ORIGINAL

IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

JANET L. PORACH, Administratrix
of the Estate of John G. Porach, Jr.,

Plaintiff,

-vs-

LORENZO S. LALLI, M.D.,

Defendant.

Case No. 316045

Judge Calabrese

- - -

The deposition *of* **BRUCE D. JANIAK, M.D.,** witness herein, called by the Plaintiff for examination under the Ohio Rules of Civil Procedure, taken before me, the undersigned, Cynthia Mueller, Certified Shorthand Reporter and Notary Public within and for the State of Ohio, pursuant to notice and stipulations *of* counsel hereinafter set forth at the Toledo Hospital, 2142 North Cove Boulevard, Toledo, Ohio on Thursday, November 13th, 1997 commencing at 1:50 p.m.

A P P E A R A N C E S

On behalf of Plaintiff:

Becker & Mishkind
660 Skylight Office Tower
Cleveland, Ohio 44113
(216) 241-2600
By: Howard D. Mishkind, Esquire

On behalf of Defendant:

Weston, Hurd, Fallon, Paisley & Howley
2500 Terminal Tower
Cleveland, Ohio 44113
(216) 241-6602
By: Ronald Rispo, Esquire

I N D E X

E X H I B I T S

(Deposition commenced at 1:50 p.m.)

- - -

BRUCE D. JANIAK, M.D.,

having been duly sworn, testified and was examined as follows:

- - -

EXAMINATION

BY MR. MISHKIND:

Q Doctor, my name is Howard Mishkind, and I represent the Estate of John Porach. I'll be asking you some questions concerning the opinions that you have set forth in a letter dated July 7, 1997 concerning this case.

And, as I'm sure you know, I'm also going to be asking you some questions about your background and your experience. My aim is obviously to find out what you're going to be saying when you take the stand next month in connection with this case. Okay?

A Yes.

Q Plaintiff's Exhibit 1, was marked for identification before the deposition began. It is an eight-page document with a revision date of June 19, 1997. Can you identify that, please?

A Yes. That is my curriculum vitae as of

June 1997.

Q Anything that would need to be added to it to bring it up to November of '97?

A The two publications in progress have now progressed to be publications, so they exist.

Q But other than that?

A Other than that, that's it.

Q Thank you.

A Well, you know what? That is not right There is one other thing.

Q Okay. Go ahead.

A I have gotten involved on a very peripheral basis with a medical transcription company, and I'm their medical director, which doesn't really take any significant time, but it's something I haven't added,

Q What is the name of that company?

A Heartland Information Services, Inc.

Q Where are they located?

A Executive Parkway, Toledo, Ohio.

Q How long has your association existed with this company?

A Officially as medical director about four months, I would say.

Q And what's involved in this position?

A Basically, I would be the one who would make a contact with an institution and ask them if they would be interested in listening to a presentation with regard to our service.

Q And what is the service that is provided by this company?

A Medical transcription.

Q How much of your time are you spending with this company?

A Probably at work, during the workday, maybe 15 minutes, but if I am to be out of town and visiting, I might spend a whole day. So far it's been two days and €our months.

Q Any other changes or additions?

A That's it.

Q In the material that's in front of you is a copy of a letter that you wrote on July 7, 1997 to Kathleen Mulligan of the Weston, Hurd Law Firm. Do you have your letter?

A Yes, I do.

Q Do you still maintain the opinions that are expressed in that letter?

A Well, if you'll just a wait a moment while I read it again.

Q Absolutely.
A The answer to your question is yes, I do.
Q And does the report contain all of the opinions that you hold at this point based upon the review of the information in this case, that at least that you anticipate testifying to at the time of the trial?
A Well, I think in general it does. There are some other more detailed information, I guess, with specific references to electrocardiogram. I mean the details of the electrocardiogram, I suppose, would be an issue

Perhaps another issue that I think might come up in the case is my feelings as to whether or not the electrocardiogram that was taken represented -- could be consistent with a myocardial infarction that was X number of hours old. I mean the issues about the relationship of a possible myocardial infarction and the cardiogram and the timing thereof, which I did not elaborate on in here, but I would be prepared to say anything about it at this deposition
Q Other than that, and we will talk about that in the deposition --
A I'm sure we will

Q -- are there any other areas with regard to opinions that you hold that aren't otherwise contained in that report of July 7, 1997?

A No. I think that's basically it.

Q Thank you.

MR. MISHKIND: Off the record.

(A short recess was taken.)

BY MR. MISHKIND:

Q Doctor, I want to ask you some questions about matters that do not relate to the practice of medicine, but relate more to your medical-legal work.

A Sure.

Q Your letter is written on stationery that says "Janiak Consulting, Incorporated.'' You are Janiak Consulting, Incorporated, correct?

A That is correct.

Q And this is essentially a private corporation that you have set up for your medical-legal work, correct?

A Correct. There is consulting though too. It's not just medical-legal.

Q What percentage of the income that's derived by Janiak Consulting, Incorporated relates to

medical-legal work?

A Ninety.

Q And correct me if I'm wrong, but all of the income generated from reviewing your medical malpractice cases or testifying in malpractice cases goes into this corporation?

A That's correct. The only time it doesn't is when my secretary makes a mistake and writes a check to me.

Q You have been serving as an expert witness since the mid-'70s, does that sound about right?

A That sounds right.

Q And am I correct in that currently approximately 75 percent of your testifying is rendered as an expert for the defense?

A I would say that's pretty accurate.

Q It's varied from time to time as high as 85 percent?

A That's correct. It's lower now because I've gotten a number of plaintiffs' cases in the last, I would say, year or two.

Q And your experience in terms of testifying has been both in Ohio and in cases outside of Ohio as well?

A Also correct.
Q You've testified as an expert in Dayton, Ohio?
A Yes.
Q You've testified as an expert here in this county, Lucas County, correct?
A I have, yes.
Q You have testified in Canton as an expert?
A Yes.
Q You've also testified in Franklin County as an expert?
A Yes, I think so. Columbus, yes.
Q And you have testified in cases in the state of Michigan?
A Yes.
Q And you've testified as an expert in Cuyahoga County, correct, in Cleveland?
A I believe I have, sure.
Q The law firm of Jacobson and Maynard, which does a lot of defense work of doctors, you've testified extensively as an expert at the request of one or more of their attorneys, correct?
A I think actually I do agree with the term extensively. I have.

Q What is your best estimate as to the number of times that you have testified at the request of the attorneys from that defense firm?

A I would say I probably reviewed 40 cases for them over the years at least. So I probably have testified 25 times, something like that

Q And in 1997, tell me what the average number of cases per year that you are reviewing?

A I used to answer that question with a 12, but it's got to be somewhere around 15 to 20 in the last two years.

Q And are you currently serving as an expert witness in one capacity or another, either case, that may be just sitting or a case that's very active in excess of 20 cases?

A Yes. Probably 40 cases.

Q Now, in connection with your testifying as an expert witness, have you ever appeared as an expert witness on behalf of a plaintiff's attorney in Cleveland, Ohio?

A Not to my knowledge.

Q Have you ever testified in the state of Ohio as an expert witness at the request of a plaintiff's attorney?

A Yes, for sure once. It went to trial. And there's a couple of other cases that are ongoing now, but I don't think I've given testimony in those yet.

Q Okay. I'm just talking about the ones that you have actually either had your deposition videotaped or you actually went into the courtroom and testified. The answer is yes?

A Yes. I can think of two.

Q And that's been quite some time since you've done that, is it not?

A Yes, those are pretty old. And there's stuff now, but, of course, that does not meet your definition.

Q Right. It's not responsive to my question I'm just talking about the ones that you've actually testified. Were those back in the '70s or the early '80s?

A I believe both were in the '70s, one mid-'70s, one late '70s.

Q So since the mid to late '70s and up to November of 1997, you've not testified in the state of Ohio as an expert on behalf of a plaintiff; is that correct?

A Not to my knowledge, I haven't. I'd have to

go back and look, but I don't think so.

Q Those two cases that you had appeared as an expert, what city or county?

A Well, one was here in Lucas County. That one went to trial as I remember. The other one was out of town, but, frankly, I don't remember which rural community in Northwest Ohio it was anymore. I don't know.

Q Who was the attorney in either of those cases?

MR RISPO: If you recall

THE WITNESS: I just don't know I can't tell you.

BY MR. MISHKIND:

Q When did you last testify in a courtroom in connection with a medical malpractice case?

A Well, it was earlier this year. I would have to look at my calendar and give you the date and the name of the case. It could be done. If you want me to ask my secretary to do that for you, I will find that information out.

Q But you do maintain that?

A Sure, we keep it on the calendar.

Q Would that have been the case down in

Dayton?

A I just don't know. It could be, but I don't know. Somehow Dayton doesn't sound familiar to me.

Q When are you next scheduled to testify?

A I would have been able to answer that by saying the 1st of December, but that is no longer true. That case was pushed off into the middle of next year, so nothing this year that I'm aware of.

Q When did you last have your deposition taken?

A I think two weeks ago.

Q And when are you next scheduled to have your deposition taken?

A That I don't know. I'd have to look at my calendar.

Q I know that things have a tendency of varying from time to time, but what does it average out during the course of a week or month?

A I would say twice a month.

Q And, again, the same question. It varies from time to time in terms of how frequently you're called in to testify in a courtroom, but on a yearly basis over the years, how has it averaged out in terms of --

A Probably in the last four years, two to three a year.

Q The percentage of your total income that you earn from all activities, what percentage is made up of income that you earn from the medical-legal activities?

A Understanding this is a guess, I'd say it's 5 to 8 percent.

Q Do you recall, for example, in the calendar year 1996 what your income was from the medical-legal?

A I think it was about 40.

Q And for 1997, are we above or below that figure?

A Above.

Q Where are we at?

A I don't know the exact number. I would guess it's probably 50.

Q What's your current hourly rate, Doctor, for deposition testimony?

A 300.

Q For review of records?

A Same.

Q Testifying at trial?

A Same.

Q Have you been asked to testify at the trial of this matter which is scheduled for next month?

A I believe so.

Q Whom do you maintain your professional liability insurance with?

A Currently P.I.E.

Q You've been with P.I.E. for quite some time now, haven't you?

A Correct. It could be as long as 15 years. It's been a while.

Q Do you have any professional dealings with Frontier Insurance Company?

A Never heard of Frontier Insurance.

MR. MISHKIND: Off the record.

(Off the record discussion.)

BY MR. MISHKIND:

Q Are you currently a defendant in any medical malpractice cases?

A Do you know what? Yes, I am. And I answered that question in the last deposition I gave, quote, "Not to my knowledge," unquote, and then I found out that I was a defendant. So I am for the first time.

Q What's the name of the plaintiff in that case?

A I don't remember.

Q Is that filed here in Toledo?

A Yes, it was, I think.

Q Has your deposition been taken yet?

A No.

Q This is a relatively recent filing?

A It's a few months now.

Q That's the first time in your career that you've been named as a defendant?

A Yes, except as a president of the corporation. But individually as a defendant whose name is on the chart, this is the first time.

Q As far as the subject matter, what is your understanding as to the allegation against you?

A I don't know what the -- well, I know the patient's problem. The case would be characterized as a missed intercranial hemorrhage from the plaintiff's viewpoint. The allegations against me, I have no clue.

Q Have you testified in any of the number of cases that you've been involved in over the years as an expert witness for a doctor other than an emergency

room doctor?

A Yes.

Q What other areas?

