The State of Ohio,)
) ss:
County of Stark.)

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IN THE COURT OF COMMON PLEAS

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Stephan Germanoff, Administrator, of the Estate of Connie Sue Germanoff,

Plaintiff,

vs.

Aultman Hospital, et al.,

Defendants.

Case No. 2000 CV 01475

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Deposition of Ginger A. Hamrick, M.D., a defendant herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Frank P. Versage, RPR, CLVS, Notary Public within and for the State of Ohio, taken at the offices of Buckley, King & Bluso, 935 W. Market, Akron, Ohio, on Tuesday, December 19, 2000, commencing at 9:31 a.m.

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APPEARANCES:

ON BEHALF OF THE PLAINTIFFS:

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Also present:
Mark N. Rose, M.D., J.D.,
Aultman Health Foundation,
Mark W. Ruf, Esq.

I N D E X

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NO EXHIBITS MARKED

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GINGER A. HAMRICK, M.D.

of lawful age, a defendant herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, being first duly sworn, as hereinafter certified, was examined, and testified as follows:

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CROSS-EXAMINATION

BY MR. MELLINO:

Q. Would you state your full name for the record, please?

A. Ginger Annette Hamrick.

Q. Your address?

A. 1148 Woodview Drive, Akron, Ohio. I just moved.

Q. Sou just moved?

A. Yes.

Q. My name is Chris Mellino. I'll be asking you a number of questions this morning. If at any time you don't understand one of them, you can just ask me to repeat it or rephrase it and I'll be happy to do so.

A. Okay.

Q. When you do answer one of my questions, you have to answer verbally because Frank, our court

reporter, is taking down everything you have to say.

A. Yes.

Q. Are there any other additions or changes to your CV?

A. No, sir.

Q. How long have you been employed with the Canton Aultman Emergency Physicians, Incorporated?

A. Since July 1, 1993.

Q. Is that the only job that you have had since you completed your residency?

A. I worked for about a year and a half part time for Akron General in their emergency department where I trained, and I also flew for Life Flight, a Life Flight physician for about five years as a part-time job.

Q. When was that?

A. It was concurrently right after, during and after graduation from residency.

Q. So it would have been from '93 to '98?

A. Actually it was before that. I flew even as a resident for Life Flight.

Q. So when was it?

A. '92, on.

Q. You did it for five years?

A. About five years. I don't recall the exact date. I stopped doing it.
Q. The other job was what?
A. Emergency physician in Akron General emergency department on a part-time basis.
Q. After you completed your residency?
A. Yes, sir.
Q. How many hours did you work there?
A. I'm not sure I understand the question. Hours per week?
Q. Yes, per week?
A. I only work about two shifts a month.
Q. Currently how many hours a week do you work?
A. Well, that varies week to week. I work approximately 20 shifts a month, so sometimes there is no set schedule.

Our schedule is a variable day-by-day schedule, so I don't work like five days a week and off two sort of thing, it can vary.

Q. How many hours is 20 shifts a month?
A. Well, they -- hours at the hospital, the main emergency department are generally nine hours a shift. We also cover Orrville Hospital, Dunlap Hospital in Orrville, which are 12 hour shifts;

and we also cover the urgent care centers, which are anywhere from 8 to 16 hour shifts, so it varies.

Q. Of the 20 shifts a month that you work, how many of those would be at Aultman Hospital?

A. I would have to look at it month by month, but I would say 75 percent of them are at the emergency department.

Q. Was that true last year?

A. Yes, sir.

Q. I'm sorry. You said shifts at the hospital are 12 hours?

A. No, generally nine hour shifts.

Q. Do you normally work any given shift?

A. Predominantly night, I mean evening shifts. Occasionally there will be day shift, afternoon shift in there too.

Q. What time is the nighttime shift?

A. It's a 10:00 p.m. to 6:00 a.m. shift.

Q. Is that the shift that you were working the morning that you saw Connie Germanoff?

A. Yes, sir.

Q. So 10:00 p.m. to 6:00 a.m., is that what you said?

A. That's the scheduled time. They never end

at 6:00 a.m.
Q. What did you review to prepare for today's deposition?
A. I reviewed my records and the records I have available to me.
Q. Which would be what?
A. The hospital records, the copy that was sent from -- that was part of her hospital record.
Q. So that would include the prior emergency department visits?
A. Yes, sir.
Q. And the admission?
A. Yes, sir.
Q. Anything else?
A. That's all I have available to me.
Q. Did you review any medical literature?
A. No, sir, I did not.
Q. Did you review the autopsy?
A. I have not seen the autopsy.
Q. You are Board certified in emergency medicine?
A. Yes, sir.
Q. Did you pass your examination on your first attempt?
A. Yes, sir.

Q. If somebody's having a heart attack in the emergency room and they're seen by you, is one of the things you do is make that diagnosis and give the person treatment?
A. I'm sorry. Would you repeat the question?
Q. If somebody is having a heart attack and they come to the emergency, are seen by you, is your job to make a diagnosis and make treatment?
A. If they present to the emergency room, I take a history, I examine them, I order appropriate laboratory studies, and based on my findings make a diagnosis.
Q. My question assumed they were having a heart attack, if that's what was wrong with them, isn't that the diagnosis that you would make?
A. I guess I'm not understanding. I mean, you're telling me that they're coming to the hospital telling me they're having a heart attack.
Q. People come to you to get a diagnosis for their condition, right?
A. They come in complaining or pain or discomfort or whatever, yes.
Q. Why do you think they're there, just to complain to you or to get a diagnosis and treatment?

MR. DU'': Objection. Argumentative.

A. People present to the emergency room for a myriad of reasons, sir.

Q. What are they?

A. I mean, they can come -- some people present just for work excuses. I mean, they present -- every patient is an individual, every situation is an individual.

Q. Why did Connie Germanoff present to you in the emergency?

A. She presented to me complaining of epigastric pain as started after she ate pizza.

Q. Was she there for diagnosis and treatment?

A. She was there for relief of her pain.

Q. I'm not sure if that answered my question.

Was she there for diagnosis and treatment?

A. I can't speak for Connie. I don't know if she came with that specific expectation.

Q. So would you disagree then that the role of an emergency room physician is to make the appropriate diagnosis and give the patient treatment for their condition?

MR. DU'': Objection.

Argumentative. It's not what she said.

MR. MELLINO: I didn't say she did. I'm just asking if she agrees or disagrees. I don't see what's argumentive about it at all.

THE WITNESS: What is the question?

MR. MELLINO: Frank, would you read it back.

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(Question read.)

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A. No, sir, I would not disagree with that statement.

Q. So you agree with it?

A. Yes, sir.

Q. When you finished your residency did you -- you started right away at Aultman?

A. Yes, sir.

Q. So you were working both jobs part time and full time at Aultman?

A. Yes.

Q. When Connie Germanoff presented to you in the emergency department, did you have this in your differential diagnosis, myocardial

infarction?
A. Yes, sir, I did.
Q. Why?
A. Because I had -- in viewing the records and in talking with Mrs. Germanoff she had stated that she had -- had been worked up several times for what was worrisome for heart disease.
She also stated that she had a history of high blood pressure, she had a smoking history, and she also stated that there was a family history of heart disease.
Q. Did you review her prior records at that time?
A. After I had interviewed the patient, yes, I had access to her prior hospital records, as well as the record from the previous ER visit with Dr. Hatcher.
Q. The symptoms that she was having at the time that you saw her, did that make you think it might be cardiac related?
A. It's always a concern. Her symptoms though she told me was like with her stomach problems.
Q. So how did you rule out myocardial infarction or did you rule out myocardial

infarction?
A. I placed her on the cardiac monitor, which monitors limb Lead 11, and as her being on continuous cardiac monitor while in the emergency department there was no evidence of ectopia or S-T segment elevation or depression of limb Lead II on the monitor.
Q. I'm not sure if that was an answer to my question.
My question was: Did you rule out myocardial infarction?
A. By the testing I did, no, sir, I did not.
Q. If something's in your differential, is it incumbent upon you to rule it out?
A. As I stated before, every patient is different and you evaluate the strengths or value of their presenting complaints, what they are telling you at the time. It's like what she had before. Connie told me this was the pain she had with her stomach problems. She had -- had been noncompliant with her diet, also told me she was noncompliant with her medication. I had a low threshold for this to be cardiac.
Q. Did you understand my question?
A. Rephrase the question.

