Original Transcript

IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

MARSHALLE PATTERSON,

Plaintiff,

vs. Case No. 571601

OHIO PERMANENTE, et al.,

Defendants.

DEPOSITION OF

RAYMOND D. MAGORIEN, M.D.

October 18, 2004
5:48 p.m.

450 West Tenth Avenue
Columbus, Ohio

Monica K. Hissong
Notary Public in and for the State of Ohio

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Deposition of Raymond D. Magorien, M.D.

October 18, 2004

RAYMOND D. MAGORIEN, M.D. of lawful age, Witness herein, having been first duly cautioned and sworn, as hereinafter certified, was examined and said as follows:

CROSS-EXAMINATION

BY-MS.TAYLOR-KOLIS:

Q. Doctor, for the record, could you please state your name, spell it, and give us your professional address?

A. Raymond Daniel Magorien, my professional address is Heart/Lung Research Building, University Hospital, Columbus, Ohio. My profession is medicine. The specialty I practice is cardiology.

Q. Okay. Dr. Magorien, it's my understanding that you are, as we shall say, ready, willing, and able to give testimony in support of or on behalf of Mr. Walters' client, Dr. Heinle; is that a correct understanding?

A. That's correct.

Q. Okay. Let's just go through some basic background. I have access to some

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information about you, but I just want to clarify it for myself. Doctor, how many years have you been doing medical-legal reviews?

A. I suspect it's ten, fifteen years, probably closer to fifteen years.

Q. Okay. And your testimony over the past five years is broken down in what percentages between plaintiffs and physicians?

A. I suspect it's probably sixty, sixty-five percent defense, the remainder plaintiff.

Q. And at present how many cases are you actively participating in?

A. It would be a guess, I would say probably ten, twelve cases.

Q. Okay. You have worked for the law firm of Reminger and Reminger on prior occasions, correct?

A. I have, yes.

Q. And on how many occasions have you worked specifically for Mr. Walters?

A. I don't recall.

Q. What other Cleveland defense firms that represent physicians do you work for or

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have you worked for?

A. I will have to apologize. I really don't keep firm names stored very long in my frontal lobes, so I can't tell you what law firms in Cleveland I have worked for.

Q. Can you recall the attorneys' names if you can't remember their firm names?

A. No.

Q. You are currently involved in some plaintiffs' cases; is that correct?

A. That's correct.

Q. And in those cases, Doctor, if my understanding that those are emergency -- at least one is an emergency room case where there was a failure to diagnose a heart attack?

A. There may be a case out there like that. Without being more specific, I -- I couldn't go -- be -- address it any further.

Q. Dr. Magorien, under oath today, did you --

A. I am sorry, just so we don't keep going, it's a hard G, Magorien.

Q. I am sorry.

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A. It's just Magorien, with a hard G.

MR. WALTERS: As opposed to Magorien.

MS. TAYLOR-KOLIS: Okay. Magorien?

THE WITNESS: Magorien.

MS. TAYLOR-KOLIS: Okay. Well, I just won't use his name anymore.

BY MS. TAYLOR-KOLIS:

Q. Doctor, did you give a plaintiff deposition in the last two to four weeks on a plaintiff's case in Cleveland, a case that is filed here in Cleveland?

A. It may be Cleveland. The deposition, of course, was down here in Columbus. But there was a firm, and I can't remember whether it was Youngstown or Cleveland, but it was -- I did do a deposition on a plaintiff's case, and it was about three to four weeks ago; that's correct.

Q. And in that case, the issue is the issue of medical negligence in the context of an emergency room department failing to diagnose a heart attack? I am asking you if that's what the case was about.

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A. The case that I am thinking of was chest pain in-hospital, not emergency room, but there may be another case out there. I really can't tell you. The case that I am thinking of was -- was more of a -- a failure to make the diagnosis about a patient that had already been admitted and was having some recurrent chest pain in-hospital.

Q. Okay. What are you billing me per hour for your deposition time?

A. Four hundred dollars an hour.

Q. Okay. In the past, have you offered opinions as to the standard of care of an emergency room physician in the failure to diagnose a heart attack case?