A One was a surgeon who was in trouble. It's not exactly a medical-legal case, but it was a State Medical Board case in which his behavior, vis-a-vis the care of an emergency patient, was called into question, and I was asked to review it from that viewpoint.

Q So it's more of an ethical type of situation?

A Well, it wasn't really ethical in terms. It was like the clinical behavior, how fast he got to the patient and whether or not the things he did from an emergency physician's perspective made sense and whether or not the allegations about his responsiveness were true or not in my viewpoint.

Q How long ago was that matter?

A Well, within the last year or two, and actually it's still up for appeal somewhere in the State Medical Board system.

Q Is this a confidential matter to your knowledge, or is it a public hearing?

A You know I don't know. I don't know the

answer to that. It could still be confidential. I just don't know.

I'm trying to think if there are others. Nothing that comes to mind right this second, but I know there were times when office physicians have had issues with some of the ways they handle things, their emergency problems. I know I've been asked, but I can't remember the names of the cases.

Q Is it your testimony that you have provided testimony or provided reports in connection with cases where you've opined relative to a physician in an office practice as to whether or not he or she met the standard of care?

A Yes, I think I've done that. I can't tell you if I've written an actual report, but I'm sure I've given testimony.

Q But you're not able to tell me the names of any of those cases?

A No. No. And I understand why you're asking it. I just can't remember what the cases were.

Q Now, the records that you referred to, is this something that's maintained on a computer in terms of the number of cases you review, who you're working for, and things of that nature?

A I think we have on the computer the names of the cases and the attorneys, but I don't think there's any details on her computer about that.

Q Would you be able to look at that computer and tell me the name of the case or cases that you've testified in where an issue was involved relative to a doctor's practice?

A The answer is I don't think so, because I think this was so long ago, it was before we were in this office with this particular computer and this system of record keeping. I don't think I have records for that.

Q Now, is it your intent to provide opinions on the standard of care of Dr. Lalli in this case? Do you understand that to be one of your responsibilities?

A No. I think we're talking about the -- well, in terms of his responsibility for the way the office runs and whether or not I think it runs in a reasonable manner from what I know about offices, I would opine about that. But in terms *of* his clinical behavior and the way he handled the arrest, I'm not dealing with that issue.

Q Well, you're not board certified in internal

medicine, are you?

A Exactly. I'm not

Q And have you ever operated as either a primary care physician or an internist in an office?

A No I mean a little bit in training, but I wouldn't count that.

Q And you're certainly not a cardiologist, are you?

A I am not.

Q And you've never worked in a cardiology practice or in a cardiology department of a hospital other than perhaps during residency training?

A Correct.

Q Do you feel as if you are qualified to render opinions on whether an internist or an internist's office met the standard of care with regard to the handling of his or her patient's complaints and specifically the handling of his or her patient's complaints in the Porsch mat er?

A Yes

Q And what is it that you feel prowides you with that qualification?

A Well, three things, I think First of all as a physician, you have more insight into how an

office operates than a layman.

Secondly, you can't interact with physicians' offices on a daily basis, both as a physician and as a patient, as I have and many of us have, without having some knowledge about how they operate.

And, thirdly, for a while when I was a medical director for an HMO called Health Maintenance Plan, there was a remote responsibility to assure that the physicians with whom we had contracted had office policies and procedures that operated in a reasonable manner. So that would be part of it.

Q Any other bases upon which you feel that you can opine?

A I think that's it.

Q How long ago was this HMO situation?

A It was early in the '90s. It might have been -- when I started in '89, I think it did occur about two and a half years.

Q Certainly you would agree with me that someone such as an internist that operates on a day-to-day basis an office practice and has responsibility for seeing patients with a variety of symptoms in his or her office would be in a better

position to evaluate the standard of care for a primary care physician or an internist than an emergency room doctor such as yourself?

A I think in most instances they would. There are some things that would be obvious to all of us and some things that would be more detailed that I would not know about and they would. So in general, yes.

Q Okay. Have you ever worked with Mr. Rispo or with the law firm of Weston, Hurd before?

A Mr. Rispo, no. Weston, Hurd, I don't think so, but I would have to go back and look through what we have in the computer there to see. I don't think so.

Q Do you know how it is that Mr. Rispo or his nurse-legal assistant, Kathleen Mulligan, obtained your name?

A No idea.

Q The material that you reviewed for purposes of your July 7th report, they're not identified per se in the letter. Can you tell me what it is that you had for purposes of the report as opposed to what information you obtained subsequent to that report?

A Sure. Everything, obviously, that came in after July 7th would not be involved in this. So the

answer to your question was, a copy of the complaint, records and the deposition of Mr Lalli, L-a-l-l-i, deposition of Janet Horach and Janet Schoch Porach, P-o-r-a-c-h and Schoch S-c-h-o-c-k, and then a summary report of two plaintiff's experts, one is David Effron, E-f-f-r-o-n and one Robert Hoffman H-o-f-f-m-a-n.

In addition, there were the records -- I can't remember whether I looked at the emergency records at that time or not I just don't know

Q Okay I'm looking at it. Does that seem to be it?

A That seems to be it, yes.

Q Now, looking at the balance of the records, it appears that sometime substantially after July 7th you saw for the very first time the autopsy?

A Yes, I think that's true

Q And you've also been provided with deposition transcripts of Mr. Selwyn, a deposition transcript of Mr Botti, and I believe you have summaries of the deposition of Mr Effron, and apparently Mr Risko must have just handed you an actual transcript of Mr Effron's deposition and --

MR. RISPO: And the

emergency room.

BY MR. MISHKIND:

Q -- and the emergency room record, and I think also a summary of the deposition of Dr. Botti as contained in the material. Does that sound about right?

A Yes to all of those.

Q Is it fair to say that you have not, to this date, seen the deposition of Mary Nary?

A Yes, that is a fair statement.

Q Do you know who Mary Nary is?

A No.

Q Is it fair to say that you have not seen the deposition of Jacquelyn DeWitt?

A Also fair.

Q And Dawn DeWitt?

A Also fair.

Q Do you know who either of these people are?

A I do not

Q If I said Jacquelyn Porach or Dawn Porach, would that help you in any connection to identify who those people are?

A Well, obviously it's the same last name, so my guess is it would be a relative.

Q But beyond saying relative, you wouldn't be able to tell me who they are?
A No.
Q Okay. Tell me, Doctor, in terms of the individuals that were residing at home with John Porach on October 14th, 1994, what is your understanding of who made up that family unit, if you will?
A My understanding was a wife and two daughters.
Q Okay. Anyone else?
A I don't think so.
Q And whose daughters were they?
A In terms of either belonging to the deceased or his wife or both?
Q Right.
A I don't think I know the answer to that.
Q Did you read Mrs. Porach's deposition?
A Yes.
Q And did you read Dr. Lalli's deposition?
A Yes.
Q And reading these depositions is an important part of the process, especially in a case where there is a dispute as to what really are the

facts in the case. Would you agree with me?

A Sure

Q And it's important in any case when you're serving as an expert and looking at things after the fact and trying to provide objective opinions concerning what did or should have taken place at the time?

A I think that's true. I think the importance is always there, although importance is relative Some things are more important than others.

Q Sure. So that when you reviewed the depositions and understood the case, it's important that you have a grasp of relevant and important facts in order to provide comprehensive opinions concerning what went on that day as well as to have comprehensive facts to support your opinions?

A I think that's true. I think the argument comes over the issue of the degree of relevancy and degree of importance.

Q Sure. I just want to make sure that the record is clear as to the importance of reviewing the depositions and grasping relevant information from those depositions as opposed to just giving it a cursory review, and certainly you did not give the

depositions that you were provided with a cursory review, correct?

A No. I read all the words of the depositions. The issue is, once again, relative importance of each thing that you read and how it strikes you as you read it.

Q I understand. Have you been provided with the life insurance form that was filled out by Dr. Lalli approximately -- or signed by Dr. Lalli a little bit over a month after Mr. Porach died?

A There's a form that starts "Frontier Life Insurance" at the top, and says "Number 081" on mine, and it has Dr. Lalli's signature on the bottom; is that what you mean?

Q I think what you just referred to was where it was faxed to you.

A Could be a fax number, right.

Q But it actually says "Jackson National Life Insurance Company" with a "Policy Number 0023163770."

A I knew that. Just testing.

Q And the information that is contained on that statement in terms of, quote, "When were you first consulted by the deceased for the condition which either directly or indirectly caused his death?"

Do you see a date and a reason stated in there?

A Yes. It's Number 4, "When were you first consulted by the deceased" --

Q And what is the information that Dr. Lalli has --

A He wrote down -- the first word I'm interpreting is either "aching" or "itching," I can't tell you which one it is, "in chest and shoulders were reported to my receptionist," is what he wrote down.

Q And from your entire review in this case, tell me what your understanding is as to when on October 14th the aching in the chest and the shoulders was first reported to Dr. Lalli's receptionist?

A Well, I think that's an issue of dispute. My understanding is that the aching, if there was aching reported, that that -- as I remember it, during a phone call a daughter said that she thought he said aching during the phone call prior to coming into the office, but the receptionist indicated that she didn't hear that, but that she heard that he wanted an electrocardiogram taken.

Q Again, Doctor, a grasp of the facts in terms of what went on when his symptoms were first

demonstrated, that's important in providing opinions in this case, correct?

A Can be.

Q Okay. And certainly is important in this case, correct, relative to the onset of symptoms and what information was provided to the doctor's office, correct?

A And what you understand the facts to be. And what you have in depositions and even in medical records are interpretations of facts that people either verbalize or put in writing.

Q Well, let me ask you this, if the facts in this case -- strike that.

Is it your understanding that Ms. Schoch, the receptionist, has taken the position in her testimony that she was not aware of the aching in the chest and the shoulders in the morning telephone call from John Porach?

A No. I don't think that is my understanding. I think that during the morning phone call there was aching mentioned, but I don't think she had an interpretation of it as chest pain.

Q Well, was she told -- did she have an understanding from John that he had aching in his

chest and in his shoulders; in other words, was that information reported to Ms. Schoch based upon information from Dr. Lalli or from Receptionist Schoch? Putting what you learned from conversations from the family aside, was the information about aching in the chest and the shoulders information that Dr. Lalli's office had reported to it in the morning of October 14th, 1994?

A Well, I'm going to ask that I not answer the question until I look up one thing,

Q Go right ahead.

A I did find the reference because I had it actually referenced myself. On page eight she was asked, "Did Mr. Porach, in fact, tell you that he had aching, aching in his chest and shoulders?" And her answer was, "Actually, he said that he had aching like all over. I asked him if he had pain in his chest and he said 'no.'"

Q Now, I'm talking about the particular insurance form and Dr. Lalli's testimony as to when Receptionist Schoch told him that she first had knowledge that he had aching in the chest and in the arms, and, basically, I'd just like to understand what you appreciate to be the first reporting of that

information whether it be in the morning, the afternoon, or when John Porach arrived in the doctor's office.

A I don't think I have an understanding of when the -- Dr. Lalli's notation of aching in the chest and shoulders on the insurance form, I don't have an understanding of when that information was transmitted to him by the receptionist.

Q And, again, you've read over Dr. Lalli's deposition, correct?

A That's correct.

Q Tell me your understanding, Doctor, from your review in this case, as to John Porach's prior medical history.

A Well, I think he had a history of hyperlipidemia and gout according to this record, and if we look back at the office records -- well, he had a history of some kind of infection process in his skin, which I don't think was significant.

Q What year was that?

