

1 The State of Ohio, )  
 2 County of Stark. ) SS:  
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 4 IN THE COURT OF COMMON PLEAS  
 5 - - -  
 6 Stephan Germanoff, Administrator, )  
 7 of the Estate of )  
 8 Connie Sue Germanoff, )  
 9 Plaintiff, )  
 10 vs. ) Case No. 2000 CV 01475  
 11 Aultman Hospital, et al., )  
 12 Defendants. )

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

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I N D E X

WITNESS :	CROSS
Ginger A. Hamrick, M.D.	
by Mr. Melino	5
by Mr. Milligan	82
by Mr. Kremer	85

- - -

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

1 reporter, is taking down everything you have to  
2 say.

3 A. Yes.

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

6 A. No, sir.

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

9 A. Since July 1, 1993.

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

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

17 Q. When was that?

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

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

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

23 Q. So when was it?

24 A. '92, on.

25 Q. You did it for five years?

1 A. About five years. I don't recall the exact  
2 date. I stopped doing it.

3 Q. The other job was what?

4 A. Emergency physician in Akron General  
5 emergency department on a part-time basis.

6 Q. After you completed your residency?

7 A. Yes, sir.

8 Q. How many hours did you work there?

9 A. I'm not sure I understand the question.  
10 Hours per week?

11 Q. Yes, per week?

12 A. I only work about two shifts a month.

13 Q. Currently how many hours a week do you work?

14 A. Well, that varies week to week. I work  
15 approximately 20 shifts a month, so sometimes  
16 there is no set schedule.

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

21 Q. How many hours is 20 shifts a month?

22 A. Well, they -- hours at the hospital, the  
23 main emergency department are generally nine hours  
24 a shift. We also cover Orrville Hospital, Dunlap  
25 Hospital in Orrville, which are 12 hour shifts;

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

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

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

9 Q. Was that true last year?

10 A. Yes, sir.

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

13 A. No, generally nine hour shifts.

14 Q. Do you normally work any given shift?

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

18 Q. What time is the nighttime shift?

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

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

22 A. Yes, sir.

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

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



1 at 6:00 a.m.

2 Q. What did you review to prepare for today's  
3 deposition?

4 A. I reviewed my records and the records I have  
5 available to me.

6 Q. Which would be what?

7 A. The hospital records, the copy that was sent  
8 from -- that was part of her hospital record.

9 Q. So that would include the prior emergency  
10 department visits?

11 A. Yes, sir.

12 Q. And the admission?

13 A. Yes, sir.

14 Q. Anything else?

15 A. That's all I have available to me.

16 Q. Did you review any medical literature?

17 A. No, sir, I did not.

18 Q. Did you review the autopsy?

19 A. I have not seen the autopsy.

20 Q. You are Board certified in emergency  
21 medicine?

22 A. Yes, sir.

23 Q. Did you pass your examination on your first  
24 attempt?

25 A. Yes, sir.

1 Q. If somebody's having a heart attack in the  
2 emergency room and they're seen by you, is one of  
3 the things you do is make that diagnosis and give  
4 the person treatment?

5 A. I'm sorry. Would you repeat the question?

6 Q. If somebody is having a heart attack and  
7 they come to the emergency, are seen by you, is  
8 your job to make a diagnosis and make treatment?

9 A. If they present to the emergency room, I  
10 take a history, I examine them, I order  
11 appropriate laboratory studies, and based on my  
12 findings make a diagnosis.

13 Q. My question assumed they were having a heart  
14 attack, if that's what was wrong with them, isn't  
15 that the diagnosis that you would make?

16 A. I guess I'm not understanding. I mean,  
17 you're telling me that they're coming to the  
18 hospital telling me they're having a heart attack.

19 Q. People come to you to get a diagnosis for  
20 their condition, right?

21 A. They come in complaining or pain or  
22 discomfort or whatever, yes.

23 Q. Why do you think they're there, just to  
24 complain to you or to get a diagnosis and  
25 treatment?

1 MR. DU " : Objection.  
 2 Argumentative.  
 3 A. People present to the emergency room for a  
 4 myriad of reasons, sir.  
 5 Q. What are they?  
 6 A. I mean, they can come -- some people present  
 7 just for work excuses. I mean, they present --  
 8 every patient is an individual, every situation is  
 9 an individual.  
 10 Q. Why did Connie Germanoff present to you in  
 11 the emergency?  
 12 A. She presented to me complaining of  
 13 epigastric pain as started after she ate pizza.  
 14 Q. Was she there for diagnosis and treatment?  
 15 A. She was there for relief of her pain.  
 16 Q. I'm not sure if that answered my question.  
 17 Was she there for diagnosis and  
 18 treatment?  
 19 A. I can't speak for Connie. I don't know if  
 20 she came with that specific expectation.  
 21 Q. So would you disagree then that the role of  
 22 an emergency room physician is to make the  
 23 appropriate diagnosis and give the patient  
 24 treatment for their condition?  
 25 MR. DU " : Objection.

1 Argumentative. It's not what she said.

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

6 THE WITNESS: What is the  
7 question?

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

10 - - -

11 (Question read. )

12 - - -

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

15 Q. So you agree with it?

16 A. Yes, sir.

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

19 A. Yes, sir.

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

22 A. Yes.

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

1 infarction?

2 A. Yes, sir, I did.

3 Q. Why?

4 A. Because I had -- in viewing the records and  
5 in talking with Mrs. Germanoff she had stated that  
6 she had -- had been worked up several times for  
7 what was worrisome for heart disease.

8 She also stated that she had a  
9 history of high blood pressure, she had a smoking  
10 history, and she also stated that there was a  
11 family history of heart disease.

12 Q. Did you review her prior records at that  
13 time?

14 A. After I had interviewed the patient, yes, I  
15 had access to her prior hospital records, as well  
16 as the record from the previous ER visit with  
17 Dr. Hatcher.

18 Q. The symptoms that she was having at the time  
19 that you saw her, did that make you think it might  
20 be cardiac related?

21 A. It's always a concern. Her symptoms  
22 though she told me was like with her stomach  
23 problems.

24 Q. So how did you rule out myocardial  
25 infarction or did you rule out myocardial

1 infarction?

2 A. I placed her on the cardiac monitor, which  
3 monitors limb Lead II, and as her being on  
4 continuous cardiac monitor while in the emergency  
5 department there was no evidence of ectopia or S-T  
6 segment elevation or depression of limb Lead II on  
7 the monitor.

8 Q. I'm not sure if that was an answer to my  
9 question.

10 My question was: Did you rule out  
11 myocardial infarction?

12 A. By the testing I did, no, sir, I did not.

13 Q. If something's in your differential, is it  
14 incumbent upon you to rule it out?

15 A. As I stated before, every patient is  
16 different and you evaluate the strengths or value  
17 of their presenting complaints, what they are  
18 telling you at the time. It's like what she had  
19 before. Connie told me this was the pain she had  
20 with her stomach problems. She had -- had been  
21 noncompliant with her diet, also told me she was  
22 noncompliant with her medication. I had a low  
23 threshold for this to be cardiac.

24 Q. Did you understand my question?

25 A. Rephrase the question.

1 Q. If myocardial infarction is in your  
2 differential, don't you have to rule it out?

3 A. I'm not sure I can answer that. I mean,  
4 every patient is a unique entity in itself with  
5 unique complaints. I mean, if I -- I would have  
6 to do every test in the world to rule out  
7 everything for everyone, if that were the case.

