significant changes - there is no significant changes.
Q: *Are* any changes?
A: Well, one has a little bit more artifact.

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These are not measuring pie to seven digits. These are traces from patients.
If I take an EKG from you now and do one ten minutes later, there will be subtle differences in the baseline, but I don't see any differences of importance. Nor do I see any on the 21st of May at 1750.
Q: You see no change between the EKG done at 7:17 in the morning or the one done at the time of admission?
A: Either. They are all basically the same.
MR. ZUCKER: As compared to the one at 5:50 p.m. on the 21st.
A: All three EKGs, the one on the 20th of May at 2204, the one on the 21st of May at 7:17 and the one on the 21st of May at 1750. There are no significant changes listed. And compared to the original or the most distant one in the past, which I have a hard time seeing the date -
MR. ZUCKER: Agree to November of '86. John, you will agree that that is November of '86?
MR. SCOTT: Yes.
A: There are some changes compared to '86. The anterior myocardial infarction, leads V1 through V4 are, at least V1 to V3, are merely identical. V4, V5 and V6 are different - it's hard to know what they mean. Leads 1 and leads AVL also have some changes compared to that one from 1986.

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Q: (BY MR. SCOTT) Are there T-wave changes in the EKGs from admission through May 21 at 5:50?
MR. ZUCKER: Are there any changes between the three?
MR. SCOTT: Right.
A: Minimal. Not that I would consider significant.
Q: (BY MR. SCOTT) What is the significance of a T-wave change?
A: They can be very nonsignificant. It depends on their pattern. They may be like we see here, those kind of changes from EKG to EKG that can change with subtle changes in your sodium or your potassium or your blood pressure. A lot of other things. When they are subtle, they are nonspecific and can be innocent, but they can be indicative of Something more serious.
When they are dramatic, we have abnormal and you have to have something to hang your hat on; again, depending on the comparison to prior traces if they are available.

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Q: Would you look at the one again for May 21 at 5:50, the EKG for that time. Are there Q-waves in V1 through V3?
A: Yes.
Q: One to two millimeter elevation at V1 through V3?
A: Yes.
Q: ST segment inversion in V4 through V6?
A: Yes.
Q: Anything else of significance?
A: There's some T-wave inversions in 1-AVL as well.
Q: Thank you, Doctor.
You are critical of the nurses in this case, are you not?
MR. ZUCKER: I object to the form. You can answer. Nurses?
MR. SCOTT: Perhaps.
A: I really haven't focused on the nurses in terms of his role in this. I thought the responsibility really laid with the physicians in this case. I didn't have any information that made me

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think that the nurse was in any way significantly responsible for the outcome here.

Q: (BY MR. SCOTT) Did you read the nurse's deposition?

A: Initially I did. I have not reviewed it for this deposition.

Q: Did you read the nurse's deposition as it related to review of the contraindications for TPA?

A: At one point I did.

Q: Were you critical of the nurse in that review?

A: You would have to special ask me a specific question.

Q: I wouldn't be able to just now as a matter of fact, but I think there are reports that detail the criticisms of the nurses in other expert reports.

MR. ZUCKER: Such as Dr. Ader's report, which indicates that the nurse was lax because the nurse didn't know what a known bleeding diathesis was. Do you recall reading that, for example?

A: I recall at some point in the documents.

MR. ZUCKER: Dr. Lach suggests that – he questions the nurse asking for a EKG. Do you recall that?

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A: No.

MR. ZUCKER: All right. I thought I could refresh his memory.

Q: (BY MR. SCOTT) When is a patient a candidate for catheterization?

A: Potentially I don't have enough data to make the decision. That is, again, something that you would want to make as a physician cardiologist assessing the patient properly at the bedside with a quality history, physical exam, review all relative data, some noninvasive tests, discuss it with the patient and family.

MR. SCOTT: That's all I have. Thanks, Doctor.

RE-EXAMINATION BY MR. JACKSON:

Q: Doctor, do you, as it relates to the hospital and the nurse, disagree with opinions of Dr. Gore and Dr. Ross?

MR. ZUCKER: Objection. Go ahead.

A: Which opinions, the letters that we went through before.

Q: (BY MR. JACKSON) Are you critical of the hospital and the nurse?

