IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

Doc. 446

RHODA SCHARFENBERG, Etc.,

Plaintiff,

-vs-

JUDGE COYNE
CASE NO. 338351

ST. LUKE'S MEDICAL CENTER, et al.,

Defendants.

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Deposition of RICHARD W. WATTS, M.D., taken as if upon cross-examination before Dawn M. Fade, a Registered Merit Reporter and Notary Public within and for the State of Ohio, at the offices of Reminger & Reminger, 7th Floor 113 St. Clair Building, Cleveland, Ohio, at 2:15 p.m. on Friday, May 1, 1998, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

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On behalf of the Defendant
St. Luke's Medical Center.

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

CROSS-EXAMINATION OF RICHARD W. WATTS, M.D.

BY MS. EKLUND:

Q. Dr. Watts, I'm going to ask you some questions. I know you have been deposed before so you're familiar with the procedure, correct?

A. Correct.

Q. Then we won't go through all of the ground rules. I assume you know them.

A. I do.

Q. Would you state your name for the record, please.

A. Richard Ward Watts, M.D.

Q. What is your business address?

A. 3885 Rocky River Drive, Cleveland, Ohio 44111.

Q. And how long have you been at that location?

A. At that location since 1960.

Q. Are you in partnership with any other physicians?

A. *Yes,* we have a corporation of six

cardiologists.
Q. Okay. You would be under the West Side Cardiology Associates, Inc.?
A. Yes.
Q. Are you an incorporator?
A. Yes.
Q. What is your residence address?
A. 12 Ashley, A-s-h-1-e-y, Court, Rocky River 44116.
Q. Doctor, I have been provided with a curriculum vitae, which is about three pages long. I will just ask you to take a look at that and tell me if that's up-to-date?
A. Oh, that's out of date. I have a 1998 one. That's 1995.

MR. SPISAK: Here, I can make some copies.

Q. Doctor, would that 1998 vitae include publications that you have authored?
A. It does.

MS. EKLUND: Do you want to make copies?

MR. SPISAK: Sure.

Q. Doctor, your medical specialty is cardiology?
A. It is.

Q You are a board certified cardiologist?
A I am.
Q How long have you been board certified?
A. Since 1959.
Q Is there any recertification in that area of specialty that you took or are required to take?
A No. There neither are we it nor do they require it.
Q And you are actively have privileges at Fairview General Hospital?
A I do.
Q At Lutheran Hospital?
A Yes.
Q And St Mary's?
A Yes.
Q And do you primarily practice at Fairview Hospital?
A I do.
Q Is that where you admit most of your patients?
A Yes.
Q And I recall from your CV that you have a, I think it's called the Kemper Cardiac Care Unit?
A That's correct
Q And did you actually establish that unit?

I did.

When was that?

A. 1964.

Q. Have you been a director of that unit since 1964?

A. Yes.

Q. Are you still presently the director of that unit?

A. I am.

Q. By director of that unit, that means you supervise that department?

A. Well, maybe I should explain. I would view myself as the administrative director. In other words, I don't, I'm not supervising the medical care being rendered, I'm supervising the administrative functions, supervising the standing orders and adjudicating any problems that arise in nursing and other staff people and interfacing with the administration of the hospital.

Q. Okay.

A. So the patients there are under the care of their own cardiologist.

Q. How many days a week do you see patients at your office?

A. Five.
Q. How much or how many hours per week do you make rounds at a hospital?
A. Probably somewhere between 20 and 25.
Q. You do not perform surgery, correct?
A. Correct.
Q. You treat cardiovascular diseases?
A. Yes.
Q. And you also have a practice in internal medicine?
A. Yes.
Q. And that's a smaller percentage of your, than your cardiology practice?
A. Yes. These are patients whose primary problem is cardiological but have associated internal medicine problems and I feel I can be helpful to them rather than sending patients to three or four different specialists.
Q. What is your date of birth, doctor?
A. August 8th, '21.
Q. And where were you born?
A. Lakewood, Ohio.
Q. Have you in the last year reduced the number of hours or number of patients that you see per week?

A No.

Q And you're a full time practicing physician?

A I am.

Q Do you have any other business ventures in conjunction with the cardiology associates?

A Not in conjunction with them. I'm the managing partner of our medical building

Q Is that the only other business interest you have?

A Yes. I think that's safe to say

Q You list on your CV that you are assistant clinical professor of medicine at Case Western Reserve University

A Yes.

Q What is required of you in terms of that appointment?

A I am engaged in the teaching of the 4th year medical students who elect our cardiology option to come to Fairview Hospital for one month in the cardiac unit

I also, for many years, have been teaching 4th year medical students internal medicine and cardiology, internal medicine residents and cardiology fellows at MetroHealth Medical Center

I haven't been as busy in that in the last two years since there has been a change of leadership within the cardiology program at Metro, but before that I was over there three months a year for half a day at a time.

Q. Do you do any teaching in emergency room medicine?

A. No.

Q. Do you do any practice in the emergency room setting?

A. The only practice would be to see a patient of mine who comes to the emergency department or, for instance, today I'm on call for patients who come with chest pain who do not have a physician who's on our staff. I would see a patient under that circumstance. But that would be the limit of my emergency room based activities.

Q. Was there a time in your practice where you had actual emergency room training or experience?

A. No.

Q. Do you do any training of the emergency room personnel at Fairview Hospital?

A. No.

Q. Any at Lutheran or Metro?

A. No.

Q Have you ever?
A No.
Q There is a residency program for emergency medicine, right?
A Not at Fairview. There is in the country, yes, but not at Fairview.
Q. Okay. You have never had emergency room residents rotate through any program that you were involved in teaching, correct?
A Correct.
Q In your position as director of the Kemper coronary unit at Fairview, do you establish any protocol for the evaluation of chest pain in the emergency room setting?
A No
Q Do you establish written protocol for the evaluation of chest pain in the coronary care unit?
A. Yes
Q. And who are patients referred to the coronary care unit if they're in the hospital?
A Well, mainly through the emergency department We just reviewed the statistics for the last three months of 1 97 and something like 85 percent of our patients in the cardiac unit came

from the emergency department.
Q. Would that be a direct admission from the ER department directly into the CCU unit?
A. Yes.
Q. Are you familiar with the protocol for the emergency room department to make a referral of a chest pain patient to the CCU unit at Fairview?
A. Yes. I think I know it in its general terms. As I say, I didn't write the protocol. I think it was evolved mainly from the emergency department physicians, but I was involved with some discussions we had with them.
Q. Can you tell me what those guidelines would be?
A. Well, the guideline as I recall it in generalities would be that a person who winds up with a diagnosis of unstable angina -- obviously this is different from the person who winds up with the diagnosis of myocardial infarction, which a different protocol is called upon, but a person who winds up with a diagnosis of unstable angina would be admitted to a monitored area, not necessarily the cardiac unit, and would receive the treatment that would be appropriate for an unstable angina patient and the

laboratory testing that would also be appropriate for that patient.

Q. Can you tell me what unstable angina is?

A. This is a condition in which chest discomfort is generated by impaired circulation to a portion of the heart muscle but not to the severity that we can detect any objective evidence for actual myocardial infarction. But, nevertheless, the basis for the symptom complex is that of an impairment in the coronary circulation.

