

IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

ROSE DAWSON, etc.,

Plaintiff,

JUDGE CHRISTOPHER BOYKO
CASE NO. CV-04-534481

-vs-

OHIO PERMANENTE MEDICAL
GROUP, et al.,

Defendants.

- - - -

Deposition of EDWARD F. HAWKINS, M.D., taken
as if upon cross-examination before Susan M.
Cebbron, a Notary Public within and for the State
of Ohio, at the offices of Reminger & Reminger,
1400 Midland Building, 101 Prospect Avenue, West,
Cleveland, Ohio, at 10:25 a.m. on Wednesday,
December 22, 2004, pursuant to notice and/or
stipulations of counsel, on behalf of the
Plaintiff in this cause.

- - - -

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On behalf of the Defendant
Ohio Permanente Medical Group;

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On behalf of the Defendants
Edward F. Hawkins, M.D. and
Medina Emergency Associates, Ltd.

- - - - -

1 EDWARD F. HAWKINS, M.D., of lawful age,
2 called by the Plaintiff for the purpose of
3 cross-examination, as provided by the Rules of
4 Civil Procedure, being by me first duly sworn, as
5 hereinafter certified, deposed and said as
6 follows:

7 CROSS-EXAMINATION OF EDWARD F. HAWKINS, M.D.

8 BY MS. TAYLOR-KOLIS:

9 Q. Doctor, good morning. Officially for the record,
10 my name is Donna Kolis, and I've been retained to
11 represent the Estate of Herbert Dawson.

12 I would like for you to state your name and
13 your professional address for the record.

14 A. Edward F. Hawkins, M.D. I work at Medina General
15 Hospital in the emergency room.

16 Q. Doctor, you are a member of what physicians
17 group? What's the name of the group that you
18 practice with?

19 A. Medina Emergency Associates.

20 Q. Does Medina Emergency Associates provide
21 emergency room services any place other than
22 Medina General Hospital?

23 A. No.

24 Q. Okay. How long has your entity been in
25 existence, if you know?

1 A. Oh, just since, I think it's April 7th of 2002.

2 Q. Okay.

3 A. It used to be part of a bigger group that did all
4 of Cleveland, and I was a partner in that group,
5 and then we broke off from that group and formed
6 our own group.

7 Q. I recall that group quite well.

8 Is Dr. Rowbottom in your group?

9 A. Not in the current group, no.

10 Q. Who is?

11 A. Eric Brown, Doug Drenth, Kim Bowen, myself, Dave
12 Levine. Those are the members of the board.

13 ~~Q. Great. All right.~~

14 ~~Unfortunately, I forgot to serve a Notice of~~
15 ~~this deposition on your counsel. So I wouldn't~~
16 ~~have reminded him to ask you to bring a CV. So~~
17 ~~I'm going to bet you don't have one?~~

18 ~~MR. MEADOWS: We will get you~~
19 ~~one. I thought I might have one, and I~~
20 ~~don't, but we'll get you that.~~

21 ~~MS. TAYLOR-KOLIS: No problem.~~

22 Q. Just briefly, so I have some context to work
23 from, where did you go to medical school?

24 A. Medical College of Wisconsin, Marquette School of
25 Medicine.

1 Q. The year you graduated?

2 A. '83.

3 Q. Following medical school I'm going to guess that
4 you entered some residency program?

5 A. Right. University of Virginia residency program.

6 Q. Residency in emergency room medicine?

7 A. It was in family practice. ~~When I was --~~

8 ~~MR. MEADOWS: Just answer her~~

9 ~~question.~~

10 ~~A. All right.~~

11 Q. Did you complete that residency in family
12 practice?

13 A. Yes, I sure did.

14 Q. What year did you finish the program?

15 A. '86.

16 Q. Okay. Did you enter into any fellowship programs
17 following that residency program?

18 A. No.

19 Q. Okay. Doctor, are you board certified in any
20 specialties?

21 A. Family practice.

22 Q. What year did you obtain your family practice
23 certification?

24 A. '86.

25 Q. Are you board certified in any other specialties?

1 A. No.

2 Q. Are you board eligible in any other specialties?

3 A. No.

4 Q. Okay. Following the completion of your residency
5 in 1986, would you briefly take me through your
6 work history?

7 A. From '86 until present I've been full-time at
8 Medina emergency room.

9 Q. Okay.

10 A. And I've worked in emergency rooms in Cleveland,
11 Huron Road Hospital. I worked in Amherst. I
12 worked in what used to be St. Alexis and then it
13 was St. Michael, I think. I don't know if it's
14 open now.