Q. If myocardial infarction is in your differential, don't you have to rule it out?
A. I'm not sure I can answer that. I mean, every patient is a unique entity in itself with unique complaints. I mean, if I -- I would have to do every test in the world to rule out everything for everyone, if that were the case.
Q. Isn't a myocardial infarction life threatening?
A. Yes, sir, it can be.
Q. If you have a life threatening condition in your differential, doesn't the standard of care require you to rule out any life threatening condition that's in your differential diagnosis?
A. A differential diagnosis means that I entertain the thought of the probability and possibility of something occurring. I mean, it's very possible today that **a** meteorite might fall and hit us on the head, am I going to call NOVA today or whatever and ask about that.
I'm not trying to be insulant here. I'm trying to give you insight into my thinking.
Q. So you felt it was just as likely she was having a myocardial infarction as having as a

meteorite striking us in the head today?

MR. DUNN: Objection. Argumentative.

MR. MELLINO: I'm asking for clarification from that answer.

A. I can't make that comparison.

Q. Well, you did make that comparison. Why did you bring that up, that's what I want to know?

MR. DUNN: Objection. Argumentative. Also mischaracterizes testimony.

A. I'm just trying to show you that anything is possible.

Q. Do you think that the possibility of her having an MI when you saw her was greater or less than a meteorite striking you in the head today?

A. I don't know.

Q. ***So*** why did you bring up meteor striking you in the head today?

A. As I stated before, I'm trying to get -- give you insight.

Q. How does that give me insight if it's totally unrelated to what we're talking about?

A. Because when we say a differential diagnosis, it includes a whole list of things, some were more probable than others.

Q. What else was in your differential?
A. With epigastric pain certainly anything in the chest, anything in the belly, back pain. I mean, you have dyspepsia, you have Leeuwenhoek's disease, you have pancreatitis, you have gallbladder disease, gastritis, acute abdomen; you could have anything in the chest, which is including lung problems, cardiac problems, abdominal wall pain.
Q. Which of those are life threatening?
A. Acute abdomen can be life threatening, perforated gallbladder could be life threatening, acute pancreatitis can be life threatening, a pneumothorax could be life threatening, a heart attack certainly can be life threatening, a dissection can be life threatening.
Q. What did you do to rule out those life threatening conditions?
A. I had her under observation, she was on a monitor. I didn't perform a myriad of tests because she had stable vital signs and she was not deteriorating for me; and in reviewing her records she had just had less than two days before an entire workup for cardiac enzymes and EKG, as well as reviewing the records for -- from previous she

had had multiple workups.
Q. Well, did you review the labs from the prior emergency department visits?
A. I did not see the labs at the time I saw the patient, no, sir. I had Dr. Hatcher's dictation.
Q. I see. So you relied on Dr. Hatcher's dictation then?
A. Yes, sir, I did.
Q. Have you since looked at the labs?
A. Yes, sir.
Q. Do you still agree with Dr. Hatcher's dictation?
A. There is an elevated troponin, it's still in an indeterminate range, not diagnostic for an MI; and slightly elevated myoglobin, which is not specific for cardiac disease.
Q. What is troponin?
A. Troponin is a cardiac enzyme released by the heart muscles.
Q. So that is or isn't specific for MI?
A. That is specific, yes.
Q. Was it elevated when Dr. Hatcher did the test?
A. It was one one hundredths of a point above what the hospital laboratory study determines as a

normal range, but it was classified in the indeterminate range, in a nondiagnostic for MI range.

Q. So it was or wasn't elevated?

A. Sir, it was elevated from above the base line normal range the hospital provides.

Q. If you had done one, wouldn't that have given you more information to see if it was still rising or went back to a normal range?

A. I'm sorry. Rephrase your question.

Q. If you had ordered a troponin and let's say it was even higher than when Dr. Hatcher saw her, what would that tell you?

A. As an elevated troponin you have to -- it is not just in isolation, you have to view it in adjunct with everything else that's presented to you. Some things can elevate troponins, congestive heart failure, myocarditis.

Q. I'm talking in Connie, if you had ordered a troponin and it was elevated from before when Dr. Hatcher saw her, would that have affected your care and treatment of her at all?

A. If I had ordered it?

Q. Yes. And it had been elevated?

A. Higher than the .04?

Q. Yes.
A. Yes.
Q. What would you have done differently?
A. Depends on how high it was.
Q. Well, what if it was.05?
A. If the remainder in the panel was up, then I would have talked with either Dr. Hollaway or cardiology.
Q. If you had known that it was elevated when Dr. Hatcher saw her, if you knew it was .04, would you have done a troponin?
A. I probably would have, yes.
Q. Why didn't you look at the labs again?
A. They were not available to me.
Q. Why weren't they available?
A. Because they are not part of the record that's sent when -- it takes almost a week and a half for the record to have the labs and everything back on to it when it is sent down to us. When the record was pulled, if you look at his record, it is not -- the findings are not written on his chart. All I had available to me at that time was this chart and his dictation.
Q. Is it possible to access those through the hospital computer?

A. Yes, sir, it would be.
Q. But you didn't do that?
A. No, I relied on Dr. Hatcher's dictation.
Q. What did you have to do to access it through the computer?
A. I have to ask the secretary to pull the labs up for me.
Q. I take it from your previous answer that you didn't at any point contact Dr. Hollaway or Dr. Lee?
A. No, sir, I did not.
Q. What was the reason for that?
A. Traditionally we contact them if the patient needs admitted or if we have a question about a patient or we feel uncomfortable with their presentation.

In this case Miss Germanoff had a history of gastroesophageal reflux disease, she stated to me this was like her stomach problems, that she had done things she was not supposed to do, and it seemed fairly straightforward and clearcut that this was an exacerbation of her stomach problems.

Q. How would the patient know whether they're having GI pain or cardiac pain?

A. She -- I mean, well, I would imagine. Don't you know sometimes whether your pain is in your arm or your foot. I mean, Connie was familiar with herself for me -- for her to come in and tell me she was having pain just like she has with her stomach. I had no reason to believe that she was lying to me.

Q. Well, isn't your stomach and your heart a little closer together than your arm and your foot? I don't know too much anatomy but I think I can get that one.

A. Well, generally, yes.

Q. Can't upper gastric pain often be confused with chest pain?

A. Yes, sir.

Q. She had never had a diagnosis of cardiac related pain, had she?

A. She had chest pain, a diagnosis of chest pain. They had not ruled in a cardiac diagnosis as my review of her records.

Q. Right. She kept coming to the hospital complaining of chest pain and they kept telling her it was her stomach, right?

A. Well, I don't know what they -- others told her.

Q. I thought you reviewed the records?
A. I did.
Q. Did you see that she kept coming to the hospital complaining of chest pain?
A. Yes, sir.
Q. Did you see she kept receiving a GI diagnosis?
A. That is one of the diagnoses that she has had, yes, sir.
Q. Do you normally rely on patients to make the diagnosis or is that your responsibility?
MR. DUNN: Objection. Argumentative. Mischaracterizes testimony.
A. I rely on patient' input as to the helpful means of making a diagnosis or treating a patient.
Q. A patient can think that they are having stomach pain or GI pain and in fact it turned out to be cardiac related; isn't that true?
A. Yes, sir, that is true.
Q. So in terms of her telling you that it was her stomach, that wouldn't be reliable in ruling out cardiac related pain, correct? You couldn't rely on that exclusively to rule out an MI in her case?
A. No, sir.

Q. Did you have any communication with the ambulance that brought her there?
A. No, sir, I did not.
Q. Do you know if anybody at the hospital did?
A. I don't know, sir.
Q. Did you have access to the ambulance record?
A. I do not remember seeing that record. Sometimes those records are put together after the chart, after the patient's disposition is arranged.
Q. Have you seen it since, *is* that one of the things you reviewed?
A. Specifically I'll have to review and see if it is here.

