State of Ohio,)
) SS:
County of Stark.)

- - -

IN THE COURT OF COMMON PLEAS

- - -

Stephan Germanoff,)
administrator of the Estate of)
Connie Sue Germanoff,)
Plaintiff,)
) Case No. CV01475
vs.)
)
Aultman Hospital, et al.,)
)
Defendants.)

- - -

Deposition of Alan Kamcn, M.D., a witness herein, called by the plaintiff for cross-examination, pursuant to the Ohio Rules of Civil Procedure, taken before Constance Versagi, Court Reporter and Notary Public in and for the State of Ohio, taken at Aultman Hospital, 2600 Sixth Street SW, Canton, Ohio, on Thursday, May 17, 2001, commencing at 4:00 p.m

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Mark N. Rose, M.D., Esq

Jennifer Curati

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ALAN KAMEN, M.D.
of lawful age, being first duly sworn, as hereinafter certified, was examined and testified as follows:
CROSS-EXAMINATION
By Mr. Kampinski:
Q State your full name, please.
A Alan Ralph Kamen.
Q Tell me the first name?
A Alan, A-L-A-N, Ralph Kamen, K-A-M-E-N.
MR. KAMPINSKI: Let the record show all counsel representing the various parties are present. Mr. Switzer is attending by phone, correct, Mr. Switzer?
MR. SWITZER: Yes, I am.
Q Dr. Kamen, I am going to ask you some questions this afternoon. If you don't understand any of them tell me, okay, I'll be happy to rephrase any question you don't understand.
When you do respond to my questions, please do so verbally. She is taking down everything that is said, she can't take down a nod of the head.
A Okay.
Q Have you been deposed before, sir?
A Yes, several times.
Q Under what circumstances?

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A I guess malpractice cases.
Q Where you've been a defendant?
A Yes.
Q Tell me the name of the case?
A I can't tell you, I don't remember.
Q How many were there?
A In my 33 years, two.
Q You don't remember them?
A I don't remember the names if that is what you mean, I have no remembrance.
Q Where were the lawsuits, here?
A In Stark County.
Q Were you named individually or was your group named, or both?
A My understanding is both were. I'm not sure I understand the legalities of it.
Q Who represented you in those cases?
A Mr. Treadon in one. The other was -- the other one was dropped. Mr. Treadon and there was one about 10 years ago, who represented me, I don't remember. I'm sorry, I don't remember. Then there was one that was dropped that was about 25, 30 years ago.
Q What were the results of the three cases? You said the one 25 years ago was dropped?

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A Right.
Q What about the one who you can't remember the attorney's name?
A For the defendant.
Q Was it a trial?
A Yes.
Q Defense verdict?
A Yes. That means my insurance company didn't pay any money, if that is what that means.
Q What about the third one?
A Third one is the insurance company paid money.
Q What were the nature of the claims in each case?
A One patient died with a heart cath.
Q Which case?
A The one between your number one and three.
Q The defense verdict?
A Yes, the defense verdict.
MR. HOWES: That one I represented you.
THE WITNESS: You didn't represent me, did you?
MR. HOWES: Yes, I think I did.
THE WITNESS: That's all right, you did. It's not high on my -- sorry.
Q So Mr. Howes represented you in the case that

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resulted in the defense verdict, where the patient died, you put in the heart catheter?
A He died with a heart catheterization, yes.
Q Did you do the catheterization?
A Yes.
Q Was that a dissection, why did the patient die?
A A fatal arrhythmia.
Q Caused by what?
A My speculation, it was a contrast allergy.
Q What happened in the case where Mr. Treadon represented you?
A Patient had a stroke after thrombolytic therapy.
Q You don't remember the name of that case?
A No.
Q Do you remember the name of the attorney --
A Mr. Treadon is the attorney that defended me.
Q Do you remember the name of the attorney representing the plaintiff in that case?
A Okey.
Q Okey.
The third case that you say was dropped, what were the allegations in that case?
A Patient lost his pulse after heart catheterization.
Q Who was the patient's attorney, do you recall?
A I don't know if he's alive, it's so long ago, 25,

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30 years ago.
Q. Are those the only three cases you've been sued in, Doctor?
A. To the best of my recollection right now, I don't remember any others.
Q. What is your residence address?
A. 6881 Glengarry, G-L-E-N-G-A-R-R-Y, Northwest, 44718.
Q. That is in Canton?
A. Um-hum.
Q. Your professional address?
A. 2600 West Tuscarawas.
Q. By whom are you employed?
A. Cardiovascular Consultants.
Q. That is an Inc?
A. Yes.
Q. Are you an employee as well as a shareholder?
A. Yes.
Q. How many shareholders are there?
A. I think 11, but I'm not sure.
Q. How long have you been a shareholder?
A. Of that and the present corporation, 32 years.
Q. Is that how long you've been an employee as well?
A. Um-hum.
Q. How many notes do you have in the chart pertaining

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to Connie Germanoff, Doctor?
A. In the progress notes?
Q. Anyplace in the chart, how many notes do you have, sir?
A. I haven't counted them.
Q. Why don't you do it then.
MR. STRONG: You want him to look at the progress notes or orders?
Q. I assume he's looked at the chart before today, right?
A. Correct.
Q. Where do you have any writing in this chart, sir' I know you've got a couple progress notes, correct?
A. Correct.
Q. Do you have more than two?
MR. STRONG: Let's look at them.
MR. KAMPINSKI: That is what I asked him to do.
MR. STRONG: Not directly.
A. Two progress notes, two order sheets and recollection is the only other place would be my interpretation of the stress test.
Q. The two progress notes, are those the two on the same page, both dated December 18th?
A. Yes.

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Q. Do you know what time you would have written those progress notes, sir?
A. One would be approximately 9:30 in the morning.
Q. That would be the first one?
A. Yes.
Q. That is December 18th?
A. Correct.
Q. There is no time on it, correct?
A. Right.
Q. Why do you say it would have been roughly 9:30?
A. Because that is when I did the stress test. I saw her concurrently with the stress test.
Q. What time would the other one have been?
A. Approximately 1:15.
Q. Why is it you say that it's 1:15?
A. Because the nurses notes signed off my orders when I saw her on the floor.
Q. The two orders that you are referring to, those are both also dated December 18th?
A. Correct.
Q. The first one, when would you have written that. that is called results of adenosine stress test?
A. Probably when I saw her the first time.
Q. Again, roughly 9:30?
A. Probably.

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Q. Why would you put an order in there that would be signed off by a nurse to call on the results of the stress test if you in fact were doing the stress test?
A. Well, I meant to call the results of the nuclear portion of the stress test, which the radiologist reads.
Q. That is what you meant?
A. Correct.
Q. Did she do that?
A. I got the results.
Q. My question is, did the nurse call in the results to you of the nuclear portion of the stress test?
A. I got the results. I'm not sure the direction, if it came from a nuclear technician, or came from a physician, or came from a nurse, I don't know.
Q. When did you get that?
A. Before I discharged the patient.
Q. Sometime between roughly 9:30 and one o'clock?
A. It would not be before the radiologist interpreted the test.
Q. What time was that?
A. Probably I would have to look somewhere between 12:30 and 1:00.
Q. You wrote the okav to discharge at what time?

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A The order was taken off at 1:10, it would have tc be between 1:00 and 1:10.
Q Then there is a later note on the 18th that says may discharge after 3:00 p.m. if not seen by GI?
A Urn-hum.
Q That is a telephone order by Dr. Hummel, did you have any discussion with Dr. Hummel?
A I do not recall any discussion with him.
Q So you said it was okay to discharge her from the cardiac standpoint I take it?
A Correct.
Q It would have been up **to** the internist to determine that it was okay to discharge her from any other standpoint?
A Correct.
Q Would you read your December 18th note for me, progress note?
A Feels okay, EKG okay, adenosine scan choking sensation, no EKG changes, sent for scanning.
Q Which EKG were you referring to when you say EKG okay?
A The EKG during the nuclear scan.
Q I don't want to be confused. You've got sent for scanning?
A Correct.

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Q Why would you put EKG okay before that?
A Because it's a dual mode procedure. One is the electrocardiographic portion and one is the nuclear portion. They are both done.
Q So where did you do the EKG?
A When the adenosine was given.
Q Where was that given?
A The location?
Q Yes, sir.
A Or the part of the body?
Q Location?
A The location in the hospital?
Q Where in the hospital?
A On 3 East.
Q Where was she located when you saw her?
A At what time?
Q At 9:30?
A I saw her on 3 East.
Q She was already there?
A Correct.
Q Is that the location where the scans are done, or was that a room?
A That is where they were done that day.
Q She was taken from her room to the location --
A Correct.

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Q -- in anticipation of receiving the scan?
A Correct.
Q Did you administer the EKG?
A I supervised it.
Q Who did it?
A **A** nurse technician.
Q Was a record kept of the EKG?
A Correct.
Q Where is it?
A The summary of it is here in the chart.
Q Where is the EKG itself!
A I'll show it to you. Here it is.
MR. KREMER: What is the page number at the bottom for us in the back?
MR. STRONG: I don't have a page number.
Q Does it have a page number on it?
MR. STRONG: I don't see a page number.
MR. KAMPINSKI: Mine looks like it says 178, right by your hand, Rick?
MR. STRONG: Got you, yes. We've got the same page.
MR. KREMER: Thank you.
Q That says adenosine pretest, correct?

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A Correct.
Q What does that mean?
A Baseline electrocardiogram before we do the test.
Q Why do you do a baseline EKG before you do the test?
A So you have a comparison with the end of the test.
Q You want to do an **EKG** before, you want to do one after?
A Correct.
Q The purpose of that is what?
A To see if there is any ischemia.
Q Where is the one that was done after?
A The one that is done after is computerized format on the chart here. I don't know how to describe the page.
Q It should have a number. Is that the same as this?
A Yes.
Q Mine is number 180, yours is whited out?
MR. STRONG: Yeah.
Q Are you saying page 180 is the EKG that was taken after the administration of the adenosine?
A During and after.
Q So how do I tell, are these the times up here at the top?
A Correct.