15 But during that time the whole time I was
16 working full-time in Medina because I was part of
17 that large group of Lakeland, and I worked in
18 other ERs.

19 Q. Wherever so required?

20 A. Right, if they needed somebody.

21 ~~MS. TAYLOR-KOLIS. Off the record.~~

22 - - - -

23 ~~(Thereupon, a discussion was had off~~
24 ~~the record.)~~

25 - - - -

MS. TAYLOR-KOLIS: Back on the

~~record.~~

Q. Dr. Hawkins, at any time since you finished your residency program have you published any articles in contribution to the medical literature?

A. No.

Q. Okay. In anticipation of today's deposition, can you tell me what materials you reviewed?

A. I just reviewed the record provided to me by Mr. Meadows.

Q. Okay. And what records would those have been?

A. The Medina General Hospital, whatever is in his book there, and I think I saw some Kaiser.

Q. Okay. That's my question.

You, obviously, would have reviewed your involvement in the care of Herbert Dawson, correct?

A. Correct.

Q. And do you have a belief that you in some fashion reviewed the subsequent treatment records from the Kaiser emergency room department?

A. Yes, I reviewed that with Bill.

MR. MEADOWS: She doesn't want to

~~know what we talked about.~~

Q. I just want to know if you looked at the records.

1 A. Uh-huh.

2 Q. When I received these records, and this isn't a
3 criticism, I preface this so nobody gets
4 defensive, do you not dictate a discharge summary
5 from emergency room visits?

6 A. No. We write it down in longhand.

7 Q. Okay. That's all I wanted to know.

8 It is not the practice of your group to
9 dictate and have transcribed a discharge summary?

10 A. I wish it was, but we don't have that.

11 Q. Okay. No problem. I just want to make sure I
12 wasn't missing a piece of paper, all right?

13 Do you have an independent recollection,
14 outside of looking at medical notes, of Mr.
15 Dawson or his family?

16 A. Well, of course, parts, like, you know, in my
17 memory, yes, sure.

18 Q. Okay. Let's sort of go through just the basics,
19 this is very, very easy. I'm going to confirm
20 what you documented, okay?

21 A. All right.

22 Q. And if at any time you feel the need to, you
23 certainly can refer to the medical records
24 because this is not a memory contest.

25 Asking you the question this way, on October

1 31, 2003, do you recall how it was you staffed
2 the emergency room in terms of timing?

3 In other words, were you on 12, were you on
4 24, how did they do that at that time, if you
5 know?

6 A. I'm not sure if I was like -- because we change
7 our staffing based on the patient volume, and it
8 has been fluctuating. Sometimes we start at
9 9:00, sometimes we start at 7:00.

10 So I would suspect that I started at 7:00
11 a.m., because I was there at 8:00.

12 Q. Right. Because the first notation I have is at
13 0818. I believe that you would have seen Mr.
14 Dawson at or around that time.

15 So that would tell you that you probably got
16 to work at 7:00 that day?

17 A. Right.

18 Q. And you hadn't been working the previous night.
19 You believe you actually came in that morning?

20 A. Right.

21 Q. Does your group, or did your group at that time
22 do 12-hour shifts?

23 A. I'm not sure if it was a 12 or an 8 that I was
24 working, or 9.

25 Q. So it could have been 12, 8 or 9, but certainly

1 not 24?

2 A. No.

3 Q. Okay. Mr. Dawson, according to medical records
4 that are available, arrived at Medina Hospital
5 via Westfield EMS. Is that your recollection?

6 A. Yes.

7 Q. Okay. When Westfield EMS would have brought the
8 patient to the hospital, would they have called
9 ahead to tell you that they were bringing a
10 patient?

11 A. Yes.

12 Q. Would they have spoken directly with you, or
13 would they have advised the personnel in the
14 emergency room?

15 A. Usually the nurse takes the call.

16 Q. Okay.

17 A. Unless there's a reason to intervene.

18 Q. Do you have any way of knowing based upon the
19 Westfield -- have you seen the Westfield Fire &
20 Rescue EMS report?

21 A. Right.

22 Q. Does that company, or did that company provide
23 you with a copy of the document that they
24 generated from their transport of Mr. Dawson?