No, I don't have a copy of that.

Q. Well, does the ambulance usually call ahead to say we have a patient coming?
A. Yes, sir.
Q. Who do they talk to?
A. They may talk to -- usually they talk to the nursing personnel because they answer the hear radio. Occasionally a physician answers.
Q. The hear radio, what is that?
A. It is a radio specific to calling in from outlining medical services to the hospital

emergency room.
Q. What is NFO?
MRS. MATTHEWS: I think NGD, here.
A. Okay.
Q. I'm looking at the bottom two lines, bottom two lines; do you see where it says --
A. No further orders is NFO, per Aultman.
Q. So who would have --
A. It would have been a nursing.
Q. What does that mean?
A. I mean, when they -- when this ambulance service called in, whoever they talked to told them there were no further orders, they were to follow their standard protocol.
Q. You don't know where they would have got the information from to give to the ambulance service? How does it work there? The ambulance calls and they speak to the nurse, does the nurse ask you if there is any orders or ask a physician, how does it work?
A. They can.
THE WITNESS: Is this another question?
MR. DUNN: Go ahead.

Q. How does it work when the ambulance calls in over the hear radio, tells the nurse we have somebody coming, does the nurse then ask you or ask a physician if there are any orders?

A. If there's a downgrade, if the ambulance is asking for a downgrade. In other words, from a paramedic to basic units they will ask a physician, that has to be cleared by a physician. If there is orders for drugs that's not on the standard protocol, they ask a physician; or if there is a patient refusal, they ask a physician.

Otherwise, both the ambulance services and the hospital has a standard protocol for things to do with certain specific presentations, and so the nurses can just tell them to continue with what they are doing; or in this case, no further orders.

Most often these calls are informational, they're just telling us they are bringing a patient in so that we have a bed available for them or if we need to make arrangements to move out a patient out of a specific bed, so they're basically informational calls.

Q. So you had no input into that?

A. Not that I am aware of, no.
Q. How many physicians were in the emergency department that night?
A. At the time she arrived?
Q. Yes.
A. Is that what you're asking?
Q. Yes.
A. One.
Q. So you were the only one there?
A. Yes, sir.
Q. Is that normal?
A. At that time, yes, sir.
Q. At that time, you mean at that time of the day or --
A. Of night, yes.
MR. MELLINO: Where is he going with my --
MR. DUNN: He's going to get copies made.
MR. MELLINO: Before you take any of my documents out of the room it would be nice if you asked.
MR. STRONG: He didn't have his coat with him.
MR. DUNN: I didn't want

to interrupt. I didn't think it would be a problem.

MR. KREMER: I don't think any defense counsel has that record.

MR. MELLINO: I don't mind you making a copy. I do mind you getting up, leaving with my record.

MR. DUNN: I apologize. I just didn't want to interrupt you.

MR. STRONG: He asked your co-counsel, got the nod.

MR. MILLIGAN: Is that the only page of it or is it two pages from the EMS?

MR. MELLINO: We have another page but it's a poorer copy of the same page.

MR. MILLIGAN: Thank you.

BY MR. MELLINO:

Q. Do you remember how many patients were there at the time that Connie was there?

A. No, sir, I do not. I know it was busy. I don't recall how many patients.

Q. You haven't looked at the census?

A. No, sir, I have not.

Q. How do you recall that it was busy? What do

you recall about that night, I guess?
A. That most of the beds were full, as is our -- in most nights.
Q. Was there a particular patient that you were concerned about or that was taking a lot of time or do you recall who the other patients who were there, what their conditions were?
A. No, sir, I don't.
Q. What do you remember about Mrs. Germanoff?
A. I remember that she, when I went in to talk to her, was uncomfortable and was holding her stomach. When I asked her why she was there, she stated that her stomach was burning, it felt like her stomach problems, that she had eaten pizza several hours before coming in, she knew she wasn't supposed to, and it was about an hour after she had eaten her pizza that she began having stomach pains.

And when I asked her if she had -- had been on her medications, she had stated that she had missed some doses of that, and she thought that was probably contributing to some of her pain. I mean, that's -- basically I remember an uncomfortable appearing female.
Q. Was she alone in the room?

A. I never saw any other family with her in the room, sir.
Q. Do you recall what she looked like?
A. I can't put eye color, no. I mean, she was I remember a little bit overweight, but I don't remember eye color.
Q. I didn't ask anything about eye color.
Do you remember anything about her appearance?
A. Not to be specific, no.
Q. Was anybody else in the room when you examined her besides the two of you?
A. I don't recall.
Q. Did you speak to the nurse before you went in and saw Connie?
A. I don't recall that, either.
Q. Did you review the nurse's note before you saw Connie?
A. I don't remember if it was before or shortly thereafter. I remember reviewing it, but I don't remember whether it was before I saw her.
Q. How long did your examination last?
A. The initial examination?
Q. How many times did you see her?
A. I was in and out of the room frequently.

She was right besides the nursing desk. I looked at her every time I walked passed her, I mean.

Q. How many times were you in the room?

A. I don't recall the exact number, sir.

Q. Did you do an examination?

A. Yes, sir.

Q. So let's talk about the first time you saw her.

You came in, you took a history from her, which you just described to me?

A. Yes, sir.

Q. Then you did an examination?

A. Yes, sir.

Q. How long did the examination last?

A. I don't know exactly, sir. I don't remember.

Q. Was it a half hour, couple minutes?

A. It wouldn't be a half hour. I would probably say five minutes, if I had to make an estimate.

Q. But you don't recall?

A. No.

Q. What did your examination consist of?

A. First of all, observation of the patient, which is always paramount; looking at her skin

tone, listening to her heart and lungs, examining her abdomen, checking for renal bruits, looking for bleeding on her extremities, some sign of bruise or signs of trauma, the standard exam.

Q. Well, other than the observation part, did you touch her at all?

A. Yes, sir.

Q. Where?

A. I touched her skin.

Q. Where?

A. I always go into the room and hold patient wrists as part of my initial examination, that way I can check their pulse, it's a point of patient contact.

Q. Did you do that to Mrs. Germanoff?

A. Yes, sir, I did.

Q. Where else?

A. I listened to her chest, I put my stethoscope on her chest, listening over her lungs and heart. I listened over her back of her kidneys, I palpated her abdomen after I had listened to her abdomen with my stethoscope. I mean, those are areas I touched.

Q. Anyplace else?

A. I don't recall specifically touching her

anywhere else, no, sir.
Q. Did your exam consist of anything other than what you told me already?
A. I don't recall of it.
Q. Then what did you do after you completed the history and your examination?
A. I ordered some medication for her.
Q. What medication?
A. The viscous lidocaine and Mylanta. I believe it's documented on the charts.
Q. You can review the charts.
A. As well as I.V. Pepcid.
Q. Why did you order those?
A. Because her pain was consistent with epigastric or gastric type pain, and I was hoping to alleviate her pain with that.

I also ordered amylase and lipase laboratory studies, and while I was in the room I had placed the patient on a heart monitor.
Q. Why did you order the amylase and lipase panel?
A. I was concerned with the pain being in the mid epigastrium, that it was possibly pancreatitis.
Q. Where is the mid epigastrium?

A. It is right here, right below your breastbone, above your umbilicus.
Q. Pretty much right in the middle of your chest?
A. No. Chest is up here.
Q. Why did you order the heart monitor?
A. I placed the patient on it while I was in the room because I was -- that was part of my differential was this cardiac.
Q. So you were using that then to rule out cardiac pain origin?
A. As -- yes, as a monitor. Yes, sir.
Q. How did you rule out aortic dissection if you didn't take her pulse in her lower extremities?
A. They were pink.
Q. What, her lower extremities were pink?
A. Yes. They were normal coloration, she was not showing cyanosis.
Q. So that's sufficient to rule out aortic dissection?
A. It's not completely, no, sir.
Q. Well, would the --
A. I would need to do CT scans of the chest or aortogram to rule that out.