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Q What time was the test in fact done, sir, 9:32?
A 9:32.
Q These times up here?
A Time infusion started.
Q You are going to have to explain the times to me then. Across the top it says starts with 0000, would that be the time the test started?
A It would be the time -- it would be the computerized baseline record, could be three minutes, five minutes, 10 minutes before. It probably would be very similar to the time the baseline EKG was taken.

It depends between the time we take the baseline and the time we start the test. I would say it would be taken very close to the 9:32 clock.
Q Well, the next time I saw says 1733, which in military time is 5:33 I guess?
A Where is that at? I'm sorry, I don't see it.
Q Yours is cut off, Doctor. Do you have one he can look at?

MS. PETRELLO: Yes.

A I can tell you that I have no clue. It's got to be something that they must have reset the computer or something. It's just a time clock. I don't know.
Q Well, okay, the next one says?

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A One minute after the infusion started.
Q So that is referring to a minute?
A Right. One minute to the adenosine infusion.
Q Next one would be two, three, four, five minutes?
A Correct.
Q If we *go* to page 181, six minutes, and six minutes and six seconds if I am reading it the way you told me is the correct way to read it?
A Right,
Q Doctor, if you go to the pretest for one second, page 178. In the aVL lead is there an inverted T wave?
A Yes.
Q What does that mean?
A Means the electric forces were going away from that lead.
Q What does that mean in terms of analyzing the patient's heart, sir?
A It means that there was -- the question doesn't make sense medically.
Q Is that new for Connie Germanoff, inverted T wave, sir?
A This is not a standardized EKG lead, number one. If it's new, I have to look at her baseline. It wouldn't surprise if it would look different. We

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don't use the same lead system for stress tests we use for baseline record.
Q Did you ever look at any old EKG on Connie Germanoff before doing this stress test?
A I looked through her chart. I'm sure I looked at the records. I have to find the baseline EKG to tell you if it's different.
Q Go ahead.
A It's meaningless.
Q It's meaningless that there is an inverted T wave?
A Yes, meaningless.
Q It's meaningless that it wasn't there before?
A Yes.
Q How many EKGs did you look at before doing the stress test, sir?
A Whatever was in the chart.
Q How much of her chart did you have?
A The whole chart.
Q How long did you spend with it before doing the stress test?
A The chart was with me for 10 minutes.
Q Before seeing the patient, or while you were with the patient?
A While I was with the patient.
Q Were you doing a physical examination while you

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were with the patient?
A I talk to the patient, listen to their chest, whatever is required at that point, yeah.
Q You had the nurse -- or you supervised the EKG itself, or did you do it?
A I supervised it. I'm the interpreter.
Q Then did you do the stress test, or did you supervised it?
A I supervised it.
Q Who actually did the injection of the contrast material?
A There is no contrast.
Q The adenosine, I'm sorry?
A A nurse.
Q You supervised that?
A Yes.
Q Were you there the whole time?
A Yes.
Q How long did the test take?
A It's a four minute infusion. We watch it for another four minutes.
Q Am I correct then you spent two minutes with her before the test, you told me you spent 10 minutes with her?
A Well, I didn't have a time clock, I'm sorry.

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Q I wasn't there, Connie is dead, so I'm asking you?
A I understand. I don't have a time clock.
Q So is it your best estimate you spent two minutes with her prior to the test?
A No.
Q What is your best estimate?
A My best estimate is I'm not sure.
Q You reviewed the record carefully before conducting the test?
A I reviewed the record.
Q That wasn't my question.
Did you review the records carefully, Doctor?
A Yes.
Q If in fact there was a change on this EKG from a prior one, to you that was not meaningful?
A It's not the same lead system.
Q What can an inverted T wave that didn't exist before mean?
A It could mean something, could mean nothing, depends on which lead.
Q Well --
MR. STRONG: Let him finish his answer.
MR. KAMPINSKI: I'm sorry, you are

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right.
A It's a whole gamut of things from something to nothing.
Q The something, can the something be ischemia?
A That is one of 50 things.
Q What is the purpose for doing this stress test, sir?
A To evaluate the ischemic burden of the patient.
Q Was this patient admitted for the purpose of ruling out an MI?
A Yes.
Q So that a finding, or potential finding of ischemia, would be something worrisome potentially to you as a cardiologist trying to evaluate this patient, trying to rule out an MI, correct?
A Correct.
Q As you sit here today -- did you review this char before coming in here today for your deposition?
A Yes.
Q Do you know how many prior EKGs there were in the chart for you to review at the time you saw Connie on the 18th?
A The hospital charts?
Q Yes, sir, how many EKGs there were for you to review?

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A I would have to look through the record now.
Q Go ahead.
MR. STRONG: The question is which would you have reviewed at the time of her admission.
A The ones in the hospital.
Q You mean for that particular admission?
A Yes.
MR. STRONG: This begins with the ER chart.
A There is one on the 16th.
Q Where was that done?
A Done at 1050 in the ER.
Q You're saying the lead system on this EKG would be different than the lead system on the adenosine pretest?
A Um-hum.
Q What would be different about it, Doctor?
A The electrodes are placed in different areas, slightly different areas.
Q So the EKG done in the emergency room, does it have an aVL lead?
A Yes.
Q Where would that have been placed, as opposed to where the one was placed in the area where she had

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the adenosine pretest?
A There was no aVL lead.
Q Where?
A There is none.
Q In the emergency room?
A You asked for the lead. There is no lead called aVL. That is the lead on the EKG, and there is a lead where the electrode is; which one do you mean?
Q Whenever one you are claiming was different in the emergency room?
A The electrodes are placed in different places.
Q Where would the electrode be placed in the emergency room, as opposed to the electrode tha were placed in the area where you did the pretest?
A There are four electrodes placed on the arm -- two on the arm, two on the legs, six on the chest. The ones on the chest are placed in different locations.
Q Are you talking about the pretest or talking abou the emergency room?
A The emergency room is done in a standardized fashion.
Q How is that different, sir, than what is done in the pretest?

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A The difference is the chest leads are different.
Q Where would the chest leads be placed differently?
A They would be placed in a different location so the gamma camera doesn't interfere, the gamma camera information is not interfered with the electrode being over it.
Q Are you saying then that had the leads in the emergency room been placed in a different area of the chest, they may have had this T wave that is reflected on the 18th?
A It could make a difference. Sometimes they put the leads, they are supposed to put the leads on the lower extremities, on the upper part of the extremities. We often use a closer lead system in the stress room where we put them on the thighs and forearms. We may use a little different system. It does change the EKGs occasionally.
Q You don't know if in fact the leads that were put on in the emergency room were put on in any different place, you weren't there I take it for the placement of the leads in the emergency room; would that be a fair statement?
A It's a fair statement that they were put on correctly.
Q That what?

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A They were put on correctly, that is a fair statement.
Q If they were put on correctly, would you expect them to find a T wave if in fact it existed, inverted T wave, I'm sorry?
A Inverted T wave?
Q Yes.
A I'm sorry, it doesn't make sense to me as a cardiologist what you are asking. It's hard for me to answer.
Q What doesn't make sense, Doctor?
A I don't look at T waves. I look at vectors. I look at vectors of the complexes. You put the whole thing together, you are supposed to have a concordant -- the electric depolarization and electric repolarization are supposed to be concordant.
Q Humor me because I'm not a cardiologist, you are.
A You are asking questions like you are.
Q No, I'm just asking questions, I would like answers to them.
MR. STRONG: He's giving you answers, he's trying to steer you so you and he can communicate in a rational way here.
Q Let's try again.

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Would you expect there to be an inverted T wave in the EKG that was done in the emergency room if in fact the leads were placed appropriately -- let me finish the question -- in light of the fact there is an inverted T wave in the EKG done on the 18th that you were supervising?
A Again, I can answer the question but the question doesn't make medical sense.
Q Then answer it.
A The QRS and T waves are supposed to have concordant axis in the normal patient. That means that whatever the axis is on that EKG at that time should be plus or minus 60 degrees of each other, and they both are, in both records. Doesn't matter if it is inverted or not inverted, inversion is not a pathology.
Q The fact that there is a change though, that there isn't one in the emergency room EKG and there is one in the EKG that was supervised by you on the 18th is of no significance to you?
A That statement is wrong on your part.
Q What is wrong about it?
A There is an inverted T wave in the one in the ER. If you look right under aVL, the T wave is inverted.

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Q Point it out to me, if you would, sir.
A aVL, that is the T wave that is inverted.
Q Do you need serial EKGs to rule out MI, Doctor?
A Not necessarily.
Q Can you rule them out with one EKG? Let me withdraw that.
Can you rule them out with EKG at all?
A What?
Q An MI?
A Rule it out?
Q Yes, sir.
A No, you can't.
Q If a patient has a suboptimal stress test, and complains of chest pain and fast palpitations with exertion, does that require further evaluation?
A Is this a hypothetical question?
Q Sure.
A Repeat it please.
Q If someone has a suboptimal stress test and continues to complain of chest pain and fast palpations with exertion, does that require further evaluation?
A Yes.
Q Would the next step in the evaluation process be a Holter monitor?