25 A. It should be in the -- the run report should be

1 in the records.

2 Q. And that's why I'm asking the question. You
3 would have had access to this document when you
4 first met with the patient, correct?

5 A. Correct.

6 Q. My understanding, as best I can read it, and this
7 is, fortunately, good handwriting, in summarizing
8 what Westfield Fire & Rescue did is that they had
9 established an IV, given Mr. Dawson oxygen,
10 administered an ASA and one nitro sublingual to
11 help his chest pain.

12 Have I accurately, and you can look at the
13 document, summarized the interventions that were
14 performed by Westfield EMS?

15 A. Gave him oxygen, put him on a 12-lead monitor,
16 gave .9 normal saline IV through an 18-gauge
17 antecubital, and gave him .4 milligrams of
18 nitroglycerin sublingual. It states here that
19 his wife had already given him two aspirins prior
20 to EMS arrival.

21 Q. Okay. It indicates that his chief complaint was
22 shortness of breath and chest pain. I gather
23 that was communicated to you via this document,
24 correct?

25 A. Right.

1 Q. Okay. When Mr. Dawson presented in the emergency
2 room department, you would have had the
3 opportunity to take an independent history,
4 correct?

5 A. That's right.

6 Q. Can you indicate for me, let's see if we can find
7 it, there's a nursing assessment that is done.
8 Is that done before you see the patient?

9 A. It just depends on what the situation is.

10 Q. Okay. Do you have a way of knowing whether the
11 nurse did her assessment first, or whether you
12 did the assessment first?

13 A. It's not a hundred percent to know because of the
14 fact that a lot of times we'll see them together,
15 and I document in the record, usually I write the
16 time that I'm actually writing, rather than the
17 time I actually saw the patient.

18 Q. Okay. Fair enough.

19 What history did you elicit relative to why
20 Mr. Dawson was presenting to your emergency room?

21 A. He had chest pain, chest pressure. He had pain
22 in his arms.

23 Q. Okay.

24 A. That he had some risk factors for heart disease.

25 Q. Tell me what his risk factors were.

1 A. He's inactive secondary to his problem with his
2 reflex sympathetic dystrophy and his chronic arm
3 pain, and he had elevated cholesterol. His
4 father had died of an MI. He's a nonsmoker and
5 no history of high blood pressure. No history of
6 diabetes.

7 Q. Okay.

8 A. Those were like what we call the main risk
9 factors.

10 Q. Okay. Were you able to during your taking of his
11 history distinguish whether the arm pain he was
12 describing on the date of October 31, 2003 was
13 different than his chronic pain from his RSD?

14 A. Could I tell if it was different?

15 Q. Did you ask him if it was different?

16 A. Yes.

17 Q. Okay.

18 A. And his chest pain was definitely different.
19 That's why we gave him nitroglycerin, and we
20 continued on the same thing from the EMS squad
21 when he arrived.

22 Q. And you were giving him nitro because --

23 A. We suspected that he was having chest pain
24 secondary to coronary artery disease.

25 Q. Okay. And you learned during that history taking

1 session from Mr. Dawson that he had not had chest
2 pain previously?

3 A. Right.

4 Q. Doctor, can you find -- can you define for me
5 acute coronary syndrome?

6 A. Acute coronary syndrome?

7 Q. Yes.

8 A. It would be, actually, it's a gradation of what
9 people are usually familiar with being acute
10 myocardial infarction.

11 In other words, somebody who has preexisting
12 coronary disease usually, and then has maybe a
13 small clot that was blocking the coronary artery
14 can then produce pain and possibly produce
15 ischemia, and being in an unstable situation,
16 actually, we used to call it unstable angina
17 before they redefined it to acute coronary
18 syndrome.

19 Q. Did you, once again, based upon reviewing the
20 records or your independent memory, advise
21 Mr. and/or Mrs. Dawson that you felt that Mr.
22 Dawson was having unstable angina?

23 A. At the point that he came in I couldn't really
24 tell him for sure if he was having unstable
25 angina or chest pain of other etiology. It was

1 possible -- that was our paramount concern at
2 that point in time, of course.