Q. Since you didn't do either one of these, I take it that aortic dissection wasn't very high in your differential?
A. No, sir, it was not.
Q. Now, when you took the history from Mrs. Germanoff, did she tell you that was the same pain that she had been having on her previous visits to the emergency room?
A. She told me this was her stomach pain, that's what she told me. She did not say it was the same pain that she was having on previous visits.
Q. Did you ask her that?
A. I asked her if this is pain into her chest, because she had complained of chest pain before, that was asked when I went back in to the room. She said this was not chest pain, that's what she told me.
Q. Do you have that documented somewhere in your note?
A. If it's not dictated, it is probably not documented down. I would have to look at this. This is such a poor copy of this.
Q. Is it in your dictation?
A. It is -- would you rephrase your question?

Q. Did you document the fact that she said this was not chest pain?
A. No, it's not indicated in my dictation.
Q. You never talked to anybody from the ambulance?
A. No, sir.
Q. People that brought her in?
A. No.
Q. Apparently you've never seen before today this ambulance run sheet?
A. No, sir.
Q. It does say on there reason for treatment was chest pain, did you happen to notice that when I showed you this before?
A. No, sir, I did not.
Q. Do you see that on there?
A. I see that. Ambulance services tend to take anything from the waist up as chest pain, but -- but I can't account for what they thought, what they heard that night.
Q. What does C/C mean underneath that?
A. Underneath what?
Q. Where the reason for treatment, chest pain, underneath it says?
A. Chief complaint.

Q. Chef complaint, chest pain. Then it says history of chief complaint, two episodes in past week, right?
A. That's what it says, yes, sir.
Q. You didn't have that information available to you?
A. I have never seen this before today, sir.
Q. This isn't available to you at all?
A. As **I** stated, sometimes they don't leave them in the ER. They leave them out front at the registration desk and they don't get assembled into the chart until the charts are torn down.
Q. You did say in your dictation that she had several workups for her epigastric burning; do you see that, that's the first --
A. Yes, sir.
Q. -- under your chief complaint?
A. Yes, sir.
Q. When did she have those workups?
A. The last that she had she was in the emergency two days before I saw her, she was admitted into the hospital I believe on the 16th of December, and I remember somewhere back in September I believe she had also had a workup for chest pain.

Q. So it was your understanding then this was the same pain that she was having on the prior visits to the emergency?
A. She told me this was her stomach pain, that's what she --
Q. I asked what your understanding was, not what she told you.
What your understanding is, according to the dictation you put down, she had several workups for this pain?
A. For similar type pain, yes. Yes.
Q. So this was your understanding at the time you saw her, this was the same pain that she had been having in the prior emergency department visits?
A. She told me on the day I saw her this was her stomach pain, not the chest pain that she had two days before, that's what she told me.
Q. I understand, you said that already, couple of times. I'm not asking you that.
I'm asking what your understanding is. You are not relying on her to make the diagnosis, are you? She's coming to you for the diagnosis; isn't that true?
A. Correct.

Q. So it was your understanding according to what you dictated here, 49 year old female had several workups for epigastric burning, this was the same, you were dealing with the same pain that she had had on her previous visits to the emergency room?

A. That she had similar pain patterns in the past, that's what I was basing this line on.

Q. Why didn't you order troponin levels?

A. Because I didn't,think cardiac etiology was the basis of the patient's complaint that night.

Q. Well, she had gone to the emergency department what, two days before, with the similar pain and they had done EKG and cardiac enzymes?

A. She did not tell me it was similar pain, sir.

Q. So you were relying on her to determine what tests to do?

A. I'm relying on her for some inputs into what to do.

Q. Well, if you thought this wasn't the same pain, then why did you say she had workups for this epigastric burning, several workups?

A. Because she had.

Q. Well, you can't have it both ways.

Is it the same pain or a different pain?

A. She has had several workups for epigastric pain. When she came to me that night or that early morning she told me this was her stomach pain, not the pain she had had in her chest the couple days before; hence, I did not order troponins, because it was not the same pain that she had two days before.

Q. If it was not the same pain, why did you say she had several workups for this epigastric burning?

A. Because she had had. Review the records.

Q. She has had workups in the past for the same pain?

A. I don't know if it's exactly the same pain. She has had workups in the past.

Q. For the pain that you were seeing her for?

A. I don't know, sir. That's an assumption if it's the same. I don't know.

Q. That's what your note says?

A. For epigastric burning. I didn't say -- if you read my note, it doesn't say for the exact same pain. Does it? Am I missing something here?

Q. Well, I think one of us is, because I'm

asking what the workups were, you were telling me it is the workups that she had on the previous emergency department visits.

A. She had had workups for pain, I don't know if it was exactly the same pain.

Q. Did you look at the previous records?

A. Yes, sir.

Q. You looked at them yourself?

A. Yes, sir.

Q. At what point did you look at the records, the previous records?

A. It was after I had examined her.

Q. Prior to looking at those records you had already determined that this was caused by GI pain rather than cardiac pain; is that true?

MR. DUNN: Objection.

A. I felt that there was higher probability of it. Now, certainly I can go back and add any other lab tests or anything else along the way.

Q. But I mean, you started her on GI medication?

A. Yes, sir.

Q. After your history and physical, right?

A. Yes, sir.

Q. So you must have thought in your own mind

this was GI at that point?
A. I had a higher probability of it, yes, sir.
Q. Why didn't you order an EKG?
A. Because under cardiac monitor she had normal sinus rhythm without any evidence of ischemia. Her pain never went up into her arms or chest and she persisted in saying that her pain was the typical pain for her stomach.
Q. How hard would it have been to do an EKG?
A. It would not have been hard at all, sir.
Q. How long would that have taken?
A. However long it takes for the machine to do it, probably less than two minutes.
Q. Where is this monitor strip or something that shows us that you were monitoring?
A. There is not a monitor strip in this chart. I don't know. Sometimes the nurses don't mount normal strips if there is not any aberrances in the monitor, if it didn't alarm for any reason sometimes they were not mounted. I don't know why that is, sir.
Q. You didn't save any parts of the strip?
A. I personally did not, no.
Q. That's the nurse's responsibility to do that?

A. Yes, sir.
Q. How does somebody that has a history of GI disease get diagnosed with an MI?
A. I don't know, sir.
Q. Just because someone has a history of GI disease, they come in with chest pain, you have to still rule out MI, don't you?
A. It's one of the considerations, yes, sir.
Q. A person that does have GI problems can have a heart attack, right?
A. Yes, sir.
Q. So even if a person has a history of GI and comes in with chest pain, MI needs to be ruled out; isn't that true?
A. Yes, sir.
Q. And you can't rule out an MI with a heart monitor, can you, you need to do EKG and enzymes; isn't that true?
A. If you were entertaining heart concerns, yes, sir.
Q. And even a Cardiolite stress test doesn't definitively rule out cardiac disease, does it?
A. There is percentage of error with that, yes.
Q. Would you agree that the only way to really definitively rule out cardiac disease is with a

cardiac catheterization?
A. Yes, sir. But Dr. Lee's dictation indicated that he would -- would not offer her catheterization.
Q. It does?
A. Due to a -- yes, sir, it does -- due to a contrast allergy.
Q. When did you find that out?
A. When I reviewed her records the night I saw her. She had been seen by -- on two different occasions for stress testing and I believe I had reviewed his consultation, which indicated that he would not offer catheterization and he did not feel this was cardiac etiology.
Q. Why wouldn't he offer her a catheterization?
A. Because of the contrast allergy.
Q. Did that factor into your treatment of her?
A. It factored in greatly. I highly respect Dr. Lee. This was a cardiologist who had seen her for a consult for chest pain, reported chest pain, and the patient had underwent her second stress test I believe in three months.
Q. Well, if you highly respect him, why didn't you call him that night and consult with him?
A. Because I had reviewed his records and the

patient had presented to me with quote, "her stomach pain," end quote.
Q. Where is that? What are you quoting from?
A. That -- I'm just saying from her. I'm sorry.
Q. You don't have anywhere in your dictation this quote stomach pain, do you?
A. No, that's what she told me.
Q. But that's not in your dictation?
A. No, it is not, sir.
Q. Well, if you relied on Dr. Lee's consultation, did you see where he said that the enzymes should be checked to make sure there is no evidence of myocardial infarction?
A. Right.
Q. So why didn't you check them that night when she came back with more chest pain?
A. He is referring to the day of his consultation, and she was discharged by one of the -- his partners after his partner had reviewed those enzymes. She was discharged from the hospital, that was her hospital visit.
Q. Apparently he didn't feel that MI was ruled out if he thought enzymes should be checked out to make sure there is no evidence?

