In The Matter Of:

Shirley Bolden vs. St. Lukes Hospital
Court of Common Pleas, Cuyahoga County, Ohio

Deposition of Bruce Janiak, M.D.
December 15, 1992

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IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO
SHIRLEY BOLDEN,
ADMINISTRATRIX, ETC.,
Plaintiffs,
JUDGE CLEARY
-vs- CASE NO. 217,592
ST. LUKE'S HOSPITAL,
ET AL.,
Defendants.

Deposition of BRUCE JANIAK, M.D., taken as if upon cross-examination before Linda A. Astuto, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of The Toledo Hospital, 2142 North Cove Boulevard, Toledo, Ohio, at 9:30 a.m. on Tuesday, December 15, 1992, pursuant to notice and/or stipulations of counsei, on behalf of the Plaintiffs in this cause.

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On behalf of the Defendant
Emergency Department Physicians,
Dr. Barron and Dr. Baumgartner

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BRUCE JANIAK, M.D., of lawful age, called by the Plaintiff for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF BRUCE JANIAK, M.D.

BY MR. PARIS:

Q: Doctor, my name is David Paris and I'm one of the lawyers that represent Thelma Lloyd in connection with this litigation.

I'd like to ask you some questions this morning about your background, about the opinions that you have in regard to the care and treatment that she received at St. Luke's Hospital.

I will try to keep my questions understandable, but being a layman and not a physician, I hope that you'll work with me. If my questions are inartfully phrased, or convoluted or not understandable, will you do that?

A: I promise.

Q: Okay. I'd like to hand you something that has been given to me and represents your curriculum

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vitae.

Is that updated? Is that current?

A: Hang on just a second. Actually this one looks a little bit old. It has several missing children and it doesn't have the fact that I was president of the American Board of Emergency Medicine. So this is a little bit old.

Q: When were you president of that organization?

A: Three years ago.

Q: For how long? One year?

A: One year.

Q: So 1989?

A: 1990 to **'91.**

Q: Okay.

A: Mid-year to mid-year.

Q: Any other additions, modifications?

A: I don't think there's anything significant.

Q: Have you written anything, presented any papers, any publications dealing with diagnosis and treatment of acute myocardial infarctions?

A: I have not.

Q: Have you written any publications or presented any papers dealing with emergency care of patients with acute myocardial infarctions?

A: I have not.

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Q: Do you now or have you ever had any privileges at St. Luke's Hospital in Cleveland, Ohio?

A: I have not.

Q: Do you know Dr. Bass?

A: I do not.

Q: Do you know Dr. Hoke?

A: I **do** not.

Q: Dr. Seballas?

A: NO.

Q: Dr. Barron?

A: No.

Q: Do you know Dr. William Boden personally or by reputation?

A: It seems I may have heard his name before but I can't remember where.

Q: Do you know what his specialty is?

A: I guess pathology but I'm not sure.

Q: Do you know Dr. Greenblatt?

A: I do not.

Q: Goldblatt. Dr. Peter Goldblatt?

A: That sounds like a cardiologist.

Q: Okay. These are not trick questions.

A: These aren't trick answers. It's because you mentioned a name like that, obviously there are a lot of similar names. That sounds like a

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gentleman that I probably read an article or two or reviewed an article.

Q: Okay.

A: There are, I'm sure, Goldblatts in every specialty.

Q: Dr. Geoffrey Mendelsohn?

A: No, I don't know him.

Q: Dr. Ralph Lach?

A: NO.

Q: Dr. Michael Frank?

A: I know a Michael, I think a Michael Frank, an emergency room physician somewhere in Ohio years ago. If there was a Michael Frank who at one point in his life sat on the Board of Directors of the Ohio Chapter of Emergency Physicians, that is probably the same Michael Frank.

MS. VANCE: I think we're talking about one and the same.

Q: You've had no contact with him except for several years ago, I take it?

A: Probably 10 years since I've seen him.

Q: Do you know a Dr. David Cooke?

A: Does not sound familiar.

Q: Dr. Kenneth McCarty?

A: NO.

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Q: Dr. Jerome Aarons?

A: No.

Q: I take it you have consulted as an expert witness over the years?

A: Yes, I have.

Q: When did you first begin consulting?

A: I think the first case I did was in the mid seventies, perhaps '76, '77, in that range.

Q: And on an average yearly basis, about how many cases did you consult with in the medical malpixctice context?

A: Let's see. Probably an average of four to five a year.

Q: This is just reviewing cases, it's not necessarily giving testimony, preparing reports.

A: Exactly, right.

Q: So for the past 15 years ballparking it, somewhere in the range of between 50 and 75, 60 and 75?

[21] **A:** I'd say probably 80 cases in that time.

[22] Q: Not all of these cases, I take it, are cases [23] that you ultimately gave depositions on, is that [24] correct?

[25] **A:** That is correct.

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[1] Q: Not all of these cases are ones in which you [2] prepared expert reports on?

[3] **A:** That is also correct.

[4] Q: Have you consulted in cases other than medical [5] malpractice cases?

[6] **A:** Yes.

[7] **Q:** And what types of cases?

[8] **A:** There were two civil cases that dealt with, one [9] was an injury that occurred on the school ground [10] and another was an automobile accident.

[11] Q: Do I understand just two over the past 15 years?

[12] **A:** That's all I can think of.

[13] Q: Okay. I just wanted to get your familiarity [14] with the medical/legal system.

[15] **A:** Sure.

[16] **Q:** Have you kept track approximately what [17] percentage of your consultations are with [18] plaintiffs as distinguished from defendants?

[19] **A:** I would say the ratio is probably five to one [20] defendant/plaintiff.

[21] Q: Five times more for defendant than with the [22] plaintiff?

[23] **A:** I think that's pretty accurate.

[24] Q: Have you ever consulted with the law firm of [25] Arter & Hadden prior to this case?

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[1] **A:** I don't believe so.

[2] Q: How about for the law firm Reminger & Reminger?

[3] **A:** Yes.

[4] **Q:** Do you recall who specifically you've worked [5] with over there?

[6] **MR. PARKER:** Let me make a [7] continuing objection.

[8] **A:** Mr. Spisak is the name that comes to mind.

[9] Q: Do you recall approximately how many times [10] you've consulted with that firm?

[11] **A:** I think twice.

[12] Q: Have you consulted with any other law firms in [13] the Cleveland area?

[14] **A:** Well, that's a good question. I don't know the [15] answer. I just don't know.

[16] Q: Have you ever consulted with, for example, [17] Jacobson, Maynard?

[18] **A:** That is one of the thoughts I have. I have [19] consulted with them, and I know I've consulted [20] with them in Kentucky and in, I think something [21] in Southern Ohio but I don't remember €or sure [22] if there was one in Cleveland.

[23] Q: Have you ever consulted on any cases involving [24] St. Luke's Hospital in Cleveland, Ohio?

[25] **A:** No, I don't think so.

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[1] Q: Have you ever consulted with any plaintiff's law [2] firms in Cleveland, Ohio?

[3] **A:** No, I don't think so.

[4] Q: Have any of the occasions that you have [5] consulted with lawyers on cases prior to today [6] involved the diagnosis and care and treatment of [7] a potential acute myocardial infarction?

[S] **A:** Yes.

[9] **Q:** Do you recall the name of that case?

[10] **A:** No, I don't.

[11] Q: Do you recall how many cases where you were so [12] consulted?

[13] **A:** Well, I can't imagine it was one or less because [14] as we all know, myocardial infarction problems [15] are frequent litigation issues.

[16] I would say probably three cases dealt with [17] myocardial infarction in some form or another.

[18] Q: Do you recall any of the particulars about any [19] of those cases?

[20] **A:** Well, one I do.

[21] Q: When, try to confine the question to where the [22] case was pending, what county, the law firms [23] involved and/or the issues presented.

[24] **A:** Well, without a review of the files, I'm not [25] sure I could answer the question very

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[1] accurately.

[2] It was a case in Dayton, it was an [3] automobile accident in which there was a thought [4] that the patient had **a** myocardial infarction and [5] the physicians paid more attention to the [6] injuries than the possibility of heart attack.

[7] And I just can't think of the name of the [8] law firm right now in Dayton but it will [9] probably come to me in another minute or so. [10] Jinks & Cowdrey.

[11] Q: Anything else about the other cases?

[12] **A:** Just nothing is coming to mind.

[13] Q: Do you keep files on the cases that you have [14] consulted on?

[15] **A:** Once a case is over. if the firm requests that I [16] return all the materials, then I do. If not, [17] then I do keep them and they're all in my attic [18] at home.

[19] **Q:** You have the ability to make a determination of [20] the cases that you may have in your attic that [21] dealt with this issue before?

[22] **A:** Just manually. I mean those are not filed in a [23] filing cabinet. They are sort of in a file. I [24] would have to go through each folder and see [25] what the issues are in each case. Certainly I

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[1] have that ability.

[2] Q: Would you mind doing that?

[3] **MS. VANCE:** Arrangements would have [4] to be made to compensate the doctor for any [5] time he spent.

[6] **A:** I would not mind doing that if you agree to [7] compensate me because it will take some time and [8] I respectfully request that you wait until after [9] the holiday season. But I'll be happy to do [10] that.

[11] **MS. VANCE:** We'll talk further [12] about that. We'll make the arrangements. [13] If that is something that they, upon [14] further reflection, want to pursue, we'll [15] discuss it.

[16] Q: You've given testimony on occasions prior to [17] today?

[18] **A:** I have.

[19] Q: And how many times do you think you've given [20] testimony total?

[21] **A:** Probably **25.**

[22] Q: And of those occasions, how many were in a [23] courtroom setting?

[24] **A:** I think four or five.

[25] Q: And how many — and the rest were in a

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[1] deposition setting?

[2] **A:** Right.

[3] **Q:** Doctor, in your file — are you able to tell [4] from your file when you were first contacted [5] with respect to this case?

[6] **A:** Not without picking up the file and going [7] through the papers.

[8] Q: All right. Let's do that.

[9] **A:** Well, it was prior to August of 1992. My guess [10] it was in the early part of this year.

[11] **MS. VANCE:** Actually not. As you [12] know, David, I only entered the case the [13] beginning of July. It was in that window [14] of time between the month of July and [15] August. We know the date of his report, so [16] it is a date in the month of July or [17] August.

[18] Q: Would you agree with Miss Vance's [19] representation?

[20] **A:** Sure.

[21] Q: What were you requested to do?

[22] **A:** I was requested to review this case with [23] specific focus on whether or not there were, in [24] my opinion, any violations of the COBRA statutes [25] with regard to patient transfer.

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[1] Q: What documents were you provided with?

[2] **A:** Deposition of a Dr. Bass and a deposition of a [3] Dr. Barron. Plaintiff's expert witness reports [4] from Dr. McCarty, Dr. Silberman, Dr. Aarons and [5] Dr. Cooke. Autopsy report on the patient. [6] Emergency department records and records of the [7] observation unit admission at St. Luke's [8] Hospital.

[9] Q: That would be the 12/17/90 records?

