COUNTY OF CUYAHOGA

IN THE COURT OF COMMON PLEAS

JANET L. PORACH, Administratrix of the Estate of JOHN G. PORACH, JR.,

Plaintiff,

vs. No. 316045

FLORENZO S. LALLI, M.D., Judge Calabrese

Defendant.

VIDEO DEPOSITION OF JEFFREY SELWYN, M.D.

MARCH 24, 1998

TUCSON, ARIZONA

BOULEY, SCHLESINGER, DI CURTI & SCHIPPERS
Registered Professional Reporters
100 North Stone Avenue
Suite 1003
Tucson, Arizona 85701
(602) 623-7573

Video Deposition *of* JEFFREY SELWYN, M.D.
March 24, 1998
Tucson, Arizona

I N D E X

Deposition Exhibits marked for identification

* * * * *

APPEARANCES:

BECKER & MISHKIND CO., L.P.A.
By Mr. Howard D. Mishkind, Esquire
Skylight Office Tower
1660 West 2nd Street, Suite 660
Cleveland, Ohio, 44113
For the Plaintiff

WESTON, HEARD, FALLON
By Mr. Ronald Rispo, Esquire (telephonically)
2500 Terminal Tower
Cleveland, Ohio, 44113
For the Defendant

MS. LILY GANN, Videographer

BE IT REMEMBERED that pursuant to notice for taking depositions in the above styled and numbered cause, the deposition of JEFFREY SELWYN, M.D., was taken upon oral examination at the office of Dr. Selwyn, 6365 East Tanque Verde Road, Suite 120, in the City of Tucson, County of Pima, State of Arizona, before Leber Schlesinger, a Notary Public in and for the State of Arizona, on March 24, 1998, commencing at the hour of 10:00 a.m. on said day, in a certain cause now pending before the Cuyahoga County Common Pleas Court.

** ** **

MR. MISHKIND: Ron, before we start the video I'm going on the record with the court reporter in terms of preliminaries relative to the deposition,

then we'll have the video start with the swearing in of the witness.

MR. RISPO: That's fine.

MR. MISHRIND: Let the record reflect that today is March 24, 1998 and I am here in the office of Dr. Jeffrey Selwyn in Tucson, Arizona in case No. 316045, the case is captioned Janet L. Porach, Administratrix of the Estate John G. Porach, Junior, versus Lorenzo S. Lalli, M.D.

It is case No. 316045, assigned to Judge Anthony Calabrese. This case is set to commence trial next week in Judge Calabrese's room and the purpose for this deposition today is to perpetuate the testimony of Dr. Selwyn who is one of Plaintiff's expert witnesses that will be called on direct examination at the trial of this matter.

Let the record reflect that the deposition is being taken by agreement between Mr. Rispo, counsel for Dr. Lalli, and the undersigned.

Let the record further reflect that the formalities with regard to notice and service are waived, and the technicalities with regard to Mr. Rispo, because of his schedule being in Cleveland and not available in person, also are waived; and the requirements with regard to court reporter and video

are also waived in terms of being out of state court reporter and out of state video.

MR. RISPO: That's correct.

MR. MISHKIND: Also, just in case we're running short on time, can we stipulate that there will be a waiver with regard to the filing of the transcript and the filing of the video as well.

MR. RISPO: Yes, of course.

MR. MISHKIND: What I will probably have done, I'll probably have Barry Hirsh from Video Discovery play the video at the time of trial. So I'll probably get the transcript and the video and just entrust it to him for purposes of playing it at the time of trial. Is that okay?

MR. RISPO: Of course.

MR. MISHKIND: I think that's all we need to cover, isn't it?

MR. RISPO: I think so.

MR. MISHKIND: With that in mind, why don't we get underway?

MS. GANN: This is the beginning of the videotaped deposition of Dr. Jeffrey Selwyn, M.D., in the case of Janet L. Porach, Administratrix of the estate of John G. Porach, Junior, Plaintiff, versus Lorenzo S. Lalli, M.D., Defendant, Case No. **316045.**

The deposition is being taken in Tucson, Arizona at 6365 East Tanque Verde, Suite 120, on March 24th, 1998. The time is 10:26 a.m.

Counsel, please introduce yourselves, then the court reporter will swear in the deponent.

MR. MISHKIND: My name is Howard Mishkind and I am the attorney that represents the estate of John Porach.

MR. RISPO: My name is Ron Rispo and I am representing the defendant, Dr. Lalli.

JEFFREY SELWYN, M.D.,

Having been first duly sworn to state the truth, the whole truth and nothing but the truth, testified on his oath as follows:

EXAMINATION

BY MR. MISHKIND:

Q Would you please state your full name for the Court and the jury, please?

A Jeffrey I. Selwyn.

Q What is your profession, please?

A Physical.

Q Do you have an area of practice that you specialize in?

A Yes, internal medicine.

Q What is your professional address, Dr.

Selwyn?

A 6365 East Tanque Verde Road, Suite 120, Tucson Arizona, 85715.

Q In fact, are we present in your office today in Tucson, Arizona for purposes of your testimony?

A Yes.

Q So, the jury understands, Mr. Rispo is present by phone, because of an unavoidable conflict that he had that prevented him from being present in Arizona for the deposition. You understand that as well, correct?

A Yes, I do.

Q For the benefit of the jury, would you please tell them why it is that we are here today for your deposition?

A I understand that the trial is set for next week, I believe March 30th or March 31st. Due to my schedule and conflicting schedules with many of my partners I was unable to leave the Tucson area. And also unable to reschedule several days of patients.

I appreciate the fact that both Mr. RISPO and Mr. Mishkind are willing to take the deposition here in Tucson.

Q Thank you, Doctor.

Would you please tell the jury about your education, starting with college, and then just for simplicity purposes continuing through medical school?

A I graduated from the University of Wisconsin in Madison, Wisconsin with a Bachelor of Science degree in 1968. I then proceeded to medical school at the State University of New York in Brooklyn, New York, from 1968 to 1972.

In 1972 through 1973 I performed a medical internship at the State University of New York, Kings County Hospital Center in Brooklyn, New York. And from 1973 through 1975 I did two years of medical residency in the Tucson Hospitals Medical Education Program.

Q You used the term "internship" and "residency." Briefly would you explain what is involved in that?

A Days ago the terminology was a bit different. When I trained in the '70s, internship was considered the first year of postgraduate training and residency was considered anywhere from years two, three and four after graduate training. In the present times it's all considered and lumped into one residency program.

Q Are you licensed to practice medicine

here in the State of Arizona?

A Yes, I am.

Q When were you first licensed, please?

A 1973.

Q When I first started questioning you, you said you have a specialization in internal medicine, was that the term you used?

A Yes, that's correct.

Q Are you board certified in internal medicine?

A Yes, I am.

Q Tell the jury, if you would, what does it mean to be board certified and what process you had to go through to become board certified?

A Board certification, which I received in 1975, requires a completion of a medical residency. It also requires a two-day rigorous written exam on all medical subspecialties from general internal medicine, allergy, immunology, kidney disease, cardiovascular disease. That test is taken over, as I mentioned, a two-day period; if you pass the examination you are awarded board certification.

Q And again you were board certified when?

A 1975.

Q Do you have hospital affiliations here in

Tucson?

A Yes, I do.

Q What hospitals?

A I'm Affiliated with Tucson Medical Center, St. Joseph's Hospital, El Dorado Hospital, Northwest Hospital, Summit Hospital, which is a rehabilitation center, and NovaCare, which is also a rehabilitation center.

Q Outline, if you would for the jury, some of the professional organizations that you are a member of.

A I am a member and a fellow of the American College of Physicians for at least the past 20 years. I am a member of the Arizona Society of Internal Medicine, and the American Society of Internal Medicine.

I am also a member of the Pima County Medical Society, which is our local society, for the general medical population.

Q What does the term "fellow" mean?

A A fellow is an award that is issued to an internist that has satisfied board certification, a complete medical residency, has also been in practice for, I believe at that time, it was minimum of five years. It also requires several letters of

recommendation to be written as a sponsorship from already fellow physicians from the American College.

It requires that community service be done, and also requires that articles in the literature be published. It also requires other positions with hospital settings, such as committees, what have you.

Q Dr. Selwyn, would you please describe so the jury understands the nature of your clinical practice here in Tucson, Arizona?

A My practice is relegated to full-time outpatient and inpatient medicine. What that means is I spend a minimum of eight hours a day in my office, seeing patients, as well as making rounds in the hospital in the morning and occasionally in the evening and on weekends when I'm on-call, to continue their followup, besides that done in my office.

Q What percentage of your professional time do you spend in the active clinical practice of medicine?

A A hundred percent.

Q Doctor, tell the jury whether you have ever previously been accepted and received as an expert witness in other medical malpractice cases?

A Yes, 1 have.

Q Is this a frequent or an infrequent

process that you participate in?

A I would say I review and participate in cases approximately one to two times per year over the past three to four years.

Q When you have served as an expert, have you been providing opinions for patients such as Mr. Porach or the estate of Mr. Porach, or for physicians such as Dr. Lalli?

A Most of the time I have been providing information on behalf of the patients. There have been several occasions that I can recall that have been applying information regarding the physicians.

Q So you have testified both in the defense of a doctor, as well as on behalf of a patient?

A Yes, I have.

Q Have you ever given expert testimony at my request on behalf of any of my clients?

A No, I have not.

Q In fact, Dr. Selwyn, before this morning have you and I ever met in person before?

A No.

Q From your review in this case, would you tell the jury what your understanding is as to the type of doctor Dr. Lalli is?

A Dr. Lalli is an internist who renders

primary care medicine.

Q Do you and Dr. Lalli share the same board certification?

A Yes, we do.

Q Doctor, are you familiar with the term that's going to be used throughout this case and perhaps the jury has already heard it by the time they hear your testimony, "standard of care"?

A Yes.

Q Tell the jury what that term means to you.

A Standard of care means the level of care that a reasonable and prudent internist or primary care physician would render under similar circumstances. It very often implies a minimum or standard level of care that is based on community accepted levels of competence.

Q Are you familiar with what the standard of care is in Cleveland, Ohio?

A Yes, I am.

Q How is that, Doctor?

A I have previously been an expert witness on another case, one or two cases in Cleveland, Ohio, as well as mentioning that the standard of care in my mind is truly a national standard of care.

Q When you say a national standard of care, what exactly do you mean, so the jury understands, what happens in Tucson and how that might be compared to what happens in Cleveland?

A I think the level of care that's expected from any internist or primary care doctor is really equitable across the board. In other words, when a physician is caring for a patient with similar circumstances, I feel that the accepted standards of care should be the same whether it's in Cleveland or in Tucson.

Q And is it your understanding, Doctor, that the standard of care being a national standard of care, is what is accepted by all internists throughout the United States?

A Yes, that's true.

Q Doctor, before I turn to your review on John Porach and his tragic death, what I'd like you to do, if you would for the jury, is help me with the definition of certain medical terms. Just so that we have a working background with regard to matters that may be of relevance in this case. Will you do that for me?

A Surely.

Q When we referred to myocardium, what is

that, please?

A That's the muscle of the heart.

Q The term myocardial infarction?

A Means insult or damage to the muscle of the heart.

Q When one refers to a myocardial infarction, is there another term that is commonly used?

A Yes, heart attack.

Q So, we referred to myocardial infarction, heart attack is an interchangeable term?

A Yes.

Q What about atherosclerosis?

A That's the process of buildup of cholesterol deposits and debris in the lining or the wall of an artery.

Q Thrombus or thrombosis?

A Thrombus is an actual clot or clod in an artery. Thrombosis is the actual process which eventually leads to the clot.

Q Thrombolytics, what does that mean?

A Thrombolytics are medications used to dissolve clots.

Q Ventricular arrhythmia.

A That's an abnormal electrical rhythm

disturbance that can very often lead to untoward outcomes; fatal events for example.

Q EKG?

A ERG means electrocardiogram. That is a tracing which depicts the electrical action of one's heart.

Q Coronary arteries?

A It's a system of arteries that arise from the major vessels going toward the heart that nourish all areas, all muscle areas of the heart.

Q Myocardial ischemia, is that a different term than myocardial infarction?

A Yes, it is.

Q Would you explain to the jury, please?

A Myocardial ischemia is a term that reflects a lack of blood flow to the heart muscle. It does not necessarily mean inherent injury, just a lack of flow causing problems in the heart muscle, but not damage.

Q Doctor, before the deposition began, I had marked for identification Exhibit 2 and I'd like to hand this to you at this point and ask you whether you would first identify for the jury what is shown in Exhibit 2, and then I have some questions for you relative to same.

(Exhibit 2 marked for identification.)

A This depicts the heart muscle and the nourishing supply of coronary arteries.

Q There are a number of lines and branches on that document?

A Yes.

Q Is that document, just so the jury has a basic understanding of the coronary arteries, would that be helpful in terms of showing the average anatomy in terms of the location of the coronary arteries and how many coronary arteries there are?

A Absolutely.

Q Would you go ahead and very briefly tell us what we're looking at.

A This reflects the major circulation of coronary arteries as it supplies the heart muscle.

There are two main systems, the left system which in this diagram has two major vessels. And the right system which has one major vessel.

Off all systems come branches that supply smaller areas of the heart muscle. In the right system the name of the artery is the right coronary artery, and that nourishes the bottom portion of the heart.

On the left side, the left system major vessels include the anterior descending artery which is

this artery here, (indicating). And the circumflex artery, which is this artery here.

The anterior descending artery supplies the majority of muscle of the left ventricle, which is the major pumping chamber of our heart. It also supplies what's called the septum of the heart.

If we were able to open this straight down the middle and you were able to look in and see what was inside you would see a septum which is like a partition which extends from the top to the bottom. That septum divides the left side of the heart and its chambers from the right side of the heart and its chambers.