8 Q. Isn't a myocardial infarction life  
9 threatening?

10 A. Yes, sir, it can be.

11 Q. If you have a life threatening condition in  
12 your differential, doesn't the standard of care  
13 require you to rule out any life threatening  
14 condition that's in your differential diagnosis?

15 A. A differential diagnosis means that I  
16 entertain the thought of the probability and  
17 possibility of something occurring. I mean, it's  
18 very possible today that a meteorite might fall  
19 and hit us on the head, am I going to call NOVA  
20 today or whatever and ask about that.

21 I'm not trying to be insulant  
22 here. I'm trying to give you insight into my  
23 thinking.

24 Q. So you felt it was just as likely she was  
25 having a myocardial infarction as having as a

1 meteorite striking us in the head today?

2 MR. DUNN: Objection.

3 Argumentative.

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

6 A. I can't make that comparison.

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

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

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

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

16 A. I don't know.

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

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

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

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



1 Q. What else was in your differential?

2 A. With epigastric pain certainly anything in  
3 the chest, anything in the belly, back pain. I  
4 mean, you have dyspepsia, you have Leeuwenhoek's  
5 disease, you have pancreatitis, you have  
6 gallbladder disease, gastritis, acute abdomen; you  
7 could have anything in the chest, which is  
8 including lung problems, cardiac problems,  
9 abdominal wall pain.

10 Q. Which of those are life threatening?

11 A. Acute abdomen can be life threatening,  
12 perforated gallbladder could be life threatening,  
13 acute pancreatitis can be life threatening, a  
14 pneumothorax could be life threatening, a heart  
15 attack certainly can be life threatening, a  
16 dissection can be life threatening.

17 Q. What did you do to rule out those life  
18 threatening conditions?

19 A. I had her under observation, she was on a  
20 monitor. I didn't perform a myriad of tests  
21 because she had stable vital signs and she was not  
22 deteriorating for me; and in reviewing her records  
23 she had just had less than two days before an  
24 entire workup for cardiac enzymes and EKG, as well  
25 as reviewing the records for -- from previous she

1 had had multiple workups.

2 Q. Well, did you review the labs from the prior  
3 emergency department visits?

4 A. I did not see the labs at the time I saw the  
5 patient, no, sir. I had Dr. Hatcher's dictation.

6 Q. I see. So you relied on Dr. Hatcher's  
7 dictation then?

8 A. Yes, sir, I did.

9 Q. Have you since looked at the labs?

10 A. Yes, sir.

11 Q. Do you still agree with Dr. Hatcher's  
12 dictation?

13 A. There is an elevated troponin, it's still in  
14 an indeterminate range, not diagnostic for an MI;  
15 and slightly elevated myoglobin, which is not  
16 specific for cardiac disease.

17 Q. What is troponin?

18 A. Troponin is a cardiac enzyme released by the  
19 heart muscles.

20 Q. So that is or isn't specific for MI?

21 A. That is specific, yes.

22 Q. Was it elevated when Dr. Hatcher did the  
23 test?

24 A. It was one one hundredths of a point above  
25 what the hospital laboratory study determines as a

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

4 Q. So it was or wasn't elevated?

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

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

10 A. I'm sorry. Rephrase your question.

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

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

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

23 A. If I had ordered it?

24 Q. Yes. And it had been elevated?

25 A. Higher than the .04?

1 Q. Yes.

2 A. Yes.

3 Q. What would you have done differently?

4 A. Depends on how high it was.

5 Q. Well, what if it was .05?

6 A. If the remainder in the panel was up, then I  
7 would have talked with either Dr. Hollaway or  
8 cardiology.

9 Q. If you had known that it was elevated when  
10 Dr. Hatcher saw her, if you knew it was .04, would  
11 you have done a troponin?

12 A. I probably would have, yes.

13 Q. Why didn't you look at the labs again?

14 A. They were not available to me.

15 Q. Why weren't they available?

16 A. Because they are not part of the record  
17 that's sent when -- it takes almost a week and a  
18 half for the record to have the labs and  
19 everything back on to it when it is sent down to  
20 us. When the record was pulled, if you look at  
21 his record, it is not -- the findings are not  
22 written on his chart. All I had available to me  
23 at that time was this chart and his dictation.

24 Q. Is it possible to access those through the  
25 hospital computer?

1 A. Yes, sir, it would be.

2 Q. But you didn't do that?

3 A. No, I relied on Dr. Hatcher's dictation.

4 Q. What did you have to do to access it through  
5 the computer?

6 A. I have to ask the secretary to pull the labs  
7 up for me.

8 Q. I take it from your previous answer that you  
9 didn't at any point contact Dr. Hollaway or  
10 Dr. Lee?

11 A. No, sir, I did not.

12 Q. What was the reason for that?

13 A. Traditionally we contact them if the patient  
14 needs admitted or if we have a question about a  
15 patient or we feel uncomfortable with their  
16 presentation.

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

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

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

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

12     A.       Well, generally, yes.

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

15     A.       Yes, sir.

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

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

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

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

1 Q. I thought you reviewed the records?

2 A. I did.

3 Q. Did you see that she kept coming to the  
4 hospital complaining of chest pain?

5 A. Yes, sir.

6 Q. Did you see she kept receiving a GI  
7 diagnosis?

8 A. That is one of the diagnoses that she has  
9 had, yes, sir.

10 Q. Do you normally rely on patients to make the  
11 diagnosis or is that your responsibility?

12 MR. DUNN: Objection.

13 Argumentative. Mischaracterizes testimony.

14 A. I rely on patient' input as to the helpful  
15 means of making a diagnosis or treating a patient.

16 Q. A patient can think that they are having  
17 stomach pain or GI pain and in fact it turned out  
18 to be cardiac related; isn't that true?

19 A. Yes, sir, that is true.

20 Q. So in terms of her telling you that it was  
21 her stomach, that wouldn't be reliable in ruling  
22 out cardiac related pain, correct? You couldn't  
23 rely on that exclusively to rule out an MI in her  
24 case?

25 A. No, sir.

1 Q. Did you have any communication with the  
2 ambulance that brought her there?

3 A. No, sir, I did not.

4 Q. Do you know if anybody at the hospital did?

5 A. I don't know, sir.

6 Q. Did you have access to the ambulance record?

7 A. I do not remember seeing that record.

8 Sometimes those records are put together after the  
9 chart, after the patient's disposition is  
10 arranged.

11 Q. Have you seen it since, is that one of the  
12 things you reviewed?

13 A. Specifically I'll have to review and see if  
14 it is here.

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

16 Q. Well, does the ambulance usually call ahead  
17 to say we have a patient coming?

18 A. Yes, sir.

19 Q. Who do they talk to?

20 A. They may talk to -- usually they talk to the  
21 nursing personnel because they answer the hear  
22 radio. Occasionally a physician answers.

23 Q. The hear radio, what is that?

24 A. It is a radio specific to calling in from  
25 outlining medical services to the hospital



1 emergency room.

2 Q. What is NFO?

3 MRS. MATTHEWS: I think NGD,  
4 here.

5 A. Okay.

6 Q. I'm looking at the bottom two lines, bottom  
7 two lines; do you see where it says --

8 A. No further orders is NFO, per Aultman.

9 Q. So who would have --

10 A. It would have been a nursing.

11 Q. What does that mean?

12 A. I mean, when they -- when this ambulance  
13 service called in, whoever they talked to told  
14 them there were no further orders, they were to  
15 follow their standard protocol.

16 Q. You don't know where they would have got the  
17 information from to give to the ambulance service?  
18 How does it work there? The ambulance calls and  
19 they speak to the nurse, does the nurse ask you if  
20 there is any orders or ask a physician, how does  
21 it work?

