IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

JANET L. PORACH, ADMINISTRATRIX OF THE ESTATE OF [illegible],

Plaintiff,

-vs-

LORENZO S. LALLI, M.D.,

Defendant.

JUDGE CALABRESE
CASE NO. 316045

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Deposition of LORENZO S. LALLI, M.D., taken as if upon cross-examination before Susan M. Cebron, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Weston, Hurd, Fallon, Paisley & Howley, 2500 Terminal Tower, Cleveland, Ohio, at 2:00 p.m. on Wednesday, March 5, 1997, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

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On behalf of the Plaintiff;

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On behalf of the Defendant.

ALSO PRESENT:

Janet L. Porach

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

CROSS-EXAMINATION OF LORENZO S. LALLI, M.D.

BY MR. MISHKIND:

Q. Would you please state your name?

A. Lorenzo, L-o-r-e-n-z-o, S middle initial, Lalli L-a-l-l-i.

Q. Dr. Lalli, we met earlier this morning. I am going to reintroduce myself on the record officially and formally. I am Howard Mishkind and I represent the Estate of John Porach in connection with the lawsuit that has been filed against you.

You were present when Mrs. Porach and her childrens' depositions were taken this morning, correct?

A. Yes.

Q. You understand, basically, then that this is a question and answer session where I will be asking the questions and you will be providing the answers to those questions.

A. Yes.
Q. I want to give you just a couple instructions to follow as I go through my questions so that when we go back and look at the transcript afterwards there won't be any questions that you didn't understand what I was asking.

The first thing I would ask you to do is wait until I am done with my question before you start answering. Will you do that?
A. Yes.
Q. If you don't understand what I am asking, and I have been accused maybe once or twice in my career of asking a question that is unintelligible, Mr. Rispo has probably been the one that has accused me of that, if I ask you something and you don't understand, will you tell me, Mr. Mishkind, I don't understand what you are asking, and I will attempt to rephrase the question?
A. Yes.
Q. I will then, therefore, assume that if you answer the question it is because you understood the question. Is that a fair assumption?
A. Yes.
Q. As we go through the questions with regard to

Mr. Porach you are certainly free to refer to your office record. You have it with you today, I see?

A. Yes.

Q. I am going to during the course of this proceeding going to take a moment or two just to take a look at the chart just to make sure that I have everything that's there, but when I am asking you questions about the patient, please don't necessarily rely on your memory unless it is something that is independent from the record. You can use the record. Fair enough?

A. Yes.

Q. Is what you have with you today the original of Mr. Porach's record?

A. No. These are copies.

Q. Where is the original?

A. In my office.

Q. Where is your office located?

A. 18099 Lorain Avenue, Suite 312, Cleveland, 44111.

Q. And what is your date of birth, sir?

A. May 12, 1954.

Q. And your Social Security number?

A. 269-56-2330.

Q. Where were you born?
A. In Italy.
Q. And when did you come to the U.S.?
A. I came to the U.S. in 1965 and lived here from '65 to '75. Then lived in Italy for nine years and came back here in 1984.
Q. And you have resided then in the U.S. continuously since 1984?
A. Yes.
Q. Where did you go to medical school?
A. The University of Balogna, B-a-l-o-g-n-a.
Q. What year did you graduate?
A. 1984.
Q. What was the reason that you went back to Italy in 1975?
A. I didn't get into medical school in the United States.
Q. Where did you go to college?
A. Case Western Reserve University.
Q. What was your undergraduate degree in?
A. Biology.
Q. Did you graduate in 1975?
A. Yes.
Q. How many different medical schools did you apply to?

A. Ten.
Q. The University of Balogna --
A. Yes.
Q. -- was it a four year degree?
A. Actually, it is a six and a half year degree there, but at the time that I attended you could take as much time as you wanted to.
Q. How long did you take?
A. It took me eight and a half years.
Q. Were you working as well as going to school?
A. No. I was not.
Q. So you were a full-time student?
A. Yes.
Q. Did you do what would be equivalent to an internship and a residency while you were going through?
A. No.
Q. Or at least an internship while you were going through your training?
A. No.
Q. So that the -- I am sorry, did you say six and a half years or eight and a half years?
A. What's the question?
Q. The number of years that you were at the University of Balogna.

A. Eight and a half years.
Q. Did you do some post-graduate training after finishing?
A. No.
Q. Eight and a half years would take us up to the latter part of '83 or would it take us into '84?
A. Well, it didn't begin, the school year did not begin until December of '75 is when classes began, and I graduated April 11th of 1984.
Q. Then when did you come to the U.S. in '84?
A. I came on April 28th, I believe, 1984.
Q. Was it your plan after graduating from medical school to return to the United States?
A. Originally, no. I had thought of staying in Italy, but two years before I graduated the field of medicine was saturated in Italy and you had to wait in line two and up to three years before finding work. So at that point I decided to come back to the United States.
Q. Did you look for work upon graduating from the University of Balogna before making the decision to come back to the U.S.?
A. In Italy?
Q. Yes.
A. No.

Q. When you came back to the U.S., did you come to the Cleveland area?
A. Yes.
Q. Did you have family back in Cleveland?
A. Yes. Parents.
Q. And do your parents still live in the Cleveland area?
A. Yes.
Q. Are either of your parents in the medical field?
A. No.
Q. Just out of curiosity, what line of work are either or both of them in?
A. They are both retired factory workers.
Q. And are you married, sir?
A. No.
Q. Have you ever been married?
A. Yes.
Q. Is your wife back in Italy or here in the U.S.?
A. She's in the U.S.
Q. Is she in the medical field?
A. No.
Q. What line of work is she in?
A. She's a homemaker primarily. Part-time as a, what's the word, school -- teacher's aide, part-time teacher's aide.

Q. What school system?
A. Brecksville.
Q. Are you a U.S. citizen?
A. Yes.
Q. When did you become a citizen?
A. 1973, I believe.
Q. When you came back to the U.S. in 1984, what did you do?
A. I did a five -- let me see -- a six to seven month externship at Lutheran Medical Center after which I was offered a position as a resident starting January 1st of 1985, and I completed training in internal medicine on June 30th of 1988. I then became board certified in internal medicine September 15th of 1988.
Q. Where was your residency?
A. Lutheran Medical Center.
Q. Were you successful in becoming board certified on the first attempt?
A. Yes.
Q. And that was in 1988?
A. Yes.
Q. Tell me where your practice went then after finishing your residency, becoming board certified, what did you do next?

A I was employed by Lutheran Medical Center to work in a clinic from, I believe, October of '88. I worked there until February or March of '89, after which I remained an employee of Lutheran Medical Center, but was an associate with Dr. William T. Wilder at Lutheran Medical Center and remained with him until June of 1990, after which I applied and was accepted as a fellow at University Hospitals in geriatric medicine. That began July 1, 1990.

After two or three months I realized I didn't want to be in geriatrics and came to know that Dr. Costanzo wanted to sell his practice. So I purchased his practice and began working there as a sole practitioner on November 1, 1990, and have been there since.

Q. In addition to being board certified in internal medicine, do you have any other board certification?

A. No.

Q. Have you sat for any other board?

A. No.

Q. Other than the State of Ohio, which I presume you are licensed in, are you licensed in any other states?

A. No.
Q. Have you ever been licensed in any other states?
A. No.
Q. Have you ever had your license in the State of Ohio revoked or suspended?
A. No.
Q. Do you have hospital privileges?
A. Yes.
Q. At what hospitals?
A. Fairview General Hospital.
Q. Are your privileges at Fairview active?
A. Yes.
Q. Have you had any other privileges at other hospitals since coming back to --
A. Lutheran Medical Center.
Q. And what's the status of your privileges at Lutheran?
A. I'm no longer on staff there.
Q. You let -- you just didn't renew your --
A. After a year I was not admitting any patients to Lutheran. So I withdrew.
Q. At Fairview General do you hold any positions in any departments at the hospital?
A. No. I'm a member of two committees.
Q. What committees?

A. Pharmacy and therapeutics committee and peer utilization review.
Q. Peer utilization --
A. Review, right.
Q. What is involved in your work on peer utilization review?
A. Attending at least six meetings a year and participating in discussion.
Q. What's the nature of the discussions that take place?
A. During the meetings we are presented data with regard to mortality tied to a specific diagnosis, for example, length of stay tied to a specific diagnosis, and we also listen to cases that are presented where there is a question that is brought up and then issue an opinion regarding that.
Q. Do you hold a position on the peer utilization review board as chairman or --
A. No.
Q. -- or any type of an officer on that?
A. No.
Q. Just a member?
A. Member, yes.
Q. And how long have you been on the peer

utilization review?
A. Three or four years.
Q. Who heads that committee?
A. Dr. Michael Waggoner, W-a-g-g-o-n-e-r.
Q. You are called on from time to time as part of that committee to review essentially the quality of the medical care provided to patients that are treated at Fairview General Hospital?
A. That's correct.
Q. And certainly, therefore, the issue of whether or not the care provided by a doctor or other health care provider met accepted standards of practice is the topic of discussion from time to time at those peer utilization review meetings, correct?
A. Yes.
Q. So you are certainly familiar with when one talks about whether or not the standard of care was met and whether or not the treatment provided met the standard of care or fell below the standard of care, that's a term that you are familiar with at the very least from your participation on this utilization review committee, right?
A. Yes.

Q. Do you have a curriculum vitae?
A. I don't have one with me, but I do have one.
Q. If you would provide a copy of that to Mr. Rispo and he then, in turn, will graciously send me a copy, I would appreciate that.
A. Certainly.
Q. Since I don't have that I am going to ask you some questions that otherwise would be answered and would have been answered had I had one.

Do you do any lecturing or teaching on a formal or informal basis?

A. No.
Q. Have you at all during your medical career?
A. Yes.
Q. When?
A. For five years, it ended in September of '96, I was preceptor in the outpatient clinic where internal medicine residents see their patients.
Q. What were your responsibilities as preceptor?
A. Residents would go in and see patients and then they would come out and discuss the patient with me and I would guide them as to the diagnosis and treatment.
Q. Were you serving in that capacity as the attending overseeing the residents?

A. Yes.
Q. Were you working as a preceptor as an employee of Fairview General Hospital?
A. Yes.
Q. What happened --

MR. MISHKIND: Off the record.

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

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Q. What happened in September of 1996 that ended that position?
A. I was asked to leave because there were other employees of Fairview Hospital who were fully salaried and that needed to be kept busy because I was receiving a salary solely for my Wednesday afternoon in the clinic.
Q. Who were you asked to leave by?
A. By Dr. Michael Waggoner.
Q. Was this termination of the position as of September of '96, this preceptor, was this something that you willing agreed to, or was there some, shall we say, difference of views as to whether you should or not?
A. I did not contest it.

Q. Was there any type of a committee meeting that led to this decision or was this solely, to your knowledge, Dr. Waggoner's call?
A. Solely Dr. Waggoner's call. I don't believe I even had a written contract with them. So I had been asked to take this position by the previous program director, and since he and I were friends he said you have to make a verbal commitment to stay on the job for at least three years. I liked it, so it stayed on.

Circumstances changed and I was asked to leave and I didn't have a problem with it.

MR. MISHKIND: Off the record.

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

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MR. MISHKIND: Back on the record.

Q. Just to finish this conversation, your position then as a preceptor ended in September *of* '96 and it was a verbal contract with no definite ending date other than you had to stay on for three years, correct?
A. Yes.

