CHAPTER 1 - A 39-YEAR-OLD WOMAN WITH MULTIPLE COMPLAINTS

Table of contents:

1. The story behind the story (how we got this case… and other interesting tidbits):

We had the data for 9 chapters and were looking for one more. I had a few appeals decisions, but didn't think this case was a good one. I called the plaintiff attorney who was very nice but never called me back. I called the defense attorney and he was excited about the project, but wanted to get permission from the defendant - said he would call me back the next day. I had my doubts as there were so many things which needed to fall into place, but, much to my surprise, the records were received right on time and it was the perfect case - had to go first!

Turns out was one of the best cases in the book, and a perfect example of the lessons we were trying to get out; history is king. In fact, all you smart EP's and PA's and NP's (me included)... your nurse made the diagnosis; this is one case where ordering tests from your workstation would have been safer than actually seeing the patient!

The icing on the cake was having the defense attorney agree to an interview. He was forthcoming and revealed information about the case which was not apparent from the trial. Then Amal Mattu and Elimie Cobert (my co-author from the EMRA bouncebacks articles) agreed to write a commentary and I knew we had a first chapter. Interestingly, they disagreed on the management of the patient.

I have presented this case at multiple conferences including the all-LA conference Feb. 2011 and invariably the audience feels the physician did not meet the standard of care. I think in the context of a conference with one patient being discussed by 100 participants this makes sense. But in the context of 100 previous patients who actually did have bronchitis, it is not so clear...

Names of characters (names changed to protect the actual characters):

Albert August - A guy I knew a long time ago and ran into recently at a camp reunion - a colorful guy with a zest for living

Plaintiff expert witness - Drew Florra, name slightly changed, very good friend, poker and backpacking buddy. Lives down the street and our kids are good friends!

Patient's husband – Mike Kaminaka was my 5th grade teacher. He had NOTHING to do w this case!

Tim Madison – Good friend of mine in town

2. COMPLETE JUDGE INSTRUCTIONS TO JURY, CASE ONE:

THE COURT: Good morning, Ladies and Gentlemen. Welcome back. We're almost ready for opening statements of counsel. Before I do that, I'm going to read you some preliminary instructions that may help you outline -- help you out when going through the proceeding. Before we do the opening statements of counsel and begin to take evidence, I believe it will be helpful if you were to have some preliminary instructions to follow in listening to and considering the evidence which you will hear in this case. Later, after you have heard all the evidence and closing arguments of the counsel, I will give you further instructions covering additional law which you are to follow in this case.

It is the duty of the judge to instruct you in the law, and it is your duty to follow the law as I will state it to you both now and at the conclusion of all the evidence.

First of all, it is your exclusive duties to decide all questions of fact submitted to you. In connection with this duty, you must determine the effect and value of the evidence. You must not be influenced in your decision by sympathy, prejudice or passion towards any party, witness or attorney in the case. If in these instructions or in the instructions which I give you at the conclusion of the evidence, any principle or idea is repeated or stated in varying ways no emphasis thereon is intended and none must be inferred by you. Therefore, you must not single out any particular sentence or individual point of instruction and ignore the others but, rather, you are to consider all of the instructions as a whole and are to consider each instruction in relation to all the other instructions. The fact that I give you some of the instructions now and some at the conclusion of the evidence has no significance as to their relative importance nor is the order in which I give you the instructions.

The attorneys for the parties will, of course, have active roles in the trial. They will make opening statements to you, question witnesses and make objections. And, finally, they will argue the case as a last step before you hear my final instructions and commence with the deliberations. Remember that attorneys are not witnesses. And since it is your duty to decide the case solely on the evidence which you hear in this case, you must not consider as evidence any statement of any attorney made during the trial. There is an exception; and that is, if the attorneys agree to any of that, any facts. Such agreement, stipulation or admission of fact will be brought to your attention and you may then regard such fact as being conclusively proved without the necessity of further evidence as to such fact.

If a question is asked and an objection to that question is sustained, you will then not hear the answer; and you will not speculate as to what that answer might have been or as to the reason for the objection. If an answer is given to a question and the Court then grants a motion to strike out the answer you are to completely disregard such question and answer and not consider them for any purpose. A question in and of itself is not evidence and may be considered by you only as it supplies meaning to the answer.

Any fact in this case may be proven by either direct or circumstantial evidence. Direct evidence means exactly what the name implies. That is, it is evidence which directly proves a fact without having to infer the fact from some other fact. Direct evidence is usually the testimony given by a witness who has seen or heard the facts to which he testifies. It includes exhibits admitted into evidence during the trial.