[10] **A:** Right. And then some medical records from [11] MetroHealth Medical Center from the 21st to the [12] 22nd of December, 1990.

[13] **MS. VANCE:** And you also had the [14] autopsy report?

[15] **MR. PARIS:** Yes, he said that.

[16] Q: I take it, Doctor, you did not review Mrs. [17] Lloyd's medical records from 1978 to 1990 from [18] the Kenneth Clement Center?

[19] **A:** No, I haven't seen that.

[20] Q: You did not review the actual GI films taken at [21] St. Luke's on December 17, 1990?

[22] **A:** That is correct.

[23] Q: You did not look at the actual chest x-ray taken [24] on December 17, 1990?

[25] **A:** That is correct.

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[1] Q: You did not look at the pathology slides of [2] Thelma Lloyd's autopsy?

[3] **A:** That's correct.

[4] Q: You did not review the deposition of Shirley [5] Bolden?

[6] **A:** Correct.

[7] **Q:** Dr. Brenda Smith?

[8] **A:** Correct.

[9] Q: Dr. Ahmet Hoke?

[10] **A:** Correct.

[11] **Q:** Dr. Seballas?

[12] **A:** Correct.

[13] **Q:** Did you review any of the protocols of the [14] emergency room at St. Luke's Hospital?

[15] **A:** Yes, I did. Well, I'm not sure that I **did.** [16] I've reviewed something that was a protocol. [17] I'm not sure, I don't know if I have it. I'm [is] not sure it was an emergency department [19] protocol. I think it dealt with the [20] observation, the 23 hour observation policies as [21] near as I remember.

[22] Q: Do you have that handy as part of your file?

[23] **A:** Well, I'll look again. I didn't see it.

[24] Q: Yes, that's why I mentioned it because I didn't [25] see it either.

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[1] **A:** I remember seeing it but I don't know where it [2] is given the fact I could skip over it looking [3] like this. I don't think it's in here.

[4] Q: I may be calling it something that it's not. It [5] may not be a protocol. It could be a standard [6] or guideline.

[7] **A:** Right.

[8] Q: Did you review any such protocol, standards or [9] guidelines relative to admission to the coronary [10] care unit at St. Luke's Hospital?

[11] **A:** I did not.

[12] Q: How about to their stepdown telemetry unit?

[13] **A:** I did not.

[14] Q: How about with regard to their pathology or [15] laboratory?

[16] **A:** No.

[17] Q: Did you see a document called the laboratory [18] summary sheet from St. Luke's Hospital? Let me [19] show you that. It is a document that has [20] previously been marked as Plaintiff's Exhibit [21] 4. It's the second page that I would be [22] interested in knowing if you saw that before.

[23] **A:** I honestly don't remember seeing it. If I did, [24] I wouldn't be surprised that I did. I just [25] don't have a memory of it.

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[1] **MS. VANCE:** So you are clear, he [2] has not seen that specific sheet that you [3] have put before him but I have sent him [4] policy and procedure manuals relevant to [5] the admission to the cardiovascular unit, [6] the cardiac stepdown unit and that the [7] patient is admitted on an observation [8] status.

[9] Those are sent to him. Obviously, [10] just so you are clear as to what he has or [11] has not seen.

[12] His other statements about not seeing [13] the other depositions is accurate, nor has [14] he been provided with the actual autopsy [15] slides or the films, other than the reports [16] that are reported in the hospital record.

[17] Q: Will you adopt what Miss Vance said as accurate, [18] Doctor, as to what you've seen?

[19] **A:** Sure. If she said she sent me that. I remember [20] the observation unit policy.

[21] **Q:** Did you receive all these materials in one lump [22] package or did you receive materials [23] periodically?

[24] **A:** I received more than one set. I think two.

[25] Q: Two packages?

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[1] **A:** Yes.

[2] **Q:** Do you know whether or not your report, which is [3] dated whatever date it has on it, was prepared [4] after receiving both packages from Miss Vance?

[5] **A:** The observation unit document that I referred [6] to, I did not have that prior to writing my [7] repoi-t.

[8] Q: And your report is dated August 28, 1992.

[9] Is it your recollection that you received [10] the 23 hour observation unit materials after you [11] prepared that report?

[12] **A:** Yes.

[13] **Q:** Anything else that you received after preparing [14] your report?

[15] **A:** Nothing other than I'm sure there was a cover [16] letter with the observation unit material. But [17] that was it.

[18] Q: Did you obtain or review a deposition of a lab [19] technician Matousek?

[20] **A:** No.

[21] **Q:** Did you review a report from an expert by the [22] name of Dr. Watts?

[23] **A:** Not familiar with that.

[24] Q: Dr. Michael Frank?

[25] **MS. VANCE:** No. He's only seen the

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[1] plaintiff's expert report, not [2] co-defendants.

[3] **MR. PARIS:** I understand. I just [4] wanted to hear it from the doctor, what he [5] has reviewed and not reviewed.

[6] Q: Is there anything else that you have reviewed in [7] connection with this case that I have not [8] addressed or that is not contained in your [9] package of materials?

[10] **A:** Well, there are some materials and knowledge [11] that I reviewed before the case ever occurred. [12] It had nothing to do with the case at the time. [13] Materials that I read, COBRA regulations, things [14] like that, but they are not in connection with [15] this. I looked at that before the case.

[16] Q: You had familiarity with that before you were [17] even approached by Miss Vance, is that correct?

[18] **A:** That's correct.

[19] Q: Did you go back and do any additional research [20] after you were approached by Miss Vance?

[21] **A:** I just looked at the COBRA regulations again.

[22] Q: Where did you find those regulations?

[23] **A:** I think they were in a publication that was, or [24] in a letter or something that came from the [25] American College of Emergency Physicians, plus

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[1] an article that was written by an attorney about [2] the COBRA regulations.

[3] Q: An article written by which attorney?

[4] **A:** Timothy Krugh.

[5] Q: C-r-e-w?

[6] **A:** K-r-u-g-h.

[7] **Q:** Where is that article found?

[8] **A:** Now, I don't know. I'm not sure where it was [9] published. I just know Mr. Krugh, he sent me a [10] draft copy of it.

[11] Q: Do you have that handy?

[12] **A:** Well, I don't know if I do or not.

[13] **MS. VANCE:** If it's a draft [14] manuscript, I don't know where it stands in [15] the publication process. I would be [16] hesitant, without Mr. Krugh's permission, [17] to be circulating that.

[18] **A:** He asked me to look at it prepublication and [19] comment on it, which is what I did. But I think [20] I sent it back to him along with the comments.

[21] Q: You were asked — an attorney sent you a draft [22] of a publication, a draft of something that he [23] wanted to publish.

[24] **A:** Uh-huh.

[25] Q: Dealing with COBRA.

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[1] **A:** That's correct.

[2] Q: And wanted your input?

[3] **A:** That's correct.

[4] Q: And you made some comments and you sent it back [5] to the attorney, is that right?

[6] **A:** Yes, sir.

[7] Q: Do you know where he intended to pnblish that [sl article?

[9] **A:** In a law journal but I don't know. I'm not that [10] familiar with law journals. So I don't know.

[11] Q: Do you have that letter or publication from the [12] American College of Emergency Physicians where [13] you obtained some knowledge of COBRA?

[14] **A:** I'm sure it's somewhere in a file. I could ask [15] my secretary to see if there is anything in the [16] file under COBRA.

[17] Q: I'd like that. I would like to get an [is] understanding of what your knowledge is of [19] COBRA.

[20] **A:** You may be making an assumption that my [21] knowledge is equal to what I read. I will ask [22] my secretary to see what I can find.

[23] Q: Sure.

[25] (Thereupon, a recess was had.)

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[2] **MS. VANCE:** This is Mr. Krugh's [3] article.

[4] **MR. GORDON:** He's not with your law [5] firm, is he?

[6] **MS. VANCE:** No.

[7] **MR. PARIS:** I'd like to take a look [8] at that.

[9] **MS. VANCE:** I'm not at liberty to [10] release this draft of Mr. Krugh's article, [11] which is a substantial — I'm looking at [12] his cover letter.

[13] **MR. PARIS:** You're paging through [14] the article.

[15] **MS. VANCE:** I am trying to find out [16] how long it is. There are several [17] footnotes and he has a cover letter dated [18] March 27, 1991 to Dr. Janiak.

[19] I've not looked at it. I've never [20] seen it in published form anywhere. So I [21] don't feel at liberty to release that to [22] you at this point. There is another [23] newspaper journal that Dr. Janiak has on [24] the subject.

[25] **MR. PARIS:** Let me see if I

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[1] understand.

[2] Q: Is some of the knowledge you profess to have [3] about COBRA derived from the article given to [4] you by Attorney Krugh?

[5] **A:** No, I don't think so. I think he was looking [6] for my input to see whether, how I felt about [7] his interpretations of COBRA.

[8] Q: I'm sorry?

[9] **A:** I'm sorry, based on my experience and knowledge [10] that I had gotten from serving as president of [11] our college and president of our board, which [12] not only are issues like this discussed [13] frequently in little news letters that come out, [14] but also there's actual incidents that happen to [15] colleagues, so you discuss them at meetings.

[16] Q: Did you prepare any notes in connection with the [17] narrative report that you made?

[18] **A:** Well, the only notes that I have are the [19] markings —

[20] Q: The markings on the cover of Dr. Barron's [21] deposition and Dr. Bass' depositions, is that [22] right?

[23] **A:** That's correct.

[24] Q: Did you make some markings within those [25] depositions on various page numbers, I take it?

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[1] **A:** Sometimes.

[2] **Q:** Quotations or something?

[3] **A:** What would be on the page that's referenced [4] would be a circled paragraph or a mark.

[5] Q: And I take it that means that there's something [6] significant in there that had some bearing on [7] your opinions?

[8] **A:** Well, that's not necessarily true. When I read [9] them, if something strikes me as possibly [10] significant, then I would circle it. I would [11] have to decide afterwards really what is [12] significant.

[13] Q: And did you make any other reports than the one [14] that I have?

[15] **A:** No, sir. That's it.

[16] Q: That's your first and only?

[17] **A:** Yes, sir.

[18] Q: No drafts?

[19] **A:** No drafts.

[20] Q: Have you discussed this case with anyone other [21] than Miss Vance?

[22] **A:** No, I haven't.

[23] Q: Have you done any independent research on [24] cardiology?

[25] **A:** None.

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[1] Q: Have you done any independent research on any of [2] the other legal issues in this case after you [3] were retained by Miss Vance?

[4] **A:** The answer to that is, just to be totally honest [5] is yes, but I'll explain to you what I looked 161 at. It was merely some other institution's [7] approaches to observation because we at this [8] hospital were setting up such a unit, an [9] observation unit.

[10] So I did look at things that dealt with [11] observation units but their purpose was because [12] we were setting one up ourselves this fall, not [13] because of this case.

[14] Q: Can you tell me what, I would like to try to [15] define some terms so we can use them hopefully [16] in the same fashion throughout the rest of this [17] deposition.

[18] What is your understanding of AST, that lab [19] value?

[20] **A:** It's actually kind of an old term. It is a new [21] enzyme. It's a new letter designation for an [22] enzyme, serum enzyme test.