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A That would be one of the tests.
Q What else could you do, or is that what you would do?
A Well, that -- there is more to it than -- it's not a simplistic answer. One would be if you want to do invasive testing, you would do an optimal stress test.
Q By invasive testing you are talking Catheterization?
A Correct.
Q It's my understanding we were delayed here today because you had a number of catheterizations you did?
A Correct.
Q How long did they take you, each one, roughly?
MR. STRONG: Objection. That is not pertinent, he doesn't have to answer that.
Q How long does a catheterization take you to do?
A Uncomplicated catheterization?
Q Sure.
A Patient time, doctor time, or time from start to finish?
Q Give me all three.
A Come down from the floor, that takes a half an hour. Then the nurses prep them for 35, 45 minutes

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to make sure the patient is explained and understands and everything, the lab work is correct. It takes about 20 minutes in the room to get the patient ready. It takes about, in an uncomplicated, simple patient, 20, 25 minutes to do a heart catheterization. Then the patient is recovered like an hour. Then they go back up to the floor, are monitored.
Q So doctor time is roughly 20 minutes you said?
A 20 minutes in the room. Obviously there is more to it than that.
Q Patient time roughly a couple hours?
A Correct, yeah.
Q Do you do catheterizations on patients with dye contrast allergies?
A Not infrequently.
Q Not infrequently?
A Yes, we do it when it's necessary.
Q What do you do to protect the patient under those circumstances?
A Prepare, if it's an elective one, we prepare them for several days on steroids, anti-histamines, serotonin blocking agents.
Q The fact that somebody had potentially a dye contrast allergy is not something that would

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prevent you as a cardiologist from doing a catheterization if you felt it was warranted?
A Yes, but my level of desire to do it -- my level of concern would be higher and the patient would be aware of it.
Q That wouldn't prevent you from doing it, if you felt it was necessary and warranted?
A Correct.
Q Going back just for a moment to the hypothetical I asked you about suboptimal stress test with the patient continuing to complain of chest pain, fast palpations with exertion, would a cardiology consult be appropriate in such a patient?
A If the patient doesn't get better, that would be appropriate.
Q Did you perform any type of physical examination on Connie Germanoff, or did you just speak with her?
A I examined her during the scan.
Q What was the nature of the exam?
A Heart and lungs.
Q What kind of exam did you conduct during the exam?
A I used a stethoscope, listened to her lungs and listened to her heart. Measured -- made sure vital signs were satisfactory.
Q How is it you knew you were doing a test on Connie

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that particular day?
A It was scheduled for me.
Q Have you read Dr. Lee's deposition?
A Yes, I read it a while ago. Not recently.
Q He apparently was going on vacation?
A Correct.
Q The day before?
A Correct.
Q Had he arranged with you to cover for his patients before going on vacation?
A Correct.
Q Did he discuss Connie Germanoff with you prior to going away?
A In writing.
Q In other words, his charting was in the chart?
A Plus we have a list that goes around, they put down problems.
Q Explain that to me.
A We have a rounds listing we make up when we are having someone cover for us, the name of the patient, location, diagnosis and problems.
Q That is not something in the medical chart?
A No, it's not kept.
Q That is something internally within your group so YOU know who it is YOU are going to see for whoever

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you are covering for?
A Right.
Q Was that a Saturday you saw her, the 18th?
A Yes, I think so.
Q Your communication would have consisted of whatever he put on that sheet, right?
A Um-hum.
Q Do you recall what that was?
MR. STRONG: He also mentioned the consult.
MR. KAMPINSKI: I'm going to get to that.
A What it was?
Q Yeah, what was said on that rounding sheet?
A I can't give you a for certain answer.
Q In other words, you can't remember as you sit here today?
A Correct.
Q The other form of communication would have been in the chart?
A Correct.
Q What part of the chart would you have looked at to know what you were doing here?
A I would look at the -- whatever was in the chart. Specifically whatever was in the chart at that

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time, which would have consisted of his consult note. Mostly his consult note would have been my major thrust of looking at things, plus the lab work and EKGs.
Q When you say his consult note, tell me what you are referring to, is it the --
A Well, I looked through the progress sheets. He has no note there. Then he has a typed one.
Q When would you have looked at the progress notes, the typed one as well as the --
A Correct.
Q -- handwritten, when would you have looked at those, Doctor?
A Probably during the scan.
Q Let's back up then.
How would you have known you were doing the scan, would this have been from the other document that you referred to earlier, the rounding form, or would you have a printed schedule telling you, how would you have known when you got to the hospital that day you were doing a test on Connie Germanoff?
A The general procedure I can't tell you. I don't suspect it's any different than any other day. We know we're making rounds, we know of the stress test on Saturday morning. The nurse calls when

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they are ready, tells you you have a stress test.
Q Would you have been the representative from your group that would have been doing stress tests that day in the hospital?
A Correct.
Q Were you the one that was on call?
A Correct.
Q So, regardless of whether it was Dr. Lee's patient or somebody else from your group, there would have been a number of people needing procedures, you being the one on call, you would have administered those procedures?
A Correct.
Q Your first knowledge of doing it on Connie Germanoff would have been some kind of a page or phone call from a nurse?
A Correct.
Q Saying it's time to do Mrs. Germanoff's stress test?
A Correct.
Q Tell me what happens then, you go to the room where the test is being conducted?
A Correct.
Q The chart is there?
A Correct.

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Q You speak to her, you talk to her?
A Um-hum.
Q The EKG is being performed on her, the pretest?
A Correct.
Q Then the test is actually done?
A Correct.
Q Then what, you leave the room and wait for the nuclear results to come back to you?
A After the patient is stabilized, make sure they are all right. The EKG doesn't show any changes, or whatever it shows. Then we leave. I tell the patient that part. I give the patient some information about what it shows usually.
Then I wait for the scanning and computerization of it and interpretation of it.
Q While the test was going on, you said you would have looked at Dr. Lee's note, correct?
A Correct.
Q You would have read both of them I take it?
A Yes.
Q Did you check the enzymes before conducting the test, were you aware of them?
A I read through the chart, so I was aware of them.
Q What did you think of them?
A Well, you mean -- what did I think of them? I'm

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not sure what you mean by that.
Q. Were you aware of troponin and myoglobin levels, Doctor?
A. Yes.
Q. What did you think of them?
A. Well, myoglobin was elevated.
Q. How elevated?
A. The one in the emergency room was 130, and the one the next morning was 145. The next one was 140.
Q. Were you aware of those before you did the test?
A. Yes.
Q. Didn't Dr. Lee say that if they were negative, referring to the enzymes, then the adenosine cardiolite stress would be done? I'm looking at page 168 which is his progress note, which you claim to have read?
MR. STRONG: Would you repeat the question? His consult note is up here.
THE WITNESS: I want to read his consult note for a second.
MR. STRONG: She is going to read it.
MR. KAMPINSKI: Give him a second.
MR. STRONG: She is going to read it.

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MR. KAMPINSKI: If he wants to read it, let him read it.
(Question read.)
A. What Dr. Lee said is if cardiac enzymes -- check cardiac enzymes, if negative. Well, myoglobin is a nonspecific enzyme, so I specifically wouldn't call it a cardiac enzyme, I call it a muscle enzyme.
Q. Is the heart a muscle?
A. Yes.
Q. Go ahead.
A. E would interpret that as being a cardiac specific enzyme.
Q. Why was the -- why is the myoglobin enzyme tested for, Doctor?
A. That is a good question.
Q. What is the answer?
A. It goes up very rapidly in myocardial infarction and falls rapidly. It also goes up if someone does too much exercise that day, falls down and bumps themselves, injures their arm, any kind of a muscle injury. It's so nonspecific that at any one time 10 or 20 percent of hospitalized patients that come in with medical problems might have it elevated. You put it together as a gestalt. You don't use it -- you look at it, say okay, see what else is

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going on. I wouldn't call it a cardiac enzyme. It's a very nonspecific enzyme.
MR. STRONG: Time out. We can take a break if you need to call.
(Recess taken.)
MR. KAMPINSKI: Where did we leave off?
(Record read.)
Q. I take it then you looked at the laboratory results at the same time -- well, did you look at them before you looked at Dr. Lee's consult, or after, or at the same time?
A. The whole chart was there, I looked through it. I can't tell you which, I don't know what order I looked at it.
Q. Well, I mean Dr. Lee was your colleague?
A. Correct.
Q. You are there because he wanted this test done I assume?
A. Correct.
Q. I assume you would have read his consult first?
A. Correct, he had that information.
Q. I'm sorry?
A. He had the myoglobin information when he dictated his note.

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Q. And the troponin?
A. Yes, I think so.
Q. So you would have relied on Dr. Lee interpreting the myoglobin and troponin for purposes of proceeding with the test?
A. Correct.
Q. Are you saying that you didn't look at those levels yourself since Dr. Lee had?
MR. STRONG: He said he already did.
A. E already answered the question.
Q. Answer it again, maybe I didn't understand.
A. I looked at the whole chart.
Q. I'm asking about a specific part of the chart, the laboratory values?
A. Yes, I looked at them.
Q. Did you look at them after you read Dr. Lee's consult?
A. It was the same time I saw his consult and the chart is there.
Q. You told me a little earlier in this deposition that you looked at his consult and now I take it the lab values, at the time that the test was being done?
A. Correct.

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So you didn't look at them beforehand?
MR. STRONG: I think we're dealing with semantics.
MR. KAMPINSKI: Listen to me, please, if you want to object, go ahead and object. Talking objections are not appropriate. We don't do it with our clients, you shouldn't do it with yours.
MR. STRONG: You'll have to check the record from the deposition a few days ago on that one. I'm not trying to interfere with your deposition, on the other hand I'm trying to expedite getting things done.
MR. KAMPINSKI: There is no question of expedition here. We accommodated the doctor because he was busy today, as long as it takes is how long this is going to take. If you would allow me to, I would like to proceed.
MR. STRONG: You are welcome to proceed. You are the one that brought up the subject, this is a trail you've gone done. We can sit here and argue about it or you can go on. I suggestion you go on.
MR. KAMPINSKI: What was my last question?