3 Q. Was to rule out --

4 A. The acute coronary syndrome and, also, MI for
5 that matter.

6 Q. Find out what was going on.

7 You had an EKG performed, correct, for Mr.
8 Dawson?

9 A. Right.

10 Q. And your interpretation of that 12-lead EKG was
11 what?

12 ~~A. Well, on the EKG, itself --~~

13 ~~MR. MEADOWS: She's asking you~~

14 ~~what your interpretation of the first EKG~~

15 ~~was~~

16 ~~MS. TAYLOR-KOLIS: Right.~~

17 ~~Q. The EKG has an electronic read on it?~~

18 A. I was in agreement with the electronic read in
19 that it was nonspecific as to ST wave
20 abnormality, based on this, that the ST segments
21 were less than a millimeter depression, but at
22 the same time I was concerned about there was a
23 slight depression on the ST segments that was
24 less than a millimeter, and there's gradations in
25 the EKG that we look at and decide, you call an

1 EKG nonspecific ST changes if it is less than a
2 millimeter, and if it is greater than a
3 millimeter in two continuous leads you can call
4 it ischemic changes.

5 Q. Okay. The results that you saw on the EKG, what
6 weight did -- I'm not going to ask you the weight
7 question.

8 How did that contribute to you being able to
9 arrive at a diagnosis? In other words, what
10 information did it provide to you that either
11 ruled in or ruled out an acute coronary syndrome?

12 A. The acute coronary syndrome can exist independent
13 of EKG changes, but I would say if you have ST
14 depression greater than a millimeter, then it's
15 at a higher level than if you don't have it.

16 Q. Okay. What time were you aware of this --

17 A. Or ST segment elevation, then you would be
18 looking for an MI.

19 Q. Sorry to interrupt you.

20 A. That's all right.

21 Q. At what time did you become aware of the EKG
22 results?

23 A. It's probably within a minute or two of when I
24 got the EKG. They usually just hand it right to
25 me.

1 Q. Okay.

2 A. When somebody comes in with chest pain, that's
3 the thing we look at first.

4 Q. And as part of your evaluation for -- I think
5 we'll just stick with acute coronary syndrome for
6 the moment, acute coronary syndrome and/or MI,
7 you ordered cardiac markers, correct?

8 A. That's right.

9 Q. The results of those cardiac markers came back
10 and were known to you before Mr. Dawson was
11 transferred to Kaiser, would that be an accurate
12 statement?

13 A. Yes.

14 Q. Okay. Did you find any of the cardiac markers to
15 have abnormalities that suggested either an acute
16 coronary syndrome or a myocardial infarction?

17 A. No. They're indeterminate. So that doesn't
18 suggest anything.

19 There is gradations, once again, for enzymes,
20 troponin or CK. If they are a certain level, or
21 if they are greater than .04 in our institution
22 they are indeterminate, which would mean --

23 ~~MR. MEADOWS: You said greater~~

24 ~~than~~

25 A. If it is greater than -- if it is less than, than

1 we know for sure it's negative.

2 Q. When you are saying, just so the record is clear,
3 because sometimes we all talk at the same time,
4 you're indicating .04, anything under .04 means
5 nothing is going on?

6 A. Well, it doesn't mean that. It just means that
7 it's less than .04, and it would be deemed to be
8 no evidence for myocardial damage yet, but you
9 can have a normal, a normal less than .04
10 troponin and still have an MI, but --

11 Q. Based upon the timing?

12 A. The timing of the pain, or it could just be that
13 it just started an hour ago to actually infarct,
14 to change from acute coronary syndrome to an
15 infarct, and you still could be less than .04.

16 Q. And Mr. Dawson's troponin was .19, correct?

17 A. Right. That would be in the indeterminate range.

18 Q. Indeterminate not meaning that he isn't or didn't
19 have an MI?

20 A. What it means, basically, is that it is not
21 giving you information one way or the other. In
22 other words, it is not helping you make the case
23 that they're having an MI or that they are not.
24 It just is not helpful at that point.

25 ~~Q. Okay~~

1 ~~A. It --~~

2 ~~MR. MEADOWS. You answered her.~~

3 ~~Wait for another question.~~

4 Q. All right. While Mr. Dawson was in the emergency
5 department, did you continue to administer oxygen
6 to him?

7 A. Yes.

8 Q. Okay. What other interventions or support did
9 you provide to him besides the administration of
10 O2?

11 A. Gave him two nitroglycerins.

12 Q. Okay.

13 A. Let's see here. We placed a nitro paste on him.
14 Nitro paste is any nitroglycerin absorbed
15 through paste.

16 Q. So you gave him two sublinguals and then nitro
17 paste, is that right?

18 A. Right. And then after each nitroglycerin he
19 received we reassessed his pain.

20 Q. If you administer nitroglycerin and there is a
21 decrease in chest pain, medically what does that
22 suggest to you?