Circumstantial evidence on the other hand is the proof of facts by direct evidencefrom which you may reasonably infer a fact in question. For example, is a question of a fact in a given case is whether or not Jonny ate the cherry pie, testimony by witness that he saw Johnny put the pie in his mouth and eat it would be direct evidence of such a fact. However, if a witness testifies that he arrived in the kitchen only to see Johnny standing there with an empty pie tin in his hand and cherry pie on his face, that would be circumstantial evidence of the fact that Johnny had eaten the pie.

The law makes no distinction between direct and circumstantial evidence as to the degree of proof required and facts may be proved by either type of evidence or combination of both. Each is accepted as a reasonable method of proof and each is respected for such convincing force as it may carry.
As jurors, you have the sole and exclusive duty to decide the credibility of witnesses who will testify in the case, which simply means that it is you who must decide whether you believe or disbelieve a particular witness and how much weight, if any, to give to the testimony of each witness. In determining these questions you will apply the tests of truthfulness which you apply in your daily lives. These tests include the appearance of each witness on the stand; his manner of testifying; the reasonableness of the testimony; the opportunity he or she had to see, hear and know the things concerning which he or she testified; this accuracy of memory; frankness, or lack of it; intelligence; interest and bias, if any, together with all the facts and circumstances surrounding the testimony. Applying these tests you will assign to the testimony of each witness such weight as you deem proper. You are not required to believe the testimony of any witness simply because it was given under oath. You may believe or disbelieve all or any part of the testimony of any witness. You should not decide any issue of fact merely on the basis of the number of witnesses who testify on each side of such issue. Rather, the final test is judging evidence --

force and weight of evidence regardless of the number of witnesses on each side of an issue. The testimony of one witness believed by you is sufficient to prove any fact. Also, discrepancies in a witnesses testimony or between his testimony and that of others, if there are any, does not necessarily mean that you should disbelieve the witness as people commonly forget facts or recollect them erroneously after the passage of time. You are certainly all aware of the fact that two persons who are witnesses to the incident may often see or hear it differently. In considering discrepancy in a witness's testimony, you should consider whether such discrepancy concerns an important fact or trivial one.
If you conclude that a witnesses willfully lied in his testimony as to a material fact you may distrust all of his testimony and you would then have the right reject all of his testimony unless from all the evidence you believe that the probability of truth favors his testimony in other particulars.
Burden of proof. The person who claims that certain facts exist must prove them by a preponderance of the evidence. This obligation is known as the burden of proof. The burden of proof is upon the plaintiff to prove facts necessary to his case by a preponderance of the evidence. Preponderance. Preponderance of the evidence is the greater weight of the evidence. That is, evidence that you believe because it outweighs or overbalances in your minds the evidence opposed to it. A preponderance means evidence that is more probable, more persuasive or of greater probative value. It is the quality of the evidence that must be -- must be weighed. Quality mayor may not be identical with quantity and the greater number of witnesses. In determining whether an issue has been proven by a preponderance of the evidence, you should consider all of the evidence regardless of who produced it. If the weight of the evidence is equally balanced or if you are unable to determine which sideof an issue has to preponderance, the partywho has the burden of proof has not established such issue by a preponderance of evidence.
During the course of the trial, certain testimony may be read into the evidence from a document or played by a videotape which will be referred to as a deposition. A deposition is many testimony which has been taken under oath before the trial and typed up into booklet for m or by video for use at trial. Likewise, certain questions known as interrogatories and the answer hereto, may be read into evidence.
An interrogatory is a question which was asked by one-party to another in writing before the trial and the answer to which was given under oath and in writing. Questions and answers in depositions and interrogatories and their answers are to be considered by you the same as if all of such questions and answers were testified to here in court. If statements in a deposition differ from the testimony given by the same witness in the courtroom, you may consider them to test the credibility of such witness.
During the course of this trial, after opening statements, my staff attorney is going to provide you with notebooks. I'm going to permit note-taking. The Court will provide you with pencil and notepad for your convenience. For many years, the practice of juror note'"taking was discouraged because the taking of notes may distract your mind from the evidence that is being presented while you are busy taking notes. The other reason was that the best note-taker might have more influence on other jurors than is appropriate. I suggest you take notes when there is a pause in testimony. It is your responsibility to listen to the testimony. Remember, each of you must individually determine the issues in this case. At the end of the case in deliberations, your collective minds will then reach a verdict. Please understand that testimony cannot be repeated nor the trial delayed to permit accurate note-taking.