A. From a cardiologist's perspective, yes, I have.

Q. Okay. I would gather, and perhaps I am completely in error, but I would suspect that in your capacity at the university that you are called into the emergency room setting on occasion to help make decisions about whether to admit a patient for acute coronary syndrome or myocardial infarction?

A. That's correct.

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Q. Doctor, are you going to be rendering standard of care opinions in this matter?

A. No, I am not.

Q. Were you asked to render standard of care opinions?

A. No, I wasn't.

Q. When were you initially contacted by Mr. Walters relative to this case?

A. You know, I have got five volumes in front of me, and I don't have any face sheets, so I can't tell you when I initially took a look at this case. I wish I could. Maybe Mr. Walters has that, but I don't know.

Q. Do you have a correspondence file?

A. No, I don't. I just have the actual five volumes that he sent me and one deposition.

Q. What deposition did you happen to have read or happen to read?

A. Dr. Celestina.

Q. Did you ask to see the deposition of Dr. Heinle?

A. No, I did not.

Q. What additional information that

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would be helpful to you in sorting out the issues -- and I guess we will get to the issues in a minute -- was gained by reading the deposition of Dr. Celestina?

A. There wasn't any really additional information above and beyond the medical records.

Q. When you initially reviewed this report, I mean this case, you had the medical records and the deposition transcript of Dr. Celestina, I think it so states, in the first paragraph, correct?

A. That's correct.

Q. Okay. Since that time have you seen any additional materials?

A. There may have been, and I don't have it with me, and it may be at home. There may have been a statement from a Dr. Friedlander that I took a look at, but I have not read his deposition. And there may have been a -- an initial statement from him that was sent my way, but I don't have it here, and I don't have any really firm recollection of what he said.

Q. Doctor, do you understand,

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obviously because you have experience in doing this, that today is my only opportunity to speak with you about the opinions that you will be rendering at trial?

A. I do understand that.

Q. And do you feel that you have completely and adequately reviewed all the material that you wish to review to formulate the opinions that you are going to tell me about shortly?

A. That is correct.

Q. Okay. Have you seen any expert reports, other than perhaps your recollection is maybe you have seen Dr. Friedlander's?

A. That would be it.

Q. Okay. Let's ask the question this way. What opinions do you plan on rendering at the trial of this lawsuit?

A. This patient obviously sustained a massive myocardial infarction. We can be more specific about it. I will render opinions as to when that infarction probably commenced. I will render opinions in regards to the likely extent of injury and damage that occurred following the onset of the

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myocardial infarction.

I will render opinions with regards to how much myocardium was likely salvageable during the patient's progression through the heart attack process. And then if asked, I can render opinions with regards to -- in some ways with regards to her status following stabilization and treatment post-heart attack.

Q. Okay. I think you made that clear enough, so I am just going to go back and go through them. When, Doctor, to a reasonable degree of medical probability do you believe that Ms. Patterson's myocardial infarction commenced?

A. The afternoon of November 22.

Q. Tell me, Doctor, with as much precision as you can the basis of that opinion.

A. If you will give me a moment, I am just going to pull up the patient's cardiac enzyme report, and then I will address that issue specifically. I have got too many volumes in front of me, but I am going to find it, if you will just give me a

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moment.

Q. That's okay. It's volume four, Doctor, page thirty-two.

A. Yeah, I have got it paper clipped here. It's the last place I looked, obviously. If you -- I guess it's marked Bates page thirty-two. The patient, Mrs. Patterson, peaked on her cardiac enzymes at 12:46 on 11/23.

And I think this is the -- the most objective way to try to understand when her heart attack likely commenced. We know from a lot of information in the medical literature that people, individuals, peak their cardiac enzymes roughly eighteen to twenty hours, twenty-four hours, following the onset of a heart attack.

So if you go back roughly twenty hours prior to her peak cardiac enzyme at 12:46, you are in the early afternoon of 11/22. So I think that is probably as accurate as we can get in terms of trying to backtrack and understand when her heart attack started. Now, when I said heart attack started, when her cardiac enzymes would have

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been initially released.