Q. And there were no complaints lodged against you that caused or contributed, to your knowledge, to your being removed as the preceptor?
A. That's correct.
Q. Other than that position for five years up until September of '96, have you lectured or taught on a formal or informal basis at any other time during your career?
A. No.
Q. Were you lecturing in that capacity or was it a clinical practice as the attending overseeing the residents' activities?
A. I was the clinical attending overseeing the residents' activities.
Q. There was no classroom lecturing?
A. There was no lecturing.
Q. Have you done any writing in any peer review articles or journals since you have been licensed?
A. No, I have not.
Q. Have you submitted anything for publication?
A. No.
Q. At any time while you were at Lutheran or while you have been at Fairview General have you had your privileges suspended or limited or

otherwise brought into question?
A. No, I have not.
Q. Have you had your deposition taken before, before today?
A. Have I ever had a deposition taken before?
Q. Yes.
A. Yes.
Q. On how many occasions, excluding today, have you been deposed?
A. One.
Q. Were you a party or were you a witness?
A. I was one of a number of physicians who was named as a defendant in a case I believe it was in 1988 when I was still a resident.
Q. Since completing your residency have you been named as a defendant in a medical malpractice case up to but excluding this case?
A. Two weeks ago I received a -- what's the formal word?
Q. A summons and complaint?
A. A summons and complaint. I was named as co-defendant along with another physician on a patient who was admitted to the hospital who had a pulmonology consult from day one, ended up staying in the hospital nearly two months, I was

off the case as of the third day, and if I remember, I was not even involved with the patient during the time in the hospital. They sued both the pulmonologist and me, only I was only involved with her care for three days and she was in ICU the whole time.

Q Obviously your deposition was not taken?

A I guess with tort reform I don't know if it is going to be an acceptable case or not.

Q What do you know about tort reform?

A Very little, but my understanding is that now before a case can go forward it has to be reviewed by someone in the medical field or by a judge in order to establish if it has some validity.

Q The source of your information about this is what?

A The other physician who was named as defendant in this last case.

Q. Who is that doctor?

A. Dr. Neil Chadwick.

Q. Chadwick?

A. Yes.

Q. Are you able to personally glean from the complaint and summons what the allegation is as

it relates to you personally?
A. No, I'm not.
Q. Going back to 1988 when you were one of a number of defendants named when you were in your residency, what was the allegation as it relates to your involvement in that matter?
A. What I can recall of that is that I wasn't involved in the care of this patient as it turns out. There was a signature on an order somewhere, and I got to the deposition and then I don't even know what happened to the case because I was no longer summoned.
Q. What was the name of the plaintiff in that lawsuit?
A. I cannot remember.
Q. Was is the name of plaintiff in this lawsuit that has just been recently filed against you?
A. I believe the plaintiff's name is Wilma Doktor, that's the decedent, the person that died. I don't know, some family member.
Q. The plaintiff that's bringing the claim last name is Doktor?
A. I believe so, yes. D-o-k-t-o-r.
Q. And this is the representative of the deceased?
A. This patient came through the emergency room. I

had never seen her before. She was sick. Someone else was called on consult. She remained sick. I said I don't have anything to offer in this case because she is solely a pulmonology case, and Dr. Chadwick accepted to take over because he was doing everything anyway, and so I don't know any family members. I never had contact with them.

Q. But the patient's last name was not Doktor?

A. Yes, the patient's last name was Doktor. Wilma Doktor was the patient's name.

Q. 1 am sorry. I thought that was the individual that was bringing the claim for the patient. Fine. That's fair enough.

A. The patient's son, I believe.

Q. Fair enough. So we have the Porach case, we have the case when you were in your residency, and we now have the Doktor case, and that constitutes three times that you have been sued in a medical negligence case?

A. That's correct.

Q. Have you been a party either as a plaintiff bringing a claim or as a defendant being sued in any other type of litigation?

A. No.

Q. Outside of your responsibilities on the utilization review committee, have you been called upon from time to time during your career to serve as an expert witness in a medical malpractice case?
A. No.
Q. Have you outside of the peer utilization review committee from time to time in your career been called upon either by a patient or by a physician or an attorney or either one of them to review records and to provide an informal opinion as to whether the care met or fell below accepted standards?
A. No.
Q. Your practice as of 1997, is it any different than it was back in 1994 when John Porach was seen in your office on the date of his death?
A. No.
Q. Do you have any partners or associates?
A. No.
Q. You obviously didn't have any partners or associates back then either?
A. Yes.
Q. Can you tell me a little bit about your practice, doctor, in terms of how you would

describe it percentagewise in terms of the type of patient population that you see?

A. Well, Monday and Thursday mornings I go to two nursing homes, one on Monday morning, one on Thursday morning. I have 130 nursing home residents that I see once a month. So that's clearly a geriatric population.

As far as the office practice, I would say that it's probably about 60 percent Medicare population and 40 percent a younger population. I would say that about 95 percent of my work is outpatient work, either in the office or in the nursing home, and less than five percent of what I do is follow patients in the hospital, and that's because fewer patients are hospitalized. The ones that are hospitalized usually need specialty care.

Q. The nursing homes that you work with, what are their names?

A. Their names are Rae, R-a-e, hyphen, Ann, A-n-n, Suburban Nursing Home in Westlake, and Rae-Ann Center, R-a-e, A-n-n, Center, which is in Cleveland.

Q. Do you have a title at either of those nursing homes?

A. Yes. I am medical director.
Q. How long have you been medical director at those two facilities?
A. I believe five and a half years.
Q. What you have just described in terms of the makeup of your practice, nursing home, outpatient, the type of patients you see, Medicare, younger patients, is that pretty much how your practice was back in 1994?
A. Yes.
Q. Do you have an area in internal medicine that you either have a subspecialty in or have a particular interest in?
A. No.
Q. I take it you do not hold yourself out in the medical community or certainly in the greater Cleveland area as an expert in the area of cardiology?
A. That's correct.
Q. You are certainly competent as an internist to diagnose coronary artery disease, correct?
A. To some extent.
Q. Certainly as an internist, and whether it be the Medicare patients or, unfortunately, some of the younger patients, you are exposed to patients

that have the signs and symptoms of some type of disease process that inevitably leads to a diagnosis of coronary artery disease, correct?

A. I would describe myself as a primary care physician who can recognize people who are at risk for developing coronary artery disease or may suspect coronary artery disease.

However, since the diagnosis of coronary artery disease is either made with cardiac catheterization or when a patient arrives in the emergency room and is diagnosed with an acute myocardial infarction, I would say that I rarely, if ever, make the diagnosis of coronary artery disease. All I do is suspect it and counsel some patients about the fact that they are at risk for it.

Q. Okay. In patients that have a confirmed diagnosis of coronary artery disease, do you from time to time in your practice follow those patients?

A. Yes, I do.

Q. And without being absolutely specific in percentages, can you tell me of the patient population that you see on an outpatient basis what percentage that you follow have confirmed

coronary artery disease?

A. I would say about 10 percent.

Q. As an internist you are certainly trained to recognize the risk factors for coronary artery disease, correct?

A. Yes.

Q. And would you tell me what those risk factors are?

A. Yes. A family history, age, gender, history of nicotine abuse, high cholesterol, history of hypertension, history of diabetes, low exercise or no exercise.

Q. Okay. Did Mr. Porach have any risk factors for coronary artery disease?

A. Yes.

Q. Tell me what risk factors he had, and I want you to be exhaustive in terms of the risk factors that he had.

A. Primarily, when I first met him, smoking. When I met him in April of '91 he smoked one and a half to two packs per day for 20 years, and other risk factors would be hyperlipidemia, namely high cholesterol.

At that time in January of '93 I inquired about his family history, both his parents were

alive and 67 years of age and he had four brothers, or two brothers and two sisters, rather, ranging in age from 48 to 26. He reported that everyone was healthy, there was no one with coronary artery disease, and at that time in January of '93, that was actually January 7th, I advised him to quit smoking and prescribed a nicotine patch and asked him to follow-up in a month.

Indeed, he came back in July of '94 and reported that he had quit smoking on January 17th of '93. So that would be 10 days after I saw him in '93.

At that time I had an SMA screening done, which indicated that he had hyperlipidemia, which I abbreviated HL, which means high cholesterol. I advised him to reduce his weight and exercise three to four times a week. His weight had gone up to 210 pounds.

Q. Let's me reel you back because you sort of got off track. I was asking you to tell me what risk factors he had and thus far you told me the smoking?

A. Smoking.

Q And the high cholesterol. Are there any others

that are specific to Mr. Porach?
A. I would say male gender. As for his age, plus/minus.
Q. What do you mean by that?
A. He's in a borderline age to consider him at higher risk because of his age, between 41 and 44. If you are over 45, I would say that you are at a higher risk. If you are under 35, you are at lower risk. Between 35 and 45 you are impossible to say just based on age whether that is a risk factor or not.
Q. You apparently were aware of the fact that he at least up until July of 1994 did not have a very active life in terms of a regular exercise program, is that correct?
A. I can't say.
Q. Well, certainly in July of 1994 you were recommending that he exercise three to four times a week?
A. Yes.
Q. Do you have any knowledge prior to that that he exercised or had a regular exercise program before that time?
A. I don't know.
Q. Nothing in the records that would indicate that?

A. No.
Q. If he didn't and he had a relatively static or stasis type of existence, would that also be a risk factor for coronary artery disease?
A. It would now, but for example, in 1991 a sedentary life-style was not yet being promulgated as a definite risk factor. I think that's only been accepted as a risk factor over the last couple of years, a year or two.
Q. Where have you learned of the risk factors, through what society or association have you obtained the promulgation of these risk factors?
A. Primarily through reading review articles in the New England Journal of Medicine or I also am a subscriber to Journal Watch, which summarizes the findings of important studies from other journals, and I'm a subscriber to Audio Digest, which is an audiotape that you listen to and then take a test, mail it in, get credit for it.
Q. This is for your CMA's?
A. Yes.
Q. Besides the New England Journal of Medicine, Journal Watch and the Audio Digest, do you subscribe to any journals or regular publications, either written or audio, on a

regular basis?
A. Yes. The Medical Letter.
Q. Who publishes that?
A. I believe it is just called the Medical Letter.
Q. How often do you receive that?
A. I receive that every two weeks.
Q. Do you own any cardiology texts?
A. No.
Q. Do you own any internal medicine texts?
A. Yes.
Q. Do you own Harrison's?
A. Yes.
Q. What else besides Harrison's?
A. Oh, let's see. The text entitled Ambulatory Medicine.
Q. Who is the author?
A. Barton.
Q. Bardon?
A. Barton.
Q. B-a-r-t-o-n?
A. Right.
Q. When you need reference material, do you refer to Harrison's more than the Ambulatory book?
A. No. I refer more to Ambulatory Medicine because Harrison's really applies more to uncommon

conditions, and practicing in an urban area such as Cleveland, when you meet with something you are not sure about, rather than refer to Harrison's, you simply refer to a specialist.

Q. So the Ambulatory Medicine is a better, more reliable text for your practice to refer to?

A. For my practice, yes.

Q. And do you refer to the Ambulatory Medicine book from time to time to provide you either with answers to questions or to update you with regard to information in the area of internal medicine?

A. Occasionally.

Q. Does it have information in there that you refer to from time to time dealing with the diagnosis and treatment of coronary artery disease?

A. No.

Q. What type of information do you routinely look to at that book for?

A. Mostly information about ear, eye and joint disease.

Q. When you want reliable information on risk factors for coronary artery disease and the diagnosis and treatment of coronary artery disease, where do you refer?

A. The diagnosis, the recognition of risk factors for coronary artery disease is something you come out of training knowing very well. Nothing much has changed in the last eight or nine years. What has changed is the treatment.

However, the treatment of coronary artery disease is not delivered by me. It is delivered by a cardiologist. At the time that I completed training thrombolytics were being introduced, but they are not being administered by general internists in Cleveland. They are administered by either emergency room physicians or cardiologists.

Q. I recognize that, but obviously you need to be familiar with the advances in medical technology as it relates to the issue of coronary artery disease as it relates to the issue of myocardial infarction, the treatment of patients with chest pain, differential diagnosis and things of that nature, you need to be familiar with those topics, correct?

A. Yes.

Q. And certainly there is information that is coming out perhaps on a fairly regular basis concerning treatment of patients with myocardial

infarction, prevention of second heart attacks, treatment of chest pain and things of that nature, correct?

A. Yes.

Q. And when you want information that is updated, and reliable in your practice to have at least that basic knowledge to make a clinical diagnosis where do you look?

A. I look to the New England Journal of Medicine, I look to the Medical Letter, I look to Audio Digest, because I collect these, and, again, to Journal Watch.

Q. Okay. Would you consider those sources then in your practice as it relates to the knowledge that you need to have about coronary artery disease and heart attacks to be the most reliable sources?