Q. And the symptom with which the patient presents is one of chest pain?

A. Usually, yes.

Q. Would you agree that angina is the most important symptom of coronary artery disease?

Well, for purposes of this discussion I could agree with it. I might think sudden death would be a more important symptom.

I suppose. Short of sudden death.

Are you familiar with the standards for evaluation of chest pain in the emergency room setting?

I think I'm familiar with it because I spent a lot of time going down to see patients there.

Do you consider yourself an expert in the area

of the standard of care for an emergency room physician in evaluating chest pain?

A. No.

Q. Doctor, have you written any articles specifically on, I guess, the evaluation of chest pain and treatment? Maybe I should just use the first part because the last may be too broad and I will just withdraw that question.

Do any of the 15 articles which appear with your CV deal with the evaluation of chest pain?

A. No, not specifically.

Q. Doctor, do you agree that coronary artery disease has undergone significant changes in the last ten years?

A. Yes, indeed.

Q. Okay. Very dramatic changes?

A. Absolutely.

Q. And these changes have resulted in saving the lives of many people?

A. Yes, indeed.

Q. And part of this change is the result of thrombolytic therapy?

A. Yes.

Q. Bypass surgery?

A. Yes.

Q. Angioplasty?
A. Right.
Q. More sophisticated testing procedures, things like that?
A. Yes.
Q. Doctor, you have been reviewing medical/legal cases for some period of time, correct?
A. Correct.
Q. At least the last 20 years?
A. Just about 20 years, yes.
Q. Is it fair to say that most of the cases you review are on behalf of physicians or hospitals?
A. It is.
Q. Can you tell me how many cases you have agreed to review on behalf of a patient?
A. How many? I don't know. It's more now than it used to be. I would think that this year it would be nearly half from the plaintiff's standpoint.
Q. In previous years what has it been?
A. Well, for many years it was all defense and in more recent years we had more cases referred to me by plaintiffs' attorneys partly because my daughter is in the medical illustration business and does a lot of work for plaintiffs'

attorneys.
Q. What is your daughter's name?
A. Shelley Coy.
Q. And she has her own business?
A. Yes.
Q. What is the name of her business?
A. Med Art and Legal Graphics
Q. Is it here in Cleveland?
A. Yes.
Q. So you work together sometimes?
A. Oh, yes.
Q. Have you ever testified in a case that an emergency room doctor improperly discharged a patient with chest pain?
A. Improperly discharged?
Q. Yes.
A. In other words, I would be testifying from the plaintiff's side?
Q. Correct.
A. No.
Q. Have you ever reviewed a case on behalf of the defendant where the issue was whether or not the doctor improperly discharged the patient from the emergency room with chest pain?
A. Yes.

Q. Did you ever find an instance where there was a failure to comply with the standard of care?

A. I'm not sure of the question now. That I, my opinion, therefore, would be on the plaintiff's side in that question?

Q. Well, I guess does it matter which side of the case you're being asked to review a matter for?

A. Well, it doesn't matter except that if I were to say yes to that then, if my opinion -- maybe I'm making too much out of the question.

Let me phrase the question, now that I think about it, in a way that I would understand it, then you can correct me. Is the question have I ever reviewed a case in which the patient was improperly discharged from the emergency department when they presented with a symptom of chest pain or something that would indicate that it was due to coronary disease?

2. Yes.

4. Yes, I have. And it comes, obviously comes into two components, one would be the source of the referral, whether it would be a defense or a plaintiff case. I have turned down cases from the defense side where I felt that the patient had not been correctly served in being

discharged from the emergency department and I have advised the defense counsel that I was unable to serve as an expert on that case.

I have also reviewed cases for plaintiffs' attorneys in which I felt that even though the patient was not admitted to the hospital, at least in retrospect it would have been more appropriate to admit to the hospital, that, nevertheless, I didn't feel that the case had enough merit for the plaintiff's attorney to pursue it.

Q. So you have turned down cases on both sides of the table?

A. Yes. Yes.

Q. Have you ever testified as an expert in either, either in deposition or actually in a courtroom, on the subject of discharge from the emergency room with chest pain?

A. Oh, yes.

Q. Can you tell me how many times?

A. Quite a few. That's one of the more common kinds of cases that I review for attorneys.

Q. No, I mean to distinguish between reviewing and actually testifying as we sit here in deposition before trial. Not every case I assume comes to

deposition or courtroom testimony?
A. Right. Right.
Q. So I'm trying to get down to a smaller number, if we can.
A. Uh-huh. So these are -- maybe you should restate the question so I'm sure we're both in agreement about what I'm answering.
Q. Okay. I'm interested in knowing how many times approximately you have testified at deposition or in trial in a case involving emergency room discharge of a patient with chest pain regardless of which side of the table you were on?
A. Uh-huh. It must be several times a year for the last seven or eight years anyway.
Q. Can you tell me when the last time was that you testified in that type of a case?
A. Could have been the case you and I had out in Western Ohio. That was, what, six months ago or something like that.
Q. And what was the name of the case?
MR. SPISAK: I'm drawing a blank on it. I have a vague recollection of it.
A. Yes, I can tell you the story but I can't remember the name of the case. It was a common

name.
Q. Do you keep a list somewhere of cases in which you have been involved?
A. I do. At home.
Q. I would ask that you provide that to Mr. Spisak and we won't have to go through all that.

MR. SPISAK: What, the whole list?

MS. EKLUND: The whole list.

MR. SPISAK: I'm going to object to that, but it's noted, your request is noted,

MS. EKLUND: Okay. Well, what would you provide? I mean, I need to know so I don't ask the questions if it's going to be given to me in the list and if you're objecting --

MR. SPISAK: Well, I don't know that you have a right to a list of whatever the question was, the cases in their entirety, and that's all I'm saying at this point. I don't know what I wouldn't think *you* would be entitled to. It depends on what you ask for, I guess.

MS. EKLUND: All right. I'm going

to want to identify cases that he has testified in as an expert in emergency room cases.

MR. SPISAK: Okay.

A. Well, the list is all the cases I reviewed, so there wouldn't be any way of designating that this is a case that bears upon your question that you have just asked. It lists all of them. I don't want to raise false hopes, because it's all in my handwriting, some people find it difficult to read, even I find it difficult to read at times, so it would be a, really sort of a mumbo-jumbo of information, so I'm not sure how helpful it would be to you.

Q. Okay. I will still ask you to produce that.

MR. SPISAK: Okay. I'll just note my objection.

MS. EKLUND: Okay.

MR. SPISAK: You produce it to me and we will go from there.