The heart attack actually can start two, three, four hours prior to release of cardiac enzymes. So that would place her -- again, her heart attack starting sometime in the early afternoon of the 23rd -- I am sorry, 22nd.

Q. Okay. And with that -- and you just can't pinpoint the hour for obvious reasons, correct?

A. Right. There is variability from patient to patient. If you wouldn't mind giving me just a moment, I am going to answer this page, if you don't mind?

Q. Not at all.

(Thereupon, an off-the-record discussion was had.)

BY MS. TAYLOR-KOLIS:

Q. Okay. Having said that you believe that Mrs. Patterson's myocardial infarction -- I don't know that you used the word, but I am going to use the simple word began sometime in the afternoon, I guess that's where we are putting it, the afternoon of the 22nd?

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A. Early afternoon, late morning, early afternoon, correct.

Q. Okay. Let's just ask a couple of basic questions. Since you believe that, Doctor, do you also hold the opinion to a reasonable degree of medical probability that had cardiac enzymes been drawn at Huron Hospital at any point between 6 p.m. and midnight on the 22nd, would those enzymes have been positive?

A. Likely.

Q. Do you need to take that?

A. I do.

(Thereupon, an off-the-record discussion was had.)

BY MS. TAYLOR-KOLIS:

Q. To loop back where we were, I believe the last question I asked before you were called upon was whether or not you had an opinion as to whether or not the enzymes would have registered as positive at Huron Hospital between 6 and midnight, and I believe that you said yes?

A. That's correct.

Q. Is that to a reasonable degree of

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medical -- too late in the day -- is that to a reasonable degree of medical probability?

A. That's correct.

Q. All right. Doctor, do you likewise believe that at that period of time at Huron Hospital between 6 p.m. and approximately midnight that an EKG would have been diagnostic for myocardial infarction?

A. That's uncertain. It's likely that EKG would have shown abnormalities; whether it would have been diagnostic or not, that's speculative.

Q. Okay. I just want to know if you are going to have an opinion, since we obviously have to talk about it.

A. Sure.

Q. Let's go, I guess, to the next thing that you indicated that you would want to talk about or would be likely to talk about at trial, and you phrased it as the likely extent of damage. Tell me what you are going to testify to and what the basis of that testimony will be.

A. I am going to testify, if asked, that the patient had on the 23rd -- had

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evidence of LAD total occlusion, a hundred percent blockage of the left anterior descending coronary artery without collateral bloodflow, without appreciable collaterals, and had a major amount of injury that, given the fact that the infarct likely started in the early afternoon of the 22nd that in patients that have total occlusion of the left anterior descending coronary artery, without collaterals.

Usually, by the time they are three, four hours into the infarction, there is an appreciable amount of irreversible myocardial damage. So if you asked about what degree of salvage, what degree of benefit earlier intervention would have had, then we can discuss that -- that issue specifically with regards to the evening of the 22nd, if intervention had been attained at that time.

Q. Okay. And I guess that's precisely what I would like to discuss, and let's see if I understand your combination. As I wrote it out in my lovely purple pen, are you indicating that the factors that

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would be considered in making substantial heart damage evident in three to four hours are A, the LID, B, it's totally occluded, and C, she has issues, appreciable collateral flow?

A. That's what I understand.

Q. Is that the combination?

A. That is the basis of my observations, correct.

Q. Okay. Working that backwards, if the jury were to accept your testimony that the heart attack began somewhere in the early afternoon, okay, given factors that you have come to learn through your investigation of the medical records, what do you believe would have been Mrs. Patterson's opportunity for a less extensive heart attack had she been diagnosed in the morning, beginning at the time of her presentation to the Cleveland Clinic Foundation but before the actual infarction occurred?

A. All I can say is that an EKG, and I don't have the exact time in my mental grasp, but an EKG obtained that morning of the 22nd showed a normal pattern with no

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injury. So I think we can say with a reasonable degree of certainty that there was no ongoing injury, appreciable EKG injury, the morning of the 22nd.

Q. And you would concur with that reading, that at that time that was a normal EKG?

A. That's correct.

Q. I think that's what you just said, actually. Doctor, what therapy is available to treat a person to prevent them from going into a myocardial infarction such as this when what they are suffering is the precursor, the ischemia?