MR. DUNN: Objection.

A. I believe at the time he saw her only one set of enzymes had been performed. His consult was early-on that day they were running those, I believe, so the series had not been completed I believe at the time of his consult.

Q. Did you look at those enzymes?

A. Yes, sir.

Q. Why wouldn't you do additional enzymes when she came back with more symptoms?

A. Because she had symptoms to me that she complained were her stomach, and after reviewing the records two different cardiologists had reviewed her enzymes even, or at least one had reviewed the enzymes on the admission of the 16th I believe, and felt they were not diagnostic of cardiac disease.

Q. Even if that's true, when she comes in later and seen by you with chest pain, don't you need to do enzymes to rule out?

A. She had -- didn't come in complaining of chest pain to me. She did not vocalize chest pain to me.

Q. Well, she vocalized that to the ambulance personnel?

A. But I didn't see that and I didn't know that. She never told me.
Q. She did have an epigastric pain?
A. Yes, sir.
Q. Which was similar to the pain that she had had on prior visits, correct?
A. She said she had had the stomach pain in the past.
Q. You interpreted that as being similar pain to what she had had on previous visits, correct?
MR. DUNN: Objection, that's not what she testified to.
A. I said before that she had -- had been worked up for pain, she told me that this was not the pain she had had the few days before, this was stomach pain.
Q. You said in your note, this is a quote, "that she had several workups for our epigastric burning"?
A. Correct.
Q. The workups you are referring to are the workups she had in the emergency room on previous visits with Dr. Hatcher, correct?
A. I'm referring to all workups, sir. All hospitalizations, all previous workups.

Q. Well, you told me before you were referring specifically to the visit on the 20th with Dr. Hatcher and the one on the 16th, correct?
A. I don't remember that I specifically said those two visits. You would have to replay that back.
When I said she had previous workups, she had previous hospitalizations and workups for pain.
Q. Shouldn't you know what her complaints are to the ambulance people?
A. I'm sorry. Rephrase that.
Q. Shouldn't you know, isn't it one of your responsibilities as an emergency room doctor to know what her complaints were that brought her there?
A. I asked the patient.
Q. Shouldn't you know what she told the ambulance team?
A. I assumed she tells me the same thing she tells the ambulance people. If the patient is coherent, cooperative, and able to speak, I assume they tell me the same thing.
Q. So you don't communicate with the ambulance people?

A. Not always. The ambulance people communicate their report to the nurse, the nurse communicates then to me, information that I need to know, or they document on the chart.
Q. Did the nurse relay to you that she was having chest pain, she told that to the ambulance people?
A. Nurse never told me she had chest pain.
Q. Should the nurse have told you that?
A. I don't know what the ambulance people told the nurse, sir.
Q. Well, regardless of how it happened, shouldn't the complaints of chest pain that Mrs. Germanoff made to the ambulance people have been communicated to you?
MR. DUNN: Objection.
MR. MILLIGAN: Objection.
MR. DUNN: Been asked and answered.
A. I don't know what Mrs. Germanoff told the ambulance people. I know what she told me.
Q. I didn't ask that.
MR. DUNN: You asked that and she answered.
MR. MELLINO: She hasn't.

First, that is the first time I asked that question; second of all, she hasn't answered the question.

Q. Isn't it your responsibility to be aware of the complaints that Mrs. Germanoff made to the ambulance people?

A. I don't know if it's specifically to the ambulance people. If the patient is able to relay the complaints to me, I can -- I have direct contact, direct rapport with the patients. I would rely more highly on what the people, patient told me directly than coming secondhand through another piece of paper or another individual.

Q. If you knew, if -- you keep telling me the reason you didn't do any cardiac workup, you were interpreting this as stomach pain, correct?

A. Correct.

Q. If you had known she was having chest pain, wouldn't you have done enzymes and EKG?

A. Yes. If she had told me she had chest pain, yes, sir.

Q. So if she told the ambulance people that, that's something that you should have been told, correct?

A. If in fact she told the ambulance people

that. I have no way of knowing that, sir.
Q. We do have a way of knowing. We have the record from the ambulance people, correct? You have seen that now.
A. I see that.
Q. It says right on there she has chest pain, that is her chief complaint, correct?
A. That's what written on the record, sir.
Q. Do you have any reason -- do you think this record is inaccurate?
A. No, sir.
Q. So if she made the complaint of chest pain to the ambulance people, you are telling me that should have been communicated to the nurse and then the nurse should have communicated that to you; is that true?
MR. MILLIGAN: Objection.
MR. DUNN: Objection.
A. I don't know that they should have. I'm telling you what generally happens.
Q. That didn't happen in this case; is that true?
MR. DUNN: Objection.
She doesn't know that.
A. I never saw that piece of paper before

today, sir.

Q. And you weren't told by anybody that she had this complaint of chest pain?

A. No, sir, I was not.

Q. So what is it that you don't know?

MR. DUNN: Objection. I'll instruct her not to answer that question.

A. I don't know how to answer.

MR. DUNN: Don't answer that question.

Q. Why didn't you get the information?

MR. MILLIGAN: What information?

MR. DUNN: Objection. What information?

MR. MELLINO: What, have you been sleeping for the last five minutes?

MR. DUNN: I want the record to be clear.

MR. MELLINO: Quit interrupting. You are not allowed to make speaking objections. I've let it go. I'm tired of it. You just say objection, that's it.

MR. DUNN: I'm entitled to state the basis of my objection.

MR. MELLINO: No, you are not.

MR. DUNN: Yes, I am.

MR. MELLINO: No, you are not.

MR. DUNN: You go call the judge. I'm not aware of a local rule, an Ohio rule that says I can't make a statement for the basis of my objection in a brief form. Doesn't exist.

MR. MELLINO: It does exist.

MR. DUNN: Call the judge and you get a ruling from the judge. I have no order in front of me that tells me I cannot state objections and the basis of my objection.

MR. MELLINO: So unless we get an order telling you what to do or not to do you're just going to do whatever you want?

MR. DUNN: I am telling you I'm going to continue to state objections as previously stated and the basis of my objections on the record, yes, sir, absolutely.

BY MR. MELLINO:

Q. Since your attorney wasn't paying attention, there was a complaint of chest pain made to the

ambulance personnel when Mrs. Germanoff was being transported to the emergency that you weren't aware of; is that correct?

A. Yes.

MR. DUNN: Objection. You are not to answer that question because it contains in the question that your attorney was not paying attention, that's improper, you are not answering.

You want to ask her a proper question, she will answer, but not answering an attack on me on the record.

MR. MELLINO: I'm not attacking you.

MR. DUNN: She is not answering the question as phrased.

MR. MELLINO: Fine. I didn't say she had to. You can instruct her not to answer all you want.

MR. DUNN: Thank you.

MR. MELLINO: Even though you're not allowed to do that unless it is a privileged matter. Apparently you're unaware of that rule too, so we'll just continue.

BY MR. MELLINO:

Q. You were not aware that until today, until I showed you this ambulance record today, that Mrs. Germanoff complained to the people transporting her via the ambulance to the emergency department that she complained of chest pain; is that a true statement?
A. That is a true statement.
Q. And is there a protocol or rule or policy at the hospital that requires a nurse to tell you what's on the ambulance report or what she finds out from or that requires her to find out what the complaints are from the ambulance people?
A. I'm not aware of any such policy, sir.
Q. Is that what normally happens in the hospital?
A. Define normally?
Q. Well, I thought you told me before generally what happens is the ambulance people tell the nurse and the nurse tells you?
A. The ambulance people give report to the nurse who's taking care of the patient, the patient then may sometimes tell me verbally what they said.
Q. The nurse you mean?
A. Yes.