A That was in '88. In '89, he had an arthritic type of condition which was worked up and it was determined to be gout, and he was placed on anti-inflammatories for that.

Q Now, in '88 and '89, are these notes of Dr. Lalli's, or are these notes, to your knowledge, Dr. Lalli's notes?

A I thought they were Dr. Lalli's notes because that's his signature on the bottom.

Q In '88?

A Yes. The handwriting's different. I don't see a signature, so I don't know. It could have been another physician. I just don't know.

Q How long had John Porach been a patient of Dr. Lalli's?

A According to Dr. Lalli's insurance record, he says '91 through '94. So I just don't have an understanding of who wrote those because I don't see a signature. Even though there may be one there, I don't know who it is.

Q And, again, do you recall the discussion in Dr. Lalli's deposition about the patient's medical history and how long he had been a patient of his and how Mr. Porach became a patient of his?

A I don't have a specific recollection of that part of it, no.

Q And certainly when a doctor takes over another doctor's practice, the medical history is an

important feature when you make that transition from one doctor to another to make sure that you have a full appreciation for relative risk factors for conditions?

A Well, I'm not sure I want to agree with full appreciation, but when you do the transition, a general idea of what that patient's major problems are.

Q Tell me what risk factors John Porach had, based upon your review in this case, for coronary artery disease?

A Well, he was a smoker.

Q How much did he smoke?

A Let's see. That was in -- says he quit smoking in '93, and he had 40 pack years to a 30 pack years of smoking history, which would be a pack and a half to two packs a day for twenty years.

Q And is that a risk factor?

A Sure.

Q Can you tell me about the hyperlipidemia and the gout?

A In terms of them being risk factors?

Q In terms of his prior medical history, you told me about those two conditions.

A Yes, I did.
Q Now I'm transposing those. Are either of those risk factors for coronary artery disease?
A The hyperlipidemia can be. I don't think the gout necessarily is
Q What other risk factors, if any, did John have for coronary artery disease?
A Could be his weight, although I don't remember his height. I think he was a little bit overweight, but I don't remember his height. I'd have to put that on a graph. Actually, weight is not a bigger risk factor unless you're morbidly obese as used to be thought. So if it is, it's a relatively minor risk factor.
Q Any other factors that you would consider a relative risk factor for coronary artery disease?
A Nothing obvious, no
Q You had the reports and the depositions of Dr. Selwyn and Dr. Hoffman and Dr. Botti, correct?
A Correct.
Q I noticed in looking at the material that you've made some notes on the deposition transcripts of a number of the experts, and I'd like to ask you to perhaps pull Dr. Selwyn's deposition for a moment.

I'd like to ask you some questions about the notes you have there.

A I sure will. I have it.

Q And would you read into the record what you have written on the outside of Dr. Selwyn's deposition?

A Okay. First thing I have is "zero point six" with a circle around it, and then after that it says, "7 November '97." Underneath that there's a "six comma seven." Underneath that there's an "eleven" with a dash and then the following quote, quote, "So must receptionist refer all calls to the doctor?" unquote.

Underneath that it says "12 dash 13 dash," quote, "What a joke," exclamation point. "He would do this as a receptionist? question mark, question mark." Underneath that it says, "39 dash 40." That's all I have.

Q Okay. Now, would you explain to me when you have -- page 12, line 13, is that what that means?

A I think it means pages 12 and 13.

Q What do you mean when you say "what a joke"?

A If one looks at pages 12 and 13, you will see that this gentleman --

Q You're talking about Dr. Selwyn now?
A Yes.
Q By the way, do you know Dr. Selwyn?
A No idea.
Q Do you know any of the experts in this case?
A I do not.
Q Do you know Dr. Carl Culley?
A No, I don't
Q You don't have anything from Dr. Culley in your material, do you?
A Not that I'm aware of, no.
Q What about Dr. Barry Effron, do you know him?
A No.
Q Did you know that Dr. Barry Effron and Dr Carl Culley are two experts for Dr. Lalli?
MR. RISPO: I think he's heard their names, but he hasn't seen the reports.
THE WITNESS: I've heard the name.
BY MR. MISHKIND:
Q You've pulled out Dr. David Effron's deposition?

A Well, you said Barry.
Q I said Barry Effron.
A I didn't know which one you were referring to. No.
Q Do you know what type of doctor Barry Effron is?
A No, no idea.
Q Do you know what kind of doctor Carl Culley is?
A No idea.
Q Go ahead with the reference to "What a joke."
A Yes. Question, "If you had been placed in the position of Jan Schoch who spoke with John Porach for the first time at 9:30, what additional questions would you have asked, if any?" And then his answer goes into the questions a physician would ask in doing a detailed physician history, and I think it is a joke that he expects a receptionist to meet the standard of care of a physician in history taking. I think that's completely inappropriate in my view.
Q Would you agree that if there are symptoms demonstrated during the course of a conversation between a patient and whoever it is that's receiving

that call, that there has to be some system set up so that calls are turned over to qualified people, whether it be a nurse or the physician, to further triage the call?

MR. RISPO: I'm going to object to the question, because it's so general it can't be answered unless you specify the symptoms.

MR. MISHKIND: Well, I appreciate your objection, but go ahead and answer the question.

THE WITNESS: Well, my answer was going to be that I would not agree, but I want to be fair about the answer because you used the word "symptoms."

I think that receptionists deal with complaints. And I understand that there's an almost semantical difference in what I'm saying, but they deal with a complaint, and so if you change the word to complaints, I agree there ought to be a system set up so that certain

complaints trigger a series of responses.

BY MR. MISHKIND:

Q Okay. And the point of your contention with regard to Dr. Selwyn's testimony is that you would not expect a receptionist to ask those questions?

A That's not the standard behavior for in-take people to do that. That's a physician's job *to* ask those detailed questions

Q Do you know where Dr. Lalli was when John Porach called in the morning of October 14th?

A No, I don't remember where he was.

Q Do you know where Dr. Lalli was when John Porach called in the afternoon of October 14th?

A No. I guess he was in the office, but I don't know.

Q Do you know whether Jan Schoch promised John Porach that she would get back in touch with him after the first telephone call?

A Yes, I remember there was that comment.

Q And she never did, did she?

A I think that is also true.

Q And certainly would you agree that if a receptionist has a call from a patient with symptoms,

benign or malignant or somewhere in between, and the patient wants to be seen and the office indicates that they will get back in touch with you, that the office, in fact, has a responsibility, whether it's the doctor, the nurse, or the person that took the call, to place a call back to that patient?

MR. RISPO: I just want to add for the record here, Howard, because my recollection is that she simply said, I'll try and fit you in in the afternoon.

MR. MISHKIND: Well, the record will speak for itself, and if I'm wrong, fine, but I don't believe I am.

BY MR. MISHKIND:

Q But if there's an indication that she will get back in touch with you, because the patient has called with an issue and wants to be seen, would you agree that the standard of care for a medical doctor's office requires that that patient be contacted back?

MR. RISPO: One more edit, I think you'll agree, she never said she promised to get back in the

afternoon.

BY MR. MISHKIND:

Q Strike the word "promised" then. Indicated that she would get back Would you agree that there's an obligation, a duty a responsibility to get back to that patient?

A No.

Q Why?

A There's no duty or responsibility to try to do it Your question implies that it will be done, and sometimes it can't be You try and the phone's busy or some other thing and you just can't get it done

Q Any indication that she tried to get back to him?

A No, there isn't I think what she said was that she just hadn't gotten to it by the time he called back. So he basically beat her to the point, I think she said in her deposition.

Q And that certainly is a good thing for a patient to do if they're concerned enough about their condition to make another call back to the doctor's office, correct?

A Absolutely

Q So certainly you give John Porach credit for calling back when he didn't hear back from her, correct?

A Well, part of the issue was whether or not he was sort of browbeaten into calling back. But I think that's sort of a detail that he call back, so he called back.

Q And that certainly was a good thing for a patient to have done?

A Better than not doing it, absolutely.

Q And do you know how busy Ms. Schoch was that day in terms of whether she was prohibited from getting back in touch with him?

A I do not know.

Q Have you ever seen the schedule of how many patients they had on that particular day?

A I have not.

Q And, obviously, the busier the schedule is, the more patients that there are, perhaps the greater the justification, if you will, for not getting back; is that a fair analogy or a fair relative statement?

A Only relative because a lot would depend on what the nature of the complaints were on those other patients. You know you have to weigh that with the

nature of the complaint of the person you're going to call back. So it's a judgment

Q All right. The other comment that you made on Dr. Selwyn's deposition, are there any other areas, other than what we've talked about on page 12 and 13, that you take issue with in terms of his testimony?

A Well, I had a comment on page 11, but I don't think it's any different from the comment we just elicited. He's talking about -- he's leading into eliciting a more detailed history when a patient gives generic symptoms, and I'm saying I disagree with him on that.

Q And why do you disagree?

A Because I don't think it's a standard for receptionists, either in an office or an emergency department or any in-take setting, to do the detailed history. I think that's a physician's job.

Q And if there are further detailed questions that need to be asked, what should someone in Ms. Schoch's position have done?

A If she feels there are detailed questions that need to be asked, then she can refer that call to the physician either immediately or have the physician get back to the patient.

Q And how does she make the decision, being that she's not a nurse, granted she's worked in the doctor's office for a number of years, but how does she make the decision as to whether more detailed questions are needed or not?

A She has to make a judgment based on her experience and based on the specific training she may have had in terms of, as we discussed earlier, key complaints which may lead her to make recommendations that the patient seek more immediate care.

Q Can we ultimately agree that it's the doctor's responsibility to put someone at that position that is qualified to make that judgment as to whether more detailed questions are needed or not?

A I think we can agree that it's the physician's overall responsibility to assure that all of his personnel, including the receptionist, are capable of performing within their job description and doing a reasonable job.

Q And certainly an internist's office, just like in an emergency room, can have a number of different presenting symptoms, a number of different presenting conditions that come in on any given day?

A No question, absolutely.

Q So that if, hypothetically, the individual that takes that call does not exercise appropriate judgment relative to asking the questions that should be done, that is ultimately the responsibility of the doctor that has put that person in that position, would you agree with that?

A Yes, absolutely.

Q So that if there is fault, hypothetically speaking, on the part of Ms. Schoch, that fault is ultimately the responsibility or falls ultimately on the shoulders of Dr. Lalli, would you agree with that?

MR. RISPO: Object. That's a legal conclusion, but answer if you can.

THE WITNESS: Well, I can't make the legal conclusion, but as a layperson I would say that I would have trouble with someone who has been, hypothetically, appropriately trained by a physician, who still makes the mistake in faulting the physician for that mistake.

BY MR. MISHKIND:

Q Okay.

A Now I'm talking not legally, but morally.
Q Okay. And you understand that legally there may be a responsibility for someone if they are trained yet they fail to do what they're supposed to do under the circumstances, you understand that the law may hold the doctor responsible for that failure, even though the doctor may have done a great job training them?
A I understand that.
MR. RISPO: Let's get off that subject, because we're just wasting time.
MR. MISHKIND: No, I'm not wasting time. I never waste time.
BY MR. MISHKIND:
Q Are there any other opinions expressed by Dr. Selwyn that you take issue with -- or feel qualified to take issue with? I should say.
A Give me just one second to look.
Q Sure. Doctor, you've had a chance to look at his testimony. Is there anything else that you take issue with?
A No.
Q Same question with regard to Dr. Botti?

A It will just take me a second to look at the references. Did you want me to answer the question? I mean are you asking me to read what I have on the front?

Q Yes, please.

A Okay.