22 A. They can.

23 THE WITNESS: Is this  
24 another question?

25 MR. DUNN: Go ahead.

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

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

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

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

25 Q. So you had no input into that?

1 A. Not that I am aware of, no.

2 Q. How many physicians were in the emergency  
3 department that night?

4 A. At the time she arrived?

5 Q. Yes.

6 A. Is that what you're asking?

7 Q. Yes.

8 A. One.

9 Q. So you were the only one there?

10 A. Yes, sir.

11 Q. Is that normal?

12 A. At that time, yes, sir.

13 Q. At that time, you mean at that time of the  
14 day or --

15 A. Of night, yes.

16 MR. MELLINO: Where is he  
17 going with my --

18 MR. DUNN: He's going to  
19 get copies made.

20 MR. MELLINO: Before you  
21 take any of my documents out of the room it would  
22 be nice if you asked.

23 MR. STRONG: He didn't have  
24 his coat with him.

25 MR. DUNN: I didn't want

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

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

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

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

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

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

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

17 MR. MILLIGAN: Thank you.

18 BY MR. MELLINO:

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

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

23 Q. You haven't looked at the census?

24 A. No, sir, I have not.

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

1       you recall about that night, I guess?

2       A.       That most of the beds were full, as is our  
3       -- in most nights.

4       Q.       Was there a particular patient that you were  
5       concerned about or that was taking a lot of time  
6       or do you recall who the other patients who were  
7       there, what their conditions were?

8       A.       No, sir, I don't.

9       Q.       What do you remember about Mrs. Germanoff?

10      A.       I remember that she, when I went in to talk  
11      to her, was uncomfortable and was holding her  
12      stomach. When I asked her why she was there, she  
13      stated that her stomach was burning, it felt like  
14      her stomach problems, that she had eaten pizza  
15      several hours before coming in, she knew she  
16      wasn't supposed to, and it was about an hour after  
17      she had eaten her pizza that she began having  
18      stomach pains.

19                       And when I asked her if she had --  
20      had been on her medications, she had stated that  
21      she had missed some doses of that, and she thought  
22      that was probably contributing to some of her  
23      pain. I mean, that's -- basically I remember an  
24      uncomfortable appearing female.

25      Q.       Was she alone in the room?

1 A. I never saw any other family with her in the  
2 room, sir.

3 Q. Do you recall what she looked like?

4 A. I can't put eye color, no. I mean, she was  
5 I remember a little bit overweight, but I don't  
6 remember eye color.

7 Q. I didn't ask anything about eye color.

8 Do you remember anything about her  
9 appearance?

10 A. Not to be specific, no.

11 Q. Was anybody else in the room when you  
12 examined her besides the two of you?

13 A. I don't recall.

14 Q. Did you speak to the nurse before you went  
15 in and saw Connie?

16 A. I don't recall that, either.

17 Q. Did you review the nurse's note before you  
18 saw Connie?

19 A. I don't remember if it was before or shortly  
20 thereafter. I remember reviewing it, but I don't  
21 remember whether it was before I saw her.

22 Q. How long did your examination last?

23 A. The initial examination?

24 Q. How many times did you see her?

25 A. I was in and out of the room frequently.

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

3 Q. How many times were you in the room?

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

5 Q. Did you do an examination?

6 A. Yes, sir.

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

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

11 A. Yes, sir.

12 Q. Then you did an examination?

13 A. Yes, sir.

14 Q. How long did the examination last?

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

17 Q. Was it a half hour, couple minutes?

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

21 Q. But you don't recall?

22 A. No.

23 Q. What did your examination consist of?

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

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

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

7 A. Yes, sir.

8 Q. Where?

9 A. I touched her skin.

10 Q. Where?

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

15 Q. Did you do that to Mrs. Germanoff?

16 A. Yes, sir, I did.

17 Q. Where else?

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

24 Q. Anyplace else?

25 A. I don't recall specifically touching her



1 anywhere else, no, sir.

2 Q. Did your exam consist of anything other than  
3 what you told me already?

4 A. I don't recall of it.

5 Q. Then what did you do after you completed the  
6 history and your examination?

7 A. I ordered some medication for her.

8 Q. What medication?

9 A. The viscous lidocaine and Mylanta. I  
10 believe it's documented on the charts.

11 Q. You can review the charts.

12 A. As well as I.V. Pepcid.

13 Q. Why did you order those?

14 A. Because her pain was consistent with  
15 epigastric or gastric type pain, and I was hoping  
16 to alleviate her pain with that.

17 I also ordered amylase and lipase  
18 laboratory studies, and while I was in the room I  
19 had placed the patient on a heart monitor.

20 Q. Why did you order the amylase and lipase  
21 panel?

22 A. I was concerned with the pain being in the  
23 mid epigastrium, that it was possibly  
24 pancreatitis.

25 Q. Where is the mid epigastrium?

1       A.     It is right here, right below your  
2       breastbone, above your umbilicus.

3       Q.     Pretty much right in the middle of your  
4       chest?

5       A.     No.   Chest is up here.

6       Q.     Why did you order the heart monitor?

7       A.     I placed the patient on it while I was in  
8       the room because I was -- that was part of my  
9       differential was this cardiac.

10      Q.     So you were using that then to rule out  
11      cardiac pain origin?

12      A.     As -- yes, as a monitor.   Yes, sir.

13      Q.     How did you rule out aortic dissection if  
14      you didn't take her pulse in her lower  
15      extremities?

16      A.     They were pink.

17      Q.     What, her lower extremities were pink?

18      A.     Yes.   They were normal coloration, she was  
19      not showing cyanosis.

20      Q.     So that's sufficient to rule out aortic  
21      dissection?

22      A.     It's not completely, no, sir.

23      Q.     Well, would the --

24      A.     I would need to do CT scans of the chest or  
25      aortogram to rule that out.

Q. Since you didn't do either one of these, I  
 2 take it that aortic dissection wasn't very high in  
 3 your differential?

A. No, sir, it was not.

Q. Now, when you took the history from  
 6 Mrs. Germanoff, did she tell you that was the same  
 7 pain that she had been having on her previous  
 8 visits to the emergency room?

A. She told me this was her stomach pain,  
 10 that's what she told me. She did not say it was  
 11 the same pain that she was having on previous  
 12 visits.

Q. Did you ask her that?

A. I asked her if this is pain into her chest,  
 15 because she had complained of chest pain before,  
 16 that was asked when I went back in to the room.  
 17 She said this was not chest pain, that's what she  
 18 told me.

Q. Do you have that documented somewhere in  
 20 your note?

A. If it's not dictated, it is probably not  
 22 documented down. I would have to look at this.

23 This is such a poor copy of this.

Q. Is it in your dictation?

A. It is -- would you rephrase your question?

1 Q. Did you document the fact that she said this  
2 was not chest pain?

3 A. No, it's not indicated in my dictation.

4 Q. You never talked to anybody from the  
5 ambulance?

6 A. No, sir.

7 Q. People that brought her in?

8 A. No.

9 Q. Apparently you've never seen before today  
10 this ambulance run sheet?

11 A. No, sir.

12 Q. It does say on there reason for treatment  
13 was chest pain, did you happen to notice that when  
14 I showed you this before?

15 A. No, sir, I did not.

16 Q. Do you see that on there?

17 A. I see that. Ambulance services tend to take  
18 anything from the waist up as chest pain, but --  
19 but I can't account for what they thought, what  
20 they heard that night.

