STATE OF OHIO ----Yavonna Lyons, Individually : and as Administratrix for : the Estate of Jeffrey Lyons, : Deceased, : Plaintiff, : vs. : Case No. 02CV-07-7550 : Capitol City Cardiology, : Incorporated, et al., :

Defendants.

April 20, 2004

Deposition of

Steven Joseph Yakubov, M.D.

a witness herein, called by the Plaintiffs for cross-examination under the applicable Rules of Ohio Civil Court Procedure, taken before me, Beth A. Higgins, a Registered Professional Reporter and Notary Public in and for the State of Ohio, taken by agreement of counsel and pursuant to Notice, at the offices of the witness, 3545 Olentangy River Road, Columbus, Ohio 43214, on Tuesday, April 20, 2004, commencing at approximately 4:40 p.m.

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17	PPEARANCES:	1	INDEX
2	JAMES M. KELLEY, III, Esquire	2	
	Elk & Elk Company, L.P.A.		
3	Landerhaven Corporate Center 6110 Parkland Boulevard	3	Steven Joseph Yakubov, M.D. Page
4	Mayfield Heights, Ohio 44124	4	Cross-examination, by Mr. Kelley 5
	Email: jkelley@elkandelk.com	5	Cross-examination, by Mr. Sewards 120
5	(888) 355-6446,	6	Cross-examination, by Mr. Lodico 124
6 →	On behalf of the Plaintiff.	7	
7	THOMAS A. DILLON, Esquire Roetzel & Andress		
8	155 East Broad Street, 12th Floor		
	Columbus, Ohio 43215	8	
9	Email: tdillon@ralaw.com		EXHIBITS
10	(614) 463-9770,	9	
10	On behalf of Defendant		Deposition Exhibits Marked Referred
11	Bruce Auerbach, M.D.	10	Deposition Exmote Marited Received
12	VINCENT J. LODICO, Esquire	10	
	Crabbe, Brown & James LLP		(No exhibits marked)
13	500 South Front Street, Suite 1200	11	
14	Columbus, Ohio 43215 Email: vlodico@cbjlawyers.com	12	
	(614) 228-5511,	13	
15		14	
	On behalf of Defendant		
16	Samir R. Tulebaev, M.D.	15	
17	FREDERICK H. SEWARDS, Esquire Hammond & Sewards	16	
18	556 East Town Street	17	
	Columbus, Ohio 43215	18	
19	Email: fsewards@hammondandsewards.com	19	
20	(614) 228-6061,	20	
20	On behalf of Defendants		
21	Barney Beaver, M.D., and	21	
	Capitol City Cardiology,	22	
22	Incorporated.	23	
23 24		24	
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2 3	Tuesday Afternoon Session April 20, 2004 4:40 p.m.	2	P R O C E E D I N G S
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1	try to use words for all your answers. Okay?	1	right here today.
2	A. Fine.	2	MR. DILLON: With one exception.
3	Q. I'm not here to rush or trick you, so feel	3	A. We have a little bit of a debate. I
4	free to utilize the records which are in front of	4	can't I can't find the
5	you or any notes that you brought before you answer	5	Q. Let me guess. Auerbach's depo?
6	a question. Okay?	6	A. No. Plaintiff's
7	A. Yes.	7	MR. DILLON: Garrett's.
8	Q. If I phrase a question either inartfully	8	A. Garrett's.
9	or you just simply don't hear it or understand it,	9	Q. All right. So the next thing is, within
10	be sure to let me know before you answer it and I'll	10	those Fayette records, do you believe those are a
11	be happy to repeat it or rephrase it. Fair enough?	11	complete copy of the records from your review?
12	A. Yes.	12	A. As far as I can tell.
13	Q. Prior to your deposition today, what	13	Q. Okay. Any notations in them?
14	materials have you been provided?	14	A. No.
15	A. I have I have the deposition of	15	Q. Any summaries of those records that were
16	Dr. Albert Kolibash, which I just received about	16	provided to you?
17	five minutes ago, so I have not read it.	17	A. My own notations or summaries, I have
18	Q. Okay.	18	none.
19	A. I have the records from Capitol City	19	Q. Okay. Did they provide you with any
20	Cardiology.	20	summaries of the records?
21	Q. Let's go slowly as you go through it.	21	A. Meaning Mr. Dillon?
22	Within the Capitol City Cardiology	22	Q. Mr. Dillon, someone from his office?
23	notes records, do you have any notations?	23	A. The only summary that he's ever given me
24	A. No.	24	is just a a letter from the office regarding the
1	Page 7	1	Page 9
1	Q. Okay. Do you ever have a custom of making	1	handling of the protected health information, and I
2	Q. Okay. Do you ever have a custom of making notations on any of the medical records?	1 2 2	handling of the protected health information, and I think that's it.
2 3	Q. Okay. Do you ever have a custom of making notations on any of the medical records?A. No.	3	handling of the protected health information, and I think that's it. Q. Okay.
2 3 4	Q. Okay. Do you ever have a custom of making notations on any of the medical records?A. No.Q. Have you been provided any summaries of	3 4	handling of the protected health information, and I think that's it.Q. Okay.A. That's it.
2 3 4 5	Q. Okay. Do you ever have a custom of making notations on any of the medical records?A. No.Q. Have you been provided any summaries of those records?	3 4 5	handling of the protected health information, and Ithink that's it.Q. Okay.A. That's it.Q. We'll get to that, I guess, in due order.
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	Page 10	1	Page 12
1	Q. And have you ever practiced with him?	1	Q. And he's somebody who you know and would
2	A. No.	2	recognize if you saw him in the community?
3	Q. Ever do any training with him?	3	A. Yes.
4	A. No.	4	Q. Do you ever do plaintiffs' work or do
5	Q. Did he do any of his training under you at	5	cases on behalf of patients who are claiming to be
6	any point?	6	injured?
7	A. No.	7	A. I have never been asked.
8	Q. The group that he is at, do you guys ever	8	Q. Okay.
9	have any sort of referrals of patients back and	9	A. Oh, I I take that back.
10	forth?	10	I was asked once on a on a case where I
11	A. No. We're at kind of separate	11	was the defense I'm was the defense expert,
12	institutions.	12	and they dropped the the defendant and asked me
12	Q. Is there a local cardiology professional	13	to serve for the plaintiff.
			-
14	association that you're both members of?	14	And I was asked on another case to give an
15	A. Uhm, there's I don't think there's any	15	opinion, and I didn't think there was a case there.
16	local cardiology professional membership. He may be	16	Q. Okay.
17	part of the Columbus Medical Association or OSMA,	17	A. But I did review the records thoroughly.
18	but I'm not very active in either of those, so I	18	And the attorney felt there was a much better case
19	wouldn't I don't go to meetings with him on a	19	than I did. And since we didn't quite agree on it,
20	regular basis.	20	I thought he would be better off finding an expert
21	Q. Okay. Do you have any notes from his	21	that was more suitable for the case.
22	depositions?	22	Q. Okay. The plaintiffs' cases that you
23	A. No.	23	reviewed, were they ever on behalf of patients here
24	Q. Have you ever spoken to him about this	24	in Columbus?
	Page 11		Page 13
1	case?	1	A. No.
2	A. No.	2	Q. Okay. Would you review a case for a
3	Q. What's the next stuff you have?	3	patient in Columbus against a local physician here?
4	A. Well, the next is the handling of	4	A. Yes.
5	protected information, and then it is the the	5	Q. Okay. Would you review a case against
6	letter from Mr. Dillon's office stating what he has	6	Dr. Auerbach and Dr. Beaver?
7	included to me.	7	A. Yes.
8	Q. Okay.	8	Q. Even though you know them and have had an
			∇ . Even mough you know mean and may mud an
- N.S		0	
9 10	A. And then finally is the deposition of	9 10	eight- to ten-year acquaintance with them?
10	A. And then finally is the deposition of Dr. Auerbach.	10	eight- to ten-year acquaintance with them? A. Yes.
10 11	A. And then finally is the deposition ofDr. Auerbach.Q. Okay. Any notes within Dr. Auerbach's	10 11	eight- to ten-year acquaintance with them?A. Yes.Q. Okay. You don't believe that relationship
10 11 12	A. And then finally is the deposition ofDr. Auerbach.Q. Okay. Any notes within Dr. Auerbach's deposition?	10 11 12	eight- to ten-year acquaintance with them?A. Yes.Q. Okay. You don't believe that relationship in any way biases you or colors you one way or
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10 11 12 13 14	 A. And then finally is the deposition of Dr. Auerbach. Q. Okay. Any notes within Dr. Auerbach's deposition? A. No. Q. Same kind of questions as with Dr. Beaver. 	10 11 12 13 14	 eight- to ten-year acquaintance with them? A. Yes. Q. Okay. You don't believe that relationship in any way biases you or colors you one way or another in your review of a case? A. I – I – It might. It might. But
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10 11 12 13 14 15 16 17 18 19 20 21 22	 A. And then finally is the deposition of Dr. Auerbach. Q. Okay. Any notes within Dr. Auerbach's deposition? A. No. Q. Same kind of questions as with Dr. Beaver. Do you know Dr. Auerbach? A. Yes. Q. Okay. How long have you known him? A. Uhm, eight or ten years. Q. Have you ever socialized with him? A. No. 	10 11 12 13 14 15 16 17 18 19 20 21 22	 eight- to ten-year acquaintance with them? A. Yes. Q. Okay. You don't believe that relationship in any way biases you or colors you one way or another in your review of a case? A. I I It might. It might. But it's I never interact with them. I don't interact with them on a regular basis. I could go clearly years without seeing them. Q. But the reality is you would eventually again see them and have to confront someone who you were critical of. A. Right. I think that there is value to reviewing cases. I think that if you have competent
10 11 12 13 14 15 16 17 18 19 20 21	 A. And then finally is the deposition of Dr. Auerbach. Q. Okay. Any notes within Dr. Auerbach's deposition? A. No. Q. Same kind of questions as with Dr. Beaver. Do you know Dr. Auerbach? A. Yes. Q. Okay. How long have you known him? A. Uhm, eight or ten years. Q. Have you ever socialized with him? A. No. Q. Obviously the fact that we're here today, you're serving as an expert witness on his behalf. 	10 11 12 13 14 15 16 17 18 19 20 21	 eight- to ten-year acquaintance with them? A. Yes. Q. Okay. You don't believe that relationship in any way biases you or colors you one way or another in your review of a case? A. I I It might. It might. But it's I never interact with them. I don't interact with them on a regular basis. I could go clearly years without seeing them. Q. But the reality is you would eventually again see them and have to confront someone who you were critical of. A. Right. I think that there is value to