Q By the way, on that deposition of Dr. Selwyn, when you had marked down "point six," July 11, 1997, was that point six hours that you spent reading the deposition over --

A Yes.

Q -- on July llth?

A 7th of November. You say Selwyn's, or which one did you just say?

Q We were talking about Selwyn's before. Was that November?

A November 7th.

Q Oh, so you just did that a few days ago, last week?

A Yes.

Q I'm sorry. I've been looking at 7/11 and thinking it was July 11th and November 7th.

A I do the military.

Q Okay. Fair enough.

A The answer to the question with regard to the deposition of Dr. Botti is, "0.7" was circled around it followed by "2 October '97," and then the following numbers, "14, 16, 41, 21, 32, 35." That's all that's on the front of that one.

Q Now, those pages from the deposition that --

A Those are all page references.

Q And are those pages that caught your eye for some particular reason?

A Thank you. That's exactly what they did.

Q Okay.

A You're the only attorney who's ever asked a question in that way.

Q I'm not that brilliant.

A That was so reasonable. I'm just awestruck Go ahead.

Q You've made my day. What's the significance of those pages or opinions expressed on those pages?

A Well, page 14 just was -- somebody asked the question about when the symptoms started, so that was nothing new there. Page 16 deals with other diseases like flu-like symptoms or shortness of breath. I don't think that's significant.

Page 21, quote, "My opinion is that the

electrocardiogram is consistent with an anterioseptal infarct, age indeterminate, but consistent with an acute myocardial infarction.' I thought that was significant.

Q And do you disagree with that?

A That's why I think it's significan , because I disagree with that.

Q And we'll talk about that.

A I understand Page 32 nothing significant there Page 35, that's where he says on the basis of the autopsy the patient had a single myocardial infarction I don't know That's his opinion

Q Do you have a different opinion?

A I think I do.

Q And what is your opinion?

A I'm not sure he had a myocardial infarction

Q If he did have myocardial infarction did he have more than one?

A I don't think there's any evidence that he had more than one. But I don't know that he had one

Q You're not a pathologist, are you?

A No.

Q You've seen Dr Hoffman's deposition?

A Yes.

Q Have you read it over?

A Yes, I have.

Q Did you see his indication of the damage to the myocardium and the timing of the damage to the myocardium?

A Well, I have to go back and read that. I remember what he said. I remember him saying it, but I don't remember what he said specifically. I'll have to go back and look at it.

MR. RISPO: Well, it will be in his report, I think.

MR. MISHKIND: Yes, you're looking at the autopsy.

THE WITNESS: Oh, yes the autopsy. Okay.

BY MR. MISHKIND:

Q And my question to you is, you're not in a position to take issue with a pathologist's interpretation of the chronicity or the acuteness of either injury to the myocardium or injury to the coronary arteries in John Porach, are you?

A The last part threw me, because I wasn't aware he had injured coronary arteries. Are you talking about the condition of the coronary arteries?

Q Right.
A No. I would not question their histological evaluation. I'm not qualified to do that.
Q So that if Dr. Hoffman, based upon his study of the slides from the actual autopsy, came to the conclusion that the damage to the myocardium indicates that he had a heart attack that was at least four to six hours and because of certain changes probably more than four to six hours old, but was not any older than ten to twelve hours because of a lack of changes that one would expect to see if it was older than that --

MR. RISPO: Wait a second. You're referring to his deposition testimony as opposed to his written report?

MR. MISHKIND: Absolutely. Right.

BY MR. MISHKIND:
Q And understand, Doctor, his deposition was taken by Mr. Rispo to understand the full nature of his opinions, just as I'm doing with you, and his opinion based upon the myocardium was that we have a heart attack that occurred no earlier than ten to twelve hours before his death, but no closer than four

to six hours.

MR. RISPO: But you're not disagreeing then in his report he said something different?

MR. MISHKIND: Now, he used generic terms of "few" and "several," and you asked him questions and he explained to you what was found in the myocardium --

MR. RISPO: We're going to have a difference of opinion as to whether they were consistent statements, but I want the record to be clear that his testimony in deposition was divergent from what he had said in his report.

MR. MISHKIND: I disagree with your characterization. You do what you want to with that at trial.

BY MR. MISHKIND:

Q My question is, Doctor, based upon Dr. Hoffman's testimony when he explained adnauseam what his language and his rapport and then ultimately what he saw in the myocardium, and I represent to you

that he indicates that this man had acute changes to the myocardium, which is an injury to the myocardium, the best way to evaluate on a postmortem basis the age of an infarct -- that he had one infarct no earlier than four to six hours before and no older than ten to twelve hours, I'll represent to you that that's his testimony and that will be his testimony at trial. Do you have any basis in terms of John Porach's findings at autopsy and findings on the coronary slides to dispute those findings?

A No, I can't dispute the autopsy findings. I'm not a pathologist, so I'm not qualified to do that.

Q And would you certainly give that some credence in terms of deciding whether or not he did or did not have a heart attack on October 14, 1994?

A Yes, I would give it some. Yes

Q If you take that into account and accept his testimony in terms of the pathologic findings on the coronary arteries and the myocardium, would you agree that more likely than not John Porach did have an acute myocardial infarct sometime during the day of October 14, 1994?

A No. I think the issue is, my feeling is

that the gentleman had an ischemic area of his heart which caused him to fibrillate, and that occurred very close to the time that he fibrillated. Now, whether it was 20 minutes or 30 minutes or what, I don't really know that.

I just don't think the guy had a heart attack that started at 5:00 o'clock in the morning, because his symptomatology and the electrocardiogram were not consistent with that.

Q Well, you believe that he had some type of fatal dysrhythmia?

A Exactly.

Q That was caused by what, Doctor?

A It's usually caused by ischemia. It doesn't have to be, but it can be caused by ischemia; in other words, poor circulation to a part of the heart that controls the heartbeat.

Q So he could have had angina, anginal symptoms caused by some ischemic process that could have then led to the ventricular fibrillation?

A Well, the anginal symptoms could be caused by ischemic process. As a matter of fact, that's the definition of angina. But there's not necessarily a relationship between angina and fibrillation.

Q Certainly, though, your opinion that he had some type of ischemic event and your question as to whether or not he had a heart attack is inconsistent with Dr. Hoffman's testimony that this man had very distinct damage to the myocardium of the duration that we're talking about, would you agree with that?

A Yes, I do.

Q Okay. So your testimony is that throughout the day, prior to arriving in the doctor's office, John Porach was not having a heart attack?

A That's what I think.

Q And only after he had the EKG taken did he then have some type of an ischemic process that then led to the fatal ventricular fibrillation?

A I don't want to say after it. You could have silent ischemia, you just don't have the pain. So it could have been within a short time period, but I just can't characterize it as 30 minutes or 10 minutes or 60 minutes.

Q Is there any evidence that you can point to that would support that conclusion?

A Well, I think the electrocardiogram is big evidence, because even though it's possible to have an electrocardiogram that -- to have a heart attack in a

normal electrocardiogram, if you're having a heart attack that looks the size of the one described by Hoffman, you should more likely than not, not a 100 percent, you will have electrocardiographic changes, and I did not see electrocardiographic changes consistent with acute myocardial infarction in this case. I disagree with the other expert's interpretation of the electrocardiogram.

Q And you would also then disagree with one or more of Dr. Lalli's experts in terms of their interpretation of the electrocardiogram as well?

A If they say that it shows an acute myocardial infarction, yes, I would.

Q Does the EKG show any abnormalities?

A Yes, it does.

Q What does it show?

A Let me get it out again and tell you what I think it shows. I think it shows Q waves in leads V1, V2 and V3, and what I would consider to be nonspecific ST-segment abnormalities in the precordial leads. It shows a sinus rhythm and a rate that's normal, by the way, which is more likely than not unusual in acute myocardial infarction. Either you get significant bradycardia with a rate in the 30's,

40's, or you get a tachycardia with a rate over 100. What it does not show is significant ST-segment elevation.

Q Does it show any ST- segment elevation and if so, in what leads?

A Yes. I see zero point five millimeter ST-segment elevation in lead V2 and approximately maybe point two or point three in lead V3, and that's all.

Q What about V4?

A Well, V4 is kind of small. I wouldn't argue about point two, but I'm not sure it's there.

Q And that particular EKG is a half standard, is it not?

A That's right. So if you double those numbers, you can come up with about one millimeter in V2, about a point four to a point six millimeter in V3, and a point three to point four in V4 at the most and those are not considered significant ST-segment elevations.

Q Do you know what time that EKG was taken?

A Well, I know it says '1539' on the report, but we have to make an assumption that the machine is programmed appropriately.

Q What do you mean by that?

A Well, you could go into an electrocardiographic mac ine and alter the time and have them run or forget to change it after daylight savings, or anything that can happen with a clock can happen to this

Q In f ct, October 14th, 1994 was before daylight savings time took place do you have any explanation for the time?

MR RISPO: Excuse me I think you mean the opposite daylight savings begins in April

MR MISHKIN: Before daylight savings time wanished

MR RISPO: Ends before it ends.

THE WITNESS: I don't know I think so. I don't remember if that was it It didn't make any difference to me whether daylight savings time was present or not I'm just talking about ways you can get a wrong number on t You asked the question, do I know what time, and my answer is it says "1639"

on this. We have to assume that's the right time.

BY MR. MISHKIND:

Q Which is 4:39 in the afternoon?

A Yes.

Q Do you know what time John Porach arrived in Dr. Lalli's office?

A It was sometime before that. I don't know the exact time.

Q Before 4:39?

A Before 4:30, sure.

Q And when did he die?

A Not too -- well, he had a cardiac arrest shortly thereafter. I'm not sure what the time of pronunciation was, because he left to go to the bathroom and collapsed in the bathroom. But I'd have to look and see what time he was actually pronounced to make it official, I guess.

Q If I told you that he was pronounced dead at 6:05 p.m., would that be consistent with your understanding of the facts in the case?

A That would fit in.

Q So if his EKG was at 4:39, is it your understanding that approximately an hour and a half

later he was pronounced?

A That would fit, sure.

Q Again, not whether it fits, is that your understanding of the facts in the case?

A Well, as I said, I told you you'd have to go back and look at what time he was pronounced, and you told me --

Q I'm going to say 6:05, and it may be 6:10. But if I represent to you that he was pronounced at or around 6 o'clock, 6:05, and ask you to assume that, is that your understanding that we've got about an hour and a half period of time between when the EKG was done and the death, is that --

MR. RISPO: Let's not confuse the record.

MR. MISHKIND: Let me finish my question first. I want to find out the Doctor's understanding of the facts based upon his review.

MR. RISPO: Let's not confuse the record because --

MR. MISHKIND: Ron, wait a second. Let me finish. We cannot talk two people at a time. I would not do

that to you, and I ask you to let me finish before you start talking. I'm asking the Doctor based upon what he has reviewed in this case --

MR. RISPO: You re trying to trick the Doctor.

MR. MISHKIND: No, I'm not.

MR. RISPO: Yes, you are. You know your own client has testified she didn't arrive -- or he didn't arrive until 5:00 o'clock in the afternoon.

MR. MISHKIND: You know I resent you making a speech on the record. Let me take my deposition and ask him questions.

MR. RISPO: If this were a medical issue, I would be happy to let you have full range, but when --

MR. MISHKIND: Fine. You know what? I'm not even going to continue. I'm going to move on to the next question, because I know exactly what you're attempting to do and I'm

not going to be a party to it. I'm going on to the next question'and that's it. No further question before the Doctor. The next line of questioning is coming.