A. I think they are very reliable sources and I think they are sufficient.

Q. Okay. And do you find the information that you gathered from these articles concerning coronary artery disease and heart attacks to be information that you deem to be authoritative in the area?

A. Most certainly.

Q. Before we move away from the risk factors I want to determine whether or not Mr. Porach's weight, in your opinion, was a risk factor as well for coronary artery disease.
A. I'm not certain.
Q. And just so --
A. It's impossible to separate the weight from the high cholesterol.
Q. That's why you say you are not certain?
A. Uh-huh.
Q. Okay. Any other risk factors that he had that, in your opinion, increased his risk over the general population of having coronary artery disease?
A. No.
Q. Now, you have indicated that in January of 1993 you went through an inventory with him essentially of family history to determine mom, dad, brothers and sisters, and you had marked down on that healthy for each one of them?
A. Yes.
Q. You have learned, obviously, that John's mom died subsequent to his death, at least you learned that during the deposition or you heard about that today?

A. Right.
Q. Did you know about that before today?
A. No.
Q. Have any family members of John's, mom, dad, brothers and sisters, been a patient of yours?
A. I believe he has one sister who was a patient.
Q. And do you recall which sister that is?
A. No.
Q. Do you know whether that's the 38 or the 48-year old sister?
A. I would say probably the 48-year old.
Q. And do you know whether she had any history of coronary artery disease?
A. What I remember is that I actually knew her mostly because she brought her son or daughter in. I can't remember.
Q. Mom and dad of John were not, to your knowledge, ever patients of yours?
A. I'll be honest, unless I see somebody five times within a short period of time, meaning two years, I can't remember. So the answer to the question is I don't remember them being patients of mine.
Q. That's not to say that they might not have been?
A. They may have been in to see me once or twice,

but I can't remember that they were.
Q. Have you checked your records at all to determine whether or not a Porach was or is a patient of yours?
A. No, I have not.
Q. In connection with this case, which obviously involves a man who suffered an anteroseptal infarct and died on October 14th, 1994, and who we know by autopsy had coronary artery disease, at least with regard to the left anterior descending, have you done any research at all in the medical literature specifically with regard to this case either to prepare for the deposition or since this lawsuit has been filed?
A. No, I have not.
Q. Have you reviewed any articles that you have in your files relating to diagnosis and treatment of coronary artery disease or the treatment of an acute MI?
A. Not specifically for this case.
Q. Okay. What have you reviewed, doctor, before today's deposition other than your chart?
A. That's all I have reviewed.
Q. Fair enough. Have you talked to -- at any time since Mr. Porach died have you talked to the

coroner?
A. No, I have not.
Q. Have you talked to any doctors concerning Mr. Porach's death and the causes of Mr. Porach's death?
A. I believe I may have spoken to a couple of colleagues at the time that this happened within the first two weeks. Since then I have not.
Q. Do you recall who it was that you talked to?
A. No.
Q. Beside the notes, the records that you have that constitute your file, do you have any personal notes that you have made at any time either while John was living or any personal notes that you have maintained since he died?
A. No.
Q. So everything that you have written down would be in the records and presumedly has already been provided to me?
A. That's correct.
Q. Okay. Fair enough. Do patients -- do all patients that are experiencing an acute myocardial infarction experience chest pain?
A. No.
Q. Can you tell me from your experience what

percentage of patients that are having an acute MI initially complain of chest pain versus making no complaints of chest pain?

A. I really can't answer that question because since I have been in primary care and out of training I don't see people who are having acute MI's. I learn about it subsequently because they directly go to the emergency room and I get a call from the emergency room doctor who says so and so is having an acute MI, what do you want me to do.

I say call the cardiologist because with the advances that have taken place over the last eight years, nine years that I have been out of training, and the fact that I am practicing in an urban area where I am not the sole practitioner, there is just no point in me handling someone who is having an MI.

They need thrombolysis, they need angioplasty, and at the very most I will act as a consultant, if there are other issues that the cardiologist is not willing to deal with.

Q. When you are on vacation, do you have a doctor that you have cover your practice?

A. I have had probably a handful of doctors,

depending on the time.
Q. Back in 1994 who was the doctor that you looked to to cover your practice when you were otherwise unavailable?
A. Dr. Fred Fisher. He retired in September of 1996.
Q. Is Dr. Fisher still residing in this area?
A. I believe so.
Q. Were there any other doctors in the October, '94 time period that you would ask to cover for you if that occasion came up?
A. We have a group of four doctors that provide weekend phone coverage. Another one would be Dr. Cristiana Boieru, B-o-i-e-r-u, and then there is Dr. Robert Riley, R-i-l-e-y.

We take turns every one weekend out of four. I turn my pager off at noon on Saturday. Whoever is on call responds between noon and midnight on Saturday between 9 a.m. and midnight on Sunday, but we all follow our own patients in the hospital, if there are any in there.

Q. And at any given time based upon the percentage of your practice you don't have a large patient population that's in the hospital, correct?
A. That's correct. I would say that on average I

have zero to two patients in the hospital.

Q. Your attorney has provided me with Answers to Interrogatories and Responses to Request for Production of Documents, which the interrogatories you have verified as being true and accurate, to the best of your knowledge and belief, and it was signed by you on or at least signed in the presence of a notary on the 25th day of November, '96.

My question to you is, are the answers still as of March 5, 1997 true and accurate?

A. Yes.

MR. RISPO: With the exception of the latest litigation he identified.

MR. MISHKIND: Well taken.

Q. There is some issue raised as to insurance coverage and denial by PIE. Can you explain to me, to the extent that you understand the issue, whether you believe that you are covered by professional liability insurance for the claim that's being asserted here by the Estate of John Porach?

A. I believe I am covered. I had PIE at the time of Jack's death, and a year later because the premium went up I changed. I think it was in

October 1st of '95 I changed to Frontier and bought a tail coverage with it.

Q. And, to your knowledge, Frontier is providing you with indemnification as well as a defense in this case?

A. Yes.

MR. MISHKIND: And, Ron, there is no issue of coverage now, is there? I was a little bit confused when I saw the denia indication. PIE is out, Frontier is in?

MR. RISPO: Off the record.

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

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MR. MISHKIND: Let me just ask this on the record, whoever wants to answer it can, is Frontier providing a defense on a reservation of rights? Is Frontier providing a defense without any reservations?

MR. RISPO: I am not informed. So I can't answer that.

MR. MISHKIND: Can we get some clarification?

MR. RISPO: We would have to ask for specific clarification because I don't have any update.

MR. MISHKIND: Will you do that?

MR. RISPO: I can confirm they are providing a defense, but I can't specify whether it is under a reservation or otherwise.

MR. MISHKIND: What's the status? Is there any pursuit being given as to PIE at this point or are they just, have you washed your hands of PIE?

MR. RISPO: I am not aware if anything has been initiated in that respect.

Q. You indicated in your interrogatory answers that Tom Repicky is your personal attorney?

A. Yes.

Q. And is he still your personal attorney?

A. Yes.

Q. To your knowledge, and without divulging any confidential communications, but has there been any notification or any action taken by your personal attorney as it would relate to making sure that PIE, if they are the proper carrier,

that they provide you with indemnification on this claim?

A. No.

MR. RISPO: To answer your question, I am not aware of any other reason for reservation of rights, except the question of whether it comes under one policy or the other.

MR. MISHKIND: Sure. And I think you can appreciate that come judgment day, if I am right and you are wrong, I don't want to have any surprises with regard to now we have to file a supplemental proceeding, and I would like to clear those things up as much as possible. I think everyone's best interests are served by making sure there is no issue of coverage.

MR. RISPO: In generalities, yes, but I don't know that there is anything you can do about it prejudgment anyway, and you have to understand that my engagement is to defend, not to counsel on coverage, and I am not necessarily informed and usually am not informed if there is any basis for denial of coverage or reservation, for that

matter.

MR. MISHKIND: Okay. And that's why I asked about personal counsel, whether personal counsel is looking into it, but be that as it may, we will move on.

MR. RISPO: Let me just supplement that. There was a reservation of rights which was drawn which does refer to the dates of notice and disclaimer as to punitive damages, and that there is an outline of four other categories for possible exclusion, which seem to relate to a potential that doesn't exist here.

Specifically, if there are any registered specialists, nurses, anesthesia, certified anesthesia people or other persons on his staff who are not identified as specialists on the policy.

But I don't believe that it applies in this case because Jan is not one of those certified people.

So if that answers your question, that's the best I can do.

MR. MISHKIND: This is the letter from PIE?

MR. RISPO: No. This is Frontier. PIE, I don't have a copy of the PIE letter. So I can't advise as to PIE.

MR. MISHKIND: The reservation is only as to those subspecialities or the anesthetist and other specialists?

MR. RISPO: Exactly.

MR. MISHKIND: Okay.

MR. RISPO: I guess there was some question initially what role Jan Schoch played in the practice.

MR. MISHKIND: Okay. All right.

Q. You have reviewed the autopsy?

A. Yes.

Q. Have you seen any of the slides, any of the cardiac slides themselves?

A. No.

MR. RISPO: Wait a second. I did receive a copy of the letter from PIE somehow, which did deny the claim coverage as of November, and it seems to be related solely to the date of notification.

According to this, the doctor didn't purchase a forward tail, but Frontier did, according to PIE, Frontier

purchased prior app coverage.

MR. MISHKIND: It certainly sounds like Frontier is the one that's going to be providing coverage, at least from what I am hearing from you at this particular point.

MR. RISPO: Under that reservation of rights as I stated to you.

MR. MISHKIND: Right. Okay. Which is really probably not an issue in this case?

MR. RISPO: It doesn't appear to be to me.

Q. Okay. Dr. Gershman, the emergency room doctor, have you talked to him at all since Mr. Porach's death about this case?

A. No.

Q. Did you talk with him at the time of the death as to his impressions of what happened in your office or what happened when he was transferred to the emergency room at Fairview General?

A. I recall going down to -- he came up to my office and began the advanced cardiac life support and then was transferred downstairs, and I saw him subsequently when he told me that after a half hour they weren't able to

resuscitate Jack and that was the extent of the conversation.

Q. Have you discussed with him at all to the extent that he has any opinions in terms of when the heart attack occurred and whether or not the resuscitative efforts were appropriate, anything along those lines?

A. I do not recall that we discussed that.

Q. As you sit here now you don't know whether he does or does not have an opinion one way or another on the issue of when the heart attack occurred?

A. No.

Q. And whether or not the efforts prior to his arrival or perhaps even after his arrival were appropriate?

A. I don't recall having this discussion with Dr. Gershman. We both go on the assumption that he had a fatal complication to include myocardial infarction at the time that he collapsed in the bathroom at my office.

Q. That's your opinion, certainly?

A. Yes.

Q. We'll talk about that a little bit further. Let me ask you concerning the office personnel in

199 Who worked for you?
A Jan Schoch
Q And that's S-c-h-o-c-h?
A Yes Sharon Phillips and Ruth Peyton.
Q Spell Ruth's last name
A P-e-y-t-o-n
Q So any of these ladies still work for you?
A All of them.
Q Starting with Janice, tell me what her job is or her title, what's that?
A All three of them are receptionists they answer the phone, they do the billing, they weigh patients and take them to the examining room, and Janice and Sharon both perform EKG's that's the extent of it
Q Have you at any time since you acquired a doctor --
A Dr. Costanzo's --
Q -- Costanzo's practice employed an R N or an LPN?
A No, I have not.
Q What type of training did Jan have with regard to EKG's?
A She has the training of 25 years of having worked with Dr Costanzo and performing his

EKG's.

Q. Does she have any formal training through any type of a program, a licensure program?

A. No.

Q. Does she have any formal training from any seminars or medical schools or nursing schools?

A. No.

Q. She has been with you for how many years?

A. Six years and four months.

Q. And she was with your predecessor for 25 years?

A. I believe so.

Q. So 31 years and four months, roughly?

A. Roughly.

Q. And not to diminish her experience on the job, but to state it accurately, she has no training or educational background outside of the workplace in terms of performing or administering an EKG, is that correct?