Q. Doctor, in Cuyahoga County can you tell me when was the last time you testified in an emergency room case?

A. This is in court?

Q. For a deposition.

A. Oh. Well, the deposition would be the one that Mr. Spisak and I had in common.
Q. Other than that case?
A. Offhand, I can't think of any. Maybe I could make a statement here that is going to assume what your next question was going to be or what your next question could have been. The last two trials I testified in were not in Cuyahoga County. The last trial I testified in was in Mahoning County, but that wouldn't bear on this question, but the next to the last case I testified in court was in Lorain County and that was exactly this question of a patient presenting to the emergency department and being discharged and then dying several days later.
Q. Do you recall the name of that case or either party, plaintiff or defendant?
A. Well, it would, the attorney was Beverly Harris and the defendant physician was Morganstern and I don't recall the name of the plaintiff.
Q. Did you testify on behalf of the defendant in that case?
A. Yeah, I did.
Q. How many cases per year do you review?
A. Last year it was 27, so far this year it's 12 or

something like that. Somewhere around that number.

Q. Do you average 27 per year?

A. No. Last year was the biggest year I have ever had.

Q. 27 was the biggest year?

A. Yes.

Q. What's more typical for your average?

A. Before that it was running around 12 to 18.

Q. That would be for the last 20 years?

A. Pretty much. Well, in the first half of the 20 years it wasn't that many, maybe half a dozen or so.

Q. You have testified at Mr. Spisak's request before?

A. Yes.

Q. You have worked with other members of his firm before?

A. I have.

Q. Do you know who you have worked for here?

A. Marc Groedel, Steve Walters, John Malone. What's Reed's first name?

MR. SPISAK: Christine.

A. Christine Reed, I have a case with her now. And I got a phone call several days ago from a

Reminger & Reminger attorney whose name slips my mind because 1 have never talked to that person before.

Q. John Scott?

A. Oh, John Scott. John Scott and I have had a number of cases.

Q. You have also worked with some of the Jacobson, Maynard attorneys?

A. Yes, a few times, but not as many as Reminger & Reminger.

Q. Do you do most of your consulting work with Reminger & Reminger?

A. Yes.

Q. What percentage of your income do you attribute to your consulting with them?

A. Less than ten percent, maybe around five or six percent.

Q. Who carries your professional liability insurance?

A. CNA.

Q. Do you recall how you were contacted in Mr. Scharfenberg's case?

A. Mr. Spisak called me up and told me the story on the phone and asked me if I would take a look at it and I said I would.

Q. Do you recall what he told you on the phone?
A. Pretty much the bear bones of what we all know to be the case, the patient presented with chest discomfort over a 12 hour period, had nonspecific electrocardiographic abnormalities, was evaluated and was then discharged home and about 30 some hours later went to see his doctor at the Curtis Clinic but while waiting in the waiting room he collapsed and could not be resuscitated.
Q. Did Mr. Spisak send you records?
A. Yes.
Q. What did he send you? Is that your file?
A. That's my file.
Q. Can I see it?
MR. SPISAK: Let me see what you have there and make sure.
Q. Doctor, your file would reflect and your report indicates that you reviewed the St. Luke's emergency room Solon records, the Curtis Clinic records, and the Meridia Hillcrest Hospital records, correct?
A. Yes.
Q. Have you been provided with depositions?
A. No.

Q The report which is dated March 15th, 1994, did you write that report?
A I did.
Q Did you prepare any drafts of that report?
A No.
Q Is this the only report that you have prepared?
A Well, the other one you have there is another report on the same case.
Q I understand. But March 15th, you obviously --
A Oh no, I didn't write that more than once. That's the original letter.
Q I'm just curious, it seems like page 2 is both on a separate sheet and on the back of the first sheet?
A I usually saw it on the back of the first sheet. I must have run off an extra copy and put it on that. I think it says exactly the same thing.
Q Did you have any discussions with Mr. Sapisak before you prepared this report about your opinions?
A Of course.
Q What did you discuss?
A Well, after I reviewed the case, as I do with every attorney, I call the attorney up and then

we have a conference on the merits of the case and my opinions and then I write the report.

Q. Doctor, what do you charge for your medical/legal work?

A. $300 per hour to review.

Q. Do you charge separately for a report?

A. No.

Q. What do you charge for a deposition?

A. $400 per hour.

Q. What do you charge for trial testimony?

A. $500 per hour.

Q. Is there a minimum for trial testimony?

A. No, I never established a minimum.

Q. Might be a good idea.

A. Thank you for that advice.

Q. Do you know any of the parties or physicians involved in the Scharfenberg case?

A. No.

Q. Do you know any of the doctors at St. Luke's emergency room?

A. I used to know a physician who rotated through the cardiac unit a long time ago at Fairview by the name of Ali Ahoddod who worked out there at one time. I haven't seen nor heard of him in a long time now, but he was the only one I have

ever known who worked there.
Q. Did you know any of the physicians in the Emergency Associates, Inc. -- I've probably got the words wrong -- it's the emergency group that staffs St. Luke's ER facility in Solon?
A. No.
Q. The only person who approached you about reviewing this case was Mr. Spisak?
A. It was.
Q. Did you have any discussions with any of the physicians involved in Mr. Scharfenberg's case?
A. No.
Q. Did you consult any literature in reaching your opinions in the Scharfenberg case?
A. The only literature that I consulted was in my second letter which bore on the question of life expectancy.
Q. And what did you consult?
A. It's given in the letter, but it's a letter from Circulation Volume 25 Page 1000. I forwarded it so many times I remember those numbers. Anyway, it has to do with the life expectancy of a patient with coronary artery disease based on the Cass study.
MR. SPISAK: Doctor, do you need to

get that?

THE WITNESS: Yes.

MR. SPISAK: Go off the record

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(Off the record.)

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Q. Okay?

A. Yes.

Q. Doctor, have you ever been sued in a medical malpractice case?

A. Yes.

Q. How many times?

A. Five.

Q. Are any of those cases pending?

A. Yes. One.

Q. In Cuyahoga County, I assume?

A. Yes.

Q. And what is the nature of the case that's pending?

A. The patient was a patient of my associate who saw the patient and recognized that he might have a deep'vein thrombosis in his leg, referred the patient for venous duplex scan, which was done the following day, which was my associate's day off, so I was notified that the venous

duplex scan did indeed show a deep vein thrombosis, so I admitted the patient to the hospital and started my favorite way of treating deep vein thrombosis, which is with streptokinase, and we followed the protocol that was in the PDR at that time. This is five years or so ago.

I knew the patient from a previous encounter. He had severe chronic obstructive pulmonary disease and severe coronary artery disease, so I certainly felt we needed to be very aggressive to treat this deep vein thrombosis, because if he had a pulmonary embolus it would almost certainly be fatal as opposed to a person who did not have the chronic lung or heart disease

In any event, about five days later, he had received streptokinase and then heparin, the laboratory values were always within the therapeutic range, however, he suffered a cerebral hemorrhage and eventually died.

The allegation of the family is that the patient had fallen out of bed at some time during the hospital course and that the hospital had covered that up. If that be true, they

covered it up very effectively because none of us ever knew a thing about that.

In any event, I was not named in the initial suit since my only contact was within that one day. My associate, of course, took over on the second hospital day. The suit was withdrawn without prejudice and then refiled. When the suit was refiled, which was last November, I was included in the list of defendants.

Q. What about the other four cases, those have all resolved?

A. Yes.

Q. Can you tell me what those were about?

A. The first one was 35 years ago when I was doing right heart catheterizations, and this was a 20 year old mentally retarded boy with congenital heart disease, who incidentally -- I may be giving you more detail than you care to know, so I won't be offended if you say you want to move on to the next one.