23 A. It suggests that it could be coronary artery
24 disease as the etiology of his pain, but once
25 again, that's something that could get better,

1 even with a nitroglycerin can make reflux,
2 gastroesophageal reflux disease better, too, and
3 the patient had that.

4 Q. Based on anything that Mr. Dawson presented with
5 that morning in terms of his historic information
6 that he revealed to you and his complaints of
7 pain at that point, did you at any point
8 seriously entertain that this chest pain might
9 have a gastroesophageal etiology?

10 ~~MR. MEADOWS: Objection. Poor~~

11 ~~form.~~

12 A. There were things that suggested the possibility
13 that he had some GI problems, too.

14 Q. ~~Okay. Mr. Meadows is a very smart lawyer, and I~~
15 ~~asked the question that led to an answer that I~~
16 ~~wasn't really looking for.~~

17 My question was, based on how he presented on
18 the 31st of October, did you believe at any time
19 from the time you saw him until the time you
20 discharged him that the cause of his chest pain
21 that day had a GI etiology?

22 ~~MR. POLITO: Objection as to~~

23 ~~form, again.~~

24 ~~MR. MEADOWS: Same objection.~~

25 ~~You can answer.~~

1 A. Okay. I didn't know.

2 ~~MS. TAYLOR-KOLIS: It may be the~~
3 ~~same answer.~~

4 A. I gave him some Maalox and Donnatal. I think
5 that most of his chest pain was gone at that
6 point in time, but when I asked him how he was
7 doing, he told me that -- we usually rate chest
8 pain on a 1 to 10 scale.

9 He was kind of joking around with me that it
10 was a half, which was like almost zero, but he
11 says well, I guess it would maybe be a little
12 less than half.

13 So I took it to mean he had gone from crying
14 to laughing and joking at that point in time. So
15 I thought that his pain had gone away, but he
16 said that his reflux might have been bothering
17 him.

18 So we gave him the Donnatal and Maalox at
19 that point, and as far as I can recall I think he
20 was pretty much pain free after that.

21 Q. The fact that Mr. Dawson left Medina pain free
22 does not mean that he didn't come in suffering
23 from acute coronary syndrome, or a myocardial
24 infarction in evolution, correct?

25 ~~MR. MEADOWS: Objection to form~~

~~and otherwise. So ahead.~~

1
2 A. I would say that you can have acute coronary
3 syndrome and be pain free for a short time, and
4 usually you would expect it to start coming back,
5 again, if that was the situation.

6 If somebody remained pain free for, say, like
7 six hours, then I guess I would have to say that
8 the probability is being reduced each second that
9 it is acute coronary syndrome.

10 Q. Why did you call Kaiser?

11 A. When did I call Kaiser?

12 Q. I said why. We'll get to when, but why?

13 A. Well, when I talked with the patient when he
14 initially arrived, he told me that his physician
15 was through Kaiser, his primary care doctor was
16 Kaiser.

17 And so when you have somebody with chest
18 pain, like Mr. Dawson did, you know that they're
19 going to have to be -- I knew he was going to
20 have to be admitted to the hospital. I knew that
21 he had chest pain, and I prefer to contact the
22 primary care physician early to get things going
23 in terms of getting a cardiology consult, or
24 making a decision where that patient is going to
25 be.

1 Q. Okay. Let me ask you a couple questions about
2 that, and I know that all you got is the records
3 to refer to.

4 Did you attempt to call his primary care
5 physician, or did you call Kaiser's emergency
6 department? Do you know what you did?

7 A. Well, I have his primary care doctor here written
8 on the record. So probably what I usually do is,
9 I call our operator and say get me Kaiser, this
10 guy's name, and then his primary care doctor is
11 Doug Fleming, it's about an admission.

12 Q. Okay. Do you know if you talked with Dr.
13 Fleming?

14 A. I don't think I did.

15 Q. Okay. Had you transferred Kaiser patients to
16 Kaiser before from Medina ED?

17 A. Right.

18 Q. You indicated in your answer when I asked you why
19 you called Kaiser that you knew he had to be
20 admitted to the hospital.