[23] Q: What would be the old designation?

[24] **A:** It seems to me it relates to the SGOT or the [25] serum glutamic oxaloacetic transaminase.

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Q: SGOT.What is the purpose of that test, obtaining that lab value, running that test?

A: I don't know that I could tell you. I never order it. Other doctors order it, so you'd have to ask them.

Q: What about LDH, what is that?

A: It's a nonspecific enzyme that goes up when there is tissue damage and I never order it.

Q: Is that part of any other labs that are customarily ordered by you in an emergency room setting?

A: No.

Q: What is the CPK?

A: CPK is an enzyme that the C is creatine, PK is phosphokinase. It is, I guess you could call it a generic muscle enzyme.

Q: Do you ever order it?

A: I don't think so.

Q: Do you know why the CPK values rise or elevate?

A: Oh, they rise and elevate whenever there is damage to muscle tissue.

Q: Isoenzymes, what are those?

A: There are several different kinds. Which one?

Q: In connection with CPK.

A: There is a subset of CPK which relates to the

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muscle which is in the heart, cardiac muscle.

Q: And what is the purpose of ordering isoenzymes in connection with the CPK?

A: Usually it's to try to make a determination as to whether or not there's an abnormal level of such enzymes, and then to correlate that clinically with what is happening to the patient.

Q: Ever order it?

A: Yes.

Q: Can you order isoenzymes without ordering a CPK at this institution?

A: Sure.

Q: Is it your custom and habit to order cardiac isoenzymes without ordering a CPK?

A: Yes.

Q: In what context would you order isoenzymes?

A: Well, various contexts. Primarily it is one in which a patient is suffering with complaints that could be related to the heart, and that same patient also has no evidence of any cardiovascular instability and has a normal electrocardiogram or electrocardiogram that has no acute injury pattern on it.

MR. PARIS: Could you read that

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answer back?

(Thereupon, the requested portion of the record was read by the Notary.)

Q: And that is one of the contexts in which you order cardiac isoenzymes?

A: Right.

Q: When you use the term instability of vital signs, what do you mean by that term or terms?

A: I mean that on repeated measurements of vital signs, and in this instance we're referring to pulse and blood pressure, that there is abnormal variation in the measurements, the results are divergent in what I would considerto be by abnormal amounts.

Q: Is that to suggest that any abnormality means that the patient would be unstable by your definition?

A: Any abnormality, anything that I would determine in my judgment to be an abnormality or variation would be unstable.

Technically speaking a blood pressure of zero and a pulse of zero taken at 9:00, and the same measurements zero, zero at 9:15, that

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patient is stable, dead but stable.

And although it sounds humorous, the reason I say that and emphasize that is when I teach it, I do not believe that one blood pressure and pulse, regardless, is evidence of using the word stable in the chart.

Stability means to me that things are staying the same when they're measured repeatedly.

Q: So then have we also just defined stable?

A: I guess we did.

Q: All right. Doctor, would you tell us what you mean by reasonable medical certainty or what your understanding of reasonable medical certainty is? You did not use that term in your report, but would you tell me what your understanding of that term is?

A: I think in the context in which we're all sitting, it means that in my judgment or in the judgment of an expert that there is greater than 50 percent probability of an event occurring.

Q: And what is your understanding of what a CHEM 12 is, it consists of?

A: I have no understanding of that.

Q: And when you use determination, Doctor, would

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you tell us what you mean by that and define it?

A: Well, determination I think would indicate that there is inability but it is in a negative direction. It's towards worsening of a disease process.

Q: What is amylase?

A: It's another chemical found in the blood, enzyme chemical which will change with certain disease processes.

Q: Have you ever ordered it?

A: Yes.

Q: Under what circumstances?

A: When I have a patient that I think may have a disease process that would be associated with an elevation of amylase.

Q: For example?

A: Parotitis and pancreatitis.

Q: Have you ever ordered that stat from your lab?

A: I don't believe I ordered it any other way but stat.

Q: Have you ever ordered cardiac isoenzymes stat?

A: Yes.

Q: Why?

A: Primarily because — I guess I ought to be very specific, none of the tests in my emergency

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department have the word stat after them because any test ordered in my department is considered to be stat.

In order to have a stat on not stat routine, an emergency physician must specifically request that. So all tests ordered are stat.

Q: Unless specifically indicated routine or ASAP or do you have a designation for ASAP at this institution?

A: Do not.

Q: Do you have a designation as routine?

A: I believe so. I've never seen a book with that in it but I would guess there would be such a thing.

Q: And tell me, I don't know if you answered my question, what is the purpose of ordering cardiac isoenzymes stat?

A: That really is an excellent question and probably one that would be the subject of a several day conference. However, I'lltry to deal with it.

[23] I don't think there is any different reason [24] to order cardiac isoenzymes stat from any other [25] test stat.

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[1] All you are saying you would like to get [2] the results as soon as they can get it to you. [3] Your message is to drop all your work and focus [4] on mine.

[5] In the emergency room we try to get them as [6] soon as possible.

[7] Q: Are there, are you familiar with how the lab [8] runs cardiac isoenzymes in this institution?

[9] **A:** Yes.

[10] **Q:** How are they run?

[11] **A:** They're run on a scheduled basis. I believe [12] they've changed this recently. I believe it's [13] three times a clay and not, I think it was four [14] times a day.

[15] I think the times are 6:00 p.m., in the [16] 6:00 to 7:00 p.m. range in the early afternoon, [17] and early morning, like midnight to 1:00 a.m.

[18] Q: Directing your attention to your report, Doctor, [19] are all of the opinions that you have in 1201connection with this case expressed in your [21] report?

[22] **A:** All of the ones that I was asked to render with [23] regards to this, yes.

[24] Q: Do you have any other opinions with regard to [25] this case that have not been expressed in your

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[1] report?

[2] **MS. VANCE:** The only opinions he is [3] expressing are those which he is expected [4] to be asked at trial. I've not asked him [5] any personal opinions he might hold on any [6] other aspect of the case, with the [7] exception of the alleged COBRA violations.

[8] He has not been asked to undertake a [9] review, for example, of the care rendered [10] by the emergency room physicians in [11] consideration of whether or not it meets or [12] complies with any standard of care. He may [13] well have opinions on that. He is not [14] going to be asked to express them. That is [15] not why he was retained in this case.

[16] I don't even know that he's reviewed [17] the case with that thought in mind. He's [18] looked at the case from the standpoint of [19] COBRA violations and that is essentially [20] what is set forth in the report.

[21] Obviously reports do not substitute [22] for depositions. But insofar as the rules [23] of evidence limits your discovery [24] deposition of this defense expert to those [25] opinions which he will be asked to express

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[1] on direct exam at trial, I think you're [2] generally confined to the subject of the [3] COBRA violations as set forth in the [4] report.

[5] **MR. PARIS:** To the extent there is [6] factual overlays between what can [7] constitute a COBRA violation and what can [8] be a departure from accepted standards of [9] care, I'm going to pursue what I think I [10] have to pursue to cover it.

[11] **MS. VANCE:** We'll take the [12] questions obviously one at a time.

[13] Q: Doctor, are you, do you have any opinion whether [14] or not the emergency room doctor, Dr. Barron, [15] deviated from accepted standards of medical care [16] in the treatment of Thelma Lloyd?

[17] **MS. VANCE:** I just answered that, I [18] said he is not going to be asked to express [19] any opinions on that subject.

[20] **MR. PARKER:** I object. I don't see [21] how that relates to COBRA. It does not [22] express standards in standards of care.

[23] **MS. VANCE:** It is a matter of [24] whether the patient is stable or not, and [25] as you well know, that is the orientation

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111 he brought to the case.

[2] **MR. PARIS:** I understand the [3] doctor's answer would be no?

[4] **MS. VANCE:** The doctor has not [5] reviewed the case nor has he been asked to [6] express any opinions as to whether or not [7] any individual physicians deviated or [si violated any standards of care or complied [9] with it.

[10] **MR. PARIS:** He is not going to be [11] expressing any opinions on that question?

[12] **MS. VANCE:** No. He's not.

[13] **MR. PARIS:** Same as it relates to [14] the deviations by the staff physicians?

[15] **MS. VANCE:** Alleged deviations, [16] same answer. He is not looking at that. [17] He is looking at what COBRA is, which is [18] not medical malpractice.

[19] **MR. PARIS:** I take it the doctor [20] has no opinions as to whether any alleged [21] deviation by either the ER doctor or the [22] staff physicians were a proximate cause of [23] Thelma Lloyd's ultimate death, is that [24] correct?

[25] **MS. VANCE:** He is looking at the

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11 status of the patient as she departed from [2] the St. Luke's Hospital and whether or not [3] upon discharge and upon transfer, as that [4] term is used in the statute, there was a [5] COBRA violation.

[6] He's not looked into, he's got the [7] records, I provided him with everything, he [8] is not going to be expressing opinions [9] about proximate causation.

[10] **MR. PARIS:** I take it the doctor is [11] not going to be expressing an opinion as to [12] Thelma Lloyd's life expectancy, various [13] type of cardiac care?

[14] **MS. VANCE:** That is exactly right, [15] he will not.

[16] Q: Doctor, do you have an opinion based upon a [17] reasonable degree of medical certainty as to [18] whether Thelma Lloyd was having an acute MI [19] while at St. Luke's Hospital on December 17, [20] 1990?

[21] **A:** I haven't really looked at it from that [22] standpoint but give me a moment just to think [23] about that because I have reviewed the [24] materials, so I could discuss that.

[25] Q: I understand that is not an opinion that you

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[1] gave in your report.

[2] **A:** Yes. I'm clear on that. But inasmuch as it [3] relates to stability of the patient, in my [4] opinion, that would be relevant, so my answer is [5] yes.

[6] Q: Yes, you have an opinion?

[7] **A:** Yes, that's correct.

[8] Q: What is your opinion?

[9] **A:** That she was not having an acute MI at that [10] time.

[11] Q: And you will be expressing an opinion as to [12] whether or not a COBRA violation occurred in the [13] care of Thelma Lloyd at St. Luke's Hospital, is [14] that right?

[15] **A:** Yes, sir.

[16] **Q:** What does it mean to be board certified in [17] emergency room care?

[18] **A:** Well, it's board cei-tified in emergency [19] medicine. What that means is that one has taken [20] an examination that has been offered by either [21] the American Board of Emergency Medicine, or the [22] American Board of Osteopathic Emergency [23] Medicine, and passed that examination.

[24] Q: Okay. Doctor, would you agree that a patient [25] who may have two or more conditions responsible

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[1] for their complaints, and one of those [2] conditions is potentially life threatening and [3] the other is not, can we agree that the accepted [4] standard of medical care is to rule out the most [5] critical condition first?

61 **MR. PARKER:** Objection.

7] **MS. VANCE:** Object. You are [8] getting back to standards of care. That is [9] not what he is here for.

[10] **MR. PARIS:** It is very important in [11] terms of determining stability of a [12] patient.

[13] **MS. VANCE:** I don't see how, Can [14] you rephrase the question?