The left anterior descending artery as I mentioned previously does not only supply blood flow to the left ventricle out here, but also supplies blood flow to the septum inside. These are major contracting muscles of the heart, the septum and left ventricle. If there's an obstruction in the left anterior descending artery, major areas of insult can occur either in the left ventricle of the heart out here, or in the septum inside.

Q In your John Porach's situation, just so the jury understands, which artery was involved that had some obstruction?

A There was an obstruction just after the branching of the left main coronary artery into its two branches, the anterior descending and circumflex. The obstruction was in the anterior descending artery.

Q This anterior descending, is that the artery which that caused John Porach's heart attack?

A Yes, it was.

Q Okay. I think that's sufficient for the time being.

I want to ask you, Doctor, what is the standard of care for a physician when presented with certain complaints that might be consistent with a heart attack?

A Standard of care in my mind would be to assess this problem immediately. When a patient presents with symptoms that may be consistent with a heart attack an immediate red flag should be raised. A physician should think of all possibilities that can include or exclude damage to the heart muscle. First and foremost would be a heart attack.

If this is entertained in the physician's mind, appropriate measures have to be enacted immediately because this is a very urgent emergent medical situation.

Q We all hear about from time to time and

perhaps know people that have had a heart attack, can you very briefly explain the evolutionary process in terms of how an artery leads to a heart attack?

A What happens is in an artery, in this case, let's take the left anterior descending artery, there may be moderate or severe degrees of cholesterol and atherosclertoic buildup in the lining or the wall of the artery, this is inside the artery. In many of us it can vary from minimal to severe.

When a heart attack occurs, the area of plaque which is actually this congloneration of material in the lining of an artery, separates from the wall of an artery. As a result of this, the separation or the little crack, if you will, in the area becomes a very, very adhesive space, it sucks up a lot of platelets and other products in our blood as it becomes a very sticky area. This is the beginning or the evolution of a clot. When the clot forms and as it grows as more debris sticks to it, an analogy would be a snowball rolling, as it rolls it picks up more snow because it's sticky and very adhesive.

With a clot, as all the material begins to stick it, it becomes larger and larger, until which time it obstructs the further flow of blood through that artery. As a result of that, blood cannot reach

its end point, which in this case would be the left ventricle or heart muscle. And as a result of that, damage to that heart muscle can occur.

Sometimes another analogy can be rust in a pipe. For instance if we have pipes that begin to build up rust, the rust adheres or sticks to the inside of the pipe, there's not a rupture of the pipe specifically, but this is an internal process. And as the water keeps flowing past this area of rust, it may dislodge part of the rust that's stuck on the wall of the pipe.

So this analogy is similar to actually what happens with a rupture of a plaque inside our arteries, as a result the clot forms and blood flow ceases.

Q Do people have certain risk factors that perhaps increase the risk or the potential for having a heart attack?

A Yes, they certainly do.

Q When one references to risk factor for coronary artery disease, and specifically in John Porach's case, did hehave certain risk factors for the existence of coronary artery disease?

A Yes, he did.

Q And would you tell the jury what those

risk factors were?

Before you do that, when we refer to coronary artery disease, are we referring to the buildup of that plaque inside the arteries or the rust inside the pipe you were referring to before?

A Yes.

Q Go ahead and tell the jury as to his risk factors.

A From review of all the records, Mr. Porach had several risk factors, No. 1, he was a male of 45 years old, which is a risk factor, in and of itself. He had used tobacco for many years, I believe he smoked at least a pack a day for well over 20 years, and had stopped a year prior to his death.

He had elevated cholesterol, as well being a risk factor. And I believe his last risk factor -- which is less of one, but still a risk factor -- was moderate obesity.

Q Meaning what?

A He was overweight.

Q Did he have any other health issues that you're aware of, whether they relate to coronary artery disease or otherwise?

A Yes, he also had gout, which is an elevated uric acid in our blood streams, which can

cause painful joints, most of the time that's expressed as a painful great toe.

Q Other health factors that in any way impacted to the likelihood of him having coronary artery disease or the likelihood of him having a heart attack?

A Nothing else that I can recall.

Q If the patient has established coronary artery disease, are there in this day and age effective treatments for this buildup of plaque inside the artery or the rust inside the pipe?

A Yes, there are.

Q Would you explain in general terms what the treatment modalities are for the treatment of coronary artery disease?

A In medical parlance we call this secondary prevention. And what that means is if we have a patient that we already know has coronary disease, if it's documented, if it's established from whatever tests we may have done, we already know that something has started, what can we do to prevent further progression, that's called secondary prevention.

Primary prevention would be trying to treat the patient in an expectant way to allow no

progress to coronary artery disease.

When someone has known coronary artery disease we try to modify the risk factors; you can't modify the fact that a male is a male, but what you can do is use dietary regimens to reduce weight loss -- excuse me, to induce weight loss, and to reduce the risk from being overweight.

You can treat high blood pressure if someone does have hypertension. You can advise and counsel on stopping smoking which could be one of the worse risk factors amongst all. You can counsel people on exercise techniques, to improve their cardiovascular fitness. You can also if one has diabetes which is another unrelated, but albeit specific risk factor for coronary disease, treat diabetes very carefully and prudently to continue risk reduction.

So I think that's a general overview of what I would do if I have a patient that has known coronary artery disease.

Q Are internists such as yourself and Dr. Lalli trained to recognize risk factor for coronary artery disease?

A Yes.

Q Why is that important, Doctor?

A Because there's no question that

modification of risk factors, if they're elicited, can save lives.

Q Is it important, Doctor, for a patient that is experiencing a heart attack, or a myocardial infarction to be in an emergency room or a coronary care unit as early as possible?

A Yes, it is.

a Would you explain why?

A The actual risk of complications of a heart attack are at its highest level very early on in the event. In other words, if a heart attack is evolving the risk of complication is extremely high in the immediate period which may be anywhere from zero to 12 hours.

Therefore it's imperative that proper assessment and evaluation of that patient occur immediately, be it putting them in a hospital coronary care unit setting; if they arrive in an emergency room, using medications to dissolve clots; putting them on oxygen, putting them on a heart monitor, having a nurse attend to them on a one-on-one basis if possible. In other words, its observation of the very intense degree. So if treatment and observation follows you can severely reduce the risk of complication from heart attack.

Q Doctor, would it be fair to say then that a patient is more likely to survive if complications of a heart attack occurs when the person is in the hospital being monitored?

A Yes.

Q Does the fact that a patient such as John Porach had certain risk factors for coronary artery disease, meaning that he is going to have a heart attack?

A No.

Q Let's talk about John Porach. When I contacted you, Doctor, relative to this matter, would you tell the jury essentially what as you understood it to be the assignment that you were asked as to whether you were willing to do?

A When I was contacted by Mr. Mishkind I was asked to review certain records and formulate an opinion as to whether Dr. Lalli fell below the standard of care.

Q And have you been provided with information in connection with this case in order to arrive at the opinions that you hold?

A Yes, I have.

Q Would it be much of a problem for you to outline for the jury the information that you have

considered?

A Not at all. Excuse me while I just look at the list.

I've been supplied with deposition transcripts of Dr. Lalli, Jan Schoch, his receptionist; the wife of John, I believe her name was Jackie Porach -- Janet Porach, excuse me. His daughters, Dawn and Jacquline. I've been supplied with office records from Dr. Lalli, records from Fairview General Hospital, an emergency room report. Further depositions have been from Dr. Robert Botti, Dr. Carl Culley, Dr. Bruce Janiak, Dr. Barry Effron, Dr. Robert Hoffman. I think that sums up all the information that I've received.

Q Do you have all of the depositions in front of you on your desk right here?

A Yes, I do. I should add that I've also been supplied with the medical autopsy report.

Q And you have a copy of the EKG that was done on John Porach?

A Yes, I do.

Q There's a deposition in the stack in front of you, I believe of Mary Neary, did you also --

A Yes, I neglected to mention that, that is Mr. Porach's mother-in-law. I was supplied with that deposition as well.

Q Is the information that you have outlined in your report and that you have on your desk, is that the type of information that physicians that are called upon to serve in the role as an expert witness routinely rely upon in order to look at a situation and provide honest and objective opinions concerning the standard of care?

A Yes.

Q Doctor, before we talk in detail about John, tell the jury when one refers to the term, "acute illness," what does that term mean?

A It's an illness of abrupt onset, it's something that occurs within a matter of hours or several days. It is usually something that is new for the patient, if the patient has been doing very well and all of a sudden has specific symptoms or problems I would refer to that as an acute illness.

Q And what is a chronic illness?

A Chronic illness is a long-standing on-going illness. Example, diabetes, high blood pressure.

Q Do you see patients in your practice sometimes with acute problems, and sometimes with chronic problems?

A Yes, I do.

Q When a patient contacts an office such as yours or Dr. Lalli's and reports an acute problem for the first time, do you have an opinion to a reasonable degree of medical certainty as to what should be done?

A Yes.

Q What is your opinion?

A When an acute problem is reported I think it raises another red flag as to the immediacy of appropriate assessment of that patient.

Q Now, when you say the immediacy of appropriate assessment, in non-medical terminology, what does that mean?

A That means that if someone calls with a new problem, I would want to see that patient or understand a bit more as to what is going on right away.

Q Dr. Selwyn, if a patient calls his doctor's office and wants to be seen by the doctor that day, and complains of aching in the chest and arms, and nothing more than that; and the receptionist at the doctor's office asks whether the patient has chest pain, and the response is "no," does the standard of care in your professional opinion demand that any immediate action be taken with regard to that patient, by the doctor's office?

MR. RISPO: Let the record reflect an objection for the defense.

Q (By Mr. Mishkind) First do you have an opinion?

A Yes.

Q And what is your opinion?

A Yes, I feel that immediate action should be taken.

Q Would you tell the jury with that hypothetical pattern, in terms of the patient calling the doctor's office, indicating aching in the chest, the response received, why it is that immediate action needs to be taken?

A Well, any complaints referable to the chest to me would indicate a list of potential problems in my mind in a matter of priority. The first would be the possibility of a heart attack. And if that were the case I would want to evaluate that patient very urgently.

MR. MISHKIND: Doctor, let's go off the record for just one second.

MS. GANN: The time is 10:57, we're going off record.

(Short recess.)

MS. GA": We're back on the record, the

time is 11:00 a.m.

Q (By Mr. Mishkind) Dr. Selwyn, when a patient is having an acute myocardial infarction or heart attack, do they, based upon your training and experience and knowledge in this area, describe the pain associated with a heart attack in the same way?

A No, the description of symptoms of a heart attack can be very variable, from chest pain in the middle of the chest to abdominal discomfort, belly pain, to an aching in the chest, to a heaviness in the chest, to achiness or heaviness in the arms, an aching in the jaw; it can be very variable. But all those types of complaints, when discussed between a patient and a physician, always bring up a red flag.

Q Does the standard of care in an internist's office, that does not have a nurse taking telephone questions, that does not have anyone other than a receptionist who has worked in the office for many years, but does not have medical training as such, does the standard of care require that the secretary or the receptionist receiving that information take certain action when a patient calls with a complaint of aching in the chest?

A Yes. I feel when a complaint is discussed between a patient and a secretary or any

other medical personnel, such as the one that was discussed that morning in October of 1994, I believe the standard of care would dictate that immediate communication with a physician be done.

Q And based upon a complaint, assuming that the patient complains of aching in the chest and the receptionist asks, "Do you have chest pain or a cardiac history," and the patient says "no," is the standard of care for the internist's office under those circumstances complied with or met between that colloquy between the receptionist and the patient?

A No.

Q Why?

A I feel, like I mentioned previously, the descriptive terms by a patient when the patient is having a heart attack can be highly variable. 1 think when any description referable to the chest, whether it be pain or aching, that needs to be communicated to the physician who's caring for the patient.

Many patients when they have pain, if asked, is it pain, they'll say, "no," I've experienced this in my own practice innumerable times. A discomfort in the chest or pressure in the chest in many of us is not often reflected as true pain, it's a very subjective answer.

So when there's any kind of reference made to chest symptoms, I think that demands automatic communication with a physician.

Q If you were in the position that Jan Schoch -- I may be mispronouncing her name, I'm certain, 1 apologize -- that's the receptionist was in, not necessarily her, but if you were taking the call, what questions would you expect to be asked in order to determine whether or not the patient's complaints were serious or not?

A If I were in her position I would have tried to elicit a little bit more detail in this history so I could indicate that to the physician.

If she was uncomfortable or not trained to elicit those symptoms, she had two options, either she would communicate that to another staff person in the office who was trained or more able to assess the situation, or she would go get the doctor out of a room or off the phone and say, "What should I do?"

Q Let's talk about your review in this case and the specifics on John Porach, tell the jury if you would, based upon your review what your understanding is as to the facts concerning Mr. Porach's condition when he woke up on October 14, 1994.

A After review of the record, it's my

understanding that he awakened fairly early that morning, I believe it was about 5:00, and he complained to his wife of chest distress, cold sweat, tingling in his arms and legs, diarrhea and just a generalized feeling of not doing very well.

Q Do you recall in your review whether he complained to his wife, according to your review, of heartburn?

A Yes, he did say that he had some heartburn,

Q Please tell the jury what your understanding is, based upon your review as to what medical treatment, if any, Mr. Porach sought that morning or that day relative to the symptoms that he woke up with.

A Well, he stayed home from work and was waiting for Dr. Lalli's office to open. I believe he called the receptionist between 9:30 and 10:30 a.m. that morning and discussed his symptoms with her over the phone.

At that time he was told that there were no appointments and that his symptoms sounded like it could be the flu, and that they would call him back from the office a little bit later that day to see if an appointment would be made available.

Q Based upon your training and experience, in your opinion -- first, do you have an opinion whether John Porach, the patient, acted reasonably in calling his physician's office about his symptoms on the morning of October 14, 1994?