21 Q. What does C/C mean underneath that?

22 A. Underneath what?

23 Q. Where the reason for treatment, chest pain,  
24 underneath it says?

25 A. Chief complaint.

1 Q. Chef complaint, chest pain. Then it says  
2 history of chief complaint, two episodes in past  
3 week, right?

4 A. That's what it says, yes, sir.

5 Q. You didn't have that information available  
6 to you?

7 A. I have never seen this before today, sir.

8 Q. This isn't available to you at all?

9 A. As I stated, sometimes they don't leave them  
10 in the ER. They leave them out front at the  
11 registration desk and they don't get assembled  
12 into the chart until the charts are torn down.

13 Q. You did say in your dictation that she had  
14 several workups for her epigastric burning; do you  
15 see that, that's the first --

16 A. Yes, sir.

17 Q. -- under your chief complaint?

18 A. Yes, sir.

19 Q. When did she have those workups?

20 A. The last that she had she was in the  
21 emergency two days before I saw her, she was  
22 admitted into the hospital I believe on the 16th  
23 of December, and I remember somewhere back in  
24 September I believe she had also had a workup for  
25 chest pain.

1 Q. So it was your understanding then this was  
2 the same pain that she was having on the prior  
3 visits to the emergency?

4 A. She told me this was her stomach pain,  
5 that's what she --

6 Q. I asked what your understanding was, not  
7 what she told you.

8 What your understanding is,  
9 according to the dictation you put down, she had  
10 several workups for this pain?

11 A. For similar type pain, yes. Yes.

12 Q. So this was your understanding at the time  
13 you saw her, this was the same pain that she had  
14 been having in the prior emergency department  
15 visits?

16 A. She told me on the day I saw her this was  
17 her stomach pain, not the chest pain that she had  
18 two days before, that's what she told me.

19 Q. I understand, you said that already, couple  
20 of times. I'm not asking you that.

21 I'm asking what your understanding  
22 is. You are not relying on her to make the  
23 diagnosis, are you? She's coming to you for the  
24 diagnosis; isn't that true?

25 A. Correct.

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

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

9 Q. Why didn't you order troponin levels?

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

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

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

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

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

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

24 A. Because she had.

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

1                   Is it the same pain or a different  
2                   pain?

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

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

13          A.       Because she had had. Review the records.

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

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

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

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

21          Q.       That's what your note says?

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

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



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

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

6 Q. Did you look at the previous records?

7 A. Yes, sir.

8 Q. You looked at them yourself?

9 A. Yes, sir.

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

12 A. It was after I had examined her.

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

16 MR. DUNN: Objection.

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

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

22 A. Yes, sir.

23 Q. After your history and physical, right?

24 A. Yes, sir.

25 Q. So you must have thought in your own mind

1       this was GI at that point?

2       A.     I had a higher probability of it, yes, sir.

3       Q.     Why didn't you order an EKG?

4       A.     Because under cardiac monitor she had normal  
5       sinus rhythm without any evidence of ischemia.

6       Her pain never went up into her arms or chest and  
7       she persisted in saying that her pain was the  
8       typical pain for her stomach.

9       Q.     How hard would it have been to do an EKG?

10      A.     It would not have been hard at all, sir.

11      Q.     How long would that have taken?

12      A.     However long it takes for the machine to do  
13      it, probably less than two minutes.

14      Q.     Where is this monitor strip or something  
15      that shows us that you were monitoring?

16      A.     There is not a monitor strip in this chart.  
17      I don't know. Sometimes the nurses don't mount  
18      normal strips if there is not any aberrances in  
19      the monitor, if it didn't alarm for any reason  
20      sometimes they were not mounted. I don't know why  
21      that is, sir.

22      Q.     You didn't save any parts of the strip?

23      A.     I personally did not, no.

24      Q.     That's the nurse's responsibility to do  
25      that?

1 A. Yes, sir.

2 Q. How does somebody that has a history of GI  
3 disease get diagnosed with an MI?

4 A. I don't know, sir.

5 Q. Just because someone has a history of GI  
6 disease, they come in with chest pain, you have to  
7 still rule out MI, don't you?

8 A. It's one of the considerations, yes, sir.

9 Q. A person that does have GI problems can have  
10 a heart attack, right?

11 A. Yes, sir.

12 Q. So even if a person has a history of GI and  
13 comes in with chest pain, MI needs to be ruled  
14 out; isn't that true?

15 A. Yes, sir.

16 Q. And you can't rule out an MI with a heart  
17 monitor, can you, you need to do EKG and enzymes;  
18 isn't that true?

19 A. If you were entertaining heart concerns,  
20 yes, sir.

21 Q. And even a Cardiolite stress test doesn't  
22 definitively rule out cardiac disease, does it?

23 A. There is percentage of error with that, yes.

24 Q. Would you agree that the only way to really  
25 definitively rule out cardiac disease is with a

1 cardiac catheterization?

2 A. Yes, sir. But Dr. Lee's dictation indicated  
3 that he would -- would not offer her  
4 catheterization.

5 Q. It does?

6 A. Due to a -- yes, sir, it does -- due to a  
7 contrast allergy.

8 Q. When did you find that out?

9 A. When I reviewed her records the night I saw  
10 her. She had been seen by -- on two different  
11 occasions for stress testing and I believe I had  
12 reviewed his consultation, which indicated that he  
13 would not offer catheterization and he did not  
14 feel this was cardiac etiology.

15 Q. Why wouldn't he offer her a catheterization?

16 A. Because of the contrast allergy.

17 Q. Did that factor into your treatment of her?

18 A. It factored in greatly. I highly respect  
19 Dr. Lee. This was a cardiologist who had seen her  
20 for a consult for chest pain, reported chest pain,  
21 and the patient had underwent her second stress  
22 test I believe in three months.

23 Q. Well, if you highly respect him, why didn't  
24 you call him that night and consult with him?

25 A. Because I had reviewed his records and the

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

1 MR. DUNN: Objection.

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

7 Q. Did you look at those enzymes?

8 A. Yes, sir.

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

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

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

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

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

1       A.     But I didn't see that and I didn't know  
2       that.  She never told me.

3       Q.     She did have an epigastric pain?

4       A.     Yes, sir.

5       Q.     Which was similar to the pain that she had  
6       had on prior visits, correct?

7       A.     She said she had had the stomach pain in the  
8       past.

9       Q.     You interpreted that as being similar pain  
10      to what she had had on previous visits, correct?

11                   MR. DUNN:                   Objection,  
12      that's not what she testified to.

13      A.     I said before that she had -- had been  
14      worked up for pain, she told me that this was not  
15      the pain she had had the few days before, this was  
16      stomach pain.

17      Q.     You said in your note, this is a quote,  
18      "that she had several workups for our epigastric  
19      burning"?

20      A.     Correct.

21      Q.     The workups you are referring to are the  
22      workups she had in the emergency room on previous  
23      visits with Dr. Hatcher, correct?

24      A.     I'm referring to all workups, sir.  All  
25      hospitalizations, all previous workups.

1 Q. Well, you told me before you were referring  
2 specifically to the visit on the 20th with  
3 Dr. Hatcher and the one on the 16th, correct?

4 A. I don't remember that I specifically said  
5 those two visits. You would have to replay that  
6 back.

7 When I said she had previous  
8 workups, she had previous hospitalizations and  
9 workups for pain.

10 Q. Shouldn't you know what her complaints are  
11 to the ambulance people?

12 A. I'm sorry. Rephrase that.

13 Q. Shouldn't you know, isn't it one of your  
14 responsibilities as an emergency room doctor to  
15 know what her complaints were that brought her  
16 there?