[15] **MR. PARIS:** No.

[16] **MS. VANCE:** Questioning him as to [17] what the standard of care calls for, I [18] don't see the relevance of that to the [19] issue of stability under COBRA analysis [20] which is what we're here about and what [21] this witness is here about.

[22] **MR. PARIS:** Bear with me and you'll [23] find out.

[24] **MS. VANCE:** I'd like to hear the [25] question either rephrased or put to him

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[1] otherwise because I just don't see that [2] there's any relevance at all.

[3] Q: When you have a patient with two conditions, [4] Doctor, I'm sorry, a patient who may have two or [5] more conditions responsible for their [6] complaints, one of those conditions is [7] potentially life threatening and the other is [8] not, why is it important to rule out the most [9] lethal condition first?

[10] **MS. VANCE:** Objection.

[11] **MR. PARKER:** Join in the [12] objection.

[13] Q: First of all, do you agree with me it is [14] essential to rule out the most lethal condition [15] first?

[16] **MR. PARKER:** Objection.

[17] **MS. VANCE:** Objection.

[18] **MR. GORDON:** I don't have to.

[19] **A:** Actually, I was waiting for — I do not agree [20] with you.

[21] Q: Why don't you agree with me?

[22] **A:** Because your question leaves out relative [23] probabilities of the existence of the entities [24] and the judgment.

[25] So it is not the way medicine is practiced,

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[1] it is not the standard of care to do what you're [2] suggesting and, as a matter of fact, it is [3] inappropriate to do what you're suggesting.

[4] Q: It is inappropriate to rule out the most lethal [5] condition first?

[6] **A:** Absolutely, for the reasons I mentioned.

[7] Q: And those are again?

[8] **A:** Relative probability of existing condition, not [9] to mention side effects of the procedures one [10] might have to go through eo rule out such a [11] condition.

[12] Q: As between a heai-t attack and a hiatal hernia, [13] Doctor, which is the more life threatening?

[14] **MS. VANCE:** Objection insofar as it [15] is not a complete recitation of several of [16] the conditions present in Thelma Lloyd on [17] December 17, 1990.

[18] **MR. PARKER:** It's not only not a [19] complete description of the ultimate [20] diagnosis or rule out diagnoses that were [21] written, it also is incomplete as to the [22] presentation of the patient.

[23] Q: You may answer.

[24] **A:** I don't know.

[25] Q: You don't know what is the most life

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[1] threatening, a heart attack or hiatal hernia?

[2] **A:** No. How would anybody know that?

[3] Q: I don't know.

[4] Have you treated patients who have died of [5] a hiatal hernia?

[6] **A:** I believe I have but I haven't followed every [7] patient through to their demise. So I don't [SI know.

[9] Q: Have you treated patients who died of a heart [10] attack?

[11] **A:** Certainly.

[12] **Q:** Have you treated more patients that die of a [13] heai-t attack than hiatal hernia?

[14] **A:** I believe so.

[15] Q: As between a heai-t attack and an esophageal [16] reflex, which is the more threatening life [17] threatening condition?

[18] **MS. VANCE:** Same objection.

[19] **MR. PARKER:** Objection.

1201 **A:** In that case, the answer usually would be the [21] heart attack.

[22] Q: Why is that?

[23] **A:** A reflex is such a common entity that rarely [24] results in esophageal perforation, which can be [25] life threatening, then I think the general

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[1] consensus would be that the heart attack has the [2] higher chance of being lethal.

[3] But the way you presented the first case, [4] comparing it to a complete hiatal hernia with [5] the entire contents of the abdomen and the [6] chest, the hiatal hernia is much more life [7] threatening.

[8] So your questions don't take into account [9] the range of disease processes. That is why [10] they are so difficult to answer. They leave out [11] important factors.

1121 Q: I didn't insert the facts that you just [13] recited.

[14] **A:** That's right. And that's why I answered the [15] question the way I did, because the potential. [16] the range of possible answers, range of entities [17] is so wide.

[18] Q: Doctor, is a GI series for epigastric discomfort [19] a test that is generally performed on an 1201 outpatient basis at this institution?

[21] **A:** I believe it is, yes.

[22] Q: Was there anything that you saw in Thelma [23] Lloyd's record which would indicate that her [24] epigastric discomfort was life threatening?

[25] **A:** No.

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[1] Q: Do you agree that Thelma Lloyd presented with [2] significant risk factors for coronary artery [3] disease?

[4] **A:** I have to tell you, I didn't review the case to [5] look at that. So I don't know.

[6] Q: Would a patient such as a **63** year old black [7] woman who had been a smoker for many years, who [8] was overweight, had high cholesterol, had a [9] history of hypertension, be one with a [10] significant risk for coronary ai-tery disease?

[11] **A:** Yes.

[12] Q: And can we agree that to determine the [13] relationship between chest pain and an acute MI, [14] it's appropriate to do serial EKGs?

[15] **MS. VANCE:** I'm sorry, can you [16] restate it?

[17] Q: To determine the relationship between chest pain [18] and acute MI, is it appropriate to do serial [19] EKGs?

[20] **A:** That depends on much more information than [21] you've given me in that question, so I can't 1221 answer the question.

[23] Q: Can you answer the question whether it is [24] appropriate to run CPKs and isoenzymes?

[25] **A:** No.

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[1] Q: You can't answer the question or it is not [2] appropriate?

[3] **A:** It is just not enough information to be able to [4] answer your question.

[5] Q: If you have an index of suspicion of either [6] unstable angina, or myocardial infarction, is it [7] appropriate to do serial EKGs?

[8] **MS. VANCE:** Objection. I think [9] this is getting back into the standard of [10] care.

[11] **MR. PARIS:** It deals with stability [12] and deterioration.

[13] **MS. VANCE:** I don't believe it [14] does, not the path you're taking.

[15] **MR. PARIS:** And it deals with [16] emergency medical conditions and it deals [17] with appropriate screening

processes and [18] tests, it deals with every COBRA issue.

[19] **MS. VANCE:** I disagree.

[20] **MR. PARKER:** I join in the [21] objection.

[22] **MR. PARIS:** That's fine. Certainly [23] you will let the doctor answer the [24] question.

[25] **MS. VANCE:** Sure. Read it back.

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[2] (Thereupon, the requested portion of [3] the record was read by the Notary.)

[5] **MS. VANCE:** I object insofar as it [6] doesn't accurately reflect the presentation [7] of the patient.

[8] **A:** Can you define index of suspicion a little more [9] for me or not? Are you talking about [10] possibility or probability?

[11] Q: Tell me as an emergency room doctor how you [12] would define index of suspicion?

[13] **A:** That is an easier question for me to answer. If [14] I thought that there was a reasonable [15] possibility that the patient's complaint was [16] related to the heart, and I did not think that [17] it was a problem which came from another system [18] such as the gastrointestinal system, and in that [19] same patient the, over the course of treatment I [20] had no other information which changed my [21] thinking, and in that same patient the original [22] electrocardiogram was normal, then I think it [23] would be appropriate to do serial cardiograms.

[24] Q: Same response as it relates to serial cardiac [25] isoenzymes?

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[1] **A:** Right.

[2] **Q:** Why is it necessary for you before doing those [3] tests or ordering those tests, why is it [4] important for you in that setting not to think [5] that complaints would be from GI?

[6] Why wouldn't it be sufficient if you have a [7] reasonable possibility that the patient's [8] complaints is related to the heart solely to run [9] those tests?

[10] **A:** Well, I think I mentioned that over time, a [11] patient — let's describe a patient over time. [12] A patient with an initial chief complaint which [13] makes you think there is a reasonable [14] possibility that it's cardiac comes in and you [15] evaluate that patient and you order an [16] electrocardiogram and you give the patient [17] something to try to relieve their pain.

[18] If you're leaning towards heai-t problems, [19] you may order nitroglycerin. If you're leaning [20] toward gastrointestinal problems, you may give [21] an antacid preparation and the cardiogram comes [22] back normal and the pain either doesn't go away [23] with the nitro or does go away with the antacid [24] preparation, and then you get more history which [25] leads you to think more about the stomach.

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[1] In that particular case you may decide this [2] is gastrointestinal and not rule —

[3] Q: How do you rule out acute MI, Doctor?

[4] **A:** If you use, if the word rule out means 100 [5] percent, and the cardiogram is normal, you'd [6] probably have to do either angiography or I [7] guess sensitivity of thallium scanning is [8] better, but the 100 percent rule out would be a [9] biopsy of the heai-t muscle itself.

[10] Q: As a diagnostician, how do you rule out MI?

[11] **MR. PARKER:** I'm real confused [12] whether the scenario you're positing is for [13] the patient's care both in an emergency [14] room setting and on a floor or are we [15] talking hypothetically about an emergency [16] room setting only? Because I'm confused.

[17] **MR. PARIS:** I'm in the emergency [18] room now.

[19] Q: How do you rule out acute MI?

[20] **A:** In the emergency department? I don't know.

[21] Q: Have you ever?

[22] **A:** I don't think so.

[23] Q: What steps do you take to assist the patient's [24] evaluation so that acute MI is ruled out?

[25] **MR. PARKER:** I'm going to object.

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[1] I think that goes into standard of care and [2] I also think it's presupposing a function [3] on an emergency room that I'm not sure an [4] emergency room has.

[5] **MR. PARIS:** It deals with [6] appropriate medical testing.

[7] **MS. VANCE:** I'm going to object as [8] well.

[9] **MR. PARIS:** It deals with [10] stability. It deals with a determination [11] of an emergency medical condition. These [12] are all COBRA issues, folks.

[13] **MR. PARKER:** That wasn't the basis [14] of my objection. If you listened to my [15] objection, you are presupposing a role for [16] an emergency room that has not been [17] established is the role for the emergency [18] room, that is to completely rule out a [19] patient's medical condition. I think [20] that's a gross —

[21] **MR. PARIS:** I didn't say that [22] though.

[23] **MR. PARKER:** That is what your [24] question presupposes and that is the basis [25] of my objection.

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[1] **MR. GORDON:** That's good. Can the [2] doctor answer the question?

[3] **MR. PARIS:** Could you read it back?

[5] (Thereupon, the requested portion of [6] the record was read by the Notary.)

[8] **MS. VANCE:** Join in all those [9] objections.

[10] **A:** There are numerous approaches to that. One [11] approach is to seek consultation and have the [12] patient cared for by another physician in an [13] inpatient setting.

[14] Another approach is one in which over a [15] period of time further testing can be done [16] either in an emergency room department that is [17] set up to do that, or in another intermediate [18] cart: setting which is set up to do that which [19] may be located near the emergency department or [20] on the floor, commonly termed an observation [21] unit.

[22] Other than that, I don't think there's any [23] way to rule out an acute MI. All one can do is [24] make a determination that it is just two [25] unlikely an event that does not warrant further

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[1] evaluation.

[2] Q: Did Dr. Barron entertain a differential [3] diagnosis of myocardial infarction for Thelma [4] Lloyd?

[5] **A:** I don't think I know that answer.

[6] Q: Did you read her deposition?

[7] **A:** Yes.