A Yes, I do have.

MR. RISPO: Objection on the record.

Q (By Mr. Mishkind) First, do you have an opinion?

A Yes.

Q And what is your opinion?

A I feel that he acted reasonably.

Q Explain to the jury why he acted reasonably, in your opinion.

A I feel he awakened with symptoms that were of an acute nature, certainly different from what I could see that he's ever had in the past. And that he was going and planning to call his doctor as soon as the office opened. I feel that's a very reasonable behavior for a patient.

Q Based upon your review, what is your understanding from Jan, the receptionist, as to what -- and perhaps Dr. Lalli -- what Mr. Porach conveyed to them that morning, or what Mr. Porach conveyed to her that morning during the conversation?

A It's my recollection that he told the receptionist when he called that he had aching all over, including his chest and shoulders, that he just wasn't feeling well. I believe he was feeling feverish, had diarrhea, had generalized aches.

I believe from Dr. Lalli's deposition these specific symptoms were also communicated to him as well.

Q According to your review, how long had Mr. Porach been a patient of Dr. Lalli?

A Since April, 1991.

Q Did Dr. Lalli then have access to Mr. Porach's prior medical records -- excuse me. Before April of 1991, was Mr. Porach -- tell the jury what your understanding is of Mr. Porach's medical treatment before April of 1991. Poorly worded question; but I think you know what I'm asking.

A It's my understanding that Dr. Lalli acquired the practice of another internist, I believe his name was Frank Constanza. And Dr. Constanza had been Mr. Porach's attending physician prior to April of 1991. It's also my understanding that Dr. Lalli had not only his own records but the prior records from Dr. Constanza as well.

Q Based upon your review of those records,

had Mr. Porach ever called Dr. Lalli's office with similar complaints to those that Jan, the receptionist, and Dr. Lalli, the doctor, acknowledge were communicated on the morning of October 14, 1994?

A No, to my knowledge, these symptoms had never been previously reported.

Q Based upon your review in this case, Dr. Selwyn, what is your understanding as to what, if anything was done, or said to Mr. Porach as a result of this morning telephone call which occurred between 9:30 and 10:30?

A As I mentioned, he was, the symptoms were conveyed to the receptionist. He was told that it sounded like the flu, no appointments were available, they would get back to him later in the day and see if one appointment would be made available for him.

Q Given the symptoms that we know, the very least and putting aside any other information, but given the symptoms that were communicated to Jan of aching in the chest and arms, and not feeling well, and with his medical history that would have been known to the doctor's office, do you have an opinion to a reasonable degree of medical certainty as to what the differential diagnosis should have been for that patient that morning?

A Yes.

Q First, before you tell me what your opinion is, I should probably ask you what the term "differential diagnosis" means.

A A differential diagnosis is a list of diagnoses that enter a physician's mind when presented with a complex of symptoms.

In other words, if a patient has specific complaints, it should trigger a thought process in our mind as to what the possible cause of those complaints could be grouped into.

Q Who should be making the differential diagnosis, is that the responsibility of Jan, the receptionist?

A Absolutely not.

Q What should Jan, the receptionist, have done in order to permit a differential diagnosis to be made?

A She should have conveyed the symptoms to Dr. Lalli, who thereby could have made a differential diagnosis.

Q Dr. Selwyn, I want you to assume in this case that Jan is going to testify that Mr. Porach called and gave her certain symptoms and obviously we don't know all of occurred in that conversation,

because we have to rely on -- my hesitation is that the tape had gone off, I just wanted to make sure we weren't off the record. We had to rely on what Jan said during the conversation.

But based upon those symptoms that morning, what requirement was there that in your professional opinion Jan had to do in order to meet the standard of care?

A She had to communicate these symptoms to another staff person who was trained to evaluate them, and if no other staff person was available then immediate communication to Dr. Lalli would have met the standard of care.

Q If I want you to assume that Jan's testimony in this case will be that Mr. Porach called for an appointment, he didn't call necessarily to talk to the doctor. Under those circumstances, having conveyed what Jan says he conveyed, was that okay for her to just take the information, because he was only calling for an appointment?

A No, many patients call and sometimes it's difficult to really ferret out what it is that they're asking for. Many people call and minimize their symptoms or maximize their symptoms and ask for an appointment. But that's not the responsibility of the

receptionist to determine. I think the responsibility of a receptionist in this case was to take what symptoms were offered and report those to Dr. Lalli so that he could make the decision as to how urgent Mr. Porach needed medical attention.

Q Assuming, Dr. Selwyn, that Dr. Lalli was with patients when Mr. Porach called, and assuming further again that he called to see Dr. Lalli not specifically to talk to him. What in order to comply with the standard of care should have been done based upon the fact that Dr. Lalli was with patients at the time of the telephone call?

A I think if it were in any office and as a similar circumstance the standard of care would have been to tell the patient to call 911 to get to the nearest emergency room.

Q What if Dr. Lalli's practice was to check with the receptionist in between patients and would it have been acceptable had the information concerning John Porach's symptoms have been brought to Dr. Lalli's attention in between the next patient for Dr. Lalli to have responded to?

A Well, that's a tough question. I think that if in between the next patient would have been 10 to 15 minutes or perhaps 15 to 30 minutes, I think that

certainly would have been acceptable. I think if a matter of hours went by and Dr. Lalli was not made aware of these complaints, that would have not met the standard of care.

Q Based upon your review in this case, did Jan, the receptionist, ever bring the subject of Mr. Porach's telephone call to Dr. Lalli's attention before the events that occurred at 5:30 to quarter of 6:00 that evening?

A No, it's my recollection after reviewing all the records that Dr. Lalli was never made aware of the patient's symptoms until he was entered into the office.

Q How then -- do you have an opinion, Doctor, to a reasonable degree of medical certainty as to whether Dr. Lalli deviated from accepted standards of care in this case?

A Yes.

Q What is your opinion?

A I feel that he did deviate from accepted standards of care.

MR. RISPO: Let the record reflect an objection.

Q (By Mr. Mishkind) Tell the jury in what respect you believe Dr. Lalli deviated from accepted

standards of care.

A The ultimate responsibility in a physician's office lies with the physician. If the patient's symptoms were brought to the attention of the receptionist earlier that morning I feel it is incumbent upon that physician to be responsible for how the treatment is rendered.

If a patient calls and needs to be seen immediately it has to be up to the physician to decide how quickly that patient needs care. So I do feel that all the things that transpired in Dr. Lalli's office are under his jurisdiction and are his responsibility.

Therefore, the fact that treatment was not rendered immediately or a decision to do something was not done immediately, fell below the accepted standards of care.

Q To your knowledge did Mr. Porach call to be seen by Dr. Lalli or by the receptionist?

A Could you repeat that?

Q Did Mr. Porach call -- who did Mr. Porach call to be seen by?

A He called to be seen by Dr. Lalli.

Q If the receptionist didn't provide the information to Dr. Lalli so that he could determine whether or not John needed to be seen, how then can you

hold Dr. Lalli responsible for information that wasn't given to him?

A Information that comes into any medical office needs to be documented and the responsibility, again, lies with the physician ultimately.

So that even if Dr. Lalli did not have the advantage of having the information at his hand before John presented to the office, I feel it is still his ultimate responsibility for all the problems that come into any office, whether they're communicated with him in a timely manner or not. The buck stops with him, he needs to assume that responsibility, even if the communication was not there.

Q What steps would have been reasonable for Dr. Lalli to have taken that would have complied with the standard of care, based upon that telephone call in the morning of October 14, 1994?

MR. RISPO: Objection.

A I think reasonable steps would have been to see the patient in his office immediately, or to send the patient to the nearest emergency room.

Q (By Mr. Mishkind) Doctor, have you reviewed the autopsy protocol and the autopsy verdict in this case?

A Yes.

Q And I think you also said that you have reviewed the report and the deposition of Dr. Robert Hoffman, correct?

A That's correct.

Q Based upon your entire review of this case, all of the information including the autopsy, the autopsy protocol, the testimony of Dr. Hoffman, do you have an opinion to a reasonable degree of medical certainty as to whether or not John Porach suffered a heart attack on October 14, 1994?

A Yes.

Q And what is your opinion?

A I feel that he suffered a heart attack on that date.

Q Do you have an opinion based upon all of the information that you have reviewed and considered as to the approximate time that the heart attack started on October 14, 19941

A Yes.

Q And what is your opinion?

A I feel it began between 5:00 a.m. and 7:00 a.m. that morning.

Q And again, based upon your review of all of the information in this case, do you have an opinion as to how many heart attacks John Porach suffered that

day?

A Yes.

Q What is your opinion?

A I feel he suffered only one heart attack.

Q Doctor, if I understand your testimony correct, if we assume that he suffered one heart attack on the morning of October 14, 1994, what caused John Porach then to collapse and to suffer a cardiac arrest in his doctor's office between 5:30 and 5:45 p.m. that same day?

A I think he had a fatal arrhythmia, which is an electrical disturbance in the heart which created an inability of the heart muscle to contract to propel blood to all areas of the body. As a result of that fatal electrical disturbance he collapsed and died.

Q Why didn't he suffer a fatal arrhythmia earlier in the day in the morning when he had the heart attack?

A An arrhythmia can usually occur at any time, and it's hard to say why he specifically didn't have a fatal arrhythmia earlier in the day. Because they can occur in the beginning, or along that time line as the heart attack evolves.

However, I would only -- I would only estimate that with the timeline of the heart attack in

the morning between 5:00 and 7:00 and the resulting problem that occurred approximately 10 to 12 hours later, his heart began to fail as a result of inadequate blood flow, that's called congestive heart failure or dysfunction or malfunction of the pump chamber.

As a result of that, it could also perpetuate these fatal electrical disturbances.

So, looking back and thinking about the course of events that occurred during that day, I feel that the fatal arrhythmia occurred later in that day because of the resulting failure of the ventricle to pump adequately, which made it more irritable and created these electrical discharges which eventually lead to his death.

Q Doctor, are there steps -- and we'll talk about them if there are -- steps that can be taken after a patient suffers a heart attack, to minimize the likelihood of a patient going on at a later point and suffering this fatal electrical disturbance?

A Yes.

Q And generically or whatever, what are the steps that are taken when a patient has a heart attack, to minimize the likelihood that they're going to suffer this fatal ventricular arrhythmia?

A The steps that need to be taken is putting the patient in a coronary care unit where adequate monitoring and treatment can be done immediately.

Q When you refer to the ventricular arrhythmia, I know from my basic understanding of the heart that there's a normal pumping action. When the heart goes into this ventricular arrhythmia, what's going on with the pumping action of the heart?

A Normally our hearts when they beat 60 to 80 times per minute have a very nice smooth regular forceful contraction. That contraction allows blood to be ejected out of the heart every time it beats. When the heart fibrillates it's a very uncoordinated dysfunctional type of action, which means that the actual power of the pump is drastically reduced.

Fibrillation is much more rapid than are normal heart rates, it can occur up to 120 to 160 beats per minute, perhaps a little more, perhaps a little less. And when a heart is beating that rapidly and each contraction is very ineffective, the ability for blood to be ejected out of the heart is severally comprised. When that occurs, problems can ensue; i.e., death.

Q Let's talk about your understanding based

upon your detailed review of the information in this case, as to what took place after the telephone call between 9:30 and 10:30, and prior to John arriving in the doctor's office that afternoon.

A It's my recollection that he stayed home from work because he really didn't feel very well. I believe his mother-in-law had called him as well sometime in the morning, to see how he was and he complained to her of discomfort in his chest and just really feeling badly.

He spoke to his wife, who called him at around noon time and he told her that he had spoken to the receptionist at Dr. Lalli's office and that an appointment wasn't available but that the office was due to recontact him later that day.

Approximately 3:00 or 3:30 he was really feeling worse, he was complaining of heaviness in his arms, difficulty breathing, chest distress, and he initiated the phone call to Dr. Lalli's office. He apparently at that time was *so* distressed and his arms felt *so* heavy and achy that his step-daughter had to dial the phone for him and put the phone up to his ear *so* he could speak to the receptionist. He was told to drive to the office, to come in to be evaluated. And the events subsequently followed as is documented in

the record.

MR. RISPO: Objection and move to strike all the prior testimony.

Q (By Mr. Mishkind) Doctor, I want you to assume in this case that Jan, the receptionist, is going to testify that Mr. Porach called in the afternoon between 3:15 and 3:30 and asked whether he could come in to the office, and that his family was concerned and could he come in and have an EKG.

I want you to assume that to be the testimony that Jan will give at the time of the trial in this matter.

If that is in fact what Jack or John Porach said, would that, or should that have been of any concern to an internist's office? And if so, why?

A Well, it's just another way of expressing cardiac-related complaints. If a patient is not really educated as to what or whatnot the symptoms of a heart attack might be, he had apparently asked for a cardiogram to be done or expressed the concern on the part of his family for an electrocardiogram to be done, to me that would raise another red flag in concern of a serious problem that could be related to an acute heart attack.

So if this were truly the testimony it

would be very disturbing that this wasn't related to Dr. Lalli immediately.

Q Doctor, what is your understanding based upon your review of Jack DeWitt, the step-daughter, her testimony as to what she understood occurred during that telephone conversation that she was present for?

MR. RISPO: Objection to her testimony.

A From reviewing her deposition, it's my recollection that Mr. Porach did not -- or this is what she heard -- did not express the desire to have an electrocardiogram performed, he just expressed his concern about what was going on and that he needed to have an appointment with Dr. Lalli.

Q (By Mr. Mishkind) Doctor, I want you to assume that the testimony in this case will be that the step-daughter, Jacqueline was present when the conversation occurred, and heard Jack talking to the receptionist, and heard Jack say that he was having chest pain, difficulty breathing, and difficulty moving his arms.

I want you to assume that that will be the testimony in this case, from Jacqueline.