During the, in those years we used a pressure injector to inject dye to flood the right side of the heart to visualize the internal structures and in those years the

company that made the catheters that we used shipped the catheter with a wire inside the catheter with an L shaped end so that the L shaped end stuck out of the catheter, that's where you pulled it out of the catheter and then you used it. However, that was broken off and so we could not see the wire, the wire was completely within the catheter, so we, when we used this high pressure injector it was like an arrow being shot into the heart. We did not recognize that at the time, nor did the x-ray department recognize it on subsequent chest x-rays when the patient continued to deteriorate.

At that time I headed up the cardiology fellowship training program. One cardiac fellow had taken a look at one of the films, he said to the radiologist, what is this wire. The radiologist said, you people put wires all over the place. We don't know. We just figured it was one of your electrodes or something. And he said no, we don't have any wires on this man. And that was when we found out he had a wire inside the chest. By that time he had deteriorated and died.

Q. I really don't mean to be rude, but I understand the gist of it.
A. That's quite all right. Okay. Case number two.
Q. Just tell me what the claim was, heart attack or stroke or whatever then --
A. Okay.
Q. Wrongful death.
A. Okay. I have got them in order now. Case number two was a patient of mine who came in with a severe stroke, developed an osteomyelitis, I'm sorry, developed a septic joint, left hip joint, which is extremely painful. I gave him a nonsteroidal antiinflammatory compound. He developed a bleeding peptic ulcer which had to be treated by an emergency gastric resection. He's still alive today and still aphasiac, which is how he came into the hospital. That was settled out of court obviously.

Case number three was the mother of a physician friend of mine who was severely demented in a nursing home for a number of years, in her late 80s, developed a severe infection, the nursing home personnel finally prevailed on the doctor's son to take her to the

hospital so he favored me with being his mother's physician. She had a respiratory arrest several days after admission, from which she was resuscitated and she spent the next 13 months in the hospital and he alleged something about, I forgot now, something about the care she received in the hospital, not the medical care. And anyway the, he also was a JD as well as an M.D. His first appearance in court he was told he should have an attorney. He came back to court with an attorney, whom he eventually fired, hired another attorney, came back to court, our attorneys filed for summary judgment which was granted.

Q. Last case?

MR. MOSCARINO: Off the record.

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

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A. What was number four? Oh, I shouldn't have forgotten that one. That was a man who was my barber, as a matter of fact, and he was admitted by another physician to the hospital because -- that's where I got osteomyelitis -- he had

severe diabetes, he had an osteomyelitis of his femur, which the orthopedist was very concerned would ultimately invade the hip joint, which would mean amputation. He also was in fairly severe heart failure. I saw him the night of the day he was to go to surgery, which was then canceled at the last minute by the hospital personnel when they recognized that he was too unstable for the surgery, which was to drain the osteomyelitis in the femur, So I spent a week getting his heart tuned up. With the induction of the anesthesia a week later he went into cardiac arrest and could not be resuscitated. Fortunately, I convinced his wife, now widow, to have an autopsy. The autopsy showed that he was not in congestive failure, that his heart condition was as good as it could get, the case went to trial and the jury found in my favor.

Q. What year was that case?

A. 19, early '80s. '81, '82, somewhere around that time.

Q. In any of these cases were you represented by anyone at Reminger & Reminger?

A. No.

Q. Doctor, when was the last time that you

Diagnosed = myocardial infarct or impending myocardial infarct in the emergency room?

A How about last night -- no, in the office about 6:00 last night

Q How about in the emergency room?

A Oh We're taking unstable angina as being part of this?

Q Yes

A Okay That would be Medical of this week

Q Was that a patient of yours who went to the emergency room and you were called in?

A A patient of my associate who is out of the country at the moment

Q Am I correct that unstable angina leads to or can lead to myocardial infarct?

A Yes.

Q If properly treated or successfully treated you can avoid a myocardial infarct?

A Yes

Q Doc or, I see that you are a member of the American College of Cardiology?

A Yes.

Q And actually you're a fellow in that association?

A I am.

Q. What does it mean to be a fellow in that group?
A. It means you have your boards in cardiology.
Q. So you have to be board certified?
A. Yes.
Q. And also the American Heart Association, you're a fellow of the Council on Clinical Cardiology?'
A. Right.
Q. Does that mean that you're board certified also for that group's purpose?
A. No. That, I don't think board certification is a requirement there. It's a designation, self-designation that you want to be a fellow of that particular council. There are a number of councils, cardiovascular, pediatric, so on.
Q. What does it mean to be a fellow?
A. It puts you on the mailing list for the publications that are developed by that particular council and the programs that that particular council puts on.
Q. You have also taught the advanced cardiac life support course?
A. I have.
Q. Do you still teach that?
A. Yes.
Q. When did you last teach it?

I think it was in March. We teach, the hospital teaches it every month. I teach as often as I can, because I think it's important to see people besides nurses.

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(Telephone interruption.)

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Q. Okay. Doctor, I think I was asking you about the last time you taught the advanced cardiac life support course.

A. Yes.

Q. And when was that?

A. 3/3, March 3rd of this year.

Q. And where did you teach?

A. It's sponsored by Fairview General Hospital, we teach it at the Wellness Center.

Q. And to whom do you teach that?

A. Usually the major portion of the student body, which runs about 25, are the nurses, but we also have surgical residents and medical residents and a few of the attending staff, mainly internal medicine, and I also teach it to the incoming residents both in family practice and internal medicine every June.

Q. And that course includes a section on the

guidelines for the management of patients with possible myocardial infarct, correct?
A. It does.
Q. You have a whole section on that?
A. Yes.
Q. Do you teach those guidelines to the students in your class?
A. Yes.
Q. And these people are, you teach them and then do you certify them by testing their knowledge?
A. We do.
Q. And it's a pass fail basis?
A. It is.
Q. Would those guidelines also include recognition of coronary artery disease or unstable angina in the emergency room setting?
A. Well, the, I guess the answer is yes, but let me say a little more about advanced cardiac life support. It's really a community based project and not a hospital based project. In other words, it was developed predominantly for the paramedics; so the main features are recognition of cardiac symptoms before an actual cardiac catastrophe and being able to respond to them in terms of medication. So it's a little bit

different focus than what the emergency department would have.

Q. Do you accept those guidelines as the standard of care in evaluating chest pain?

A. Well, I think they're very useful, yes. I'm sure we all know that people vary enough so that any guideline is a guideline, it's not an iron clad mandate. That's one of the problems of medicine or maybe one of its good features, that there's no two people who are exactly alike so any guidelines can only be considered a guideline and not an iron clad approach.

Q. And standard of care is also in general, has a general application?

A. Yes.

Q. And the American College of Cardiology in November of 1996 published guidelines for the management of patients with acute myocardial infarct, correct?

A. They did indeed.

Q. And those guidelines are incorporated in the ACLS course?

A. Yes. Not all of them. That document you're referring to, though, is a hundred three pages in length and obviously we're not trying to

teach the entire content of that in a one-day course, no matter how bright the students are. So, as I said before, the ACLS is really a mainly out of hospital kind of information.