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(Question read.)
A I can't tell you exactly the minute I looked all them.
Q I'm confused here, sir. You are telling me Dr. Lee looked at them, you were relying on Dr. Lee having looked at them to proceed with the test?
MR. STRONG: Objection.
A I said I looked at the chart.
Q I know.
A I also said I looked at Dr. Lee's notes.
Q It's your testimony that Dr. Lee looked at the laboratory values?
A He did look at the laboratory values.
Q Did he tell you that?
A It's in his notes.
Q Point that out to me, please.
MR. STRONG: You want the consult or progress note?
A His dictation probably. It says in the end of the first paragraph, full paragraph, since admission she had a CK-MB done which was unremarkable. So he did look at them.
Q You're interpreting that to mean he looked at myoglobin and troponin as well?
A I don't see how he would look at one without the other. I can only tell you what he says.
Q In other words, if you look at the CK-MB you would necessarily look at the myoglobin and troponin?
A That would be the usual way of doing things.
Q Of course to the extent he ordered the enzyme, it would be appropriate for them to look at them, right?
A Correct.
Q Just hypothetically, if he failed to do so, would that be below the standard of care required of him?
MR. STRONG: Objection. Go ahead.
A What do you mean by standard of care?
Q The usual and ordinary thing that physicians would do under the same or similar circumstances?
A He was away that day, how could he look at them?
Q No, he wasn't the day the results back came, sir.
MR. STRONG: Which results are you talking about?
Q The ones done on the 16th and the ones done on the 17th.
A The enzymes I can see from the 17th that were done was before he left, would be the myoglobin and troponin, which it says 8:00 a.m. were drawn.
Q Would you expect that he had looked at those before he left?

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A Yes.
Q Again, if he had not looked at those, would that be below the standard of care required of Dr. Lee?
A That is a legal term. I'm scared to give legal terms. I don't know the significance of the question.
Q Don't be scared, Doctor.
A I am. I don't know the innuendoes of standard of care.
Q You've been sued three times, certainly you are aware of the innuendoes of standard of care, Doctor.
MR. STRONG: That is not a question, that is his comment.
Q Is it appropriate?
A Yes, he should look at his tests. There is no question about that.
Q That would be part of his doing his job correctly correct, to look at the test results?
A Yes. What are available when he's there, sure.
Q If he didn't, then he wouldn't have done his job correctly; wouldn't that be a fair statement, Doctor?
A That is an open-ended question. That is something someone else can decide. I'm not going to make a

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comment about that.
Q Well, the tests that were available to him reflected that both the myoglobin and troponin were rising; isn't that true?
A That what were rising?
Q The myoglobin and troponin?
MR. STRONG: Which tests are you referring to?
Q Myoglobin and troponin done on December 16, 1999 at 2349, correct, you see those?
A Um-hum.
Q That is a yes, right?
A Yes.
Q The troponin --
A I would say the numbers are higher, I don't know if it's a significant rise.
Q Well, they went up is my only question?
A They did go up.
Q And the one done on December 16th -- by the way, troponin is specific for cardiac, is it not?
A Troponin-I is specific for, yes, gives you a long list below there, long list there of other things that can do it.
Q They are all cardiac-related, are they not, Doctor?
A Yeah, sure.

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Q The gestalt by the way would be to look at both the troponin and myoglobin, right?
A And CPK and SGOT.
Q CPK, is that specific for heart?
A CK-MB is, yes.
Q If you have a rising myoglobin and troponin, is that worrisome to you as a cardiologist, sir?
A It's enough concern that I would follow it up.
Q By doing what?
A By doing more testing.
Q Like what?
A It depends on the clinical situation with the patient.
Q I don't understand. The patient is there to rule out MI you told me, correct?
A Well, some of your questions are hypothetical, some are not. I'm not sure. If you would be clear when you make a statement. I don't know if you are talking any patient that walks in the door, or this patient. If you would be specific about whether you are talking about this patient or hypothetical, it would make a lot of help to me.
MR. KAMPINSKI: Can you read back my last question.
(Question read.)

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Q Is there any confusion about that question, Doctor, I'm talking about this patient?
A This patient, okay, correct.
Q Yes. The laboratory values we're talking about are this patient, correct?
A Correct.
Q You just told me that these test results on this patient would require further follow-up?
A Correct.
Q What further follow-up?
A You would, if they are inconclusive, as these are, I would do a nuclear scan.
Q Why is it that Dr. Lee wanted to only do the adenosine scan if the enzymes were negative?
A If they were positive he thought it would be a duplication of -- let me say what I would do. I don't know what he would do because -- what I would do is if there was clear-cut enzyme elevation and EKG change, then I would think that if there was no contraindication to it, I would do more definitive tests, nuclear scan.
Q Which is a heart catheterization?
A Right.
Q The enzyme tests were not negative, were they?
A They were inconclusive.

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Q Please, sir, you want me to be specific, I would like you to be specific in terms of responding.
MR. STRONG: Objection.
A I am.
Q My question was were they negative, that is the only question?
A They were above the normal levels, put it that way.
Q Not only were they above the normal level, the myoglobin was in excess of twice the normal level?
A Correct.
Q The troponin by the time you got there, sir, had gone from less than .03 to .05, then to .08?
A Um-hum.
Q That is a yes?
A They went up.
Q Is that a good sign, a rising troponin, or doesn't that mean anything?
A It's inconclusive.
Q Doctor, my question is, is that a good sign, that the troponin level is rising?
MR. STRONG: I'm going to object.
He answered your question with a very specific answer.
A What do you mean by good?
Q Is it worrisome?

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A. Is there pathology there? Could be, you would have to investigate for further pathology. I don't think illnesses are good or bad. That is what you have.
Q. Is it worrisome to you as a cardiologist that the troponin level had gone from less taken .03 to .05 to .08, assuming you knew about it, sir?
A. As a cardiologist I think they are inconclusive.
Q. Again my question is, is it worrisome to you as the cardiologist in terms of this rising level of an enzyme that is specific for the heart?
A. It raises questions about whether something else should be done, yes.
Q. When you say something else, again, what are you referring to?
A. More testing, to see if this is cardiac or not.
Q. What tests, sir?
A. In this patient, nuclear scan.
Q. Is nuclear scan definitive in determining -- in ruling out MI?
A. Significant size, yes.
Q. I'm sorry?
A. If it's a significant size, yes.
Q. If what is a significant size?
A. The heart attack, myocardial infarction is a

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significant size it will tell you if there is scar there.
Q. What if you are dealing with ischemia, that isn't necessarily an MI yet?
A. It should be 90 percent. It should be 90 percent specific for ischemia with a perfusion scan, yes.
Q. Who takes the risk of the other 10 percent when you have an elevated myoglobin and troponin, the patient?
You look puzzled; do you understand the question?
A. The question seems like an inappropriate question basically.
Q. Why is that? Mrs. Germanoff is dead, why is it inappropriate, Doctor?
A. Because you are asking me who is taking a chance, it's not gambling.
Q. Sure it is. You are giving me percentages. You are the one that brought up 90 percent.
A. Correct.
Q. If there is a 10 percent chance of you being wrong, who is taking the chance, you or her?
MR. STRONG: I'm going to object.
It's an inappropriate question. It's not him, it's the test.

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MR. KAMPINSKI: No, he made it him.
A. Because we don't treat tests, we treat patients.
Q. So your treatment of this patient was to determine that she had a 10 percent chance of cardiac involvement, say it was okay for her to go home?
A. I didn't say that at all. You said that.
Q. That is what are you saying now.
A. No, I didn't say that. You are distorting the information, sir.
Q. What am I distorting? Did I mislead you as to the troponin or myoglobin levels, or did I read those from the chart?
MR. STRONG: Is the question whether or not you read those from the chart? This is getting argumentative. You can ask questions, you are not here to argue with the doctor.
MR. KAMPINSKI: I have no interest in arguing with him.
MR. STRONG: Good, because if you do, we might be done. You can ask your questions.
MR. KAMPINSKI: I'm trying to.
Q. You want to answer the question?
MR. STRONG: Rephrase the question.
A. I did not say the patient had a 10 percent chance of having a heart attack. I said the test is

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90 percent specific for heart trouble. That is all I said.
Q. That means 10 percent of the people are not going to have ischemia show up on this test, right?
A. Not necessarily so.
Q. Well then, how many of them, 20, 30 percent?
A. Depends on Bayes' theory and pretest likelihood of someone having -- I'm giving you a global number that could take care of a whole population in the world. If the pretest likelihood is low, then the sensitivity of the test goes up.
Q. When you say pretest likelihood, are you talking about people that you do the test on that don't have chest pain for example, that don't have risk factors; what do you mean pretest likelihood?
A. Pretest likelihood, the population base you are dealing with, what are the chances of them, before you do the test, of them having trouble.
Q. What was the pretest likelihood of Mrs. Germanoff having a cardiac related complaint, or problem rather?
A. 50, 60 percent.
Q. What level of comfort did you have after a negative adenosine stress test, with a rising troponin, and an elevated myoglobin?

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A I think the patient had no evidence of myocardial infarction.
Q What about unstable angina, sir?
A That was more -- that was really the issue when she came in, was she having unstable angina.
Q Are you saying that is not an issue you addressed at the time you saw her?
A No, I addressed it.
Q Tell me, what was the likelihood of her having unstable angina with an elevated myoglobin, an elevated troponin, which was rising, and a negative adenosine stress test?
A I would say 90, 95 percent chance. I would say it was a high likelihood, 90, 95 percent chance she did not have it.
Q How do you get rid of the other 5 to 10 percent?
A Depends on the situation. The clinical situation. In her case, probably follow her as an outpatient, see how she does.
Q If she came back with additional complaints of chest pain, what would you do?
A Then I would investigate her.
Q By doing what?
A I would see what the next EKG looked like, talk to her, see what the symptoms were, make sure she

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didn't have some noncardiac cause, gastrointestinal, gallbladder or whatever. If those -- or if it seemed more likely cardiac pain, I would do a cardiac catheterization on her after preparing her.
Q Did you make arrangements for her to be followed as an outpatient?
A Her primary care doctor did. I'm sure we made it clear to her if she had more pain, she should get medical attention promptly.
Q Have you reviewed the chart in terms of her being seen subsequent to you doing this test?
A I scanned that part. I basically looked at the part I knew about at the time of the hospital stay. I did look at the rest of the chart.
Q She came back to the emergency room complaining of chest pain and crying, was radiating into her arm?
A Urn-hum.
Q Does that sound like it's cardiac to you, sir?
A Yes, I would be very concerned about it.
Q Should she have been referred to a cardiologist on those occasions?
A It would have been a good idea. Should she be, yes. I wasn't there. I can't say exactly the situation. Patients are more complicated than just

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giving a few sound bytes about what complaints she had,
If she was having more chest pain, then it would require, yes, it would be something I would like to see.
Q Well, Doctor, you're telling me that you left it up to her attending for her to be followed up, but that was from a GI standpoint.
My question is, did you make any arrangement for her to be followed up from the cardiac standpoint, which I take it is what you were telling me a few minutes ago, to eliminate the additional 5 to 10 percent you would have liked to have seen?
A Correct.
Q Did you make any arrangements for her to be followed up from a cardiac standpoint?
A The communication to the patient was that if she has more problems, she should get -- she should see her doctor, or call us.
Q She did have more problems, she did see her doctor?
A Yes,
Q She was seen here in the emergency room again, wasn't she?
A That is what I understand.