MR. RISPO: That's fine.

BY MR. MISHKIND:

Q Doctor, is there anything else with regard to Dr. Botti's testimony, I think that's the one we were talking about before, that you take issue with?

A I don't think so.

Q Now, have you had a chance yet to read Dr. David Effron's deposition since it was just given to you?

A I have not.

Q Have you had a chance to read over the summary that Mr. Rispo sent to you?

A I scanned it, but that's about it.

Q So is it fair to say that without having read the deposition you're really not in a position to comment on whether or not you agree or disagree with what he has to say?

A I think that would be fair. I'd rather take the time to read it before we can discuss exactly what

I feel about it at the time.

Q Okay. Can we agree that cardiac arrest related to coronary artery disease is the most prominent medical emergency in the U.S. today?

A No. I don't think we can do that.

Q Why is that not a statement that you can agree with?

A A lot of people would say trauma is the most prominent medical emergency.

Q As an emergency room doctor, are you confronted with issues of patients arriving in the emergency room with coronary artery disease and the issues of initiating either medical or surgical intervention in an effort to save their lives on a daily basis?

A Yes, I guess that would be true.

Q Should you agree that a large number of patients -- a large number of deaths from cardiac arrests can be avoided by prompt recognition of symptoms and immediate referral to an emergency department for appropriate treatment?

A Well, yes, I think there certainly would be a number of people that could be prevented if we can characterize the prompt recognition as prompt

recognition by the patient,

Q But certainly there's an exchange when there's a dialogue going on with a doctor, there's an exchange between a patient and then an obligation on the doctor's part to recognize the significance or insignificance of those symptoms, would you agree with that?

A As a generic issue, yes.

Q Can we also agree, Doctor, that the majority of deaths secondary to a fatal arrhythmia caused by coronary artery disease, unfortunately, occur prior to patients arriving in the emergency room for treatment?

A I think that's probably true,

Q Can we also agree, Doctor, that patients that are fortunate enough to reach coronary care units or emergency rooms equipped with appropriate resuscitative and life-support type of equipment, that death secondary to acute myocardial infarctions can be substantially reduced?

A I think that's true in the short term. I don't know about the long term.

Q Well, I'm just talking about in the acute phase.

A I understand.

Q Would you also agree that cardiac arrest may be prevented by early therapy aimed specifically at prevention of the life-threatening dysrhythmia, continuous EKG monitoring, and other forms of aggressive therapy?

A Well, it can be postponed, I think I don't know that you can prevent that, because eventually that's what many people get, but you can postpone it

Q And postponing it in many situations with appropriate medical management thereafter can prevent that fatal event for many, many years to come?

A It can be, sure.

Q Okay. Although typically we all ultimately die of cardiac arrest, do we not?

A Yes, it's underlying there. Yes.

Q So if you can prevent early on, with appropriate treatment, a life-threatening dysrhythmia, there is a strong probability with continuous EKG monitoring and other forms of therapy that people's lives can be saved and their life expectancies can be extended?

A Actually, that's true, but probably the automatic internal defibrillator is probably the one thing that does that more th n anything else

Q The automatic defibrillator?
A Implanted. You implant it in the patient, and if they fibrillate, it shocks them. That eliminates the big problem of fibrillating when you're away from medical help.
Q Now, we know in John's case that he went into V-fib, correct?
A Yes.
Q Do you know whether or not Dr. Lalli was set up sufficiently enough to address the V-fib when it occurred?
A Well, I think he had most of the equipment, but I didn't review all the equipment he had. So I don't know. I don't know the full answer to that
Q Where would have been the most appropriate place for John to have been if he was going to suffer the V-fib and have a chance of survival?
A Well, if you know a patient's going to suffer a ventricular fibrillation, the best chance of survival is either in the emergency department or in an intensive care coronary care unit.
Q What's been your experience here at Toledo with regard to patients that arrive in the emergency room, that are in there mid-40s, that have a high

suspicion, in your mind, of an evolving acute MI, and we can take it even one step further, an anteroseptal wall infarct, arrives hemodynamically stable within the first six hours of what is perceived to be the onset of the infarct, what's been your experience in terms of morbidity and mortality?

A It's hard to answer the question because in the emergency department you don't always get follow-up on all the patients that come through. And in place like ours, a patient is evaluated quickly and then referred to the cath lab to have catheterization.

But from what the cardiologists tell me, that set of patients who has an a'cute myocardial infarction in any part of their heart, that goes to the cath lab, they do much better than those who don't, and so their morbidity and mortality is certainly lower than it would be if they never came to the hospital.

Q And that's with the presentation within six hours of the onset of the infarct?

A Right. Correct.

Q And to put it into terms that you're somewhat familiar with and having done this before, in a situation like that, the patient that presents to

an emergency room, mid-40s, with an acute MI, within the first six hours, more often than not, that type of patient is going to survive his heart attack?

A Yes, that's true. That's probably true for a much broader range of patients than you characterized, but it's true.

And I'm just trying to limit it because that's what we're ta ing about with John Porach.

I understand.

Q Define for me what your definition is of sudden coronary death or sudden cardiac death?

A A sudden cardiac death to me is a death that occurs within the space of a few minutes, or at least an irreversible event characterized clinically by ventricular fibrillation in almost all instances, sometimes characterized by other cardiac events such as a ventricle rupture, that would also be termed as sudden cardiac death. But the patient exhibits going from a state of consciousness and fairly comfortable stability to being pulseless and breathless within the space of 15 to 30 seconds.

Q Does, by definition, a patient that has had an acute MI four or six or more hours before the loss of consciousness and the fatal arrhythmia, is that

patient, by your definition, a sudden cardiac death?
A That's an interesting question. I've never thought about that. Give me a moment to think about that.
Q That's all right. Take your time. Thinking is good, Doctor.
A Yes. We have to exercise our muscles.
Q I hear you.
A Well, I think I would agree. That it sounds like a sudden cardiac death even if they have a myocardial infarction, only because if they came in with pneumonia and had a sudden death it would be that or bowel infarction and sudden death, it would all be sudden cardiac death.
Q Would you agree that if a patient is having an acute MI that is four to six or more hours prior to that sudden cardiac death and you have that patient in a hospital, monitored with appropriate medical intervention, that there is a high likelihood that the fatal arrhythmia can be avoided?
A It's the same, generally speaking
Q More often than not?
A The longer after a myocardial infarction the sudden fibrillatory event occurs, the poorer the

survival rate in general. The sooner after a myocardial infarction in a monitored setting that fibrillation occurs, the better the survival rate.

I'm struggling with the four to six hours answer for more likely than not. I think in general it would be more likely than not that you would have survival, especially in a patient that was under age 60 or something.

Q Now, cutting straight to the chase with John Porach, if we assume that he had been directed, for whatever reason, to an emergency room in the morning between the hours -- strike that.

If we assume in this case that John Porach, had he been directed, for whatever reason, to an emergency room and arrived in an emergency room between the hours of 9:30 and 12 o'clock, and assuming appropriate intervention was provided by way of diagnostic workup, medication, oxygen, monitoring, whatever is the appropriate protocol for a patient that comes in with a suspicion of a coronary event, can we agree that more likely than not the fatal arrhythmia that occurred late that afternoon would not have occurred?

A I don't think I have an opinion on that.

Q Okay. Let's take it to the afternoon. If John Porach had, for whatever reason, not been directed to an emergency room during the evolving process of this heart. attack, but did arrive at the emergency room hemodynamically stable between the hours of 3:30 and 5:00 o'clock, with prompt recognition that he was suffering from a coronary event and monitoring and appropriate medication had been started, do you have an opinion as to whether more likely than not the fatal arrhythmia which occurred -- and I'm going to represent to you that the fatal arrhythmia, I think based upon the records, occurred somewhere around 5:30'ish or so, or a quarter of 6:00, does that sound --

MR. RISPO: I'm assuming that the EKG machine was on eastern daylight time while everybody else in October was on eastern -- wait a minute. Reverse. That it was on standard time while everybody else in the world was still on daylight time and that it was otherwise correctly calibrated as to minutes, which would be 1739. So I would agree with the

statement if you're saying that the V-fib occurred sometime after 1740 military time.

MR. MISHKIND: Your statement about daylight savings and standard, it doesn't fit with the chronological calendar and that's the only reason I'm --

MR. RISPO: Let's go off the record.

(Off the record discussion.)

BY MR. MISHKIND:

Q To complete the question, 5:30, 5:40, do you have an opinion more likely than not that that fatal arrhythmia would have been prevented?

A Well, I guess it depends on your definition of appropriate therapy. I'll just tell you exactly what I'm thinking, and that is if intravenous arrhythmic agents would have been given, for whatever reason, maybe appropriately or not, then it's more likely that that arrhythmia at that time would have been prevented. We're not saying anything about the heart attack, just the arrhythmia.

Q I understand that. The heart attack had

already occurred based upon --

A Theoretically.

Q Okay. Based upon the pathology, the evidence on pathology, the heart attack had occurred I'm just asking you to assume for purposes of the question that that's accurate and that your assumption that he didn't really have a heart attack is not accurate and then that may or not --

A That may or may not be true, because the coroner says no evidence of recent or remote But the guy looked at the slides I understand

Q Okay What type of agents would have been on board?

A You could have to give an agent specific to stop vasoconstriction irritability, and the agent that's most commonly used is lidocaine.

Q And is that a fairly standard emergency medicine that's given when a patient comes in that has chest pain, shortness of breath, perhaps difficulty or pain in the arms, difficulty lifting the arms, and there's a high index of suspicion that the patient is having an acute MI?

A Not anymore. That's part of the issue

Q Was it back in 1994?

A No. It's been a number of years since we used it. It used to be that it was given to'every patient and that has dropped now. Now you have to have a patient that shows arrhythmia, like multiple premature ventricular contractions associated with possible developing heart attack, and then it's okay to give it. But we don't give it prophylactically anymore.

This patient's cardiogram did not have that, which is why I answered the question. If that were given, even inappropriately, that would have been one of the medicines we could have prevented something that happened.

Q What would have been standard procedure for this patient in the afternoon between the hours of 3:30 and 5:00 if he presented to a qualified emergency room with complaints of chest pain, shortness of breath, difficulty lifting his arm, and there was a suspicion -- irrespective of what's shown on the EKG, there was a suspicion that this man was having an acute MI?

A Exactly. If that were the suspicion and you were not giving an electrocardiogram to look at, then the patient would have been evaluated, would placed

on the monitor, and would be evaluated over time with serial enzymes.

If you throw an electrocardiogram to the mix, then you look at the electrocardiogram and if you interpret it the way I do, then you would still do the same thing, serial electrocardiograms and serial enzymes until you decide whether you think this is really cardiac origin discomfort. And that was the standard in '94 and is still the standard now.

Q Would there be any medication given to the patient?

A Something to relieve the pain would be commonly given.

Q And what would that medication be?

A In the absence of acute changes on the electrocardiogram and in the presence of a reasonable blood pressure, the two common medications are intravenous nitroglycerin and morphine.

Q And do either of those assist the body at all in fighting off, if you will, any dysrhythmias?

A Morphine, no; but intravenous nitroglycerine, yes, indirectly.

Q So in the absence of an EKG that shows evidence consistent with an acute MI, but in the face

of a patient with chest pain, shortness of breath, as well as difficulty with moving the arms, where there's at least an index of suspicion of an MI, the IV introduction nitroglycerine would be beneficial to prevent a fatal dysrhythmia?