[8] Q: Did she, she so testified.

[9] **MS. VANCE:** If you want him to, [10] refer him to a particular page to assist [11] him. He has read it.

[12] Q: I want to know whether you have a recollection [13] of that or not.

[14] **A:** I don't have a recollection of her specific [15] words.

[16] Q: Did Dr. Barron's differential diagnosis include [17] chest pain cardiac versus GI?

[18] **A:** Yes.

[19] Q: Was that appropriate?

[20] **A:** I thought that was appropriate.

[21] Q: Did Dr. Barron order CPK and cardiac [22] isoenzynies?

[23] **MS. VANCE:** Objection.

[24] **A:** It is my memory that at some point in the [25] emergency room a CPK was ordered.

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[1] Q: And cardiac isoenzymes?

[2] **A:** I don't know about that.

[3] Q: Did you read her deposition in that regard?

[4] **A:** I read her deposition.

[5] Q: I want you to assume that Dr. Barron indicated [6] she ordered CPK and cardiac isoenzymes.

[7] Will you assume that to be true?

[8] **A:** Sure.

[9] **MS. VANCE:** I will object to the [10] assumption insofar it is not supported by [11] the totality of the facts in this case.

[12] Q: Would the action by Dr. Barron in entertaining [13] the differential diagnosis of chest pain cardiac [14] versus GI, and ordering CPK and cardiac [15] isoenzymes be appropriate in the face of a [16] patient with significant cardiac — risk factors [17] for cardiac, for coronary artery disease and [18] chest pain?

[19] **MS. VANCE:** Can you reread the [20] question?

[21] **MR. PARIS:** I'll withdraw that.

[22] Q: Did Dr. Barron appropriately order CPK and [23] cardiac isoenzymes in an effort to rule in or [24] rule out acute MI?

[25] **MS. VANCE:** I'm just going to

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[1] object and ask for clarification of the [2] term appropriate. In the context of a [3] COBRA analysis?

[4] Q: Was it appropriate to do that, to determine [5] whether or not an emergency medical condition [6] existed?

[7] **A:** I guess I don't think that the tests are [8] inappropriate but I wouldn't say they are done [9] to determine if an acute emergency medical [10] condition existed.

[11] Q: Would ordering a CPK and cardiac isoenzymes be [12] an appropriate test to order if you were trying [13] to rule in or rule out an acute MI?

[14] **MS. VANCE:** Objection to the form [15] of the question.

[16] **A:** See, the answer is yes, it's okay to order the [17] tests, but the patient has to be evaluated over [18] time. So the test alone is only one small piece [19] of the picture.

[20] Q: There is no question. I just want to know if [21] that is a step in the right direction in ruling [22] in or ruling out an acute MI?

[23] **A:** We have the same problem with ruling in or [24] ruling out. But ordering the test is a step in [25] the right direction.

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[1] Q: And it's a seep in the right direction in trying [2] to determine whether or not the patient is [3] having an acute MI?

[4] **MR. PARKER:** Objection. Asked and [5] answered.

[6] **MS. VANCE:** Same objection.

[7] **MR. PARIS:** I didn't get an [8] answer.

[9] Q: Is the answer yes?

[10] **A:** I said it was an appropriate step to order as [11] long as it is not taken out of context.

[12] **MR. PARKER:** Four times now.

[13] Q: And can we agree, Doctor, that an acute [14] myocardial infarction is an emergency medical [15] condition?

[16] **MS. VANCE:** Objection.

[17] **A:** I think I documented acute myocardial infarction [18] would be considered an acute emergency medical [19] condition.

[20] **MR. PARIS:** Let's take a short [21] break.

[23] (Thereupon, a recess was had.)

[25] Q: Doctor, what condition or conditions was Thelma

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[1] Lloyd suffering from that were causing her [2] complaints and symptoms at St. Luke's Hospital [3] on December 17, 1990?

[4] **A:** You're asking me for my opinion of what was [5] bothering her?

[6] Q: Yes. I want to know in your opinion what [7] conditions or condition she was suffering from [8] that were causing her complaints and symptoms.

[9] **MS. VANCE:** I object. I think it [10] goes beyond the scope of what this witness' [11] testimony is intended to be about in terms [12] of what COBRA requires.

[13] **MR. PARIS:** It goes to emergency [14] medical condition, stability.

[15] **MR. PARKER:** I join in the [16] objection.

[17] Q: Do you know, Doctor?

[18] **A:** Well, yes, in looking at that, I do have an [19] opinion.

[20] Q: What is your opinion?

[21] **A:** I think she was suffering from some esophageal [22] reflex.

[23] Q: Anything else?

[24] **A:** Not on the 17th of — I'm sorry, I forgot the [25] month.

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[1] **MR. GORDON:** December.

[2] **A:** December.

[3] **Q:** December 17, 1990?

[4] **A:** Correct.

[5] **Q:** Do you have an opinion based upon a reasonable [6] degree of medical certainty as to the cause of [7] her elevated CPK?

[8] **MS. VANCE:** Same objections.

[9] **A:** I've never looked at that. I don't know.

[10] Q: You are aware that she had an elevated CPK, is [11] that correct?

[12] **A:** I'm aware that the CPK number from the lab was [13] elevated according to that particular lab, yes.

[14] Q: You are aware that her LDH was elevated?

[15] **A:** I do. I didn't pay much attention to that. I [16] think that is true, too.

[17] Q: And her AST?

[18] **A:** Right.

[19] **Q:** Do you know the significance of those [20] elevations?

[21] **A:** The CPK is for muscle. The other two are more [22] nonspecific and in general any organ can cause [23] elevation. So I have no opinion about the other [24] elevations.

[25] Q: Do you know the significance of those three

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[1] values being elevated in the face of a patient [2] having chest pain with significant coronary [3] ai-tery disease risk factors?

[4] **A:** No, I don't.

[5] Q: Did any of the physicians on the general floor [6] perform one test to rule in or rule out an acute [7] MI of Thelma Lloyd?

[8] **MS. VANCE:** Objection.

[9] **MR. PARKER:** Objection.

[10] **A:** Are you referring to either further enzyme [11] testing or electrocardiographic testing?

[12] Q: Any test that you feel would be appropriate to [13] rule in or rule out an acute MI.

[14] **MS. VANCE:** Object. Assumes facts [15] not in evidence.

[16] **MR. PARKER:** Join.

[17] **MS. VANCE:** It makes assumptions [18] about what should or should not have been [19] appropriately done in that scenario and in [20] that situation.

[21] **A:** I don't remember any specific tests that related [22] to myocardial infarction.

[23] Q: When she came in — strike that.

[24] Were her vital signs stable on the [25] emergency ambulance run in any of the documents

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[1] that you have? This should not be a guessing [2] game for you, Doctor.

[3] **A:** It can't be because I don't guess very well.

[4] **MR. GORDON:** Here, let me help [5] you.

[6] **A:** Thank you.

[7] Q: What were her vital signs?

[8] **MS. VANCE:** In the ambulance?

[9] **A:** Yes. In the ambulance. Cuyahoga County EMS [10] run, I think dated 17 December, she had a blood [11] pressure of 108 systolic over something [12] diastolic. I don't know what.

[13] Q: Is that P?

[14] **A:** It means palpable. The pulse was 80 and [15] respirations was 20.

[16] Q: Is that normal?

[17] **A:** Cei-tainly can be.

[18] Q: What are the normal ranges?

[19] **A:** Well, for — I'm not sure. Normal ranges for [20] what? For patients of this age riding in [21] ambulances or for patients of this age or for [22] all humans?

[23] Q: How would you make a determination of whether or [24] not this was a normal vital sign for this [25] person?

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[1] **A:** By doing a history and physical examination.

[2] Q: Based on what you know about this patient, based [3] on the history and the physical exam that was [4] performed by others, do you have an opinion as [5] to whether these vital signs are normal?

[6] **A:** Yes.

[7] Q: And what is your opinion?

[8] **A:** That they are totally normal. They're fine.

[9] Q: In the emergency room, are you aware of what her [10] vital signs were?

[11] **A:** I have to look that up, too.

[12] Q: I think I saw a blood pressure of 130 —

[13] **MR. GORDON:** Page 24, Doctor.

[14] Q: 130 over 90? I think that appears there.

[15] **A:** On that page I see 130 over 90.

[16] Q: How does that compare to her prior blood [17] pressure?

[18] **A:** Well, a systolic increase of 22 points.

[19] **Q:** What is the significance of that?

[20] **A:** None that I'm aware of.

[21] Q: There's no change or divergence there between [22] the two blood pressures?

[23] **A:** Absolutely. There is a 22 point systolic [24] difference.

[25] Q: One would not be normal and one would not be

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[1] abnormal, they are both normal?

[2] **A:** They are both within normal limits.

[3] Q: Anybody check her pulse or respiration?

[4] **A:** Well, there's a pulse of 64 written down and a [5] respiration rate of 16.

[6] Q: Is that stable?

[7] **A:** Well, it represents a change in pulse of 16 and [8] a change in respiratory rate of four.

[9] Q: But is it stable?

[10] **A:** Strict technical definition of instability [11] meaning change over time that one thinks is [12] significant, I think it's stable.

[13] Q: Is it nornlal?

[14] **A:** Yes.

[15] **Q:** So in the ambulance, her vital signs are normal [16] and stable? I don't want to misquote you.

[17] **A:** You would be misquoting me if you said that.

[18] Q: In the ambulance, are her vital signs normal?

[19] **A:** Yes.

[20] **Q:** Are they stable?

[21] **A:** I don't know.

[22] Q: You don't know because you don't have anything [23] to compare it to?

[24] **A:** Right.

[25] **Q:** In the emergency room, are her vital signs

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[1] normal?

[2] **A:** Yes.

[3] **Q:** Are they stable?

[4] **A:** Now I'd have to look further to see if they were [5] taken again.

[6] Q: In the emergency room, is that what you're [7] saying?

[8] **A:** Right. If you're just looking at that, if you [9] have in the emergency department the information [10] from the ambulance, then you have two sets of [11] vital signs. Normally you do have such a [12] thing.

[13] Q: Look at page 10 or 11, Doctor. I don't have [14] anything else in the emergency room.

[15] **A:** There's your page number 30, St. Luke's [16] Hospital.

[17] Q: That is the history and physical?

[18] **A:** Yes.

[19] Q: That's up on the floor?

[20] **A:** I am just asking you.

[21] Q: That's up on the floor. Is there anything else [22] in the emergency room that you were able to spot [23] that would give us an indication of —

[24] **A:** I would like to look at one more sheet of paper [25] and that is the physician's record in the

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[1] emergency department.

[2] **MR. GORDON:** That's it right [3] there. Page 24.

[4] **A:** All right. Okay. I do not see anything on this [5] particular sheet which indicates anything [6] further as to blood pressures or pulses.

[7] **Q:** If her blood pressure by, let's say, 1:30 in the [8] morning was 130 over 65, would that indicate [9] that that was normal and stable?

[10] **A:** Right.

[11] Q: Can you have an emergency medical condition, [12] Doctor, and still have vital signs that are [13] normal?