A. That's correct.

Q. Does she actually interpret the EKG's or does she just hook up the leads, get the equipment going and leave the interpretation and assessment of the results to you?

A. She simply obtains the EKG. She does not interpret it.

Q. Did you have anyone in 1994 that worked on a part-time basis for you other than the individuals that you have described?
A. No.
Q. Were these individuals, Janice, Sharon and Ruth, were they full-time employees?
A. No. They are all part-time employees.
Q. Between the three of them they would cover --
A. Jan works 20 to 25 hours. Sharon works about 30 hours, and Ruth works about 10 hours a week.
Q. When someone calls into the office with a complaint of some illness or injury, what procedure was in effect back in October of 1994 for any of those three women in terms of obtaining that information and communicating it to you?
A. Generally they pass the message on to me within a half hour.
Q. Was there any type of a procedure that you had in effect that prioritized certain complaints to be communicated to you quicker than other complaints?
A. Not formally written.
Q. Okay. Well, the fact that these women are not medically trained, do not have medical training

or education, can we agree that in order to efficiently operate a medical office they have to have some direction from you so that they know what to do with a given set of circumstances?

A. Yes.

Q. And certainly you are responsible for the acts or perhaps omissions, if they happen, of these women in terms of their communication and contact with your patients?

A. Yes.

Q. And certainly as a physician in an urban practice you have a duty and responsibility to make sure that the triage of information communicated by phone to your office is properly handled so that emergencies are handled in the proper order and nonemergent or less critical situations are prioritized but not handled as urgently as a life threatening situation, correct?

A. When someone calls and it's not for an appointment, but because they need something, they put a sticker on the chart, and when I finish with the patient that I am seeing at the time I just see it and then either tell them to

call back and do this or I call the patient myself, but I don't have the type of practice where I let all these calls wait until the end of the day.

So if it's not a call asking for an appointment, if it is a call saying I am feeling sick, what should I do, it gets to me within I would say a half hour.

Q. Are the women instructed that when someone calls in with an illness that they communicate relevant information from that telephone call to you?

A. Yes. In fact, it's written on the sticker.

Q. So the way that it's communicated or the way it is supposed to be communicated to you is they take the information while they are talking to the person on the phone and put it on some type of a sticky?

A. Right.

Q. Like a Post-it type of note?

A. Like a Post-it, exactly.

Q. And then they put that on the patient's chart?

A. They put the Post-it on the patient's chart and put the chart on my desk. Everytime I am finished with a patient I go out of the

examining room back to my office and write a note and I see that the chart is there, or else they may verbally communicate besides writing it down on a Post-it.

Q. Can we agree that it's inappropriate for any one of these women to be making recommendations to a patient or diagnosing a patient's condition over the telephone?

A. Yes.

Q. So that to indicate to a patient that their condition sounds to be -- sounds like the flu, that would be an inappropriate thing for Janice or any of the other women to do, correct?

A. Yes. I will go a step further. I think in most instances it is inappropriate for me to be making a diagnosis over the phone.

Q. But certainly as it would relate to information communicated to you, *you* can better assess whether or not that patient needs to be seen that day or the next day or that afternoon, you can assess from a differential standpoint whether or not the symptoms sound to be life threatening as opposed to something that can be handled on a less urgent basis?

A. I am sorry. Could you restate the question?

Q. You certainly as a physician are in a better position to assess information communicated by a patient and make a determination whether or not that patient needs to be seen on an emergent, urgent or nonurgent basis?
A. Better than --
Q. Better than a receptionist?
A. I think that's intuitively obvious.
Q. I think it is, too. But you do that from time to time when information is given to you, if it is accurately communicated by the receptionist to you, you look at the information that's communicated, Mrs. so and so, Mr. so and so called in, these are the symptoms, and then you make judgments as to whether they should be seen, whether they shouldn't be seen, or what other course of action to be taken, correct?
A. That's correct.
Q. And that certainly is your duty and responsibility in order to comply with the standard of care?
A. That's correct.
Q. Okay. And it's not the duty and responsibility of Janice or anyone else in your office to make recommendations to a patient as to what

medication, if any, to take pending your calling the patient, correct?

A. That's correct.

Q. And it would be a deviation from the standard of care for Janice or anyone else working under your direction to make a comment even on an informal basis that it sounds like your condition is the flu or something along those lines, correct?

A. I'm not sure.

Q. Do you give these women the authority to tell patients that their condition sounds like the flu and that they need not come into the office immediately to be seen by you?

A. No, I do not.

Q. Do you give them authority to comment at all to the patients as to what they believe their symptoms sound like?

A. No, I do not.

Q. That certainly would be inappropriate for them to comment to patients as to what they feel their symptoms sound like?

A. That's correct.

Q. Okay. When a call comes in, and bear with me if I seem to been going into this in detail, but I

have never been to your office. So I just want to understand the mechanics of it.

I now appreciate that when a call comes in a note on a Post-it sheet is to be placed, I presume, on the outside of the patient's chart?

A. That's right.

Q. And either left on your desk, handed to you or put in some conspicuous location for you to see?

A. Yes.

Q. And that conspicuous location may be right at the counter as you are done with one patient and coming to see the next one?

A. Yes.

MR. RISPO: Just so the record is clear, we are all understanding that this is a call other than one asking for an appointment?

MR. MISHKIND: Okay.

Q. When patients call up with symptoms, do they, in your experience, always know whether they need to be seen by you?

A. The obvious answer to that question is not always.

Q. Can we further agree that frequently a patient will call up with a series of symptoms and not,

for lack of sophistication or knowledge, not know whether this is something that they should or should not be concerned about?

A. I am sorry. Could you restate the question, please?

Q. Absolutely. In your practice patients will call up and will indicate that they have certain symptoms and not appreciate whether they need to be seen or whether they don't need to be seen?

A. 1 think it's exceptional that they would call not knowing whether they need to be seen or not.

Q. Can we agree that patients will call up with symptoms and sometimes want to talk to you as to what course of action to take?

A. Only with regard to such things as upper respiratory infections, acute cystitis, which would be a lower urinary tract infection.

With regard to chest pain, with regard to a syncopal episode, where you pass out, I don't learn about it until I get a call from the emergency room physician.

Q. Well, what do you tell the women to do when a patient calls up and indicates that they have numbness and tingling in their legs and in their arms, that they aren't feeling well, that they

felt that they have had diarrhea, that they have just felt weak, that they have been sleeping or anything in that category, what do you tell them to do?

A. You are describing a symptom complex here, not one symptom. In a situation like that, what they are instructed to do is to advise the patient to either come in or if there isn't room to see that patient, then the patient has the freedom to go to an urgent care center or an emergency room. Unfortunately, everyone has to make a decision for himself as to how serious the situation is.

If I have an entire day that's booked, I am not running an urgent care center or an emergency room.

Q. These people that call are your patients, aren't they?

A. I am sorry?

Q. These people that call with the symptom complex are your patients, are they not?

A. Yes, they are.

Q. And when they call because they are your patients, aren't they calling because they want your advice, guidance and consultation as their

physician as to what to do, isn't that a reasonable reason for them to be calling?

MR. RISPO: You are assuming that they ask the question?

Q. Well, I am assuming that they call and indicate that they have some symptom complex. Aren't they calling because you are their doctor and they want to know what to do?

MR. RISPO: I am going to object and I am going to have a continuing objection throughout this deposition because you are assuming that certain things were said in this case on the telephone, which were not, at least the evidence will show as far as we can tell, and, therefore, I am going to have a continuing objection to all of those kind of questions.

MR. MISHKIND: That's fine. That's fine. I got no problem with you doing that.

A. Could you restate the question?

Q. No.

MR. MISHKIND: Please read it back.

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

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A. I think that's a fair assumption.

Q. And, further, when you said the patient has the right to go to the emergency room, well, they also have the right, do they not, to call you and to determine what treatment to receive based upon your advice to them?

A. Yes, they do have that right, obviously, but I think more than anything else they have a responsibility to themselves to decide what to do, based on their own assessment of how severe their illness is or concern is.

Q. And are patients, in your opinion, sophisticated enough that they can make that assessment independent of the physician's input?

A. I would say that when it comes to chest pain that is an universal rule because of the dissemination of information in this society about the meaning and interpretation of chest pain. I have not had an experience in my office of somebody coming in with chest pain.

When someone calls the office and reports active chest pain, the office staff is

instructed to direct those people to the emergency room because there is really nothing that a primary care physician can do for someone who has an acute MI.

Q. You heard the testimony from Jackie as to what she heard her stepfather say in the afternoon when a telephone call was made to your office, you heard her testimony, didn't you?

A. Yes, I did.

Q. And that testimony, if I recall correctly, included an identification of who the person was, that they were calling again, and that they had chest pain and shortness of breath, there may have been one other symptom, but I remember chest pain and shortness of breath. Do you remember that testimony as well?

A. I remember that testimony.

Q. If that testimony, if that call was made and that information was conveyed to your office, what obligation, responsibility did your office have in terms of responding to Mr. Porach's call?

A. My receptionist's obligation would be to instruct the patient to go to the closest emergency room and then inform me that someone

called with these complaints and that she, indeed, did direct this person to go to the closest emergency room.

Q. If she failed to advise the patient to go to the closest emergency room and those symptoms were conveyed to her --

MR. RISPO: Objection on the basis of the hypothetical. Go ahead.

MR. MISHKIND: That's fine.

Q. -- can we agree that that would not be in keeping with accepted standards of medical care?

MR. RISPO: Well, first of all, Jan is not a physician. So it is not a question --

MR. MISHKIND: I will rephrase it.

Q. You are responsible for what Jan does in terms of handling of patient complaints that come in through a telephone call, correct?

A. Yes.

Q. And if she does not indicate to a patient indicating that they are short of breath and having chest pain for that patient to go to the emergency room, that is not in compliance with what you have instructed your personnel to do,

correct?
A. That's correct.
Q. And can we agree that if the procedures that you have established in your office for directing patients with chest pain and shortness of breath are not complied with, that your office, and specifically you as the individual ultimately responsible for those employees, have failed to comply with accepted standards of medical care?
A. Yes.
Q. And why is it important that the patient calling with chest pain and shortness of breath for your employees to indicate to them that they should go to the closest emergency room?
A. Because there is always the risk that someone may be having an acute myocardial infarction, which is an occurrence that needs to be handled in an emergency room in a hospital and not in an office.
Q. Do you advise your receptionists to tell them to drive to the closest emergency room or do you tell them to call 911?
A. Call 911 or have someone else drive them.
Q. So, again, it would be inappropriate for your receptionist to advise a patient that has

communicated chest pain and shortness of breath to come and drive into the office for an EKG, that would be inappropriate, correct?

A. Absolutely.

Q. And that would be substandard practice for you to permit a receptionist to give that kind of advice to your patients?

A. It would be absurd.

Q. Okay. Clearly below the standard of care?

A. Absurd.

Q. Which can we agree it would be clearly below the standard of care?

A. Okay.

Q. I am not sure that your absurd may be a different absurd, a different situation to me.

Is there any procedure where you have for memorializing telephone calls other than the Post-it on the file when a call comes in from someone?

A. Well, if someone calls in because they have symptoms of what is suggestive of sinusitis, for example, there is a Post-it. Then what I simply do is put down the date and indicate that there was a telephone order for an antibiotic and a follow-up in three days or a week.

Q. And where does that Post-it go then?
A. The Post-it: goes to the trash.
Q. How is that information memorialized in the patient's chart?
A. It is only memorialized as far as what the treatment for that was.
Q. Well, do you mark on the chart telephone call, prescribed such and such?
A. Yes.
Q. So that there should be some memorialization ultimately in terms of what recommendation is made for the patient that calls in, but is actually not being seen at that particular point?
A. There isn't always a memorialization. If someone calls with a one-day history of a sore throat and I am not going to prescribe an antibiotic for them and I don't think they need to go to the urgent care center and I simply instruct my receptionist to call them back and say come on in tomorrow, there will be no memorialization on the chart, as it turns out.
Q. Is there any type of a log maintained for any calls?
A. No, there is not.