Q. You said the patient.
A. The nurse. I'm sorry. The nurse.
Sometimes the chart is just racked, so therefore I don't have direct contact with the nurse immediately. I see the patient beforehand but I read the nursing notes. If I have concerns about something, I can go ask the nurse at any time.
Q. Don't the paramedics always give a report to the nurse?
A. Yes, sir.
MR. KREMER: Objection.
Q. So then it's the nurse's responsibility to convey the information to you?
MR. MILLIGAN: Objection.
A. I don't know if it's a set policy, sir.
Q. But that's what normally happens?
A. Yes, sir.
Q. Isn't that what you as a physician would want to happen, wouldn't you want to be given the information the nurse obtains from the paramedics?
A. Yes, sir.
Q. I guess you don't know why that didn't happen in this case, until today, this morning, you didn't even know this information was out

there, true?
A. That's correct.
Q. Had you known that there was a complaint of chest pain by Mrs. Germanoff that night, you would have ordered an EKG?
A. If she had told me she had chest pain, yes, sir, I would have.
Q. Well, if you had been told too that she told the paramedics that, would you have ordered an EKG?
A. More than likely, yes.
Q. Would you have ordered cardiac enzymes?
A. I don't know. I think it would have depended on the situation, how much she complained of it, what her EKG looked like. I -- I can't second guess. I know retrospectively we would all have done everything, but I don't know. I can't speculate what it would have shown that might.
Q. The EKG?
A. Yes, sir.
Q. But the fact that she had this complaint of chest pain alone, as you sit here today you don't know whether that would have caused you to order the enzymes?
A. I can't make that assumption, sir.

Q. If she was having an MI at the time that she was in the emergency department, isn't it true it's more likely than not an EKG would have shown something?
A. If she was having an MI at that time, I would expect the EKG to show abnormality, yes.
Q. I assume the same would be true about the cardiac enzymes?
A. Yes, sir.
Q. Are you aware of the fact that she was probably having an MI at the time that she was in the emergency?
MR. DUNN: Objection.
MR. KREMER: Objection.
MR. MILLIGAN: Objection.
A. No, sir.
Q. You have never seen the autopsy?
A. I do not remember visualizing the autopsy or seeing the paper, no.
Q. Well, the autopsy states that she had transmural acute myocardial infarct of the posterior wall of the left ventricle, two to three days, 48 to 72 hours, old?
A. I'm sorry. Say it again.
Q. Sure. Transmural acute myocardial infarct

of the posterior wall of the left ventricle, two to three days, 48 to 72 hours, old?

A. Okay.

Q. And she died on the 26th; were you aware of that?

A. Yes, sir.

Q. You saw her on the 24th, which would have been two days earlier, correct?

A. 24th is two days before the 26th, yes, sir.

Q. So if the MI was two to three day old, it's more likely than not she was having it during the time she was in the emergency department, correct?

MR. DUNN: Objection.

MR. KREMER: Objection.

MR. MILLIGAN: Objection.

A. I can't say that.

Q. Why not?

A. Because I don't know that.

Q. Why don't you know that?

A. Because I don't.

Q. Well, if you have the information when she died, how old the MI was, what's wrong with the math?

A. I don't know. I don't know if she was having an MI when I saw her. She did not have

symptoms consistent of myocardial deterioration when I saw her.

Q. Well, if in fact she was having an MI while she was in the emergency department when you saw her, isn't it true the pain was more likely cardiac than stomach related?

MR. DUNN: Objection.

A. That's an assumption.

Q. What is?

A. That's your assumption she had an MI, and if she had an MI, that pain would have been coming from the MI.

Q. Well, she did have an MI, right?

A. I don't know that.

Q. I just read you the autopsy.

A. On the 26th, yes.

Q. Well, the autopsy said it was two to three days old.

A. I think it said more likely, didn't it say 24 to 48 hours. What did you read as the --

Q. Transmural acute myocardial infarct, posterior wall of left ventricle, two to three days, 48 to 72 hours, old?

A. Okay.

Q. So she did have an MI?

A. According to the autopsy she had an MI, yes, sir.
Q. According to the autopsy it was two to three days old, correct?
A. That's what's typed in the autopsy report as you're reading it to me.
Q. Now, I am asking you to assume this, she was having an MI at the time she was in the emergency department.
A. I can't assume that.
Q. It's a hypothetical question, so if it turns out that that's not to be true, than your answer doesn't matter; but I'm asking you to assume that is true, that she was having an MI when she was there, wouldn't it be more likely than not that her pain was cardiac related and not stomach related?
A. I don't know that's correct, sir.
Q. Why don't you know that?
MR. DUNN: Objection.
A. Pain can come from many sources, people have silent MI's, painless MI's.
Q. But she was having pain?
A. She was having pain, yes, sir.
Q. Do you think it is -- which seminar is more

likely, that she was having stomach pain and a silent MI or that she was having pain from her heart --

MR. DUNN: Objection.

Q. -- attack?

A. You have to restate the assumption to the question.

Q. If she was having an MI at the time that you saw her, which would be more likely, that the pain was cardiac related or that she was having stomach problems and a silent MI?

MR. DUNN: Objection.

Q. You can answer.

A. I don't know. I can't answer that.

Q. You think they're equally likely?

MR. DUNN: She didn't say that.

A. I just --

MR. DUNN: Objection.

A. -- said I can't answer that.

Q. Why can't you answer?

A. Because I don't know.

Q. Don't know what?

A. What the source of her pain was at that time. I assumed it was her stomach. I don't

know.
Q. Well, if she is in the emergency department having an MI, it's your job to find out what the source of pain is, correct?
MR. DUNN: Objection.
MR. STRONG: This is getting tediously redundant.
Q. You can answer.
MR. STRONG: That's my take on it.
MR. MELLINO: It's also meaningless.
A. Restate your --
Q. If somebody, a patient is having an MI and you're there examining them, it's your responsibility as an emergency room doctor to determine what the source of their pain is; isn't that a true statement?
MR. DUNN: Objection.
A. If they're having an MI, yes, sir.
Q. How many times did you see her that night? You said, I think you told me you went into the room multiple times?
A. Right. I don't recall how many times exactly, sir.

Q. You dictated in your studies, discussion, treatment, that she did get some relief with the lidocaine and Mylanta but it was incomplete?
A. Correct.
Q. Did that cause you some concern as to why she was having pain?
A. No.
Q. That it wasn't related to her stomach?
A. No, it's not unusual to not have complete relief with a GI cocktail.
Q. Is it normal to have, after you give a GI cocktail, to give Demerol and Phemerol to relieve pain?
A. She requested those medications to help her sleep. She stated she hadn't slept through the night.
Q. So you gave her those to help her sleep?
A. To help relief of pain and help her sleep.
Q. I asked if that's normal to give those medications for pain relief after GI cocktail if the pain is from her stomach?
A. That -- yes, sometimes that dose is given.
Q. Can you rely on relief of pain to determine if the pain is GI or cardiac?
A. I'm not sure I understand your question.

Q. Did the fact that she had some pain relief from the GI cocktail, did that tell you one way or the other whether it was cardiac or stomach related?
A. Well, I wouldn't expect Mylanta and viscous lidocaine which interact with the esophageus to relieve cardiac pain, so if she got some relief with this I would expect this was not cardiac.
Q. So did that further lower your suspicion for cardiac origin then?
A. Yes, sir.
Q. Did the Demerol or Phemerol help her pain?
A. Yes, sir.
Q. What kind of deterioration were you observing her for?
A. Increasing pain, drop in blood pressure, change in cardiac monitoring, change in vital signs.
Q. Is epigastric pain consistent with acute myocardial infarction?
A. Some myocardial infarctions can have epigastric pain, yes, sir.
Q. Could you run a cardiac enzyme with the same blood you drew for the amylase and lipase?
A. I believe the lab can do that. Sometimes

the blood is clotted off and they can't, that would have to be something asked specifically of the lab. I don't know.

Q. On your dictation you put that her family history was noncontributory?

A. To her present problem.

Q. Well, she did have a family history?

A. Of heart disease, yes, sir.

Q. But you didn't put that down?

A. No, sir, I did not.

Q. Wouldn't the family history of cardiac disease raise your suspicion of cardiac origin in a person that's having chest pain?