17 A. I asked the patient.

18 Q. Shouldn't you know what she told the  
19 ambulance team?

20 A. I assumed she tells me the same thing she  
21 tells the ambulance people. If the patient is  
22 coherent, cooperative, and able to speak, I assume  
23 they tell me the same thing.

24 Q. So you don't communicate with the ambulance  
25 people?



1 A. Not always. The ambulance people  
2 communicate their report to the nurse, the nurse  
3 communicates then to me, information that I need  
4 to know, or they document on the chart.

5 Q. Did the nurse relay to you that she was  
6 having chest pain, she told that to the ambulance  
7 people?

8 A. Nurse never told me she had chest pain.

9 Q. Should the nurse have told you that?

10 A. I don't know what the ambulance people told  
11 the nurse, sir.

12 Q. Well, regardless of how it happened,  
13 shouldn't the complaints of chest pain that  
14 Mrs. Germanoff made to the ambulance people have  
15 been communicated to you?

16 MR. DUNN: Objection.

17 MR. MILLIGAN: Objection.

18 MR. DUNN: Been asked and  
19 answered.

20 A. I don't know what Mrs. Germanoff told the  
21 ambulance people. I know what she told me.

22 Q. I didn't ask that.

23 MR. DUNN: You asked that  
24 and she answered.

25 MR. MELLINO: She hasn't.

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

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

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

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

17 A. Correct.

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

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

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

25 A. If in fact she told the ambulance people

1       that. I have no way of knowing that, sir.

2       Q.     We do have a way of knowing. We have the  
3       record from the ambulance people, correct? You  
4       have seen that now.

5       A.     I see that.

6       Q.     It says right on there she has chest pain,  
7       that is her chief complaint, correct?

8       A.     That's what written on the record, sir.

9       Q.     Do you have any reason -- do you think this  
10      record is inaccurate?

11      A.     No, sir.

12      Q.     So if she made the complaint of chest pain  
13      to the ambulance people, you are telling me that  
14      should have been communicated to the nurse and  
15      then the nurse should have communicated that to  
16      you; is that true?

17                   MR. MILLIGAN:           Objection.

18                   MR. DUNN:               Objection.

19      A.     I don't know that they should have. I'm  
20      telling you what generally happens.

21      Q.     That didn't happen in this case; is that  
22      true?

23                   MR. DUNN:               Objection.

24      She doesn't know that.

25      A.     I never saw that piece of paper before

1       today, sir.

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

4       A.     No, sir, I was not.

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

6                       MR. DUNN:                       Objection.

7       I'll instruct her not to answer that question.

8       A.     I don't know how to answer.

9                       MR. DUNN:                       Don't answer  
10       that question.

11       Q.     Why didn't you get the information?

12                      MR. MILLIGAN:                What  
13       information?

14                      MR. DUNN:                      Objection.  
15       What information?

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

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

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

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

1                               MR. MELLINO:               No, you are  
2       not.

3                               MR. DUNN:                Yes, I am.

4                               MR. MELLINO:               No, you are  
5       not.

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

11                              MR. MELLINO:               It does exist.

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

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

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

23      BY MR. MELLINO:

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

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

4 A. Yes.

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

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

13 MR. MELLINO: I'm not  
14 attacking you.

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

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

20 MR. DUNN: Thank you.

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

25 BY MR. MELLINO:

1 Q. You were not aware that until today, until I  
2 showed you this ambulance record today, that  
3 Mrs. Germanoff complained to the people  
4 transporting her via the ambulance to the  
5 emergency department that she complained of chest  
6 pain; is that a true statement?

7 A. That is a true statement.

8 Q. And is there a protocol or rule or policy at  
9 the hospital that requires a nurse to tell you  
10 what's on the ambulance report or what she finds  
11 out from or that requires her to find out what the  
12 complaints are from the ambulance people?

13 A. I'm not aware of any such policy, sir.

14 Q. Is that what normally happens in the  
15 hospital?

16 A. Define normally?

17 Q. Well, I thought you told me before generally  
18 what happens is the ambulance people tell the  
19 nurse and the nurse tells you?

20 A. The ambulance people give report to the  
21 nurse who's taking care of the patient, the  
22 patient then may sometimes tell me verbally what  
23 they said.

24 Q. The nurse you mean?

25 A. Yes.

1 Q. You said the patient.

2 A. The nurse. I'm sorry. The nurse.

3 Sometimes the chart is just  
4 racked, so therefore I don't have direct contact  
5 with the nurse immediately. I see the patient  
6 beforehand but I read the nursing notes. If I  
7 have concerns about something, I can go ask the  
8 nurse at any time.

9 Q. Don't the paramedics always give a report to  
10 the nurse?

11 A. Yes, sir.

12 MR. KREMER: Objection.

13 Q. So then it's the nurse's responsibility to  
14 convey the information to you?

15 MR. MILLIGAN: Objection.

16 A. I don't know if it's a set policy, sir.

17 Q. But that's what normally happens?

18 A. Yes, sir.

19 Q. Isn't that what you as a physician would  
20 want to happen, wouldn't you want to be given the  
21 information the nurse obtains from the paramedics?

22 A. Yes, sir.

23 Q. I guess you don't know why that didn't  
24 happen in this case, until today, this morning,  
25 you didn't even know this information was out



1       there, true?

2       A.     That's correct.

3       Q.     Had you known that there was a complaint of  
4       chest pain by Mrs. Germanoff that night, you would  
5       have ordered an EKG?

6       A.     If she had told me she had chest pain, yes,  
7       sir, I would have.

8       Q.     Well, if you had been told too that she told  
9       the paramedics that, would you have ordered an  
10      EKG?

11     A.     More than likely, yes.

12     Q.     Would you have ordered cardiac enzymes?

13     A.     I don't know. I think it would have  
14     depended on the situation, how much she complained  
15     of it, what her EKG looked like. I -- I can't  
16     second guess. I know retrospectively we would all  
17     have done everything, but I don't know. I can't  
18     speculate what it would have shown that might.

19     Q.     The EKG?

20     A.     Yes, sir.

21     Q.     But the fact that she had this complaint of  
22     chest pain alone, as you sit here today you don't  
23     know whether that would have caused you to order  
24     the enzymes?

25     A.     I can't make that assumption, sir.

1 Q. If she was having an MI at the time that she  
2 was in the emergency department, isn't it true  
3 it's more likely than not an EKG would have shown  
4 something?

5 A. If she was having an MI at that time, I  
6 would expect the EKG to show abnormality, yes.

7 Q. I assume the same would be true about the  
8 cardiac enzymes?

9 A. Yes, sir.

10 Q. Are you aware of the fact that she was  
11 probably having an MI at the time that she was in  
12 the emergency?

13 MR. DUNN: Objection.

14 MR. KREMER: Objection.

15 MR. MILLIGAN: Objection.

16 A. No, sir.

17 Q. You have never seen the autopsy?

18 A. I do not remember visualizing the autopsy or  
19 seeing the paper, no.

20 Q. Well, the autopsy states that she had  
21 transmural acute myocardial infarct of the  
22 posterior wall of the left ventricle, two to three  
23 days, 48 to 72 hours, old?

24 A. I'm sorry. Say it again.

25 Q. Sure. Transmural acute myocardial infarct

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

3 A. Okay.

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

6 A. Yes, sir.

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

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

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

13 MR. DUNN: Objection.

14 MR. KREMER: Objection.

15 MR. MILLIGAN: Objection.

16 A. I can't say that.

17 Q. Why not?

18 A. Because I don't know that.

19 Q. Why don't you know that?

20 A. Because I don't.

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

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

1 symptoms consistent of myocardial deterioration  
2 when I saw her.