There is no requirement that you take notes. Please place your name on the front of your notepad. The notepad will be collected at lunch break and every afternoon by the bailiff at the evening recess. Your notes will be redistributed to you when we reconvene. You may not remove the notepad from the courtroom. However, during jury deliberations you may have your notes with you in the jury room. All notes are confidential and for consideration of the jury only. After you have concluded your deliberations, your notes will be collected and destroyed.
One other note before we begin opening statements, one of the parties asked me to inform you of the fact that you may be aware that during the pendency of the case none of the attorneys are permitted to speak to you. And, obviously, in this building during lunch breaks there may be occasion where you run into one of the attorneys or one of the parties in the case in the building. Please don't be offended. They are not permitted to speak to you until this case is over with. So, please, don't feel hurt if they don't say hi to you or talk to you. That being said, I'm going to allow the parties to begin with opening statements.
Mr. August, are you prepared with your opening statement?

3. CROSS-EXAMINATION OF TIMOTHY MADISON BY PLAINTIFF ATTORNEY MR. AUGUST:

Q. State your full name, please.
A. Timothy Madison.
Q. You are a physician?
A. I am,
Q. You are a defendant in this case?
A. I am.
Q. You are employed by Emergency Services, Incorporated?
A. Emergency Specialists, Incorporated.
Q. Okay. Is that a corporation that – my recollection from our having had sworn testimony before is that you were employed by Emergency Services, Incorporated. Is that an error?
A. Yes. It's -- Emergency Specialists is the title of our corporate -- or our corporation.
Q. Okay. And you're an owner of that corporation?
A. I'm a partner in that corporation.
Q. Well, partner meaning you have an ownership interest in the corporation, right?
A. That's Correct.
Q. Okay. And were you working in the course and scope of your employment when you were in the emergency room on November 6, 2002, taking care of Mrs. Kamianka?
A. Yes, I was.
Q. Okay, And is Dr. George Smith one of your partners?
A. Yes, he is.
Q. And I believe that your group covered the No Name Hospital emergency room, correct?
A. That's correct.
Q. And just to orient the jury, Dr. XX is the person who dictated and signed the note for the time at the end of the day on November 6, 2002, when Mrs. Kamianka was brought in dead on arrival, right?
A. Yes. That's correct.
Q. So your partner filled out that note at the end of the day and the dictation, correct?
A. Yes. That's correct.
Q. Now, you have been at No Name since 1997?
A. That's right.
Q. Are you still working in emergency medicine?
A. I am.
Q. And are you still working at No Name?
A. Yes, I am.
Q. By the way, is No Name a part of the Clinic Health System?
A. Yes, it is.
Q. And it was in 2002?
A. Yes, I believe it was.

Q. And No Name didn't have the capability to do catheterizations, did it?
A. That's correct.
Q. So, if you had to have a patient undergo a catheterization or bypass surgery or any other kind of intervention that patient would be sent from No Name over to the Clinic main campus; is that right?
A. They can be sent either to Clinic, or the other option that we have is Hilltop Hospital.
Q. Okay. But both clinic facilities that would have the capabilities of doing those kinds of things, right?
A. That's correct.
Q. Now, would you agree with me that potential cardiac symptoms include back pain, chest pain, vomiting and arm pain?
A. They are potential symptoms, that's correct.
Q. Now, when you are interested in trying to determine or diagnose whether a patient has myocardial ischemia, what kind of things do you do?
A. Initially I would talk to the patient, try and elicit a history. I would look at notes or vital signs that the nursing staff had taken. And, then, I would examine the patient to try to get some further information about what's going on with the patient.
Q. Okay. And you stop there and the examination?
A. No. After the examination and their history is taken, then I would make a determination as to whether further testing needed to be done and whether further treatment at that point was indicated.
Q. Okay. Well, I was talking about a patient where you suspected cardiac ischemia, okay?
A. Yes.
Q. Okay. So, would it be true that after the history and after the physical in a patient with potential cardiac ischemia you would do an EKG?
A. That is a possibility.
Q. And you would probably order blood work to determine whether or not there was something that may have occurred in the form of a heart attack, right?
A. That's a possibility, also.
Q. Because enzymes will show that, right?
A. Well, enzymes are a part. They won't necessarily show it all of the time.
Q. I understand that. I understand that. But if it's a more recent bit of damage to the heart, the cardiac enzymes will show up as abnormal on the blood work, right?
A. They can, yes.
Q. And, likewise, an EKG is going to show if the patient has an abnormality from past damage that left some scar in the heart or acute ischemia at the time of the EKG, right?
A. That's a possibility. It is not 100 percent.
Q. And I'm not suggesting that it's always 100 percent. Part of what you do when you're talking to the patient and getting this history is to also assess risk factors to whatever extent you can, right?
A. In relation to a patient that's presenting with cardiac symptoms, is that your question?
Q. Right, yes.
A. Yes, that's correct.
Q. Okay. Now, you had indicated before that patients that may need a cath or treatment intervention, for example, with a cardiac problem, would be sent to the Clinic main campus or over to Hilltop. Was there a time when they used to be sent over to St. Angel as well?
A. I don't recall that in my experience at No Name. I can't say for sure about that.
Q. You can't recall ever having a patient that you know of from No Name that was sent over to St. Angel?
A. Not off the top of my head, no.
Q. Now, on the day in question, November 6th, 2002, you worked from 9 p.m. the night before until 7 a.m. on the morning of November 6th, right?
A. That's correct.
Q. And I believe, based on the records that we looked at in this case the emergency room has about 17 beds or rooms, correct?
A. That's correct.
Q. And, again, I'm talking about 2002, just to orient you in the event there has been any changes.
A. Yes.