A. If you have got clinical evidence of what we call an acute coronary syndrome, there are various treatments that can be utilized. They -- do you want me to specifically note what can be utilized; is that your question?

Q. Yes, I would appreciate that.

A. The mainstay of therapy for an acute coronary syndrome is aspirin, aspirin and/or Heparin, oftentimes a beta blocker. Depending on other factors, you might use

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nitroglycerin intravenously.

Q. And the goal of that is to -- just so that I want to make sure I understand, which I never do at this time of day, or -- the goal in treating an acute coronary symptom where you don't have a proven MI is to treat it prophylactically to prevent the MI from occurring, would you agree with that?

A. That's one of the primary goals, correct.

Q. Do you have any reason to believe that if any one of these combinations of treatment had been initiated for Mrs. Patterson prior to the time of her infarction that she might not have had a much better outcome?

A. It's totally uncertain as to whether it would have prevented her from going on to have an infarction.

Q. Well, without therapy, would you say that as a certainty that she was going to have an infarction?

A. I think we can assume that, correct.

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Q. Okay. Do you have any statistical basis -- let me retract that question. Doctor, you are pretty well-written and published, I can see from your curriculum vitae. Do any of your publications do you feel deal directly with this issue on predictive value outcomes, so to speak, in terms of treating acute coronary syndromes?

A. A lot of them involve treatment in acute coronary syndromes, but I don't recall any of them talking about predictive value of any given specific therapy.

Q. All right. Let's do this a different way. Getting back, I guess, to where you were asked to look at this matter for Mr. Walters on behalf of Dr. Heinle, if after Mrs. Patterson presented to Huron Road, if an EKG had been taken, and you said you are not entirely sure what it would have shown, but you are to a reasonable degree of medical certainty certain that our cardiac enzymes would have been positive, given what you saw of Mrs. Patterson's clinical picture at Huron Road Hospital that night, would therapy have lessened the effects of the

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myocardial infarction?

A. What kind of therapy would you be referring to?

Q. Well, if the physician -- if the physician at Huron Road Hospital had recognized that she had this MI that you think started in the afternoon, what therapy should they have initiated?

A. Assuming that she was having an anterior myocardial infarction, which I think is more likely than not, the therapy would be aspirin, Heparin, probably a beta blocker. And then if the EKG pattern showed a major injury pattern, a potential consideration of transfer to a tertiary center to intervene and open up the blockage. That would have probably been the sequence of events.

Q. Okay. And, once again, having given me that sequence of events, if those things had occurred in a sequential pattern between 6 p.m. and midnight, do you have an opinion to a reasonable degree of medical probability whether or not the extent of the damage from the myocardial infarction would have been less?

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A. My opinion is that it would have likely been somewhat less, but not appreciably. And I can explain why if you would like, but I will just stop at that point.

Q. This is your day to get to explain so that I can learn or consider, I guess. So tell me what the basis is that you would think would be somewhat less but still considerable.

A. We know from her enzyme release that she likely started the event in the early afternoon of the 22nd. And if you walk through sort of the sequence of events, she arrives at Huron, I believe, at around 6 p.m.

By the time she would have made the diagnosis, got an EKG, gotten blood tests, started her on medications, evaluated the EKG, and then made a decision to potentially transfer her to another hospital where they would have to have a team, a cath lab team, in place to perform a procedure, we are probably talking at the very best 10 or 11:00 o'clock on the 22nd as the opportunity

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to be in the cath lab and potentially opening up a blood vessel.

Assuming that she started to infarct, and it's an LAD hundred percent occluded like we know it was the next day, it's likely that that is the case that evening. By the time they get her to a tertiary center, open up, do the angiogram, see the blockage, mechanically open up the blockage, she has likely had a very extensive amount of irreversible myocardial necrosis.

And I can tell you the basis of that, but it's my clinical experience and it's evidenced in the literature that if you have total occlusion of a left anterior descending coronary artery, most damage occurs in the first four hours. That is the window where you salvage muscle.

She is well out of that window by the time she gets in and gets intervened on. So, in quick summary, that's my explanation of the rationale that she may have had some benefit, but not appreciable in terms of improving heart muscle function, unfortunately.