Q. And the guidelines of the American College of Cardiology, are they used in your hospital?

A. Oh, yes.

Q. And does the emergency room at your hospital consult with you in terms of the guidelines for recognition and treatment of chest pain?

A. No, not on a formal basis. Some years ago we had some meetings in which this was discussed before the American College of Cardiology publication that you referred to.

Q. Now, Mr. Scharfenberg, from your review of his records, had a number of factors which made him at high risk for myocardial disease, correct?

A. Yes.

Q. Can you list for me some of those factors?

A. Well, he had diabetes, he had hypertension. Let me look at my notes to make sure I cover all the things. He was 59, he had chest discomfort. I think those are the main features.

Q. What was his weight?

A. I don't have a note to that. I'm not sure that

I -- I'm not sure that the information I have has that on it.

Q. Whether or not he is obese would be a risk factor in --

A. Well, not as much as you might think. It actually works through hypertension, diabetes, and high cholesterol and things like that, so it's been the opinion of some people that obesity in and of itself without any of those other factors is not really a risk factor.

Q. If Mr. Scharfenberg was obese in addition to having diabetes and hypertension and being 59 years of age, he is at high risk for coronary artery disease, is that correct?

A. I think that's fair enough to say. I don't have a weight. The only thing I have is the St. Luke's Medical Center record and I don't see that they have height or weight and that's probably not done on an emergency room basis.

Q. Listed or not listed?

A. I did not see it.

Q. Okay. I'm sorry. Is it usually listed or not listed?

A. No, it's usually not listed.

Q. Doctor, what is ischemic chest pain?

A. Ischemic chest pain is -- actually we should probably, my patients correct me if I say pain, they say no, it's a pressure. It's a pressure that's in the middle of the chest.
Q. Can it be a symptom of unstable angina?
A. Yes, indeed.
Q. Is it identical with unstable angina?
A. Well, that same kind of pain, of course, can come from other causes, such as esophageal spasm, for instance.
Q. Would you agree that indigestion type chest pain described as dull and which has been present for 13 hours would be classified as unstable angina?
A. Well, it could be, but obviously it's not guaranteed to be of cardiac origin.
Q. But it certainly could be?
A. It's not inconsistent with it I think would be a better way to say it.
Q. And those symptoms in a patient who has high risk factors for coronary artery disease there is even a higher correlation, would you agree?
A. Yes, I think that's fair enough.
Q. Do you agree that the job of the emergency room physician is to rule out myocardial infarct or unstable angina when a patient presents with

chest pain?

A. I do.

Q. Do you agree that if a patient comes to the emergency room with chest pain and is improperly discharged there is a high likelihood *of* death?

A. No. I wouldn't -- I think I might -- my problem with your question is high. I would say -- well, what would I say. There is a possibility of death. I'm not sure about high likelihood. Fortunately many people who have actually gone that route have not died even though it turned out they were having a myocardial infarct.

Q. Is it true that the vast majority of people who have a myocardial infarct but arrive at a hospital alive can be saved?

A. Yes.

MR. SPISAK: I'm sorry, please read that back to me.

- - - -

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

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MR. SPISAK: Thank you.

A. Yes. The mortality rate for acute myocardial infarction for people in the hospital is

somewhere around seven to ten percent

Q Meaning?

A 90 --

Q 90 to 93 percent survive?

A Right.

Q And the treatment modality for a person having a myocardial infarct, if taken to a hospital setting, would be bypass surgery -- what do you do when they're actually having an infarct?

A Well, ideally what we do is to recognize it promptly and if the patient has arrived within six hours of the onset of the discomfort, then they receive an agent to dissolve the blood clot that is obstructing the coronary circulation and that clot dissolves and that helps to save some of the heart muscle that otherwise would be damaged to one extent or another and then the patient has an uneventful course from that point on. That's what we hope to achieve

Q So with prompt and early treatment you can avoid completely a myocardial infarct or at least reduce the damage that one might cause?

A Yes.

Q Do you agree that the earlier the treatment, the better the result?

Absolutely.
Do you agree that chest pain that lasts for hours versus chest pain that lasts for days is more typical of a myocardial infarct?
I guess in general that's true. There is enough exception to that that I can think of that I would say it's not uniformly true.
Okay. Do you agree that patients who have ST or T-wave abnormalities on EKG with associated chest pain are at high risk for coronary artery disease?
Yeah, they're at higher risk than the person who has chest pain and ST segments that are normal.
Would you agree that a patient with chest pain who has abnormalities with the ST segment require a repeat EKG?
It would be helpful.
Is it required?
I think the best way to put it, it would be prudent. As I said before, there's so many varieties, I think saying required would be perhaps too strong a word. I think it has to do with the entire picture that the patient has.
But would a reasonable physician do a repeat EKG under these circumstances?

A. It certainly would be helpful.
Q. Okay. I need to distinguish what is reasonable and what a reasonable physician would do under those circumstances.
If the patient presents with chest pain and the first EKG shows abnormalities of the ST segment, would a reasonable physician do a repeat EKG?
A. Yes.
Q. And ST abnormalities can either be elevations or depressions?
A. Correct.
Q. And is an abnormality in the ST segment diagnostic of myocardial infarct?
A. Well, if the ST segment is elevated, particularly if it's elevated more than one millimeter and in more than, and in two contiguous leads, that would be suggestive for a myocardial infarction.
Q. Suggestive versus diagnostic, are you making the distinction?
A. I am, because acute myocardial infarction is the most common cause for ST segment elevation but it's not the only cause.
Q. What are other causes of abnormalities in the ST

segment?
A. Elevation?
Q. Elevation.
A. Pericarditis.
Q. That's infection?
A. Yes, it's an inflammatory condition of the pericardium which can mimic myocardial infarction not only with the electrocardiogram but also the presence of chest pain.
Q. What other symptoms would you have with pericarditis?
A. Well, they're very similar to what you said, chest pain and electrocardiographic abnormalities would make it very difficult to separate one from the other.
Q. What about white blood count, would you show signs of infection there?
A. It depends on what the cause. If it's a viral pericarditis the white blood count may not be elevated.
Q. What is the usual presentation, if there is one?
A. Hard to say. Fortunately for everybody it's not very common. You're asking about the white count?
Q. Yes.

A. Oh, I would guess maybe 50 percent have a normal white count, 50 percent have an elevated white count.
Q. What does an ST segment depression on EKG with associated chest pain mean to you as a cardiologist?
A. Well, that may be a manifestation of ischemia.
Q. And ischemia again is a shortage of blood supply to the heart?
A. Yes.
Q. Indicative of coronary artery disease?
A. Usually.
Q. Is it indicative of an impending myocardial infarct?
A. It may be.
Q. Cardiac enzyme testing, that is routinely done in cases where there is a suspicion of myocardial infarct, correct?
A. Correct.
Q. And cardiac enzymes are not positive until some time has passed from the actual damage to the heart muscle, is that correct?
A. Yes. But the elevation may be very acute if it's a total obstruction of the coronary artery.