A Well, I guess I have a couple comments about that. One is that the intravenous nitroglycerine would lessen the chance of a fatal dysrhythmia only indirectly, because it dilates the coronary arteries and reduces ischemia in some cases, not in all cases.

The second comment is that you've mentioned twice this difficulty with moving the arms. Difficulty in moving the arms points against it being of cardiac origin, but whether the patient complains of that or not doesn't mean you should ignore the fact that it's the heart. But if a patient told me I have difficulty moving the arms, I would have lessened the suspicion of cardiac origin than if the patient said it didn't hurt to move the arms.

Q If this patient presented to you at Toledo Hospital between 3:30 and 5:00 o'clock with chest pain, shortness of breath, but hemohynamically stable, what would have been the protocol that you would have followed?

A I would have an electrocardiogram done as soon as I could get one, prior to registration if possible, and an IV would be started, nasal oxygen would be started, I would do a history and physical which was relatively short, because you want to get right to what's going on with the patient.

Q And what would that history include, what kind of questions?

A Actually, I could refer you to your expert who asked all those questions that he thought that the receptionist ought to ask, those kinds of questions.

Q Tell me what those questions are?

A Well, the questions are related directly to how the patient answers the first question: Are you having pain? Yes. What's the character of your pain? How long have you had it? Does it radiate? Does it stay in one place? Is it associated with nausea, vomiting, shortness of breath, diarrhea? What is it associated with? Do you have fever? Do you have chills? What makes it get better? What makes it get worse? And what is your risk factor history? Those are the questions you would ask.

And then you would listen to the heart and lungs, and look at the neck veins, and by that time

your electrocardiogram was ready for you to look at. And if we can get to this specific patient, I would look at that electrocardiogram, say it doesn't help me one way or the other, order enzymes, and start some intravenous nitroglycerine and see what happened to the patient.

Q And do you have an opinion in this case, with that scenario going on between 3:30 and 5:00 o'clock, whether or not John Porach would have survived?

A No, I don't.

a You don't have an opinion?

A No.

Q If a patient, in response to your question, says I've got aching in the chest and I've got shortness of breath, but then when you say, do you have chest pain? and he says, no, what would be your response?

A As a physician, my response would be, what do you mean by aching? And then you have to branch out in a million different branches from what the patient's response is to that question.

Q So sometimes patients use terms inartfully and it's the job of a doctor to find out what he means

Q You would certainly agree with me that if the jury concludes that John did have chest pain, John was short of breath, and John conveyed that to Ms. Schoch in the telephone call, and if Ms. Schoch then said, come on in to the office and we'll get an EKG taken and you can see the doctor, that that would not be the type of care that you would expect from an internist's office given those symptoms?

A Correct. If a patient communicates to a -- the hypothetical patient says I have chest pain and shortness of breath and it's an internist, excluding babies, then I would agree with your statement.

Q Have you talked to Dr. Lalli at all?

A No. No, I don't know anything about him.

Q And in terms of his training, do you know where he went to medical school?

A I've forgotten.

Q Do you know whether he's board certified?

A My memory of that was that he was not.

Q Tell me what your understanding is, and then my next question is going to be from what do you base that understanding as to the symptoms that John Porach had and conveyed to the office the morning of October 14th, 1994?

by aching or what he means by pain?

A Sometimes. But to tell you the truth, in patients with heart problems, they will rarely, rarely characterize it as aching. Patients with viruses and bronchitis and chest tightness secondary to too much smoking will use the word "aching" much, much more often. Patients who have heart problems usually say "pain,"

Q Doctor, though, in your experience you would certainly agree that you have had patients that you have treated in the emergency room that have come in complaining of aching in the chest and the diagnostic workup is done and low and behold they're having a heart attack?

A I can't imagine that has not happened.

MR. MISHKIND: Off the record.

(A short recess was taken.)

BY MR. MISHKIND:

Q Would you agree, Doctor, that the prodromal symptoms in the form of chest discomfort, unusual fatigue or shortness of breath may occur in patients that are suffering cardiac arrest?

A Well, you used the word "may occur," and so

the answer is yes because any predicate would have fit, but I'm not sure why you said "cardiac arrest."

Q Well, let me change that, actually, as I'm thinking about it more appropriately for a myocardial infarction.

A Okay. The answer is yes then.

Q Okay. And, again, you carefully identified the term "may" in that sentence. And I'm talking about prodromal symptoms, just so you and I are on the same page, when one refers to "prodromal symptoms," what does that mean to you?

A Symptoms that precede a particular event or disease, which occur with enough reproducibility and regularity in the human condition so as to be thought to be causally related to the eventual disease that develops.

Q And with regard to an acute myocardial infarction, the symptoms that I am including are, and the verbiage is very carefully picked out, chest discomfort, unusual fatigue or shortness of breath, any one or more of those symptoms, are they, in an acute myocardial infarction, a prodromal symptom or symptomatology?

A Sure they can be. Shortness of breath alone

is probably the most unusual of the three, but it's possible.

Q And when one refers to chest discomfort, it's then incumbent upon the doctor that is treating that patient to determine what is meant by chest discomfort, correct?

A Exactly.

Q So if I understand the opinion that you're going to express at trial is that on the basis of the EKG, you don't feel that John Porach ever suffered a heart attack?

A On the basis of the EKG, he did not have an EKG consistent with an acute heart attack, that's what I will say.

Q But you would certainly defer to the pathologist who studied the myocardium to indicate whether or not he did, in fact, suffer an acute MI?

A Well, except for the clinical basis, I would have no basis to dispute that pathologist, but another pathologist might since there's conflicting reports of pathologists or perhaps conflicting reports.

Q Well, do you know of any pathology experts that have been retained by Dr. Lalli to review the

slides and to testify in this case?

A No, not at all.

Q Did I ask you whether you know Mr Hoffman? I know I asked you about Botti and the others

A I don't think you asked about Mr Hoffman but the answer is no.

Q Dr Hoffman, in his deposition indicates that the staging of a thrombus differs from a staging that takes place in a myocardial infarction. Do you have any basis to --

A None whatever.

Q -- dispute that?

A I do not.

Q And when a doctor talks about a thrombus and the blood vessel is converted from a matrix consisting of protein called fibrin and then to a matrix consisting of a protein called collagen, are you aware of that process happening?

A Right.

Q And is that an accurate --

A As far as I know, it is

Q Mr Hoffman also talks about the fact that the myocardium showed early coagulation with scanty neutrophil infiltrate and foci of contraction

band necrosis, which would suggest the heart attack was more than four to six hours old. Again, would you have any basis to dispute that statement?

A None whatsoever.

Q Do you agree with that statement from the standpoint of if that description is, in fact, what existed in John, that that finding would be consistent with a heart attack that occurred more than four to six hours before the fatal event?

A I don't have any reason to disagree with his characterization. I don't have any knowledge of how he relates that to the time. I mean I just don't know about that.

Q Just simply outside of your area of expertise?

A Correct

Q And certainly you're not in a position to suggest that John suffered more than one thrombotic event during the course of the day, are you?

A No, I'm not.

Q Do you believe that he suffered more than one?

A No, I didn't say that.

Q I'm not suggesting that you did

A Yes. Okay.

Q Can we agree, doctor, that an EKG that is consistent with remote myocardial ischemia does not mean that a patient is not suffering from an acute myocardial ischemia?

A I guess I am not aware of ever hearing of the phrase 'remote myocardial ischemia, so I don't know what that means.

Q Can we agree that an EKG that's consistent with a remote myocardial infarct does not rule out or mean that a patient that presents with certain symptoms of a cardiac nature isn't having an acute myocardial infarct?

A We can agree.

Q Okay. So it's nice to have an EKG that's consistent with a particular event, but it doesn't really get you where you need to in terms of treating the patient and deciding whether or not that patient is or is not having a heart attack?

A Correct It's a piece of information.

Q So the fact that you looked at this EKG and in your interpretation, even with the half standard size, you say that the elevation in the three leads, 2 3 and 4, AVF, with the exception V2, the others are

less than one millimeter?

A Yes.

Q And therefore that elevation is not consistent, in your opinion, with an acute myocardial infarct?

A Yes.

Q You're certainly not going to say to the jury, therefore, because of the EKG, my opinion is that John Porach was not having an acute myocardial infarct?

A Right, I can't say that.

Q It is going to require an assimilation of facts as to what his symptoms were during the day and perhaps consideration of the evidence at the time of autopsy in terms of whether he was or was not having an acute MI?

A I agree.

Q Okay. And certainly if he was having an acute MI and sufficient symptoms were communicated to the doctor's office in the morning, that should have raised a concern about a cardiac event, you certainly would agree with me that John Porach should have been told to go to an emergency room or call 911?

A In the hypothetical situation you just

mentioned, sure.

Q Failure to do that in the hypothetical situation would be a clear violation of the standard of care?

A Sure.

Q Same situation in the afternoon, if he called the doctor's office with a complaint of shortness of breath, chest pain and, in fact, was so short of breath that you could detect it on the phone, under those circumstances that would be a violation of the standard of care to do anything other than to tell the patient to call 911, correct?

A Correct. You don't have to hear it on the phone.

Q Just hearing them say I've got shortness of breath and chest pain, immediately, no matter whether it's a receptionist, a nurse, or a doctor, the standard of care in 1994 mandated call 911?

A Well, that is an interesting twist on it. The standard of care would mandate that you advise the patient to seek immediate assistance in some medical facility. I'm not sure that 911 -- I don't know what that standard is, whether 911 would be the standard. I think not, but I don't know.

Q Well, you certainly wouldn't advise a patient to drive a half an hour to 45 minutes to a doctor's office that isn't -- well, strike that

Would it be acceptable, Doctor, to advise a patient to drive to a physician's office in the face of the symptoms that I've just described in the hypothetical?

A No. The answer's no.

Q Assuming hypothetically that a patient calls up and indicates they want to come in for an EKG and that patient does not have any prior known cardiac history, do you have an opinion as to whether or not in an internist's office that should cause there to be a level of concern on the part of the receptionist receiving that telephone call?

MR. RISPO: Excuse me. Could you just repeat that. I missed it.

MR. MISHKIND: Off the record.

(Off the record discussion.)

THE WITNESS: I don't have an opinion.

BY MR. MISHKIND:

A My understanding is that he conveyed generalized symptomatology which included aching in many areas of his body including his chest and he had some vague symptomatic complaints in terms of fatigue and diarrhea. So generalized complaints, that's what I think he communicated to the office, and then she said, I'll try to get back to you.

Q You understand that she said, I'll try to get back to you?

A Well, that's an excellent question. Now, I think she said -- it was much stronger than that. Like, I will get back to you.

Q And she should have gotten back to him, correct?

A At some point. I don't think she said I promise I will get back to you by three minutes after twelve. I think she said she'd get back to him.

Q But my question to you was, she should have gotten back to him, correct?

A Sure. If you say, I'm going to get back to you in a medical situation, you need to either get back to that person or attempt to get back to them. I say that again because you could call and they're not there.

Q If in fact she told John Porach that his symptoms sounded like the flu, would that be appropriate or inappropriate in your opinion, if you have an opinion, for a receptionist in an internist's office to do?

A I think if that's what she said, that would be fine, would be appropriate.

Q And on what do you base that, that it's okay?

A On the fact that if you say your symptoms sound like the flu, that's a far different case than saying you have the flu. I think receptionists have an ability and can, within the standard of care, be somewhat reassuring to patients without making diagnoses.

Q So they can tell the patient what it sounds like to them?