[14] **MS. VANCE:** Objection. Again [15] you're using the phrase as it is defined in [16] the COBRA statute?

[17] Q: What do you understand emergency medical [18] condition to mean, Doctor?

[19] **MS. VANCE:** It is your question.

[20] Q: I would like to know what your understanding is, [21] Doctor.

[22] **A:** You want to know what my definition of an [23] emergency. medical condition is? Any condition [24] which prompts a patient to come in to the [25] emergency department to seek advice or care.

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[1] Q: Would that include a condition which if left [2] untreated would in all likelihood lead the [3] patient to some serious health problems?

[4] **MS. VANCE:** Objection.

[5] **MR. PARKER:** I join in the [6] objection.

[7] **MS. VANCE:** If you're quoting the [8] COBRA statute, why don't you do so [9] accurately.

[10] **MR. PARIS:** I am not trying to do [11] so.

[12] Q: I would just like to know if that would include [13] that scenario.

[14] **A:** If your scenario was a condition which prompted [15] a patient to come in to the emergency [16] department, yes.

[17] Q: Can one under that definition, Doctor, an [18] emergency medical condition, have vital signs [19] that are normal?

[20] **A:** Yes.

[21] Q: And —

[22] **A:** Excuse me, I'm sorry, nlay I ask you a question? [23] I'm not sure I understood your question. Under [24] what condition? Under my definition?

[25] Q: Did you accept my addition to your definition?

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[1] **A:** I had a very broad definition and you had one [2] that was a subset of that. I said if your [3] subset is what prompted the patient to come in, [4] yes, it was.

[5] Q: We are agreed on the definition then as between [6] ourselves for the purposes of this next [7] question.

MS. VANCE: Your subset?

MR. PARIS: Yes. Which includes my subset.

Q: Are we on the same wavelength?

A: I don't think so. Anything that prompts the patient to come into the emergency room, gunshot wound to the head or hangnail, it is an emergency medical condition to them. That is my definition.

Q: Can one have vital signs that are normal and still have an emergency medical condition?

A: Based on my definition, absolutely.

Q: Can one have vital signs that are stable and still have an emergency medical condition?

A: Yes.

Q: Doctor, how do you come by your knowledge of the COBRA law?

A: Well, I suppose the term osmosis might be a good

one. It is just a matter of having the responsibility for being director of a department and having read the literature which has come out with analysis of such law by various organizations to which I belong.

Q: Well, are you the house officer in charge of this hospital's compliance with COBRA?

A: Well, I'm not a house officer.

Q: I'm sorry. Are you the person at this institution who's in charge to insure that this institution complies with the COBRA laws?

A: I would say no.

Q: Who is at this institution, if anyone?

A: I would guess, and I'm not sure, but I would guess the institutional responsibility would probably lie with the hospital's counsel.

Q: And do I understand that the publications that you have read that have providedyou with this knowledge of COBRA includes the news letter that we're going to mark as an exhibit and the undisclosed publication by Attorney Krugh?

A: Correct, plus other materials and discussions.

Q: Have you attended any seminars?

A: I have never attended a seminar that related specifically to COBRA.

Q: Would you tell us what are the purposes of COBRA?

A: I think that you would have to ask Congress. I don't know but the original idea was a Congressional reaction to a perception that patients were being inappropriately transferred but it was referred to as dumping, quote, unquote, and Congress formulated what they thought was a law that tried to prevent this.

Q: Would you agree that one of the purposes of COBRA is to insure that poor patients without private doctors or without insurance or without wealth get the same standard of medical care as patients with insurance or with wealth or with private doctors?

MS. VANCE: Objection. I think you are confusing standard of care.

MR. PARIS: No, I'm not.

Q: Can you answer the question, Doctor?

MR. PARKER: I join in the objection.

A: I don'tthink I could tell you what was in Congress' mind when they formulated this thing.

Q: Would you agree that COBRA requires hospitals to conduct an appropriate screening test to

determine if the patient has an emergency medical condition?

MS. VANCE: Objection. You are misstating the statute.

Q: Would you agree with that?

A: I don't think that's what it says. That is my memory.

Q: What is your understanding —

MS. VANCE: Well, he's not —

Q: — of what that requirement is?

MS. VANCE: I don't think it is incumbent on him to quote the statute. If you have it before you, you can just rephrase your question.

Q: Doctor, tell me the elements which constitute COBRA violations based on your understanding of the law.

A: Based on my understanding, a failure to perform, to evaluate a patient and to dismiss that patient without such evaluation would be a violation.

A transfer of a patient from one institution to another without a screening evaluation would be a violation.

A transfer of an unstable patient in

certain circumstances could be a violation, if that transfer were done, at least originally the intent was for financial reasons, and I believe another element was that the patient had to suffer some harm in that transfer.

Q: Any other components relevant to COBRA that you're familiar with?

A: Well, the answer to that is yes but it's like asking me is there anything I'm familiar with in a text book. I can'trecite them. I'dhave to study it.

Q: Can we agree that COBRA requires that all tests, evaluations and transfers of a patient be conducted on the basis of needs of the patient, and not on whether the patient is a private paying patient or a poor Welfare recipient?

MS. VANCE: Objection.

Q: Can we agree on that?

A: I think in general we could agree but I'm not sure, you use the word all tests, and every time the word all is thrown in, I will withdraw and say I'm not sure about all.

Q: Same question, I'll rephrase the question.

Would you agree that COBRA requires that tests, evaluations and transfers of a patient be

conducted on the basis of the needs of the patient?

A: The medical needs of the patient.

Q: Yes, the medical needs.

A: Yes.

Q: And not on whether the patient is a private paying patient as opposed to a poor Welfare recipient, would you agree with that?

MS. VANCE: Objection to the form of the question.

A: I'm not sure I can agree with that because I think they don't even have to be Welfare recipients. I think they could just be people without any money.

So I don'tthink — as I remember, it didn't single out alleged mistreatment of Welfare people.

Q: So people without funds, is that right?

A: Yes.

Q: People without private doctors?

A: There could be people, yes.

Q: Are you familiar with the penalty set forth in COBRA?

A: I don'tremember the number but I think there's some per incident which is moderately

substantial. I don'tknow whether it is $10,000 or $50,000.

Q: Are you familiar with any penalties that is associated with the hospital's receipt of or participation in Medicare or Medicaid programs?

A: Yes.

Q: What are the penalties?

[8] **A:** Well, if, I think if an appeal is lost, it is [9] possible for a hospital to lose its affiliation [10] with Medicare. I don't remember Medicaid. But [11] I'm sure Medicare.

[12] Q: Doctor, would an acute myocardial infarction in [13] a patient constitute a medical condition which [14] could be reasonably expected to result in [15] placing that patient's health in jeopardy if [16] left untreated?

[17] **MS. VANCE:** Objection. Either [18] restate the question or read it.

[20] (Thereupon, the requested portion of [21] the record was read by the Notary.)

[23] **MS. VANCE:** Object to the form of [24] the question, particularly in light of [25] COBRA, insofar as it is taking into

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[1] consideration diagnoses that was not then [2] known or appreciated.

[3] **MR. PARKER:** I object as well.

[4] **A:** I need to answer your question in this [5] particular way. You said if left untreated, and [6] I believe that patient's health would be in [7] jeopardy if complications of an acute myocardial [8] infarction were left untreated.

[9] Leaving the MI itself untreated may not [10] necessarily change anything in terms of the [11] patient's health or future health.

[12] Q: Well, are some of the dangers in leaving an [13] acute myocardial infarction untreated, at least [14] which are foreseeable, are those that relate to [15] extension of the MI?

[16] **MS. VANCE:** Objection.

[17] **A:** The answer to that is yes.

[18] Q: And reinfarction?

[19] **A:** I don't know the answer to that. I don't know [20] whether reinfarction —

[21] Q: But certainly extension, is that right?

[22] **A:** Extension is one of the complications.

[23] Q: It is more likely than not, is it, Doctor, that [24] an untreated acute MI will — strike that.

[25] Are patients who have an acute MI more

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[1] likely to have a better prognosis with admission [2] to a coronary care unit and access to the full [3] range of cardiac care than with being sent home [4] to exert themselves and receiving no treatment [5] at all?

[6] **MS. VANCE:** Objection.

[7] **MR. PARKER:** Objection.

[8] **MS. VANCE:** Incomplete statement of [9] the facts. Doesn't accurately reflect the [10] presentation of the patient.

[11] Q: As a general proposition, Doctor, would you [12] agree with me?

[13] **MS. VANCE:** Objection,

[14] **A:** Yes.

[15] Q: Does this institution have any regulations [16] related to CQBRA?

[17] **A:** I believe we have, we have some. They're [18] probably, for our purposes in the emergency [19] department, related to a checklist for [20] transfers.

[21] Q: Including discharge, is that right?

[22] **A:** No.

[23] **Q:** Do you consider a transfer discharge?

[24] **A:** Not that I know of.

[25] Q: Do you consider a discharge a transfer?

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[1] **A:** No.

[2] **Q:** Is it your understanding that — strike that.

[3] Did Thelma Lloyd have any clinical evidence [4] of an acute MI on December 17, 1990?

[5] **A:** Not any more so than clinical evidence of other [6] disease processes.

[7] Q: GI disease processes?

[8] **A:** Correct.

[9] **Q:** It was both equally the same?

[10] **A:** I'm not sure what that question means.

[11] Q: You said not any more so than other disease [12] processes being GI, I suppose?

[13] **A:** My answer is that her symptomatology could have [14] been caused by GI but probably more so than [15] myocardial infarction, if you add in some of the [16] other findings over time.

[17] Q: By how much percentage wise?

[18] **A:** I can't give it a percent.

[19] Q: One percent cardiac, *99* percent GI?

[20] **MS. VANCE:** Objection.

[21] **MR. PARKER:** Objection.

[22] **MS. VANCE:** He said he can't do [23] that.

[24] **A:** I don't know.

[25] Q: You can't give us any measurement, any

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[1] quantitative measurement at all?

[2] **A:** No.

[3] **Q:** Based on her clinical presentation?

[4] **A:** More likely than not.

[5] Q: It could be 51 percent GI, *49* cardiac?

[6] **MS. VANCE:** Objection.

[7] **A:** More likely.

[8] **MR. PARKER:** Objection.

[9] **MS. VANCE:** He stated he cannot do [10] that.

[11] Q: It is your understanding more likely than not in [12] the medical/legal context is anything over 50 [13] percent?

[14] **A:** I think that is the system you people use.

[15] Q: And what is the basis of your opinion that [16] Thelma Lloyd did not have an acute MI or was not [17] suffering the effects of an acute MI when she [18] presented at St. Luke's on December 17, 1990?

[19] **A:** There are several things. She did not have a [20] tachycardia. She did not have any arrythmia [21] that was significant. She may have had an extra [22] breath. I don't know the answer to that.

[23] No significant arrythmia. She had pain [24] that was alleviated by antacids. She had no [25] response to nitroglycerin.

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[1] **MR. GORDON:** Did you say no [2] response?