Q. But the fact is that the test wouldn't be positive until the damage had occurred?
A. Yes.
Q. So an enzyme test wouldn't tell you that there is an impending myocardial infarct?
A. Unfortunately that's true.
Q. How long after damage does a cardiac enzyme usually show a positive result?
A. Usually in the first hour or two depending on the magnitude of the injury.
Q. And how long do they stay elevated?
A. Well, it depends on which enzyme, but the most common enzyme is CK-MB, which is specific for cardiac muscle, and in the course of acute myocardial infarction which is not altered by giving an agent to dissolve the blood clot, that will peak in about 18 to 24 hours and be down to normal in 36 to 48 hours.
Q. What is meant by the term serial enzyme testing? And specifically what do you mean by serial?
A. Well, you repeat the test over the course of time. Routinely we get the test every eight hours for the first 24 hours.
Q. What about serial EKGs?

A. Same thing.
Q. How frequently are EKGs run?
A. We usually do them every eight hours or, of course, if there's a change in the patient's condition we do it more frequently than that, but the usual routine is every eight hours for the first 24 hours.
Q. Okay. Is that what is done in the Kemper coronary care unit when you're monitoring a patient for a suspicion of myocardial infarct or impending myocardial infarct?
A. It is.
Q. Is that standard of care?
A. Yes.
Q. Is that standard of care to rule out myocardial infarct or impending myocardial infarct?
A. Well, it's what we do for unstable angina, yes.
Q. Do you agree that it would be beneath the standard of care for an emergency room physician to discharge a patient if he has not ruled out unstable angina as a cause of chest pain?
A. Yes, I would agree with that.
Q. In the Kemper coronary care unit what objective test results do you look for to determine whether or not a person is having unstable

angina or myocardial infarct?
A. Well, pretty much what we have just talked about. The symptom, of course, would be variable, it would be most important and changes on the electrocardiogram and the changes on the cardiac enzymes and particularly the serial changes showing progression of ischemia.
Q. And by symptoms, you mean whether the patient has relief of chest pain or not?
A. Yes.
Q. Is it true that you cannot rule out unstable angina or myocardial infarct with a single EKG?
A. The fact that you have a normal electrocardiogram when the patient is still having pain is a very strong indication that the heart is not the source of the trouble, that would be true in the vast majority of patients, but not exactly a hundred percent, of course.
2. Okay. What is the percentage of patients who present to the emergency room with chest pain who are having a myocardial infarct who have a positive finding on EKG?
A. I'm not sure of the focus of your question. You're -- let me state it as I understand it. You're talking about the patients who do indeed

have myocardial infarct who present to the emergency department with chest pain and the question, therefore, with that group of patients, the question, therefore, is those who have an abnormal electrocardiogram or diagnostic electrocardiogram?

Q Diagnostic

A Diagnostic electrocardiogram. Well, it's a guess, but I would think somewhere around 50 percent.

Q Okay.

A If we're talking now about the first electrocardiogram

Q Correct The first which is why physicians do repeat EKGs, correct?

A Yes.

Q And is it fair to say that you can't rule out myocardial infarct or unstable angina with a single CK-MB test?

A. It is, well, I think it's sort of hard to say yes to that question because again you have to take into context the entire picture As we all know. Mr. Scharfenberg had had discomfort for about 12 hours before he presented in the emergency department, so it would be more

substantial in a person who has had the pain for 12 hours who still has a normal CK that this is not due to his heart, there would be more reason to think that than if his symptoms are less than one hour duration and you have a normal CK.

Q. In general in your department at the Kemper coronary care unit do you rule out myocardial infarct based on a single CK-MB test?

A. No. But we have an advantage, the patient is already in the hospital.

Q. Do you do stress testing at the coronary care unit?

A. In the hospital we do, yes.

Q. And that's to rule out coronary artery disease or myocardial infarct?

A. Yes.

Q. Do you agree that the standard of care requires an emergency room physician who is unable to rule out unstable angina or myocardial infarct to transfer the patient for monitoring?

A. Could you read that to me again.

- - - -

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

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I agree with that. By transfer you mean admit the patient to the hospital, wherever the hospital is?

Q. Right. I mean, hospitals have telemetry units now where you simply monitor the patient.

A. Yes.

Q. And that's different from an actual admission to a hospital, isn't it?

A. Well, we don't. I'm not sure anybody in Cleveland does. We would have to admit the patient to the hospital.

Q. Okay. That's what the Kemper coronary care unit is, it's actually a hospital admission?

A. Oh, yes. Absolutely. Actually, most of our unstable angina patients never go there because that's really for sicker patients than those whom we are ruling in or ruling out a cardiac diagnosis.

Q. Where do the patients go when you are ruling in or ruling out?

A. Well, they're on telemetry and the patient I admitted last night didn't go to the cardiac unit, she went to the floor to be monitored and we did the stress test this morning.

Q. What symptoms did the patient have last night?

A. She had atypical chest pain which was left anterior and rather brief, but the cause for concern was that she had described it as a feeling of something closing and there wasn't anything that seemed to cause this to occur, it would occur in the frequency of every two to seven minutes, and she also had a background of extreme hypertension and untreated hypercholesterol elevation in a patient 77 years old.

Q. And what tests did you order for her in the telemetry unit?

A. Those are the things we talked about. Every eight hours electrocardiogram, every eight hours cardiac enzymes, all of the other usual blood tests, echocardiogram, and this morning they did a stress test.

Q. Has she been admitted to the Kemper coronary unit?

A. She was admitted to the telemetry unit, not to the Kemper unit.

Q. What is meaht by nonspecific findings on EKG?

A. Well, I'm afraid I can't elaborate very much. The electrocardiogram has a rather broad range of appearances which we know to be normal and

also the electrocardiogram has a number of specific diagnostic abnormalities, myocardial infarction being one of them, for instance, pericarditis being another, ventricular hypertrophy being a third, then there are a lot of electrocardiograms which are not within the normal limits and yet not specifically abnormal, so the terminology, not abnormal in a diagnostic fashion, so the terminology, therefore, would be nonspecifically abnormal electrocardiogram.

Q. So they don't indicate positively --

A. They don't give us the diagnosis, they just say this is not a normal electrocardiogram. We don't know why it's abnormal, but it's not normal.

Q. Does a nonspecific finding on EKG in a patient with chest pain require a reasonable physician to do a repeat EKG or further testing?

A. Again, it has to do with the clinical presentation. I can't say that if he didn't repeat it and there was no real reason to suspect anything with the heart or there was no other finding to indicate there was something wrong with the heart that not repeating the electrocardiogram would be falling below the

standard of care.
Q. Do you agree that a chest wall tenderness is present in some patients with ischemia or myocardial infarct?
A. Well, unfortunately it is. I'm not sure, I don't think it's part of the disease. It may be that people have more tender chest walls than they were aware of until somebody pushed on their chest. The fact that there is chest wall tenderness seems to be a cause of people making mistakes in emergency departments, but I don't think it's because the chest wall tenderness is due to what's going on in the heart.
Q. Doctor, if you would look for a minute at Mr. Scharfenberg's EKG in the emergency room at St. Luke's.
A. I have got two of them.
Q. Okay. In your report you indicate that there is an elevation of the ST segment in V1.
A. I did.
Q. How much of an elevation is that there?
A. It looks like about one millimeter. I can't make it any more than that.
Q. Because you have a bad copy or you just -- is your copy too poor?