A Sure, they can tell them what it sounds like to them. Sure.

Q So you then would disagree with Dr. Lalli in terms of his testimony as to what his receptionist can or cannot say to a patient?

A Well, I'd have to go look and see exactly what he said. I can't tell you whether I agree or

disagree until I see his quote.

Q Now, you say in your report, Doctor, that the patient had nonspecific discomfort with tingling in his arms and legs and diarrhea and other symptomatology, who called his physician's office for an appointment. I want to understand all of what you mean by the "nonspecific discomfort" and the sources for that information.

A I think the sources were the multiple comments in the deposition from both the receptionist and the family. To characterize it further, the achiness, the generalized achiness that the receptionist heard him describe, which is a nonspecific discomfort. Generalized achiness is nonspecific.

Q And what about the tingling in the arms and legs?

A Very nonspecific.

Q And diarrhea?

A Diarrhea is little bit more specific, although it's specific to the gastrointestinal tract, certainly not to the heart or the lungs.

Q And other symptomatology, what do you mean by "other symptomatology"?

A That was the achiness that we just talked about.

Q The achiness in the chest and arms?

A Arms and I think shoulders and back, something like that.

Q Can a patient present symptoms of achiness in the chest and the arms, and as you put it, the shoulders and back, tingling in his arms and legs and diarrhea, yet be experiencing a heart attack?

A It's certainly possible.

Q Would you agree that further questions need to be asked to understand the nature of those symptoms before someone can make the quantum leap that you are having a heart attack?

MR. RISPO: By whom?

MR. MISHKIND: By whomever it is that's entertaining those symptoms.

THE WITNESS: Yes. Certainly you would need to ask further questions and get the answers before you could go any further at all, let alone get to the heart attack diagnosis.

BY MR. MISHKIND:

Q And the additional questions and the differential diagnoses, that's the physician's responsibility? Arriving at a differential diagnosis is not the patient's responsibility, correct?

A Correct.

MR. RISPO: Nor the receptionist's.

MR. MISHKIND: Thank you, Ron.

MR. RISPO: You're welcome.

BY MR. MISHKIND:

Q In your report, you say the patient had requested an electrocardiogram?

A Yes, that was my understanding.

Q And from whose testimony was it that you arrived at that conclusion?

A I think the receptionist indicated that that's what he wanted.

Q And did the receptionist indicate that he asked for an electrocardiogram when he called on the phone, or asked for the electrocardiogram when he arrived in the office?

A I think it was when he arrived in the

office. I think it was the family that said they heard him ask for it on the phone.

Q Do you know whether there's any inconsistency between Dr. Lalli's testimony and Ms. Schoch's testimony as to when John allegedly asked for the EKG?

A No. But I can't imagine two humans describing anything and not having inconsistencies. It's always there.

Q Do you know whether' it's standard practice for a doctor's office to have a receptionist okay the performance of an EKG on a patient that doesn't have a known cardiac history or any recent cardiac symptoms without the doctor even knowing that the EKG is being performed or why it's being performed?

A I don't know the answer to that.

Q So as to whether or not that's standard practice, that's something that you're not qualified to comment on?

A Correct. The specific answer, I just don't know what the standard practice is.

Q Would a receptionist in an emergency room perform an EKG on a patient that came into the emergency room without getting clearance from a nurse

or a doctor?

A I'd say in most emergency departments, probably not In mine, they would, but that's a little different So if we're talking about the standard, I would say probably not, although it would not be because of clearance, it would be because receptionists don't perform cardiograms in emergency departments except in mine

Q Do you have any explanation for why Ms Schoch felt it appropriate to go ahead and do an EKG on a patient that did not have a known cardiac history, that based upon her testimony didn't complain of any cardiac symptoms at any time even while sitting in the lobby, without discussing it with the doctor first?

A Sure.

Q Why?

A Because the vast majority of patients who have cardiograms done in offices are not automatic and it would be done by request frequently, so that would be a non-issue to me

Q What's done frequently that they come in and ask for an EKG?

A Well I don't know how frequently patients

ask for an EKG, but asymptomatic patients do ask for electrocardiograms for insurance purposes for lots of reasons and they're just done.

Q Well, what about a patient that's coming in, that is coming in on an unscheduled basis, that has now made two calls to the office and wants to be seen, that according to the receptionist doesn't have any cardiac symptoms, do you find that at all unusual that a receptionist, without checking with the doctor first, would go ahead and perform an EKG on such a patient?

A No, I don't.

Q You don't. Okay.

A No.

Q In the second paragraph of your letter you say, "I did not find that the patient verbalized chest pain to the receptionist prior to his coming to the office." I take it for purposes of that letter in that sentence you are accepting Ms. Schoch's testimony, correct?

A Yes.

Q And you are rejecting the'testimony of Mr. Porach's stepdaughter?

A Correct.

Q And you are rejecting the testimony of Mr. Porach's mother-in-law?

A Yes.

Q And is there any particular reason that you've chosen to accept Ms. Schoch's testimony and reject other testimony?

A No. Just that people who work in a medical environment are more used to a more accurate recording. Patients or patient's relatives frequently have rather divergent memories of what actually happened.

Q So you're suggesting and will suggest to the jury that the recollection of Jacquelyn DeWitt standing there with her stepfather when the telephone call was made and the conversation that Mary Nary had with her son-in-law immediately after that telephone call was made, those conversations and their observations in terms of what he was doing, vis-a-vis shortness of breath, etc., those things are less reliable than Ms. Schoch's testimony in your opinion?

A Yes. Yes, exactly,

Q And it has nothing to do with which side you are representing in this case?

A No. No. It has something to do with my

life experience in dealing with patients.

Q Now, in your reports you say you don't feel that the outcome would have been any different had Dr. Lalli seen the patient immediately, and by that I presume you mean when he arrived in the office sometime after 5:00 o'clock and then was taken back for the EKG sometime around 5:20 or 5:30, is that the period of time that you don't think the outcome would have been any different?

A Exactly.

Q Before that, had he been in an emergency room, we've already talked about the probabilities of whether or not he would have survived in the morning and the probabilities whether or not he would have survived in the afternoon?

A Yes, we have talked about that.

Q Do you know what the EKG would have shown had one been done in the morning given and accepting the testimony of Dr. Hoffman concerning the damage to the myocardium?

A The answer is no.

Q There is a history given in the emergency room record by Dr. Howard Gershman. Do you know Dr. Gershman by chance?

A No, I don't.
Q And, Dr. Gershman, just for your information, was summoned, as was EMS, by Dr. Lalli's office --
A Yes.
Q -- came over, assisted in the resuscitative efforts and then transported the patient back to Fairview General Hospital, which is connected to his office --
A Right.
Q -- where he was then worked on for a short period of time and then pronounced.
A Yes.
Q And Dr. Gershman, in his dictated note, which was dictated moments after he died, indicates this 44-year-old white male, who complained of chest pain all day today, and then it goes on.
A Right.
Q Do you know the --

MR. RISPO: Just for the record, let me object because this is a subject of a motion in limine.

MR. MISHKIND: Right. Let me finish my question, and then you can go

ahead and object until the cows come home.

MR. RISPO: I just wanted to make sure there wasn't an answer before I got my objection in.

MR. MISHKIND: Pause before you answer.

THE WITNESS: Okay.

BY MR. MISHKIND:

Q Do you know who the likely source of that information was to Dr Gershman.

MR. RISPO: Object. Go ahead.

THE WITNESS: No.

BY MR. MISHKIND:

Q Do you have any understanding as to where Dr Gershman obtained that information from?

A No.

Q At the time that Dr. Gershman is involved in treating this patient, the effort is still to try and save his life, correct?

A Absolutely.

Q So that when he obtains a history on a patient and is involved in treating the patient, this

isn't a foregone conclusion at least from what you can see, that this patient was going to die? He wanted to do everything possible to try and save the man's life, correct?

A I would think so, sure

Q So when he talks about the history of the patient, and the fact that the patient had gone to the doctor's office, and when Dr Gershman arrived, he found the patient in full arrest with Mr. Lalli performing CPR and then EMS arrived and his continued notation about his electrical activity --

A Yes.

Q -- is this something that an emergency room doctor would expect to be included in a detailed history gathered by such a doctor?

A All the information that you see there?

Q Yes

A Yes, that would be pretty similar, pretty common

Q Okay The EKG done in the afternoon between 3:30 and 5:00 o'clock, taking into account the pathology evidence of the myocardium and accepting that as true, do you have an opinion as to what likely would have shown up on the KG?

MR. RISPO: When?

MR. MISHKIND: Between 3:30 and 5:00 o'clock.

MR. RISPO: You mean before the one that was taken?

MR. MISHKIND: Yes. I'm saying that had an EKG been done between 3:30 and 5:00 o'clock.

MR. RISPO: Earlier Okay.

THE WITNESS: Do I have an opinion what that would have shown given the evidence?

MR. MISHKIND: Yes, sir.

THE WITNESS: Well, I think I do for that one. I think it would be more likely than not it would be quite similar to the one that we did do since it's quite close to that one.

BY MR. MISHKIND:

Q Okay. So you would have had an EKG that would have been non-diagnostic?

A Yes.

Q It wouldn't have told whether he's an having

an acute MI or whether this is a remote infarct?
A Well, it would tell you he's had a remote infarct. It just wouldn't tell you how remote it is. But it doesn't tell you there's no sign of an acute MI.
Q When you say it will tell you that he's having a remote infarct, on what do you base that?
A The fact that he has Q waves in V1, V2 and v3.
Q Can you have Q waves in the presence of an acute MI?
A Sure, but the ST segments need to be elevated.
Q And your measurement -- I'm not going to have you take out a ruler because we had Dr. Effron do that and had Dr. Botti measure it. Your measurement of the Q waves, whether they be standard or nonstandard, your measurement of the ST elevation is not, in your opinion, consistent with an acute MI?
A That's correct.
Q And do you have any explanation why your interpretation of the elevation, when we're looking at the same EKG, would be inconsistent with three other doctors, a cardiologist, an internist and an emergency

room doctor?

A No, I don't know why, because I looked at it very carefully to look at the elevation.

Q And presumably all four of you had been looking at the same thing?

A I hope so.

Q If John Porach had been seen at an emergency room in the morning and accepting the pathology evidence of a heart attack occurring no earlier than four to six hours before his demise and no earlier than ten to twelve hours before his demise, at what period of time was the window of opportunity for thrombolytic therapy closed?

A I would ask you to repeat the question. I'm not sure I understood it.

Q Sure. Pathology suggests myocardial infarct no earlier than four to six hours before death.

A Okay.

Q And no older than twelve hours before death for a number of explained reasons by Dr. Hoffman.

A Okay.

Q At what point in time was the window of opportunity for the use of thrombolytics closed?

A Well, if you looked at the way they were

used, the standard of use in '94, they were used up to six hours of the time of the onset of the patient's discomfort. That discomfort though has to be characterized as discomfort that's consistent with a heart problem and it has to be associated with an electrocardiogram which has certain characteristics, which this one doesn't show. Unless you can tell me when the cardiogram showed that, then I would be unable to say when thrombolytics would be useful, because I don't know that they ever would have been used and that's the issue.

MR. MISHKIND: Off the record.

(A short recess was taken.)

BY MR. MISHKIND:

Q Now, you're basing your testimony on an assumption that the EKG in Dr. Lalli's office, had it been done in the morning, would have had the same nonspecific findings, correct?

A Yes.

Q If in fact, the EKG -- strike that.

Do emergency rooms normally use half standard size EKGs?