MR. DU'': Objection.

A. If they were having chest pain, certainly.

Q. What if they were having epigastric pain?

A. Certainly it raises your suspicion.

Q. Who in her family had heart disease?

A. I believe it was her mother.

Q. Is that of significance?

A. Heart disease in females, yes, sir. Anyone having heart disease is of significance.

Q. Is the fact that it was her mother as opposed to somebody else make it more significant?

A. Makes it significant, yes, sir.

Q. If MI was in your differential, why didn't you document that in the family history?
A. I don't know, sir. I don't have an answer for that.
Q. What did she tell you about her medications?
A. She told me she was supposed to be on medicine for her stomach.
Q. What medicine?
A. I believe she had said Prilosec, but she hadn't been taking it on a regular basis; and that she was -- also told me that she should take over-the-counter medicines like Mylanta or Maalox if her symptoms got worse, and she was -- wasn't taking that.
Q. Anything else?
A. I don't recall.
Q. Why did you order the amylase and lipase?
A. The location of her pain was worrisome for it being pancreatitis, especially with the patient having eaten pizza, et cetera. Sometimes if they have an occult history of gallbladder disease, they can have gallstone pancreatitis, I wanted to make sure this is not pancreatitis.
Q. Can you rule out pancreatitis with just amylase and lipase?

A. If they are low your suspicion for that is fairly low. Pancreatic enzymes accelerate rather quickly in a pancreatitis state.
Q. Hadn't she previously had CT scans and ultrasounds that showed she had no gallstones?
A. I'd have to review the record. I don't remember that specifically.
Q. You didn't review it that night?
A. I don't remember that, sir.
Q. Did she have swelling of her lower extremities?
A. I don't remember that.
Q. Did you check for it?
A. I looked at them, yes.
Q. The fact that she had no frank deterioration wouldn't rule out an **MI** either, would it?
A. That in and of itself, no.
Q. Does Aultman has a chest pain unit?
A. Yes, sir.
Q. Why didn't you send her there?
A. Because she wasn't having chest pain.
Q. If you had known that she had complained to the ambulance people of chest pain, would you have sent her to the chest pain unit?
MR. MILLIGAN: Objection.

MR. DUNN: Objection.

A. I don't know.

Q. Well, who goes to the chest pain unit?

A. Patients who have what we consider equivocal chest pain with pain of unknown etiology without unstable vital signs.

Q. How many beds are there in the emergency room?

A. Major and minor beds?

Q. Yes.

A. 27 without doubling any rooms up.

Q. Do you recall how many were full that night?

A. It was busy, I don't recall exactly, sir.

Q. Do you have the ability to call additional help if you need it?

A. Yes, sir.

Q. Who would you call?

A. The on call physician.

Q. At what point would you call that person?

A. If there were an overwhelming amount of patients, traumas, critical patients that I was not able to get to in an expedient and timely manner.

Q. What would be an overwhelming number of patients?

A. If there are more than ten patients waiting to be seen or critical patients there that are decompensating. I mean, it's a variable thing. You can't just say you call on X number of patients, it's variable with the situation.
Q. Did you call for help that night?
A. No, sir.
Q. Who was the on call physician?
A. I have no way of knowing, sir.
Q. There wouldn't be any kind of record of that?
A. There would be a record. I don't recall it at this time.
Q. Would the schedule show that?
A. The schedule for that day, yes, sir.
Q. As an emergency room doctor, when somebody comes in multiple times with the same problem, don't you consider that the previous diagnoses that she has been given may be inaccurate?
A. You take lots of things into consideration. I wouldn't say I specifically say the previous diagnosis was inaccurate, no, sir.
Q. Well, do you think that maybe a new approach to the problem needs to be taken?
A. You approach every patient and every problem

uniquely.
Q. So you wouldn't rely on previous visits then, you take every patient as they come into the ER?
A. I use previous information as helpful information. In this case Mrs. Germanoff came in complaining of stomach pain to me and she told me it was not the discomfort she had two days before.
Q. But you didn't document that anywhere, did you, ma'am?
A. It's not part of my typed dictation.
Q. Is it in any part of the record at all?
A. I don't see that I wrote it down as such, no, sir.
Q. In fact, the only thing we have written down from that visit is the ambulance run which says that she had chest pain?
A. There is nurse --
MR. DUNN: Objection.
A. Nursing notes all over it that do not state chest pain. In fact, if you read the nursing notes they do not refer to chest pain. The chief complaint as written by the nurse is not chest pain.
Q. Pardon me?

A. The chief complaint as written by the initial nurse assessment is not chest pain, and I assume I have to -- that is the nurse who took the report from the medics.

Q. Why do you have to assume that?

A. Because that's usually the first contact with the patient is when the patient -- the nurse goes in to take report from the medic, she was the one that fills out that front sheet.

Q. Well, assume that this was the same pain that she had on previous emergency room visits --

A. That's what she told --

MR. DU'': He hasn't finished. Let him finish the question.

Q. I'm asking you to assume that to be true only for the purpose of answering this question, that the complaint she had on the night she saw you was the same pain that she had on the two previous visits to the emergency room, if you had known that, would you have considered that maybe the previous diagnoses were in error, that a new approach may be needed because whatever they were doing for her wasn't helping the problem?

MR. DUNN: Objection. You can answer.

A. If I am to assume, this is an assumption only, that she presented to me with the same complaint as she had presented the day before, then I would -- would have pursued in a cardiac manner, meaning I would have at least got an EKG.
Q. Are you telling me that you asked her if this was the same pain she had on the previous two visits?
A. I said if this pain was the same and she said no, this was her stomach pain, that is why I pursued the course that I did.
Q. Because that's what she told you?
A. Correct.
Q. That's why you pursued this course, but yet you didn't document that in your dictation?
MR. DUNN: Asked and answered. Objection. Three time at least.
MR. MELLINO: That' okay. I might ask it another three times,
A. No, sir, that is not dictated in the record.
Q. And you don't have any handwritten notes in the record, correct?
A. The handwritten things are on the chart.
Q. But none of that is your handwriting, is it?
A. Yes.

Q. What is your handwriting on the chart?
A. Orders, this, this down here, D/C.
Q. You got to go slow.
A. The orders, this part that says ate pizza, the discharge.
Q. Where it says D/C?
A. Correct. The diagnosis, where it says diagnostic impression on the bottom, that is my handwriting.
Q. What does that say?
A. Says recurrent epigastric pain and noncompliance with medical regimen.
Q. Anything else that you have written in the record?
A. The back discharge sheet.
Q. Pardon?
A. The home-going instructions.
Q. What did you write on that sheet?
A. Contact Dr. Hollaway, and then it says to continue your medications, and the -- the other orders below it.
Q. *Go* ahead. Read those into the record.
A. No pizza or spicy foods, no alcohol, no tobacco.
Q. Did she have epigastric pain on her prior ER

visits?
A. I believe she came in complaining of chest pain. I would -- would have to review what her chief complaint was. She had told me she is -- has had stomach pain in the past but the pain she had the night I saw her was not the chest pain she had had couple days before; and I believe when -- on Dr. Hatcher's evaluation, which was on the 20th, I believe, triage complaint was midsternal chest pain.
Q. So did she or didn't she have epigastric pain on the prior ER visits?
A. I don't know if she had them on the prior ER visits, sir.
Q. Well, so what did the recurrent epigastric pain in your diagnosis refer to?
A. Because she has had epigastric pain in the past.
Q. When?
A. She told me she has had it in the past. She has a previously documented diagnosis of gastroesophageal reflux disease.
Q. That was based on what she told you?
A. I'm sorry. What was?
Q. The recurrent epigastric pain?

A. Yes.
Q. Why do you work on the night shift?
A. It's my preference.
Q. Are there any other conversations that you had with Mrs. Germanoff that either aren't in the record or that we haven't talked about today?
A. I don't recall, sir.
MR. MELLINO: Why don't we take about a five minute break.
MR. DUNN: Okay.
- - -
(Recess had.)
- - -
BY MR. MELLINO:
Q. Are you ready?
A. Yes.
Q. Have you been sued before?
A. Yes, sir.
Q. How many times?
A. I have been named three other times before.
Q. Were those all in --
MR. MELLINO: Which county is this?
MRS. MATTHEWS: Stark.
Q. -- Stark County?