A. No, it's all right.
Q. All right.
A. I'd say it's about a millimeter. A millimeter is a pretty small thing.
Q. One millimeter, though, is significant in reading and determining an EKG, isn't it?
A. It begins to be, yes.
Q. There is also, according to your report, a depression in V6?
A. Yes.
Q. And how much of a depression is there in V6?
A. One millimeter.
Q. And a QRS of 12 milliseconds?
A. Yes.
Q. I have no idea what that means. Could you tell me?
A. Well, the normal QRS is less than .10 so --
Q. Let me stop you. What is a QRS?
A. Oh, that's, that's the ventricular depolarization. That's these things. The biggest deflections that you see are QRS complexes.
Q. Going up and down?
A. Up and down.
Q. What is that, is that the timing?

A. That's the time that the muscle is stimulated electrically to contract and then the balance of the electrocardiogram is when the contraction has occurred and then the cell membranes are repolarized so the next electrical current will again stimulate a response to the muscle and it can retract.

Q. Okay. Those abnormalities that you note in your report are consistent with unstable angina, correct?

A. Well, the widening of the QRS is not.

Q. Okay.

A. That's probably more consistent with the fact that he was 59 years old, had hypertension, so on.

The only thing that could come close to being consistent with unstable angina is actually V6 in which the ST segment is depressed one millimeter. The other 11 leads of the electrocardiogram do not show anything that would indicate that this was unstable angina including the elevation in V1.

Q. You don't make anything of the elevation in V1?

A. No. Because it's not duplicated by V2, which is the adjacent lead, so I would feel that that is

a nonspecific abnormality and not diagnostic of even unstable angina.

Q. But it could be consistent with unstable angina?

A. No. We tend to see more ST segment depression with that.

Q. Okay. Would you look at V5 and V6?

A. I am.

Q. Do you see a depression in the ST segment there?

A. Well, in V5 there is a depression at the beginning of the ST segment but then it slopes up to the baseline, so at its worse it's one millimeter depressed but quickly comes up to the baseline.

V6 is more significant because the ST segment depression persists throughout the ST segment.

Q. Those are contiguous leads, aren't they?

A. Yes.

Q. In V3 tell me if you see an elevation in the ST segment there?

A. I do. I would also point out that this is very common in normal people and it's called a J point elevation. It's an overshoot from the S wave of the previous complex. The other thing

that I would say --
Q. Before you say that, I wanted to ask you a question about V3.
A. Okay.
Q. And that is although it is found in other circumstances, is it also found in people having unstable angina or a myocardial infarct?
A. Not unstable angina, but myocardial infarct. But again, we would be looking for two contiguous leads, which we don't have.
Q. Do you agree that the most probable cause of death of Mr. Scharfenberg was coronary artery disease with acute myocardial infarction?
A. Well, the first half, I can agree with it. I think it was ischemic heart disease. I'm not sure that he ever had a myocardial infarct. It could very well have been an arrhythmic death.
Q. What is the most probable cause of death?
A. Ventricular fibrillation.
Q. According to the EKG that was taken at the emergency room at St. Luke's Hospital on 2/2/97, had Mr. Scharfenberg had a myocardial infarct at that time?
A. No.
Q. Does that EKG show any injury to the heart?

A. No.
Q. What caused, if you know, the ventricular fibrillation that you believe caused his death?
A Well, I think he had ischemic heart disease, but since we don't have an autopsy anything that I say is obviously speculative It could very well be that if you had had an autopsy that no myocardial infarct would have been found
Q Do you think that's reasonable given his history of diabetes, hypertension, obesity, and history of chest pains?
A I think it's -- I can't answer your question specifically I think it's not at all unlikely, because when people do die suddenly and do have autopsies, quite often we don't see any myocardial infarct that the pathologist can point to, we see disseminated, severe coronary disease, but they did not live long enough to have a myocardial infarct
Q Do you believe if Mr Scharfenberg had been hospitalized and monitored with repeat EKGs that there would have been, in all probability, some changes shown on EKG?
A Hard to say.
Q What percentage of patients would show a change

on EKG when they're monitored prior to suffering a myocardial infarct?

A. Well, your question is supposing that he did have a myocardial infarct.

Q. Correct.

A. Probably a high percent.

Q. 80 percent?

A. That's as good a number as any.

Q. What percentage of patients would show changes in the CK-MB enzymes prior to a, well, at the time of a myocardial infarct?

A. Within an hour afterward it would be a very high percentage, but afterwards you might have trouble making a diagnosis.

Q. Is it somewhere in the area of 90 percent?

A. That's a good number.

Q. In a patient who with monitoring shows changes in their EKG, what treatment would be offered to that patient?

A. Well, if we were sure that this is within the first six hours of the event of myocardial necrosis, then obviously a thrombolytic agent would be ideal. If it's beyond six hours, especially if it's beyond 12 hours, then thrombolysis is probably of very low value, it

may even be more dangerous than beneficial. Heparin, aspirin, beta blockers, ACE inhibitors, intravenous or other forms of nitroglycerin would be the usual modalities.

Q. And those agents would serve to avoid or reduce?

A. Yes. Avoid extension, reduce complications.

Q. What's the rate of effectiveness of these medications?

A. I think in terms of mortality we're probably looking at, instead of seven to ten percent mortality, looking more like 20 percent. But again, that obviously is categorized by the age of the patient, the other diseases which they have and so forth. In any event, if we haven't had the golden opportunity of giving the agent to dissolve the blood clot, then we automatically have an increase in mortality.

Q. 80 percent of the patients survive?

A. Yes, that's a good guess.

Q. What about bypass surgery, when is that offered?

A. Well, usually not in the setting of acute myocardial infarction. The only justification there would be if the patient continued to have recurring episodes of ischemia in spite of all

the medical efforts being offered, then cardiac catheterization would be appropriate and in the setting of high grade multiple coronary artery stenosis, then coronary artery bypass surgery might be indicated.

Q. In the second report that you wrote, doctor, you said you assumed that Mr. Scharfenberg had ischemic heart disease with three vessel coronary disease.

A. Based upon age, diabetes and hypertension.

Q. Are those the risk factors that normally accompany his age and medical condition?

A. Well, they often do. In the absence of autopsy data, I have to make some assumptions. Actually assuming three vessel compared to two vessel or one vessel doesn't really change the numbers very much.