Image 16 Page 16 1 Q. In this ~ this case here, have you ever prepared a report? In this ~ this case here, have you ever prepared a report? I education, your training, and your review of the corourds. 3 A. I was never asked to prepare a report. A. I was never asked to prepare a report. A. Okay. 4 Q. Do you have any notes that you generated? A. No. A. Okay. 5 A. No. C. Okay. So you just reviewed the stuff and have kind of kept it in your own mind? A. The would assume that's what you meant. C. Okay. And you don't have a - be secondary to an arrhythmia? 11 A. I would assume that's what you meant. C. Okay. A. I have no notes. 12 A. I would assume that's what you meant. C. Okay. A. I have no notes. 12 Q. Okay. A. I have no notes. II A. Probably the myocardial infarction, not to be secondary to an arrhythmia? 11 A. Trave no notes. II A. I have no notes. II A. I have no notes. 12 Q. Okay. A. I have no notes. II A. Probably the myocardial infarction, not to keep going down the road, but was that caused by inscient with file care? 13 Q. Okay. And the massible causes of his in myocardial infarction. II ha trave heep sosible caus			1	
2 prepared a report? 3 A. Iwas never asked to prepare a report. 4 Q. Do you have any notes that you generated? 5 A. No. 6 Q. Okay. So you just reviewed the suff and 7 have kind of kept it in your own mind? 8 A. Yeah. 9 Q. Okay. And you don't have a – 10 And by 'notes." The including anything on 11 a. Theorem on a supply processor or otherwise. 12 A. Iwould assume that's what you meant. 13 Q. Okay. 14 A. Thave no notes. 15 Q. Okay. And let me ask you first, what is 16 assume, starting on lune 18th? 17 A. Standard of care? 18 Q. Okay. And let me ask you first, what a comptech 19 provide to a patient that is consistent with 12 cardiologist in my – in my field would be expected 14 this reace. I assume? 2 Q. Okay. Du have standard-of-care opinions in 1 this tasce. I assume? 2 A. Ido you have an opinion as to poy ou have an opinion as to poy ou have an opinion as to poy ourinities. <td< td=""><td></td><td>Page 14</td><td></td><td></td></td<>		Page 14		
2 prepared a report? 3 A. I was never asked to prepare a report. 3 A. Okay. 3 A. I was never asked to prepare a report. 3 A. Okay. 4 Q. Do you have any notes that you generated? A. No. S. Yeah. 7 A. Yeah. Yeah. Polady the myocardial inflarction. Polady the myocardial inflarction. 10 And poly ously and cort have a - 10 A. I would assume that's what you meant. 10 What caused his archythmia? 11 A. I would assume that's what you meant. 10 What caused his archythmia? 12 A. I would assume that's what you meant. 10 What caused his archythmia? 12 A. I would assume that's what you meant. 10 Q. Okay. 13 A. I would assume that's what you first, what is 10 A. I don't know. 14 A. Sundard of care? 11 A. I don't know. 14 provide to that patient whit he care that is 11 A. I don't know. 12 go	1	Q. In this – this case here, have you ever	1	education, your training, and your review of the
3A.I was never asked to prepare a report.3A.Okay.4Q.Do you have any notes that you generated?Q.First, what is your opinion to a6Q.Okay. So you just reviewed the stuff andJeffrey Lyons was?7A.I believe he had sudden cardiac death.8A.Yeah.9Q.Okay. And you don't have a -10And by 'notes," I'm including anything on11a word processor or otherwise.12A.I would assume that's what you meant.13Q.Okay.14A.I have no notes.15Q.You reviewed the care and treatment, I16assume, starting on June 18th?17A.Yes.18Q.Okay. And let me ask, you first, what is19your definition of standard of care is the care that would be11assume; starting on June 18th?12to provided to a patient that is consistent with the13guidelines and is consistent with the care that is14catrologist in my	2		2	
4 Q. Do you have any notes that you generated? 4 Q. First, what is your opinion to a 5 A. No. 5 probability as to what the cause of death for 6 Q. Okay. So you just reviewed the stuff and 7 A Ibelieve he had sudden cardiac death. 8 A. Yesh. 9 Q. Okay. And you don't have a - 10 And obviously any cardiac death is going 10 A and by "notes," Fm including anything on 11 A. Probably the myocardial inflarction, not 12 A. I would assume that's what you meant. 12 Q. Okay. And the moveardial inflarction, not 13 Q. Okay. No 10 What caused bow. 14 A. Thave no notes. 11 A. Probably the myocardial inflarction, not 15 Q. Okay. No 12 Vantare the possible causes for his 17 A. Yes. 16 A. He probably had a blockage of an artery 18 A. Standard of care? 18 A. He probably had a blockage of an artery 19 your clinition of standard of care? 19 Which of the coronary arteries? And I don't mean 22 Which of the coronary arteries? 14 I distribution? <td>1</td> <td></td> <td></td> <td></td>	1			
 5 Å. No. 6 Q. Okay. So you just reviewed the stuff and have kind of kept it in your own mind? 8 A. Yeah. 9 Q. Okay. And you don't have a 10 And by 'motes," I'm including anything on 11 a word processor or otherwise. 12 A. I would assume that's what you meant. 13 Q. Okay. 14 A. I have no notes. 15 Q. You reviewed the care and treatment, I 16 assume, starting on June 18th? 17 A. Yes. 18 Q. Okay. And let me ask you first, what is 19 your definition of standard of care is the care that would be 21 provide to a patient that is consistent with the care that is 23 characteristic of your community, what a competent 24 cardiologist in my in my field would be expected 10 Q. Day un have standard-of-care opinions in 4 this case, I assume? 5 A. I do. 9 A. No. 10 Q. Okay. Do you have any standard-of-care opinions in 4 this case, I assume? 5 A. I do. 10 Q. Do you believe that they all met the 11 stamply have no opinions an? 3 A. I was really only asked to make an opinion in 4 about Dr. Auserbach. 21 Q. And when I ask you an opinion, I'm going 22 Okay? 23 A. Sure. 24 Colkay. And the ny candid hor fractine? 25 A. I do. 26 Q. Okay. Do you have an opinion in? 36 A. I was really only asked to make an opinion in? 37 A. Sure. 37 A. Sure. 38 A. Sure. 				
6 Q. Okay. So you just reviewed the stuff and 7 have kind of kept it in your own mind? 7 A. Telleve he had sudden cardiac death. 8 A. Yeah. 9 Q. Okay. And you don't have a 10 And by "notes," Tm including anything on 11 a word processor or otherwise. 10 What caused his arihythmia? 12 A. I would assume that's what you meant. 12 Q. Okay. And the myocardial infarction, not 13 Q. Okay. And the myocardial infarction, not 13 Lo Ne 14 A. Thave no notes. 14 A. Howas that caused by 14 15 Q. Okay. And let me ask you first, what is 15 A. How the care that would be 16 provide to a patient that is consistent with 20 Okay. Okay. A. He probably had a blockage of an artery 17 to provide to that patient under similar 21 which of the coronary arteries? 16 Q. Okay. And you have standard-of-care opinions in 14 this case, assume? A. Ho The assume? 12 Michio'the coronary arteries?				
7 A. Telleve he had sudden cardiac death. 8 A. Yeah. 9 Q. Okay. And you don't have a 10 And by "notes," I'm including anything on 11 A. I would assume that's what you meant. 12 A. I would assume that's what you meant. 13 Q. Okay. 14 A. I would assume that's what you meant. 15 Q. You reviewed the care and treatment, I 16 assume, starting on June 18th? 14 7 A. Yes. 19 your definition of standard of care? 15 20 A. Standard of care is the care that would be 21 provided to a patient that is consistent with 2 22 Q. Okay. And doy uhave an opinion as to 23 Q. Okay. And doy uhave an opinion as to 24 to provide to that patient under similar 2 2 circlustances. 3 3 Q. A. You reviewed the care is the care that would be 4 this case, Lassume? 2			E	
8 A. Yeah. 8 Q. And obviously any cardiac death is going 9 Q. Okay. And you don't have a 10 Mahd by "hotes," I'm including anything on 11 a word processor or otherwise. 11 A. I would assume that's what you meant. 13 Q. Okay. 11 A. I would assume that's what you meant. 13 Q. Okay. 11 A. Probably the myocardial infarction. 14 A. I have no notes. 11 A. I don't know. 16 assume, starting on June 18th? 15 A. I don't know. 17 A. Yes. 16 Q. What are the posable causes for his 17 Your reviewed the care and treatment, I 16 Q. What are the posable causes for his 18 Q. Okay. And let me ask you first, what is 17 myocardial infarction? 18 Q. Okay. And let me ask you first, what is 17 myocardial infarction? 18 C. Okay. And let me ask you first, what is 17 myocardial infarction? 19 your definition of standard of care? 20 O. Okay. And bo you have an opinion as to 21 provide to a patient that is consistent with multiples. 21	6		1	
9 Q. Okay. And you dow't have a And by 'notes," I'm including anything on 1 a word processor or otherwise. 9 to be secondary to an arrhythmia. 10 And by 'notes," I'm including anything on 1 a word processor or otherwise. 10 What caused his arrhythmia? 12 A. I would assume that's what you meant. 12 Q. Okay. And let motes. 11 13 Q. Okay. 11 A. Thave no notes. 12 Q. Okay. And let me ask you first, what is 16 assume, starting on June 18th? 15 A. Toon't know. 16 Q. What are the possible causes for his 17 A. Yes. 16 Q. What are the possible causes for his 17 18 Q. Okay. And let me ask you first, what is 16 Q. What are the possible causes for his 18 your definition of standard of care? 18 A. He probably had a blockage of an artery 19 that caused box mem my moriming a standard of care is the care that would be expected 16 Q. Okay. And ley ou have an opinion as to the 21 roprovide to that patient under similar 21 which of the cornary arteries? And thon't mean 22 roprovide to that patient under similar 1 distribution? 2 A. Hay. No.<	7	have kind of kept it in your own mind?		A. I believe he had sudden cardiac death.
10 And by "notes," I'm including anything on 11 a word processor or otherwise. 10 What caused his arhythmia? 11 A. I would assume that's what you meant. 13 Q. Okay. 14 A. I have no notes. 13 Q. Okay. 14 A. I have no notes. 15 Q. Okay. 16 assume, starting on June 18th? 17 Nevcantial infarction? 16 assume, starting on June 18th? 17 Nevcantial infarction? 18 Q. Okay. A. I don't know. 16 assume, starting on June 18th? 17 myocardial infarction? 18 A. I don't know. 12 guidelines and is consistent with 17 myocardial infarction? 18 A. He probably had a blockage of an artery 19 that caused some myocardial damage. 20 O kay. And to you have an opinion as to 12 guidelines and is consistent with acardiologist in my in my field would be expected 21 which of the coronary arteries? And I don't mean 22 "multiples. 13 Q. And you have standard-of-care opinions in 4 distribution? 2 A. Yeas.	8	A. Yeah.	8	Q. And obviously any cardiac death is going
10 And by "notes," I'm including anything on 11 a word processor or otherwise. 10 What caused his arhythmia? 11 A. I would assume that's what you meant. 13 Q. Okay. 14 A. I have no notes. 13 Q. Okay. 14 A. I have no notes. 15 Q. Okay. 16 assume, starting on June 18th? 17 Nevcantial infarction? 16 assume, starting on June 18th? 17 Nevcantial infarction? 18 Q. Okay. A. I don't know. 16 assume, starting on June 18th? 17 myocardial infarction? 18 A. I don't know. 12 guidelines and is consistent with 17 myocardial infarction? 18 A. He probably had a blockage of an artery 19 that caused some myocardial damage. 20 O kay. And to you have an opinion as to 12 guidelines and is consistent with acardiologist in my in my field would be expected 21 which of the coronary arteries? And I don't mean 22 "multiples. 13 Q. And you have standard-of-care opinions in 4 distribution? 2 A. Yeas.	9	O. Okay. And you don't have a	9	
11 a word processor or otherwise. 11 A. Probably the myocardial infarction. 12 A. I would assume that's what you meant. 12 O. Okay. And the myocardial infarction, not 13 Q. Okay. Not herrow. 12 14 A. I have no notes. 13 O. Okay. And the myocardial infarction, not 15 Q. You reviewed the care and treatment, I 13 A. I don't know. 16 assume, starting on June 18th? 15 A. I don't know. 17 A. Yes. 16 Q. Way. And let me ask you first, what is 17 19 your definition of standard of care? 18 A. He probably had a blockage of an artery 11 that caused some myocardial infarction? 18 A. He probably had a blockage of an artery 12 your definition of standard of care? 10 Q. Okay. And doy ou have an opinion as to 12 guidelines and is consistent with the care that is 11 A. He probably had a blockage of an artery 12 guidelines and is consistent with the care that is 11 Mich of the coronary arteries? And I don't mean 12 to provide to that patient under similar 11 distribution? 24 Do you				
12 A. I would assume that's what you meant. 12 Q. Okay. And the myocardial infarction, not 13 Q. Okay. 13 to keep going down the road, but was that caused by 14 A. I have no notes. 13 to keep going down the road, but was that caused by 14 A. I have no notes. 14 ischemia or a supply-and-demand issue? 15 Q. You reviewed the care and treatment, I 16 A. I don't know. 16 assume, starting on June 18th? 16 Q. What are the possible causes for his 17 A. Yes. 18 A. He probably had a blockage of an artery 19 your definition of standard of care is the care that would be 20 Q. Okay. And do you have an opinion as to 21 provide to that patient under similar 21 "which'i to be only one. There may have been 22 id astribution? 14 distribution? Page 17 14 to provide to that patient under similar 24 Do you know, can 1 see – I wanted to 3 Q. And you have any standard-of-care (Discussion held off the record.) 7				
 13 Q. Okay. 14 A. Thave no notes. 15 Q. You reviewed the care and treatment, I 16 assume, starting on June 18th? 17 A. Yes. 18 Q. Okay. And let me ask you first, what is 19 your definition of standard of care? 20 A. Standard of care is the care that would be 21 provided to a patient that is consistent with 22 guidelines and is consistent with the care that is 23 characteristic of your community, what a competent 24 cardiologist in my in my field would be expected 24 cardiologist in my in my field would be expected 24 Do you have an opinion as to the 25 A. I do. 20 Q. Okay. And you have standard-of-care opinions in 4 this case, I assume? 5 A. I do. 2 Q. Okay Do you have any standard-of-care opinions in 4 this case? 3 A. I was really only asked to make an opinion 3 A. I was really only asked to make an opinion as to the 21 standard of care or there are certain people who you just simply have no opinions on? 3 A. I was really only asked to make an opinion 4 A. Yes. 13 A. Yes. 14 Standard of care or there are certain people who you just simply have no opinions on? 3 A. Yes. 3 A. Yes. 3 A. Yes. 3 A. Surc. 3 A. Surc. 				A. Trobably the myocardial information not
14 Å. I have no notes. 15 Q. You reviewed the care and treatment, I 16 assume, starting on June 18th? 17 A. Yes. 18 Q. Okay. And let me ask you first, what is 19 your definition of standard of care? 20 A. Standard of care is the care that would be 21 provided to a patient that is consistent with 18 22 characteristic of your community, what a competent 24 23 characteristic of your community, what a competent 24 24 cardiologist in my in my field would be expected 24 7 critcumstances. 2 3 Q. And you have standard-of-care opinions in 4 this case, I assume? 1 5 A. I dos 6 Q. Okay. Do you have any standard-of-care 7 criticisms of any of the physicians involved in this cases? 9 A. No. 10 Q. Do you have an opinion as to - and 11 tististip and of care or there are ceratin people who you <tr< td=""><td></td><td></td><td></td><td></td></tr<>				
15 Q. You reviewed the care and treatment, I 15 A. I don't know. 16 assume, starting on June 18th? 16 Q. What are the possible causes for his 17 A. Yes. 16 Q. What are the possible causes for his 18 Q. Okay. And let me ask you first, what is 17 myocardial infarction? 18 Q. Okay. And let me ask you first, what is 18 A. He probably had a blockage of an artery 19 your definition of standard of care? 10 Q. Okay. And do you have an opinion as to 20 Q. Okay. And bet me ask you first, what is 12 "which" to be only one. There may have been 21 scharacteristic of your community, what a competent 21 which of the coronary arteries? And I don't mean 22 "which" to be only one. There may have been 23 multiples. 24 Do you have an opinion as to the 24 Do you have an opinion as to the 25 A. I do. 1 distribution? 3 32 characteristic of your community, what a competent intis 3 ace the stress test result one more time. 4 Do you have any standard-of-care 1 distribution? 4			1	
16 assume, starting on June 18th? 16 Q. What are the possible causes for his 17 A. Yes. mycocardial infarction? 18 Q. Okay. And let me ask you first, what is new provided in farction? 20 A. Standard of care is the care that would be new provide to a patient that is consistent with 21 provided to a patient that is consistent with 20 22 Correct and the coronary arteries? And I don't mean 23 characteristic of your community, what a competent 21 24 cardiologist in my in my field would be expected 24 Do you have an opinion as to the 24 cardiologist in my in my field would be expected 24 Do you have an opinion as to the 25 A. I do. 3 Q. And you have standard-of-care opinions in 4 this case, 1assume? 1 distribution? 5 A. I do. 20 Q. Asy but have an opinion as to and 10 Q. Do you believe that they all met the 1 distribution of his coronary disease was? 12 just simply have no opinions on? 3 Q. And what is your opinion? 14 about Dr. Auerebach. 10 Q. And	E Contraction of the second se		•	
17 A. Yes. 17 myocardial infarction? 18 Q. Okay. And let me ask you first, what is 17 myocardial infarction? 18 Q. Okay. And let me ask you first, what is 18 A. He probably had a blockage of an artery 20 A. Standard of care is the care that would be 18 A. He probably had a blockage of an artery 20 A. Standard of care is the care that would be 20 Okay. And do you have an opinion as to 21 provided to a patient that is consistent with the care that is 21 which of the coronary arteries? And I don't mean 22 guidelines and is consistent with the care that is 22 which of the coronary arteries? And I don't mean 24 Do you have an opinion as to the 24 Do you have an opinion as to the 24 2 Multiples. 24 Do you have an opinion as to the 24 24 2 A. I do. 6 Q. Okay. Do you have any standard-of-care 1 distribution? 2 4. Yes. 20 A. Wesh. You know, can I see - I wanted to 3 see the stress test result one more time. 4 20 0 you mind if I close this door? 5 Q. Abyou may one poinion as to - and	15	Q. You reviewed the care and treatment, I	15	A. I don't know.
17 A. Yes. 17 myocardial infarction? 18 Q. Okay. And let me ask you first, what is 17 myocardial infarction? 18 Q. Okay. And let me ask you first, what is 18 A. He probably had a blockage of an artery 20 A. Standard of care is the care that would be 18 A. He probably had a blockage of an artery 20 A. Standard of care is the care that would be 20 Okay. And do you have an opinion as to 21 provided to a patient that is consistent with the care that is 21 which of the coronary arteries? And I don't mean 22 guidelines and is consistent with the care that is 22 which of the coronary arteries? And I don't mean 24 Do you have an opinion as to the 24 Do you have an opinion as to the 24 2 Multiples. 24 Do you have an opinion as to the 24 24 2 A. I do. 6 Q. Okay. Do you have any standard-of-care 1 distribution? 2 4. Yes. 20 A. Wesh. You know, can I see - I wanted to 3 see the stress test result one more time. 4 20 0 you mind if I close this door? 5 Q. Abyou may one poinion as to - and	16		16	Q. What are the possible causes for his
18 Q. Okay. And let me ask you first, what is 19 your definition of standard of care? 20 A. Standard of care is the care that would be 21 provided to a patient that is consistent with 22 22 guidelines and is consistent with the care that is 23 23 characteristic of your community, what a competent 24 24 characteristic of your community, what a competent 23 25 characteristic of your community, what a competent 24 26 Q. Okay. And do you have an opinion as to the 27 circumstances. 24 3 Q. And you have standard-of-care 7 criticisms of any of the physicians involved in this 26 8 case? Q. 9 A. No. 10 Q. Do you believe that they all met the 11 standard of care or there are certain poople who you 12 just simply have no opinions on? 13 A. I was really only asked to make an opinion 14 A. I was really only asked to make an opinion 15	E		F	
 19 your definition of standard of care? 20 A. Standard of care is the care that would be provided to a patient that is consistent with 21 provided to a patient that is consistent with 22 guidelines and is consistent with the care that is 23 characteristic of your community, what a competent 24 cardiologist in my in my field would be expected 24 Do you have an opinion as to the 23 multiples. 25 A. I do. 26 Q. Okay. Do you have standard-of-care opinions in 4 this case, I assume? 27 A. No. 28 A. No. 29 A. No. 20 Q. Okay. Do you believe that they all met the 3 about Dr. Auerbach. 29 A. I was really only asked to make an opinion 4 about Dr. Auerbach. 20 And when I ask you an opinion, Tm going 20 to ask you only to give me opinions if you hold them 21 to a reasonable degree of medical probability. 20 Okay? 21 A. Standard of care of medical probability. 20 Okay? 21 A. Standard of care of medical probability. 22 Okay? 23 A. Stre. 	1			<i>v</i>
20 A. Standard of care is the care that would be 21 provided to a patient that is consistent with 20 Q. Okay. And do you have an opinion as to 22 guidelines and is consistent with the care that is which of the coronary arteries? And I don't mean 23 characteristic of your community, what a competent "which" to be only one. There may have been 24 cardiologist in my in my field would be expected 24 Do you have an opinion as to the 24 and you have an opinion as to the 24 Do you have an opinion as to the 25 1 to provide to that patient under similar 2 A. Yeake 1.7 2 A. M you have standard-of-care opinions in 4 Do you mini if 1 close this door? 5 3 Q. Okay. Do you have any standard-of-care 6 (Discussion held off the record.) 7 4 Do you make an opinion as to - and again, this is to a probability - as to what the 1 11 standard of care or there are certain people who you 12 A. Yes. 13 A. I was really only asked to make an opinion 13 Q. And what is your opinions? 14 <td></td> <td></td> <td></td> <td></td>				
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23 characteristic of your community, what a competent 23 multiples. 24 cardiologist in my in my field would be expected 24 Do you have an opinion as to the 24 cardiologist in my in my field would be expected 24 Do you have an opinion as to the 1 to provide to that patient under similar 2 24 Do you have an opinion as to the 2 A. Mayou have standard-of-care opinions in 4 distribution? 2 A. Yeah. You know, can I see I wanted to 3 gene 15 1 distribution? 2 A. Yeah. You know, can I see I wanted to 3 circumstances. 2 A. Yeah. You know, can I see I wanted to 3 see the stress test result one more time. 4 Do you mind if I close this door? 5 5 A. I do. 6 (Discussion held off the record.) 7 A. Yes. I'm sorry. Can you repeat the 8 question? 9 A. No. 10 Q. Okay. Do you have an opinion as to and again, this is to a probability as to what the 11 standard of care or there are certain people who you 13 A. I was really only asked to make an opinion 13 Q. And what is your opinion?			4	
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5 (Pages 14 to 17)

	Page 18		Page 20
1	A. Uhm, most likely.	1	the damage that was done from that heart attack.
2	Q. Okay. Do you agree to a probability that	2	A. Yes.
3	on June 8 on or about June 18th, the first day	3	Q. The area of reversible ischemia, is that
4	when he presented to the hospital, that he had had a	4	representative of areas where there's a
5	non-Q-wave myocardial infarction?	5	supply-and-demand issue between rest and stress?
6	A. He had a non-ST-segment elevation	6	A. I don't know what you mean.
7	myocardial infarction.	7	Q. Okay. When we talk about reversible
8	Q. Okay. That's not something that you need	8	ischemia, let's make sure that I understand it
9	the benefit of retrospect to know. That was	9	correctly. I understand that reversible ischemia
10	something that you could tell from his clinical	10	in a nuclear stress test, you're actually looking
11	presentation combined with his laboratory values	11	at sections cut of the heart, and you're looking at,
12	that day. Correct?	12	for lack of a better term, the doughnut at rest
13	A. I'm not as clear on that comment. I would	13	versus the doughnut at stress to see if, in fact,
14	make my assessment based upon a retrospective	14	there is a difference between rest and stress for
15	analysis of this case.	15	reperfusion.
16	Q. Okay. And what is it in retrospect that	16	A. Okay.
17	makes you conclude that he had a non-ST-segment	17	Q. Is that accurate?
1		18	
18	myocardial infarction on June 18th, to a		A. Simplistically, yes.
19	probability?	19	Q. I keep it as simple as possible so that I
20	A. I believe the Cardiolite scan is very	20	can understand it.
21	helpful in helping me make that diagnosis clearly.	21	A. Okay.
22	Q. Did you actually look at the images from	22	Q. That is reversible ischemia, where there
23	the Cardiolite scan?	23	is a difference between the resting and the stress
24	A. No.	24	images.
1	Page 19	1	Page 21 A. Most instances.
1	Q. Okay. You're simply relying on the report that describes a fixed defect and also an area of		
$\frac{2}{2}$		2 3	Q. I am asking, the area where there was reversible ischemia seen in this case on
3	reversibility of the ischemia?	1	
4	A. Yes.	4	Jeff Lyons's scan, are you able to conclude that
5		L	
1 1	Q. And the area where you believe the non-ST	5	that was representative of ongoing coronary artery
6	infarct was that was on the 18th, would that be	6	disease?
7	infarct was that was on the 18th, would that be represented by the area of reversible ischemia or	6 7	disease? A. No.
7 8	infarct was that was on the 18th, would that be represented by the area of reversible ischemia or the area where the fixed defect was?	6 7 8	disease? A. No. Q. Okay. Do you have any opinion as to why
7 8 9	infarct was that was on the 18th, would that berepresented by the area of reversible ischemia orthe area where the fixed defect was?A. The I thought the Cardiolite was done	6 7 8 9	disease?A. No.Q. Okay. Do you have any opinion as to why he had reversible ischemia on the Cardiolite stress
7 8 9 10	infarct was that was on the 18th, would that berepresented by the area of reversible ischemia orthe area where the fixed defect was?A. The I thought the Cardiolite was doneon a different date.	6 7 8 9 10	disease?A. No.Q. Okay. Do you have any opinion as to why he had reversible ischemia on the Cardiolite stress test?
7 8 9 10 11	infarct was that was on the 18th, would that be represented by the area of reversible ischemia or the area where the fixed defect was?A. The I thought the Cardiolite was done on a different date.Q. I know the Cardiolite was done on a	6 7 8 9 10 11	disease?A. No.Q. Okay. Do you have any opinion as to why he had reversible ischemia on the Cardiolite stress test?A. Well, do you mind if I just read the
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	Page 22		Page 24
1	infarction has happened?	1	a clinician, what does that raise your index of
2	A. Yes.	2	suspicion for?
3	Now, the fixed defect implies that there	3	A. As a cardiologist, my main job is to make
4	had been a myocardial infarction.	4	sure that chest pain is or is not related to the
5	Q. When we say that a marginal amount of	5	heart.
6	reversibility, does that mean, though, that there's	6	Q. And chest pain or angina which is
7	still heart tissue which is not getting blood during	7	consistent with, you know, the heart as an
8	stress but at rest is able to reperfuse and is still	8	underlying cause, does it have a typical type of
9	not infarcted?	9	presentation?
10	A. Perhaps.	10	A. Yes.
11	Q. Okay.	11	Q. And can you describe that for me?
12	A. Not always.	12	A. It's chest pain that usually is
13	Q. What else could that reversibility account	13	substernal. It's often not so much of a pain but a
14	for?	14	discomfort, a discomfort that's difficult to put
15	A. It's not uncommon to have a small amount	15	into words often. It can be a pressure-like
16	of margin effect even in a completed infarction.	16	sensation. It often has modifying factors.
17	He's very early from the time of the infarction, so	17	Physical activity tends to bring it on, rest tends
18	that area, it can take on many different meanings.	18	to relieve it, sublingual nitroglycerin can relive
19	Q. Could it still be the progression of death	19	it; and it can be radiating to the jaws, to the
20	from that infarction?	20	arms, to the back. It can be in various places.
21	A. Yes.	21	Q. As far as assessing whether or not
22	Q. Looking at While we're on the	22	somebody has had a myocardial infarction or the
23	Cardiolite image, we might as well finish off there.	23	heart as a cause, I guess, for their chest pain, is
24	It does appear that he has good left ventricular	24	an EKG in and of itself diagnostic one way or
<u> </u>			
	Page 23		Page 25
1	function within an ejection fraction of 55 percent.	1	another?
2	Correct?	2	A. It can be.
3	A. Yes.	3	Q. Can an EKG be normal, though, and a
4	Q. Do you believe, as of June 26th of 2000,	4	patient still be having a myocardial infarction?
5	which is when the Cardiolite stress test was done,	5	A. Yes.
6	knowing that an exercise stress test had been done	6	Q. The EKG which was performed on June 18th,
7	before that, that there was any significant heart	7	do you know how many leads that was?
8	muscle damage that had occurred that would have	8	A. This is not a trick question, right?
9	impacted upon his quality of life?	9	Q. No.
10	A. The amount of heart muscle damage,	10	A. Twelve lead.
11	according to the stress test, was very small. His	11	Q. Okay.
12	prognosis typically in this type of report is quite	12	A. Okay. I
13	good.	13	Q. Why did you think it was a trick?
14	Q. One of the things, though, for his	14	A. They're all 12 leads unless something
15	prognosis to be good is to stabilize the heart, make	15	I've never seen anything but a 12-lead in a long
16	sure there's adequate perfusion so there's not	16	time.
17	another infarction.	17	Q. And are there specific types of myocardial
18	A. Maybe.	18	infarctions that a 12-lead EKG is not going to be
19	Q. We'll come back to that.	19	sensitive for?
20	A. Okay.	20	A. The the least sensitivity that it
21	Q. What is angina?	21	displays is in posterior myocardial infarctions.
22	A. Uhm, angina typically refers to what I	22	Q. Another way to test for a myocardial
23	talk about is angina pectoris, chest pain.	23	infarction is through laboratory testing, enzymes
	Q. And what is that symbolic of; or to you as	24	particularly, and markers.
24	Q. Find what is that symbolic of, of to you as	2,	particularly, and markets.