MR. RISPO: Objectio to assumptions.

Q (By Mr. Mishkind) Assume that to be the case for purposes of this question. If in fact that is

what she heard her stepfather say on the telephone with Jan, the receptionist, on the other end talking to him. Do you have an opinion to a reasonable degree of medical certainty as to whether the standard of care for an internist's office was violated in the afternoon between 3:15 and 3:30 when this telephone call occurred?

MR. RISPO: Same objection.

A Yes, I have an opinion.

Q (By Mr. Mishkind) Tell the jury what your opinion is.

A I feel that the standard of care was violated at this time.

Q And tell the jury the reason for that.

A Mr. Porach called again complaining of chest pain at this juncture, shortness of breath as well as a heaviness and an aching in his arms. That should have created immediate concern, which should have been communicated to Dr. Lalli to advise the patient to go to the nearest emergency room.

Q Doctor, let's take the other side, let's assume that the testimony --

MR. RISPO: Excuse me, motion to strike all the prior opinion.

Q (By Mr. Mishkind) Let's assume that the

testimony of Jan is that that wasn't said, but that Jack Porach called back, that she did not call Jack before this time, even though she said she would get back in touch with him. And further assume that it's her testimony that Jack asked to have an EKG; and in fact she said, "Come on in the office, we'll fit you in and we'll do an EKG." And further assume that when he arrived in the office after having him sit for 20 to 30 minutes, then hooked him up, did an EKG. And assume further that she never talked to Dr. Lalli about Jack coming in, or the need for doing the EKG.

If you assume those facts and disregard the testimony of the daughter, do you have an opinion to a reasonable degree of medical certainty as to whether the standard of care was met or violated by Dr. Lalli's office that afternoon?

A Yes, I do.

Q And what is your opinion?

A I feel that the standard of care was violated that afternoon.

Q Tell the jury why.

A If indeed this occurred, I feel that, again, the index of suspicion, the index of concern of a very, very significant heart problem should have been raised. And I feel immediate communication to Dr.

Lalli should have been done to properly treat Mr. Porach.

Q Is an EKG on a patient that has an acute illness done, absent a concern about the cardiac condition?

A No.

Q What benefit does an EKG provide to a doctor, unless the issue relates to the heart?

A None.

Q If a patient called into your office and asked for an EKG and the patient did not have a known cardiac history, and did not complain of any cardiac symptom, what responsibility, if any, would your office, or any internist's office have, relative to that inquiry or request by the patient?

A I think it's incumbent upon the staff or the physician to find out what it is that the patient's concerned about that prompted the request for the cardiogram.

If the patient has no symptoms and asks for an EKG, something doesn't make sense, something is left out. I really feel it's again another indicator that something may be going on with the patient and needs to be solicited to see what the problem is.

Q If John Porach had a heart attack that

started in the morning and went untreated during the day, and continued to cause damage to him all day, is there anything that modern medicine has available and that was available back in **1994** that should have been provided to Mr. Porach to treat his condition?

A Yes.

Q And what is that, doctor?

A Hospitalization in a coronary care unit or intensive care unit depending on the hospital setup. Administration of oxygen, medication to reduce pain, performing electrocardiogram, oxygen determinations in ones blood. Blood tests to see how serious the injury may be. And if deemed necessary, intravenous medication to decrease the possibility of life-threatening rhythm disturbance, and intravenous medications that can help dissolve the clot.

Subsequently if the patient is evaluated to be having further problems, he could be taken to the laboratory to have an angiogram to assess how significant the blockage is, and in **1994** when this was the case, if there was an acute blockage it could also be removed with a balloon called an angioplasty.

So I think all those possibilities were available in **1994** and should have been considered once the treatment of Mr. Porach began in a hospital

setting.

Q Doctor, let me ask you this, in terms of Mr. Porach's condition in the afternoon, if the patient asked for an EKG and there was no history of prior cardiac condition, and no indication at that time that he was having chest pain or shortness of breath. In order to comply with the standard of care, what steps should have been taken?

A A detailed history and physical examination of that patient. Again, knowing that Mr. Porach had risk factors for coronary artery disease would raise my level of concern if he were to ask for an EKG, even in the absence of other symptoms. If the patient with those risks factors asks for a cardiogram then something again is not right. So I think appropriate treatment would have been to evaluate him very quickly with a detailed history, physical exam, and any subsequent tests that would have helped clinch the diagnosis.

Q Doctor, you have on the desk there a copy of the actual EKG that we know was done by, that was performed by Jan in the office before Dr. Lalli was even advised the patient was in the office; is that correct?

A Yes, I do.

Q And it I think you've got several of them. Let me hand you one that I've marked as Plaintiff's Exhibit 1. Mr. Rispo also has one there that is Exhibit 2 for questioning for you. But is that identical to what Mr. Rispo has provided?

A Yes.

Q Can you turn that around and show the jury what that is? And is that the **EKG** that was performed on Mr. Porach at approximately I think it was about 5:39 p.m. in the doctor's office?

A Correct.

Q Does this **EKG** demonstrate findings consistent with an acute myocardial infarction?

A Yes.

MR. RISPO: Objection to "consistent **with**".

Q (By Mr. Mishkind) In looking at an **EKG**, Doctor, what are you looking for on the **EKG** that tells you or should tell any internist that there are things going on that suggest that the patient has a heart attack?

A You're looking for changes in two or more leads, which means specific points either on the limbs or the chest where the electrocardiogram is attached. You're looking for changes in two sequential leads,

meaning two in a row or more, which would raise concern for injury to an area of muscle in the heart.

Q Now, the squiggly lines, do they tell you certain things that are helpful to you?

A Yes, they do.

Q There's a term that is used in terms of ST segment elevations?

A Yes.

Q What does that mean?

A Well, when you look at an ERG you basically see several things, you see the heart rate and the rhythm, and you see whether there are changes indicative of injury to the heart muscle.

S.T. segments are those areas of the cardiogram which are right here, after the deep deflection, you see a little area, (indicating).

Q Which leads are we referring to? There's numbers on there.

A We're looking at leads V2, V3, and V4. And in those leads the S.T. segments which are areas of electricity generated by parts of the heart muscle, are not normal.

Q Now when someone has a heart attack, is there a classic type of finding that you expect to see on an electrocardiogram?

A Yes.

Q Do all patients that are suffering a heart attack have classic findings?

A No.

Q Would you explain to the jury why some do and why some don't?

A Just as the symptoms of a heart attack may not be classic, or those that are described in medical textbooks, electrocardiogram evidence of a heart attack is not always classic. Cardiograms change as changes in blood flow and damage to the heart muscle occur. This is a continuous time line, it depends on how much damage, how much lack of flow, and how much muscle is involved at a specific point in time that will be reflected on the cardiogram.

So not every episode of damage to the heart muscle is identical. Some may be classic as depicted in textbooks, some may be very atypical or unlike those depicted in textbooks. Depending on which point in time you check the electrocardiogram.

Q This cardiogram obviously we know was taken many hours after the testimony in this case suggests that his heart attack started, correct?

A Yes.

Q The findings in V2, V3 and V4 you said

are not normal?

A That's correct.

Q And in order to consider findings -- strike that.

Do you need to have a certain abnormal situation, if you will, or certain elevation in the S.T. segment elevations before you consider using certain medication to treat the heart attack?

A Yes.

Q And first, this EKG that we have, is it what's known as a standard, or a half standard ERG?

A It's a half standard.

Q Can you show or explain to the jury the difference between a standard and half standard and how you know this is a half standard?

a Here is the standard, it's a rectangular deflection at the beginning of every strip along the cardiogram.

This is a button that is present on every electrocardiogram machine, when you press the button it should deflect the amount of electrical action according to an international or national standard of electrical deflection. In other words, a standard depiction of electrical deflection between two points. And that is standardized for all cardiogram machines.

In this specific EKG it is a half standard, which means that the actual deflection across the EKG are half of what they actually would be in a full standardized cardiogram.

Q Do you know why this particular EKG was on the half standard as opposed to the standard?

A No.

Q Would you measure the S.T. segment elevation and tell the jury in V2, V3, V4 what we are looking at?

A I'll have to put it down.

Q That's okay, take your time.

A What I'm doing is, I'm placing a straight line across what's called the baseline. And the baseline of the EKG is that line from which every deflection starts. S.T. segment elevation would be how many millimeters, or on this ERG how many boxes above the baseline that S.T. segment ends.

Normally the S.T. segment should be on the same level as the baseline, that's the normal heart. When there's injury and S.T. segments are elevated it will be above the baseline anywhere from a small amount to a large amount. In Lead V2 the S.T. segment elevation is just a little bit over one millimeter, maybe 1.1, 1.2 millimeters.

In Lead V3 it is one millimeter. And in Lead V4 it is half a millimeter.

So if you extrapolate that to a full standardized cardiogram, in Lead V2 it would be approximately 2.1, 2.2; in Lead V3, 2 millimeters; and Lead V4, one millimeter.

Q Of what significance, if any, is that to a physician that is looking at this electrocardiogram and trying to determine what steps, if any, should be taken?

A When you have S.T. segment elevations that's a millimeter or greater in two sequential leads -- meaning one after another -- that's indicative of a heart attack or acute injury to the heart muscle.

Q If this EKG, Doctor, had been taken rather than at 5:30, but had been taken sometime in the morning of October 14, 1994, prior to noon, do you have an opinion to a reasonable degree of medical certainty as to whether the EKG would have shown elevations similar or dissimilar to the elevations that are shown in this EKG?

A Yes, I have an opinion.

Q And what is your opinion?

A I feel that if they had been taken earlier prior to noon it's very possible that the

elevations in the S.T. segments of the leads that I mentioned would have been even higher.

Q When you say very possible, do you hold an opinion to a reasonable degree of probability as to whether the elevations would have been higher than what they are shown at 5:39?

A Yes. My feeling is that they would have been higher than they were shown at 5:39.

Q Why do you say that, Doctor?

A Because I feel that was the initial beginning and acute onset of Mr. Porach's heart attack. And very often in the evolutionary pattern of all electrocardiograms, that try to correlate with what's going on in the artery and the muscle, you get S.T. segment elevation that's fairly significant in the beginning, and it becomes less significant or less traumatic as the heart attack evolves.

Q Doctor, I want you to assume that John Porach had been advised to go to the emergency room or call 911 in the morning of October 14, 1994, after talking with Jan, the receptionist. And further assume that he would have been seen and evaluated in the emergency room.

With this EKG that we have, or an ERG that would have been taken at that time, based upon the

patient's symptoms in the morning and the EKG information, do you have an opinion to a reasonable degree of medical probability as to whether a heart attack would have and should have been diagnosed?

A Yes, I do have an opinion.

Q And what is your opinion?

A I feel that a heart attack would have been diagnosed.

Q And do you have an opinion to a reasonable degree of medical probability as to what treatment would have been reasonable and appropriate had John Porach been in the hospital prior to 12 noon with a diagnosed heart attack, based upon what you believe to be the onset of his heart attack starting sometime between 5:00 and 6:00 a.m.?

A Yes.

Q And what is your opinion?

A 1 feel that appropriate treatment such as oxygen, morphine to reduce pain, intravenous medication to reduce the possibility of electrical problems, and/or intravenous medication to dissolve the clot would have been administered in a very timely fashion, certainly within the window of opportunity, and my feeling is that the subsequent outcome would have been dramatically changed.

Q When you say dramatically changed, what do you mean by that?

A I feel he would be alive.

Q When you say the medication to dissolve the clot, what is that? What are we talking about?

A It is a medication that has been given for years, some of the medications have changed over time as far as which specific clot dissolving medication has been given. But most hospitals, even in **1994** have a protocol for the window of opportunity at which time they can administer these medications intravenously. And if done within this window, which is usually within **12** hours, you can dissolve the clot and allow reestablishing the blood flow to the area of muscle, and drastically diminishing the amount of heart muscle that's permanently damaged.

Q Doctor, if for whatever reason John Porach was not told to go to the emergency room in the morning, but based upon the conversation in the afternoon he was advised to call **911** and was in an emergency room at any time prior to experiencing the ventricular fibrillation or the ventricular arrhythmia we know he had at approximately **5:45**. Do you have an opinion to a reasonable degree of medical probability as to what the outcome would have been in this case?

A Yes.

Q What is your opinion?

A I feel that the outcome would have been the same as I mentioned had he been treated earlier, I feel he would have survived this event.

Q What treatment would likely have been given had he not been in the hospital in the morning, but had been seen anywhere between 3:30 and prior to sustaining the ventricular fibrillation at 5:30 to 5:45?

A I think probably the same treatment that I alluded to earlier would have been given. At this time the diagnosis being made once he hit the emergency room or the coronary care unit, the same medication could have been administered, it was sometime within the window of opportunity to use the intravenous medication to dissolve clots. He could have been given medication to prevent this subsequently fatal ventricular arrhythmia.

So along this time line whether it would have been 5:00 in the morning or 3:00 in the afternoon I still think there was that opportunity to save his life.

Q Doctor, is there some controversy in the medical literature into when the effectiveness of the

clot busters starts to diminish in terms of clearing out the artery and reestablishing blood flow?

A Yes.

Q And what is your understanding as to what is considered that window the opportunity in the medical literature?

A I think the outside limit is 12 hours. It's best if you can really get the patient there as soon as possible. I mean within several hours would be terrific,

If it's within time zero, meaning at the onset of symptoms to within eight to 12 hours I think you would find that to be the window. But there is a lot of controversy as to whether or not you should use intravenous medication after 12 hours.

Q Now, Dr. Botti, who is a cardiologist in this case that will be testifying, I believe if he testifies that the window is somewhere, and Dr. Effron also, that the window is somewhere in the range of four to six hours. As a cardiologist or as an emergency room doctor, in terms of the efficacy or the successful nature of that type of clot buster, would you defer to them in terms of that window of the use of that medication?