Q. And at the time when Mrs. Kamianka was in the emergency room at about 4:45 to 6:35 in the morning, the maximum number of beds in use or rooms in use was eight, right?
A. I'm sorry, can you rephrase the question? I'm not sure I understand it.
Q. There were about eight patients in the ER when Mrs. Kamianka was there, right?
A. I don't recall exactly, but that -- that may be right.
Q. Well, I'm going to hand you what's been marked as Exhibit 3 which I have been told is the emergency room log or emergency department log for this day at No Name, and you'll see that Mrs. Kamianka is listed as one of the patients that morning, correct?
A. That is correct.
Q. And it shows the date and the time as well as her account number, how she got there, her sex, her age, her complaint, medical record number, and the discharge time, right?
A. That's correct.
Q. And the entry date -- I guess the time of arrival is 4:44 according to this and the discharge is 6:35, right?
A. That's correct.
Q. And pain in the chest is one of the complaints that's listed in the log, correct?
A. It's one of the complaints. There are multiple complaints.
Q. Okay. Pain in the arms, pain in the back, pain in the chest and vomiting, right?
A. That's correct.
Q. I assume the complaint would be what amounts to the chief complaint of the patient for the visit, right?
A. That's right.
Q. Now, if you look down this list particularly as it relates to the times, would you agree with me that there are eight patients who were in the ER including Mrs. Kamianka at the time when she was being treated?
A. That may not necessarily be true. This is the log which begins at midnight and goes on throughout the day. There are eight patients listed up to that time. So, there had been eight patients checked into the emergency room after midnight. I can't say for sure whether some of those patients had been discharged or whether they were still in the department.
Q. Okay. So the maximum number of patients that would have been there when Mrs. Kamianka was is eight and it could have been less?
A. Yes, that's right.
Q. So it could be that there were only three, four, or five patients in the ER at the time when she was being treated?
A. That is a possibility.
Q. All right. So this is by no means a real busy day or time for your work, right?
A. It's probably an average day for that time of the morning.
Q. Now, when you were taking care of Mrs. Kamianka in the emergency room -- I understand she comes in and the nurse sees her and does a nursing assessment of the patient, right?
A. That's correct.
Q. And this is done before you even see the patient, right?
A. Yes.
Q. And, then -- and this nursing -- just so the jury is oriented, this nursing assessment sheet is what's been on the board and we have talked about here that lists at the very top chief complaint, back pain, chest pain, vomit, arm pain, timed at 5:05, correct?
A. Yes.
Q. And then gives this history of the present illness about what brought her there in the first place, correct?
A. Yes.
Q. Now, this is prepared by the nurse before you ever see the patient, correct?
A. Yes.
Q. And it's available for you before you see the patient to go in -- before going in to see the patient, the material -- or this sheet is there for you to review if you so choose, correct?
A. Yes, I will see that. I'll pick it up, I may review it just before going in to see the patient I may review it as I'm going in to see the patient.
Q. You also have the option of talking to the nurse directly and conversing a little bit about what this patient -- what is going on with this patient and so on, correct?
A. Yes, I do.