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Q See the doctors that I talked to from the emergency room -- have you read any of their depositions by the way?
A I think I did. Six months ago, I don't know how long.
MR. STRONG: I don't know if I sent you those or not.
A Maybe I didn't, I don't know.
Q Let me paraphrase, I'll try not to misconstrue what they are saying.
That is, once they reviewed the fact you did a negative stress test, they were reassured there was no cardiac problem. You see, so I've got this difficulty in trying to analyze this, Doctor.
You are telling me they should have referred her back to you if she had additional chest complaints, they are saying well, we already sent her to a cardiologist, he cleared her, said there were no cardiac problems. Help me out. What should have happened in terms of communication so she could have then been followed-up by your group or another cardiologist?
MR. STRONG: I am going to object, ask you to restate the question. You gave a lot of preliminary information.

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Q Do you understand the question, Doctor?
A Now that he interrupted, I need to hear it again. Sorry.
Q In other words, you understood it, until Mr. Strong interjected?
A Correct.
MR. KAMPINSKI: Read it back, Connie.
(Question read.)
MR. KREMER: Objection.
MR. SWITZER: Can I have a continuing objection to this so I don't interrupt?
MR. KAMPINSKI: I will tell you what, you can have a continuing object to the entire deposition.
MR. SWITZER: Thanks. Go ahead.
MS. PETRELLO: Same here.
MR. KAMPINSKI: You can all have a continuing object to the entire deposition.
MR. STRONG: We'll take it.
A First of all, I don't think I can tell any patient, no matter how many tests, including a heart cath that they definitively don't have something wrong with their heart. That is an impossible thing, number one. It's impossible, unless you've cut their heart and chopped it in postmortem. Even

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then you can't be sure, because people die with totally normal hearts, no other cause. That happens. That is unfortunate, but it does.
In this case I didn't say the patient had no heart trouble. I said I don't know what the cause of pain is, it needs further evaluation and follow-up. That is it.
Q What were your discharge instructions for her? Did you have any written discharge instructions?
A No, I didn't because the attending physician is supposed to do that.
Q What were his discharge instructions, sir?
A I don't have them.
Q Take a look.
A The attending physician said in two to three weeks see Dr. Korkor, diet, salt restricted, low cholesterol.
Q Was she supposed to follow-up with GI?
A Yes.
Q Was there any follow-up with a cardiologist?
A No.
Q In your history -- you said you took a history of Connie when you met with her; is that correct?
A I did a supplemental history.
Q Had she fallen down, or exercised, or done anything

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that would have caused her myoglobin to be elevated?
A I don't have any information that she did.
Q You had no other explanation for the elevated myoglobin; is that correct?
A That's correct.
Q Is there anything on the list for an elevated troponin other than cardiac?
A Yeah, it goes up in renal failure.
Q Is there any evidence of renal failure with her?
A No.
Q Is there anything that would be on the list for elevated troponin that is not pathologic?
A I don't think so.
Q Now, Doctor, would it be fair to say then based upon what you are telling me so far, that you could not rule out unstable angina in Connie Germanoff based upon your testing and the test results that were in the chart; would that be a fair statement?
A I could say with a high level of certainty she did not have large areas of ischemia, or signi'ficant areas of ischemia at the time of that test.
Q I don't mean to be glib with you, is that --
THE WITNESS: I wasn't expecting this to go on this long. I'm on call for 12 people

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tonight. I have to tell my answering service to hold things.
(Recess taken.)
By Mr. Kampinski:
Q Doctor, assuming for the *sake* of argument you were aware of the laboratory values for the myoglobin and troponin; what was your explanation for the elevation?
A Of these enzymes?
Q Yes, sir.
A The troponin is insignificant in our lab, based on my clinical experience with this test literally thousands of times. And the same with myoglobin, very nonspecific test. It's almost to the point we shouldn't even do it. Personally I don't order them.
Q So, you just ignored them then, you didn't feel they were significant?
MR. STRONG: Which question is it?
Q Both.
MR. STRONG: Take one at a time.
A I didn't ignore them because I looked at them. I did not think -- unless something else correlated with it, I wasn't going to use it.
Q So then Dr. Lee was just wasting the insurance

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company's money by ordering these tests?
A It was ordered in the emergency department, he didn't order it.
Q They were just wasting the insurance company's money by ordering those tests?
MR. HOWES: Objection.
A I don't know what they are doing in the emergency room, I don't -- I'm not talking about what is wasting insurance company's money. That is not my business.
Q Well, is it your business to stay knowledgeable about the literature?
A Yes, it is.
Q Isn't it true, sir, that there are a number of well controlled studies that indicate that an elevated troponin, even in what has been referred to as a gray zone, correlates to increased cardiac mortality?
A Above one.
Q I'm sorry?
A Above a level of 1.0, which is about 20 times higher than this area.
Q 20 times higher than what number?
A The highest number recorded in the chart.
Q Is it the number that is significant, or the fact

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that the level is rising?
A I'm not sure the level is significantly rising because I'm not sure that the variation from taking that sample and doing it twice wouldn't give two different answers.
Q It was done three times serially.
A The same test done at the same time, taking the specimen, use it putting it in two separate things, it wouldn't come out with a different number in that range, because I think the plus or minus of these tests are such that, and knowing the way it's done in our laboratory, in this hospital, what the clinical experience is, is that this is not a significant rise.
Q Doctor, I'm confused. This hospital, you're referring to Aultman Hospital?
A Correct.
Q Are you saying they don't know what they are doing when they put the reference ranges down here?
A I'm saying first of all the reference ranges are incorrect.
Q They are incorrect?
A Correct, they are incorrect. The top off should be .15.
Q How long have you practiced at this hospital?

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A 33 years.
Q Have you had any input into these reference ranges?
A Yes.
Q What was your input into them?
A The input is that at these low levels it's extremely difficult to make any clear diagnosis out of them.
Q What positions have you held here at the hospital, Doctor?
A Chairman of the Department of Internal Medicine, Chairman of the Cardiac Cath Lab, Chairman of the Coronary Care Unit, President of the Medical Staff. Let's see what else. A number of others. Critical Care Unit Committee, Credentialing Committee. A lot of the committees.
Q Do you have a CV?
A Not here.
Q You do have one?
A Yeah.
MR. KAMPINSKI: Could you provide that to us, Mr. Strong?
MR. STRONG: Yes.
Q Tell me again what was your involvement in establishing the reference ranges that are on this chart on pages 191 and 192 for both troponin an

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myoglobin?
MR. STRONG: I object. He didn't say he established them.
A I didn't establish them.
Q You said you had input into them?
A Correct.
Q What was your input?
A My input?
Q Your input into the reference ranges?
A None. At this point, no.
Q At any point in your last 35 years?
A They had concerns that these low numbers were extremely misleading, they were resulting in a number of patients having inappropriate hospitalizations. I don't know if -- I don't know the time frame, before or after this period of time, they reanalyzed it, they found out that the numbers they were using were not correct for this institution.
Q Did they change them?
A I think they changed -- they worked on the technique, I don't know the specifics.
Q Have the reference ranges changed --
A First of all --
Q -- since December 18th of 1999?

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A I don't really know if they are using the same company's reagents right now, I don't know.
Q The question is have the reference ranges changed since December of 1999?
A I don't know when they changed, they did change. I don't know the date. They did change from when they started using it.
Q Are you saying they may have changed before December, '99, we're seeing a result of the change on pages 191 and 192?
A I don't know.
Q Doctor, are you the one that has to deal with these numbers?
A That's correct, I am.
Q You don't know whether the numbers are meaningful?
A I didn't say that. I said these levels are not meaningful.
Q They were with Connie.
A No, they weren't.
Q Is it your testimony that these elevations, Doctor were not cardiac-related; is that your testimony?
A I'm saying they are not significantly elevated.
Q Are you saying they are not cardiac-related is my question. She died less than two weeks later.
A What I'm saying is that everybody has a troponir

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level in their blood. You have it, everybody in this room has it. What the range of normal is, everybody has troponin in their blood, period.
Q That is why there is a reference range on these tests, sir, that is what I'm saying.
A I'm saying the reference range that we've learned to use is usually above -- usually so obvious it's not even an argument. But usually a reference range at least over .2 or .25 is something to be concerned about any muscle damage.
Q Is that the same as cell damage? Are you using the term muscle damage synonymous with cell damage?
A Yes, muscle tissue is cells. Yes.
Q That is the same as unstable angina?
A What?
Q Muscle damage?
A No.
Q Isn't that what it is that you are trying to rule in or out in Mrs. Germanoff is unstable angina?
A Unstable angina is no longer unstable angina if there is muscle damage.
Q Fine. Don't you want to catch it before it becomes muscle damage; isn't that the point?
A In this patient?
Q Yes, sir.