Q. Have you ever had that type of procedure?
A. I have never had that type of procedure.
Q. In a situation where a patient calls up and indicates that they have had symptoms that may or may not be flu like symptoms, are those symptoms to be marked down on a Post-it and left for you to respond to?
A. Yes.
Q. Now, is the receptionist ultimately to schedule the patient to come in or is that ultimately a decision that you make?
A. It's a decision that I make.
Q. So certainly if a patient gives a description that the receptionist deems could be flu like symptoms, it would not be inconsistent for the receptionist to say I will discuss it with the doctor and we'll get back in touch with you?
A. That would be ordinary.
Q. Okay. In the morning on October 14th, 1994, was any information provided to you by Janice that John Porach called prior to noon on that date conveying information that may or may not have been consistent with a flu like syndrome?
A. I only learned of John Porach's presence in my office or *of* his existence on that day when Jan

knocked on my examining room door and reported that she heard a thud in the bathroom. Prior to that I had no knowledge whatsoever of John Porach.

Q. It doesn't really answer my question, though, and I gather that that was what you --

A. No information was conveyed to me by Jan.

Q. If information was conveyed by the patient in the morning in a telephone call, Jan had a duty to convey that to you before Mr. Porach collapsed in your office that evening?

MR. RISPO: It depends on what information you are asking, and I think you are assuming evidence which is not properly on the record.

MR. MISHKIND: Well, there certainly is going to be testimony in this case that a telephone call was made in the morning.

Q. Have you talked to Jan about whether she received a telephone call from Mr. Porach in the morning?

MR. RISPO: You mean after the fact?

MR. MISHKIND: Right.

A. After the fact? Yes, of course.
Q. And what did she tell you?
A. She told me that he called to make an appointment, and she told him that we were booked all day, and that if there were any openings available, because people cancel from time to time, in the afternoon she would call him back.
Q. All right. So that when the testimony is in this case that Mr. Porach was waiting to hear back from the office for an appointment, that certainly is consistent with what Jan may have told Mr. Porach as to we'll get back in touch with you later in the day if there is a time slot open?
A. That's correct. If there is a time slot open, we will get back in touch with you, right.
Q. Did she tell you what he indicated were his symptoms after the fact?
A. After the fact?
Q. Right.
A. Yes.
Q. What did she tell you?
A. She told me that he was feeling achy and feverish and had some diarrhea, an upset stomach

and wanted to come in. She said we don't have room for you today, but if we do, we will call you back.

Q. Did she recommend to him or indicate to him that if you are having diarrhea, achy, what were some of the other symptom?

A. Upset stomach.

Q. That you could go to the emergency room to be seen?

A. As far as I know she did not.

MR. RISPO: We're talking about after the fact, of course.

MR. MISHKIND: Oh, sure.

MR. RISPO: I just wanted to be sure the record is clear.

MR. MISHKIND: No. I will even state it on the record.

Q. My understanding loud and clear is that before you heard the thud you didn't know anything about Mr. Porach's condition on October 14th?

A. That's absolutely correct.

Q. Now, as to whether you should or shouldn't have known, that's going to be for someone else to decide. I am just asking you whether or not after the fact you learned that there had been

contact with your office, and the answer to that is after the fact, Mr. Mishkind, I did learn from Janice that Mr. Porach had called, and we're now talking about in the morning of the 14th, he had called sometime that morning and gave some complaints and she said if there was an opening I would get back in touch with you?

A. That's right.

Q. Okay. Did she mark down what his symptoms were on that little yellow Post-it?

A. No.

Q. Do you know why she didn't?

A. No.

Q. Should she have?

A. I don't know.

Q. Well, it's your office, she works for you. Should she have marked those symptoms down?

A. She should have marked those symptoms down if the patient is asking for my opinion about those symptoms, but if the patient is calling and asking for an appointment because of certain symptoms and not asking for what should I do, but simply asking I would like to come in, she says well, we don't have room.

Q. Well, if you don't have room and the patient is

calling up and they want to be seen, do you have a duty and responsibility to convey to that patient what they should do, given the fact that you can't see them?

A. Yes, I believe I do.

Q. Okay. Did you convey -- strike that.

Obviously Jan did not provide you with the information for you to either tell him what to do or give him an appointment, correct?

A. That's correct.

Q. Can we agree that she should have given you the information, notwithstanding the fact that you didn't have any appointments, but she should have passed that information on to you so that you could have either made an appointment or provided information that could be conveyed back to him as to what he should do?

MR. RISPO: Objection.

A. I don't know.

Q. You don't know?

A. No, I don't know, because I don't know what the content of the conversation between Jan and Jack Porach was.

Q. And can we agree that because -- it's important for the doctor to know -- strike that.

When you say you don't know, it's because you don't know how he described his symptoms?

MR. RISPO: Let me interject here. You are assuming, Howard, that every person who calls in for an appointment necessarily must have some symptoms, must be cleared, reviewed and an opinion stated by the doctor and a telephone response from the doctor on every patient.

Now, that is obviously not the standard of care. The doctor has already distinguished from situations where the patient has expressly asked for advice from those that merely ask for an appointment, and you are assuming that Mr. Porach was asking for advice rather than an appointment, and the evidence is to the contrary. All he was asking for was an appointment.

MR. MISHKIND: Well, okay. I appreciate that, and I always enjoy hearing from you.

Q. But let's get back to Mr. Porach, and specifically you don't know what the content of his complaints were during that conversation, do

you?

A. I don't know what the content of the conversation was because I wasn't there.

Q. Okay. And you don't know -- because you weren't there you don't know whether, even though he was calling for an appointment, you don't know whether you would or wouldn't have had him come on an emergent basis or whether you would have just said come in tomorrow or the next day, do you?

A. No, I don't.

Q. And can we agree that depending upon the information that had been conveyed to you, had it been conveyed to you by Janice that Mr. Porach called, here is a little note with his symptoms, he is calling for an appointment, but we don't have an appointment, can we agree that depending upon how those symptoms were conveyed to you, you would have at least had the opportunity to make a decision whether or not this is a patient that needs to be seen and squeezed in-between other patients?

MR. RISPO: Now, are you assuming in the same hypotheses that you put forth earlier that the patient was calling in the

morning complaining of fever, diarrhea, upset stomach and achy feelings, is that your assumption?

MR. MISHKIND: Sure.

Q. I mean, that is what she has indicated Mr Porach said to her. Whether that is accurate or whether there was more to it, with those symptoms and he is calling presumedly for an appointment, certainly there is nothing preventing her from noting those on a yellow -- on a Post-it, correct?

A. I believe that when someone calls a doctor's office they are either going to call for an appointment or they are going to call for an opinion.

Now, if they call for an opinion, then my receptionist has an obligation to pass on what information was conveyed to her that I need to render an opinion on.

If the patient calls to get an appointment and she doesn't have an appointment to give them, then I don't think she needs to tell me, because if I get those kind of interruptions all day long I might as well just answer the phone myself.

Q. Let's assume that he called then under those circumstances and with that understanding, he called and wanted an opinion as to what to do. Would she have had an obligation to provide you with her notes of the conversation on a yellow Post-it so that you could respond?

A. I think I have already answered that question positively, yes.

Q. Okay. And she would have had an obligation to convey that to you as soon as reasonably possible?

A. Within a half hour, yes.

Q. That's pretty reasonable. Had that information been conveyed to you and he wanted an opinion, what would you have -- what would your opinion have been?

MR. RISPO: Based on the same hypotheses, feverish, diarrhea, upset stomach and achy feeling?

MR. MISHKIND: Yes.

A. I would have said to him I think it is probably the flu based on these symptoms. I can't see you today because we don't have any time, but if you are really worried about it, then go to an urgent care center or an emergency room. I can

only see so many people in a day, and some people are over worriers, some people are under worriers.

Q. Was Mr. Porach, in your experience, albeit limited in terms of the history, was he the type of person that called a lot and was a malingerer or a worrier in terms of problems?

A. I have no opinion about that.

Q. Does the record seem to indicate that he called excessively or seemed to be a malingerer or a complainer?

A I would say no.

Q Okay.

A I remember him as an average nice guy who was very pleasant.

Q Flu like symptoms are not infrequently seen in a patient that is experiencing an acute MI, can we agree upon that?

A I cannot answer that question.

Q And why is that?

A Because I don't consider myself an expert on acute MI and, I repeat, because that is not what I treat. Typically people with acute MI go to the emergency room.

I learn about it subsequently, and I would

say that typically, I will further state that flu like symptoms are not typical, in my experience, of an acute MI.

Q. Are you saying to me that patients do not present with the first symptom complex being flu like symptoms?

A. That's what I am saying, yes.

Q. Are you aware of situations where acute MI's occur and patients do present with the initial symptoms being flu like in description?

A. It's conceivable, but in my limited experience as a primary care physician for the past nine years I haven't seen it.

Q. Do you consider yourself to be a family practitioner or internist?

A. No. I am a general internist and this new category of primary care physician has come into being since I have been out of training.

Q. Is there any society for primary practitioners that you belong to?

A. No.

Q. Are there any type of guidelines that you follow in terms of making sure that patients that have serious conditions such as potential heart attack or appendicitis or something of that

nature are directed to or call for emergency care?

A. It's up to the patient. If they have a problem, they call, or if they have a problem and feel that I can't handle it, they go directly to the emergency room or call 911.

Q. So it's the patient that makes the decision as to whether or not where to go as opposed to the doctor directing that the patient should have emergency care?

MR. RISPO: Now, that's assuming that the patient is making a telephone call from his home, the patient is not in the office examining room.

MR. MISHKIND: I understand that.

A. I can answer that question. This is the reality that I see. Most people who end up in the hospital don't ask for my opinion first. I would say that probably less than five percent of people that end up in the hospital come to me first in the office and --

Q. Or by phone?

A. Or even by phone. They just end up in the emergency room and then I get a call from the emergency room doctor.

Q. Doctor, can we agree, though, that if a patient for whatever reason calls you and asks you what to do, even though most patients would go to the emergency room first, if that patient calls you, you have an obligation to competently respond to that patient so that he or she knows what to do, whether it be to come into your office or to, in fact, go to that emergency room?

A. Oh, definitely. If they are asking me what should you do, I got this problem, yes.

Q. And if a patient calls and indicates that they are short of breath and that they are having chest pain, it would be inappropriate for your office to advise them to drive to your office for examination or evaluation?

A. Absolutely.

Q. Okay. Now, what else did Janice tell you she talked about with Mr. Porach the morning of the 14th other than what we have already talked about?

A. Nothing that I can recall.

Q. And there is no notations that she has made of anything from that conversation, to your knowledge?

A. That's correct.

Q. Did she have any personal notes that she maintained?
A. Not that I know of.
Q. And, again, I understand you didn't know about this telephone call until after the fact, did Janice tell you that she spoke to Mr. Porach in the afternoon of October 14th?
MR. RISPO: After the fact?
MR. MISHKIND: Again, everything is after the fact, I understand that.
A. Yes.
Q. And what time -- by the way, what time did she tell you the call in the morning occurred at?
A. I don't recall.
Q. Did she seem to have an idea as to the time of the call?
A. I can't remember.
Q. When did she tell you the call in the afternoon was made?
A. After the fact.
Q. I know that. Everything is after the fact. What time did she tell you the call was made by Mr. Porach?
A. That I cannot recall. It must have been after 3:00, because I am not in the office until 3:00.

Q. I was going to ask you --
A. I have office hours from 3:00 to 6:00 on Fridays in the afternoon,
Q. What are you doing between 12:00 and 3:00 on Fridays? I notice that there was a period of time that you had no patients on the 14th.
A. Well, typically I finish seeing patients around 12:30. Then I go to lunch. If I have in-house patients, I see them. Sometimes I go home and have lunch at home. Sometimes I go out to lunch. Sometimes I dictate discharge summaries.

So if I am busy I do something, if I am not, I just enjoy it.