21 Tell me why you knew Mr. Dawson needed to be
22 admitted to a hospital.

23 A. Well, in my mind, once the issue of chest pain,
24 possible MI or acute coronary syndrome with the
25 risk factors that he had and nonspecific ST

1 changes on his EKG, there's absolutely no way
2 that I can send him home or say go somewhere
3 else, plus you have to intervene early if you're
4 going to, and the cardiologist, again, I want to
5 talk to his primary care and see if I have to get
6 my cardiology involved, keep him in Medina, or
7 get them at Kaiser.

8 Q. I'm going to ask this question inartfully because
9 I don't know an easy way to ask it.

10 Your familiarity with Kaiser, does it extend
11 to Kaiser health care plans and what Kaiser wants
12 its patients to do?

13 A. My answer to all the patients when they call me
14 is that we're not going to worry about the
15 insurance, we're going to worry about your
16 problem, and we'll deal with that later.

17 Q. You did speak with a Kaiser doctor before you
18 transferred Mr. Dawson, correct?

19 A. Right.

20 Q. Do you believe it was the emergency room
21 physician?

22 A. I think so.

23 Q. Do you recall his name, or did you write his name
24 in the record?

25 A. I don't know if I did write his name in the

1 record. I'm pretty sure it was Dr. Kaforey,
2 though.

3 Q. Do you know Dr. Kaforey?

4 A. I've talked to him on the phone before. I don't
5 think I've ever met him in person.

6 Q. Okay. What information would you have given Dr.
7 Kaforey about Herbert Dawson?

8 A. The main information that he has to know, which
9 he has a lot of risk factors, he has pain, he was
10 relieved by sublingual, he has had two aspirins
11 already. He had some EKG changes on the EKG that
12 are nonspecific, but are at the same time a
13 concern because he is having chest pain.

14 Q. Okay. The basis what you believe you would have
15 told him, that is based on what you recorded on
16 the chart, correct? Let me withdraw it.

17 I don't see a separate independent note,
18 unless I'm just not reading this chart correctly,
19 where you actually sit down and write spoke with
20 Dr. Kaforey at this time, related the following
21 information. This is a compilation of what
22 you've documented in the examination portion?

23 A. I just pick up the chart when I call somebody and
24 I read, basically, what I got here on this chart,
25 and when I present it to him, it is pretty much

1 what I documented here. So I will tell them all
2 the information that I have at that point in
3 time.

4 Q. Okay.

5 A. You know, as much as they are willing to
6 tolerate.

7 ~~MR. MEADOWS: You answered the~~
8 ~~question.~~

9 Q. Do you recall what Dr. Kaforey's response was to
10 you on October 31, 2003?

11 A. I remember that I talked to him about chest pain,
12 I talked to him about the EKG, and he asked me
13 was it greater than a millimeter ST depression,
14 and I said no.

15 Q. And was it your understanding that Kaiser wanted
16 him transferred to Kaiser's emergency room?

17 ~~MR. POLITO: Objection. Go~~
18 ~~ahead.~~

19 Q. If you know.

20 A. He was going to be transferred to see Dr. Kaforey
21 at the Kaiser emergency room, as far as I knew.

22 Q. Did you advise Dr. Kaforey that it was your
23 opinion that Mr. Dawson needed to be admitted to
24 a hospital for a workup for coronary artery
25 disease?

1 A. Before I could even tell him what I thought about
2 that, he said well, he sounded like he needed to
3 be observed and get serial enzymes, in view of
4 the fact that I had nothing more than a little
5 bit less than one millimeter ST depression, and
6 he was going to minimally get the enzymes, that
7 seemed standard care.

8 Q. When Mr. Dawson was getting ready for discharge,
9 transport, I guess, is a better word, because you
10 were transferring him to another facility, did
11 you speak with the ambulance drivers for Kaiser?

12 A. You know, I don't recall, specifically.

13 Q. Okay. I couldn't make out one way or another.
14 Let me just see.

15 A. If --

16 Q. That's all right. I got three minutes to look
17 for it.

18 While I'm looking for it, because I don't
19 always write down everything, did you indicate
20 that you did tell Dr. Kaforey that the troponin
21 was indeterminate at .19?

22 A. When I talked with Dr. Kaforey, that wasn't back
23 yet. We called him up subsequently before the
24 ambulance arrived.