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

7 MR. DUNN: Objection.

8 A. That's an assumption.

9 Q. What is?

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

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

14 A. I don't know that.

15 Q. I just read you the autopsy.

16 A. On the 26th, yes.

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

19 A. I think it said more likely, didn't it say  
20 24 to 48 hours. What did you read as the --

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

24 A. Okay.

25 Q. So she did have an MI?

1 A. According to the autopsy she had an MI, yes,  
2 sir.

3 Q. According to the autopsy it was two to three  
4 days old, correct?

5 A. That's what's typed in the autopsy report as  
6 you're reading it to me.

7 Q. Now, I am asking you to assume this, she was  
8 having an MI at the time she was in the emergency  
9 department.

10 A. I can't assume that.

11 Q. It's a hypothetical question, so if it turns  
12 out that that's not to be true, than your answer  
13 doesn't matter; but I'm asking you to assume that  
14 is true, that she was having an MI when she was  
15 there, wouldn't it be more likely than not that  
16 her pain was cardiac related and not stomach  
17 related?

18 A. I don't know that's correct, sir.

19 Q. Why don't you know that?

20 MR. DUNN: Objection.

21 A. Pain can come from many sources, people have  
22 silent MI's, painless MI's.

23 Q. But she was having pain?

24 A. She was having pain, yes, sir.

25 Q. Do you think it is -- which seminar is more

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

4                       MR. DUNN:                       Objection.

5       Q.       -- attack?

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

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

12                   MR. DUNN:                   Objection.

13      Q.       You can answer.

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

15      Q.       You think they're equally likely?

16                   MR. DUNN:                   She didn't say  
17      that.

18      A.       I just --

19                   MR. DUNN:                   Objection.

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

21      Q.       Why can't you answer?

22      A.       Because I don't know.

23      Q.       Don't know what?

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

1 know.

2 Q. Well, if she is in the emergency department  
3 having an MI, it's your job to find out what the  
4 source of pain is, correct?

5 MR. DUNN: Objection.

6 MR. STRONG: This is  
7 getting tediously redundant.

8 Q. You can answer.

9 MR. STRONG: That's my take  
10 on it.

11 MR. MELLINO: It's also  
12 meaningless.

13 A. Restate your --

14 Q. If somebody, a patient is having an MI and  
15 you're there examining them, it's your  
16 responsibility as an emergency room doctor to  
17 determine what the source of their pain is; isn't  
18 that a true statement?

19 MR. DUNN: Objection.

20 A. If they're having an MI, yes, sir.

21 Q. How many times did you see her that night?  
22 You said, I think you told me you went into the  
23 room multiple times?

24 A. Right. I don't recall how many times  
25 exactly, sir.

1 Q. You dictated in your studies, discussion,  
2 treatment, that she did get some relief with the  
3 lidocaine and Mylanta but it was incomplete?

4 A. Correct.

5 Q. Did that cause you some concern as to why  
6 she was having pain?

7 A. No.

8 Q. That it wasn't related to her stomach?

9 A. No, it's not unusual to not have complete  
10 relief with a GI cocktail.

11 Q. Is it normal to have, after you give a GI  
12 cocktail, to give Demerol and Phemerol to relieve  
13 pain?

14 A. She requested those medications to help her  
15 sleep. She stated she hadn't slept through the  
16 night.

17 Q. So you gave her those to help her sleep?

18 A. To help relief of pain and help her sleep.

19 Q. I asked if that's normal to give those  
20 medications for pain relief after GI cocktail if  
21 the pain is from her stomach?

22 A. That -- yes, sometimes that dose is given.

23 Q. Can you rely on relief of pain to determine  
24 if the pain is GI or cardiac?

25 A. I'm not sure I understand your question.



1 Q. Did the fact that she had some pain relief  
2 from the GI cocktail, did that tell you one way or  
3 the other whether it was cardiac or stomach  
4 related?

5 A. Well, I wouldn't expect Mylanta and viscous  
6 lidocaine which interact with the esophagus to  
7 relieve cardiac pain, so if she got some relief  
8 with this I would expect this was not cardiac.

9 Q. So did that further lower your suspicion for  
10 cardiac origin then?

11 A. Yes, sir.

12 Q. Did the Demerol or Phemerol help her pain?

13 A. Yes, sir.

14 Q. What kind of deterioration were you  
15 observing her for?

16 A. Increasing pain, drop in blood pressure,  
17 change in cardiac monitoring, change in vital  
18 signs.

19 Q. Is epigastric pain consistent with acute  
20 myocardial infarction?

21 A. Some myocardial infarctions can have  
22 epigastric pain, yes, sir.

23 Q. Could you run a cardiac enzyme with the same  
24 blood you drew for the amylase and lipase?

25 A. I believe the lab can do that. Sometimes

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

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

6 A. To her present problem.

7 Q. Well, she did have a family history?

8 A. Of heart disease, yes, sir.

9 Q. But you didn't put that down?

10 A. No, sir, I did not.

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

14 MR. DU " : Objection.

15 A. If they were having chest pain, certainly.

16 Q. What if they were having epigastric pain?

17 A. Certainly it raises your suspicion.

18 Q. Who in her family had heart disease?

19 A. I believe it was her mother.

20 Q. Is that of significance?

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

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

25 A. Makes it significant, yes, sir.

1 Q. If MI was in your differential, why didn't  
2 you document that in the family history?

3 A. I don't know, sir. I don't have an answer  
4 for that.

5 Q. What did she tell you about her medications?

6 A. She told me she was supposed to be on  
7 medicine for her stomach.

8 Q. What medicine?

9 A. I believe she had said Prilosec, but she  
10 hadn't been taking it on a regular basis; and that  
11 she was -- also told me that she should take  
12 over-the-counter medicines like Mylanta or Maalox  
13 if her symptoms got worse, and she was -- wasn't  
14 taking that.

15 Q. Anything else?

16 A. I don't recall.

17 Q. Why did you order the amylase and lipase?

18 A. The location of her pain was worrisome for  
19 it being pancreatitis, especially with the patient  
20 having eaten pizza, et cetera. Sometimes if they  
21 have an occult history of gallbladder disease,  
22 they can have gallstone pancreatitis, I wanted to  
23 make sure this is not pancreatitis.

24 Q. Can you rule out pancreatitis with just  
25 amylase and lipase?

1 A. If they are low your suspicion for that is  
2 fairly low. Pancreatic enzymes accelerate rather  
3 quickly in a pancreatitis state.

4 Q. Hadn't she previously had CT scans and  
5 ultrasounds that showed she had no gallstones?

6 A. I'd have to review the record. I don't  
7 remember that specifically.

8 Q. You didn't review it that night?

9 A. I don't remember that, sir.

10 Q. Did she have swelling of her lower  
11 extremities?

12 A. I don't remember that.

13 Q. Did you check for it?

14 A. I looked at them, yes.

15 Q. The fact that she had no frank deterioration  
16 wouldn't rule out an **MI** either, would it?

17 A. That in and of itself, no.

18 Q. Does Aultman has a chest pain unit?

19 A. Yes, sir.

20 Q. Why didn't you send her there?

21 A. Because she wasn't having chest pain.

22 Q. If you had known that she had complained to  
23 the ambulance people of chest pain, would you have  
24 sent her to the chest pain unit?

25 MR. MILLIGAN: Objection.

1 MR. DUNN: Objection.

2 A. I don't know.

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

4 A. Patients who have what we consider equivocal

5 chest pain with pain of unknown etiology without

6 unstable vital signs.