A. Yes, sir.
Q. What were the circumstances of them?
A. One was settled.
Q. The facts of the case?
MR. DUNN: Can I just have a continuing objection?
MR. MELLINO: Sure.
MR. DUNN: For prior lawsuits?
MR. MELLINO: Sure.
Q. Take them one at a time.
A. The one was for failure, alleged failure to diagnose a Type A dissection, thoracic dissection.
Q. When was that?
A. I want to say '93, December of '93, I believe.
Q. Do you recall the name of the patient?
A. McIntyre, I believe. Dwayne McIntyre.
Q. What was the disposition in that case?
A. It was settled.
Q. Who represented you in that case?
A. David Best.
Q. What was the next one?
A. I was named in a suit for -- I believe her name was Clapper, I don't remember the first, and

they -- I don't know what the term is for it, dropped the suit.
Q. What were the allegations?
A. Failure to diagnose diskitis.
Q. Were you deposed in that case?
A. No, sir.
Q. Were you deposed in the McIntyre case?
A. Yes, sir.
Q. In the McIntyre case you said was failure to diagnose thoracic aneurysm?
A. Dissection.
Q. You saw the person in the emergency room?
A. Yes, sir.
Q. How soon after you saw him did the person have the dissection? What happened to him?
A. They presented 36 or 38 hours later as a syncopal episode.
Q. And was the diagnosis made then?
A. After multiple CAT scans and vascular and cardiology consults.
Q. What happened to Mr. McIntyre?
A. He went to the operating room and he expired 30 days later I think with multiple organ failure.
Q. What was the third suit?
A. It is a suit alleging failure to diagnose an

MI, it's a pending suit, ongoing suit.
Q. What's the name of the patient in that suit?
A. Barker is the last name and Homer is the first.
Q. What are the specifics of that case?
A. As I said, it is an allegation that I failed to diagnose an MI.
Q. When did Mr. Barker present to you?
A. March 1st of '98, I believe.
Q. What was his presentation?
A. Shoulder pain.
Q. Did he have any other symptoms?
A. He only complained of shoulder pain to me.
Q. Did you take any measures to rule out MI?
A. Yes, sir.
Q. What did you do?
A. An EKG, chest x-ray, and cardiac isoenzymes.
Q. Were any of these abnormal?
A. In comparison with what I had available to me that night, no.
Q. Did you only see him once?
A. I actually discharged him then from the chest pain center I believe in August, or sometime later that year when he was admitted by another physician into the chest pain center, and **I**

believe I had seen him several times prior to that for trauma related things.
Q. When did he have his MI?
A. It is alleged that he had it in March.
Q. But the basis of the lawsuit is this one presentation in the emergency department, correct, in March when you saw him?
A. I'm sorry. Rephrase it.
Q. The basis of the allegations against you are this one presentation that he made to you in March in the emergency room?
A. As opposed to what?
Q. You said you saw him in August?
A. Right.
Q. That would have been after?
A. Right.
Q. So that has nothing to do with the lawsuit, that visit in August, I'm assuming?
A. I assume also.
Q. Have you been deposed in that case?
A. Yes, sir.
Q. Who took your deposition?
A. I don't recall. I'm sorry.
Q. Do you know what firm is handling the plaintiffs, representing the plaintiffs?

A. I don't remember offhand. I would have to get that information to you.
Q. Is that case set for trial?
A. I don't believe there is a trial set, no, sir
Q. That's in Stark County also?
A. Yes, sir.
Q. Who is representing you in this case?
A. David Best.
Q. Were these all patients that you saw at Aultman?
A. Yes, sir.
Q. How long have you been working the night shift?
A. All my life since I have been working.
Q. You mean even before you became an emergency doctor you worked night shifts?
A. Yes.
Q. The only test that you did for Connie Germanoff in the emergency room for cardiac origin, for her pain, would have been the heart monitor, right?
A. Correct.
Q. That isn't sufficient to rule out an MI, correct?

A. If the MI is elsewhere than the inferior leads, no, it wouldn't show that up.
Q. So you did not do any testing that would have ruled out an MI in her, correct?
A. Record reflects I did not do any EKG or isoenzymes.
MR. MELLINO: That's all I have.
MR. MILLIGAN: I got a couple questions.
Doctor, I'm Rich Milligan and I represent Aultman Hospital. I just have a few question.
- - -
CROSS-EXAMINATION
BY MR. MILLIGAN:
Q. As I understand your testimony, you have said that you repeatedly saw this patient in the emergency room; is that accurate?
A. On the night?
Q. On the night in question?
A. Yes.
Q. As part of your examination and treatment of this patient you did in fact inquire of the patient concerning the nature of their complaints?

A. Yes, sir.
Q. And you did that in detail?
A. Yes, sir.
Q. Did you have any reason to believe that you were not being told the truth by the patient?
A. No, sir.
Q. Was what she told you consistent with what you physically observed?
A. Yes, sir.
Q. I think you already said this, but is it not true that you rely upon the patient to accurately, completely describe what their complaints are to you?
A. Yes, sir, if the patient is a competent patient. Yes, sir.
Q. And she was, as far as you know was competent?
A. Yes, sir.
Q. There was some discussion about the EMS report, which you had not previously seen, and I think, correct me if I am wrong, but I thought that you said that it has been your experience that the EMS squad does not describe with particularity pain that the patient has above their waist and call it all chest pain; is that an

accurate description?
A. That has been my observation, yes. Anything that comes in from above the waist is oftentimes by EMS people described as chest pain.
Q. Would you rely upon the EMS squad description of her complaints in treating a patient in a normal situation?
A. I would have that information along with what the patient told me. If the patient is not able to relay a history, then oftentimes the EMS report as well as perhaps nursing, family history are important; but if the patient is able to communicate and is competent, I regards the patient history much stronger than secondhand history by someone else.
Q. That certainly would have been the case with Connie Germanoff?
A. Correct.
Q. In the final analysis, you would agree that getting the information you need to treat this patient from the competent patient is more reliable than getting it second and third hand?
A. Definitely.
MR. MILLIGAN: Thank you. That's all 1 have.

MR. KREMER: Doctor, I'm Stephan Kremer. I represent Dr. Hollaway. I just have a couple.

- - -

CROSS-EXAMINATION

BY MR. KREMER:

Q. Have you had conversations with Dr. Hollaway regarding Connie Germanoff?

A. No, sir, I have not.

Q. Did you have any conversations with Dr. Hummel regarding Connie Germanoff?

A. No, sir.

Q. Have you had any conversations with Dr. Linz regarding Connie Germanoff?

A. No, sir, I have not.

Q. Have you had an opportunity to review Dr. Hollaway's chart of Connie Germanoff?

A. Yes, sir.

Q. You reviewed Dr. Hollaway's --

A. Her office records?

Q. Her office records?

A. No, I have not seen her office records.

MR. KREMER: I don't have any further questions.

MR. STRONG: I have none.

MR. MELLINO: Okay.

MR. DUNN: Read and sign, standard type. Send it to me, I'll get it to her.

- - -

(Discussion had off the record.)

- - -

MR. MELLINO: You want the 28 days?

MR. DUNN: Yes, please.

(Deposition concluded.)

(Signature not waived.)

- - -

I have read the foregoing transcript from page 1 through 86 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

_____
Ginger A. Hamrick, M.D.

Subscribed and sworn to before me this_____day of_____, 2000.

_____
Notary Public

My commission expires: _____

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

I, Frank P. Versagi, Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, Ginger A. Hamrick, M.D., was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given by her was by me reduced to stenotypy/computer in the presence of said witness, afterward transcribed by me, and that the foregoing is a true and correct transcript of the testimony so given by her as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 27th day of December, 2000.

Frank P. Versagi, RPR, CLVS and
Notary Public in and for the State of Ohio.
My commission expires 03/09/2003.

-D-

-I-

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