Q. Do you know what you were doing on October 14th between 12:00 and 3:00?
A. No.
Q. If you had to go back and recreate what was going on in Dr. Lalli's life between when you finished your last morning patient and when you saw your 3:00 p.m. patient, could you do it?
A. No way.
Q. What did Janice tell you after the fact was the substance of Mr. Porach's call that afternoon?
A. He called again to see if he could get an

appointment. She said well, just come on in and we will fit you in somehow, and then after the fact she told me that he came to the window when he arrived and he said that he wanted an EKG because his family was concerned about him. Since I was seeing another patient she went ahead and got this EKG.

Then after the EKG was obtained he asked for the key to the bathroom door and whatever, a minute or two later, he collapsed.

Q You heard, again, the testimony of the daughter, and I submit to you that there will be other testimony confirming the symptoms that Mr. Porach indicated in terms of shortness of breath and chest pain being communicated to Janice. Is it your testimony that Janice does not recall him saying that?

A That's correct.

MR. RISPO: Are you saying there is someone else who was a witness to a conversation between John Porach and Janice?

MR. MISHKIND: Sure. Yes.

MR. RISPO: That afternoon?

MR. MISHKIND: Yes.

MR. RISPO: That you have not identified?

MR. MISHKIND: You learned about it during the deposition of Mrs. Porach, and that's Mary Nary.

MR. RISPO: She wasn't present at the time of that phone conversation.

MR. MISHKIND: No, not heard the conversation, talked to Jack.

MR. RISPO: Talked to Jack after the fact?

MR. MISHKIND: Right. Exactly.

MR. RISPO: So that's still hearsay.

MR. MISHKIND: Well, but under the evidence rules in this type of a case it comes in, but we'll deal with that, especially when it is being denied as having occurred. You and I will have our evidence discussion at a later time.

Q. So Janice told you that he called back in the afternoon and she told you that he said that he wanted to be seen?

A. He checked back to see if there were any spots available.

Q. And according to your list you didn't have any spots available? I mean --

A. The list is here, his name does not appear here, and as I was seeing the last patient, Mr. Wayne Hayes, who helped me pull Jack out of the bathroom, I was fully expecting to go home within about 10 minutes before 6:00.

Q. Well, if Janice got a call from Jack in the afternoon and he said are there any openings left, according to that list with Mr. Hayes being the last person what would Janice have likely told Mr. Porach?

MR. RISPO: Objection.

A. I don't know.

Q. What should she have told Mr. Porach based upon your schedule of patients that afternoon?

A. Come on in, he might see you at the end of the day. I mean, that happens from time to time. I am not rigid in my hours that I have to leave by 6:00. I am usually three until 6:30, quarter to 7.

Q. But you didn't have any openings in the schedule and nothing changed during the day from the morning when she told him that there weren't any openings available, correct?

A. I guess.
Q. And nothing is crossed out on the schedule in terms of cancellation?
A. Nothing is crossed out.
Q. Has she told you that she told him to come on in?
A. That's what she told me.
Q. So she had indicated to you that she told Mr. Porach to drive in, to come into the office?
A. She told him to come in.
Q. Okay. And she had no idea how he was going to get there, but certainly she didn't tell him to go to the emergency room at the local hospital, did she?
A. No, she did not.
Q. Okay. Take a look at your records, doctor, and specifically the EKG. This is a 12 lead?
A. Yes.
Q. Did you interpret that?
A. Yes. It is says probable old anteroseptal MI. Nonspecific ST changes.
Q. Now, you told me before that you don't hold yourself out as a cardiologist and you don't typically treat cardiac symptoms. Can you tell me where on the 12 lead EKG you see evidence

that caused you to say probable old anteroseptal MI?

A. Well, probable because one cannot establish with certainty based on an EKG whether there is an MI. There is an absence here of an R wave from lead V-1 to V-3, which is consistent with an old anteroseptal MI, but it's not proof of it because you see EKG's that look like this where you get an echocardiogram and where you get a cardiac catheterization that is completely normal, and I don't see any changes that are consistent with an acute MI, such as an elevation of the ST segment.

Q. Do you always have elevation of ST segments during the early phases of an acute MI?

A. There is no such thing as always.

Q. So that certainly --

A. Not always.

Q. You can certainly have an EKG presentation in an acute MI without ST changes?

A. Well, if I were to see this EKG, let's say, how I am going to interpret it as a clinician and not as an electrocardiologist will depend on who the patient is and how he's presenting, and if I have someone in the emergency room that is

presenting with chest pain and shortness of breath and I am seeing this kind of EKG, then I am probably going to get a set of enzymes and he has got risk factors.

I say okay, you don't have this ST elevation, but I am going to put you on thrombolytic therapy anyway, or I am going to call the cardiologist and fax him the EKG and tell him what is going on.

Q. When did you mark down this diagnosis?

A. I marked it down after Jack was taken down to the emergency room because that's the first time that I knew about this EKG.

Q. Okay. There is a time in the upper left-hand corner?

A. Yes.

Q. October 14th, '94 and that's military time. Can you tell me, that's what, 4:39?

A. 4:39, right.

Q. Okay. How is that time determined?

A. I think that EKG machine was set at the time that it was bought back in 1990 or '91.

Q. Okay.

A. And I really couldn't understand why it said 1639 if Jan tells me she got this -- I was in

the examining room somewhere between 5:30 and quarter to six when Jan knocked on my door. Jack went into the bathroom immediately afterward, after the EKG was obtained. How could an EKG have been obtained at 4:39 and she knocks on my door at somewhere between 5:30 and quarter to six?

So I thought it is probably because this thing has not been reset with the time changes that we have, with the change of seasons.

Q. Do you do EKG's on an infrequent basis on patients?

A. **I** do them as needed. I don't do them routinely. If somebody comes in and they say I am having chest pain on and off, but they are not having chest pain that minute, I often do not do it because my experience tells me that you are usually not going to see anything.

So at that point depending on who the patient is and what the risk factors are, if it is someone who I think is low risk for coronary artery disease I will say let's schedule a stress test. If you want an EKG right now because it is going to reassure you to know that it is normal, we'll do it. If it is someone

with highest risk I will refer them to the cardiologist.

Q. Did you go back and check any of your other charts to determine whether or not the time calibration on other EKG's was off by an hour?

A. No. It did not occur to me.

MR. RISPG: Howard, I don't know if you want this on or off the record, but it occurs to me that the difference here is the difference between Eastern Standard Time and Daylight Savings Time, and the machine was probably calibrated on the basis of Eastern Standard and it was never switched to accommodate Daylight Savings Time, which was in effect on the date when this occurred.

MR. MISHKIND: And I got no problem with that except there wasn't a change in time until weeks after October 14th. So I am just wondering --

MR. RISPG: But that's the point. It was not changed in the spring to accommodate Daylight Savings Time.

MR. MISHKIND: So if we went back and looked at other charts on patients, all

of the EKG's ostensibly should be off by an hour in your office?

MR. RISPO: If they were done in the summer season.

MR. MISHKIND: If they were done at any time between April 1st or April 2nd when we --

MR. RISPO: Whenever the time change is.

MR. MISHKIND: -- we spring forward, fall back, that should be the case?

MR. RISPO: That's our best estimate.

A. Yes.

Q. Okay. Is your statement probable old anteroseptal MI, is that an opinion to a reasonable degree of medical probability or is that just a possible diagnosis?

A. I will stand by that.

Q. So your opinion is that this EKG shows an old anteroseptal MI and that's to a reasonable degree of medical probability?

A. To me this EKG, if I were presented with it without knowing anything about the patient, I

would read it as a probable old anteroseptal Mi, but no specific ST changes. But I have seen EKG's that look just like this where you go into an echo and there is nothing there.

Q. You have also seen EKG's like this in patients that eventually are proven to have experienced an acute myocardial ischemia or acute myocardial infarctions?

A. it's possible, because you can do EKG's once an hour while deciding that this could be an early change, but as it stands, I mean, an EKG can only tell you so much. As it stands, that's how i would interpret this EKG.

Q. Now, going back to Janice's call from Mr. Porach, she told him or she should have told him that we don't have any openings -- well, strike that.

Why don't you tell me, to the best of your recollection, everything that she has told you?

A. Again?

Q. Well, you sort of went through it and then jumped ahead to the appointment itself when he showed up. I just want to know about the conversation on the phone, what she told you after the fact.

MR. RISPO: After the fact?

Q. After the fact what did she tell you he said and what did she tell you she said on the phone?

MR. RISPO: In the afternoon?

MR. MISHKIND: Yes.

A. In the afternoon? He called back in the afternoon to see if there was an available opening, and she said to him yes, come on in towards the end of the day and we'll fit you in somehow.

Q. So she told him that there was an opening?

A. She told him come on in and we'll see what we can do, or we'll fit you in somehow, that's what I remember, come on in and we will fit you in somehow. He showed up at the window --

Q. Doctor, don't get ahead. I am not to the window yet, I am not to the window. We will get to the window.

Did she tell you after the fact when she said come on in, did -- do you know why she didn't mark him down on the list of patients at that point?

A. Sure.

Q. Okay. Why?

A. Because the list of patients is made in the

morning, and if there are additions in the afternoon she doesn't mark them in, or if there are cancellations, she doesn't come around and write everytime someone says I am not going to come in. If somebody calls in at 3:30 and says I am not coming in at 4:30, she won't cross that out. There is always possible variations on how an afternoon is going to go.

Q. Next she told you that at some time he shows up in the office. Did she tell you what time it was that he showed up?

A. No.

Q. Do you know how long it was that he sat in the lobby before he was brought in for the EKG?

A. No.

Q. Did she indicate to you how long he was sitting in the lobby?

A. No.

Q. And she told you then after she brought him in she took him back to an area and performed the EKG?

A. She told me that he came to the window and stated his name, he said Jan, I would like to get an EKG because my family is worried about me. She went ahead and got the EKG. Then he

asked for the key to the bathroom and collapsed.
Q. Well, where did she go ahead and get the EKG?
A. In another examining room.
Q. So she would have brought him back into the examining room outside of the lobby area?
A. Yes.
Q. And how long normally does the EKG take to perform?
A. I would say less than five minutes, five minutes.
Q. And then after the EKG is performed he said that he wanted to use the bathroom?
A. Uh-huh. Yes.
Q. And it was -- then he walked from the EKG room to the bathroom?
A. Yes.
Q. What did she tell you as to the time period from finishing the EKG until the time that he collapsed?
A. He did not go back from the EKG room, if we may call it such, to the waiting area. He went from the EKG room to the bathroom. So I imagine it was one or two minutes. He finished getting dressed and then he went to the bathroom.
Q. So from the time that he would have left the

lobby and gone back into one of the examining rooms where the EKG was done until the time that he collapsed, we're talking five minutes, six minutes?

A. I would say less than five minutes probably.

Q. Okay. So that when Jackie testified that it was several minutes, that would be less than what it would normally take for the EKG to be performed?

MR. RISPO: Howard, we're going into two and a half hours in deposition and we have a witness sitting out there patiently waiting since about 12:30.

You're examining a person who was not even a witness to these events over and over and over again on the basis of hearsay.

I think we should get on with it, conclude this deposition and get to the witness who knows what is going to happen.

MR. MISHKIND: Well, I appreciate that, and I am going to move along as quickly as I possibly can, but with all due respect, I am going to take the deposition. I will tell you, though, as I am looking at the time --

MR. RISPO: Should I send Miss Schoch home?

MR. MISHKIND: Off the record.

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

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MR. RISPO: I want the record to reflect that I tried to salvage your trip to Floralscape with your family tonight, and it was not my fault, it is yours.

MR. MISHKIND: Let the record further reflect that I have indicated that I want to finish this doctor's depo and I have offered to come out and accommodate the witness at her office, at any location, but for some reason the choice was to suspend the doctor's deposition in the middle and do her deposition now, or to continue to do it and do her deposition afterwards.

I don't think I was presented with the option of doing her deposition at another point. So my --

MR. RISPO: The point is well made

that I insisted that you proceed with Miss Schoch who has been sitting out there for three and half hours waiting for this deposition, and I thought that was common courtesy. But we have a difference of views.

MR. MISHKIND: We certainly do.