Q. At no time as it relates to Mrs. Kamianka did you ever talk to Nurse Deitrick about her evaluation or assessment of this patient, correct?
A. I don't believe that I did.
Q. So the only information you would have had available would be the documentary information from the chart which would include this nursing assessment sheet?
A. Yes
Q. Correct?
A. That's right.
Q. Now, from your review of the nurse's assessment sheet, which I assume you did look at before you saw her, correct?
A. Yes.
Q. Okay. From your review of this sheet, you were certainly aware that she had awakened from a sound sleep with back pain, chest pain, vomit and arm pain, right?
A. Yes.
Q. Doesn't say anything in there, in that history about her having been awakened from a cough, does it?
A. No, it doesn't.
Q. As a matter of fact, you don't remember ever having gotten a history when you talked to Mrs. Kamianka directly about coughing being the cause of her being awakened, right?
A. I was able to obtain a history of the cough. I don't have any documentation that it was the cough that woke her up.
Q. Okay. What she did do when she woke up is she took Motrin, an over-the-counter painkiller, right?
A. That's right.
Q. Now, Motrin is not the kind of medication that you would take for a cough as a layperson, is it?
A. No.
Q. Motrin is the kind of a pain -- or a medication you would take for pain that you were experiencing; I mean, that's typically what people use it for, right?
A. That's correct.
Q. So, you would agree with me at least in the mind of Mrs. Kamianka that she had a severe pain that caused her to take Motrin and not a cough for which she would have taken something like a cough medicine, right?
A. No. I elicited a history that she did have a cough, but I would agree that she took the Motrin for the pain that she was having at that time.
Q. Now, when you saw this patient, you also took a history yourself, right?
A. That's correct.
Q. And that history ultimately was dictated by you, correct?
A. Yes.
Q. The very first thing you show is the chief complaint for Mrs. Kamianka that morning was chest pain, correct?
A. Yes. I also included the other two complaints that she had initially which were coughing and vomiting.
Q. I understand that. The fact is the very first thing you listed in this case as a complaint of this patient was chest pain, right?
A. The order of those complaints is not significant. She had all three complaints as her initial assessment.
Q. Okay. Well, ,you would agree with me that chest pain is often associated with a cardiac problem, isn't it?
A. It is a possibility.
Q. Now, you never even asked her about the intensity of her chest pain, did you?
A. I did not ask her that specifically. The intensity of the chest pain was documented on the nurse's notes.
Q. And that's the thing that shows that she had an intensity that was eight out of ten, correct?
A. That's right.
Q. Now, eight out of ten is a very severe degree or level of pain, isn't it?
A. Yes, it is.
Q. Have you -- are you familiar with pain scales? I'm sure in medicine you have dealt with a lot of different pain scales, right?
A. Yes.
Q. And are you familiar with the description that is typically given to describe an eight out of ten on a pain scale?
A. I'm not sure I understand the question about description.
Q. Well, obviously, the more -- the higher the number the more severe your pain?