A Oh, yes, absolutely.

Q Now let's assume, Doctor, for purposes of this question that he was outside the window to give clot busters, in other words, you couldn't go in and give him this medication to dissolve the clot. Is John then under those circumstances likely to have died anyway?

A No.

Q Why?

A Because other modalities could have been used. And in 1994 it's my recollection that once a cardiologist would have been consulted in a case similar to this, the patient would have been taken to the cardiac catherization lab where an angiogram would have been performed. And if indeed it discovered the obstructive clot in his left anterior descending artery, a balloon could have been used to alleviate the obstructive clot.

Q Doctor, isn't it a fact that a lot of people, perhaps the majority of people that suffer sudden cardiac death secondary to coronary artery disease, die outside of the hospital and within two hours of the onset of their symptoms?

A Yes.

Q Why then, Doctor, are you of the opinion that John Porach would have survived?

A Because I don't feel he had sudden cardiac death; I feel he started to have problems at 5:00 a.m. to 7:00 a.m. that morning and I feel that getting involved in treating these problems on a very early time line would have allowed the outcome to be survival.

Q I want you to assume, Doctor, that Dr. Lalli and possibly one or more of his experts will testify that John Porach is to blame for not adequately describing his symptoms, for not insisting that he be seen sooner, for not calling back sooner, and for not driving to the hospital rather than driving to the doctor's office when he did, and that those things caused John Porach's death.

First assume that that testimony will be corning from Dr. Lalli and some of his experts. Do you agree or disagree with any of that?

A No, I strongly disagree.

Q Tell the jury why.

A I don't feel it's the responsibility of the patient to make a diagnosis for his physician, I think it's the responsibility of the physician to get information and a history, and if able to examine the patient; if not able, to make a tentative differential diagnosis right away.

And I feel in that way proper care can be rendered.

I feel Mr. Porach acted as a responsible patient. He conveyed in his own mind what his problem was, to the staff, to his family, on numerous occasions. I feel on two occasions he explained his symptoms to the receptionist and these were not taken in a serious nature, and therefore when he came to the office at 5:30 he died.

I don't feel it was incumbent upon him to do anything more than he did, I feel he acted as any responsible patient that I would have, should have acted.

Q Doctor, with regard to this ventricular fibrillation or ventricular arrhythmia he had in the doctor's office, was there anything that Dr. Lalli, or for that matter you as an internist can do in the office to treat ventricular arrhythmia?

A Yes. The only thing we can do is pound the chest, which miraculously can occasionally terminate the rhythm. But that's the only thing. There's no other things that I can do in my office and I would assume that in Dr. Lalli's office that could have been done to treat this arrhythmia.

Q What is done when someone has a

ventricular arrhythmia in the hospital, to treat it?

A Depending on the extent of the arrhythmia. And I mean by that some arrhythmias don't cause immediate decompensation of the patient, others cause definite dramatic decompensation of the patient. Meaning, drop in blood pressure, rapidity of pulse, difficulty in breathing.

In a hospital setting, intravenous medications can be used. Or if it's deemed more serious electro shock can be applied to the chest to convert the rhythm to normal.

Q Doctor, I want you to assume that Dr. Lalli will testify that John Porach didn't complain when he arrived in the lobby of the doctor's office, that he didn't have classic EKG findings, and in fact Dr. **Lalli** marks down on the top of the EKG "remote" as opposed to "acute" findings.

That he seemed to improve at times during the day with regard to his symptoms. Don't those facts suggest that the level of concern, Dr. Selwyn, the level of concern necessary on Dr. Lalli's part, concerning his patient, would be substantially less?

A No.

Q Why?

A It's quite usual for symptoms of a heart

attack to wax and wane throughout this period of time. Patients don't experience, even if untreated, patients don't experience pain continuously over hours. They may, but then again they may not. So I don't feel that the fact that Mr. Porach felt more comfortable while sitting in Dr. Lalli's office would soften my concern at all.

Q Do you have any explanation, based upon your review in this case, as to why John Porach was not contacted by Jan, the receptionist, at some time prior to the call back, that John made himself?

A No.

Q Do you see any evidence based upon where Dr. Lalli was, his patient load, if you will, the number of patients he had, that there wasn't a time period that would have been reasonable and appropriate for the doctor's office to get back in touch with John?

A No, there should have been no reason that couldn't have occurred.

Q Doctor, I want you to assume that with reasonable and appropriate care in the morning, or with reasonable and appropriate care in the afternoon, as you've stated before, that John would have survived.

Based upon that, do you have an opinion to a reasonable degree of medical certainty as to what

John Porach's life expectancy would have been?

MR. RISPO: Objection.

A If he had survived this event, knowing now what I know about his prior history, and considering survival from a heart attack, I think he would be likely to have survived until is late 60s, early 70s.

Q (By Mr. Mishkind) Let me ask you the same question but reword it from a legal standpoint.

Do you have an opinion to a reasonable degree of medical certainty as to John Porach's life expectancy?

A Yes.

MR. RISPO: Objection.

Q (By Mr. Mishkind) And your opinion please?

A I feel that he would have lived, he was 44 at the time; probably 68, 69, 70 or possibly a few years thereafter.

Q Doctor, do you have an opinion to a reasonable degree of medical certainty whether or not John Porach's death was preventable and avoidable if he received good and appropriate and standard medical care and treatment on October 14, 1994?

A Yes.

Q And what is your opinion?

A I feel that he would have survived had he been treated in a timely and appropriate manner.

MR. MISHXIND: Okay, I don't believe I have any further questions.

Mr. Rispo, you may inquire.

MR. RISPO: I'm ready to proceed if the reporter is ready.

MS. GA": 12:00, we're going off the record.

(Short Recess)

MS. GANN: The time is 12:05 p.m., we're back on record.

EXAMINATION

BY MR. RISPO:

Q Doctor, I'd like to begin with a few general propositions, hopefully we can reach an agreement on them.

Are you there?

A Yes.

Q All the testimony you've given up to this point in time is based upon hypothetical information that has been provided to you. You were not there in person, were you?

A No.

Q So, you have no personal knowledge of what John Porach told his wife, or what he told his step-daughter, or what he told to Jan Schoch?

A No.

Q And your opinions were based upon those assumptions and that data that was provided to you?

A Yes.

Q And if the information provided to you were radically different, would you change your opinions?

A I'm not sure I understand the nature of that question.

Q I'm asking you whether your opinion is fixed regardless of the facts as presented to you.

MR. MISHKIND: Objection. w/d

A If I had other facts obviously it would change some of my thought process in developing my opinion, yes.

Q (By Mr. **Rispo)** Well, certainly. We do agree on that then?

A Yes.

Q Can we also agree that the classic symptoms for myocardial infarction or heart attack includes chest pain, shortness of breath, and radiation of pain to the jaw, to the back, to the neck or to the

left arm?

A Correct.

Q If I understand correctly, the patient was 45, was 44 years of age on the date of death. Do I assume correctly that the number of young men under the age of 45 would have myocardial infarctions are extremely low?

A I can't give you that statistic, because I don't know.

Q Well, it's far less frequent than for men in excess of 45 years, isn't it?

A Yes.

Q In fact one of the risk factors you mentioned earlier was a male, age 45 or older?

A That's correct.

Q And John Porach at age 44 did not in fact have that risk factor?

A That's correct.

Q And of course he was a male, and many males over the age of 45 have heart attacks, but being a male under the age of 45 is not a risk factor, is it?

A Not to my knowledge.

Q As a matter of fact, half of the population is under age 45, is it not?

A Correct.

Q And the high percentage of the population do smoke?

MR. MISHKIND: Objection. O/R

Q (By Mr. Rispo) Is that not correct?

A Correct.

Q And as a matter of fact a goodly number of us men are a little overweight?

A Correct.

Q And many of us have a degree of increased cholesterol over what it ought to be?

A Correct.

Q So, in that respect, John Porach was not much different as far as his risk factors are concerned, in a very large percentage of the population under the age of 45?

A Correct.

Q And among those, that segment of the population, the incidence of myocardial infarction is pretty low, as compared with those in the higher risk category?

A Well, again I can't quote you specific statistics; but, yes, it would be lower.

Q Also is it not true that there's a fairly low incident of patients with myocardial infarction who have no symptoms at all?

A Well, in some instances it depends on how you define low. In some instances you can have silent infarction in 10 to 20 percent of cases.

Q So for 80 percent of the cases a patient would have symptoms of a myocardial infarction?

A Yes.

Q For a patient under 45 years of age who had a silent M.I. and in that 20 percent, it would be pretty difficult to diagnosis, wouldn't it?

A Yes, usually it's diagnosed after the fact,

Q And for a patient who did not have classic symptoms, that is chest pain, shortness of breath and radiating pain, it would be very difficult to diagnose?

A No, I don't agree with that.

17-92 ovrl

Q If he had no risk factors and he had none of the classic symptoms and he had a silent M.I. he would be very difficult to diagnose, would he not?

MR. MISHKIND: Objection. Subs

A Yes

Q (By Mr. Rispo) Now if I understood correctly the testimony that you gave, your assumption was that when John Porach had his heart attack it was 5:30 in the morning?

A Yes.

Q And he did not go to the emergency room between 5:30 in the morning and 9:30?

A Correct.

Q And his wife did not call 9113

A Correct.

Q Is that because his symptoms were silent, or atypical?

A 1 don't believe his symptoms were silent at all, I feel his symptoms were not classic. I wouldn't necessarily say atypical.

Q What do you mean by "not classic"?

A Well, you described what classic symptoms are, chest pain, shortness of breath, sweating, radiation to the neck or jaw. His symptoms were that he had, he did describe to his wife that he had achiness in his chest and he was short of breath. That's not atypical as far as I'm concerned.

Q You're talking about what he told his wife?

A That's correct.

Q Somewhere between 5:00 and 7:00 in the morning.

A That's correct.

Q To distinguish from what he told the

receptionist, Jan Schoch?

A Correct.

Q As a matter of fact when he called Jan Schoch, based on the information available to you, he said nothing whatever about shortness of breath?

A That's correct.

Q He did say, however, that he had fever and diarrhea?

A That's correct.

Q And in fact when Jan Schoch asked him specifically and expressly whether he had chest pain, he said no?

A That's correct.

a And when she asked him if he had any history of heart disease, he denied it?

a Correct.

Q As a matter of fact, Doctor, with the symptoms as provided to Jan Schoch, including fever and diarrhea, the differential diagnosis includes a large number of other possibilities, does it not?

A That's correct.

Q And do those possibilities include infection or viral flu?

A Yes.

Q Do they include pneumonia?

A Yes.

Q And pulmonary embolus?

A Yes.

Q And gallbladder disease?

A Yes.

Q And acute cholocystitis?

A That's the same thing, yes.

Q In the absence of risk factors, which of those differential diagnoses is the leading differential or the leading diagnosis when a patient does not complain of shortness of breath, radiating pain to the jaw, neck or left arm, or chest pain?

MR. MISHKIND: Let me object to the hypothetical. O/R

But go ahead.

A You're asking me if Mr. Porach complained of what he complained to the receptionist, what would my differential be in the absence of risk factors?

Q (By Mr. Rispo) Yes.

A My primary differential would start with heart disease.

Q It would still include viral flu?

A Yes.

Q And you would start with heart disease because he described fever and diarrhea?

A No.

Q Is fever or diarrhea consistent with heart disease?

A No.

Q In fact fever and diarrhea is more consistent with flu or viral symptoms?

A Correct.

Q If he had said nothing whatever about chest pain, or actually denied chest pain, are you still saying that you would still suspect heart disease, or heart attack?

MR. MISHKIND: Objection to the hypothetical. w/d

A He said he didn't have chest pain, he said he had aching all over including his chest. To me that is chest pain.

Q (By Mr. Rispo) And you're a doctor?

A Yes.

Q Would you agree that a non-medically trained receptionist does not have the same degree of sophistication as a board certified specialist in internal medicine?

A Correct.

Q Would you agree that she would be correct in assuming that diarrhea and fever was consistent with

the flu?

A Could be consistent, yes.

Q Would you agree that when John Porach told her that he did not have chest pain or history of heart disease, that he actually misled her into the assumption that he probably had the flu?

MR. MISHKIND: Objection. O/R

A No, I don't agree with that.

Q (By Mr. Rispo) Are you saying that any patient who calls in with fever, diarrhea, generalized achiness of the arms and the legs, the shoulders and the chest, should be referred to the emergency room?

A I'm saying that any patient that calls with those symptoms should be evaluated immediately, whether it be in the emergency room or in the physician's office, yes.

Q And if they can't get in to see the physician within an hour, he should be sent to the emergency room?

A Yes, I feel that's appropriate.

Q And if that were true then the emergency room would the filled with people with pneumonia, gallbladder disease and viral flu.

MR. MISHXIND: Objection. O/R

A You're asking a question as if the

patient couldn't be seen in his physician's office. This is a problem that all of us as physicians face. Chest pain is probably the leading cause of visits to the emergency room, and probably non-cardiac chest pain is a very high incident of reason for patients to go to the emergency room.

However, the reason they go to the emergency room or the reason they're attended to so quickly is because the possibility of a cardiac event has to be high on one's list. In his practice and I'm trying to use Dr. Lalli's practice as an example, because it is different from my practice because of the size, I feel that a patient with any chest distress needs to be evaluated immediately.

1 also feel it's not the receptionist's job to decide whether it is or is not the flu, that's the responsibility of the physician.

Q (By Mr. Rispo) Well, what you're saying then is that even though the patient described fever, diarrhea, generalized malaise, and aching in the chest, the shoulders and the legs, and even though he expressly denied in answer to a question that he had chest pain, and even though he had no history of cardiac disease, that the receptionist in all these cases should ignore his denials, assume that he has the

classic or at least suspicious symptoms of cardiac disease and refer all those patients to an emergency room unless he could be seen in the doctor's office within an hour?