A We have the capability of -- what you do is

you do the first part of the electrocardiogram, and if the deflections are too high, then you flip it to half standard just to keep the lines within the allotted space.

Q Do you know why Ms. Schoch flipped the electrocardiogram to half standard?

A No, I don't. I don't even know that she did. I don't know.

Q Do you know whether she even has an appreciation for the difference between a standard and a half standard?

A I have no idea.

MR. RISPO: Wait. She's not reading this EKG, so that's an unfair question.

MR. MISHKIND: Doing a lot of things that she may or may not have been appropriately doing, so I think it's an appropriate question to ask.

BY MR. MISHKIND:

Q Assuming electrocardiographic changes that would meet the criteria for the implementation of thrombolytics in the morning and accepting the myocardial infarct evidence of Dr. Hoffman, when is

the latest that the thrombolytic therapy would have more likely than not saved this man's life?

MR. RISPO: I'm confused, and I don't know if it's because the question was confusing or I just didn't hear it

BY MR. MISHKIND:

Q Do you understand the question? And even if you do understand it, I'll rephrase it for Ron.

A I understand it.

MR. MISHKIND: Off the record

(Off the record discussion.)

MR. RISPO: Have the record show an objection on the basis of ambiguity. Go ahead.

THE WITNESS: I have two responses. One is I would never agree that thrombolytics can be characterized as lifesaving and imply that they always do. And, secondly, I don't have an opinion about when that could possibly have happened. I just don't know. But I don't know that you can

say they save lives. In a big population you can, but one person you have no way of knowing.

BY MR. MISHKIND:

Q Well, certainly you have to base opinions as an expert witness on statistics as to the likelihood based upon experiences of thrombolytics successfully preventing a fatal event in the face of an acute MI, correct?

A See, I think of thrombolytics as successfully opening arteries and successfully reducing ischemia and successfully saving myocardium, but I don't take the next step and say that links it to X number percentage of lives saved in that short time frame. That's the part of it I have trouble with.

Q That aspect then I suggest or I submit to you, you would probably defer to a cardiologist?

A Yes, especially one who does a lot of that, if anybody does it anymore.

Q So the idea is the sooner you get this patient in, the less amount of myocardium is going to be damaged, and then you would defer to a cardiologist as to what type of intervention in the cath lab or

otherwise would take place?

A Correct.

Q The whole idea is that John Porach would have been a lot better off had he been in an emergency room in the morning and a lot better off had he been in an emergency room in the afternoon than the situation where he walks into the doctor's office at 5:00 o'clock?

A I would say Mr. Porach would have had, in retrospect and hypothetically, and patients like him, an improved chance, but to say that they're better off when you can still die from all this doing it perfectly, I couldn't say.

Q Can you state that more likely than not he would have died anyway?

A No, I cannot state that.

Q Okay. Do you have an opinion at all and do you intend to offer an opinion at all at trial concerning what John Porach's life expectancy would have been had he received appropriate intervention in the morning and/or in the afternoon?

A I have no opinion as to his life expectancy, whether he received intervention or not.

Q So you're not going to be providing any

opinions as to had he survived this event how long he would have lived or how many years his life expectancy would have been reduced?

A That is correct.

Q If cardiac enzymes had been drawn in the morning on October 14th, given the evidence on autopsy of the cardiac slides, do you have an opinion as to whether or not his cardiac enzymes would have been elevated?

A Yes. If we assume those enzymes -- I'm sorry, that pathology report, that 12-hour estimate is correct, yes, I have an opinion.

Q And what is your opinion, sir?

A That they would be normal.

Q What about at 3:00 o'clock or 3:30 to 5:00 o'clock?

A Then it depends on which enzymes.

Q Which enzymes would you be looking at?

A Probably the CK MB. It might have been somewhat elevated at that time, but how elevated, I don't know.

Q And the reason you say that they probably would not have been elevated is that he would have been in the emergency room too early in the evolving

MI to have had a substantial elevation in the cardiac enzymes?

A Exactly

Q But it's good to be in an emergency room too early rather t an too late?

A You know I wish I could tell you that that was true 100 percent of the time. But sometimes it is not because a disease has to evolve sometimes to become diagnosable So it is not always good to be there too early.

Q But we can certainly agree and perhaps need in conclusion that it's better from a probabilistic standpoint to be there early in the process of an evolving MI than lack on in the process of an MI?

A Of course.

Q Doctor, have we covered all of the opinions that you set forth in your report and those which you indicated you were in a position to talk about when I asked you at the very beginning of the deposition about the EKG?

A Yes, I think we have Keep in mind that there's one deposition that I haven't read yet, so I can't tell you if t at will change anything. But I will let you know if it does

Q And I would appreciate that if after reading it there are any additional opinions or any changes in your opinion, I would reserve the right to question you, albeit on a limited basis, prior to your taking the stand.

MR. MISHKIND: I thank you very much, and I have no further questions for you.

THE WITNESS: Okay.

MR. MISHKIND: Do you want the Doctor to read the depo?

MR. RISPO: Yes, I would, I'd appreciate it.

(Deposition concluded at 4:30 p.m.)

IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

JANET L. PORACH, Administratrix of the Estate of John G. Porach, Jr.,

Plaintiff, **Case No. 316045**

-vs- **Judge Calabrese**

LORENZO S. LALLI, M.D.,

Defendant.

\- - -

WITNESS SIGNATURE PAGE

This is to certify that I have read the transcript of my deposition taken on Thursday, November 13th, 1997 in the foregoing case, and that the foregoing transcript accurately states the questions asked and the answers given by me, with the changes or corrections, if any, noted on the errata sheet attached hereto.

_____

BRUCE D. JANIAR, M.D.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at _____ on this _____ day of _____, 1996.

_____

My commission expires NOTARY PUBLIC

C E R T I F I C A T E

COUNTY OF LUCAS)
ss.)
STATE OF OHIO)

I, CYNTHIA A. MUELLER, a Certified Shorthand. Reporter and Notary Public, do hereby certify:

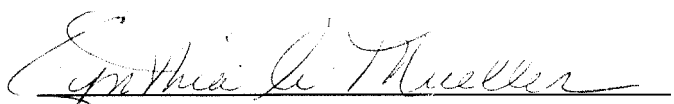
That the witness in the foregoing deposition,

BRUCE D. JANIAK, M.D.,

was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the within entitled cause; that said deposition was taken at the time and place therein named; that said deposition was reported by me in shorthand and was later transcribed under my direction into print by means of computer-assisted transcription, and that the foregoing 112 pages is a full, true, and correct record of the testimony adduced at the aforementioned time and place.

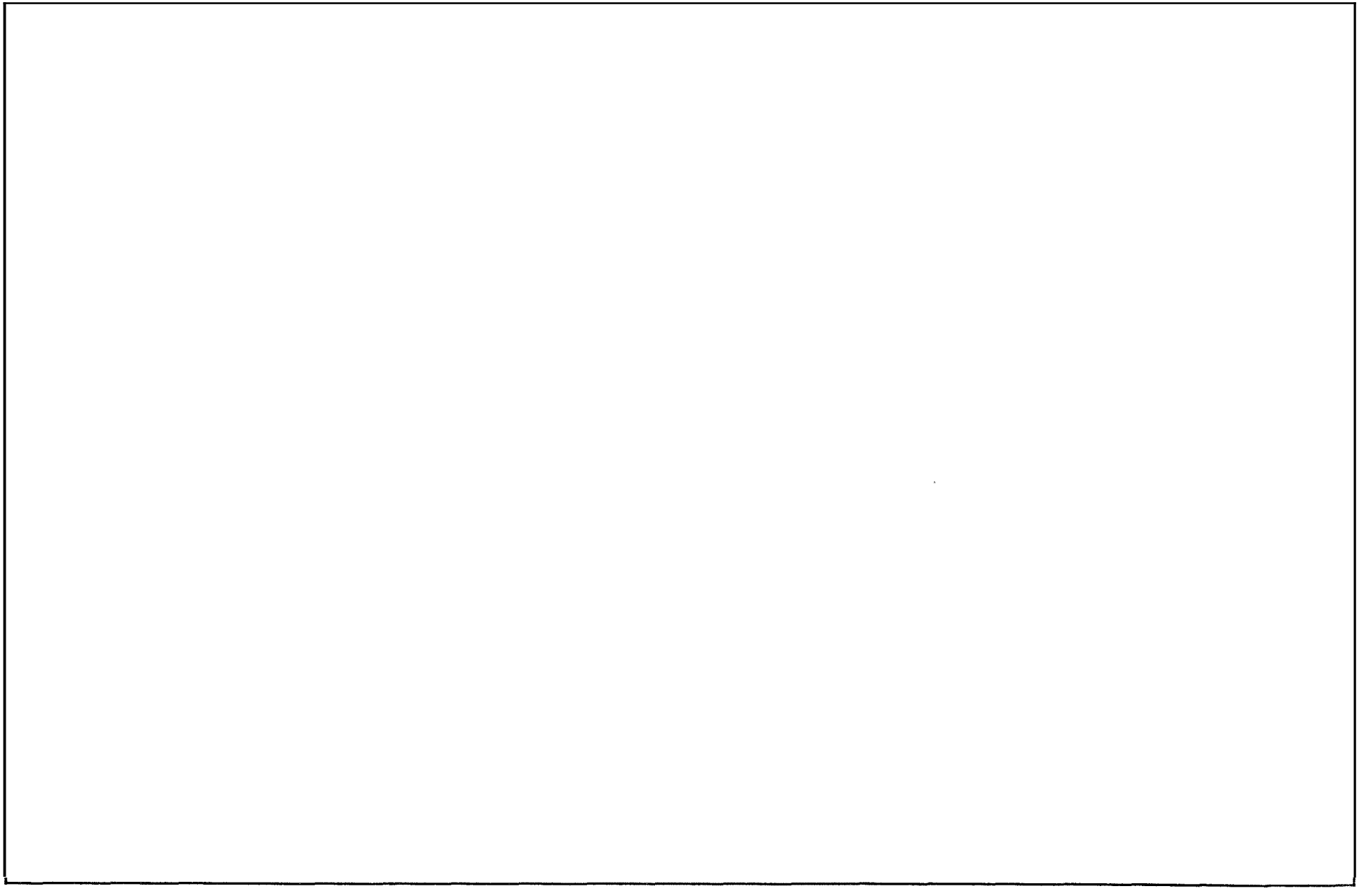
And I further certify that I am a disinterested person and am in no way interested in the outcome of said action, or connected with or related to any of the parties in said action, or to their respective counsel.

IN WITNESS WHEREOF, I have hereunto set my hand on this 24th day of November, 1997.



CYNTHIA A. MUELLER
Notary Public
In and for the State *of* Ohio

My commission expires
July 22, 2001



IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

JANET L. PORACH, Administratrix
of the Estate of John G. Porach, Jr.,

Plaintiff,

-vs-

LORENZO S. LALLI, M.D.,

Defendant.

Case No. 316045

Judge Calabrese

- - -

WITNESS SIGNATURE PAGE

This is to certify that I have read the transcript of my deposition taken on Thursday, November 13th, 1997 in the foregoing case, and that the foregoing transcript accurately states the questions asked and the answers given by me, with the changes or corrections, if any, noted on the errata sheet attached hereto.

BRUCE D. JANIAK, M.D.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Toledo, Ohio on this 5th day of December, 1997.

SUE T. THAYER, PUBLIC

My commission expires

Notary Public - State of Ohio
My Commission Expires July 23, 1998