Q. Okay. I am trying to process what

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you are saying. What leads you -- your contention that there was a total occlusion in the afternoon is working your CPKs backwards. That is probably too simplistic of a way to say it, but am I correct in that assumption?

A. Well, to have necrosis, and that's irreversible damage to heart tissue, that's what you have to have before the enzymes start leaking. We know from a voluminous amount of literature that enzymes peak eighteen to twenty hours after the infarction.

So we can go back with a reasonable degree of certainty and ballpark when the heart attack started. You are not going to start necrosing heart muscle with a fifty, sixty percent blockage. You have to have very severe interruption of blood flow before you start necrosing heart tissue.

So I think it's more likely than not that early in the afternoon of the 22nd, she either had total occlusion or effectively total occlusion of her left anterior descending coronary artery. And it's likely that in the first four hours of that event,

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she had an appreciable amount of irreversible myocardial injury.

Q. I am thinking, sorry. I think very quietly. If -- I may have asked this already. If Mrs. Patterson had been in telemetry, let's say, at 12:00 o'clock in the afternoon, and let's just say she never left Kaiser between 12 and 6, do you have an opinion whether it was more likely or not that she could have, if they observed her, caught this before she actually infarcted?

A. That would be totally speculative on my part. Sometimes, people will show an intermediate EKG pattern. More often than not, she had a flat-out normal EKG pattern late in the morning of the 22nd. Whether she would have had an intermediate pattern that would have allowed them to intervene to interrupt the infarction, that would be totally speculative on my part. I just don't know.

Q. I guess I am going to ask one of those questions that I hadn't really thought about prior to having the opportunity to meet you. If Mrs. Patterson has a total occlusion

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early in the afternoon, pinpointing the time, November 22, how did -- how was it she didn't die from this heart attack? It's curiosity, I would love to hear the answer.

A. Certainly. Mortality rates now with heart attack in the United States are down in the -- under ten percent. It depends a little bit on the age and the gender. This is a relatively young female. So her mortality rates are less than ten percent.

So most people don't die of heart attack. Most survive. The people that do expire usually expire of a lethal arrhythmia in the early stages of a heart attack. They don't die of shock. They don't die of cardiac rupture. They can, but their greatest risk is sudden death due to an arrhythmia.

And some people don't have lethal arrhythmias. So the majority of the people in the United States do survive their heart attacks.

Q. So she simply had this massive occlusion and then ended up in surgery the

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next morning and cardiogenic shock?

A. That's correct.

Q. Is that essentially how you stand?

A. That's correct. And can I back up to that last statement? When I said ten percent --

Q. Oh, absolutely.

A. When I said ten percent, that's ten percent of the patients that make it into the hospital. That doesn't include the people that die in the field. Slightly less than half will die suddenly before they get into the system. The ten percent survival or better is people that survive to get into the medical system. Just wanted to clarify that for you.

Q. All right. I appreciate that. I am going to ask you a couple more medical questions, but I always get nervous that I haven't asked something in an appropriate way. You have no opinion as to whether Dr. Celestina or Dr. Heinle complied with the standard of care in this case?

A. That's correct.

Q. Okay. All right. What do you

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think Marshalle Patterson's prognosis is?

A. My records, and I would have to go back and look and see when the most contemporary records I have, but my recollection without going specifically is that her ejection fraction is markedly depressed. She has had some bouts of heart failure. So her survival has been substantially impacted adversely.

Q. Can you quantify that, Doctor? Are you talking about a reduction in life expectancy?

A. Correct. Survival, yes, ma'am.

Q. Okay. Are you going to be opining a number? Ms. Marshalle is now -- she would be mad at me for not knowing -- I think she is forty-four right now or thereabouts. To what extent do you believe this initial myocardial infarction and the extensive damage that was caused by it reduced her life expectancy?

A. Well, without having an actuarial curve to know what a forty-four year old female would normally live to, but let's assume that if she had never had the

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infarction that she is going to live potentially into her late seventies, early eighties, I would suspect with this degree of myocardial dysfunction and with evidence of overt heart failure following the event that her -- her five year survival -- five to seven year survival is probably in the fifty percent range, and that's excluding the potential for transplantation.