 Page 26 A. Correct. Q. What is troponin? A. It is a cardiac enzyme. Q. Is troponin considered the gold standard as far as the utilization of enzymes to detect whether or not there's been loss of heart muscle? A. I I think troponin and CPK-MBs are are the measures that we do, that we look at to determine myocardial damage. Q. The troponins in this case went from 1 to I.8 to 1.9. Do you believe that those represented an increase in the troponin? A. Yes. Q. Okay. Do you believe that that was related to loss of heart muscle on June 18th and June 19th? A. Yes. Q. What else can account for that elevation M. Yes. Q. What else can account for that elevation in troponin other than a myocardial infarction? A. Tes. A. Yes. B. A. Yes.<	
 2 Q. What is troponin? 3 A. It is a cardiac enzyme. 4 Q. Is troponin considered the gold standard 5 as far as the utilization of enzymes to detect 6 whether or not there's been loss of heart muscle? 7 A. I I think troponin and CPK-MBs are 8 are the measures that we do, that we look at to 9 determine myocardial damage. 10 Q. The troponins in this case went from 1 to 11 1.8 to 1.9. 12 Do you believe that those represented an 13 increase in the troponin? 14 A. Yes. 15 Q. Okay. Do you believe that that was 16 related to loss of heart muscle on June 18th and 17 June 19th? 18 A. Yes. 19 Q. What else can account for that elevation 20 in troponin other than a myocardial infarction? 21 A. Set an account for that elevation 22 things legally, you're aware we discuss to a 3 probability. 4 A. Yes. 10 Q. The most likely cause for an elevation, 6 the significant the clear the clearly most 7 A. I I think troponin and CPK-MBs are 8 are the measures that we do, that we look at to 9 A. Correct. 10 Q. And when a troponin comes back that's 11 abnormal, particularly when more than one comes 12 abnormal. 14 A. Yes. 15 Q. Okay. Do you believe that that was 16 A. We typically try to rule out coronary 17 June 19th? 18 A. Yes. 19 Q. What else can account for that elevation 20 in troponin other than a myocardial infarction? 	
 3 A. It is a cardiac enzyme. 4 Q. Is troponin considered the gold standard 5 as far as the utilization of enzymes to detect 6 whether or not there's been loss of heart muscle? 7 A. I I think troponin and CPK-MBs are 8 are the measures that we do, that we look at to 9 determine myocardial damage. 10 Q. The troponins in this case went from 1 to 11 1.8 to 1.9. 12 Do you believe that those represented an 13 increase in the troponin? 14 A. Yes. 15 Q. Okay. Do you believe that that was 16 related to loss of heart muscle on June 18th and 17 June 19th? 18 A. Yes. 19 Q. What else can account for that elevation 20 in troponin other than a myocardial infarction? 3 probability. 4 A. Yes. 16 related to loss of heart muscle on June 18th and 17 June 19th? 18 A. Yes. 19 Q. What else can account for that elevation 20 in troponin other than a myocardial infarction? 3 probability. 4 A. Yes. 16 related to left the toponin? 17 June 19th? 18 A. Yes. 19 Q. What else can account for that elevation 20 in troponin other than a myocardial infarction? 3 probability. 4 A. Yes. 4 A. Yes. 5 Q. As abnormal. 6 A. We typically try to rule out coronary 17 June 19th? 18 A. Yes. 19 Q. What else can account for that elevation 20 symptomatic with intermittent left-sided chest patient is 20 symptomatic with intermittent left-sided chest patient is 	
 4 Q. Is troponin considered the gold standard 5 as far as the utilization of enzymes to detect 6 whether or not there's been loss of heart muscle? 7 A. I I think troponin and CPK-MBs are 8 are the measures that we do, that we look at to 9 determine myocardial damage. 10 Q. The troponins in this case went from 1 to 11 1.8 to 1.9. 12 Do you believe that those represented an 13 increase in the troponin? 14 A. Yes. 15 Q. Okay. Do you believe that that was 16 related to loss of heart muscle on June 18th and 17 June 19th? 18 A. Yes. 19 Q. What else can account for that elevation 20 in troponin other than a myocardial infarction? 4 A. Yes. 16 related to less of heart muscle on June 18th and 17 June 19th? 18 A. Yes. 19 Q. What else can account for that elevation 20 in troponin other than a myocardial infarction? 4 A. Yes. 16 A. We typically try to rule out coronary 17 artery disease first. 18 Q. And when you're trying to rule out 19 coronary artery disease where a patient is 20 symptomatic with intermittent left-sided chest patient is 	
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 6 whether or not there's been loss of heart muscle? 7 A. I I think troponin and CPK-MBs are 8 are the measures that we do, that we look at to 9 determine myocardial damage. 10 Q. The troponins in this case went from 1 to 11 1.8 to 1.9. 12 Do you believe that those represented an 13 increase in the troponin? 14 A. Yes. 15 Q. Okay. Do you believe that that was 16 related to loss of heart muscle on June 18th and 17 June 19th? 18 A. Yes. 19 Q. What else can account for that elevation 20 in troponin other than a myocardial infarction? 6 the significant the clear the clearly most 7 likely cause of elevated troponin is myocardial 8 necrosis; correct? 9 A. Correct. 10 Q. And when a troponin comes back that's 11 abnormal, particularly when more than one comes 12 Do you believe that that was 14 A. Yes. 15 Q. Okay. Do you believe that that was 16 A. We typically try to rule out coronary 17 artery disease first. 18 Q. And when you're trying to rule out 19 coronary artery disease where a patient is 20 symptomatic with intermittent left-sided chest patient is 	
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10Q. The troponins in this case went from 1 to111.8 to 1.9.12Do you believe that those represented an13increase in the troponin?14A. Yes.15Q. Okay. Do you believe that that was16related to loss of heart muscle on June 18th and17June 19th?18A. Yes.19Q. What else can account for that elevation20in troponin other than a myocardial infarction?10Q. And when a troponin comes back that's11abnormal, particularly when more than one comes12Do you believe that those represented an13increase in the troponin?14A. Yes.15Q. As abnormal.16Image: A. Yes.18A. Yes.20in troponin other than a myocardial infarction?20symptomatic with intermittent left-sided chest particularly and the section	
 11 1.8 to 1.9. 12 Do you believe that those represented an 13 increase in the troponin? 14 A. Yes. 15 Q. Okay. Do you believe that that was 16 related to loss of heart muscle on June 18th and 17 June 19th? 18 A. Yes. 19 Q. What else can account for that elevation 20 in troponin other than a myocardial infarction? 11 abnormal, particularly when more than one come 12 abnormal, is there an attitude that it's cardiac 13 until proven otherwise? 14 A. When more than one comes back as abno 15 Q. As abnormal. 16 A. We typically try to rule out coronary 17 artery disease first. 18 Q. And when you're trying to rule out 19 coronary artery disease where a patient is 20 symptomatic with intermittent left-sided chest patient is 	
12Do you believe that those represented an increase in the troponin?12abnormal, is there an attitude that it's cardiac13increase in the troponin?13until proven otherwise?14A.Yes.14A.When more than one comes back as abno15Q.Okay. Do you believe that that was15Q.As abnormal.16related to loss of heart muscle on June 18th and16A.We typically try to rule out coronary17June 19th?17artery disease first.18Q.And when you're trying to rule out19Q.What else can account for that elevation 2019coronary artery disease where a patient is 202020symptomatic with intermittent left-sided chest patient20symptomatic with intermittent left-sided chest patient	
 13 increase in the troponin? 14 A. Yes. 15 Q. Okay. Do you believe that that was 16 related to loss of heart muscle on June 18th and 17 June 19th? 18 A. Yes. 19 Q. What else can account for that elevation 20 in troponin other than a myocardial infarction? 13 until proven otherwise? 14 A. When more than one comes back as abno 15 Q. As abnormal. 16 A. We typically try to rule out coronary 17 artery disease first. 18 Q. And when you're trying to rule out 19 coronary artery disease where a patient is 20 symptomatic with intermittent left-sided chest patient is 	mal?
 13 increase in the troponin? 14 A. Yes. 15 Q. Okay. Do you believe that that was 16 related to loss of heart muscle on June 18th and 17 June 19th? 18 A. Yes. 19 Q. What else can account for that elevation 20 in troponin other than a myocardial infarction? 13 until proven otherwise? 14 A. When more than one comes back as abno 15 Q. As abnormal. 16 A. We typically try to rule out coronary 17 artery disease first. 18 Q. And when you're trying to rule out 19 coronary artery disease where a patient is 20 symptomatic with intermittent left-sided chest patient 	mal?
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18A.Yes.19Q.What else can account for that elevation18Q.And when you're trying to rule out20in troponin other than a myocardial infarction?18Q.And when you're trying to rule out20in troponin other than a myocardial infarction?20symptomatic with intermittent left-sided chest participantic	
19Q.What else can account for that elevation19coronary artery disease where a patient is20in troponin other than a myocardial infarction?20symptomatic with intermittent left-sided chest patient	
20 in troponin other than a myocardial infarction? 20 symptomatic with intermittent left-sided chest pa	
	n
21 A. There are other there are other causes 21 which radiates to the left arm or shoulder, time is	
22 of them. 22 of the essence; correct?	
23 You can have congestive heart failure, you 23 A. Sometimes.	
24 can have left ventricular wall stress that are 24 Q. Well, it's not something that you are	
Page 27	Page 29
1 brought on by a variety of factors, and then you can 1 going to put on the back burner. It's potentially	
2 have renal insufficiency. And those are just a few 2 life-threatening.	
3 of the things that can cause spurious elevations in 3 A. Some myocardial infarctions need to be	
4 troponins without a true myocardial infarction being 4 taken care of right away.	
5 present. 5 Q. Do you agree	
6 Q. When it's brought on by a renal cause, 6 The ER impression from June 18th was t	at
7 renal insufficiency, is it usually accompanied by a 7 Jeffrey Lyons had angina. Did you see that in t	ie
8 chest pain which radiates to the shoulder? 8 records?	
9 A. It's not unusual for patients with renal 9 A. Yes.	ļ
10 disease to have chest pain. 10 Q. Do you agree with that?	
11 Q. Does the chest pain, though, radiate to 11 A. Yes.	
12 the shoulder typically? 12 Q. Do you agree that it was unstable angina	?
13 A. It can radiate anywhere. 13 A. It's easy for me to say that he's had a	ļ
14 Q. Well, the other two causes that you gave 14 myocardial infarction. Not being there to take	is
15 me were both potentially cardiac in nature. One was 15 history, it would be much more difficult for me	
16 left ventricular 16 say that this was unstable angina.	
17 A. Disfunction. 17 Q. What is stable angina?	
18 Q dysfunction, 18 A. It's angina that's occurred over and over	
19A.Yes.19again and is relieved with rest and is more of a	
20 Q and the other was congestive heart 20 chronic condition. Patients know what can mal	e it
21 failure. 21 come on. They know what can stop it. It has n	
22 A. Well, that's that's congestive heart 22 changed in character, frequency over time.	-
23failure. The other is Another cause is left23Q.Does he give a history of this being	
24 ventricular wall strain.	

8 (Pages 26 to 29)

		<u> </u>	
	Page 30		Page 32
1	A. No.	1	Q. Stable angina is a more reassuring finding
2	Q. He gives actually that it's been	2	than unstable angina; correct?
3	intermittent chest discomfort for two days,	3	A. Yes.
4	A. Correct.	4	Q. When you're dealing with the heart as a
5	Q which wouldn't fall into the category	5	problem where you're not certain if it's stable or
6	of stable angina or chronic angina; correct?	6	unstable angina, because of the potential
7	A. That's correct.	7	life-threatening nature of coronary artery disease,
8	Q. He describes this discomfort is heavier	8	do you treat the worst-case scenario until you've
9	and harder than he's had in the past and radiates to	9	ruled it out?
10	his left shoulder.	10	
		1	J1 J
11	That change in symptoms is also	11	scenario, and you may need to treat it.
12	inconsistent with calling it stable angina; correct?	12	Q. Looking at this as the worst-case
13	A. Correct.	13	scenario, that he believed there was angina and the
14	Q. He has variations in the degree of pain,	14	troponin suggests an acute MI, he actually lists, do
15	he says, between two of ten to six of ten. That's	15	you believe the standard of care required a cardiac
16	not consistent with stable angina, either; is it?	16	consult be ordered?
17	A. No.	17	MR. DILLON: At what time? Are you still
18	Q. What more historical information do you	18	on the 18th?
19	need to know?	19	MR. KELLEY: I'm on the 18th still.
20	Other than the history and physical that	20	A. No.
21	was taken there, that it's intermittent for two	21	Q. At any point in time was it okay to say,
22	days, it's different than any chest pain he's had in	22	you're fine; Go home; You never need to see a
23	the past, that it's heavier and harder, it's now	23	cardiologist, or did a consult need to be ordered at
24	radiating, and it has fluctuations in degree, what	24	any point?
2r	radiating, and it has indetautons in degree, what	14-T	any point:
1		1	
	Dogo 21	ļ	Dago 2.7
1	Page 31	1	Page 33
1	more information do you need to know clinically to	1	A. I think that cardiac consult is not an
2	more information do you need to know clinically to know that this is not stable angina, if any?	2	A. I think that cardiac consult is not an unreasonable thing to do, but I do feel that his
2 3	more information do you need to know clinically to know that this is not stable angina, if any?A. The cardiac enzymes.	2 3	A. I think that cardiac consult is not an unreasonable thing to do, but I do feel that his condition at that time could be adequately handled
2 3 4	more information do you need to know clinically to know that this is not stable angina, if any?A. The cardiac enzymes.Q. We know that the troponin came back at	2 3 4	A. I think that cardiac consult is not an unreasonable thing to do, but I do feel that his condition at that time could be adequately handled by an internist.
2 3 4 5	more information do you need to know clinically to know that this is not stable angina, if any?A. The cardiac enzymes.Q. We know that the troponin came back at 1, 1.8, and 1.9; the CPK-MB, I believe, came back	2 3 4 5	A. I think that cardiac consult is not an unreasonable thing to do, but I do feel that his condition at that time could be adequately handled by an internist.Q. This patient had a lot of risk factors for
2 3 4 5 6	 more information do you need to know clinically to know that this is not stable angina, if any? A. The cardiac enzymes. Q. We know that the troponin came back at 1, 1.8, and 1.9; the CPK-MB, I believe, came back within I think he came back within normal limits. 	2 3 4 5 6	 A. I think that cardiac consult is not an unreasonable thing to do, but I do feel that his condition at that time could be adequately handled by an internist. Q. This patient had a lot of risk factors for coronary artery disease; correct?
2 3 4 5 6 7	 more information do you need to know clinically to know that this is not stable angina, if any? A. The cardiac enzymes. Q. We know that the troponin came back at 1, 1.8, and 1.9; the CPK-MB, I believe, came back within I think he came back within normal limits. A. Yes. 	2 3 4 5 6 7	 A. I think that cardiac consult is not an unreasonable thing to do, but I do feel that his condition at that time could be adequately handled by an internist. Q. This patient had a lot of risk factors for coronary artery disease; correct? A. Correct.
2 3 4 5 6 7 8	 more information do you need to know clinically to know that this is not stable angina, if any? A. The cardiac enzymes. Q. We know that the troponin came back at 1, 1.8, and 1.9; the CPK-MB, I believe, came back within I think he came back within normal limits. A. Yes. Q. Does the CPK-MB being within normal limits 	2 3 4 5 6 7 8	 A. I think that cardiac consult is not an unreasonable thing to do, but I do feel that his condition at that time could be adequately handled by an internist. Q. This patient had a lot of risk factors for coronary artery disease; correct? A. Correct. Q. Family history has a is a very
2 3 4 5 6 7 8 9	 more information do you need to know clinically to know that this is not stable angina, if any? A. The cardiac enzymes. Q. We know that the troponin came back at 1, 1.8, and 1.9; the CPK-MB, I believe, came back within I think he came back within normal limits. A. Yes. Q. Does the CPK-MB being within normal limits somehow factor into whether it's stable or unstable 	2 3 4 5 6 7 8 9	 A. I think that cardiac consult is not an unreasonable thing to do, but I do feel that his condition at that time could be adequately handled by an internist. Q. This patient had a lot of risk factors for coronary artery disease; correct? A. Correct. Q. Family history has a is a very prognostic risk factor; correct?
2 3 4 5 6 7 8 9 10	 more information do you need to know clinically to know that this is not stable angina, if any? A. The cardiac enzymes. Q. We know that the troponin came back at 1, 1.8, and 1.9; the CPK-MB, I believe, came back within I think he came back within normal limits. A. Yes. Q. Does the CPK-MB being within normal limits somehow factor into whether it's stable or unstable angina? 	2 3 4 5 6 7 8 9 10	 A. I think that cardiac consult is not an unreasonable thing to do, but I do feel that his condition at that time could be adequately handled by an internist. Q. This patient had a lot of risk factors for coronary artery disease; correct? A. Correct. Q. Family history has a is a very prognostic risk factor; correct? A. Correct.
2 3 4 5 6 7 8 9 10 11	 more information do you need to know clinically to know that this is not stable angina, if any? A. The cardiac enzymes. Q. We know that the troponin came back at 1, 1.8, and 1.9; the CPK-MB, I believe, came back within I think he came back within normal limits. A. Yes. Q. Does the CPK-MB being within normal limits somehow factor into whether it's stable or unstable angina? A. They can. 	2 3 4 5 6 7 8 9 10 11	 A. I think that cardiac consult is not an unreasonable thing to do, but I do feel that his condition at that time could be adequately handled by an internist. Q. This patient had a lot of risk factors for coronary artery disease; correct? A. Correct. Q. Family history has a is a very prognostic risk factor; correct?
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9 (Pages 30 to 33)