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A Yes, you want to rule out but -- there is a gradation of everything, it's not yes, no.
Q In this case it was yes, no, because you said no.
A To what?
Q Unstable angina, didn't you?
A No.
Q You didn't?
A I didn't stay unstable angina, no. I didn't say that, no.
Q Was that part of your job, was to rule out unstable angina in Mrs. Germanoff?
A Yes, that was the role is to rule out unstable angina. The way we rule it out is finding out th ischemic burden.
Q Is elevated and rising troponin three times in excess of the reference range, and myoglobin twice as much as the reference range, evidence of unstable angina?
A No.
Q So is it your testimony then that the elevations o both troponin and myoglobin were not cardiac-related; is that your testimony?
A My judgment at the time these were not significant abnormalities.
Q My question again to you is, is it your testimony

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that these elevations were not cardiac-related? You can use hindsight if you want, because we know she died of a cardiac incident in two weeks. My question to you now, even looking at it backwards, okay, were these elevations cardiac-related, Doctor?
A You are asking me in hindsight, not the way you practice medicine?
Q Maybe not the way you practice medicine.
A I don't look at the end of the book.
MR. STRONG: Wait a minute.
A I have to practice medicine before --
MR. STRONG: Wait, I have to make an objection here. Ask a question, not a repartee --
MR. KAMPINSKI: He started the repartee. If he wants to answer my question, I would be happy to hear it.
MR. STRONG: You changed your question.
MR. KAMPINSKI: No, I didn't.
MR. STRONG: Ask it again, or have it read back, one or the order.
Q Were these elevations, sir, cardiac-related, the elevation in myoglobin and troponin?
MR. STRONG: He answered that

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already as to that point in time. Are you asking him in retrospect? I don't want to ask your questions for you. You asked it two-ways, you just asked it what I consider to be ambiguous.

Q Go ahead, Doctor, answer the question.

A At the time I saw the patient, I evaluated this information, I did not think it was a significant clinical abnormality when taken in the global situation she was in. Retrospectively, I still doubt it.

Q So what do you attribute the elevated myoglobin and troponin to, or don't you attribute it to anything?

A I attribute it to the plus/minus evaluation our lab has.

Q Correct me if I'm wrong, isn't the plus/minus the reference range?

A No, the plus/minus is -- if I can use an analogy maybe. If you have a cholesterol level of 200, the FDA approves a lab work that will have a number between 180 and 220. If the test comes out to 200, they say that is still within the range.

There is a range this test has. As you can see, the numbers are tiny, minuscule numbers. Imperceptible measurements and you are talking .04, .08, minuscule amount. This is a tiny little

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difference. In absolute numbers it's tiny. You can use statistics to make it sound like it's double or triple. You know, if you have one ant, that is small; two ants, that is huge because it's double. That is about what it amounts to. It's nothing.

Q Well, are you saying that the plus/minus can be double the actual numbers that are recorded here?

A I don't know. I know from clinical experience of seeing this in hundreds, hundreds of patients in this hospital, that these numbers are not enough to make a diagnosis with.

Q Based upon your vast experience then, what would you say the plus/minus is on these laboratory results?

MR. STRONG: He already answered the question.

MR. KAMPINSKI: No, that he hasn't said.

A If the number is over .2, .25, I would say that it is significant. Unless I ran a series of tests, with 20 or 30 of them, I wouldn't be able to tell you. I don't think that I could answer that question without running a scientific test.

Q So am I correct that what you are saying is that

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these numbers could have in fact been significantly higher in this particular lab, even though these numbers are reported as what they are, if you are not trusting the numbers?

MR. HOWES: Objection.

MR. KREMER: Objection.

MR. KAMPINSKI: Anybody else?

MS. PETRELLO: I thought we had a continuing.

MR. KAMPINSKI: I thought you did too.

Q Go ahead.

A That's your interpretation of it, that's not mine.

Q Isn't that what labs do, test little numbers? You are making it seem as though little numbers are somehow not to be trusted, isn't that precisely why we have laboratories?

A Well, that is because you don't know what goes on in a lab, to know that labs are all gradations of information. Measuring things and biologic systems are not yes/no, this/that, it's always -- there are always subtleties to these tests.

Q Did you pick up the phone and call the laboratory when you looked at these results, to determine the subtleties in this particular test, or did you order another test for example?

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A Yes, SGOT.

Q When did you order that?

A It's on the chart there.

Q How will that tell you if --

A That goes up in cardiac damage.

Q How does that tell you whether the myoglobin and troponin is rising, if it's accurate?

A My base of information comes from the medical literature and taking care of thousands of patients, including taking care of dozens of patients every week with chest pain syndromes.

I know from experience and from doing cardiac caths, and from getting consults on patients with these low levels, knowing that we find nothing in most of these patients. I have a vast personal experience in taking care of patients and dealing with it. Having done heart caths in patients with these minuscule numbers, 99 percent of the time it's meaningless in those levels.

Q Are you saying that you do do heart caths on patients with numbers such as Mrs. Germanoff?

A I stopped because in those levels we got very limited information. Limited information and we felt it was not appropriate, so that was my clinical experience in this institution.

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Q Why did you order the SGOT?
A Because it's another cardiac enzyme. It's a nonspecific enzyme, it is a cardiac marker.
Q Is that more specific than troponin or myoglobin?
A Yes, more specific than myoglobin.
Q How about troponin?
A No.
Q Isn't it a fact that is a liver enzyme, Doctor?
A It also goes up in cardiac damage.
Q If we're talking about unstable angina, which I thought we were talking about, then would you have expected to see an increase in SGOT?
A I wouldn't expect to see any elevation of enzymes with unstable angina.
Q Including myoglobin and troponin?
A I don't think they should go up. Once you have muscle damage, it's no longer unstable angina. My definition of unstable angina means there is ischemia. We may be talking about different things.
Q Give me your definition?
A My definition of unstable angina is transient ischemia to the heart, without muscle damage.
Q Something is causing a limit of blood supply to the heart?

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A Um-hum.
Q A stricture in one of the arteries perhaps?
A Um-hum, and it's transient.
Q That would be a good time of course to catch that problem, before in fact it caused muscle damage, wouldn't it?
A Yes.
Q Because that would be the optimal time to have intervention, bypass or stent or something, to prevent a heart attack and prevent somebody from dying?
A You are talking in general terms now, not about this patient?
Q Fine.
A I want to know what are you getting at, there are a lot of subtleties to your question, I want to make sure I'm answering them correctly.
Q In general?
A In general, it's a good idea. There is more to it than that.
Q It would have been a good idea with this patient in particular, wouldn't it?
A To what?
Q To have prevented her from dying?
A Oh. veah. sure.

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MR. HOWES: Want to take a vote on that?
MR. KAMPINSKI: I'm sorry, I didn't hear that.
MR. HOWES: I said maybe we should take a vote on that.
MR. KAMPINSKI: I'm not sure I understand it.
MR. HOWES: Do you think he was going to say it was better for her to die?
MR. KAMPINSKI: Is that your vote?
MR. HOWES: No, that is not my vote. That is why I don't understand question.
Q How do you get an elevation in troponin, Doctor, how does that happen within the body, what causes it to happen?
A Well, the most common cause is muscle damage to the heart. Heart muscle damage.
Q Is there leakage from the cells that causes that?
A Yes.
Q Does unstable angina cause leakage from the Cells?
A Not usually to a significant degree. I wouldn't say that -- I don't know how you would differentiate on clinical grounds between muscle damage and unstable angina. I'm sorry, I don't

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know how would you separate the two.
Q Maybe by virtue of the troponin being in the gray range, something above the reference range, but below the muscle damage range?
A There is always a gradation.
Q I don't understand what you are --
A There is always gradation between muscle that it ischemic and muscle that is totally necrotic, or dead. So I would say there is a gradation going from one to another, yes. There might be a litt bit of an elevation, sure.
Q The smaller the number, the less muscle damage, but yet, if it's an enzyme that is specifically related to being cardiac, such as troponin, that is evidence to you as a cardiologist, is it not, of there being unstable angina causing ischemia an cell leakage?
A If it's up significantly, yes.
Q We're back to the issue of whether or not the reference range at this particular hospital where you practice, you've apparently been the Chairman of Medicine, all sorts of things, is an accurate reflector whether or not there is leakage from cells establishing unstable angina.
MR. STRONG: That is a statement.

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MR. KAMPINSKI: It's a question.
MR. STRONG: I didn't hear a question.
A Typically if you have enzyme elevation, I no longer call it unstable angina. I'm not saying for sure that unstable angina may cause a leak in -- transiently in troponin, if I see an elevation in troponin, I no longer call it unstable angina, then it's myocardial infarction.
Q What levels of troponin elevation do you call it unstable angina?
A I don't.
Q Ever?
A I don't use troponin to make a diagnosis of unstable angina.
Q Can you have an elevation in troponin in the gray zone, that can be unstable angina?
A You can also have it in the normal range.
Q So the answer to my question is yes, you can?
A Um-hum.
Q That is a yes?
A Give me the question again.
Q Can you have an elevation of troponin in the gray zone that can be reflective of unstable angina?
A You could speculate that, sure.

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Q I'm not asking you to speculate. I'm saying as a matter of medical fact, can you have an elevation of troponin in the gray zone, that is reflective of unstable angina?
A Let's put it in two senses. Can you have it in theory, yes. Can you in practical terms figure that out, no.
Q You can figure it out by doing a catheterization?
A No.
Q You can't?
A No.
Q What would a catheterization on Connie Germanoff have shown? You looked at the autopsy, correct?
A When we saw her or when she died?
Q You saw the autopsy when she died. If you had done a catheterization when you saw her, what would it have shown in light of the autopsy?
MR. KREMER: Objection.
A That would be speculation.
Q Why?
A Because I don't know what it would look like then, I didn't look at it then. It's changed obviously between the time I saw her and the time she died.
Q She had blockage at the time of the autopsy?
A Right.

