

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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## APPEARANCES

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ATTORNEY AT LAW

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AND LAKELAND EMERGENCY ASSOCIATION:

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

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

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

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

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

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

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

20 A. I have, yes.

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

23 A. I don't recall.

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



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1 have you worked for?

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

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

9 A. No.

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

12 A. That's correct.

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

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

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

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

25 Q. I am sorry.



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

2 MR. WALTERS: As opposed to

3 Magorien.

4 MS. TAYLOR-KOLIS: Okay. Magorien?

5 THE WITNESS: Magorien.

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

8 BY MS. TAYLOR-KOLIS:

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

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

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



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

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

11          A.       Four hundred dollars an hour.

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

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

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

25          A.       That's correct.



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

4 A. No, I am not.

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

7 A. No, I wasn't.

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

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

15 Q. Do you have a correspondence file?

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

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

21 A. Dr. Celestina.

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

24 A. No, I did not.

25 Q. What additional information that



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

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

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

13 A. That's correct.

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

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

25 Q. Doctor, do you understand,



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

5 A. I do understand that.

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

11 A. That is correct.

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

15 A. That would be it.

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

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



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1 myocardial infarction.

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

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

16 A. The afternoon of November 22.

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

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



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1 moment.

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

4 A. Yeah, I have got it paper clipped  
5 here. It's the last place I looked,  
6 obviously. If you -- I guess it's marked  
7 Bates page thirty-two. The patient, Mrs.  
8 Patterson, peaked on her cardiac enzymes at  
9 12:46 on 11/23.

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

18 So if you go back roughly twenty  
19 hours prior to her peak cardiac enzyme at  
20 12:46, you are in the early afternoon of  
21 11/22. So I think that is probably as  
22 accurate as we can get in terms of trying to  
23 backtrack and understand when her heart attack  
24 started. Now, when I said heart attack  
25 started, when her cardiac enzymes would have



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1       been initially released.

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

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

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

15          Q.       Not at all.

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

18          BY MS. TAYLOR-KOLIS:

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



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

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

11 A. Likely.

12 Q. Do you need to take that?

13 A. I do.

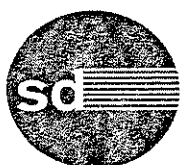
14 (Thereupon, an off-the-record  
15 discussion was had.)

16 BY MS. TAYLOR-KOLIS:

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

24 A. That's correct.

25 Q. Is that to a reasonable degree of



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

3 A. That's correct.

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

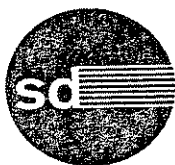
9 A. That's uncertain. It's likely that  
10 EKG would have shown abnormalities; whether it  
11 would have been diagnostic or not, that's  
12 speculative.

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

16 A. Sure.

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

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



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

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

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



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

6 A. That's what I understand.

7 Q. Is that the combination?

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

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

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



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

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

8 A. That's correct.

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

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

21 Q. Yes, I would appreciate that.

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



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1       nitroglycerin intravenously.

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

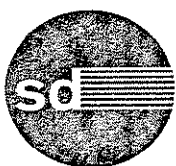
10          A.       That's one of the primary goals,  
11       correct.

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

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

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

24          A.       I think we can assume that,  
25       correct.



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1 Q. Okay. Do you have any statistical  
2 basis -- let me retract that question.

3 Doctor, you are pretty well-written and  
4 published, I can see from your curriculum  
5 vitae. Do any of your publications do you  
6 feel deal directly with this issue on  
7 predictive value outcomes, so to speak, in  
8 terms of treating acute coronary syndromes?

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

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



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1 myocardial infarction?

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

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

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

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



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

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

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

17                   By the time she would have made  
18 the diagnosis, got an EKG, gotten blood  
19 tests, started her on medications, evaluated  
20 the EKG, and then made a decision to  
21 potentially transfer her to another hospital  
22 where they would have to have a team, a cath  
23 lab team, in place to perform a procedure, we  
24 are probably talking at the very best 10 or  
25 11:00 o'clock on the 22nd as the opportunity



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

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

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

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

25 Q. Okay. I am trying to process what



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

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

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

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



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1 she had an appreciable amount of irreversible  
2 myocardial injury.

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

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

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



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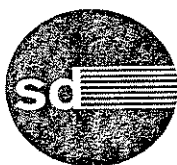
1 early in the afternoon, pinpointing the time,  
2 November 22, how did -- how was it she  
3 didn't die from this heart attack? It's  
4 curiosity, I would love to hear the answer.

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

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

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

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



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1 next morning and cardiogenic shock?

2 A. That's correct.

3 Q. Is that essentially how you stand?

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

7 Q. Oh, absolutely.

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

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

24 A. That's correct.

25 Q. Okay. All right. What do you



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1 think Marshalle Patterson's prognosis is?

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

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

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

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

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



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

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

15 A. That's correct.

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

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

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

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



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

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

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

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

18 BY MS. TAYLOR-KOLIS:

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



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

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

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

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

19          A.       That's correct.

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

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



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1 Q. Okay.

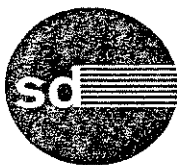
2 A. -- she has got a device, if she  
3 does have an implantable defibrillator, that  
4 if she has a defibrillator, that does improve  
5 her survival somewhat because it decreases the  
6 risk to die of a lethal arrhythmia.

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

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

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

25 A. If you will give me a moment, I



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1 will pull up that tab and take a look.

2 Q. Okay.

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

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

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

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

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

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

23 BY MS. TAYLOR-KOLIS:

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



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

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

8 Q. I am just going to paraphrase a  
9 little bit, and Steve will hold me  
10 accountable for paraphrasing wrong, I am sure.  
11 But at Dr. Friedlander's deposition, he  
12 indicated some of the same kinds of  
13 information you did about when CPKs peak, et  
14 cetera, and a concern that he had was that  
15 there was a laboratory value reported at 2  
16 a.m. on November 24 where the CPK was still  
17 1951. Do you recall seeing that laboratory  
18 value?

19 A. I did, yes.

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



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1 convention?

2 A. Could you repeat that?

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

5 (Question read.)

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

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

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



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

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

7 THE WITNESS: I am in shock.

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

12 THE WITNESS: That's fine.

13 (Thereupon, the deposition was  
14 concluded at 6:35 o'clock p.m.)  
15  
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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.

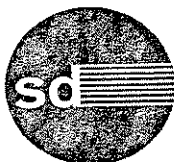
IN WITNESS WHEREOF, I have hereunto  
set my hand and seal of office at Dayton,  
Ohio, on this 28th day of October, 2004.

/s/ Monica K. Hissong

MONICA K. HISSONG

NOTARY PUBLIC, STATE OF OHIO

My commission expires 4-18-2005



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CAPTION

1  
2 The Deposition of Raymond D.  
3 Magorien, M.D., taken in the matter, on the  
4 date, and at the time and place set out on  
5 the title page hereof.

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

9 It was agreed by and between counsel  
10 and the parties that the Deponent will read  
11 and sign the transcript of said deposition.  
12  
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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.

Page No. \_\_\_\_\_ Line No. \_\_\_\_\_ Change to: \_\_\_\_\_

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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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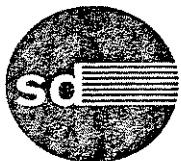
1 AMENDED CERTIFICATE

2 STATE OF GEORGIA:

3 COUNTY OF FULTON:

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

10 SetDepo, Inc.  
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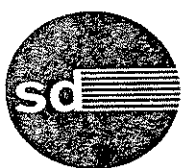
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