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	Page 34		Page 36
1	A. Yes.	1	Q. So at this point, now we know that he's
2	Q. In addition to family history, did you see	2	had an MI.
3	that the physicians found any other risk factors?	3	With all of the other risk factors that
4	A. Yes.	4	we can think of absent diabetes, is this still a
5	Q. First, the fact that he's a male, is that	5	patient who is okay to be managed, in your opinion,
6	in and of itself a risk factor?	6	by a family practitioner or an internist or does he
7	A. It is.	7	need a full cardiac consult?
		8	A. I still think at this point in time, you
8	Q. He was 42 years old age. Is that in any		
9	way a risk factor?	9	could handle him with an internal medicine
10	A. No.	10	evaluation.
11	Q. He smoked, I believe, two and a half packs	11	Q. What would have to change with Jeff Lyons
12	of cigarettes or was a two-pack-per-day smoker.	12	for you to say that he needed a cardiac consult?
13	Is that a risk factor?	13	A. He would need to go to the cath lab.
14	A. Of course.	14	Q. Okay. How does he get to the cath lab
15	Q. He had central obesity. I believe he was	15	without a cardiac consult?
16	five-eleven and weighed about 220 or 215. Is	16	A. An internist can call you and say, I
17	obesity a risk factor?	17	believe or the emergency room physician can call
18	A. Yes.	18	a cardiologist such as myself and say, I have this
19	Q. He had hypertension. Is that a risk	19	patient with these symptoms; I believe he needs to
20	factor?	20	go to the cath lab. That often gets them there.
21	A. Yes.	20	•
22	Q. He had hyperlipidemia. Is that a risk	22	practitioner in and of themselves has the ability to
23	factor?	23	order or request from you to just take him straight
24	A. Yes.	24	to the cath lab?
		1	
1	Page 35	т	Page 37
1	Q. Can you give me some cardiac risk factors	1	A. Yes.
2	Q. Can you give me some cardiac risk factors that you're aware of that are common that he didn't	1 2	A. Yes.Q. Is that the way it typically happens?
2 3	Q. Can you give me some cardiac risk factors that you're aware of that are common that he didn't have?	3	A. Yes.Q. Is that the way it typically happens?A. It's not atypical.
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10 (Pages 34 to 37)

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	Page 38		Page 40
1	Q. And with single-vessel disease, would he	1	A. Yes.
2	then be a candidate for stents, angioplasty as one	2	Q. And I'm kind trying to understand the
3	of the methods of revascularization?	3	treatment options.
4	A. Perhaps.	4	Do you have an opinion to a probability
5	Q. And do you have an opinion as to what the	5	which treatment option he would have required,
6	degree of occlusion would have been in his right	6	whether it be angioplasty, stenting, or a bypass of
7	coronary?	7	that proximal lesion?
8	A. Uhm, judging from the nuclear scan, it's a	8	A. Assuming that it was single-vessel
9	greater likelihood than not that the vessel would	9	disease, there is a high likelihood he would not
10	have been 100 percent occluded.	10	have needed bypass surgery. That's probably the
11	Q. Okay. Do you believe it would have been	11	easiest thing for me to say.
12	occluded in the proximal or distal portion? Are you	12	Then would he have been better off with
13	able to tell that from the scan?	13	medical therapy or angioplasty would only be
14	A. There there is some evidence that this	14	determined by the angiographic appearance. But we
15	would have been a proximal right coronary artery	15	know that with single-vessel disease, you the
16	stenosis blockage.	16	outcomes are similar with medical therapy versus
17	Q. If it wasn't amenable to revascularization	17	balloons and stents or at least balloon angioplasty
18	by way of stents or angioplasty, would this have	18	of single-vessel disease.
19	been the type of lesion that would have been	19	Q. And by "medical therapy," are we talking
20	recommended for bypass surgery?	20	about things like beta blockers and calcium channel
21	A. Again, it all depends on what the	21	blockers?
22	catheterization showed, if there was multivessel	22	A. Mostly beta blockers, aspirin, perhaps
23	disease, et cetera.	23	cholesterol-lowering agents.
24	Q. And that's what	24	Q. And obviously he would have required
	Page 39		
1	I'm trying to kind of sift through.	1	Page 41 medications for his hypertension and cholesterol
2	A. Uh-huh.	2	going forward.
3	Q. To a probability, do you believe that it	3	A. More than likely.
4	would have been multivessel disease or	4	Q. Had he received either
5	single-vessel disease?	5	Let's assume that it was single-vessel
6	A. The only way that you can decide that is	6	disease, had he been cathed, it showed what you
7	on	7	believe it would have shown to a probability. Do
8	Q. Internal?	8	you have an opinion as to what his life expectancy
9	A on the data that you are given, short	9	would have been with medical therapy?
10	of doing the heart catheterization.	10	A. The likelihood, based upon single-vessel
11	Q. Okay.	11	disease, is excellent.
12	A. If I had to predict based upon his	12	Q. Okay. And can we quantify what
13	presentation, his enzyme elevation, and his stress	13	"excellent" means in terms of years? He's 42 years
14	test results, I would predict he had single-vessel	14	old.
15	disease.	15	A. Yeah. Uhm, the only thing that I could
16	Q. And you believe it would be proximal	16	give you is, I know there was one study looking at
17	single-vessel disease in the right coronary artery?	17	medical therapy for single-vessel disease, and I
18	A. Right. But you don't absolutely know	18	think the event rates, the cardiac death rate with
19	unless you do the heart catheterization.	19	medical therapy was, I think, less than one percent
20	Q. And I'm simply asking to a probability the	20	within six months, clearly less than three percent.
21	most likely scenario,	21	Q. Do you have an opinion as to what his life
22	A. Okay.	22	expectancy would have been had he been diagnosed
23	Q and that's what you believe most	23	with single-vessel disease and either received
24	likely?	24	medical therapy or, I guess, angioplasty or
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11 (Pages 38 to 41)

24

Do you see that?

1	Page 46 A. I'm unclear of what page you are on.	1	Q. (Handed documents to witness.)
12	1 0 1	12	Q. (Handed documents to witness.)A. I remember this.
		$\frac{2}{3}$	He was seen in the emergency room the
3	And to be honest, I went to it just because it's		
4	kind of a decent summary page.	4	other day because of an episode of chest pain. He
5	A. Is that before she has her these notes?	5	has a pretty good story for angina, but his stress
6	After the labs?	6	test was negative. We don't have the Cardiolite
7	Q. I don't know in yours. We have tabs.	7	part yet. If it is normal, and it will be back
8	I'll show you mine.	8	tomorrow, then we'll have to decide that he does not
9	(Discussion held off the record.)	9	have coronary artery disease. He abbreviated it
10	Q. Do you agree that those were the admitting	10	C-A-D.
11	diagnoses?	11	He does have a lot of epigastric distress,
12	A. Yes.	12	and this may be giving him esophagitis or reflux
13	Q. Going on, when he was discharged, what is	13	causing some chest pain.
14	your understanding factually of what the follow-up	14	Q. So according to a couple things that
15	plan for him was?	15	Dr. Gebhart
16	A. The follow-up plan was per Dr. Tulebaev's	16	We know Dr. Gebhart was aware he was in
17	note. That's the only plan that I I had.	17	the hospital. Correct?
18	Q. Okay. And let's go through.	18	A. Yes.
19	A. Okay.	19	Q. We know Dr. Gebhart was aware of the
20	Q. What do Dr. Tulebaev's notes say is going	20	stress test results.
21	to occur?	21	A. Part of them.
22	A. I prefer to read that to you so I don't	22	Q. And it appears that he relayed to
23	misquote him or take him out of context.	23	Dr. Gebhart that he was still having some chest
24	Q. Absolutely.	24	pain?
	D 47		D 40
1	Page 47 A Let me just get to that Here it is	1	Page 49 A Veah enigastric nain
1	A. Let me just get to that. Here it is.	1	A. Yeah, epigastric pain.
2	A. Let me just get to that. Here it is. His assessment is, The patient is admitted	1 2 3	A. Yeah, epigastric pain.Q. Well, 'cause we don't want to take
2 3	A. Let me just get to that. Here it is. His assessment is, The patient is admitted with chest pain which I think is unlikely to be	3	 A. Yeah, epigastric pain. Q. Well, 'cause we don't want to take anything out of context,
2 3 4	A. Let me just get to that. Here it is. His assessment is, The patient is admitted with chest pain which I think is unlikely to be related to coronary artery disease since the patient	3 4	 A. Yeah, epigastric pain. Q. Well, 'cause we don't want to take anything out of context, A. Uh-huh.
2 3 4 5	A. Let me just get to that. Here it is. His assessment is, The patient is admitted with chest pain which I think is unlikely to be related to coronary artery disease since the patient is involved in heavy physical exertion on a daily	3 4 5	 A. Yeah, epigastric pain. Q. Well, 'cause we don't want to take anything out of context, A. Uh-huh. Q he says, He does have some epigastric
2 3 4 5 6	A. Let me just get to that. Here it is. His assessment is, The patient is admitted with chest pain which I think is unlikely to be related to coronary artery disease since the patient is involved in heavy physical exertion on a daily basis and never experiences chest pain.	3 4	 A. Yeah, epigastric pain. Q. Well, 'cause we don't want to take anything out of context, A. Uh-huh. Q he says, He does have some epigastric distress, and this may be giving him esophagitis or
2 3 4 5 6 7	A. Let me just get to that. Here it is. His assessment is, The patient is admitted with chest pain which I think is unlikely to be related to coronary artery disease since the patient is involved in heavy physical exertion on a daily basis and never experiences chest pain. The plan is, I am going to discharge the	3 4 5 6 7	 A. Yeah, epigastric pain. Q. Well, 'cause we don't want to take anything out of context, A. Uh-huh. Q he says, He does have some epigastric distress, and this may be giving him esophagitis or reflux causing some chest pain.
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$\begin{array}{c} 2\\ 3\\ 4\\ 5\\ 6\\ 7\\ 8\\ 9\\ 10\\ 11\\ 12\\ 13\\ 14\\ 15\\ 16\\ 17\\ 18\\ 19\\ 20\\ 21\\ \end{array}$	 A. Let me just get to that. Here it is. His assessment is, The patient is admitted with chest pain which I think is unlikely to be related to coronary artery disease since the patient is involved in heavy physical exertion on a daily basis and never experiences chest pain. The plan is, I am going to discharge the patient home today and have him follow up with Dr. Gebhart in one week for a full physical examination. I think it would be useful also to follow up with Dr. Auerbach next Tuesday for a stress Cardiolite test. Q. Okay. When he sees Dr. Gebhart, are you familiar with the history that he gave Dr. Gebhart? A. I did review that. Q. And what does he describe to Dr. Gebhart? A. You know, I hate to take these things out of context. Q. I don't want you to take any That's why I said earlier take as much time as you need A. Okay. 	$\begin{array}{c} 3 \\ 4 \\ 5 \\ 6 \\ 7 \\ 8 \\ 9 \\ 10 \\ 11 \\ 12 \\ 13 \\ 14 \\ 15 \\ 16 \\ 17 \\ 18 \\ 19 \\ 20 \\ 21 \\ \end{array}$	 A. Yeah, epigastric pain. Q. Well, 'cause we don't want to take anything out of context, A. Uh-huh. Q he says, He does have some epigastric distress, and this may be giving him esophagitis or reflux causing some chest pain. A. Okay. Q. You read that; correct? A. He You know, his note says that he has epigastric distress. I don't know if he was referring to the chest pain as being remote or if that's another complaint of chest pain to him. Q. Cardiac and epigastric pain can sometimes be difficult to distinguish; correct? A. Absolutely. Q. And in light of the troponins and things like that, his history in the emergency room, this would be relevant information that would make you question the stability of this patient. Correct? A. Yes.

13 (Pages 46 to 49)

Page 50 A. Yes. But at the time that Dr. Gebhart saw him, he had a normal stress EKG, so he's starting to be led down the path that this isn't his heart.	1	Page 52
him, he had a normal stress EKG, so he's starting to	1	
		stress tests?
	2	A. Rarely.
	3	Q. Do you ever read them as part of your
Q. He had the report of a normal stress EKG.	4	assessment of a patient before making the
A. Yes.	5	determination as to what interventional procedure to
Q. Have you been provided Dr. Garrett's	6	perform?
deposition?	7	A. Yes.
		Q. So you are qualified to read them.
		A. Yes.
		Q. Okay.
		•
		if you have it for me.
		Q. Do you Were you not provided it?
		A. You know, I don't see it in here. No. It
		could be in another place, but I don't see it.
		Q. Did you receive the medical records of
A. Yes.		Dr. Auerbach?
Q. But you have not read it as you sit here?	18	A. I received his letter that he wrote to
A. Right.	19	Dr. Tulebaev.
Q. Have you reviewed the stress test?	20	Q. You mean to Dr
A. No.	21	How about the one to Dr. Gebhart?
Q. You have never reviewed the stress test to	22	A. To Dr. Gebhart. I apologize. Yes.
		Q. Does he describe it as a normal stress
	1	test or an abnormal stress test in that letter?
Page 51		Page 53
	1	A. He described the Cardiolite as being
Dr. Beaver.	2	abnormal.
A. No. I read his interpretation of the	3	Q. The exact phrase is, Mr. Lyons has
stress test.	4	unstable angina postinfarction. He had an abnormal
O. Did you read the actual stress test	5	stress test which I think underestimates the
		severity of the problem.
		A. Right.
		Q. Do you believe that's only referring to
		the Cardiolite portion?
		A. Yes.
		Q. Is that
-		A. Dr. Beaver's interpretation is his resting
		and exercise electrocardiograms remain normal during
		the stress test.
correct?	15	Q. I understand that's what Dr. Beaver
A. I know how to read them. I don't do them	16	reported.
	17	A. Okay. Would you like me to review the
on a daily basis.		
Q. Describe for me briefly, then, your	18	EKGs of the stress test? I would be happy to do
Q. Describe for me briefly, then, your practice. Is it mainly interventional cardiology?	19	that.
 Q. Describe for me briefly, then, your practice. Is it mainly interventional cardiology? A. Yes. 	19 20	that. Q. I'm going to pull them out for you.
 Q. Describe for me briefly, then, your practice. Is it mainly interventional cardiology? A. Yes. Q. What percentage would you say is 	19 20 21	that.Q. I'm going to pull them out for you.A. Okay.
 Q. Describe for me briefly, then, your practice. Is it mainly interventional cardiology? A. Yes. Q. What percentage would you say is noninterventional, if any? 	19 20 21 22	that. Q. I'm going to pull them out for you.
 Q. Describe for me briefly, then, your practice. Is it mainly interventional cardiology? A. Yes. Q. What percentage would you say is 	19 20 21	that.Q. I'm going to pull them out for you.A. Okay.
Alordordordordordordordordordordordordordo	 A. Uhm, I think so, but I I can't seem to locate it. Q. Have you read it? A. No, I have not read it. Q. So you were either provided it and misplaced it, a filing issue, A. Exactly. Q or it hasn't gotten here for some reason or another? A. Yes. Q. But you have not read it as you sit here? A. Right. Q. Have you reviewed the stress test? A. No. Q. You have never reviewed the stress test to see whether or not if you agree if it was normal? A. The EKGs? Page 51 Q. The stress test that was performed by Dr. Beaver. A. No. I read his interpretation of the stress test. Q. Did you read the actual stress test test? A. Did I see all of the EKGs associated with t? Q. Yes. A. I don't believe I have. Q. Can I see in your chart what portions of t you have? A. Okay. Q. You read stress tests here in your job;	A.Uhm, I think so, but I I can't seem to tocate it.8Q.Have you read it?10A.No, I have not read it.11Q.So you were either provided it and misplaced it, a filing issue,13A.Exactly.14Q or it hasn't gotten here for some15reason or another?16A.Yes.17Q.But you have not read it as you sit here?18A.Right.19Q.Have you reviewed the stress test?20A.No.21Q.You have never reviewed the stress test to22See whether or not if you agree if it was normal?23A.The EKGs?24Page 51Q.The stress test that was performed by1Dr. Beaver.22A.No. I read his interpretation of the stress test.3Q.Did you read the actual stress test5tself?64A.Did I see all of the EKGs associated with t?7Q.Can I see in your chart what portions of t you have?11A.Okay.13Q.You read stress tests here in your job;14

14 (Pages 50 to 53)

Page 56 st pain. So nysical e symptoms epartment. He iditional hat's ed to the word he word o the whole
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15 (Pages 54 to 57)

		r	
	Page 58		Page 60
1	electrocardiogram. It has nothing to do with his	1	not know what made him stop his his stress EKG
2	duration of exercise or the interpretation of his	2	early,
3	exercise performance or to the Cardiolite	3	Q. Okay.
4	interpretation.	4	A but it's doubtful that it was
5	Q. Have you seen his deposition as to what he	5	cardiac-related symptoms, because he specifically
6	described that this meant?	6	stated he denied precipitation of clinical symptoms.
7	MR. SEWARDS: What Who is "his"?	7	Q. First, what's your definition of a
8	MR. KELLEY: Dr. Beavers.	8	consultation?
9	MR. SEWARDS: Thank you.	9	A. Uhm, a consultation is when I am asked as
10	A. I did read his deposition.	10	a consultant to be involved in the care with another
11	Q. That's your understanding.	11	physician from a cardiac standpoint and assess their
12	What if we assume hypothetically that	12	cardiovascular status and make recommendations in
13	'cause he says things on that box like, Cardiolite	13	their care.
14	images pending, things of that sort that the	14	Q. Okay. Reading the chart And do you
15	stress electrocardiogram being normal is the	15	have his You have right in front of you the
16	conclusion, for lack of a better term.	16	second page of it.
17	A. The stress electrocardiogram is normal.	17	Does it actually say on there "Report of
18	Q. From the exercise portion and the EKG	18	consultation"?
19	portion?	19	A. Yes.
20	A. Yes.	20	Q. Do you interpret this to be a cardiac
21	Q. Does that make sense where I'm at right	21	consultation based on your review of the records?
22	now?	22	MR. SEWARDS: Object.
23	A. Yes.	23	A. I don't know.
24	Q. Okay. If we assume that, was it, in fact,	24	Q. What If it says it's a cardiac
	Page 59		Page 61
1	normal, since he was unable to reach his target	1	consultation and a report of a consultation, does it
2	heart rate, he only reached 76 percent, and he was	2	look like a consultation?
3	only able to exercise for 5 minutes and 16 seconds?	3	MR. SEWARDS: Object. It doesn't say
4	A. His stress electrocardiogram was normal.	4	"cardiac consultation."
5	His exercise duration was submaximal.	5	Q. I'm sorry. It says "Report of
6	Q. Why was his exercise portion submaximal?	6	consultation."
7	Was it secondary to his cardiac disease, most	7	A. He has a physical examination and history
8	likely?	8	of present illness. He has many features that are
9	A. I don't believe that.	9	consistent with a consultation.
10	Q. Okay. Do you have any opinion as to why	10	Q. And it also actually says
11	his exercise was submaximal?	11	Under "Chief Complaint," it doesn't say we
12	A. Well, his exercise duration could be	12	were asked to perform a single stress test. It says
13	submaximal due to his coronary disease, but it can	13	we were asked to evaluate this patient regarding
14	be it could be explained that way if the patient	14	chest discomfort. Correct?
15	stopped because of cardiac symptoms.	15	A. That's correct.
16	Dr. Beaver stated that he he denied	16	Q. Which would be consistent with a
6		17	consultation; correct?
17	precipitation of clinical symptoms with the stress	1.7	
17	precipitation of clinical symptoms with the stress test, so my impression or my assumption would be	$17 \\ 18$	A. Perhaps that
F	test, so my impression or my assumption would be		1
18 19	test, so my impression or my assumption would be that the stress test was stopped for other reasons.	18 19	Yes, that may be the case.
18 19 20	test, so my impression or my assumption would be that the stress test was stopped for other reasons. And some of those reasons that people stop or don't	18 19 20	*
18 19 20 21	test, so my impression or my assumption would be that the stress test was stopped for other reasons. And some of those reasons that people stop or don't go to target heart rates are they are out of shape	18 19 20 21	Yes, that may be the case. This isn't the form of that my consultations take.
18 19 20 21 22	test, so my impression or my assumption would be that the stress test was stopped for other reasons. And some of those reasons that people stop or don't go to target heart rates are they are out of shape or they have orthopedic problems to prevent them	18 19 20 21 22	Yes, that may be the case. This isn't the form of that my consultations take. Q. At the end of his report of consultation,
18 19 20 21	test, so my impression or my assumption would be that the stress test was stopped for other reasons. And some of those reasons that people stop or don't go to target heart rates are they are out of shape	18 19 20 21	Yes, that may be the case. This isn't the form of that my consultations take.