A: I certainly agree with Dr. Gore that the patient was not treated well. I also agree with him to some extent that it's hard to know from the interpretation of events who said what to whom.

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I have, as I stated, very firm opinions about the responsibility of the physicians who always must and should bear the ultimate responsibility for taking care of patients.

I think that the nursing care may have been less than optimal, but I really point my fingers more at the physicians in this case.

Q: So you do or do not disagree with Dr. Gore? Is that Gore you are reading?

A: I tried to answer the question as best I could.

Q: How about Dr. Ross?

A: I certainly agree with Dr. Ross that there was a departure from the standard of care with respect to Dr. Chentow and really at this point would have to go back and review in detail the information and have you ask me specific questions about Nurse Jordan to render an opinion as to whether I agree with him or not in that regard.

Q: So that I am clear, one last point. In a patient such as Mr. Grasgreen, if it is in fact true

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that he was having chest pain for an excess of 30 minutes, or approximately 30 minutes, unrelieved by an increase in nitroglycerin and that the EKG had been read as indicating an acute interior MI with changes from the morning to the afternoon EKG, would you agree that that patient would be a candidate for TPA?

MR. ZUCKER: Hold that thought. I object. That is a mischaracterization of the facts in this case, but as a hypothetical go ahead and answer.

A: I was going to answer the same way. The reality was that there weren't acute changes indicative of an acute myocardial infarction.

Q: (BY MR. JACKSON) My question to you, Doctor, was if in fact the things that I just said to you are true, if in fact it is true, I am asking you to assume the following, okay: If a patient such as Mr. Grasgreen had chest pain for 30 minutes or more, unrelieved by increase in doses of nitroglycerin, an EKG has been read as acute interior MI with changes from an earlier EMG, that man is a candidate for TPA administration; is that correct?

A: Correct.

MR. JACKSON: I have no further questions.

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MR. SCOTT: Let me just ask a couple more follow up.

RE-EXAMINATION BY MR. SCOTT:

Q: Where a patient is having chest pain and with a coronary history and it's unrelieved by nitroglycerin, are those consistent with the patient having an MI, that is, the unrelieved chest pain, is that consistent with a patient having an MI?

A: Consistent with, but not diagnostic of.

Q: You, in your practice, rely upon nurses to give information that you give to them to other doctors, do you riot?

MR. ZUCKER: Object. Go ahead.

A: If I have important clinical informtion, I communicate it to a physician directly.

Q: (BY MR SCOTT) For example, you might tell a nurse to advise another doctor of certain laboratory findings?

A: Yes.

Q: You might tell a nurse to advise another doctor - let me back up. You might tell a CCU nurse to advise another doctor of EKG findings?

A: Depending on the situation I would either do it directly if I thought it was a critical issue or I

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might do it indirectly if I thought it was something that could be communicated indirectly.

Q: By indirectly you have sometimes asked nurses to communicate EKG findings to another doctor?

A: I am not sure that I ever have. I think findings, yes.

Q: Nothing unreasonable in doing that?

A: Depends on the situation.

Q: When you say findings, do you mean, for example, ST changes?

A: You moved from do I have nurses communicating with physicians about information to EKGs, and I don't use nurses to communicate with others physicians important findings like changes in an EKG, no, I don't.

Q: Do you find that is not appropriate?

A: In that particular kind of case, no, I don't think it's appropriate

Q: Is it appropriate in your mind for a doctor to rely upon a nurse to accurately convey information given to her to another doctor?

A: Absolutely. It's important that we all communicate accurately, whether it's from a secretary to a lab technician or physician or a nurse. I mean

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we all work together. We have to communicate together, but there is a chain of command and there are responsibilities. And depending on the context of the problem and the problem itself, these are things that can be communicated through others, there are things that have to be communicated directly and there are situations in which physical presence is necessitated.

Q: I understand what your position is in that regard. I asked a slightly different question.

Should a CCU nurse be able to accurately convey EKG findings given by a doctor to another doctor?

A: I think the way you phrased it you could have an answering service do it or you could do it over voice mail.

MR. ZUCKER: So the answer is yes?

A: To that extent, yes. You could do it with a telegram or E-mail.