MR. MISHRIND: Objection. w/d

A 1 feel it's not the receptionist's decision to make, I feel it's the receptionist's responsibility to defer that judgment to the physician.

Q (By Mr. Rispo) So are you saying that in all of those cases the receptionist should tell the patient to hold on until she can talk to the doctor and get the doctor on the line?

A Either that or get some information that would render a decision on the doctor's part, yes.

Q Would you agree that diagnosis is a very difficult thing, even for physicians?

A Yes.

Q That aching in the chest is a very subjective complaint?

A Yes.

Q It can very easily be misinterpreted by anyone else besides the doctor?

A Yes.

Q As an internist, a medical doctor, you yourself could not even arrive at a reliable diagnosis

without seeing the patient?

A That's correct.

Q And if you did see the patient you would have to take a detailed history and you would have to take additional steps, including testing, EKGs, enzyme studies before you could confirm a diagnosis of a myocardial infarction?

A Correct.

Q And until you took those steps your differential diagnosis would still include other possibilities like the flu?

A Correct.

Q You would agree the standard of care expected of a board certified cardiologist or an internist is higher than the standard of care for a nurse?

A Well, I don't agree with the term "higher." There are different standards of care, depending on the profession and the level of training. But all standards of care are standards of care; I can't use the word "higher."

They may be different as far as what nursing care is, compared to physician care. But "higher" is not a good term.

Q I'll use your term "different" then, you

would agree with my statement?

A Yes, they may reflect different levels of skill needs and different levels of the type of practice. Certainly nursing care standards are going to be different than physician care standards.

Q Would you agree that the standard of care for a non-medically trained receptionist is different from that of a board certified cardiologist or internist?

A I think the standard of care for a non-medically certified or non-medically trained receptionist, should be the same standard of care that's operated or issued by her physician in charge. I think it's a continuum, I can't agree with the fact that there are two standards of care in an office, because one's untrained and one's the doctor. The doctor has ultimately responsibility for the standard of care. And in that vein if the receptionist received symptoms, it is her responsibility if the symptoms appear worrisome and a red flag is raised, to convey those immediately to the physician.

Q Doctor, I'm asking for a general proposition. Would you agree with the statement that the standard of care for a receptionist is different from that which is imposed on a cardiologist who's

board certified or an internist who's board certified?

MR. MISHKIND: Let me object to the o/R question, it's already been asked and answered. And you're now asking it in a general manner, so for that reason I object as well.

But go ahead, Doctor.

A The standard of care is different.

Q (By Mr. Rispo) Okay. As a matter of fact there are no written or published standards of care or protocol in your office for your nurses or your receptionists, telling them what they should do or what they should ask when a patient calls in?

A Well, I can't say that's entirely true. In our office we do have some written standards and protocols of care, not for many things, but we're trying to initiate more of those for the staff.

Q As of the date that you wrote your opinions, which was in June of '97, you didn't have any written standards or protocol in your office for nurses dealing with the diagnosis or treatment or triage of an acute myocardial infarction?

A No, nothing written, that's correct.

Q There are no such standards anywhere that are published and in writing for receptionists?

A Well, I'm not sure that there aren't any

anywhere. There's lots of health plans now that are issuing to their physician members specific standards of care and different diagnoses. But again 1 don't know if that's germane to what we're saying.

I can't answer that by saying there are no written standards of care. There may be some in some instances.

Q Can you tell me where they are?

A I can tell you that our HMO plan in Tucson has issued for our manual different specific diagnostic problems and different things we should consider when these arise, yes.

Q But you have none in your office, or at least you didn't have any in your office as of the date you wrote your report?

A That's correct.

Q Would you agree then that the medical receptionist is not much any different from the general population in terms of her understanding or interpretation of a medical diagnosis?

MR. MISHKIND: Objection. O/R

A Well, in this case or in general? In this case the receptionist had worked with Dr. Lalli or in the field for 30 years. So there would have been some experience that counts for some elevation of her

knowledge above the general public.

Q (By Mr. Rispo) Are you of the opinion that the public is generally aware of the symptoms shortness of breath, chest pain, as emergency situations requiring urgent care?

A Again, a lot of my patients that I see are aware that when they get chest pain or shortness of breath, it's a serious problem.

Q Would you agree that Jan Schoch was not present in John Porach's home at 5:30 in the morning?

A Correct.

Q And she was not present in his home at 7:00 or 9:30 in the morning?

A Correct.

Q She didn't see or have an opportunity to examine John Porach or his appearance?

A Correct.

Q She had to rely entirely upon what she was told?

A Correct.

Q And she certainly couldn't guess at his complaints?

A No.

Q Would you agree that John Porach had the opportunity between 5:30 and 7:00 in the morning to

call for emergency medical help, either **911**, or go to the emergency room?

A Sure, he did have the opportunity.

Q He did not take it?

A No, not to my knowledge.

Q And would you agree that his wife was with him between 5:30 and 7:00 in the morning, and that she had the opportunity to likewise call for emergency care, and she did not?

A Correct.

Q If she had a general idea that chest pain and shortness of breath were emergent problems requiring urgent medical care, then she did not follow a reasonable course of action?

MR. MISHXIND: Objection. w/d

A No, I can't agree with that. When I mentioned before that many of my patients know that chest pain and shortness of breath is a serious problem, I can tell you that they rarely call **911**, unless there's a sudden collapse at the house.

What I mean by that is that they realize it's an urgent problem, they're not to go to work and to call your doctor. And as far as an immediate request to go to the emergency room more often than not that's not done. What they do do, they're alerted to

the fact that this is unusual and they call their physician as soon as the doctor's office opens, or whenever a timely fashion would be appropriate.

Q (By Mr. Rispo) If the doctor's office is not open, they general go to the emergency room, don't they?

A Or they make a call to the doctor who's on call, to get some advice.

Q As a matter of fact, more patients go to the emergency room in that condition than wait for the doctor's office to open?

A I can't say that that's true. I have many patients who have had chest distress for several hours or aching and what have you that do wait to call the doctor's office. But they are alerted to the fact that it's something to inquire about.

Q Do you have any idea what percentage of patients go to the emergency room, as opposed to waiting for their doctor's office to open?

A None at all.

Q As a matter of fact, John Porach stayed at home, even after he called the doctor's office, for a period of 10 hours before he went to the doctor's office, right?

A Correct.

Q At any time during that period of time he could have gone to the emergency room on his own initiative?

A Well, he could have, yes. But I still feel that what should have been done was, his physician should have seen him when he first called at 9:00 o'clock in the morning.

Q Once he found out that the doctor did not have an open appointment on his schedule, he recognized he couldn't get in to see the doctor for at least another few hours during that morning, he had all the more reason to consider other options, didn't he?

A No, I think what you're doing is putting the responsibility on the patient. He did get advice, whether it was correct or incorrect, from his physician's office. That advice was, "It sounds like the flu, we'll call you back."

I feel he acted responsibly, and I don't necessarily feel that because he couldn't get in to see Dr. Lalli he should have just taken his own initiative and presented to an emergency room. He was calling his doctor for an opinion, that's what most of the general public does. If your doctor renders an opinion, they generally stick by it.

Q Are you staying that John Porach was or

should have been satisfied with the opinion that he had the flu?

A No, I think he shouldn't have been satisfied with that opinion. I think he was concerned enough to want to be seen by Dr. Lalli, but the nurse told him stay home until we recontact you. Which could have been 20 minutes; but for what it was, it never happened, he had to call on his own.

Q He knew he was talking to a receptionist, didn't he?

A Correct.

Q He knew he wasn't talking to the doctor?

A That's correct.

Q And he knew what his own condition was better than anyone else?

A Yes.

Q And there was nothing stopping him from going to the emergency room, was there?

A No.

Q He had a car available to him?

A Correct.

Q He had a valid driver's license?

A Correct.

Q And he could have called emergency medical service, 911, if he felt so badly that he

couldn't drive?

A He could have done that, yes.

Q In fact he didn't call his wife until she called him at 12:00 noon. Were you aware of that?

A yes, I am.

Q Were you aware of the fact that when he spoke to his wife he told her that there had been no change in his condition since she left him at 7:00 in the morning?

A Well, I don't recall seeing "no change"; I just recall his discussion at about noon reflecting that he still had the discomfort that he had described before. If you want to say "no change" and it was the same, that would be, I would agree with that.

Q In fact he didn't take any further steps between 12:00 noon and 3:15 in the afternoon?

A No.

Q To suggest emergency medical care?

A No.

Q And his step-daughter was awake and watching soap operas I believe between 12:00 and 3:00 p.m., he did not interrupt her television viewing to tell her of his condition between 12:00 and 3:00?

A Not that I'm aware of.

Q As a matter of fact, you're aware of the

fact that he also spoke to his mother-in-law?

A Yes.

Q On at least one occasion during the morning, and he didn't ask her to call for emergency medical help?

A No.

Q And she didn't call for emergency medical help?

A Correct.

Q Would you consider it reasonable for a patient who had a heart attack between 5:00 and 7:00 in the morning, to just sit around his house for a period of nine hours without calling for emergency medical help or calling anyone to take him to the emergency room?

A Well, that question has to be qualified. I would consider it reasonable in this case because the symptoms waxed and waned over the day, which is not unusual at all in a patient who sustained a heart attack.

What you're asking is, if the patient had a heart attack and became acutely decompensated at home, meaning blood pressure drop, congestive failure, rhythm disturbances, became less conscious. I mean that's a reason to take him to the emergency room.

But it's well-known that many patients who suffer the prelude to a heart attack or actually incur a heart attack will have symptoms that may wax or wane during one day, two day period of time. But if they're in the right place it really reduces the possibility of adverse outcomes.

Q Doctor, the type of patient you're describing typically is the patient who has angina and pain which is a precursor to a myocardial infarction, is that right?

A Not necessarily. People with unstable angina can have the symptoms I just mentioned and have the course I just mentioned. But patients who do have a heart attack can have a waxing and waning throughout the day.

I'll refer you to people with silent infarctions. If everyone had the same type of symptoms we'd be much better fixing up silent infarcts. But it's obvious to all of us that people live and survive very well after sustaining a heart attack that they never knew about. In that way I would draw in context the type of symptoms that Mr. Porach had during the day. These did wax and wane, which can certainly occur after a heart attack, and they don't have to be of a severe serious nature during the entire day, they can

come and they can go, they can wax and they can wane.

So I don't feel it was unreasonable, knowing what I know about the case, reading what I've read for Mr. Porach to act in the way that he acted.

Q Well, Doctor, you will concede of course in this case John Porach had a heart attack between 5:00 and 7:00 in the morning, he already had a serious cardiac event?

A That's correct.

Q And the waiting around that he did was after he had the heart attack?

A Absolutely.

Q Now, are you saying that his was a silent heart attack?

A No, not at all, I was just giving reference to the fact that patients can have different symptoms after a heart attack. An example, a patient that has a silent heart attack has no symptoms after the heart attack, or for that matter during the heart attack.

A patient that has a myocardial infarction with symptoms, as did Mr. Porach, can have the symptoms wax and wane throughout the eight to 12 hours he remained at home.

Q Are you saying that his symptoms were not

the typical classic presentation?

A That's correct.

Q Are you saying that he had a right to anticipate that the receptionist who hadn't seen him in person, who's receiving his report of atypical symptoms, non-classic symptoms, should have advi ed him correctly to go to the emergency room?

A If she was unsure of these symptoms she should have conveyed them immediately to Dr. Lalli, so that a judgment could have been made by Dr. Lalli to send Mr. Porach to the emergency room.

She was not trained to make the diagnosis nor should she give or render a diagnosis. That is the responsibility of his attending physician. So if those symptoms were elicited, were discussed with the receptionist, I feel one of two things should have happened: If she had no idea that this could have been, what it could have been, but that it was disturbing because he had achiness in his chest, immediate action should have taken place. The best thing to do would be, "Dr. Lalli, what should I do? What should he do? He's having discomfort in his chest."

Q You're saying that a non-medically trained receptionist who was not a physician, who was

not board certified, should be expected to anticipate a diagnosis without even having been presented with the classic symptoms?

A No I'm not saying that at all. I'm not saying she should make a diagnosis, and I hope she wouldn't. What I am saying, he has the responsibility to put a receptionist in that position, with the training that she has it is incumbent upon him to accept the responsibility that if someone calls with an achiness all over, including the chest, that patient be taken care of immediately. And that means communication of that problem be done immediately.

I'm not saying that she should make a diagnosis or think in her mind what this could be. I'm saying that this was a serious report of symptoms that was new for this patient, something unusual. It should have been given to Dr. Lalli to determine and decide what should have been done.

Q Even though he was under age 45, right?

A Absolutely.

Q Even though he did not have a prior diagnosis of coronary artery disease?

A Absolutely.

Q Even though he did not have a diagnosed history of high blood pressure?

A Absolutely.

Q Even though he did not have diabetes?

A Correct.

Q And did not have any of the other risk factors?

A That's not correct, he did have risk factors which I mentioned before; he was a tobacco user and had smoked at least a pack a day for well over 20 years, and he had elevated cholesterol. Those in my mind are two very serious risk factors.

Q About 50 percent of the population fit that profile, don't they?

A That makes no difference. Yes, they do but I don't understand how that makes a difference in this case.

Q Doctor, there are a few pieces of objective evidence that we have in this case. One of them is the EKG?

A That's correct.

Q And the other is the autopsy.

A Correct.

Q Let's discuss the EKG for a few minutes.

Referring to Exhibit 2. If you have it before you. Exhibit 3, along with it.

A Yes, I do.

Q Are you ready?

A I am.

Q Would you agree that the EKG study, Exhibit 2, is not diagnostic of an acute M.I.?

A Correct.

Q Would you agree that the EKG is equally compatible with a remote myocardial infarction?

A It could be, yes.