16 (Pages 58 to 61)

	Page 62	1	Page 64
1	scintigraphy.	1	care?
2	be abnormal, we would recommend	2	MR. SEWARDS: Object to all the facts left
3	diagnostic coronary angiography.	3	out of that question, but go ahead.
4	Do you agree with that recommendation?	4	MR. KELLEY: Facts left out of a question
5	A. Maybe.	5	is not a formal objection.
6	Q. Okay. You say "maybe."	6	(Discussion held off the record.)
7	What are the other options or why do you	7	A. Could you read that back to me, please?
8	hesitate?	8	Q. I am asking whether or not it's beneath
9	A. Because medical therapy can be a	9	the standard of care if a physician does not look
10	reasonable option, also.	10	even try to get the prior records?
11	Q. Okay. Would you start medical therapy	11	A. You know, it all depends upon what the
12	without visualizing the coronary arteries if there	12	clinical situation is. Sometimes sometimes past
13	was an abnormal Cardiolite?	13	medical records are irrelevant, so they wouldn't
14	A. You may. Depends on the degree of	14	matter at all.
15	abnormality of the nuclear scan and it depends on	15	Q. In this case, were the past medical
16	the patient's clinical presentation.	16	records relevant?
17	Q. This patient's clinical presentation, we	17	A. They could be relevant. They became more
18	know at this point in time there's no reference in	18	relevant after the stress test was done.
19	this history to the prior MI.	19	Q. When the Cardiolite stress test comes
20	When you perform a consultation, do you	20	back, we also know that he is also having as
21	get the records from the prior hospitalization?	21	described by Dr. Gebhart, is having some ongoing
22	A. As often as possible.	22	epigastric pain and/or chest pain; correct?
23	Q. And you can see this is a report of	23	A. Correct.
24	consultation on Fayette County Memorial Hospital	24	Q. The plan is to do a cardiac
	Page 63		Page 65
1	Page 63 letterhead. That's the same institution he was at	1	Page 65 catheterization. You agree that that was a
1	letterhead. That's the same institution he was at	1	catheterization. You agree that that was a
2	letterhead. That's the same institution he was at before; correct?	1 2 3	catheterization. You agree that that was a reasonable plan by them?
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$\begin{array}{c} 2\\ 3\\ 4\\ 5\\ 6\\ 7\\ 8\\ 9\\ 10\\ 11\\ 12\\ 13\\ 14\\ 15\\ 16\\ 17\\ 18\\ 19\\ 20\\ 21\\ \end{array}$	 letterhead. That's the same institution he was at before; correct? A. Yes. Q. And laboratory values appear to be computer generated; correct? A. Yes. Q. The fact that he was just hospitalized with a suspected MI is relevant; correct? A. Yes. Q. Obviously, they know he's there for some reason. Someone asked him to go for some form of cardiac workup. Correct? A. Correct. Q. In what situations do you not get the prior medical records? A. When they're not available. Q. Okay. You always try, though. A. Yes. Q. Okay. And the reason you try is because it allows you to provide the best care for the patient. 	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 catheterization. You agree that that was a reasonable plan by them? A. Yes. Q. Do you believe that at this point he had unstable angina still? MR. DILLON: Talking about the 26th? MR. KELLEY: Yes. A. He he The Dr. Beaver says he currently denies any symptoms of palpitations, tachycardia. And in I It's hard for me to make that call on unstable angina, 'cause it doesn't really say in there whether he has chest pain at the time of presentation again. Q. Okay. A. Now, he did have pain at the time of his emergency room visit. He obviously had some epigastric pain leading up to his visit with Dr. Gebhart, but Q. Well, it says under "History of Present Illness" A. Yes.

17 (Pages 62 to 65)

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	Page 66		Page 68
1	We're now about nine days later or eight	1	palpitations, tachycardia or syncope, he does
2	days later. We're at June 26th.	2	describe shortness of breath with exertion,
3	He says for two weeks he's been	3	shortness of breath when laying down, intermittent
4	experiencing intermittent midsternal chest	4	chest tightness which can last from minutes to hours
5	tightness; and when laying down, there is radiation	5	with spontaneous resolution. Correct?
6	into the left arm associated with dyspnea.	6	A. Yes.
7	First, what is dyspnea?	7	Q. So there is a clinical history there which
8	A. Shortness of breath.	8	is consistent with unstable angina.
9	Q. Shortness of breath, chest pain, or	9	A. Maybe. I'm not I'm not convinced of
10	midsternal chest tightness radiating to the left	10	that.
11	arm, that's consistent with angina; correct?	11	Q. You're not saying I'm wrong, but it's one
12	A. It could be.	12	of the possibilities?
13	Angina related to coronary disease?	13	A. It it is a possibility.
14	Q. Yes.	14	Q. Is there anything more likely than angina
15	A. Yes.	15	as to the cause of his symptoms as of June 26th,
16	Q. And that's I understand that this note	16	2001?
17	does show that he has knowledge of what appears to	17	A. Is there anything more likely than
18	be ongoing intermittent chest pain.	18	coronary artery disease?
19	A. He does have intermittent chest pain,	19	Q. Artery disease.
20	according to this note.	20	A. That would be the the leading
21	Q. And this intermittent chest pain is also	21	suspicion.
22	associated with radiation to the left arm and	22	Q. Okay.
23	shortness of breath.	23	A. He These are not perfectly classical
24	A. Yes.	24	symptoms, either. If they were perfectly classical,
1	Page 67 Q. Shortness of breath is another symptom	1	Page 69 Dr. Beaver probably would not have done the stress
1 2		1 2	
	Q. Shortness of breath is another symptom	1 2 3	Dr. Beaver probably would not have done the stress
2	Q. Shortness of breath is another symptom that's potentially consistent with a cardiac		Dr. Beaver probably would not have done the stress test, so he was not convincing enough for a
2 3	Q. Shortness of breath is another symptom that's potentially consistent with a cardiac problem; correct?	3	Dr. Beaver probably would not have done the stress test, so he was not convincing enough for a cardiologist to disregard his symptoms and go
2 3 4	Q. Shortness of breath is another symptom that's potentially consistent with a cardiac problem; correct?A. Potentially, yes.	3 4	Dr. Beaver probably would not have done the stress test, so he was not convincing enough for a cardiologist to disregard his symptoms and go straight to catheterization.
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18 (Pages 66 to 69)

	Page 70	1	Page 72
1	he has every risk factor for coronary artery disease	1	unreasonable to not have done the heart
2	with the exception of possibly diabetes.	2 3	catheterization within 24 hours of the scan being
3	A. Correct.		done.
4	Q. And he knew all of that at the time,	4	Q. Do you know Dr. Kolibash?
5	'cause he actually describes the multiple risk	5	A. Yes.
6	factors. Correct?	6 7	Q. How do you know him?A. He's a cardiologist at Ohio State
7	A. Yes.		
8	Q. Now, when he makes the recommendation for	8	University.
9	coronary angiography if the nuclear scan is	9	Q. Do you respect him?
10	abnormal, the nuclear scan does come back as abnormal. Correct?	10 11	A. Yes.
11		12	Q. Is he somebody who you ever refer patients to?
12	A. Yes.	12	
13	Q. Is there a time frame in which that has to		
14	be accomplished to comply with the standard of care?	14	Q. You have been provided a deposition, but I
15	A. No.	15	know you haven't had a chance to read it yet; correct?
16	Q. When we say that it's abnormal, I know	16 17	
17	that there are I've seen five categories for		
18 19	reporting a nuclear scan. I have seen I think it's strongly abnormal it's abnormal, slightly	18 19	Q. Do you agree that if you have a patient referred to you for an outpatient consultation
20	abnormal, equivocal, slightly positive, and	20	following a non-ST or a non-Q myocardial infarction,
1		20	patient continues to have chest pain which you
21 22	positive, or you know what I'm saying.	21	believe may be cardiac related, an EKG had been
22	How would you, on that five-scale prong by the American Heart Association, categorize his test,	22	performed which was normal, would you still want to
23	or are you unable to since you haven't seen the	23 24	get that patient into the hospital within 24 to 48
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19 (Pages 70 to 73)

	Page 74		Page 76
1	Q. Well, you see how he's feeling according	1	A. Again, it depends upon the information you
2	to Dr. Beaver's notes.	2	have available to you.
3	A. Yes.	3	Q. I'm not trying to make up information.
4	Q. He's having intermittent chest pain, he	4	A. Yeah.
5	has exertional dyspnea, he has chest tightness	5	Q. I'm trying to go on the information that
6	that's lasted over had been intermittent over two	6	you see in Dr. Beaver's own note.
7	weeks that could last minutes to hours, it radiates	7	A. Yes.
8	to his arm. That is ongoing chest pain; correct?	8	Q. That's a sign of ongoing problems with
9	A. He must not have had it at the time that	9	chest pain after that first hospitalization, isn't
10	he put him on the treadmill or else he wouldn't have	10	it?
11	put him on there. So he was having no symptoms at	11	A. I agree with that.
12	the time most likely. He did not have precipitation	12	Q. One of the things you said to me earlier
13	of his symptoms with the stress test, so it's very	13	was that at discharge, it was important to you that
14	reasonable to reassess the patient. That's what I	14	he did not have chest pain.
15	would have done. I would have I would have	15	A. Correct.
16	reassessed the patient.	16	Q. We now know eight days later he's had the
17	Q. He actually describes on page 37 of his	17	chest pain back.
18	deposition that if there's further chest pains,	18	A. Okay.
19	there's guidelines that the patient should be taken	19	Q. As reassuring to you as the fact that the
20	straight to the cath lab after a non-Q-wave MI.	20	chest pain was gone, is the fact that the chest pain
21	A. There are there are guidelines. You	21	keeps coming back of concern to you as a
22	know, those guidelines were established after 2001.	22	cardiologist?
23	And the question that you had asked him was, the	23	A. Yes, it is of concern.
24	patient is having ongoing chest pain. I think	24	Q. And is it a concern because it raises your
			· · · · · · · · · · · · · · · · · · ·
	Page 75		Page 77
1	that's the key.	1	index of suspicion for a cardiac problem?
2	Q. Well, if a patient is having	2	A. Yes.
3	MR. DILLON: Just for the record, he's	3	Q. Does it make timing of the therapy or
4	referring to the prior question.	4	intervention more relevant?
5	A. Ongoing chest pain is different than I had	5	A. Yes.
6	chest pain two days ago before I came in for the	6	Q. Knowing that he's had two weeks of
7	stress test.	7	additional pain after that emergency room
8	Q. His chest pain is intermittent by his own	8	presentation, should he be cathed a week later or 24
9	history; correct?	9	to 48 hours later to meet the standard of care?
10	A. Yes.	10	A. In 2001?
11	Q. Which means it comes and goes.	11	Q. Yes.
12	A. I I agree with your definition of	12	A. No one knows.
13	intermittent.	13	Q. Has medicine changed in the last three
14	Q. It's been coming and going consistently	14	years that significantly as it pertains to
15 16	for two weeks by his history; correct?	15	diagnostic catheterizations?
10	A. I agree.	16 17	A. The guidelines are clearer.
17	Q. So obviously you can pick moments of time within that two weeks to say he's symptomatic or	17	Q. And the guidelines, as we sit here today,
10	within that two weeks to say he's symptomatic or	18	are cath within 24 to 48 hours. A. Not necessarily.
20	nonsymptomatic. A. Correct.	20	
20	Q. You treat the fact that he's symptomatic,	20	Q. Okay. What guidelines are we talking about?
22		21	A. ACC guidelines for treatment of unstable
 X.Z. 	though at nointe correct? Vou react to the worst		
	though, at points; correct? You react to the worst		0
23 24	though, at points; correct? You react to the worst possible scenario, not best possible scenario when it's potentially cardiac.	23 24	angina, Q. Okay.

Т

20 (Pages 74 to 77)

		1	
	Page 78		Page 80
1	A acute coronary syndromes.	1	treat this gentleman with medical therapy to see if
2	Q. Are you telling me that before 2001, there	2	he has recurrent symptoms or to do a heart
3	was dispute as to whether or not there should be a	3	catheterization once you know the Cardiolite
4	catheterization?	4	results.
5	A. No. I'm saying there's variability in	5	Q. Okay.
6	methodology of when the patient goes to the cath	6	A. Those are both very reasonable.
7	lab.	7	Q. Okay. And if you were going to choose the
8	Q. Okay. And what is the outside range when	8	medical route, that first reasonable route, would
9	you have a patient with an acute coronary syndrome	9	you start with in addition to beta blockers and
10	or unstable angina that you wait to take them to the	10	aspirin, is there anything else you would put him
11	cath lab?	11	on?
12	A. Well, you can elect to treat these	12	A. Yes.
13	patients with medical therapy alone.	13	Q. What else?
14	Q. What medical therapy was instituted to	14	A. Cholesterol-lowering agents.
15	treat Jeffrey Lyons on June 26th?	15	Q. Okay. Would you use a statin,
16	A. I think he was on an aspirin daily.	16	A. Yes.
17	Q. Was he on any beta blockers?	17	Q a lipid-lowering agent?
18	A. Not that I'm aware of.	18	A. Most likely a statin.
19	Q. Should he have been?	19	Q. Okay. Anything else?
20	A. I don't think that that's unreasonable	20	A. Perhaps nitroglycerin.
21	therapy.	21	Q. Okay.
22	Q. If he was your patient, would you have put	22	A. That would be about it.
23	him on a beta blocker that day while you waited for	23	Q. Would the nitroglycerin be on an as-need
24	the cath?	24	basis?
	Page 79		Page 81
	A. There's a high degree of probability I		A. Yes.
2	would have recommended a beta blocker.	2	Q. Okay. Would you start those medical
3	Q. And that's because What benefit do you	3	therapies immediately after receiving the Cardiolite
4	believe a beta blocker would provide to a patient	4	results?
5	such as him?	5	A. Refresh my opinion about who am I. Which
6	A. Well, if you're convinced that he has	6	doctor am I?
7	coronary artery disease, I try to treat as many of	7	Q. You are right now the cardiologist on
8	those patients as possible with beta blockers.	8	June 26th, 27th, who has seen the patient.
9	Q. And you wouldn't wait for	9	A. Okay.
10	You would start the medical therapy	10	Q. You are waiting for the Cardiolite result,
11	immediately?	11	which we know comes back on June 26th, as well, from
12	A. Not necessarily.	12	Dr. David Reece (phonetic). He actually dictates it
13	Q. When would you start after June 26th the	13	on the 27th, so that information is back in the
14	medical therapy for him?	14	chart as of the 27th.
15	A. Probably after I had seen the stress	15	A. I As soon as I became
16	Cardiolite study.	16	If this was a formal consultation for me
17	Q. Okay. But before the cath?	17	to see the patient, as soon as I became aware of the
18	A. Yes.	18	Cardiolite results, I would probably instruct my
19	Q. Would you do one or the other? Am I kind	19	nurse to call the patient, to put that patient on
20	of hearing you right, that you would either try him	20	beta blockers and see me in the office at their
21	for a period of time on medical therapy or cath him?	21	earliest convenience and to seek care in the
22	A. No. I'm just saying those are options.	22	emergency department if their symptoms became
	You never asked me what I would do.	23	significantly worse.
23		1	÷ .
23 24	I would The It is very legitimate to	24	Q. Okay. Why would you undertake that plan

21 (Pages 78 to 81)

1	Page 82	1	Page 84
1	of therapy?		A. It would be very small.
2	A. Because now it is absolutely clear that	2	Q. By "very small," less than 10 percent,
3	this man has known coronary disease.	3	more than 10 percent?
4	Q. Okay. So as of June 27th when the	4	A. Much less than 10 percent.
5	Cardiolite result comes back, it's clear he has	5	Q. If you put him on calcium or beta
6	coronary disease.	6	blockers with nitroglycerin and with statins, would
7	A. Yes.	7	those medications in combination have altered the
8	Q. And it's clear it needs to be intervened	8	outcome to a probability?
9	upon by either medical therapy or some other	9	A. Probably not more than beta blockers
10	intervention.	10	alone.
11	A. Yes.	11	Q. Okay. At the time that he is seen on
12	Q. Okay. If you're not going to choose to	12	July 3rd
13	place him on medical therapy such as what you have	13	And let me go back to one housekeeping
14	described, does a catheterization quickly become	14	question for June 26th.
15	more relevant?	15	You believe that Dr. Beaver met the
16	A. Uhm, I don't think that's a fair question.	16	standard of care?
17	Q. Okay.	17	A. Yes.
18	A. He should be on medical therapy regardless	18	Q. You do still agree, though, that had a
19	of your decision to cath him.	19	catheterization been performed on or about
20	Q. If you're not going to be on medical	20	June 27th, it would have revealed the same thing,
21	therapy Well, no matter what, he should be.	21	single-vessel proximal disease in the right coronary
22	Putting him on medical therapy, then, as	22	artery?
23	you believe he should be, when should he be cathed,	23	A. Well, my initial evaluation was based upon
24	if ever?	24	the Cardiolite, so that hasn't changed at all.
	D		n
1	Page 83 A. That all depends upon his clinical	1	Page 85 Q. Okay. I'm just saying that had for some
2	symptoms. If he has ongoing chest pain despite	2	reason the course for this patient been altered,
3	medical therapy, cardiac catheterization should be	3	they cathed him on the 27th, he still would have
4	the next option if you've chosen to delay	4	been amenable to treatment with that same excellent
5	catheterization.	5	prognosis you testified to earlier?
6	Q. Now, from June 27th to July 3rd, do you	6	A. That's because all of the information that
7	see any documentation that he was placed on beta	7	I used to make the assessment initially is the same.
8	blockers?	8	Q. Okay. But I just want to make sure I have
9	A. When Dr. Auerbach saw him, he was placed	9	it clean in the record.
10	on beta blockers.	10	It's your opinion, based on a reasonable
11	Q. Which was on July 3rd?	11	degree of medical probability, that had he been
12	A. Yes.	12	catheterized on June 27th or the 28th, we'll even
13	Q. Had he been placed on beta blockers as	13	give another day, that it would have revealed a
14	early as June 27th, would that have altered the	14	proximal lesion of the right coronary artery; and
15	outcome to a probability?	15	with either medical therapy or revascularization, he
16	A. It's doubtful.	16	would have had an excellent prognosis because of his
17	Q. Doubtful?	17	good left ventricular function. True?
18	A. Yes.	18	A. That would be the most likely scenario
19	Q. Is it possible?	19	based upon his stress test results.
20	MR. SEWARDS: Objection.	20	Again, I don't have privy to his
21	A. Perhaps.	21	angiogram.
22	Q. Are you able to quantify the percent of	22	Q. Okay. June July 3rd, that's the visit
23	likelihood that it may have altered the outcome?	23	with Dr. Auerbach?
24	MR. SEWARDS: Objection.	24	A. Yes.
1			