7 Q. How many beds are there in the emergency

8 room?

9 A. Major and minor beds?

10 Q. Yes.

11 A. 27 without doubling any rooms up.

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

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

14 Q. Do you have the ability to call additional

15 help if you need it?

16 A. Yes, sir.

17 Q. Who would you call?

18 A. The on call physician.

19 Q. At what point would you call that person?

20 A. If there were an overwhelming amount of

21 patients, traumas, critical patients that I was

22 not able to get to in an expedient and timely

23 manner.

24 Q. What would be an overwhelming number of

25 patients?

1 A. If there are more than ten patients waiting  
2 to be seen or critical patients there that are  
3 decompensating. I mean, it's a variable thing.  
4 You can't just say you call on X number of  
5 patients, it's variable with the situation.

6 Q. Did you call for help that night?

7 A. No, sir.

8 Q. Who was the on call physician?

9 A. I have no way of knowing, sir.

10 Q. There wouldn't be any kind of record of  
11 that?

12 A. There would be a record. I don't recall it  
13 at this time.

14 Q. Would the schedule show that?

15 A. The schedule for that day, yes, sir.

16 Q. As an emergency room doctor, when somebody  
17 comes in multiple times with the same problem,  
18 don't you consider that the previous diagnoses  
19 that she has been given may be inaccurate?

20 A. You take lots of things into consideration.  
21 I wouldn't say I specifically say the previous  
22 diagnosis was inaccurate, no, sir.

23 Q. Well, do you think that maybe a new approach  
24 to the problem needs to be taken?

25 A. You approach every patient and every problem

1 uniquely.

2 Q. So you wouldn't rely on previous visits  
3 then, you take every patient as they come into the  
4 ER?

5 A. I use previous information as helpful  
6 information. In this case Mrs. Germanoff came in  
7 complaining of stomach pain to me and she told me  
8 it was not the discomfort she had two days before.

9 Q. But you didn't document that anywhere, did  
10 you, ma'am?

11 A. It's not part of my typed dictation.

12 Q. Is it in any part of the record at all?

13 A. I don't see that I wrote it down as such,  
14 no, sir.

15 Q. In fact, the only thing we have written down  
16 from that visit is the ambulance run which says  
17 that she had chest pain?

18 A. There is nurse --

19 MR. DUNN: Objection.

20 A. Nursing notes all over it that do not state  
21 chest pain. In fact, if you read the nursing  
22 notes they do not refer to chest pain. The chief  
23 complaint as written by the nurse is not chest  
24 pain.

25 Q. Pardon me?

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

5       Q.     Why do you have to assume that?

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

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

12      A.     That's what she told --

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

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

24                       MR. DUNN:               Objection.

25      You can answer.



2 A. If I am to assume, this is an assumption  
3 only, that she presented to me with the same  
4 complaint as she had presented the day before,  
5 then I would -- would have pursued in a cardiac  
6 manner, meaning I would have at least got an EKG.

7 Q. Are you telling me that you asked her if  
8 this was the same pain she had on the previous two  
9 visits?

10 A. I said if this pain was the same and she  
11 said no, this was her stomach pain, that is why I  
12 pursued the course that I did.

13 Q. Because that's what she told you?

14 A. Correct.

15 Q. That's why you pursued this course, but yet  
16 you didn't document that in your dictation?

17 MR. DUNN: Asked and  
18 answered. Objection. Three time at least.

19 MR. MELLINO: That's okay. I  
20 might ask it another three times,

21 A. No, sir, that is not dictated in the record.

22 Q. And you don't have any handwritten notes in  
23 the record, correct?

24 A. The handwritten things are on the chart.

25 Q. But none of that is your handwriting, is it?

A. Yes.

1 Q. What is your handwriting on the chart?

2 A. Orders, this, this down here, D/C.

3 Q. You got to go slow.

4 A. The orders, this part that says ate pizza,

5 the discharge.

6 Q. Where it says D/C?

7 A. Correct. The diagnosis, where it says

8 diagnostic impression on the bottom, that is my

9 handwriting.

10 Q. What does that say?

11 A. Says recurrent epigastric pain and

12 noncompliance with medical regimen.

13 Q. Anything else that you have written in the

14 record?

15 A. The back discharge sheet.

16 Q. Pardon?

17 A. The home-going instructions.

18 Q. What did you write on that sheet?

19 A. Contact Dr. Hollaway, and then it says to

20 continue your medications, and the -- the other

21 orders below it.

22 Q. Go ahead. Read those into the record.

23 A. No pizza or spicy foods, no alcohol, no

24 tobacco.

25 Q. Did she have epigastric pain on her prior ER

1 visits?

2 A. I believe she came in complaining of chest  
3 pain. I would -- would have to review what her  
4 chief complaint was. She had told me she is --  
5 has had stomach pain in the past but the pain she  
6 had the night I saw her was not the chest pain she  
7 had had couple days before; and I believe when --  
8 on Dr. Hatcher's evaluation, which was on the  
9 20th, I believe, triage complaint was midsternal  
10 chest pain.

11 Q. So did she or didn't she have epigastric  
12 pain on the prior ER visits?

13 A. I don't know if she had them on the prior ER  
14 visits, sir.

15 Q. Well, so what did the recurrent epigastric  
16 pain in your diagnosis refer to?

17 A. Because she has had epigastric pain in the  
18 past.

19 Q. When?

20 A. She told me she has had it in the past. She  
21 has a previously documented diagnosis of  
22 gastroesophageal reflux disease.

23 Q. That was based on what she told you?

24 A. I'm sorry. What was?

25 Q. The recurrent epigastric pain?

1 A. Yes.

2 Q. Why do you work on the night shift?

3 A. It's my preference.

4 Q. Are there any other conversations that you  
5 had with Mrs. Germanoff that either aren't in the  
6 record or that we haven't talked about today?

7 A. I don't recall, sir.

8 MR. MELLINO: Why don't we  
9 take about a five minute break.

10 MR. DUNN: Okay.

11 - - -

12 (Recess had.)

13 - - -

14 BY MR. MELLINO:

15 Q. Are you ready?

16 A. Yes.

17 Q. Have you been sued before?

18 A. Yes, sir.

19 Q. How many times?

20 A. I have been named three other times before.

21 Q. Were those all in --

22 MR. MELLINO: Which county  
23 is this?

24 MRS. MATTHEWS: Stark.

25 Q. -- Stark County?

1 A. Yes, sir.

2 Q. What were the circumstances of them?

3 A. One was settled.

4 Q. The facts of the case?

5 MR. DUNN: Can I just  
6 have a continuing objection?

7 MR. MELLINO: Sure.

8 MR. DUNN: For prior  
9 lawsuits?

10 MR. MELLINO: Sure.

11 Q. Take them one at a time.

12 A. The one was for failure, alleged failure to  
13 diagnose a Type A dissection, thoracic dissection.

14 Q. When was that?

15 A. I want to say '93, December of '93, I  
16 believe.

17 Q. Do you recall the name of the patient?

18 A. McIntyre, I believe. Dwayne McIntyre.

19 Q. What was the disposition in that case?

20 A. It was settled.

21 Q. Who represented you in that case?

22 A. David Best.

23 Q. What was the next one?

24 A. I was named in a suit for -- I believe her  
25 name was Clapper, I don't remember the first, and

1       they -- I don't know what the term is for it,  
2       dropped the suit.