[3] **A:** No significant pain relief from nitroglycerin, [4] and if one reviews — well, I don't remember, I [5] was going to say if one reviews the autopsy, but [6] I guess I don't remember what the autopsy [7] shows. So give me a moment to take a look at [8] that.

[9] Oh, yes. Autopsy revealed extensive recent [10] myocardial infarction *24* to *48* hours old.

[11] Q: Absent the autopsy, Doctor, and on a clinical [12] basis, have we discussed all of your opinions [13] why you don't believe she had an MI while, she [14] was suffering from an acute MI while at St. [15] Luke's Hospital?

[16] **A:** All I can think of right now.

[17] Q: Do you know why, Doctor, her chest —

[18] **A:** Excuse me. You asked the question so I thought [19] of something else.

[20] Q: Okay.

[21] **A:** As I remember, although I didn't see the x-rays, [22] I told you I didn't, that the x-rays were [23] consistent with esophageal reflex.

[24] *Q:* The GI series?

[25] **A:** The GI series, correct. That is the other

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[1] thing. I'm sorry to interrupt.

[2] Q: That is why you feel she did not have an acute [3] MI?

[4] **A:** That whole list of reasons.

[5] Q: Doctor, what was the reason that her chest pain [6] returned after she was given antacids?

[7] **A:** I don'tthink we know the answer. I don'tknow [8] the answer to that.

[9] Q: Do you know what her response was on the second [10] time she was given sublingual nitro?

[11] **A:** No, I don't.

[12] **Q:** Would it affect your opinion if she received [13] questionable relief?

[14] **MS. VANCE:** You're referring to St. [15] Luke's or now you're referring to [16] Metropolitan?

[17] **MR. PARIS:** St. Luke's. I'm on [18] December 17,1990.

[19] **A:** No, it would not.

[20] Q: Would it affect your opinion if her chest pain [21] came back after she was given antacids?

[22] **A:** No.

[23] **Q:** And I take it her elevated LDH, CPK and AST have [24] no significance to you in your opinion that she [25] was not suffering an acute MI, is that right?

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[1] **A:** That is correct.

[2] Q: Doctor, is it a violation of COBRA to elect not [3] to review a patient's laboratory studies because [4] she is a staff patient as distinguished from a [5] private patient?

[6] **MS. VANCE:** Objection. It [7] misstates the fact. It misstates Dr. Bass' [8] testimony. It is not what the record in [9] this case would present.

[10] Q: Assume that could be true.

[11] **A:** If I assume that, I do not feel that is a [12] violation of COBRA.

[13] Q: Do you consider that to be providing a separate [14] system of medical care based upon the [15] classification of a patient?

[16] **MS. VANCE:** Objection, all the [17] reasons previously stated. It is an [18] incomplete recitation of facts relating to [19] this case.

[20] **A:** I'm not sure what you mean. Could you ask the [21] question differently?

[22] Q: All right. Does a COBRA violation encompass [23] providing a separate diagnostic and treatment [24] approach to a patient based upon their [25] designation as a staff patient versus their

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[1] designation as a private patient?

[2] **MS. VANCE:** Objection. [3] Incomplete. It is not what the record [4] shows.

[5] **A:** I don't know how to answer the question.

[6] **Q:** Why?

[7] **A:** Well, because I'm not sure what you mean by [8] separate diagnostic and treatment approach. If [9] you are saying that patients who are insured can [10] receive some life saving diagnosis or therapy, [11] and patients who are not insured will have that [12] deliberately withheld, then I would say that [13] probably would be a violation.

[14] If you're saying that private patients [15] aren'tcared for by private physicians and staff [16] patients are treated by a team, then I don't [17] think that is any violation or anything to do [18] with COBRA.

[19] Q: Do you have a designation in this hospital [20] between staff patients and private patients?

[21] **A:** Yes.

[22] Q: And who, how are they categorized? Who [23] comprises the staff patients in this hospital?

[24] **A:** Staff patients are patients that do not have a [25] relationship with a private physician that is on

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[1] the staff of this hospital.

[2] Q: Anybody else or is that it?

[3] **A:** This is the end of the definition.

[4] Q: Private patients are who?

[5] **A:** Patients who have a relationship with a private [6] physician that is on the staff of this hospital.

[7] Q: A physician at this hospital, I want you to [8] assume that a physician at this hospital is [9] assigned a staff patient, and because the person [10] is a staff patient, this attending physician [11] consciously elects not to review the patient's [12] laboratory studies, whereas he would review the [13] patient's laboratory studies if it was his own [14] private patient, and the staff patient was then [15] discharged without having the labomtory studies [16] looked at by the attending physician.

[17] Does that conduct constitute a COBRA [18] violation in your opinion?

[19] **MS. VANCE:** Objection.

[20] **A:** No.

[21] **Q:** What does that constitute, if not a COBRA [22] violation?

[23] **A:** It is a system of health care in which an [24] attending physician has a relationship with [25] physicians who are in training in that

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[1] particular specialty and it'sa different [2] communication methodology. It is nothing more.

[3] Q: Do you work with residents and interns in the [4] emergency room?

[5] **A:** Every day.

[6] **Q:** Do you review their work?

[7] **A:** It depends on your definition of review their [8] work.

[9] Q: Well, I mean do you allow them to make life and [10] death decisions without any input?

[11] **A:** I don't think they make, I don't think they make [12] any decisions without any input. But whether [13] the input is general or specific to that [14] particular patient, it varies with each patient.

[15] Q: Well, if one of the interns or residents that [16] you're working with orders a test, do you review [17] it with them?

[18] **A:** Not necessarily.

[19] Q: Under what circumstances would you not review a [20] test that was ordered by an intern, resident on [21] a patient of yours?

[22] **A:** If their laboratory values, they just ask them [23] if they're normal or not.

[24] Q: Why? Why would you rely on them?

[25] **A:** Because it's a very reasonable thine. to do, to

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[1] rely on another physician to communicate to you [2] written information.

[3] Q: How do you teach them if they're right or wrong?

[4] **A:** In terms of being able to read? That part is [5] taken care of in the high schools and in [6] colleges and in medical school in terms of [7] looking at tests and interpreting results. That [8] is not part of the educational process in the [9] medical post-graduate system anywhere in the [10] country.

[11] Q: You don't consider correlating laboratory [12] studies with a clinical presentation important [13] to the teaching process?

[14] **MS. VANCE:** Objection.

[15] **MR. PARKER:** That is different from [16] your previous question.

[17] **A:** My answer is yes, sure, I do.

[18] Q: And is it important to review those laboratory [19] data with your students to correlate the [20] clinical complaints with the laboratory data?

[21] **A:** It is not necessarily important that I myself [22] look at a piece of paper and see, for instance, [23] that a white count is 10,800 if they told me [24] that the white count is 10,800.

[25] **MR. PARIS:** Let'stake a break.

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[2] (Thereupon, a recess was had.)

[4] Q: Doctor, what was causing Thelma Lloyd — was her [5] EKG normal or abnormal? Did you read the [6] tracing?

[7] **A:** Oh, I did. I have to kind of glance at that [8] again. I have to find it real quick. As I [9] remember, it was slightly

abnormal. It had one [10] premature ventricular contraction.

[11] Q: What was causing that?

[12] **A:** I don'tthink anybody knows why patients have [13] premature ventricular contiactions in an [14] individual patient but they're very common and [15] one is not considered to be of significance.

[16] So you have no, it doesn't mean anything [17] one way or the other. There was no acute [18] changes on the electrocardiogram.

[19] There was one millimeter of ST segment [20] depression, and one millimeter is not considered [21] significant.

[22] Q: Do you know what was causing that?

[23] **A:** It is a normal variant but a lot of ST segment [24] depression is abnormal.

[25] Q: But this was not an abnormal ST?

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[1] **A:** This was not an abnormal ST segment depression, [2] so I would say the same thing. There are some [3] abnormalities or variance but no acute changes.

[4] ***Q:*** Are you familiar with the term non-Q wave [5] infarction?

[6] **A:** Yes, I have heard that before.

[7] Q: Is this EKG compatible with a non-Q wave [8] infarction?

[9] **MS. VANCE:** Objection.

[10] **A:** My answer is all EKGs without Q waves are [11] compatible with non-Q wave infarction.

[12] Q: Is this an abnormal EKG?

[13] **A:** Yes. I think I said that.

[14] Q: I understand, Doctor, forgive me if I'm being [15] redundant, does an esophageal reflex cause [16] elevated CPKs?

[17] **A:** You did not ask that I remember and I don't [18] know.

[19] Q: Have you ever given testimony regarding COBRA [20] violations prior to today?

[21] **A:** I have not.

[22] Q: This is the first time you've been asked?

[23] **A:** Yes, sir.

[24] Q: Turning to your report, top of the second page, [25] and before I specifically get to that question,

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[1] why is it, Doctor, that you feel qualified to [2] speak to the COBRA issues in this case?

[3] **A:** Well, because I've been practicing emergency [4] medicine as an emergency medicine departmental [5] director for 18 years, and because I have served [6] as president of the American College of [7] Emergency Physicians and president of the Ohio [8] Chapter of Emergency Physicians and during that [9] course of time have had enumerable meetings with [10] both the Government Affairs Committee of our [11] college and our chairman of the college and am a [12] regular recipient of materials that are [13] published by the Government Affairs section of [14] the American College of Emergency Physicians, [15] many of which reference changes in law of all [16] kinds that relate to emergency medicine, and [17] many of those relate to COBRA and its [18] implication for the practice of emergency [19] medicine.

[20] Q: And can you tell me why in your opinion there [21] was no COBRA violation in this case?

[22] **A:** Yes, my opinion is that Congress, when they [23] wrote the law, were nonspecific and left the law [24] open to interpretation, because they just had no [25] concept of what they were trying to do.

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[1] That is my opinion. And that's one of the [2] reasons we're sitting here today.

[3] However, what the main issue that I felt [4] that Congress wanted to deal with was [5] Representative Stark's concern about, A, getting [6] re-elected; and B, stopping patient dumping.

[7] The way he wanted to stop patient dumping, [8] especially for people who were uninsured or [9] underinsured, was to mandate that patients have [10] an evaluation.

[11] I do not believe it was the intent of [12] Congress now or then to mandate that all [13] possible disease processes be totally and [14] completely evaluated prior to the patient being [15] cared for in another setting.

[16] Q: And why is it specifically that you feel that [17] there was no COBRA violations involving Thelma [18] Lloyd?

[19] **A:** Very specifically because not only did she have [20] a physical exam in the emergency department, but [21] she was kept in the hospital for an evaluation [22] over several more hours, it was approximately [23] 24, and at that time had no significant change [24] in her vital signs, did not go into shock, did [25] not develop arrythmia which produced cvanosis.

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[1] did not develop any significant issues like [2] nausea, vomiting, diarrhea, intractable pain, [3] none of those things happened. She pretty much [4] remained the same. She was stable and they [5] proved it in spades.

[6] Q: Who proves it?

[7] **A:** The interns and the doctors that were taking [8] care of her.

[9] Q: How did they prove it?

[10] **A:** My answer to that would be would be read back, [11] just print it again.