22 (Pages 82 to 85)

		Γ	
	Page 86		Page 88
1	Q. At this point you've seen the letter from	1	sees him in the office. His blood pressure was 140
2	Dr. Auerbach to Dr. Gebhart.	2	over 90, his pulse was 88. To me, the patient
3	A. Yes.	3	sounds stable. My terminology would have been he
4	Q. And in Dr. Auerbach's very first	4	has angina postinfarction.
5	paragraph, second sentence, he says that, Barney saw	5	Q. What benefit is there to the patient in
6	him, "him" being my client, Jeff Lyons, last week	6	waiting? Is there any single medical benefit you
7	for evaluation of chest discomfort.	7	can think of?
8	A. Yes.	8	A. In waiting for what?
9	Q. Do you see that?	9	Q. Is there any singular medical benefit
10	A. Yes.	10	that's conferred upon this patient by waiting to
11	Q. Does that appear to be consistent with the	11	have his catheterization done till early next week,
12	chief complaint that was on the report of	12	as Dr. Auerbach suggests in his letter?
13	consultation?	13	A. Well, he just started him on medical
14	A. Yes.	14	therapy. I don't think there's any detriment to
15	Q. If you were asked to do an evaluation of	15	waiting. He had been on no medi He had only
15	chest discomfort, to you, would that be a complete	16	been on aspirin previous to that visit.
10		10	Q. At this point in time, July 3rd, we are 17
1	workup of the patient's chest discomfort?		
18	A. From a cardiac standpoint, yes.	18	days following his presentation to the emergency
19	Q. The next thing he specifically says, that	19	room. Correct?
20	his nuclear scan showed evidence of a previous	20	A. That's correct.
21	infarction.	21	Q. Where he We now know, and even
22	You agree with that; correct?	22	Dr. Auerbach knew, he had a myocardial infarction;
23	A. Yes.	23	correct?
24	Q. He describes here, as of July	24	A. Correct.
	р Q2	******	т. од
1	Page 87 3rd, continued intermittent episodes of chest	1	Q. He had given at that point a two-day
2	discomfort associated with physical activity.	2	history of pain that preceded that visit; correct?
$\frac{2}{3}$	You saw that?	$\frac{2}{3}$	A. That's correct.
4	A. Yes.	4	
5		1	· · · · · · · · · · · · · · · · · · ·
	Q. That's exertional; correct?	5	symptomatology.
6	A. That's correct.	6	A. Correct.
7	Q. And he's also had brief episodes at rest;	7	Q. He receives his first medical therapy at
8	correct?	8	this point; and according to Dr. Auerbach, the
9	A. Yes.	9	angina is unstable, he's had an infarction, he has
10	Q. He concludes, as of July 3rd, Mr. Lyons	10	all of the risk factors that you described, and he
11	has unstable angina postinfarction.	11	even notes he has mildly elevated sugar but does not
1 + ~		1-	10 a a a a a a a a a a a a a a a a a a a
12	Do you agree with him?	12	carry the diagnosis of diabetes. Even that's
13	Do you agree with him? A. I think	13	becoming a clouded issue now; correct?
13 14	Do you agree with him?A. I thinkI would have used different terminology.	13 14	becoming a clouded issue now; correct? A. Except for the part that he'd received no
13 14 15	 Do you agree with him? A. I think I would have used different terminology. Q. Okay. What terminology would you have 	13 14 15	becoming a clouded issue now; correct?A. Except for the part that he'd received no medical care. Aspirin is considered to be medical
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13 14 15 16 17 18 19 20	Do you agree with him? A. I think I would have used different terminology. Q. Okay. What terminology would you have used? A. I would have used he has angina postinfarction. Q. Do you disagree that it was unstable angina postinfarction? A. Ah, I I'm obviously not there to see	13 14 15 16 17 18 19 20 21	 becoming a clouded issue now; correct? A. Except for the part that he'd received no medical care. Aspirin is considered to be medical therapy. Q. He goes on to say that he had an abnormal stress test which I think underestimates the severity of this problem. Do you agree with him? A. That's his opinion.
13 14 15 16 17 18 19 20 21	Do you agree with him? A. I think I would have used different terminology. Q. Okay. What terminology would you have used? A. I would have used he has angina postinfarction. Q. Do you disagree that it was unstable angina postinfarction? A. Ah, I I'm obviously not there to see the patient, but in his physical assessment of the	13 14 15 16 17 18 19 20 21 22	 becoming a clouded issue now; correct? A. Except for the part that he'd received no medical care. Aspirin is considered to be medical therapy. Q. He goes on to say that he had an abnormal stress test which I think underestimates the severity of this problem. Do you agree with him? A. That's his opinion. I have I have no way of knowing that.
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13 14 15 16 17 18 19 20 21 22 23	Do you agree with him? A. I think I would have used different terminology. Q. Okay. What terminology would you have used? A. I would have used he has angina postinfarction. Q. Do you disagree that it was unstable angina postinfarction? A. Ah, I I'm obviously not there to see the patient, but in his physical assessment of the patient, he said the patient looks fine. So I would	13 14 15 16 17 18 19 20 21 22	 becoming a clouded issue now; correct? A. Except for the part that he'd received no medical care. Aspirin is considered to be medical therapy. Q. He goes on to say that he had an abnormal stress test which I think underestimates the severity of this problem. Do you agree with him? A. That's his opinion. I have I have no way of knowing that.

23 (Pages 86 to 89)

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	Page 90		Page 92
1	standard of care or he did not meet the standard of	1	He wouldn't have needed the cath?
2	care. And it impacts all of the parties in the	2	A. He has a fixed defect in his inferior
3	case, obviously. And so what you've undertaken to	3	wall, and he has had symptoms on no medical therapy.
4	do is to assess whether or not he, in his care and	4	So he is receiving new therapy, and there is nothing
5	treatment, was reasonable.	5	significant in that nuclear scan that absolutely
6	A. I do believe he was reasonable. That's	6	says that he would benefit from coronary
7	the opinion of the stress test.	7	intervention.
8	Q. Do you agree with that opinion?	8	Q. So is it your belief that a week later, if
9	A. I don't think that it's wrong, but I can't	9	that therapy had worked, he may not even need the
10	honestly tell you that it's correct.	10	catheterization?
11	Q. Okay.	11	A. It's very reasonable to put this man on
12	A. He's taking a very conservative approach	12	medical therapy and follow him clinically.
13	to the management of this patient. He is he is	13	Q. And not do a cath?
14	concerned about the coronary artery disease status	14	A. Correct.
15	of the patient.	15	Q. Why, then, were you so strong in your
16	Q. Let's take him at his word, then.	16	answer that medical therapy started on June 27th, a
17	A. Okay.	17	week earlier than that, would not have altered the
18	Q. You say he's concerned about the coronary	18	outcome for this patient? You just sat here and
19	artery disease status of this patient. At his word,	19	told me that medical therapy on the 3rd may have
20	he has unstable angina; at his word, it is	20	negated even the need you said very reasonable
21	postinfarction; at his word, he has every risk	21	that he may not have even needed the
22	factor with the exception of diabetes; at his word,	22	catheterization.
23	he has an abnormal stress test; and at his word, it	23	Why, then
24	underestimates the severity of his problem.	24	If therapy was started a week earlier,
1	Page 01		Poge 02
1	Page 91 Is timing of the catheterization of the	1	Page 93
$\frac{1}{2}$	Is timing of the catheterization of the	$\frac{1}{2}$	isn't it just as very reasonable that he would have
2	Is timing of the catheterization of the essence?	2	isn't it just as very reasonable that he would have not ended up having this myocardial infarction that
2 3	Is timing of the catheterization of the essence? A. Do you think that he needs to be admitted	2 3	isn't it just as very reasonable that he would have not ended up having this myocardial infarction that led to his death?
2 3 4	Is timing of the catheterization of the essence? A. Do you think that he needs to be admitted to the hospital right now and be done right away?	2 3 4	isn't it just as very reasonable that he would havenot ended up having this myocardial infarction thatled to his death?A. I think you put a lot of words in my
2 3 4 5	Is timing of the catheterization of the essence? A. Do you think that he needs to be admitted to the hospital right now and be done right away? Is that the question you're asking me?	2 3 4 5	isn't it just as very reasonable that he would have not ended up having this myocardial infarction that led to his death?A. I think you put a lot of words in my mouth.
2 3 4	Is timing of the catheterization of the essence? A. Do you think that he needs to be admitted to the hospital right now and be done right away? Is that the question you're asking me? Q. My question is, do you believe time is of	2 3 4 5 6	isn't it just as very reasonable that he would have not ended up having this myocardial infarction that led to his death?A. I think you put a lot of words in my mouth.Q. I'm not trying to cause
2 3 4 5 6	Is timing of the catheterization of the essence? A. Do you think that he needs to be admitted to the hospital right now and be done right away? Is that the question you're asking me?	2 3 4 5 6 7	 isn't it just as very reasonable that he would have not ended up having this myocardial infarction that led to his death? A. I think you put a lot of words in my mouth. Q. I'm not trying to cause - And the record is going to speak for
2 3 4 5 6 7	Is timing of the catheterization of the essence? A. Do you think that he needs to be admitted to the hospital right now and be done right away? Is that the question you're asking me? Q. My question is, do you believe time is of the essence in performing this catheterization?	2 3 4 5 6	isn't it just as very reasonable that he would have not ended up having this myocardial infarction that led to his death?A. I think you put a lot of words in my mouth.Q. I'm not trying to cause
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Is timing of the catheterization of the essence? A. Do you think that he needs to be admitted to the hospital right now and be done right away? Is that the question you're asking me? Q. My question is, do you believe time is of the essence in performing this catheterization? A. Yes. Q. And what time frame is the reasonable time frame in this clinical scenario? A. I would say within a week he should have a heart catheterization. Q. What's the basis If he needs it within a week, what medical benefit is conferred upon him by Does being on medications for that week make him a better candidate for a cath? A. No. I didn't really get to finish that. Q. Okay. A. I said within a week would be a reasonable time frame for the catheterization if he didn't respond to medical therapy.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 isn't it just as very reasonable that he would have not ended up having this myocardial infarction that led to his death? A. I think you put a lot of words in my mouth. Q. I'm not trying to cause - And the record is going to speak for itself. A. Okay. Q. Remember when we talked earlier and I said, do you believe that medical therapy to a probability would have altered the outcome in this case. Do you remember that? A. Yes. Q. Do you remember telling me that it was significantly less than 10 percent chance? A. That's correct. Q. That was any of the medications, whether it was beta blockers alone or all of them in combination; right? A. That's correct. Q. But now I understand you to be telling me
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Is timing of the catheterization of the essence? A. Do you think that he needs to be admitted to the hospital right now and be done right away? Is that the question you're asking me? Q. My question is, do you believe time is of the essence in performing this catheterization? A. Yes. Q. And what time frame is the reasonable time frame in this clinical scenario? A. I would say within a week he should have a heart catheterization. Q. What's the basis If he needs it within a week, what medical benefit is conferred upon him by Does being on medications for that week make him a better candidate for a cath? A. No. I didn't really get to finish that. Q. Okay. A. I said within a week would be a reasonable time frame for the catheterization if he didn't respond to medical therapy.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 isn't it just as very reasonable that he would have not ended up having this myocardial infarction that led to his death? A. I think you put a lot of words in my mouth. Q. I'm not trying to cause - And the record is going to speak for itself. A. Okay. Q. Remember when we talked earlier and I said, do you believe that medical therapy to a probability would have altered the outcome in this case. Do you remember that? A. Yes. Q. Do you remember telling me that it was significantly less than 10 percent chance? A. That's correct. Q. That was any of the medications, whether it was beta blockers alone or all of them in combination; right? A. That's correct. Q. But now I understand you to be telling me

24 (Pages 90 to 93)

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	Page 94		Page 90
1	medical therapy may have negated the need for a	1	lived an excellent life to a probability.
2	catheterization.	2	A. That's not what I said.
3	A. Absolutely.	3	Q. What did you say?
4	Q. I am asking you how, then, can you answer	4	A. I said the odds are with medical therapy
5	the question the other way if you if you're	5	he has a very good prognosis, and the odds are with
6	telling me here that, Hey, I can put him on medical	6	revascularization he has a very good prognosis,
7	therapy and in a week he can be great and not even	7	either way, based upon his Cardiolite defect in his
	need a catheterization?	8	LV function.
8			
9	A. That may be the case.	9	Q. Okay.
10	Q. And you say that's very reasonable, was	10	A. But he defied those odds. He had sudden
11	your exact words.	11	death.
12	A. Yes.	12	Q. And you What is your evidence that he
13	Q. Do you stand by those?	13	had sudden death only from that fixed defect?
14	A. Yes.	14	A. I have no other evidence that he had
15	Q. Because I want to put no words in your	15	another infarction.
16	mouth.	16	Q. Does dead tissue continue to hurt
17	A. Good.	17	A. It can.
18	Q. Why, then, wouldn't medical therapy on	18	Q in the heart?
19	June 27th be very reasonable in stabilizing this	19	A. You can have peri-infarct ischemia. There
20	patient and preventing the need for a	20	is nothing to say that he didn't have pericarditis
		t	
21	catheterization and the myocardial infarction that	21	following the myocardial infarction. There are
22	killed him?	22	other causes of postinfarct angina.
22	A. He already had the myocardial infarction	23	Q. Did he have a fever or any symptoms of
23			
23 24	before June 27th.	24	pericarditis that any of these physicians picked up
		24	
	Page 95	24	pericarditis that any of these physicians picked up
24 1	Q. Not the one that killed him.	1	Page 9'
24 1 2	Q. Not the one that killed him. A. How do you know that?	1 2	on? A. I don't know.
24 1 2 3	 Page 95 Q. Not the one that killed him. A. How do you know that? Q. When do you believe he had the myocardial 	1 2 3	Page 9 on? A. I don't know. Q. Did you see anywhere in the records that
24 1 2 3 4	Page 95 Q. Not the one that killed him. A. How do you know that? Q. When do you believe he had the myocardial infarction that killed him?	1 2 3 4	Page 9 on? A. I don't know. Q. Did you see anywhere in the records that he had a single symptom of pericarditis?
24 1 2 3 4 5	Page 95 Q. Not the one that killed him. A. How do you know that? Q. When do you believe he had the myocardial infarction that killed him? A. He had his myocardial infarction in	1 2 3 4 5	Page 9 on? A. I don't know. Q. Did you see anywhere in the records that he had a single symptom of pericarditis? A. I'm just saying that he could have had
24 1 2 3 4 5 6	Page 95 Q. Not the one that killed him. A. How do you know that? Q. When do you believe he had the myocardial infarction that killed him? A. He had his myocardial infarction in documentation at the time of his admission to the	1 2 3 4 5 6	Page 9 on? A. I don't know. Q. Did you see anywhere in the records that he had a single symptom of pericarditis? A. I'm just saying that he could have had other causes.
24 1 2 3 4 5 6 7	Page 95 Q. Not the one that killed him. A. How do you know that? Q. When do you believe he had the myocardial infarction that killed him? A. He had his myocardial infarction in documentation at the time of his admission to the emergency room.	1 2 3 4 5 6 7	Page 9 on? A. I don't know. Q. Did you see anywhere in the records that he had a single symptom of pericarditis? A. I'm just saying that he could have had other causes. Q. And I'm questioning you on the things that
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1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 Page 95 Q. Not the one that killed him. A. How do you know that? Q. When do you believe he had the myocardial infarction that killed him? A. He had his myocardial infarction in documentation at the time of his admission to the emergency room. Q. Do you believe that's the myocardial infarction that killed him or do you believe that it was a subsequent one? A. I believe it was the one that killed him. Q. The first one? A. Yes. Q. Okay. Do you believe it was a continuation of that one infarction or that it was that fixed defect happened to cause an arrhythmia? A. I believe that the fixed defect caused an arrhythmia that caused him to die. Q. Okay. A. That's - Although there can be other causes, that's what I believe happened to him. 	$ \begin{array}{c} 1\\2\\3\\4\\5\\6\\7\\8\\9\\10\\11\\12\\13\\14\\15\\16\\17\\18\\19\\20\\21\end{array} $	Page 9 on? A. I don't know. Q. Did you see anywhere in the records that he had a single symptom of pericarditis? A. I'm just saying that he could have had other causes. Q. And I'm questioning you on the things that you're throwing out there. A. Okay. Q. You said he could have had pericarditis. I want to know what symptom in the records you see that supports that. A. I said he could have had pericarditis. I didn't say he had it. Q. I'm asking this I'm not attacking you. I'm asking you a simple question. What symptoms You say he could have had it. What's your basis? A. Because patients who have myocardial infarction often have pericarditis after that. Q. Okay. So it's a general medical

25 (Pages 94 to 97)