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Q That is not a trick question. If you had done a catheterization, you presumably you would have seen the blockage?
A The mechanism of myocardial infarction is a ruptured plaque. You can have a plaque on the wall you don't see arteriographically. The plaque cracks, breaks, ruptures, a clot forms under it and pushes it into the wall. You could have an arteriogram theoretically a week before, a plaque could rupture and a patient could die.
In fact, most serial studies show that patients that have myocardial infarctions documented do have heart disease. The plaques that you think are the worst are the ones that don't cause the next heart attack, it is the mild ones that often cause it. I'm not saying this is her case. You want me to give you a definitive answer, or you want me to speculate?
Q I'm just asking you is it likely had you done a catheterization you would have seen the blockage they ultimately saw on autopsy?
MR. KREMER: Objection.
A I would say that would be speculation. Do you want me to speculate, or do you want me to give you a definitive answer? A ruptured plaque occurs

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abruptly.
Q I'm not talking about the plaque that comes off. I'm asking the degree of blockage noted on autopsy, Doctor?
A Do you want me to draw you a picture of what happens, because you are asking a question I'm answering honestly, you are not understanding.
Q Sure, draw me a picture. Put it on this piece of paper, Doctor, we can mark it. We can see it, ultimately we can't keep that.
A I'm not a good artist. I say you can only speculate. This circle is an artery. When an artery builds up with atherosclerosis, it develops a cholesterol plaque, which is like a hard wax, it can be on a wall, like this, which is -- this is the plaque. That has narrowed it maybe 30, 40 percent, 20 percent, I don't know what that area is, maybe 15, 20 percent. Nothing there.
Then, a blood clot forms here. It pushes this plaque out across there. Then this whole area is blocked. This happens like a volcano, abruptly. A clot forms inside there, that blocks off the artery.
You are telling me -- I don't know exactly what it would look like. I could speculate. I car

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tell you what I think. I can't tell you for sure, if you want a 100 percent answer, I can't.
Q The reason I ask the question is your partner, Dr. Lee, testified had a catheterization been done at the time she was seen, it would reflect the blockage; you disagree with him?
A No, I said I could speculate that. I can't give you 100 percent assurance, knowing the mechanism of action. Since you want an answer that is all or nothing, I can't give you that.
Q I want an answer to a reasonable degree of medical certainty. Do you agree or disagree with Dr. Lee in terms of what his statement was?
A I would have to read his statement you are quoting.
Q You said you read his deposition?
MR. STRONG: Isn't it 100 some pages?
A I read it a month ago. Anyway, she could have had a plaque this severe, it clotted off. I can't say she didn't, I can't say she did. That's the mechanism. Heart attacks do occur abruptly, that is why you can have a normal stress test one day, die from a massive heart attack the next day.
Q Have you read any of the expert reports, sir?
A I think I read some of them. I'm sure I didn't

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read all of them.
Q Do you recall which ones you did read?
A No.
Q Is it your testimony that an emergency room doctor cannot rely on a negative stress test to rule out unstable angina?
A I think no physician should rely on any one test. You take a lot of information, put it together, including age, risk factors, all sorts of things.
Q Dr. Waller is an expert that was retained by Dr. Hamrick.
A Okay.
Q In his report he said, I'll quote this, "The presence of continued chest pain and suspicious enzymes made it mandatory to perform a cardiac catheterization prior to release." He was referring to Dr. Lee.
A Um-hum.
Q Do you agree or disagree with that?
A I disagree with the statement she was having continuous chest pain.
Q Dr. Waller said, I'll quote, "The failure to perform the diagnostic catheterization by Dr. Lee fell below the standard of care for a cardiologist, and led directly to Connie Germanoff's fatal acute

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myocardial infarction."
Do you agree or disagree with that, sir?
A I do not think that statement you read fulfills the the evidence based medicine practice which we do.
That falls below the -- that falls to -- they are using a different method. We use an evidence based medicine, which is designed from I think the National Institute of Health, American College of Cardiology, American Heart Association. We use evidence based medicine.
His statement is -- his statement of having two negative stress tests, going eight and a half minutes on a stress test, all other criteria we use, it does not fall within evidence based medicine at that time.
I would agree if a patient had recurrent pain, beyond one hospitalization, then that is a different story.
Q Well, tell me what you mean by evidence based medicine, I'm not sure I understand the term?
A One of the most common admissions to the hdspital is chest pain. We have chest pain units, we take care of tens of thousands, millions of patients a year. Because of that there is a tremendous amount of medical literature, because of that there are

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published guidelines, they tell you based on literature and medicine what is a reasonable approach to handling these tremendous millions of patients. Everybody in this room has had chest pain at some time, I'm sure. There are guidelines how to manage that.
Basically I don't use guidelines as a cookbook. I use evidence based medicine. I think the standards that I used and Dr. Lee used was based on that criteria.
Q Where do I find the guideline that you are referring to?
A Where do you find it?
Q What is the name of it, tell me what you are talking about?
A American Heart Association.
Q That is an association, what is it that they publish -- where would I go to find what you are talking about that sets forth the guideline that says what you and Dr. Lee did was okay?
A I don't know. I looked it up in a journal.
Q What journal?
A American Heart Association journal.
Q Which journal?
A Circulation.

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Q Which publication?
A I just know it from medical -- you are asking me like I looked it up. I just know it. That is what I deal with every day of the week, so I know basically what I'm dealing with. You are asking me, I can't tell you anything other than probably in Circulation because that is where they publish the guidelines.
Q Are those guidelines we can rely on by the American Heart Association, is that what you are telling me?
A That is generally the way I practice, yeah.
Q Doctor, you said you looked at the other emergency room visits?
A Yes, casually I looked through them. I didn't study every --
Q Help me out here for a second, turn to the December 20th visit. I'm looking at page 35, which is the emergency department nursing assessment notes, which was the complaint when she came in. I think you've got **34** there.
Connie Germanoff came in clenching her chest and breathing heavy, complaining of chest pain, radiating left arm. Then later she had an emesis, clutching of chest, patient continues to complain of chest pain and one more emesis.

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You had seen her two days earlier, Doctor?
A Um-hum.
Q Should she have been referred to a cardiologist with additional workup in your opinion?
A That would concern me a great deal, yes. Based on that limited piece of information there, yes.
Q This is her telling --
A That is not her whole chart.
Q I understand.
A You are basing it on this piece of information without knowing anything else, yes. I would, yes, based on that limited information there.
Q The doctor, this Dr. Hatcher said that he reviewed her old record, she had a normal cardiolite stress test in the last month. He said that that is what he relied on.
A Um-hum.
Q Based on our earlier discussion, I take it it was inappropriate for him to rely on the stress test you did two days earlier to rule out unstable angina in this patient?
MS. PETRELLO: We still have a continuing objection?
MR. KAMPINSKI: Sure.
Q Would that be accurate, sir?

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A Can you repeat the question.
(Question read.)
A Based on the information in the chart at this time, knowing what the previous stress test said, I'm not sure exactly what you are saying from before, I would be very concerned and make sure she had further workup.
Q Further workup being what, at this point, Doctor?
A She probably should be hospitalized, observed, get enzymes, maybe another heart cath -- a heart cath at that time.
Q You don't mean another heart cart, a heart cath?
A A heart cath, right.
Q She then comes back, Doctor, to the emergency room on December 24th, by ambulance. Her complaint is chest pain. Reason for treatment is chest pain. Should she have been referred to a cardiologist on that occasion?
A What were her complaints at that time?
Q Chest pain, chest pain, same chest pain she had been having. Of course it does say patient states cardiac ruled out on two prior trips.
A Says she is having epigastric -- is that epigastric pain?
Q Where are you reading from, Doctor?

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A 29.
Q Let's start with rural Metro ambulance, which she is the one that made the complaints of what was bothering her, that is page 225. You can look at this if you don't have it.
Reason for treatment, chest pain. Complaints, chest pain. That is what she told them. History, two episodes in the past week. So I mean the lady is still coming back to the hospital complaining of chest pain, should she have been seen by a cardiologist?
A I think we should have been called to assess that recurrence.
Q Again I take it at that point had you been notified, I think Dr. Lee addressed this issue also, she would probably have been catheterized':
A Probably at that time, yes.
Q Again, it would not have been appropriate for th emergency room physicians at that time to have relied on a negative stress test to rule out unstable angina when she comes in with continuing complaints of chest pain?
A That is right. In fact, if a patient had a heart cath, was normal, came back with chest pain, I would put them into the hospital.

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Q That dovetails into your explanation to me how these heart attacks happen?
A Right.
Q I'm almost done.
A That's okay.
Q Did you at any time, Doctor, have any discussions with either the emergency room physicians, or any of the primary care physicians regarding Connie Germanoff!
A I don't think I ever have. I don't remember if I did.
MR. STRONG: You need to check?
(Recess taken.)
(Plaintiff's Exhibit 1 marked for identification.)
MR. KAMPINSKI: Without trying to characterize it at all, Doctor, that diagram that you drew reflecting the blockage of an artery, it's now been marked as Plaintiff's Exhibit 1, correct?
THE WITNESS: Okay.
MR. KAMPINSKI: Attach that to the transcript.
I really want to put something on the record as to Miss Petrello's client. Basically we are done. We sent your office a letter a couple

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days ago asking for answers to interrogatories that we filed with the case initially, which we never received answers. If you could look into that, see that we get the answers, I would appreciate it. Do we need it from anybody else?
MR. MELLINO: You never answered on behalf of the group, only the one with Dr. Lee.
MR. STRONG: Is that right?
MR. KAMPINSKI: That was referring to Mr. Strong. If we could get answers, we would appreciate it. I think that's all we have. I don't know if you guys have any questions of the doctor. Don, any questions?
MR. SWITZER: Just a few questions. You want to go ahead?
MR. KAMPINSKI: I quite frankly forgot you were there, Don.
MR. SWITZER: Not the first time.
Doctor, can you hear me?
THE WITNESS: Yes, I can.
MR. SWITZER: Just a few questions for you. I represent Dr. Hamrick.
THE WITNESS: Okay.
CROSS-EXAMINATION
By Mr. Switzer:

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Q When you reviewed the ER records for December 24, 1999, did you note that according to those ER records the complaints to the physician and ER nurses, Mrs. Germanoff was complaining of epigastric pain?
A Yes, I think I said that.
Q That is different than chest pain, isn't it?
A Correct.
Q I apologize if you already answered this question, Rick, just tell him it's already been answered, you don't have to answer it again.
Did you rule out MI in that admission on December 16th through December 18, '99?
A Yes, there was no evidence -- there was no evidence of significant amount of heart damage.
Do you have to take that?
MR. STRONG: Possibly. Hang on.
THE WITNESS: I'm sorry. This is ridiculous.
(Recess taken.)
MR. STRONG: Don, the Doctor is' back.
By Mr. Switzer:
Q My question, I don't think I heard this, did you say they no longer use the troponin levels at