Q Would you agree that the S.T. elevations in Exhibit 2, that's John's EKG, are closer to those elevations which are shown in Figure D of Exhibit 3?

MR. MISHXIND: Let me object, Ron. Just for the record I'm going to object to the reference to that exhibit for a number of reasons, including it is a page out of a textbook, it is not an actual EKG strip. There is information contained on that, we don't know the leads or the area that that EKG is taken. I don't have the opportunity to cross-examine the author of that, and there is language in there that describes certain patterns.

We know that John Porach did have an acute M.I. And I've got about three or four other reasons why I'm reserving them for the record in terms of referencing that exhibit, and correlating it in this particular case, I think it's --

Q (By Mr. Rispo) Doctor, we've talked before, you recall, that 1 had an opportunity to take your deposition back in September or October of last year?

A Yes.

Q And we addressed the same figures in Exhibit 3, and you agreed that the conditions, the S.T. elevations in Exhibit 2 are closer to those in the elevations which are shown in Figure D of Exhibit 3.

MR. MISHKIND: Let me indicate for the record the fact he may or may not have agreed in the discovery deposition, I'm preserving my objection in terms of admission of that to the jury, and that's the reason for my objection. But go ahead. O/K

Q (By Mr. Rispo) Did you in fact degree, Doctor?

A Yes, at that time I did, correct.

Q Now, the figures in Exhibit 3 demonstrate, do they not, classic or typical presentation of an M.I. at different stages over a period of time?

A That's correct.

Q And Figure D of Exhibit 3 is the presentation typically of an M.I. which occurred days or weeks prior to the test?

A That's correct.

Q Therefore, the EKG in Exhibit 2, which was done on John Porach, is typical of a patient who had a remote M.I. days or weeks earlier?

MR. MISHRIND: Objection. O/R

A No, the other thing I would like to mention here is that if you take into account -- which I don't believe I may have done with the discovery deposition -- is the fact that this is half standardized; and if you look at the full standard ERG, which we don't have the advantage to look at, the S.T. segment elevations in Leads V2, V3 and V4 may have been more typical of Figure C in Exhibit 3 than Figure D. But I don't have that full standardized EKG to give me that advantage.

Q (By Mr. Rispo) In response to that question when I asked you last time, your answer on page 20, line 4 was: "If I did not have the patient in front of me, nor any history, and I just looked at this cardiogram that came across my desk I could not tell you whether this would be indicative of an acute injury or antecedent infarct."

A That's correct.

Q As a matter of fact, if the patient appeared in the emergency room with this EXG

presentation, without other complaints, they would not even initiate thrombolytic therapy, would they?

MR. MISHKIND: Objection to the hypothetical.

A Without any other complaints?

Q (By Mr. Rispo) That's correct.

A Probably not.

Q And that's because they would assume that it was too late for thrombolytic therapy to be effective?

MR. MISKKIND: Objection.

A Correct.

Q (By Mr. Rispo) Let's go to the autopsy. Do you have Dr. Hoffman's report handy?

A Yes, I do. I'll just take a minute to find it.

Yes, I do.

Q I direct you, please, to the first page of his report, the last sentence of the second paragraph. Would you read that into the record?

A Is it the deposition you're asking, or just his report?

Q His report.

A That's a two-page report.

Q That's correct.

A Could you repeat the question?

Q Could you read into the record here for the benefit of the jury, the last sentence of the second paragraph on the first page?

A "There is no evidence of fibrovascular organization of the thrombus indicating that the lesion could not be more than a few hours old."

Q And if you would skip to the next page, the second last sentence beginning with the word "The changes."

A "The changes in the myocardium and the freshness of the arterial thrombus indicate that the fatal lesions occurred just hours before death."

Q Now, if Dr. Hoffman meant one to three hours when he said "just hours," or "more than a few hours old," then his opinions as to the dating of the myocardial infarction would be inconsistent with yours?

MR. MISHKIND: Objection, you are mischaracterizing the testimony that has been given in this case and I move to strike the question, the doctor has already testified as to what his findings were and his definition, so you're trying to subject or interject to this jury testimony relative to the use of "few," where Dr. Hoffman has already explained at great detail what he meant in his discovery deposition, and I

think it's inappropriate to be cross-examining this doctor based upon some other expert's testimony when that testimony will speak for itself.

MR. RISPO: With all due respect, Howard, the fact that Dr. Hoffman recanted his own opinion doesn't mean I can't cross-exam based on his opinion.

MR. MISHKIND: He never recanted his opinion, Mr. Rispo, the fact that you don't appreciate when one says "a few" and then he explains what he means by "a few," from a medical standpoint, doesn't mean that he recanted, and still it's inappropriate to try to cross-examine one expert based upon another expert's testimony when Dr. Selwyn is not a pathologist and is not going to be offering opinions relative to pathologic interpretation.

MR. RISPO: Howard, you're going to miss your plane, if you're not quiet.

MR. MISHKIND: I'm already well there, based upon your questioning; well, missing it, I should say.

Q (By Mr. Rispo) Doctor, in the same manner that Mr. Mishkind has asked you to assume a few things I'm going to ask you to assume a few things. I want you to assume Dr. Hoffman, when he wrote his report and before his deposition, meant "a few hours"

to mean two to three hours. And based upon that assumption, would you agree that your conclusions as to the date of the myocardial infarction, the timing of the myocardial infarction would be inconsistent with his statement that the M.I. occurred within a few hours earlier.

MR. MISHKIND: O/A Objection to the question.

A Yes.

MR. MISHKIND: Move to strike.

Q (By Mr. Rispo) And your opinion would also be inconsistent with a reading of the EKG indicating that it was "remote" rather than "acute"?

MR. MISHKIND: Objection. O/A

A Could you repeat that question, please?

Q (By Mr. Rispo) Your opinion that the myocardial infarction occurred between 5:00 and 7:00 in the morning is also inconsistent with the EKG?

A No, I don't think.

Q The remote infarction, or at least the classical presentation would be a remote infarction days to weeks earlier.

A I don't necessarily agree with the fact that if he had his heart attack at 5:00 in the morning and the EKG was taken at 5:30 in the evening that this EKG would be inconsistent with my timing of the event,

at all.

Q You used the word inconsistent. I'm asking you typical classic interpretation.

MR. MISHKIND: Objection. w/o

A You were asking me typical classic presentation from 5:00 in the morning to the time this EKG was done?

Q (By Mr. Rispo) That's correct.

A If it was typical classic this EKG would be different than the one that I see before me.

Q Thank you. Now if these objective tests are both correct, that is the EKG and the autopsy as reported in Dr. Hoffman's report, then the only logical consistent explanation for what occurred would have to be that there were two separate M.I.s, one quite a bit earlier and one after the ERG was done.

MR. MISHKIND: Objection. o/r

A No, I don't feel that there were two M.I.s, I don't agree with that.

Q (By Mr. Rispo) Is it possible there could have been?

MR. MISHKIND: Sua Objection to "possible."

A No, I don't think it was possible.

Q (By Mr. Rispo) If there were, would you agree that it would be, it would explain an EKG which

shows a remote infarction.

MR. MISHKIND: Objection.

A Remote can be weeks to days. So you're asking if there was a second myocardial infarction could it be consistent with this EKG? Not necessarily.

Q (By Mr. Rispo) Let's take that step by step. Obviously if there was a second M.I. after that the EKG was done it wouldn't reflect on the EKG?

A Correct.

Q But if there was a remote EKG -- I'm sorry, remote M.I., it would be consistent with the EKG?

A It could be consistent.

Q If he had a second heart attack as indicated by the autopsy, within a few hours, then it could have occurred after the EKG?

A Yes, if there had been a second heart attack, which I don't think there was.

Q Let's go on then to a slightly different subject.

If a patient had an M.I. in progress, then you would typically find elevated S.T. waves within a short period of time after the onset of symptoms, is that correct?

A Typically, yes.

Q If he did have an M.I. in progress then you would not expect to find elevation in the S.T. waves if the EKG was taken a few hours after?

A Well, that's not necessarily true. I think for the sake of this discussion that would be a bit more complex than is necessary. People don't necessarily have to have an M.I. to have S.T. segment elevations.

Q If he did have a S.T. wave elevated, however, in the exhibit that I gave to you, more consistent with Figure B -- as in boy -- then you would expect that he'd have an M.I. in progress within a few hours earlier?

A Correct.

Q If he did not have a typical presentation of an elevated S.T. wave, then it would be reasonable to assume he did not have an M.I. within a few hours before the test?

A No, that's incorrect. You don't necessarily have to have S.T. segment elevation within a four hours of the infarcts to clinch your diagnosis. EKG's change, as well as symptoms change.

Classically you would expect to have the evolutionary changes as seen in Exhibit 3. But there are many instances other than classic which do not

necessarily correlate with S.T. segment elevation in the time you're speaking of.

Q I understand not every case is the same. But in the typical presentation you would expect to find elevated S.T. waves if there were heart attack earlier?

A In the classic presentation, yes.

Q Okay. And furthermore, if the patient did have an M.I. in progress, you would typically expect the patient would have symptoms such as chest pain, shortness of breath, radiating pain at the time of the myocardial infarction?

A Typically and classically, yes.

Q And if the patient had no symptoms and this EKG presentation, it would be reasonable to assume that he did not have a M.I. within the few hours before the test?

MR. MISHKIND: O/R Objection to the hypothetical.

A No, that's incorrect.

As I mentioned, people can have silent M.I.s and have reflected changes on cardiograms from hours to years later and never have a symptom at all.

Q (By Mr. Rispo) If the typical patient came through, did not have elevated S.T. waves, did not

have symptoms, you would not expect to find that he had a myocardial infarction?

MR. MISHKIND: Objection.

A Typically and classically, that's correct.

Q (By Mr. Rispo) He would not have had symptoms of chest pain, radiating or shortness of breath?

A I'm not sure I understand that.

Q If he did not have a myocardial infarction within a few hours earlier, in other words, if the presentation we see here in the EKG was put to us and it was typical of, as you've said earlier, a remote myocardial infarction, then you would not expect to find symptoms of chest pain, radiating pain or shortness of breath within a few hours before that?

MR. MISHKIND: Objection.

A If you're talking typically or classically, again I could agree with that. But I don't feel everything is typical or classical, that's what we're trained to understand.

Q (By Mr. Rispo) If my hypothesis is correct, Doctor, and if he did have two M.I.s, one of which was remote and the other followed the EKG study, that is late that afternoon about 5:45 in Dr. Lalli's

office, then that second M.I. would be hard to predict, wouldn't it?

A What do you mean, hard to predict?

Q You wouldn't be able to anticipate the timing or the occurrence of a second M.I., would you?

A It would be very difficult.

Q Doctor, is there such a thing as a sudden massive M.I.?

A Yes.

Q And as a matter of fact, there's a high percentage of those in the general population?

A That's correct.

Q Of those that do have sudden massive infarctions, death usually occurs within an hour?

A Within one to two hours.

Q Is there also a problem of denial that is experienced in the general population?

A Yes.

MR. MISHKIND: Objection.

A Yes.

Q (By Mr. Rispo) Especially among men?

A Yes.

Q And is the incidence of death among men who are in denial, much greater than the general population?

A I could not tell you that.

MR. RISPO: Thank you, Doctor, I have no further questions.

MR. MISHKIND: Doctor, I have a few questions, I want to clear up some things.

REEXMAINATION

BY MR. MISHKIND:

Q We've been talking about classic or typical situations. Let's talk now and bring us back and focus in on John Porach, okay?

A Yes.

Q Let's take a look at the EKG, and let's just review a few basic propositions *so* that the record is clear and unambiguous. That is a half standard EKG, correct?

A Correct.

Q Are the findings in Leads 2, 3 and 4, recognizing that that is a half standard EKG, are those findings consistent with an acute myocardial infarction?

A Yes.

Q When one says "consistent with acute myocardial infarction," what does that mean to you as an internist?

A That means it can reflect acute injury at

this point in time.

Q Now, Doctor, do you know the reason in this case that an EKG was done on John Porach, if in fact he did not complain of any chest discomfort or anything that would have caused someone in Dr. Lalli's office to have ordered the EKG?

MR. RISPO: Objection to the Scott hypothetical, calls for speculation.

Q (By Mr. Mishkind) Doctor, let me rephrase that. Based upon reasonable medical practice, is there any justification for having done an EKG on a patient without checking with the doctor if in fact the patient did not have any complaints referable to a cardiac condition?

A No.

Q Now, if that -- and is it in your opinion within the standard of care for a doctor's office to have performed an EKG on a patient, that does not have any chest pain, without first checking with the physician to determine the need or the necessity for the EKG?

A It is below the standard of care to do that in any office; if an EKG is done it should be done with authorization from the physician?

MS. GANN: At 12:58 we're going off the

record.

(Short recess.)

MS. GANN: The time is 1:00 p.m., we're back on record.

Q (By Mr. Mishkind) Doctor, before we went off the record we talked about the appropriateness of doing the EKG.

Let me ask you if this EKG that we are looking at that you've already indicated is a half standard is consistent with an acute myocardial infarction; it's also consistent, is it not, with a remote myocardial infarction?

A Yes, it is.

Q If you had a patient with this EKG in hand and that patient gave a history of having achiness in the chest arid in the arms, and nothing more, and you had this EKG which is consistent with an acute myocardial infarction, what, if anything, would you have done?

A Hospitalized him.

Q Why?

A Because this would have raised a significant concern, my clinical suspicion index would have become very high, coupling the symptoms with the EKG changes. I would have placed the patient in the

hospital to reduce his risk of a fatal event.

And perhaps I'd have been able to use some medications I alluded to before to reduce discomfort and to dissolve his clot.

Q Doctor, it seems when Mr. Rispo was questioning you, he kept on asking you whether this is typical, whether this is classic findings, and you indicated that his findings aren't typical or not classic.