Q. What does the term triage mean to you?

A. The term triage means selecting who needs immediate attention from who could wait.

Q. And is there a triage process that takes place in a hospital, in a hospital emergency room?

A. I suspect so. I don't know for sure, but I think so.

Q. Is there a triage process that takes place in a doctor's office?

A. If it's a walk-in clinic, yes. If it's an office that sees patients only by appointment, there isn't.

Q. What about an office that has patients that call in from time to time with acute illnesses, is there a triaging process that takes place in terms of which patients need to be seen and which patients don't need to be seen?

A. There isn't one in my office. Simply people

call for an appointment, they will speak to the receptionist. If they call for an opinion, as I stated before, the receptionist passes on the conveyed information from the patient to me, and I usually get that information within a half hour and make a decision, but I wouldn't call that process triaging, though.

Q. So you actually do the triaging, ultimately?

A. Well, I wouldn't call it triaging. I just answer the question, if it is posed.

Q. And sometimes that question involves whether or not the patient needs to be seen or doesn't need to be seen?

A. That's correct.

Q. Okay. And certainly it's important in order for you to make that decision that the information is being accurately conveyed to you, correct?

A. That's a matter of course.

Q. I am sorry?

A. It's a matter of course.

Q. Well, it certainly is the standard of care, is it not, in order to comply with the standard of care, that information has to be accurately communicated to you so that you can make the decision?

A. It would be onerous otherwise.
Q. Not only would it be onerous, but it would not be in compliance with the standard of care?
A. Yes, you are correct.
Q. When Mr. Porach arrived at your office, you were in with Mr. Hayes?
A. Yes.
Q. When Janice told you after the fact about Mr. Porach's arrival at your office, she told you that the first thing he did was came in and said that he wanted to have an EKG because his family was worried?
A. Yes.
Q. Did he describe to your receptionist what his symptoms were?
A. As far as I know he did not.
Q. Did you ever learn at any time after he died that Mr. Porach had, in fact, told Janice sometime before the EKG was done what his symptoms had been?
A. No.
Q. And, obviously, you have had a chance to talk to Janice as time has gone on, you have talked to her today at lunch and perhaps even during the course of our breaks, your testimony is that Mr.

Porach never told Janice that he was having any cardiac symptoms?

A. Yes. From speaking with Jan, Jack Porach never told her that he had chest pain, arm pain or shortness of breath.

Q. What about aching in the chest?

A. Not aching in the chest. Aching, achyness in the limbs.

Q. He never told your receptionist that he was having aching in the chest and in the shoulders, is that --

A. That's what I recall.

MR. RISPO: I think you should ask these questions of the receptionist.

MR. MISHKIND: Your objection is noted.

MR. RISPO: Let me just record, it pains me to do this, Howard, but I have to protect my record here.

If we are going to continue to repeat hearsay information, then I will object and instruct the witness not to answer any further to the extent the questions are repetitive. We have gone into this just about enough.

MR. MISHKIND: I am not even going to dignify a response. 1 am surprised that you are even doing this.

Q. Where exactly was Mr. Porach located when you first saw him?

A. He was slumped under the bathroom sink.

Q. Were you the first one to arrive at the bathroom sink or was Janice already there?

A. No. She wasn't there.

Q. Did you hear a noise?

A. No, I did not.

Q. She came and knocked on your door?

A. She knocked on my door.

Q. And said what to you?

A. She said there was a thud in the bathroom.

Q. And you immediately left the room and went to the bathroom?

A. Yes. Fortunately the door was open and I found Jack slumped. He was too big for me to pull out. So I called Mr. Wayne Hayes to help me pull him out.

Q. Were you in the middle of an examination of Mr. Hayes or had you completed it?

A. I was in the middle of an examination of Mr. Hayes. Certainly I was talking to him about

whatever he was in for.
Q. Mr. Hayes then came over and helped you?
A. Pull Jack out of the bathroom, right.
Q. And what happened next?
A. I checked to see if he was breathing and found that he wasn't breathing. I instructed Jan to call the emergency room and began CPR, mouth to mouth resuscitation with chest compressions.
Q. You told Jan to call the emergency room?
A. Yes, because we're located right next to the ER.
Q. To your knowledge, did the emergency room tell her to call 911?
A. They did tell her to call 911, which I said okay, call 911, because I hope they can get up here because I think they can get up here faster because we are located next door to each other than 911 could.
Q. Do you have any explanation for Dr. Gershman's note from the emergency room where he says the office called the emergency room, they were told to call 911. However, there was some delay in them getting the message, and, therefore, I went to the doctor's office, and he goes on, which is in an adjacent building to see the patient, and my question is do you know or have any

understanding as to what he meant when it is stated that there was some delay in them getting the message?

A. No, I don't know what that means.

Q. Did you ever talk to him to try to get any clarification as to what he meant?

A. No.

Q. Describe for me the CPR that you did.

A. Well, I gave him chest compressions, and alternated 15 compressions within two breaths.

Q. And what kind of response, if any, did you get?

A. I didn't get any response.

Q. How long did you continue your CPR?

A. Until the people from the emergency room came up, Dr. Gershman, they came up and then probably a couple minutes later the people from 911.

Q. How long were you doing the CPR?

A. I would say I was probably doing it for about five minutes.

Q. When is the last time you had done CPR on any type of a patient?

A. Probably 1987, '88.

Q. What was the circumstance?

A. I was working as a medical resident.

Q. Do you have training or have you had any

training since finishing your residency?
A. I think the last time I had training was probably somewhere around 1989, 1990 because I worked as a house physician for two or three years after I went into practice and you had to be recertified in CPR and a CLS, but once I went into my own practice and wasn't working in a hospital anymore I didn't recertify for it because --
Q. So at the time that you did the CPR you were not certified in a CLS --
A. I had not been recertified in it, no.
Q. It was your choice, certainly it is something that you could have gotten recertification on?
A. I could have, yes.
Q. Okay. Janice and anyone in your office have CPR training?
A. No.
Q. And certainly they are not certified in advanced cardiac life support, that sort of goes without saying?
A. You're correct.
Q. But my statement is accurate?
A. Your statement is accurate.
Q. Okay. Did you talk with Jackie after the fact?

A. What I recall was that I went out into the waiting room and told Jackie that her stepfather wasn't doing well, that I needed to get ahold of her mom, and somehow she helped me get ahold of you, of her mom, and then I told her that her stepdad would have to be transferred down to the emergency room, and then I remember talking to Mrs. Porach and telling her that he wasn't doing well. I don't remember what I told her, that he had collapsed or what not, but I said he needs to go down to the emergency room because he is just not in good shape. So I will meet you down there.

Then the child specialist came up and took Jackie down to the emergency room area. At that point I spoke with Jan, I said gee, I don't know anything about this, what a surprise, and then I went down to the emergency room to see what was going on. When I arrived there Dr. Gershman told me that they called off resuscitative attempts after a half hour because they were unsuccessful.

Then I remember walking into a room where Mrs. Porach was and I believe her mother and children were in and had to give her the bad

news and she said to me you killed him.
Q. Mrs. Porach said you killed him?
A. Uh-huh.
Q. That's a yes?
A. Yes. And I just shrugged my shoulders and said okay, if that's how you feel about it.
Q. Who was present when Mrs. Porach allegedly said to you you killed him?
A. As far as I can recall it was her and her mother and at least Jackie, but it was such a tense moment that one's sight is -- it was like being in a wind tunnel.
Q. You mentioned --
A. I just remember seeing her and her telling me this. I said great, you know, I didn't even know about this man being in my office, I find him dead in my bathroom and now I am being told that I killed him, this is just fabulous.
Q. Do you know why you didn't know about this patient?
A. I wasn't told about this patient.
Q. You weren't told about it because Janice didn't tell you about the patient?
A. That's correct, sir.
Q. All right.

A. Is there any other reason why I shouldn't have known about this patient?
Q. Well, is there any reason that Janice didn't tell you about the patient?
A. I can't answer that question.
Q. Okay. And don't you think you should have known about the patient before he collapsed?
A. I don't know.

MR. RISPO: Wait a second here. We are getting into an argument based upon varying assumptions which are not identified on the record. Nothing is to be gained by this kind of exchange.

MR. MISHKIND: I don't think -- I am going on to my next question.

MR. RISPO: Wait until a proper question has been presented.

MR. MISHKIND: It was a proper question and a proper answer, but I am going to move on anyway.

Q. You mentioned that Jan, that you spoke to Jan, and maybe I misunderstood you, did you say that you spoke to her from your office by phone and then spoke to her in person in the emergency room?

A. To Janice?
Q. Oh. I am talking about to Mrs. Porach. Did you talk to her on the phone?
A. I spoke to Mrs. Porach on the phone asking her to come to the emergency room at Fairview. Then subsequently after Jack had been pronounced dead I spoke to her in a room at Fairview emergency room.
Q. Okay. Did you ever indicate to Mrs. Porach an explanation for why he suffered a fatal MI?
A. No, I did not.
Q. Now, you had examined Mr. Porach back in July of 1994, correct?
A. Yes.
Q. Do you know what the reason was that he was in for an examination at that time?
A. Yes. He came in for refills on his medications for gout.
Q. And did he -- did you give him a thorough physical exam at that time?
A. Not at all.
Q. Did you do any type of a physical exam at that time?
A. I believe I only took his pulse, blood pressure, I asked him how he was doing, he said he was

doing well, presumedly, because I wrote down doing well, and he informed me that he had quit smoking and I must have informed him about his cholesterol being high because I wrote down high hyperlipidemia, and I asked him to reduce his weight to 110 pounds and exercise twice a week.

Q. You also ordered blood work to be done. Why did you order that?

A. To recheck his cholesterol.

Q. How did you know his cholesterol was high before doing the blood work?

A. Well, let's see now. If we look back at January of '93, there was a cholesterol of 264. It's in the back of the same sheet that has the cholesterol for the July of '94.

Q. Okay. This was a recheck then that you were doing?

A. Right.

Q. So you didn't know that he was continuing to have high cholesterol, you were doing the SMA to determine --

A. Well --

Q. To determine --

A. -- his cholesterol in January of 1993 was 264.

Q. Let me finish my question first. Were you doing

this blood work in July to determine whether or not he still had high cholesterol?
A. My assumption was that he still had high cholesterol because he hadn't lost weight, and I could see no reason why he would have a lower cholesterol and to confirm that he did have it so that he would be more motivated to lose weight and exercise.
Q. What else did you do on that date beside ordering the SMA, doing the -- giving him the recommendations and --
A. Nothing that I can recall.
Q. And he wasn't scheduled for any follow-up after that, correct?
A. I don't know. I hadn't indicated in the chart, so --
Q. And if it is not indicated in the chart you would have no way of knowing whether he had been scheduled for --
A. Generally people have to come back for a follow-up if there isn't a follow-up indicated within a year because if I were to prescribe Allopurinol for his gout he would run out of the prescription within a year, and I do not customarily refill a prescription unless

somebody comes back in.
Q. You are not suggesting that he had an appointment after July 18, 1994 that he missed, are you?
A. I am not. But had he lived he would have had to come back to see me again in a year's time because he would have run out of Allopurinol, because when you write a prescription you can't get it filled for more than a year without getting a new prescription.
Q. In July of 1994 his risk factors for coronary artery disease were the weight and his high cholesterol and his gender?
A. Well, his previous history we spoke of, his gender.
Q. Was the risk factor of smoking still a significant one, even though he had quit a year and a half ago?
A. I believe so.
Q. So he was still at risk for coronary artery disease because of his long-standing albeit stopped smoking history, his weight, his gender and his high cholesterol?
A. I didn't think his weight. The reason I asked him to lose weight is because that's the way you

lower your cholesterol.
Q. Weight and cholesterol go hand and hand as factors in terms of risk factors?
A. Generally. Generally they do, but I didn't think his weight, per se, was a risk factor. I thought that was the way to get his cholesterol down low.
Q. Okay. When Dr. Gershman arrived, did you then cease your efforts at CPR?
A. Yes.
Q. And he took over?
A. He took over with some other people.
Q. Was your active involvement then in any resuscitative efforts essentially done?
A. Yes. It was terminated.
Q. Do you have any criticism at all of what was done by Dr. Gershman or anyone at Fairview General Hospital in terms of trying to save his life?
A. No. I think they did everything they could.
Q. Okay. Do you have an opinion, doctor, in this case if, hypothetically, Mr. Porach had gone to an emergency room at 3:30 or thereabouts in the afternoon and if, hypothetically, he had chest pain and shortness of breath at that time and

had been seen in the emergency room, do you have an opinion as to whether or not that would have altered the outcome in this case?