Q. Okay.

A. But in view of age, diabetes and hypertension it seemed to me more likely that he had three vessel disease.

Q. What is your basis for saying the left ventricle was unimpaired?

A. Well, he didn't seem to have any symptoms of heart failure.

Q. What would those be?
A. Shortness of breath, easy fatigue, swelling of the ankles.
Q. Do you agree that costochondritis does not cause EKG abnormalities?
A. I do.
Q. Do you agree that an emergency room physician should be able to read and interpret an EKG?
A. It's very helpful. Nowadays with the computer assisted interpretation I think it takes some of the burden off the shoulders to be fully competent in electrocardiographic interpretation because the computer is helping them out.
Q. You teach in your course, ACLS course, EKG interpretation?
A. Mainly in terms of rhythm, because, again, this is basically an out of hospital paramedic kind of course and the need to recognize the abnormal heart rhythms and to know the medications for them, but we don't spend a lot of time teaching the diagnosis of acute myocardial infarction because their job is to stabilize and transport the patient.
Q. Do you expect an emergency room physician to be familiar with the ACLS guidelines for evaluation

of chest pain?
A Yes.
Q Do you expect an emergency room physician to be familiar with protocol for evaluation and treatment of patients with chest pain?
A Yes.
Q Do you expect an emergency room physician to call in a consultation if they were unable to rule out unstable angina or myocardial infarct?
A Yes.
Q How is it that you believe Dr. Christensen met the standard of care in discharging Mr. Scharfenberg?
A. I think he met the standard of care because he did all of the appropriate things to make the diagnosis or rule out the diagnosis of unstable angina, based upon considerable laboratory testing and electrocardiographic as well as physical and history information, came to the conclusion that the patient did not have unstable angina.
Q What tests did Dr. Christensen administer that ruled out unstable angina?
A Two electrocardiograms separated by three hours as well as the history and physical and all of

the normal laboratory data except for one abnormality.

Q. Can you point me to the two electrocardiograms that are separated by three hours?

A. The time was given on both of the electrocardiograms and unless I'm not reading it correctly, this electrocardiogram, it's really hard to see on the top, but it looks like this one right here, down here I can see better 2, February '97, 0005, which sounds like it's 5 minutes after midnight.

Q. It actually says 3:05. They both say 3:05.

A. This says 3:05 very clearly.

Q. This is a little lighter copy. You can read mine. There was in this case, doctor, a single electrocardiogram.

A. Oh. There was. Okay. Mine looks like 0005.

Q. Is your opinion that the standard of care was met based on the fact that myocardial infarct was ruled out by two EKGs taken that were separated by three hours?

A. Actually, no. I think when I reviewed this I think I might have seen the correct time, when I looked at it again today it looked like 12:05, 0005.

Q. So do you want to withdraw your statement previously?
A. Well, it was not separated by three hours, but, nevertheless, I still felt that he had done the appropriate things in ruling out myocardial infarction and of course we both know that the patient had had chest pain for 12 hours before he came to the emergency department.
Q. Okay. I guess my question to you was what tests did Dr. Christensen administer that ruled out unstable angina or myocardial infarct and your answer was, I'm sorry, your answer first was that he had administered two EKGs separated by three hours.
A. Which is incorrect.
Q. Which is incorrect. Now I'm reasking the question. What test was it that he ruled out?
A. Well, certainly myocardial infarction was completely ruled out by all of the negative laboratory data.
Q. Would a CK-MB necessarily be elevated if the myocardial infarct occurred half an hour before the test was run?
No.
So a single CK-MB would not rule out myocardial

infarct, would it?
A. It wouldn't. But, again, you're taking it out of the context, of course, but we have to consider this case as Mr. Scharfenberg presented, with chest pain of more than 12 hour duration and an electrocardiogram which was certainly not indicative of unstable angina in my opinion so, and also during this period of time there was a reduction, a mild reduction in the amount of pain that he had, which was not very severe anyway.
Q. He was discharged with continuing pain, correct?
A. Well, I think that, I think he had some pain, especially when he coughed. He described it as level five when he coughed, but otherwise his pain had decreased to three. So he had pain when he coughed, yes.
Q. Do you know from the chart whether or not he continued to have chest pain whether or not he was coughing when he was discharged?
A. No.
Q. I guess I want to reask the question I asked you twice before and that is what test did Dr. Christensen administer that ruled out

myocardial infarct or unstable angina?
A. I think my answer is the same as before. All the laboratory tests failed to substantiate either diagnosis.
Q. Did it rule it out?
A. It certainly ruled out myocardial infarction with a normal white blood count and a normal CK. The electrocardiogram shows nonspecific abnormalities in a man who has had chest pain for 12 hours and I think in the setting, of course we're focused on this particular patient, in the setting of a man who has an increase in pain when he coughs and has had a respiratory infection for which he's being treated, it would seem to me that in that setting with that electrocardiogram and those laboratory data that the diagnosis has been ruled out satisfactorily.
Q. Doctor, what makes you say that this man had a respiratory infection?
A. I think that was his testimony.
Q. There's some mention of the flu.
A. He said, quote, just getting over the flu and he was taking Tessalon capsules for his cough and Cipro for bacterial causation of respiratory

infection.
Q. Does it say respiratory infection?
A. Well, what does the flu mean to most people?
Q. I think it means many things.
A. You're right.
Q. Doesn't it?
A. You're right.
Q. Could be stomach?
A. If he s taking a cough medicine it probably means a respiratory infection, doesn't it?
Q. I don t think we know, do we?
A. Well, I would guess that it does.
Q. But you're guessing, aren't you?
A. Yes, I certainly am, but I'm doing it with a very educated, experienced background.

MR. SPISAK: I don't think he's going to take cough medicine for a stomach flu, is he, doctor?

A. I don't think so. In the history it says patient had flu, just now getting over it. Has had cough, taking Tessalon pills. Sounds like a respiratory infection.
Q. Okay. He had no findings on physical examination consistent with respiratory infection, correct?

A. He was coughing.
Q. Other than that? His physical examination was normal according to Dr. Christensen?
A. Except for the tenderness, yes. He didn't have any findings.
Q. And his white blood count was not elevated?
A. Correct.
Q. His cholesterol level was elevated, was it not?
A. I wrote down 169. Did I write down the wrong number.
Q. Well, you're correct.
A. I'm impressed by that. That's pretty low.
Q. In the cardiac enzyme testing the LD level was reported high at 1253?
A. Uh-huh.
Q. What does that refer to?
A. Well, I don't find the LDH a very helpful enzyme. It's elevated in a great many things. For instance, anything involving the liver would cause it to be elevated. It can be elevated in myocardial infarction. It comes up later than the CK-MB and goes down later, but my experience with LDH enzymes is that quite often it's the only abnormality and I just can't explain why it's abnormal. It was the only abnormality

here, so I would tend to put that one aside as being one of those unexplained elevations that I can't use as a help in evaluating the patient.

Q. Doctor, if a patient has had 12 hours of chest pain which is unstable angina, am I correct that he wouldn't have elevated enzymes unless he in fact suffered a myocardial infarct?

A. Correct.

Q. So 12 hours of chest pain does not necessarily mean a patient has suffered a myocardial infarct?

A. Correct.

Q. It could be coming, it just hasn't arrived yet?

A. Right.

Q. So you wouldn't necessarily see an elevated cardiac enzyme after 12 hours of chest pain?

A. Correct.

Q. Let me just have a quick look. I'm just about finished. I am finished. Thank you.

A. Okay.

MR. MOSCARINO: I don't have any questions at this time. Thanks.

MR. SPISAK: If it's ordered, let me have a copy and I'll have the doctor take a look at it and then he will waive

signature subject to corrections.

THE WITNESS: Okay.

RICHARD W. WATTS, M.D.

C E R T I F I C A T E

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

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

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

_____
Dawn M. Fade, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires October 27, 2002