[12] **Q:** All right. Fine. So then do I understand, [13] Doctor, it is your opinion that St. Luke's [14] Hospital conducted an appropriate medical [15] screening test for Thelma Lloyd?

[16] **A:** Absolutely.

[17] Q: And it was reasonable?

[18] **A:** Absolutely.

[19] **Q:** Do I understand it is also your opinion that St. [20] Luke's Hospital — strike that — that a [21] determination was not made that she was [22] suffering from an acute MI on 12/17/90?

[23] **A:** The decision to focus in on gastrointestinal [24] disease as part of her problem was made after [25] the evaluation based on the physician's judgment

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[1] and some tests that they had done. That to me [2] has nothing to do with COBRA.

[3] Q: I take it it is your opinion she was not [4] suffering from an emergency medical condition [5] while she was at St. Luke's Hospital?

[6] **A:** Correct.

[7] **Q:** And that there was no need for St. Luke's [S] Hospital to do anything to stabilize her [9] condition before discharging her at 3:00 or *4:00* [10] on the 17th?

[11] **A:** Her condition was already stable so there was [12] nothing more to stabilize.

[13] Q: Do you know what the cause of her myocardial [14] infarction was subsequent to her discharge at [15] St. Luke's Hospital?

[16] **A:** I think it was atherosclerotic heai-t disease.

[17] Q: Was there any connection in your opinion, based [18] upon reasonable medical certainty, between any [19] conditions that she presented with at St. Luke's [20] Hospital, and her infarction after discharge?

[21] **MS. VANCE:** Objection.

[22] **A:** Well, I think I answered that by saying I [23] thought it was more likely than not that the [24] reflex was the cause of her pain on the 17th.

[25] So I guess the obverse of that is saying

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[1] that the myocardial infarction that she [2] suffered a couple of clays later was a [3] coincidental event.

[4] Q: With regard to the second page of your repoi-t, [5] Doctor, what do you mean by the first [6] sentence?

[7] **A:** The sentence that begins with the words "with [8] regards to"?

[9] Q: Yes. What do you mean by "unrecognized CPK dash [10] MP enzyme result"?

[11] **A:** I think what I meant, I remember something in [12] the deposition about the emergency physician not [13] being aware that that result was back. That is [14] what I was referring to.

[15] Q: So what you're referring to is Dr. Barron did [16] not recognize that CPK result?

[17] **A:** Correct.

[18] **MR. PARKER:** I'll object.

[19] **A:** That is what I was referring to.

[20] Q: What do you mean, was it your understanding Dr. [21] Bass was aware of that CPK enzyme result?

[22] **A:** I don't remember that. I'd have to look that [23] back up.

[24] Q: What do you mean by the next sentence, "the [25] absolute value of that number does not effect

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[1] the fact that the patient was stable and quite [2] comfortable while an inpatient"?

[3] **A:** If the CPK were a billion or zero, that doesn't [4] detract from the fact of stability and that's [5] what we're talking about when we're talking [6] about COBRA.

[7] Q: So that I understand that if her CPK was, as you [8] said, a billion, that would not render her, in [9] your opinion, unstable?

[10] **A:** That's right, exactly right.

[11] Q: Given this presentation of the patient?

[12] **A:** That's right.

[13] Q: And that is because she appeared to be quite [14] comfortable while an inpatient, is that [15] right?

[16] **A:** Yes. Right. All of the things I said [17] before.

[18] Q: You indicate that you have a feeling that had [19] additional CPKs been done later, the results [20] would have been normal or more towards normal, [21] is that right?

[22] **A:** Correct.

[23] Q: What do you mean by feeling?

[24] **A:** Well, because I felt that the patient, the [25] patient's problem was probably from esophageal

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[1] reflex and because as I indicated to you [2] earlier, I didn't know whether that would [3] produce this mild elevation in the CPK, and [4] because it is possible eo have CPK elevations [5] from minor events like a venipuncture, if you [6] injure some muscle, that repeating the test [7] would have in retrospect, in my opinion, [8] probably not been more elevated.

[9] Q: So when you say feeling, you're talking about a [10] reasonable degree of medical certainty, an [11] opinion?

[12] **A:** Right.

[13] Q: Is it your opinion, Doctor, that Thelma Lloyd's [14] elevated CPK was from some injury to the muscle [15] when she got the venipuncture?

[16] **A:** No. I think I said I didn't know what her CPK [17] reading was.

[18] Q: Have you ever gone to law school, Doctor?

[19] **A:** No.

[20] Q: Have you ever taken any law courses?

[21] **A:** No. Would you like to know if I want ever to do [22] that? I can answer you that.

[23] **MR. GORDON:** Yes, I would like to [24] know that.

[25] **A:** No.

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[1] **MR. PARIS:** I don't have any [2] further questions.

[3] **MR. PARKER:** I have very few [4] questions, just to make sure.

[6] CROSS-EXAMINATION OF BRUCE JANIAK, M.D.

[7] **BY MR. PARKER:**

[8] **Q:** Did I understand laboratory tests for LDH is [9] nonspecific for cardiac conditions?

[10] **A:** That's what I'm telling you. That is my [11] understanding of it, too. I don't use it and my [12] colleagues don't use it. Our cardiologists [13] don't come down and order it.

[14] So if all that's true, then I don't think [15] we'd be using it for myocardial infarctions.

[16] Q: Is the same thing true for AST, it is [17] nonspecific?

[18] **A:** That's right.

[19] Q: When the materials you reviewed, do you know if [20] the CPK results were available to Dr. Barron, [21] the ER physician, while Thelma Lloyd was still [22] in the emergency room?

[23] **A:** I don't know. I'm not sure what you mean by [24] available. I don't think she had them as near [25] is my memory.

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[1] Q: Do you know, do you even know if the CPK test [2] had been run?

[3] **A:** I do not know that.

[4] Q: I believe I heard you indicate that in your [5] opinion there was nothing in Thelma Lloyd's [6] emergency room records eo suggest that her [7] gastric condition was life threatening?

[8] **A:** Correct.

[9] Q: Was there anything in Thelma Lloyd's emergency [10] room records to indicate she was suffering a [11] cardiac condition which appeared life [12] threatening at that time?

[13] **A:** There was not.

[14] **MR. PARKER:** That's all I have.

[16] CROSS-EXAMINATION OF BRUCE JANIAK, M.D.

[17] **BY MR. PARIS:**

[18] **Q:** Do you know why the physicians, pathologists and [19] labomtory people at St. Luke's Hospital utilize [20] AST, LDH?

[21] **A:** I have no idea.

[22] Q: When you're ordering a CPK and cardiac [23] isoenzymes from the emergency room, is it your [24] custom and habit to order them, I think you told [25] me it is your custom and habit to order them

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[1] stat, is that right?

[2] **A:** The way I characterized that any test that we [3] order in our department is automatically stat. [4] So we don't write the word stat or say the word [5] stat.

[6] Q: How do you facilitate getting that requisition [7] over to the lab?

[8] **A:** It's done by computer.

[9] Q: You order it via the computer?

[10] **A:** Well, I tell, I write it down on the emergency [11] record or check a box, depending on which [12] desk it is, and a clerk types it into a [13] computer.

[14] Q: And it automatically goes to the lab?

[15] **A:** To the lab, right.

[16] Q: Do you customarily document your ordering of the [17] CPK, I'm sorry, cardiac isoenzymes?

[18] **MR. PARKER:** I object.

[19] **A:** Yes, I do.

[20] Q: Why?

[21] **A:** If I don't write it down on the chart, nobody [22] would know that I wanted it. So there's not [23] much choice.

[24] To be fair, it's possible for me to [25] verbally do that, but it is just my habit to

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[1] write it down on the chart in the rare instances [2] when I do verbally do that.

[3] Q: What is the importance of having anybody else [4] know if you ordered it?

[5] **MR. PARKER:** Objection.

[6] **A:** I think the same, the same answer would be true [7] generically for documentation. It is always [8] better to document what you've done and what [9] you're thinking than it is not to document it, [10] and I recognize "we all would

do better with [11] documentation, that is true for all emergency [12] records, but in general you document all you can [13] document.

[14] *Q:* How does that come into play in the transfer of [15] the care of the patient from the emergency room [16] to the floor?

[17] **A:** It is another interesting question because, you [18] know, I'd like to tell you how critically [19] important it is, but I can't do that because of [20] the logistics of the way the pieces of paper go [21] up to the floor.

[22] Many times the emergency room record, which [23] is not yet dictated, doesn't arrive for *14* [24] hours. *So* much of this is done verbally and then [25] all of this material arrives.

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[1] So ideally I think it ought to be more [2] important than it is. Practically speaking, [3] there is a delay in our hospital. I can't speak [4] for every other hospital.

[5] Q: As a practical matter, when there is a delay in [6] this hospital of getting the written, your [7] written notes up to the floor for the continuity [8] of care of a patient, how do you impart that [9] information to the subsequent care giver? [10] Verbally?

[11] **A:** Yes, over the telephone, or in person, depending [12] on where the person is.

[13] Q: Why is that important to do?

[14] **MR. PARKER:** Objection.

[15] **A:** Well, I don't know that I can answer that. [16] That's so obvious.

[17] Q: Help me.

[18] **A:** Okay.

[19] **MR. PARKER:** Objection. I think [20] this is beyond COBRA.

[21] **A:** A physician who is accepting the care of a [22] patient from another physician usually will [23] benefit from some knowledge about the initial [24] thought process and diagnostic and treatment [25] activities that the original first physician had

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[1] undertaken.

[2] In some instances it's helpful. I [3] would guess in the majority of instances [4] it is helpful. It is sometimes when it [5] isn't.

[6] Q: Is that your custom and practice at this [7] hospital?

[8] **A:** Yes, it is.

[9] Q: Do you know whether or not an elevated CPK is [10] consistent or compatible with an acute MI?

[11] **MS. VANCE:** Objection.

[12] **A:** An elevated CPK, plain CPK — well, actually [13] the answer to your question is yes, elevated [14] CPK, regardless of whether it is isoenzyme, [15] would be compatible with acute myocardial [16] infarction.

[17] Q: Would an elevated LDH be compatible with an [18] acute MI, if you know?

[19] **A:** I just don't remember.

[20] Q: If you remember, would an elevated AST be [21] compatible or consistent with an acute MI?

[22] **A:** I don't know.

[23] **MR. PARIS:** Okay. I think that's [24] it. Thank you very much, Doctor.

[25] THE **WITNESS:** You're welcome.

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[1] **MS. VANCE:** We'll not waive [2] signature.

BRTJCE JANIAK, M.D.

[S] (Thereupon, Plaintiffs' Exhibit 1, [9] an article, was mark'd for purposes of [10] identification.)

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CERTIFICATE

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

I, Linda A. Astuto, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named BRUCE JANiAK, M.D., was by me, before the giving of his deposition, first duiy sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or empioyee or attorney of any of the parties, or a reiative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of _____, A.D. 19 __.

Linda A. Astuto, Notary Public, State of Ohio
1750 Midland Building, Cieveiand, Ohio 441 15
My commission expires October 24, 1977

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