1			D 100
1	Page 98	1	Page 100 on to a probability, there was ongoing
	A. Correct, just as you do not have anything	2	myocardial cell death from the first documentation
2	to support another heart attack.	3	of the heart attack on the 16th through the time he
3	Q. Let's go on, 'cause	1	+
4	A. Okay.	4	died?
5	Q I'm not testifying here.	5	A. No.
6	A. Okay.	6	Q. Okay. When do you believe the death to
7	Q. I'm trying to understand your opinions.	7	the heart muscle cells stopped?
8	The next thing that you say it could be is	8	A. Probably at the time of his initial
9	you say it could be some sort of ongoing pain caused	9	presentation.
10	from the first heart attack.	10	Q. Okay. So June 16th of 2001?
11	A. My my impression is that he has	11	A. Yes.
12	coronary artery disease, he's had one myocardial	12	MR. DILLON: 18th.
13	infarction, and there's a likelihood that he still	13	Q. The 18th. I apologize.
14	has coronary artery disease causing his symptoms of	14	A. June 18th.
15	angina. That's what I believe is going on with him	15	Q. From there forward, did he have any
16	at this present time.	16	additional death, in your opinion to a probability,
17	Q. The fixed defect that he had would not	17	of any of his myocardial cells?
18	account for his pain, would it?	18	A. I don't know.
19	A. Why do you ask me that? Why why are	19	Q. Okay. Do you have an opinion as to what
20	you assuming that?	20	was the mechanism? Was it a supply-and-demand issue
21	Q. I'm not assuming.	21	from coronary artery disease that was causing his
22	Do you agree or disagree?	22	ongoing angina?
23	A. You can have pain with fixed defects.	23	A. Yes.
24	Q. Is there an adage in the in all of the	24	Q. Okay. And when we say that, that's
1	Page 99 major cardiology texts that pain equals death?		Page 101
2	A. Say that again.	1 2 3	actually an infarction, not necessarily necrosis, but an infarction of tissue or hypoperfusion of heart muscle
3	A. Say that again.Q. Is there an adage and we'll use	2 3	but an infarction of tissue or hypoperfusion of heart muscle.
3 4	 A. Say that again. Q. Is there an adage and we'll use Hurst's 	2 3 4	but an infarction of tissue or hypoperfusion of heart muscle.A. It's hypoperfusion of heart muscle.
3 4 5	 A. Say that again. Q. Is there an adage and we'll use Hurst's You've heard of Hurst's textbook; correct? 	2 3 4 5	but an infarction of tissue or hypoperfusion of heart muscle.A. It's hypoperfusion of heart muscle.Q. You believe that was going on after
3 4 5 6	 A. Say that again. Q. Is there an adage and we'll use Hurst's You've heard of Hurst's textbook; correct? A. I have. 	2 3 4 5 6	but an infarction of tissue or hypoperfusion of heart muscle.A. It's hypoperfusion of heart muscle.Q. You believe that was going on after June 18th?
3 4 5 6 7	 A. Say that again. Q. Is there an adage and we'll use Hurst's You've heard of Hurst's textbook; correct? A. I have. Q that pain equals death? 	2 3 4 5 6 7	but an infarction of tissue or hypoperfusion of heart muscle.A. It's hypoperfusion of heart muscle.Q. You believe that was going on after June 18th?A. Yes.
3 4 5 6 7 8	 A. Say that again. Q. Is there an adage and we'll use Hurst's You've heard of Hurst's textbook; correct? A. I have. Q that pain equals death? A. I I have never read that. 	2 3 4 5 6 7 8	 but an infarction of tissue or hypoperfusion of heart muscle. A. It's hypoperfusion of heart muscle. Q. You believe that was going on after June 18th? A. Yes. Q. Okay. Do you believe that that is what
3 4 5 6 7 8 9	 A. Say that again. Q. Is there an adage and we'll use Hurst's You've heard of Hurst's textbook; correct? A. I have. Q that pain equals death? A. I I have never read that. Q. Okay. Have you heard that 	2 3 4 5 6 7 8 9	 but an infarction of tissue or hypoperfusion of heart muscle. A. It's hypoperfusion of heart muscle. Q. You believe that was going on after June 18th? A. Yes. Q. Okay. Do you believe that that is what was accounting for his intermittent chest
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3 4 5 6 7 8 9 10 11	 A. Say that again. Q. Is there an adage and we'll use Hurst's You've heard of Hurst's textbook; correct? A. I have. Q that pain equals death? A. I I have never read that. Q. Okay. Have you heard that A. That pain Q spoken? 	2 3 4 5 6 7 8 9 10 11	 but an infarction of tissue or hypoperfusion of heart muscle. A. It's hypoperfusion of heart muscle. Q. You believe that was going on after June 18th? A. Yes. Q. Okay. Do you believe that that is what was accounting for his intermittent chest discomfort? A. Yes.
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3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 A. Say that again. Q. Is there an adage and we'll use Hurst's You've heard of Hurst's textbook; correct? A. I have. Q that pain equals death? A. I I have never read that. Q. Okay. Have you heard that A. That pain Q spoken? A. Pain of? Q. That chest pain is symbolic of actual cells dying in the heart. A. Oh, that that can be true. Q. Okay. A. That's not what you said. You said death. I thought you meant 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	 but an infarction of tissue or hypoperfusion of heart muscle. A. It's hypoperfusion of heart muscle. Q. You believe that was going on after June 18th? A. Yes. Q. Okay. Do you believe that that is what was accounting for his intermittent chest discomfort? A. Yes. Q. Okay. And do you believe that was also related to the right coronary artery lesion that you suspect was there? A. I believe that the problem was in the right coronary artery distribution. Q. Is it your testimony that Mr. Lyons was just that unfortunate individual that more likely
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$\begin{array}{c} 3 \\ 4 \\ 5 \\ 6 \\ 7 \\ 8 \\ 9 \\ 10 \\ 11 \\ 12 \\ 13 \\ 14 \\ 15 \\ 16 \\ 17 \\ 18 \\ 19 \\ 20 \\ 21 \\ 22 \\ 122 \\ \end{array}$	 A. Say that again. Q. Is there an adage and we'll use Hurst's You've heard of Hurst's textbook; correct? A. I have. Q that pain equals death? A. I I have never read that. Q. Okay. Have you heard that A. That pain Q spoken? A. Pain of? Q. That chest pain is symbolic of actual cells dying in the heart. A. Oh, that that can be true. Q. Okay. A. That's not what you said. You said death. I thought you meant Q. Not of the patient. A. Oh, okay. Q. I'm talking about heart muscle. A. Chest pain is very consistent with 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 but an infarction of tissue or hypoperfusion of heart muscle. A. It's hypoperfusion of heart muscle. Q. You believe that was going on after June 18th? A. Yes. Q. Okay. Do you believe that that is what was accounting for his intermittent chest discomfort? A. Yes. Q. Okay. And do you believe that was also related to the right coronary artery lesion that you suspect was there? A. I believe that the problem was in the right coronary artery distribution. Q. Is it your testimony that Mr. Lyons was just that unfortunate individual that more likely than not was going to fall outside of the the norm? A. Perhaps. Q. Obviously, we don't have any studies out
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 A. Say that again. Q. Is there an adage and we'll use Hurst's You've heard of Hurst's textbook; correct? A. I have. Q that pain equals death? A. I I have never read that. Q. Okay. Have you heard that A. That pain Q spoken? A. Pain of? Q. That chest pain is symbolic of actual cells dying in the heart. A. Oh, that that can be true. Q. Okay. A. That's not what you said. You said death. I thought you meant Q. Not of the patient. A. Oh, okay. Q. I'm talking about heart muscle. A. Chest pain is very consistent with myocardial cells dying. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 but an infarction of tissue or hypoperfusion of heart muscle. A. It's hypoperfusion of heart muscle. Q. You believe that was going on after June 18th? A. Yes. Q. Okay. Do you believe that that is what was accounting for his intermittent chest discomfort? A. Yes. Q. Okay. And do you believe that was also related to the right coronary artery lesion that you suspect was there? A. I believe that the problem was in the right coronary artery distribution. Q. Is it your testimony that Mr. Lyons was just that unfortunate individual that more likely than not was going to fall outside of the the norm? A. Perhaps. Q. Obviously, we don't have any studies out there where we don't treat certain patients
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 A. Say that again. Q. Is there an adage and we'll use Hurst's You've heard of Hurst's textbook; correct? A. I have. Q that pain equals death? A. I I have never read that. Q. Okay. Have you heard that A. That pain Q spoken? A. Pain of? Q. That chest pain is symbolic of actual cells dying in the heart. A. Oh, that that can be true. Q. Okay. A. That's not what you said. You said death. I thought you meant Q. Not of the patient. A. Oh, okay. Q. I'm talking about heart muscle. A. Chest pain is very consistent with 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	 but an infarction of tissue or hypoperfusion of heart muscle. A. It's hypoperfusion of heart muscle. Q. You believe that was going on after June 18th? A. Yes. Q. Okay. Do you believe that that is what was accounting for his intermittent chest discomfort? A. Yes. Q. Okay. And do you believe that was also related to the right coronary artery lesion that you suspect was there? A. I believe that the problem was in the right coronary artery distribution. Q. Is it your testimony that Mr. Lyons was just that unfortunate individual that more likely than not was going to fall outside of the the norm? A. Perhaps. Q. Obviously, we don't have any studies out

26 (Pages 98 to 101)

		Ι	D 104
1	Page 102 treat them; correct?	1	A. Not that I'm aware of.
2	A. Yes.	2	Q. Left ventricular dysfunction is one of the
3	Q. But you believe that even with treatment,	3	best prognostic factors for revascularization of
4	he, for some reason, would not have been amenable to	4	patients; correct?
5	any benefit from it, and he would have been an	5	A. That's correct.
6	outlier who died?	6	Q. And obviously, my client, Jeff Lyons, had
7	A. No. I didn't say that.	7	that in his favor; correct?
8	Q. Okay. With medical therapy initiated on	8	A. That's correct.
9	June 27th, to a probability, does he live?	9	Q. The location of this fixed defect you
10	A. No.	10	believe is at the distal aspect of the heart, is it
11	Q. Why not?	11	near the septum or is it on the back wall of the
12	A. Because he died on medical therapy.	12	left ventricle?
13	Q. How long do you have to be on medical	13	A. I said it's the inferior wall, proximal
14	therapy before you believe you have a maximum	14	inferior wall was affected by the stress Cardiolite
15	benefit?	15	study.
16	A. Well, beta blockers begin immediately.	16	Q. Where's that in relation to the sinus
17	Q. Okay. So the fact that he was on beta	17	node?
18	blockers from July 3rd to the moment of his death	18	A. The sinus node? Sinus node is usually
19	you believe negates any risk or any question that	19	in in the it typically is in the valvular
20	they would have helped having been given earlier?	20	plane. It's between the septum It's in the high
21	A. It would have been unlikely that they	21	right atrium.
22	would have helped earlier.	22	Q. Is that sometimes called the apical area?
23	Q. Same question with reperfusion. Had he	23	A. No.
24	been reperfused by some sort of intervention,	24	Q. Okay. Where the fixed defect is, is it
	Page 103		Page 105
	stenting, angioplasty, or bypass, do you believe he	1	close to the sinus node?
2	would have died anyway?	2	A. The sinus node tend typically is in the
3	A. I believe there's a good chance that he	3	atrium. It's not doesn't involve the left
4	could have died anyway.	4	ventricle.
5	Q. Can you quantify what you mean by "good chance"?	5	Q. Okay.A. Now, you can affect the sinus node by
6 7	A. The the value of the angiogram would	7	A. Now, you can affect the sinus node by location of the coronary artery lesion, but it's
ý	have told you your chances of survival. So if you	8	that's not what's looked at by the nuclear scan.
0 9	tell me If I assume that it's only single-vessel	8 9	
9 10	disease, revascularization conveys no mortality	9 10	Q. I'm just trying to look at things about this fixed defect.
11	benefit compared to medical therapy for	11	What about this fixed defect would put it
12	single-vessel disease. The nuclear scan says it's	11	at high risk to cause an arrhythmia?
13	single-vessel disease.	12	
13	Q. In addition to knowing he has a normal	13	
14	left ejection fraction, do you know whether there	14	always at risk for an arrhythmia. You can't
16	were gated images in his nuclear scan?	15	stratify the risk of the arrhythmia based upon the nuclear scan unless the left ventricular function is
17	A. I don't know. I'd have to go back and	17	abnormal.
18	look at the report.	17	Q. Does the location of the defect sometimes
19	Q. Do you know whether they found any	10 19	increase the likelihood of an arrhythmia?
1	dilatation of the left ventricular cavity?	20	A. Yes.
20		L 2 0	
20	-	21	• Where this defect is located is it in the
21	A. I don't recall seeing that in the report.	21	Q. Where this defect is located, is it in the location that's likely to lead to a fatal arrhythmia
21 22	A. I don't recall seeing that in the report.Q. Do you know if they found a singular sign	22	location that's likely to lead to a fatal arrhythmia
21	A. I don't recall seeing that in the report.		

27 (Pages 102 to 105)

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			May 6, 2004
[Page 106		Page 108
1	arrhythmia?	1	Q. He says at page
2	A. I would approach it as two questions.	2	A. I'm just reading this for the first time,
3	Q. Okay.	3	so I'm just reading it.
4	A. It can cause an arrhythmia.	4	Q. I just wanted to read it out loud to you.
5	The anterior wall is usually more suspect	5	I didn't want to blindside you with it.
6	for causing fatal arrhythmias.	6	A. I think I have exactly where you are on
7	Q. Have you ever had a patient who died from	7	line 12.
8	an arrhythmia from a fixed de a small fixed	8	Q. I'm not on line 12.
9	defect on the inferior portion of the heart?	9	A. Okay.
10	A. Yes. I have been in practice a long time.	10	Q. I'm on page 23. And I can hand it to
11	Q. The patient died on July 13th. You don't	11	you.
12	believe that anything that anybody would have done	12	A. Okay.
13	before July 13th would have altered the outcome;	13	Q. Line 16, it says, "The most likely cause
14	right?	14	is that he he he died from sudden death from a
15	A. I didn't say that.	15	myocardial infarction; but it is also possible that
16	Q. What, to a probability, could have been	16	he could have died from sudden death from a cardiac
17	done before July 13th to alter the outcome?	17	arrhythmia from the scar that he had on his heart
18	A. Cardiac catheterization.	18	from his previous infarction."
19	Q. And how would the catheterization have	19	The fact that he uses "previous
20	altered the outcome, to a probability?	20	infarction" makes it pretty clear that he thought he
21	A. It depends on what was found at the	21	had two; correct?
22	angiogram.	22	A. I would agree with that.
23	Q. If we assume what was found is what you	23	Q. Do you disagree with him as to the cause
24	suspect, how would it have altered the outcome?	24	of death, then?
	Page 107		Page 109
1	A. If there was only single-vessel disease,	1	A. I would put them in reverse order.
2	then it would not have altered the outcome.	2	Q. Okay. You agree that they're both
3	Q. If there was multivessel disease?	3	possible causes, but you believe the scar from the
4	A. It may have altered the outcome.	4	previous from the original infarction, we'll call
5	Q. Because there would have been	5	it, was the most likely cause.
6	revascularization?	6	A. Correct.
7	A. More than likely.	7	Q. You do realize that Dr. Kolibash is the
8	Q. Dr. Kolibash testified at page 23 that he	8	expert for Dr. Beaver and the group who employed
9	believed the most likely cause of death was from a	9	Dr. Auerbach?
10	myocardial infarction, but it's also possible he	10	A. Okay.
][could have died from a sudden death from a cardiac	11	Q. Do you believe there's any other potential
12	arrhythmia from the scar that he had on his heart	12	causes that are out there for death that are
13	from his previous infarction.	13	reasonable other than those two?
14	Do you see that?	14	A. It's unlikely that it's anything other
15	A. Yes, sir.	15	than one of those two, but I still would consider
16	Q. So he clearly testified that he believes a	16	these the arrhythmia more than likely number one.
17	second myocardial infarction occurred. You disagree	17	Q. You have testified in other cases before;
18	with him?	18	correct?
19	A. He stated that he died from sudden death	19	A, Yes.
20	from a myocardial infarction.	20	Q. You have testified in other cases where
21	Are you implying that he meant to say that	21	scope and extent of consultation has been at issue,
22	he died from a second myocardial infarction?	22	too; correct?
23	Q. No. I think he outright says it.	23	A. Maybe.
24	A. Okay.	24	Q. Do you remember the Mary Boley case?
1		1	

28 (Pages 106 to 109)

	Page 110		Page 112
1	A. I don't. Can you refresh my memory?	1	especially if the physician has recommended that.
2	Q. Mary Boley was a patient who had a	2	Q. Do you see any evidence that he was ever
3	perforation of her aorta. The cardiologist	3	told he had an MI?
4	requested an evaluation of why she was having an	4	A. I I have no knowledge of personal
5	alteration of her vital signs.	5	discussions between the patient and the doctor.
6	A. Oh, yes, I do remember that. I sure do.	6	Q. Did you see the form he filled out for
7	Q. Dr. Polinski?	7	Dr. Auerbach when he first went to see him?
8	A. Yes.	8	A. I I did review that.
9	Q. The central issue in that case was	9	Q. Did he specifically circle "No" where it
10	between the two physicians was what was meant by a	10	says "History of Previous Myocardial Infarction"?
11	consultation; correct?	11	A. Right. I don't know if Dr. Auerbach
12	A. As I recall, you're correct.	12	informed him that he had a myocardial infarction.
12		12	He was pretty clear in his letter to his referring
1			
14	that case, I assume; correct?	14	physician, so it wouldn't surprise me if he told him
15	A. Yeah.	15	he had a myocardial infarction.
16	Q. In that case you testified for	16	(Discussion held off the record.)
17	Dr. Polinski, the cardiologist; correct?	17	BY MR. KELLEY:
18	A. Yes.	18	Q. Why was Jeff Lyons starting to pass out in
19	Q as to what was meant when a	19	July?
20	consultation was requested?	20	A. I don't know that he had passed out. I
21	A. I'm sure I stand by my testimony.	21	know he filled it out on one of the forms in their
22	Q. Okay.	22	office. That's the only knowledge that I have of
23	MR. KELLEY: Take a second. I'm almost	23	it. I saw nothing else in the medical record other
24	done.	24	than Dr. Beaver's consultation that he had had no
	Page 111		Page 113
1	(Brief recess was taken.)	1	syncope. So I am I'm not sure when he passed
2	BY MR. KELLEY:	2	out, if it was in relation to this visit or not.
3	Q. Do you have an understanding as to why the	3	Q. Do you You have read Dr. Auerbach's
4	catheterization wasn't performed the first day that	4	testimony?
5	Jeff Lyons went for it?	5	A. Yes.
6	A. The only understanding I have is probably	6	Q. He testified at page 43 that, heart pain
7	superficial. And I know he had an initial date and	7	greater than 20 minutes at rest is consistent with
8	it was canceled; and I'm not exactly perfectly clear	8	unstable angina.
9	why it was canceled, but I thought it was by the	9	Do you agree with that?
10	patient.	10	A. It can be consistent with unstable angina.
11	Q. Do you have any criticisms of the patient	11	Q. He testifies at 44 that unstable angina is
12	in this case?	12	· ·
12			a more serious condition and the physician needs to
1	A. I think there are a few things he could have done better.	13	be more needs to quickly diagnose and treat the
14		14	situation.
		1 -	17
15	Q. And what are those?	15	Do you agree with what?
15 16	Q. And what are those?A. Not smoke, hopefully have gotten his	16	A. It's more unsta it's more serious than
15 16 17	Q. And what are those?A. Not smoke, hopefully have gotten his catheterization earlier.	16 17	A. It's more unsta- – it's more serious than what?
15 16 17 18	Q. And what are those?A. Not smoke, hopefully have gotten his catheterization earlier.Q. So you believe it was his fault that the	16 17 18	A. It's more unsta it's more serious than what?Q. If you look on 44, I'll let you look at
15 16 17 18 19	Q. And what are those?A. Not smoke, hopefully have gotten his catheterization earlier.Q. So you believe it was his fault that the catheterization wasn't done?	16 17 18 19	 A. It's more unsta it's more serious than what? Q. If you look on 44, I'll let you look at his words. There is my summary of it. That it is a
15 16 17 18 19 20	 Q. And what are those? A. Not smoke, hopefully have gotten his catheterization earlier. Q. So you believe it was his fault that the catheterization wasn't done? A. No, I didn't say that. 	16 17 18 19 20	 A. It's more unsta it's more serious than what? Q. If you look on 44, I'll let you look at his words. There is my summary of it. That it is a more serious condition, and there needs to be a
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15 16 17 18 19 20 21 22	 Q. And what are those? A. Not smoke, hopefully have gotten his catheterization earlier. Q. So you believe it was his fault that the catheterization wasn't done? A. No, I didn't say that. I know there was an issue with his insurance in not getting it done. Sometimes And 	16 17 18 19 20 21 22	 A. It's more unsta it's more serious than what? Q. If you look on 44, I'll let you look at his words. There is my summary of it. That it is a more serious condition, and there needs to be a
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15 16 17 18 19 20 21 22	 Q. And what are those? A. Not smoke, hopefully have gotten his catheterization earlier. Q. So you believe it was his fault that the catheterization wasn't done? A. No, I didn't say that. I know there was an issue with his insurance in not getting it done. Sometimes And 	16 17 18 19 20 21 22	 A. It's more unsta it's more serious than what? Q. If you look on 44, I'll let you look at his words. There is my summary of it. That it is a more serious condition, and there needs to be a quick diagnosis and treatment of the situation. Do you see that?