Under those circumstances, is that then a justification for why John Porach's heart attack was not timely diagnosed in this case?

A No.

Q Why?

A A physician is trained to be aware of, especially with cardiac disease, very atypical presentations. We're all aware that younger populations now can have certainly sustain heart attacks, albeit less than older population, especially younger males. And everything in medicine, in addition to things other than cardiac disease or cardiovascular disease isn't always out of a textbook or classic. We are trained to try to recognize symptoms that may masquerade as other symptoms; diagnoses that may masquerade as other diagnoses. If our index of

suspicion is not high, then we will not be able to evaluate these problems on an emergent basis.

But I believe it is the standard of care for any internist or primary care physician when they hear a patient has chest distress, whether it be pain, aching, heaviness, what have you, to evaluate that patient appropriately in a very timely manner.

Q In a heart attack, you indicated the symptoms can wax and wane.

A Yes.

Q And based upon what you see in John Porach's case, especially in the morning, did his symptoms wax and wane?

A Yes.

Q I want you to assume that the testimony will be that after he had the initial symptoms that he woke up with, that he felt better, that his wife and he talked, he agreed that he was going to call the doctor when the doctor's office opened; that he did call the doctor's office, that he did then convey symptoms. And let's just accept what Jan says in terms of the aching in the chest.

Is that pattern, in terms of the onset of the heart attack and then his symptoms getting better, but yet still having aching in the chest. Is that

inconsistent with an acute myocardial infarction?

A Not at all.

Q Do you need to have the classic pattern of EKG or the classic pattern of pain in order for a doctor to have an index of suspicion that would cause the patient to be seen?

A Not at all.

Q What would happen, Doctor, if you only treated heart attacks that had classic presentations on EKG or classic symptoms?

A We'd miss a lot of patients with significant cardiac problems and miss a lot of patients having heart attacks.

Q Can you give an example in this particular situation as to who was missed?

A In this situation Mr. Porach's less than classic presentation was missed and treated inappropriately.

Q Now, Doctor, Mr. Rispo asked a lot of questions about a medical receptionist. And quite frankly, how can we hold the medical receptionist responsible,.or more importantly how can we hold Dr. Lalli responsible if he didn't have classic symptoms,. when she's not a licensed trained nurse or a doctor?

A I think it's the ultimate responsibility

of Dr. Lalli, who is a licensed trained doctor, to make the decision that was instrumental in this case, or could have been instrumental for appropriate treatment in this case.

Q Did John Porach in your professional opinion, based upon the description of symptoms, did he know he was having a heart attack?

A No.

Q Do patient always know that they're having a heart attack?

A No.

Q Do you feel that it was reasonable for the patient, John Porach, to stay at home waiting to hear back from the doctor's office, based upon the statement made to him by the receptionist that it sounded like it was flu?

A Yes.

Q And what is your opinion?

A My opinion is that it was very reasonable behavior on his part.

Q Do you have an opinion whether or not it was appropriate and reasonable for the receptionist to have told John that it sounded like the flu?

A Yes.

Q What is your opinion?

A I feel that it was not in her ability to make that diagnosis, nor render that opinion.

Q Now the fact that John Porach could have, or his wife could have called the hospital, in the morning or could have gone to the hospital, do you feel that John Porach or his wife somehow are to blame for his death?

A Not at all.

Q Why?

A I feel it is not the responsibility of the patient to make a diagnosis, it's the responsibility of the patient to convey whatever subjective feelings he has at the time. It is the responsibility of the trained physician to make objective opinions, a differential diagnosis and render appropriate care.

Q Now, doctor, Mr. Rispo brought up this very interesting theory about two heart attacks. Do you recall that just a moment ago?

A Yes.

Q Assume for purposes of this question that John Porach had been directed to the emergency room, either in the morning after that first telephone call, or had been directed to the emergency room in the afternoon when he called back with complaints of chest

pain and shortness of breath. And was either in the hospital in the morning or in the hospital in the afternoon.

And let's assume then that he had this second heart attack that Mr. Rispo has opined. Do you have an opinion to a reasonable degree of medical probability as to whether or not John Porach would have survived had he had that second heart attack?

A Yes.

Q And what is your opinion?

A I feel he would have survived because he would have been treated appropriately on an earlier basis.

Q Can you be more specific? Let's assume he has a second heart attack, he's in the hospital; what would have been done?

A Well, if the second heart attack created any kind of electrical disturbances, congestive heart failure, any problems with the patient or with the electrocardiogram at the time, he would have been in a facility that was capable to take care of the matter right away and direct the proper care.

Q And specifically let's assume that he had this heart attack, before he had the heart attack, what kind of equipment would he be hooked up to, what kind

of interventions would be done across the Untied States to treat such a patient?

A He would be placed in a bed in a telemetry unit, which means a monitor of his heart rate and rhythm is done instantaneously.

He would be given oxygen, he would be given intravenous medication to ease his pain. He would be given intravenous medication to protect against lethal arrhythmias, these little electrical disturbances. And then depending on the timing and on the window of opportunity be given intravenous medication to dissolve the clot.

He could have also have been seen by a consulting cardiologist, been taken to the Cath lab, have an angiogram, and perhaps if necessary a subsequent angioplasty.

Q Doctor, that diagram that Mr. Rispo had you looking at in terms of various sections. Are you able to tell what lead those various lines are coming there?

A No, I cannot.

Q Are you able to tell what type of heart attack is related in those leads?

A Absolutely not.

Q Does that provide you with any

information that is reliable in order to correlate or to compare the EKG on John Porach to say whether or not he had an acute or remote heart attack?

A No, it does not.

Q If Dr. Lalli did that EKG that we have in front of you, and Dr. Lalli had knowledge about symptoms that John Porach had during the day of aching in the chest; even if Dr. Lalli knew that John Porach wanted to come in to have an EKG done and he has this EKG done, is it reasonable and appropriate for the doctor to exclude on what he writes on the top, the possibility that this was an acute myocardial infarction?

A Yes, if he had in a timely fashion assessed the history and done a physical exam and taken the EKG and done the appropriate measures he could have been able to include or exclude an acute insult.

Q And again based upon that EKG, with symptomatology that you know from only Jan the receptionist, should this patient have been treated for an acute myocardial infarction?

A Absolutely.

Q And with good and reasonable care and treatment, Doctor, do you have an opinion to a reasonable degree of medical certainty as to whether or

not John Porach would have survived the heart attack that he suffered on October 14, 1994?

A Yes, I have an opinion.

Q And your opinion?

A He would have survived the heart attack.

Q And would be alive today?

A Yes

MR. MISHKIND: No further questions. Thank you.

MR. RISPO: Doctor, just a few more.

REEXAMINATION

BY MR. RISPO:

Q Would you define for us what is meant by the term "diagnostic symptoms"?

A Diagnostic symptoms are symptoms related by a patient to help you render a diagnosis.

Q Would you distinguish between the term "diagnostic" and the definition of the term "consistent"?

A Diagnostic is more fixed and fast. In other words, diagnostic to me would mean this is sine qua non. In medicine we mean that is the answer to give us the diagnosis if something is diagnostic of.

"Consistent" could mean this, or could mean something else.

Q So, in other words symptoms which are diagnostic are symptoms which clearly lead to the correct diagnosis?

A Yes.

Q And symptoms which are merely consistent may or may not lead to the correct diagnosis?

A Correct.

Q Are you fully aware of the fact here that we're talking about a receptionist and that Ms. Jan Schoch is not medically trained?

A I'm aware that she's a receptionist, I'm aware she's not medically trained.

Q Are you asking us to believe that you expect a receptionist to be totally familiar with not only the diagnostic symptoms but also the non-diagnostic symptoms which are atypical, or not classical, sufficient that she would recognize a medical emergency when the patient wasn't even in the same room with her?

A No, I'm not saying that at all. What I am saying is that Dr. Lalli hires an employee it is incumbent upon him to have a standard of care in his office to allow that employee who takes descriptive symptoms on the telephone to dispense with those symptoms properly.

I'm not saying she should make a diagnosis, I'm not saying she should be able to discriminate typical from atypical. What I am saying is it is his ultimate responsibility that she communicate and convey those symptoms that Mr. Porach stated, quickly and appropriately.

Q Doctor, we're in agreement, aren't we, that Dr. Lalli himself did not have the opportunity to make any judgment call on this case?

A He did not have the opportunity, that's correct.

Q He did not physically examine the patient before he had his fatal event?

A That's correct.

Q He did not have a chance to take his history?

A That's correct.

Q If this patient had been conveyed to an emergency room at some earlier time and if he was outside the window of four to six hours, he would not have had the thrombolytic therapy, would he?

A Well, depends on what the window of four to six hours, there's a lot of debate on that. But for purposes of this discussion, if you're using four to six hours as a window, then I would say he would be

outside the window of opportunity.

Q You earlier testified that you would defer to Drs, Botti and Effron on that issue, wouldn't you?

A That's correct.

Q And that the window is four to six hours?

A Well, again I think that's a window that could be disputed by different authorities. I don't consider myself an authority, I just consider myself well versed on what the authorities write.

Q Dr. Botti is the cardiologist?

A That's correct.

Q Dr. Effron, David Effron is an emergency room specialist?

A Correct.

Q You know they've previously testified that the window is four to six hours?

A I didn't recall that, but if they did, I'll take that as correct.

Q Okay. So that if the patient didn't arrive in the emergency room until after 12:00 noon, under their interpretations of the therapeutic window he would not have had thrombolytic therapy?

MR. MISHKIND: Let me just object, it's outside the scope of my redirect. But go ahead.

A Yes.

Q (By Mr. Rispo) Even if he were treated traditionally in the more classical fashion, he still could have had complications?

MR. MISHKIND: Objection to the "could still," and it's also outside the scope of my redirect examination. Go ahead.

A Can you ask the question again, please?

Q (By Mr. Rispo) He could still have had the complications of a myocardial infarct in the emergency room.

MR. MISHKIND: Objection, again to "could."

A Yes.

Q (By Mr. Rispo) And those complications would include pulmonary edema?

MR. MISHKIND: Show a continuing line of objection. But go ahead.

A Yes.

Q (By Mr. Rispo) Congenital heart failure; congestive heart failure, excuse me.

A Correct.

Q Correct?

Q Cardiogenetic shock?

A Correct.

Q Multiple system failure?

A Correct.

Q Renal failure?

A Correct.

Q Each one of those could have been fatal?

A Correct.

MR. RISPO: Thank you, doctor, I have no further questions.

MR. MISHKIND: I just have a couple questions.

REEXAMINATION

BY MR. MISHKIND:

Q Mr. Rispo has said though you "could." Do you have an opinion to a reasonable degree of medical probability as to whether it's likely that John Porach would have suffered any of those complications had he been timely and appropriately treated in this case?

A Yes, I have an opinion.

Q And your opinion?

A I feel it would have been very unlikely that he would have suffered these complications.

Q Mr. Rispo said to you that Dr. Lalli didn't have an opportunity to take a history, didn't have an opportunity to examine.

Do you have an opinion as to first why he didn't have an opportunity to take a history and to examine?

A Yes,

Q What's your opinion?

A The symptoms were not communicated to him.

Q And why were they not communicated to him?

A I can't tell you that; I'm still baffled as to why those symptoms weren't communicated from the receptionist to Dr. Lalli immediately.

Q Does that excuse Dr. Lalli, in your professional opinion, from the fact that his patient who called and wanted to be seen by him, called twice, responded to the receptionist when she told him to drive into the office, winds up dying in his office?

A No, that doesn't excuse him at all.

MR. MISHKIND: I have no further questions,

MR. RISPO: Doctor, one question.

REEXAMINATION

BY MR. RISPO:

Q Isn't it a fact that the reason that the symptoms were not reported to Dr. Lalli is because

symptoms were not diagnostic of myocardial infarction?

A No, I feel the symptoms were not reported because there was no standard of protocol, whether it be verbal or otherwise that was inacted in Dr. Lalli's office. For that reason there was a gap in communication, and things weren't told to the doctor when they should have been.

Q You also agree, however, the symptoms were not diagnostic?

MR. MISHKIND: Objection. o/a

A That's correct.

MR. RISPO: Thank you.

MR. MISHKIND: Nothing further.

MS. GANN: The time is 1:18 p.m. and this is the end of the video tape.

MR. **MISHKIND**: Doctor, will you agree to waive the requirement of reading and signing the deposition?

THE WITNESS: Yes.

MR. MISHKIND: And will you waive the requirement of viewing the video tape?

THE WITNESS: Yes.

MR. MISHKIND: Mr. Rispo, will *you* agree to waive the requirement of reading and signing and viewing as well?

MR. RISPO: Yes, of course.

MR. MISHXIND: I think we've covered all other stipulations in terms of filing.

MR. RISPO: Yes.

** ** **

STATE OF ARIZONA)
) ss.
COUNTY OF PIMA)

BE IT KNOWN that I, Leber Schlesinger, took the foregoing deposition pursuant to notice at the time and place stated in the caption hereto; that I was then and there a Notary Public in and for the County of Pima, State of Arizona; that by virtue thereof, I was authorized to administer an oath; that the witness, JEFFREY SELWYN, M.D., before testifying was duly sworn to testify the truth, the whole truth and nothing but the truth; that the testimony of said witness was reduced to writing under my direction and the foregoing 132 pages contain a full, true and correct transcription of my notes of said deposition.

I FURTHER CERTIFY that I am not of counsel nor attorney for either or any of the parties to said action or otherwise interested in the event thereof, and that I am not related to either or any of the parties to said cause.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my seal of office this 26th day of March, 1998.

Leber Schlesinger
Notary Public

OFFICIAL SEAL
LEBER SCHLESINGER
NOTARY PUBLIC - ARIZONA
PIMA COUNTY
My Comm. Expires Nov. 27, 2000

My commission expires:
November 27, 2000