3       Q.     What were the allegations?

4       A.     Failure to diagnose diskitis.

5       Q.     Were you deposed in that case?

6       A.     No, sir.

7       Q.     Were you deposed in the McIntyre case?

8       A.     Yes, sir.

9       Q.     In the McIntyre case you said was failure to  
10      diagnose thoracic aneurysm?

11      A.     Dissection.

12      Q.     You saw the person in the emergency room?

13      A.     Yes, sir.

14      Q.     How soon after you saw him did the person  
15      have the dissection? What happened to him?

16      A.     They presented 36 or 38 hours later as a  
17      syncopal episode.

18      Q.     And was the diagnosis made then?

19      A.     After multiple CAT scans and vascular and  
20      cardiology consults.

21      Q.     What happened to Mr. McIntyre?

22      A.     He went to the operating room and he expired  
23      30 days later I think with multiple organ failure.

24      Q.     What was the third suit?

25      A.     It is a suit alleging failure to diagnose an

1 MI, it's a pending suit, ongoing suit.

2 Q. What's the name of the patient in that suit?

3 A. Barker is the last name and Homer is the  
4 first.

5 Q. What are the specifics of that case?

6 A. As I said, it is an allegation that I failed  
7 to diagnose an MI.

8 Q. When did Mr. Barker present to you?

9 A. March 1st of '98, I believe.

10 Q. What was his presentation?

11 A. Shoulder pain.

12 Q. Did he have any other symptoms?

13 A. He only complained of shoulder pain to me.

14 Q. Did you take any measures to rule out MI?

15 A. Yes, sir.

16 Q. What did you do?

17 A. An EKG, chest x-ray, and cardiac isoenzymes.

18 Q. Were any of these abnormal?

19 A. In comparison with what I had available to  
20 me that night, no.

21 Q. Did you only see him once?

22 A. I actually discharged him then from the  
23 chest pain center I believe in August, or sometime  
24 later that year when he was admitted by another  
25 physician into the chest pain center, and I

1 believe I had seen him several times prior to that  
2 for trauma related things.

3 Q. When did he have his MI?

4 A. It is alleged that he had it in March.

5 Q. But the basis of the lawsuit is this one  
6 presentation in the emergency department, correct,  
7 in March when you saw him?

8 A. I'm sorry. Rephrase it.

9 Q. The basis of the allegations against you are  
10 this one presentation that he made to you in March  
11 in the emergency room?

12 A. As opposed to what?

13 Q. You said you saw him in August?

14 A. Right.

15 Q. That would have been after?

16 A. Right.

17 Q. So that has nothing to do with the lawsuit,  
18 that visit in August, I'm assuming?

19 A. I assume also.

20 Q. Have you been deposed in that case?

21 A. Yes, sir.

22 Q. Who took your deposition?

23 A. I don't recall. I'm sorry.

24 Q. Do you know what firm is handling the  
25 plaintiffs, representing the plaintiffs?



1       A.     I don't remember offhand. I would have to  
2       get that information to you.

3       Q.     Is that case set for trial?

4       A.     I don't believe there is a trial set, no,  
5       sir

6       Q.     That's in Stark County also?

7       A.     Yes, sir.

8       Q.     Who is representing you in this case?

9       A.     David Best.

10      Q.     Were these all patients that you saw at  
11      Aultman?

12      A.     Yes, sir.

13      Q.     How long have you been working the night  
14      shift?

15      A.     All my life since I have been working.

16      Q.     You mean even before you became an emergency  
17      doctor you worked night shifts?

18      A.     Yes.

19      Q.     The only test that you did for Connie  
20      Germanoff in the emergency room for cardiac  
21      origin, for her pain, would have been the heart  
22      monitor, right?

23      A.     Correct.

24      Q.     That isn't sufficient to rule out an MI,  
25      correct?

1 A. If the MI is elsewhere than the inferior  
2 leads, no, it wouldn't show that up.

3 Q. So you did not do any testing that would  
4 have ruled out an MI in her, correct?

5 A. Record reflects I did not do any EKG or  
6 isoenzymes.

7 MR. MELLINO: That's all I  
8 have.

9 MR. MILLIGAN: I got a couple  
10 questions.

11 Doctor, I'm Rich Milligan and I  
12 represent Aultman Hospital. I just have a few  
13 question.

14 - - -

15 CROSS-EXAMINATION

16 BY MR. MILLIGAN:

17 Q. As I understand your testimony, you have  
18 said that you repeatedly saw this patient in the  
19 emergency room; is that accurate?

20 A. On the night?

21 Q. On the night in question?

22 A. Yes.

23 Q. As part of your examination and treatment of  
24 this patient you did in fact inquire of the  
25 patient concerning the nature of their complaints?

1 A. Yes, sir.

2 Q. And you did that in detail?

3 A. Yes, sir.

4 Q. Did you have any reason to believe that you  
5 were not being told the truth by the patient?

6 A. No, sir.

7 Q. Was what she told you consistent with what  
8 you physically observed?

9 A. Yes, sir.

10 Q. I think you already said this, but is it not  
11 true that you rely upon the patient to accurately,  
12 completely describe what their complaints are to  
13 you?

14 A. Yes, sir, if the patient is a competent  
15 patient. Yes, sir.

16 Q. And she was, as far as you know was  
17 competent?

18 A. Yes, sir.

19 Q. There was some discussion about the EMS  
20 report, which you had not previously seen, and I  
21 think, correct me if I am wrong, but I thought  
22 that you said that it has been your experience  
23 that the EMS squad does not describe with  
24 particularity pain that the patient has above  
25 their waist and call it all chest pain; is that an

1 accurate description?

2 A. That has been my observation, yes. Anything  
3 that comes in from above the waist is oftentimes  
4 by EMS people described as chest pain.

5 Q. Would you rely upon the EMS squad  
6 description of her complaints in treating a  
7 patient in a normal situation?

8 A. I would have that information along with  
9 what the patient told me. If the patient is not  
10 able to relay a history, then oftentimes the EMS  
11 report as well as perhaps nursing, family history  
12 are important; but if the patient is able to  
13 communicate and is competent, I regards the  
14 patient history much stronger than secondhand  
15 history by someone else.

16 Q. That certainly would have been the case with  
17 Connie Germanoff?

18 A. Correct.

19 Q. In the final analysis, you would agree that  
20 getting the information you need to treat this  
21 patient from the competent patient is more  
22 reliable than getting it second and third hand?

23 A. Definitely.

24 MR. MILLIGAN: Thank you.

25 That's all I have.

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

4 - - -

5 CROSS-EXAMINATION

6 BY MR. KREMER:

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

9 A. No, sir, I have not.

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

12 A. No, sir.

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

15 A. No, sir, I have not.

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

18 A. Yes, sir.

19 Q. You reviewed Dr. Hollaway's --

20 A. Her office records?

21 Q. Her office records?

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

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

25 MR. STRONG: I have none.

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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.)

- - -

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

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\_\_\_\_\_  
Ginger A. Hamrick, M.D.

Subscribed and sworn to before me this\_\_\_\_day  
of \_\_\_\_\_, 2000.

\_\_\_\_\_  
Notary Public

My commission expires: \_\_\_\_\_

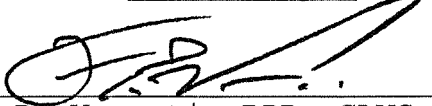
1 State of Ohio, )  
2 County of Cuyahoga.) SS: CERTIFICATE

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

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

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

20 IN WITNESS WHEREOF, I have hereunto set my hand  
21 and affixed my seal of office at Cleveland, Ohio, on  
22 this 27<sup>th</sup> day of December, 2000.

23   
24 Frank P. Versagi, RPR, CLVS and  
25 Notary Public in and for the State of Ohio.  
My commission expires 03/09/2003.



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