A. Yes.

Q. And what is your opinion?

A. I think that if he had gone to an emergency room and reported the symptoms of not feeling well, having chest discomfort, shortness of breath, pain in an arm, he would have been admitted, at the very least been admitted and monitored in a telemetry unit, and if the EKG were normal and the CBK's were normal he would at the very least be admitted. That is why people are admitted to telemetry units and the CCU, so that when they have a fatal arrhythmia it can be treated immediately.

Q. And had he been admitted through an emergency room at that time, 3:00, 3:30 with the symptoms that hypothetically I just described and evaluated, knowing what we know happened several hours later, do you have an opinion more likely than not as to whether Mr. Porach would have survived?

A. That I can't say, because people will end up dying even if they go to the emergency room or

if they go to the hospital. I think it increases the changes of survival substantially, but I don't think it is a guarantee.

Q. And I understand there are no guarantees, I am just asking in terms of probability, is it more likely than not, is it probable that had he been evaluated at 3:30 or earlier with symptoms of chest pain, shortness of breath in the proper setting, is it more probable or more likely than not that he would have survived?

MR. RISPO: Before you answer let's make sure the record is clear.

You are asking whether this individual, Mr. Porach, would he himself have survived under those circumstances as opposed to general statistics?

Q. Yes. I am talking about what's the likelihood, probability of him surviving had he been seen in an emergency room setting with the appropriate workup being done as opposed to arriving in your office to essentially -- well, at 5:30 or so, and my question to you, again, in a more artful manner is, is it probable had he been evaluated and seen in an emergency room earlier that he would have survived?

MR. RISPO: Answer if you know and you have an opinion, but if you do not have an opinion, do not guess.

MR. MISHKIND: Well, I think he gave his opinion before, but go ahead.

A. I don't know because he would have had a higher probability of survival because they could have intervened more quickly because when you go to an emergency room, if you collapse in the emergency room they usually have you hooked up to an EKG and they can do a zap on you there and then, but people die in the emergency rooms also, so --

Q. But the probability, although you can't state whether in his case he absolutely would have survived, but the probability is --

A. The probability of survival would have increased. That's obvious because, otherwise, if that weren't the case nobody would waste the time and money going to emergency rooms and CCU's and telemetry units.

Q. And is it more likely than not, greater than 50 percent likelihood, that with appropriate evaluation and treatment he would have survived?

A. Well, that I don't know, if it is greater than

50 percent or what the number is.
Q. Okay. Do you have an opinion in looking at the autopsy and taking into account all of the information that you have as to when the infarct first started?
A. No.
Q. Do you have an opinion as to whether or not he suffered an acute anteroseptal infarct sometime on the day of his demise?
A. The findings of an infarct, these are findings that could have happened after death. He could have been in an unstable situation all day, and I think what caused his collapse in the bathroom was a fatal arrhythmia.
Q. Well, and the arrhythmia, the fatal arrhythmia, can we agree, was in all likelihood caused by, the precipitating factor was that he developed a thrombus that caused an infarct in the left anterior descending artery that then caused a fatal arrhythmia, is that most likely the scenario?
A. That's most likely the scenario. I think it probably happened when he was in the bathroom.
Q. The arrhythmia occurred when he was in the bathroom?

A. I think the arrhythmia and probably the infarct, too, the occlusions of the left anterior descending artery.
Q. And certainly if a patient is evaluated as having chest pain and has a thrombus that is about to cause an infarct, that the best situation for the patient is to have streptokinase or other clot busting intervention?
A. That's correct.
Q. Do you have an opinion as to when intervention with streptokinase or other clot busting medication, if you will, when it was too late to make a difference?
A. I don't have a personal opinion, but according to the studies it should be given within six hours, at the very most within 12 hours, and the earlier the better.
Q. Okay. And do you accept those opinions in terms of the range that the streptokinase and other treatments are most likely to be effective in that six to 12 hour range?
A. I think my opinion is immaterial, but I subscribe to that standard of care because it has been established by controlled, doubled and

blind trials, and I accept it.

Q. Okay. Can we agree that by the time he presented into your office and had the EKG that the thrombolytic therapy in all likelihood would not have altered his outcome?

A. No, we cannot agree on that.

Q. So that had he received thrombolytic therapy at 5:30 or so before he suffered the fatal arrhythmia there still -- let me finish -- there *is* still a statistical chance that he would have survived?

A. I can't answer that question. I don't know when he developed chest pain, I don't know if he reported chest pain. There are people who do not report chest pain. There are people who are in denial. That's why there are people who have sudden death syndrome outside the hospital.

So I really cannot give an opinion on that.

Q. Do you hold Mr. Porach responsible for his own death?

MR. RISPO: Objection. Legal conclusion, but you may answer.

A. I don't have an opinion on the matter.

Q. Is there something that Mr. Porach failed to do that caused or contributed to his death, in your

opinion?
A. As far as I can tell he failed to report to my receptionist that he was having chest pain, shortness of breath and pain in an arm when he called back after 3:00.
Q. And if he did communicate that information to your receptionist, would you then have any criticism of Mr. Porach in terms of him causing or contributing to his death?
A. Yes, because if he is having those type of symptoms I think that he should call 911 or have some one transport him to an emergency room, regardless of what I say.
Q. Regardless of the fact that hypothetically your receptionist may have said come on in to the office?
A. Absolutely, because in the end I think everyone is responsible for themselves. I mean, this is such an awful outcome, who cares what Jan Schoch says or Lorenzo Lalli has to say.

If you are worried about how you are doing, in Italy there is a saying, to trust is good, not to trust is better. There is no one that you trust absolutely.
Q. Well, certainly you are not suggesting that

Lorenzo Lalli, if communicated information about the patient having chest pain and shortness of breath, Lorenzo Lalli wouldn't have some responsibility for the outcome in this case, are you?

A. I don't understand the question.

Q. If Lorenzo Lalli was aware or reasonably should have been aware through his receptionist that at 3:30 or so Jack Porach had complaints of chest pain and shortness of breath, can we agree that Lorenzo Lalli then would have had a responsibility to give recommendations to Mr. Porach as to what should be done immediately?

MR. RISPO: Objection to the form of the question.

A. Certainly had I received that information, and I would have only received that information if my receptionist had received that information, the recommendation would have been even before the information reaches me by the receptionist directly to tell the patient to call 911 or have some one drive them to the emergency room.

And, furthermore, I will say that if I were in a state of folly and recommended to the patient not to go to the emergency, but come to

my office, but still given that it is 1994, I would say gee, there is something about this doctor, you know, that I think I am feeling sick, I ought to get myself to the emergency room, because what the hell is he going to do in his office.

Q. So the patient should question the doctor's office if you were in a state of folly and didn't recommend it to him that he call 911?

A. Absolutely.

Q. But you certainly wouldn't before a jury suggest that if you didn't recommend that he call 911 that that is acceptable, would you?

MR. RISPO: There is too many double negatives in the question.

A. I don't understand the question.

Q. Fair enough. Certainly you are not suggesting, even though I heard you loud and clear say that the patient in this day and age has a duty and responsibility, you are not suggesting that the physician doesn't bear some responsibility if that physician failed to advise the patient to go to the emergency room, if that information had been conveyed about chest pain and shortness of breath, correct?

MR. RISPO: If I understood your question earlier it was whether the doctor had any opinion as to whether Mr. Porach contributed.

MR. MISHKIND: Right, and I have now come up with a different question. I asked him whether or not he will admit that you also have a responsibility and bear some responsibility if that information had been conveyed to you --

A. Yes, I agree.

Q. And that responsibility would have been to make sure that the patient was told, regardless of whether he listened to you or not, but if the patient was told call 911?

A. Absolutely. I agree entirely.

Q. And if you didn't do that, that would be below the standard of care by you?

A. It would be an act of omission.

Q. And that would be substandard medical care?

A. If you so wish to state it, yes.

Q. You agree with me, don't you? You are familiar with the standard of care from your utilization of it today?

A. Yes.

Q. And if the patient is walking and is able to drive a car, certainly even though there may be something evolving by way of this thrombus that is about to cause the fatal heart attack, he certainly would have been in a much better situation to be subjected to thrombolytic therapy so as to increase the likelihood of survival, correct?

MR. RISPO: How many times do you want him to say it?

A. Yes.

Q. Is there anything -- tell me what else you recall discussing with the family --

MR. RISPO: Excuse me. I would. like the record to reflect that we began this deposition shortly before 2:00. It is now 10 past 5.

MR. MISHKIND: I appreciate the time update. What is the purpose?

MR. RISPO: The purpose is I want the record to reflect if we get to the point where this gets out of control I am going to have to discontinue this deposition.

Now ask the questions. Let's not

be repetitive. Let's get to the point. Let's get this over with.

MR. MISHKIND: Ron, I am surprised. I have known you for a long time and I am really surprised at your conduct. Be that as it may, I am going to move on.

Q. Did you discuss anything else at the hospital with the family? Was there any further discussion other than what you have already told me?

A. No.

Q. Did you have any contact with the family after October 14th, 1994?

A. I only wrote a card expressing my condolences and offered any help.

Q. Who did you send the card to?

A. Mrs. Porach.

Q. And when you say you offered any help --

A. I stated if I can be of any assistance, please call me.

Q. Did you keep a copy of that by chance?

A. No.

Q. Was that the only contact you had after the death?

A. Yes, sir.

Q. Did you go to the funeral, for example?
A. No, I did not.
Q. There was some question asked in the deposition of Mrs. Porach about her insurance. Are you a member of a Super Blue --
A. I am a provider with Super Blue, but with a number of PPO's and HMO's.
Q. To your knowledge, was there anything that limited Mr. Porach's access to your medical care?
A. No.

MR. MISHKIND: Let me just take a couple minute break to your delight, and to your attorney's euphoria I may be very close to being done.

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(Thereupon, a recess was had.)

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Q. In your interrogatory answers you reference Doris Douser as a possible witness, and I see that she was scheduled at 5:00 before Mr. Hayes.

My question to you is, was Doris still in the office when all of this happened?
A. All I know from Jan is that Doris arrived late.

So I ended up seeing Mr. Hayes first, and then Jack collapsed in the bathroom and Doris Douser was asked to go home. So I don't know whether -- I don't know.

Q. You don't know what, if anything, she saw?

A. Exactly.

Q. Okay. Below Mr. Hayes' name on your calendar it says CPE and what does CPE --

A. Means complete physical exam.

Q. That's what Mr. Hayes was scheduled for?

A. Yes.

Q. And I take it because it was a complete physical examine you had a half an hour blocked off as opposed to a 15 minute segment?

A. Actually, 45 minutes blocked off, because he was supposed to go to 5:15. So it is usually 45 minutes, and then there is a question mark about EKG, whether Mr. Hayes needed an EKG as part of his complete physical or not.

Q. Was an EKG done on Mr. Hayes?

A. I believe not, because usually I see the patient first and then determine whether they need an EKG. It is not done as a routine.

Q. Do you know whether you had ever seen Jack's mom as a patient?

A. I can't remember.
Q. If you had, and, obviously, she's deceased now, but would you still have a chart for her?
A. I imagine so, unless she transferred her records somewhere else, but even if she did I would still have a chart on her.
Q. Okay. Would you check your records? I had asked earlier for a CV, if you can locate that. Would you also check and see if you can locate a chart for Mrs. Porach -- Eileen Ruth Porach?
A. Sure.

MR. MISHKIND: With that, I have no further questions. Thank you.

THE WITNESS: Thank you.

MR. MISHKIND: I presume you want him to read it?

MR. RISPO: Yes.

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LORENZO S. LALLI, M.D.

C E R T I F I C A T E

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

I, Susan M. Cebron, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named LORENZO S. LALLI, M.D., was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this _____ day of _____, A.D. 19 ___

_____
Susan M. Cebron, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires August 17, 1998