Q. In a -- in a way that would allow you to answer the question, you have been able to evaluate the care rendered to Marshalle by the Cleveland Clinic Foundation and Kaiser after her heart attack?

A. That's correct.

MR. WALTERS: I don't know if you have the most recent records.

MS. TAYLOR-KOLIS: I don't know that I do.

MR. WALTERS: In fairness, Doctor, I don't know that you have -- because I don't know that we do have the most recent records.

THE WITNESS: If you want me to be specific about that, I have records that

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clearly are in '03. I don't recall whether I have any records that go to '04.

MS. TAYLOR-KOLIS: I know that she has been -- well, let me try to clear this up. I know that she has been seen in '04. The records could be sitting on my desk, for all I know, in a packet. All I have got to do is find them and make copies for everybody, and I will do that tomorrow. I know I asked for them.

MR. WALTERS: I will provide you those records. And if we are going to supplement that opinion, we will do that immediately.

MS. TAYLOR-KOLIS: That's perfectly acceptable to me. I just write one or two lines I have looked at these records.

BY MS. TAYLOR-KOLIS:

Q. Because the question I want to ask is it seems to me that the physicians both at the Cleveland Clinic and Kaiser are concerned for her health and are rendering good medical care to help her sustain cardiac function. I was wondering if you agreed with that.

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A. Yes, I would agree with that, based on what I have seen.

Q. Should Mrs. Patterson -- I don't even know how to ask this question because you have never met Marshalle, so this would be a hard question for me to ask. When you say her five to seven year survival is approximately fifty percent, excluding transplant, what would be the most likely cause of death for her in that five to seven year period of time?

A. It's about fifty-fifty. One is arrhythmia. The second -- arrhythmia, and that is lessened by placement of an implantable defibrillator. The second is heart failure.

Q. You know she has -- she got a device?

A. That's correct.

Q. I don't know if you knew that, okay. In your opinion, should Mrs. Patterson, with what you know right at this moment, should she be on a transplant list?

A. I couldn't answer that. I would say if --

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Q. Okay.

A. -- she has got a device, if she does have an implantable defibrillator, that if she has a defibrillator, that does improve her survival somewhat because it decreases the risk to die of a lethal arrhythmia.

Q. Doctor, based upon your review of the records, if you haven't answered this, for how many days do you believe before Mrs. Patterson presented to Kaiser that she was experiencing cardiac ischemia?

A. That would be very speculative on my part. From looking at the records going back to 19, I believe, '96, she had similar chest pain syndromes, back pain that was felt to be due to fibromyalgia. So to try to speculate whether her symptoms prior to coming into the Kaiser system or the other emergency department were ischemic would just be speculative on my part.

Q. When Mrs. Patterson presented to Kaiser's emergency room on November 22, you might have the records handy, what clinical presentation did she have?

A. If you will give me a moment, I

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will pull up that tab and take a look.

Q. Okay.

A. From my review of the records, it sounds as if she was complaining of what was referred to as a typical chest pain, upper back pain radiating to both arms.

Q. With that set of symptoms and the history that's available, what would have been within the differential diagnosis or what should have been within the differential diagnosis?

MR. WALTERS: I am going to object. He has indicated on three separate occasions that he is not rendering standard of care opinions, and I think we are now in the region of standard of care.

MS. TAYLOR-KOLIS: I am just testing --

MR. WALTERS: You are just testing, if I am paying attention.

MS. TAYLOR-KOLIS: Well, we know you are not.

BY MS. TAYLOR-KOLIS:

Q. No, Doctor, I withdraw the question because now I have got Mr. Walters on the

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record saying he is never going to go there. Have you been made aware of Dr. Friedlander's deposition testimony?

A. I have not read his deposition testimony. Mr. Walters and I had a brief conversation about it prior to the -- this deposition this evening.

Q. I am just going to paraphrase a little bit, and Steve will hold me accountable for paraphrasing wrong, I am sure. But at Dr. Friedlander's deposition, he indicated some of the same kinds of information you did about when CPKs peak, et cetera, and a concern that he had was that there was a laboratory value reported at 2 a.m. on November 24 where the CPK was still 1951. Do you recall seeing that laboratory value?