Q: (BY MR. SCOTT) So in this instance, of course, assuming that the nurse did not convey accurately what was told to her by Dr. Chentow to Dr. Van Dyke, I presume you would be critical of the nurse in that regard?

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A: That's a hypothetical. Could you rephrase that for me.

Q: Sure. I will try to.

If the nurse in this instance did not accurately convey what was given to her by Dr. Chentow - let me back up. If the nurse in this instance did not convey to Dr. Van Dyke the information given to him by Dr. Chentow, you would be critical of the nurse in that regard, would you not?

A: Yes, I would.

MR. SCOTT: That's all I have. I thank you very much, Doctor.

MR. JACKSON: I have one other point, Doctor.

RE-EXAMINATION BY MR. JACKSON

Q: What is your understanding of who the Defendants are in this action, in the legal action?

MR. ZUCKER: Their names or their legal status?

MR. JACKSON: Who they are.

MR. ZUCKER: Their names.

A: You know I never asked - I assumed that it's - I assume that Dr. Van Dyke is a Defendant and I assume that Dr. Chentow is, other than that I don't

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know.
Q: (BY MR. JACKSON) As a part of your package you received information with requests for admissions and other legal pleadings relative to the hospital as being a Defendant in this action also. I assume you reviewed all of that information?
A: I didn't really focus on the legal documents themselves.
Q: You didn't review the documents?
A: I probably looked at them briefly paging through it. I tried to focus more on the medical issues.
Q: When you wrote your report on February 28th of 1995, what was your understanding of the status of the claim against the hospital?
A: I don't think I ever focused on it or addressed it. My responsibility was to analyze the case and comment on the medical care.
MR. ZUCKER: Did you know that I had settled with the hospital?
A: No.
MR. ZUCKER: Okay.
Q: (BY MR. JACKSON) Were you aware that the hospital was a Defendant in this action?

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MR. ZUCKER: Technically probably not. I told you that I had settled with the lawyer for the nurse and the hospital.
We will stipulate to it. He knows about it.
Q: (BY MR. JACKSON) Were you told when you wrote your report that the claims against the hospital had been resolved by settlement?
A: No.
MR. ZUCKER: It hadn't been settled until thereafter and I told him immediately.
A: I don't even know if I knew it up until this point.
Q: (BY MR. JACKSON) Were you asked to focus on just the doctors care in this?
MR. ZUCKER: Asked and answered.
A: No.
MR. JACKSON: No further questions.
MR. ZUCKER: For the record I have got an hour-and-a-half. It's now almost 5:30. I have an hour-and-a-half, two-and-a-half, two hours and 45 minutes of your time, Doctor, we took here today; is that correct?
A: I don't punch a clock. We started at 2:30.

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MR. ZUCKER: And your rate is $500 an hour?
A: Only because these guys were gentlemen.
MR. ZUCKER: I am sure they will be gentlemen and pay you promptly as well.
Doctor, you have the right to read this deposition to make sure that your testimony is transcribed properly. I might suggest only because - I am sure this court reporter is extremely competent - only because it is from another jurisdiction and the names and places may be foreign that you do not waive and that you review your deposition.
A: I would be happy to.
(Deposition concluded at 5:30 p.m.)

SIGNATURE OF THE WITNESS

SUBSCRIBED AND SWORN to before me this day of ,19 .

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NOTARY PUBLIC
My Commission expires: .

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CERTIFICATE OF NOTARY

STATE OF MICHIGAN)
)SS
COUNTY OF OAKLAND)

I, Joan Martin, CSR 0111, a Notary Public In and for %he County of Oakland, Sate of Michigan, do hereby certify that the deposition of James A. Goldstein, M.B. Was taken before me on the Ist day of June, 1995, at the time and place hereinbefore set forth; that the witness was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth, that thereupon the foregoing questions were asked and the foregoing answers were made by the witness which were duly recorded by me stenographically and later reduced to computer transcription under my personal supervision; and I do certify that this is a true, full and correct transcript of my stenographic notes so taken.

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I do further certify that the signature to and the reading of the deposition by the witness was requested by counsel for the respective parties hereto; also, that I am not related to, nor of counsel to either party, nor interested in the event of this cause.

Joan Martin CSR 0111
Oakland County, Michigan

My Commission expires:
October 16, 1998

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