29 (Pages 110 to 113)

Page 116 Page 114 1 Yes. Q. Do you agree with that statement? A. 1 2 It's a relevant biomarker; correct? 2 О. Α. Yes. 3 I agree. 3 Do you agree that unstable angina patients Α. О. 4 Q. Do you see on page 162, where he says he 4 are at more risk for future cardiac events and death disagrees with Dr. Tulebaev that possible coronary 5 than patients with stable angina? 5 artery disease was unlikely at that time? 6 6 А. Yes. 7 7 О. Do you agree that troponin -- that's page Α. Yes. 56 of his deposition -- is now a preferred biomarker Do you agree? 8 8 Q. 9 With? 9 to diagnose myocardial infarction? A. 10 10 А. I think that it's a useful biomarker for О. Dr. Auerbach's assessment that 11 Dr. Tulebaev's assessment of possible coronary 11 diagnosing myocardial infarction. artery disease being unlikely was wrong, that he Did you see his testimony on page 69 12 12 О. regarding when he would have cathed this patient? 13 disagreed with it. 13 14 Tell me that again. I have page 69 here. 14 Α. Uhm, you know, it's -- it's easy to say Α. MR. SEWARDS: It's at the bottom of the that in retrospect. It's -- it would be much easier 15 15 to have seen the patient, make a comment. But at page, I think. 16 16 17 this point in time, I would agree with Dr. Auerbach. 17 A. Okay. I see this. Does he describe when he would have 18 Q. He also says on page 162 he believes more 18 О. performed a catheterization on Jeffrey Lyons? 19 likely than not that his presentation was consistent 19 20 with coronary artery disease. Correct? 20 A. Yes. 21 21 Correct. О. When does he say he would have? А. 22 He -- When they're talking about schools 22 Q. You agree with that; correct? Α. of invasive strategies for acute coronary syndromes, 23 23 А. Yes. 24 he refers to being a believer in an early invasive 24 О. Do you see page 88 of Dr. Auerbach's Page 115 Page 117 testimony? 1 strategy, early being within that hospitalization. 1 2 And I thought they were generally talking about 2 A. Yes. sir. 3 3 acute coronary syndromes in that -- in that regard. О. He says that Dr. Tulebaev called for a 4 Do you agree that he was a high-risk 4 consult with stress test. О. 5 5 patient, Jeff Lyons, based upon his family history, Do you see that? 6 the risk factors we've gone through, his troponin? 6 Yes. Α. 7 7 What do you take that to mean? A. Yes. О. 8 8 MR. SEWARDS: Object. О. On page 70, Dr. Auerbach says, With 9 unstable angina and high risks, he would cath the 9 Can you give me exactly where you're A. 10 patient before they go home. 10 talking about again? Do you see that? I just have in my notes that it was on 11 11 О. 12 А. Yes. 12 page 88 that he testified that Dr. Tulebaev called 13 Q. 13 for a consult with stress test. Do you agree that that's a reasonable 14 position to take for a physician? 14 I'll show you page 88 here. 15 Α. Yes. 15 Α. It says here there's a requisition for the 16 Q. Do you know why that wasn't done here? 16 stress test. 17 I think the real key is the -- the Α. 17 Q. So it would have been his call whether or examination by the doctor; did they truly have 18 18 not --19 unstable angina? 19 (Discussion held off the record.) 20 Do you see on page 161 of Dr. Auerbach's 20 BY MR. KELLEY: Q. 21 testimony that he believes Dr. Tulebaev should have 21 On page 118, he describes that nothing on Q. 22 noted the troponin? 22 the 26th, that's the note of Dr. Beaver, was 23 I see that. 23 inconsistent with unstable angina. Α. 24 Do you agree with him? 24 Q. Do you agree with that statement?

30 (Pages 114 to 117)

[
-	Page 118	1	Page 120
	A. I agree with that statement.		Are you licensed to practice in the state
2	Q. He also testifies I think it's around	$\begin{vmatrix} 2 \\ 2 \end{vmatrix}$	of Ohio? Goofy question. I got to ask it, though.
3	page 98 that he believes the acute myocardial	3	A. Yes, sir.
4	infarction was 24 to 48 hours before the 18th, which	4	MR. KELLEY: All right. I have no further
5	is when he presented.	5	questions.
6	Do you agree with that?	6	MR. SEWARDS: I have just a couple. I
7	A. I have no reason to dispute that.	/	promise not to take long, 'cause I know that it's
8	Q. Dr. Beaver I think it was on page 13	8	later in the evening and everybody wants to go on to
9	testified that he didn't even know the patient was	9	other things.
10	in the hospital on the 18th when he saw him on the	10	
11	26th.	11	CROSS-EXAMINATION
12	Did you see that?	12	BY MR. SEWARDS:
13	A. I'll go find that.	13	Q. Doctor, when a patient has chest pain,
14	Will you give me the page one more time,	14	there are lots of ways that physicians can evaluate
15	please?	15	the nature, extent, and cause of chest pain. Is
16	Q. It's 13. I think it's line 13.	16	that fair to say?
17	A. Okay.	17	A. Yes.
18	Q. Do you see that Dr. Beaver testified he	18	Q. One of the things that can be done to
19	didn't even know he had been hospitalized on the	19	evaluate a patient who has chest pain is to have
20	18th?	20	them undergo a Cardiolite stress test. Is that fair
21	A. Correct.	21	to say?
22	Q. Do you have any understanding as to how	22	A. Yes.
23	that could occur?	23	Q. In your review of the records, the
24	A. Uhm, yes.	24	hospital records, the office charts, and the
	Page 119		Page 121
1	Q. Can you explain it?	1	deposition testimony of the various physicians as
2	A. I'm not sure of the answer, but I I do	2	you have described, did you see anywhere where it
3	see how that can occur.	3	had been directly communicated or indirectly
4	Q. Obviously, you get paid for imposing on	4	communicated to Dr. Beaver that this patient had
5	your time.	5	been hospitalized and had suffered a myocardial
6	How much do you charge?	6	infarction?
7	A. For this deposition?	7	A. Not that I'm aware of.
8	Q. For first your review of cases, then	8	Q. I'm going to come over to you because it
9	obviously depositions and trials.	9	will be faster if I just show you things.
10	A. I charge \$400 an hour to review cases,	10	(Discussion held off the record.)
11	\$450 an hour to do deposition.	11	Q. And I'm looking at the Fayette County
		3 A I	$\langle \cdot \rangle$ is a set of the country of the transformed to the country
•		12	
12	Q. And do you have any idea of how much	12 13	Memorial Hospital records, and specifically
12 13	Q. And do you have any idea of how much First, were there any other letters that	13	Memorial Hospital records, and specifically Dr. Tulebaev's typewritten discharge summary.
12 13 14	Q. And do you have any idea of how much – First, were there any other letters that were provided to you that you didn't keep, any cover	13 14	Memorial Hospital records, and specifically Dr. Tulebaev's typewritten discharge summary. In his discharge summary, he makes
12 13 14 15	Q. And do you have any idea of how much – First, were there any other letters that were provided to you that you didn't keep, any cover letters or things that came afterwards?	13 14 15	Memorial Hospital records, and specifically Dr. Tulebaev's typewritten discharge summary. In his discharge summary, he makes reference that he was going to have the patient
12 13 14 15 16	 Q. And do you have any idea of how much – First, were there any other letters that were provided to you that you didn't keep, any cover letters or things that came afterwards? A. Everything I have is right here. 	13 14 15 16	Memorial Hospital records, and specifically Dr. Tulebaev's typewritten discharge summary. In his discharge summary, he makes reference that he was going to have the patient follow up with Dr. Gebhart, and then he also
12 13 14 15 16 17	 Q. And do you have any idea of how much First, were there any other letters that were provided to you that you didn't keep, any cover letters or things that came afterwards? A. Everything I have is right here. Q. Okay. And when you get paid for your 	13 14 15 16 17	Memorial Hospital records, and specifically Dr. Tulebaev's typewritten discharge summary. In his discharge summary, he makes reference that he was going to have the patient follow up with Dr. Gebhart, and then he also mentioned that he thought it would be useful also
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12 13 14 15 16 17 18 19 20 21	 Q. And do you have any idea of how much – First, were there any other letters that were provided to you that you didn't keep, any cover letters or things that came afterwards? A. Everything I have is right here. Q. Okay. And when you get paid for your deposition, will you charge \$900 for it or is it an hourly rate and we'll owe you more if you go over? A. You could owe me more if this keeps going. Q. What I like to hear. Like to keep the 	13 14 15 16 17 18 19 20 21	Memorial Hospital records, and specifically Dr. Tulebaev's typewritten discharge summary. In his discharge summary, he makes reference that he was going to have the patient follow up with Dr. Gebhart, and then he also mentioned that he thought it would be useful also to follow up with Dr. Auerbach next Tuesday for a stress Cardiolite test. Is that correct? A. That's correct. Q. And he doesn't mention anything there

		F	
	Page 122		Page 124
1	Q. A stress Cardiolite test does not equate	1	CROSS-EXAMINATION
2	with a full cardiology consultation. Is that	2	BY MR. LODICO:
3	correct?	3	Q. Doctor, I just want to be sure that I
4	A. Correct.	4	understand your earlier testimony. And I represent
5	Q. Now, on the order sheet that Dr Tulebaev	5	Dr. Tulebaev.
	signed off on, he wrote, Follow up with Dr. Auerbach	6	As I understood your earlier testimony,
6		7	it whether or not certain tests and so forth are
7	next Tuesday for a stress test Cardiolite.	E	
8	Do you see that?	8	ordered and conducted at the time depends upon the
9	A. Yes.	9	doctor's clinical evaluation of the patient at the
10	Q. Did anywhere on there did he order a full	10	time he's seeing him. Correct?
11	cardiac consultation?	11	A. Absolutely.
12	A. No.	12	Q. And based upon what Dr. Tulebaev was
13	Q. A moment ago, Doctor, you said in response	13	seeing at the time that Mr. Lyons was in the the
14	to a question that you could understand how	14	hospital at Fayette County, it was, as I understood
15	Beaver Dr. Beaver would not know that the patient	15	your testimony, reasonable for him to have sent the
16	was hospitalized.	16	patient home to have follow-up examinations later.
17	Was there a particular circumstance or set	17	A. As long as the patient was clinically
18	of circumstances that you might be referring to?	18	stable.
19	A. Yes.	19	Q. And again, that's based on a number of
20	Q. Could you explain that to us?	20	factors, the results of whatever testing was done,
21	A. Sure.	21	but also on the appearance of the patient as far as
22	I I can imagine a circumstance where	22	the doctor is concerned. Correct?
23	all patient records don't come over with the patient	23	
1	1 /		
24	at the time of examination. That's happened to me	24	with the physician.
	Page 123		Page 125
1	before. And if if you don't ask the question,	1	Q. Right.
2	before. And if if you don't ask the question, Have you specifically been hospitalized recently, or	2	Q. Right. And based upon what you see in the
2 3	before. And if if you don't ask the question, Have you specifically been hospitalized recently, or if the patient doesn't volunteer that information,	2 3	Q. Right. And based upon what you see in the records, it's your opinion that it was reasonable
2 3 4	before. And if if you don't ask the question, Have you specifically been hospitalized recently, or if the patient doesn't volunteer that information, that can happen.	2 3 4	Q. Right. And based upon what you see in the records, it's your opinion that it was reasonable for Dr. Tulebaev to have sent this patient for a
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2 3 4	before. And if if you don't ask the question, Have you specifically been hospitalized recently, or if the patient doesn't volunteer that information, that can happen.	2 3 4 5 6	Q. Right. And based upon what you see in the records, it's your opinion that it was reasonable for Dr. Tulebaev to have sent this patient for a
2 3 4 5	before. And if if you don't ask the question,Have you specifically been hospitalized recently, orif the patient doesn't volunteer that information,that can happen.Q. And you have reviewed Dr. Beaver's report	2 3 4 5	Q. Right. And based upon what you see in the records, it's your opinion that it was reasonable for Dr. Tulebaev to have sent this patient for a follow-up at a later time?
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2 THE STATE OF OHD: SS 2 COUNTY OF REAMALIN' 4 LStaven basch Valahov, M.D. do hereby or crity that how read the forgen granceity of any dopation given on April 30, 2004; that together advit the conscion page attached incerto roting charges to form or substance, If any, it is in an all control. 10 Seven forseph Valadoor, M.D. 11 How ready carrier that the forgeting charges to form or substance, If any, it is in an all control. 12 How ready carrier that the forgeting that the forgeting. 13 How ready carrier that the forgeting reading and disposition for stress for reading and disposition for stress for readin		Page 126 A F F I D A V I T	PERSONAL T
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1 Neven Joseph Yakubov, M.D., do hereby 6 certify that Lave read the Gregoring transcript of my depository gives on April 2, 20th, that tagefaire the test so testion regulated. Thereto noting a correct. 1 The So hereto is abalined. Thereto noting a correct. 1 The So hereto is abalined. Thereto noting a correct. 1 The So hereto is abalined. The so here and a correct. 1 The So hereto is abalined. The so here and a correct. 1 The So hereto is a correct. 2 The So hereto is a correct is a correct is a correct is a correct is a correcto is a correct is a correct is a correct is correct is a c		SS:	Construction of Construction
Steen Joseph Yakubov, M.D. 12	5 6 7 8 9	I, Steven Joseph Yakubov, M.D., do hereby certify that I have read the foregoing transcript of my deposition given on April 20, 2004; that together with the correction page attached hereto noting changes to form or substance, if any, it is true and	
11 13 14 transcript of the deposition of Steven Joseph 15 reading and signing: that after the fad stated to the undersigned to these that he had read and the summer signed the same in my presence on thus days of	10	Steven Joseph Yakubov, M.D.	XXXXXXXXX
14 transcript of the deposition of Steven Joseph Yakubow, DA, was similar to one winess for 15 trading and signing, that after he had stated to the andersigned Neary Public that he had read and 16 examined his deposition, the signed the same in my presence on this day of 17 18 19 NOTARY PUBLIC, STATE OF OBIO 20 NOTARY PUBLIC, STATE OF OBIO 21 23 24 24 25 26 27 28 29 20 21 22 23 24 State of OBO: 3 3 3 4 State of Nath Hights Adoption in a far 5 6 1, Breh A. Higgsis a Registered 7 Professional Robort Na	12		di Allaha Antonio
20 My Commission Expires: 21	15 16 17	transcript of the deposition of Steven Joseph Yakubov, M.D. was submitted to the witness for reading and signing; that after he had stated to the undersigned Notary Public that he had read and examined his deposition, he signed the same in my	
23 24 Page 127 1 CERTIFICATE 2	20	NOTARY PUBLIC, STATE OF OHIO My Commission Expires:	Subdescription of
24 Page 127 1 CERTIFICATE 2 3 THE STATE OF OP OHIO: 4 SS: COUNTY OF FRANKLIN: 5 6 1. Beth A. Higgins. a Registered 7 Professional Reporter and Notary Public in and for the State of Ohio, do hereby certify that before the 8 taking of his said deposition. the said Steven Joseph Yakubov, M.D. was first duly sworn by ne to 9 tell the truth, the whole ruth, and nothing but the mult. 10 That said deposition was taken in all respects pursuant to the stipulations of counsel heretofore set forth, that the foregoing is the deposition given at the said time and place by the said Steven Joseph Yakubov, M.D.; That larm tot an automey for or relative 13 14 IN WITNESS WHEREOF, I have hereunto set my land and official exid Ordine at Columbus, Ohio, this 30th day of April, 2004. 17 18 19 20 Beth A. Higgms, RPR			100 100 100 100 100 100 100 100 100 100
1 C E R TI FI C A T E 2			10000000000000000000000000000000000000
1 CERTIFICATE 2 3 THE STATE OF OHIO: 4 SS: COUNTY OF FRANKLIN: 5 6 1. Beth A. Higgins, a Registered 7 7 8 1. Beth A. Higgins, a Registered 7 7 9 10 staid deposition, the said Steven 10 sage for his said deposition, the said Steven 10 sage for said deposition was taken in all respects pursuant to the stipulations of counsel 11 11 heretofore set forth; that the foregoing is the deposition given at the said time and place by the 2 said Steven loseph Yakubov, M.D.; That I am not an attorney for or relative 10 That Said deposition was taken in all respects work loseph Yakubov, M.D.; That I am not an attorney for or relative 13 of either party and have no interest whatsoever in the event of this litigation. 14 IN WITNESS WHEREOF, I have hereunto set my hand and official scal of office at Columbus, Ohio,			Constanting of the
3 THE STATE OF OHIO: 4 SS: COUNTY OF FRANKLIN: 5 6 1 Beth A. Higgins, a Registered 7 Professional Reporter and Notary Public in and for the State of Ohio, do hereby certify that before the taking of his soid deposition, the said Steven Joseph Yakubov, M.D. was first duly swom by me to 9 tell the truth, the whole truth, and nothing but the truth; 10 That said deposition was taken in all respects pursuant to the stipulations of counsel 11 heretofore set forth; that the foregoing is the deposition given at the said time and place by the 12 said Steven Joseph Yakubov, M.D.; That 1 am not an attorney for or relative 13 of either party and have no interest whatsoever in the event of this hitigation. 14 IN WITNESS WHEREOF, I have hereunto set my hand and official seal of office at Columbus, Ohio, 15 this 30th day of April, 2004. 16 17 17 18 18 19 20 Beth A. Higgins, RPR	, ·	CERTIFICATE	
4 SS: COUNTY OF FRANKLIN: 5 6 . 7 Professional Reporter and Notary Public in and for the State of Ohio, do hereby certify that before the 8 8 taking of his said deposition, the said Steven Joseph Yakubov, M.D. was first duly swom by me to 9 9 felt the truth, the whole truth, and nothing but the truth. 10 That said deposition was taken in all respects pursuant to the stipulations of counsel 11 heretofore set forth; that the foregoing is the deposition given at the said time and place by the 12 said Steven Joseph Yakubov, M.D.; That I am not an attorney for or relative 10 14 IN WITNYES WHEREGOF, I have hereunto set my hand and official seal of fine at Columbus, Ohio, 15 this 30th day of April, 2004. 16 17 18 19 20 Beth A. Higgins, RPR			All an and
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19 20 Beth A. Higgins, RPR	17		anno-conte
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Notary Public, State of Ohio 21		Beth A. Higgins, RPR Notary Public, State of Ohio	All and a second second
22 My Commission Expires: July 17, 2005. 23	22 23	My Commission Expires: July 17, 2005.	and the second se
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