A. I did, yes.

Q. Dr. Friedlander indicated in his testimony that he couldn't be sure that the reason that the number still was that high was because there had been a successful angioplasty and, thus, a pouring out of CPK into the system. What do you think of that

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convention?

A. Could you repeat that?

MS. TAYLOR-KOLIS: Yeah, maybe the court reporter can read it back to you.

(Question read.)

THE WITNESS: That's not usually the way it works. When you have a successful angioplasty and you get markedly improved profusion into the heart muscle and the actual CK curve narrows, not widens. So it's the actual opposite of that, if I am understanding your paraphrasing of what he said correctly.

So, basically, what you do is you narrow the curve, not widen it if you have successful angioplasty. And by successful angioplasty, it's not just opening up the blood vessel. It's also getting blood flow into the heart muscle.

And if you look closely at the angioplasty report, they did not get brisk flow. They had low flow, almost no reflow, and they had to dilate several times to get some improvement in flow. So the fact that the CK curve hung out into the next day, I

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think, is a function of this massive infarction with a low reflow phenomenon and not good effective reperfusion.

MS. TAYLOR-KOLIS: Doctor, I know you are going to be in absolute shock, but I don't have any other questions for you.

THE WITNESS: I am in shock.

MR. WALTERS: We are going to get it typed up, and we will send it to you right away. And I will be in touch in the next week or so, okay?

THE WITNESS: That's fine.

(Thereupon, the deposition was concluded at 6:35 o'clock p.m.)

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STATE OF OHIO)
COUNTY OF MONTGOMERY) SS: CERTIFICATE

I, Monica K. Hissong, a Notary Public within and for the State of Ohio, duly commissioned and qualified,

DO HEREBY CERTIFY that the above-named RAYMOND D. MAGORIEN, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth; that said testimony was reduced to writing by me stenographically in the presence of the witness and thereafter reduced to typewriting.

I FURTHER CERTIFY that I am not a relative or Attorney of either party nor in any manner interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Dayton, Ohio, on this 28th day of October, 2004.

/s/ Monica K. Hissong

MONICA K. HISSONG
NOTARY PUBLIC, STATE OF OHIO
My commission expires 4-18-2005

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CAPTION

The Deposition of **Raymond D. Magorien, M.D.**, taken in the matter, on the date, and at the time and place set out on the title page hereof.

It was requested that the deposition be taken by the reporter and that same be reduced to typewritten form.

It was agreed by and between counsel and the parties that the Deponent will read and sign the transcript of said deposition.

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CERTIFICATE

STATE OF_____:

COUNTY/CITY OF_____:

Before me, this day, personally appeared, **Raymond D. Magorien, M.D.**, who, being duly sworn, states that the foregoing transcript of his/her Deposition, taken in the matter, on the date, and at the time and place set out on the title page hereof, constitutes a true and accurate transcript of said deposition.

_____

Raymond D. Magorien, M.D.

SUBSCRIBED and SWORN to before me this _____ day of_____, 2004 in the jurisdiction aforesaid.

_____ _____

My Commission Expires Notary Public

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DEPOSITION ERRATA SHEET

RE: SetDepo, Inc.
File No. 5308
Case Caption: Marshalle Patterson vs. Ohio Permanente, et al.

Deponent: **Raymond D. Magorien, M.D.**
Deposition Date: October 18, 2004

To the Reporter:
I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me. I request that the following changes be entered upon the record for the reasons indicated. I have signed my name to the Errata Sheet and the appropriate Certificate and authorize you to attach both to the original transcript.

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Deposition of Raymond D. Magorien, M.D.

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SIGNATURE: _____ DATE: _____

Raymond D. Magorien, M.D.

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AMENDED CERTIFICATE

STATE OF GEORGIA:

COUNTY OF FULTON:

I Hereby certify that in addition to the certification made on the Reporter's Certificate Pages, this Original Depostion has been sealed pending the witness' right to review said deposition within 30 days, which time has not elapsed.

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