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Aultman Hospital?
A I did not say that. They use them, it's a good test if it's used properly.
Q You may recall that the troponin level on December 24th was I believe .04?
A Correct. I don't know that.
Q I think I'm correct on that, I believe .08 for the second test on the 17th.
Do you have any opinion as to whether the troponin level -- at what period of time -- what the level was when it peaked?
MR. KAMPINSKI: Don, wait a second. Are you telling the doctor on the 24th there was a troponin done?
Q I'm sorry, the 20th. Thank you. Let me withdraw the question, start again.
On the 20th I believe the troponin is .04?
A Correct.
Q On the 17th, I think in the afternoon it was .08?
A Correct.
Q Do you have any opinion as to whether the troponin level ever peaked to a level higher than .08, if so what that number was?
A That would be speculation. I could tell you with myocardial infarction the enzyme troponin goes up

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and stays up.
Q How long does it stay up with an MI?
A I can't tell you an exact answer. In terms of weeks.
MR. SWITZER: Thank you very much, Doctor.
MS. PETRELLO: I have some questions. My name is Colleen Petrello, I represent Dr. Hatcher, who is the emergency room physician who saw Mrs. Germanoff on the 20th.
MR. KAMPINSKI: You also represent the group as I understand. You also represent Dr. Hatcher, as I understand by virtue of representing the group, and therefore I object to both of you asking questions, but go ahead.
MS. PETRELLO: Did you want to take your page?
THE WITNESS: Go ahead.
MR. STRONG: If she is quick. If she gets to a point you need to go, say so.
THE WITNESS: I don't know if it is an emergency or it is from the emergency room. The answering service doesn't know the difference. There are doctors there, if it's an emergency they can usually handle the situation.

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MS. PETRELLO: I would like to think so, Doctor.
CROSS-EXAMINATION
By Ms. Petrello:
Q Doctor, you did review the emergency room records, including the emergency room visits after the admission?
A Yes, just in a very casual fashion. I would not want to comment without looking at a very specific piece of information.
Q Doctor, you did comment and testify that you felt that perhaps the emergency room physician should have called a cardiologist; is that correct?
A Yes, based on the information that was shown to me. I don't have a long -- I haven't studied these long notes typed here.
Q Were you aware that Dr. Hatcher also did some blood work, did you review the lab studies?
A No.
Q Were you aware that the CPK was 62 and they couldn't even do a CK?
MR. KAMPINSKI: Which are you referring to?
MS. PETRELLO: 20th.
MR. KAMPINSKI: Which page?

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MS. PETRELLO: 40.
A I saw that when I saw the troponin.
Q Couldn't do a CK because it was too low. They did the troponin and myoglobin, those two levels were lower than what it was in the hospital, correct?
A The troponin is. I think the myoglobin is. I don't remember. The CPK by itself without -- is too small to fractionate.
Q We will take them one by one.
MR. STRONG: Why don't you ask him something so we don't have to go back through all these things that have been asked.
MS. PETRELLO: I don't think it's been asked.
Q I want you to acknowledge the myoglobin, let's start with that 125.8, don't you agree that is lower than what it was in the hospital?
A Yes.
Q How about the troponin, don't you agree it's lower than what it was in the hospital?
A Yeah.
Q Did you note that there was an EKG done by Dr. Hatcher, it was normal?
A I will be glad to look at it.
Q Page 38, interpreted as normal compared to the

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previous one on 12-16?
A Yes, okay.
Q So, Doctor, at least based on some of the things I've shown you, Dr. Hatcher didn't simply rely on a negative stress test in evaluating Mrs. Germanoff on the 20th; do you agree with that?
A Yes.
Q Are you aware that it was Dr. Hatcher's impression that it could have possibly -- her complaints could have been due to a GI problem, and in fact he gave her a GI cocktail, and she got relief from her pain; are you aware of that?
A I'm aware of it because you told me. What I see here, correct.
Q You're not an emergency room physician, correct?
A Correct.
Q You don't practice in the emergency room?
A Correct.
Q You would agree with me you're not familiar with the standard of care for emergency room physicians?
A Correct.
MS. PETRELLO: I don't have anything else.
MR. STRONG: Anybody else?
MR. KREMER: My name is Stephan

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Kremer, I represent Dr. Hollaway and her group.

CROSS-EXAMINATION

By Mr. Kremer:

Q I think I heard you correctly before you did not speak with Dr. Hollaway, or Dr. Hummel, or Dr. Linz, or Dr. Schall, or anyone from that practice on December 18th when you saw the patient; is that correct?

A I have no recollection of that. That is the best I can say.

Q Nowhere in the chart did you write a progress note or an order that this patient was to follow-up with you or your group; is that correct?

A I didn't write that, correct.

MR. KREMER: I don't have anything further, thank you.

MR. HOWES: Nothing.

MR. KAMPINSKI: Doctor, I won't be long, but just to follow-up on some of these questions just asked now.

MR. STRONG: Before you continue, I apologize for interrupting, the Doctor had a page.

MR. KAMPINSKI: Let him take it then.

MR. STRONG: The question is whether he thinks he needs to or not.

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(Recess taken.)

MR. KAMPMSKI: Doctor, I take it we're okay for a few minutes?

THE WITNESS: I hope so.

MR. KAMPINSKI: Based on the page you just took?

THE WITNESS: Yes, it was not an emergency.

RECROSS-EXAMINATION

By Mr. Kampinski:

Q The emergency room physicians retained this Dr. Waller, okay. He's the expert who I quoted from his report earlier that indicated that he believed that Dr. Lee deviated from the appropriate standard of care required of you.

A Correct.

Q Now you've been asked questions by these emergency room physician's attorneys, suggesting that their clients, the emergency room doctors, could rely on relief of symptomatology which they believed was epigastric, despite the woman complaining of chest pain and clutching her chest, saying the pain is the same as it has been, breathing heavy, radiating down her left arm, they asked you a question if it's appropriate and within the standard of care for an emergency room doctor to rely upon relief of symptomatology with a GI cocktail as it not being cardiac.

My question is the following: You referred me to heart standards, isn't it a fact that the American Heart Association standards say you cannot rely on relief of symptomatology by virtue of giving somebody a GI cocktail?

MS. PETRELLO: Objection.

A If you are asking me what the American College --

Q Heart Association?

A -- says, I don't know that. I would have to see those words to say you are saying it accurately.

Q Let me ask you this: Can an emergency room physician rely on relief of symptoms by virtue of giving a GI cocktail to rule out pain that is cardiac in origin?

MS. PETRELLO: Objection.

A No.

Q That question was a fair question to ask you, in terms of suggesting that that somehow exculpates an emergency room physician from determining what the cause of the sternal chest pain is?

MS. PETRELLO: Objection.

Q Would that be a fair statement, sir?

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A It's global information. You don't just -- it's everything put together. It's not just any one thing.

Q These emergency room doctors who are criticizing the cardiologists, yourself and Dr. Lee, and I apologize if this is repetitive, I want to make very sure there is no confusion in this, they did not have a right to rely on the negative stress test you did in order to rule out unstable angina when this woman came back on two additional occasions after you saw her, continuing to complain of chest pain; would that be correct?

A The way I would put it is that when a patient keeps on coming back to the hospital with recurrent pain, the onus is on the doctor to find out what is going on.

Q Would not the standard of care of any physician, whether he be emergency room, whether he be a family practitioner, whether he be an internist, require him under these circumstances that are set forth on both December 20th and December 24th, require that doctor to get a cardiology consult to allow you to do, if it were you, to do your job?

MR. STRONG: Objection. He already answered part of that question as to what standard

of care he can or cannot testify to.
MR. KAMPINSKI: The reason I ask that is he was asked, or he did respond to Dr. Waller's comment about standard of care. So apparently he has some conversance with standard of care.
MR. STRONG: Waller is a cardiac pathologist.
MR. KAMPINSKI: I don't know what he is. He's the guy they hired to criticize your group.
Q My question to you, I thought I had it there, is would it not be the appropriate thing for a doctor to do, if you don't want to use the words standard of care, any physician to refer such a patient as Connie Germanoff when she returns on December 20th and December 24th, continued to complain of chest pain, refer her to a cardiologist?
A Yes.
MS. PETRELLO: Note a continuing objection.
A As it's presented, yes, I think so.
Q I take it you have no disagreement with your colleague, Dr. Lee, in terms of his testimony to the effect that if in fact Connie had been referred on either December 20th or December 24th, the

appropriate intervention would have occurred and in light of the findings on autopsy, that she probably would have been successfully treated and be alive and well today?
A Probability, yes. I mean if -- probably if she hac angiography she may well have been properly treated. I have seen patients treated for this problem who still rupture their heart.
Q We have to talk in terms of probability since nothing to that effect was done?
A Yes, I would say that is certainly -- that is reasonable.
MR. KAMPINSIU: That's all I have. Anything else?
MR. SWITZER: Not from this end.
MR. STRONG: You have a right to read it. I'm asking her to print it up, send it to me, you'll review it for clerical accuracy.
(Deposition concluded at 6:33 p.m.)
(Signature not waived.)
- - -

I have read the foregoing transcript from page 1 through 103 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

_____
Alan Kamen, M.D.
Subscribed and sworn to before me this _____ day of _____, 2001.
_____
Notary Public
My commission expires: _____

State of Ohio, } SS: CERTIFICATE
County of Cuyahoga,)
I, Constance Versagi, Court Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, Alan Kamen, M.D., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy/computer in the presence of said witness, afterward transcribed, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.
I do further certify that this deposition was taken at the time and place in the foregoing caption specified, and was completed without adjournment.
I do further certify that I am not a relative, counsel, or attorney of either party, or otherwise interested in the event of this action.
IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 22nd day of May, 2001.

_____
Constance Versagi, Court Reporter and Notary Public in and for the State of Ohio.
My Commission expires January 4, 2003.