25 Q. There's a nursing note that reflects that the

1 information was communicated to Kaiser, is that
2 correct?

3 A. Yes, and it was communicated to me, also.

4 Q. Do you believe that you called Dr. Kaforey back,
5 or did you allow the nursing staff to call
6 Kaiser?

7 A. I asked the nurse to call -- Helen Japanowski was
8 the nurse, actually.

9 ~~Q. I did find the document I was looking for.~~

10 ~~You have an ambulance certification, and I~~
11 ~~was confused -- here, I can show it to you.~~

12 A. Right. That's basically --

13 ~~MR. MEADOWS: Let her show it to~~

14 ~~you.~~

15 Q. Is this the document you would have signed? In
16 other words, when you're releasing the patient,
17 you don't just throw him in the ambulance and say
18 good-bye?

19 A. Right.

20 Q. Is that the document you would have signed and
21 handed to the Kaiser folks, right?

22 A. Right.

23 Q. And on that particular document, if I can read
24 your great handwriting, it says, "Patient having
25 chest pain, needs IV, 02," and then I can't make

1 out the very last word.

2 A. "Monitoring."

3 Q. Is that monitoring?

4 A. Yes. Now, what that means is, he is not
5 necessarily having chest pain at that very
6 moment, but that he had chest pain, and he could
7 continue to have chest pain. It's the same kind
8 of thing.

9 Q. So I don't want to misinterpret.

10 A. Well, see, my diagnosis is had chest pain when he
11 arrived. So having chest pain, is he currently
12 having chest pain when I pulled this out,
13 probably not, because he said he was better, but
14 just you have to put your diagnosis down that's
15 consistent with that. So just to inform whoever
16 the ambulance person is.

17 Q. So if I am interpreting this wrongly, you will
18 tell me, you are indicating to the squad that
19 while they are transporting, he should remain
20 with an IV, remain on O2, and please monitor this
21 patient, correct?

22 A. Right. ~~And then if~~

23 ~~MR. MEADOWS. You answered.~~

24 ~~Q. You answered, that's great.~~

25 **Q.** And then the second page I'm looking at is a

1 transfer form, and this simply is a listing of
2 those things which you sent to Kaiser?

3 A. Yes. That's probably filled out by a secretary
4 or nurse or something.

5 Q. Okay. Fair enough. You didn't fill this form
6 out, but you're assuming that these are the
7 documents that were -- documents and/or studies
8 that were sent to Kaiser with the patient, right?

9 A. Right.

10 ~~Q. All right.~~

11 ~~MS. TAYLOR-KOLIS: Doctor, I~~
12 ~~don't have any other questions for you.~~

13 ~~THE WITNESS: All right.~~

14 ~~MR. MEADOWS: We will have him~~
15 ~~read it. Can we get 28 days, if that's~~
16 ~~okay?~~

17 ~~MS. TAYLOR-KOLIS: That's fine.~~

18

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EDWARD F. HAWKINS, M.D.

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1
2
3 C E R T I F I C A T E
4

5 The State of Ohio,) SS:
6 County of Cuyahoga.)

7 I, Susan M. Cebron, a Notary Public within
8 and for the State of Ohio, authorized to
9 administer oaths and to take and certify
10 depositions, do hereby certify that the
11 above-named witness was by me, before the giving
12 of their deposition, first duly sworn to testify
13 the truth, the whole truth, and nothing but the
14 truth; that the deposition as above-set forth was
15 reduced to writing by me by means of stenotypy,
16 and was later transcribed into typewriting under
17 my direction; that this is a true record of the
18 testimony given by the witness; that said
19 deposition was taken at the aforementioned time,
20 date and place, pursuant to notice or stipulation
21 of counsel; and that I am not a relative or
22 employee or attorney of any of the parties, or a
23 relative or employee of such attorney, or
24 financially interested in this action; that I am
25 not, nor is the court reporting firm with which I
am affiliated, under a contract as defined in
Civil Rule 28(D).

17 IN WITNESS WHEREOF, I have hereunto set my
18 hand and seal of office, at Cleveland, Ohio, this
19 4th day of January A.D. 2009.

20 Susan M. Cebron
21 Susan M. Cebron, Notary Public, State of Ohio
22 1750 Midland Building, Cleveland, Ohio 44115
23 My commission expires August 17, 2008
24
25

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