A. That's right.
Q. So if somebody has got a two, it's a lesser degree of pain; if somebody has got an eight or a nine or a ten, it's a more severe degree of pain, right?
A. That's right.
Q. So, there are characterizations that are given for pain scales so that people know whether they fall into the five, the six, the three, the eight, kind of scale, correct?
A. Yes.
Q. Would you agree that an eight would have – is characterized -- or can be characterized as physical activity severely limited; you can read and converse with effort; nausea and dizziness set in as factors of pain on occasion?
A. It sounds to me like you're reading that from a text. Could I-
Q. I'm reading this from a pain scale called Mankoski Pain Scale, okay, just pulled off the internet. Do you have any reason to disagree with that pain scale description for an eight out of ten?
A. No, I don't.
Q. Now, you never even asked Mrs. Kamianka about -- you didn't ask about the intensity. You also didn't ask about the duration of the pain, correct?
A. That's correct.
Q. It would be something that would be important to know, isn't it?
A. Depending on the presentation of the patient, yes.
Q. And that's something which is helpful to make a diagnosis, isn't it?
A. It can be.
Q. And would you agree that if a patient has chest pain for more than five minutes that they should go to an ER for evaluation and assessment?
A. That is not necessarily true. It would depend on what other symptoms the patient is experiencing and what the context of the chest pain is.
Q. You never asked Mrs. Kamianka about the intensity or the duration and the fact is you cannot remember why you didn't ask her more detail about her chest pain, do you?
A. I'm not sure I understand that question.
Q. Well, do you know why at this -- as you sit here and after you have evaluated this case in your mind for years, why you didn't ask her more detail about her chest pain? You don't remember that, do you?
A. Well, the presentation of the patient was fairly straightforward when I asked her the questions in the history.
Q. Do you know if Mrs. Kamianka ever had chest pain in the past? I don't mean now. I mean when you were seeing her. Did you know on November 6th, 2002, after talking with Mrs. Kamianka at the end of that visit whether she had ever had chest pain in the past?
A. I don't know. Or I didn't know at that time.
Q. Right. You know now, obviously.
A. Yes.
Q. But at that time you didn't know, right?
A. Right.
Q. And that's because you didn't ask her, right?
A. That's correct.
Q. You also didn't ask her about any family history of heart disease, did you?
A. That's right. And the reason that I didn't was--
Q. I didn't ask that, sir. You can give that later. The fact of the matter is you didn't ask about prior chest pain; you didn't ask about family history; and you didn't know anything about her brother being 32 at the age of his MI and death, right?
A. At that time, no.
Q. Okay. That sort of information in a patient who presents with chest pain as a complaint would be important to know, wouldn't it?
A. It would be important depending upon the history and physical exam that was taken initially and on the context of the presentation of the patient.
Q. Now, the other thing that this history tells us when she says she's awakened from a sound sleep with the symptoms including chest pain is that that chest pain by definition is unstable angina, right?
A. No. That is not necessarily true.
Q. Okay. Is there, in fact, a definition of unstable angina that means you get chest pain at rest or without exertion?

A. That is a definition of unstable angina.
Q. And unstable angina, at least as defined in that context, is dangerous, is it not?
A. Yes, it can be.
Q. . Because it can lead to an MI or a heart attack, can't it?
A. Yes, it can.
Q. And now as we sit here we know that indeed occurred, correct?
A. No, I don't think that can be said. I mean, eventually the demise of the patient was due to an MI; we can say that.
Q. Well, again, I think what you're trying to tell the jury is that this woman had absolutely no cardiac problem at all when she was in the emergency room on the morning of the November 6th, right?
A. No. I'm not saying that at all.
Q. Okay. So would you admit that on the morning of November 6, 2002, when she was in the emergency room with a chest complaint that she had a cardiac problem?
A. She -- from the -- in hindsight from the pathology report we understand that she did have cardiac disease. I'm not denying that.
Q. Okay, You're not suggesting that she was without any cardiac problem at the time of the emergency room visit but sometime in the next 12 hours there was some migration of a clot to her left anterior descending, are you?
A. No, I'm not.
Q. Now, one of the things you ordered for her was Tylenol, right?
A. Yes.
Q. And that, I guess, would be for pain, right?
A. That's correct.
Q. You also ordered a chest x-ray, correct?
A. Yes.
Q. And you -- when she ultimately went to get the chest x-ray in the radiology department, she actually was made to walk there, right?
A. Yes. She did walk to the radiology department to get the chest x-ray done.
Q. Would it be your practice to send somebody with chest pain and a potential cardiac problem to another department in the hospital, have them walk there as opposed to going by wheelchair?
A. Not if they came in with a clear-cut cardiac problem. This patient presented with cough, post tussive vomiting. The cough was productive. She coughed so hard she was vomiting. That is not a presentation of a patient who has cardiac ischemia. Therefore, both my assessment and the assessment the nurse on this presentation was such that the patient was able to walk to the radiology department to get her chest x-ray.
Q. Well, were you relying on the nurse's assessment?
A. I take that into consideration.
Q. Well, okay, we will get to that. You say if there are clear-cut cardiac problems or symptoms you wouldn't have them walk; you would have them go by wheelchair; is that what you said?
A. What I'm saying is if a patient comes in with heavy chest pain complaining that this is a terrible pain that they have in their chest; they can't breathe; it gets worse when they exert themselves; that is a patient that I would not send to the radiology department. I would get a portable chest x-ray•
Q. Well she had severe pain in her chest as well as her back that was rated eight out of ten, right?
A. And if you read in the nurse's notes it says in the second line that most of that pain was between the shoulder blades and radiating down the right arm.
Q. Right. Where is your heart?
A. It's in the -- it's actually a little left of the center of the chest.
Q. A little left of center in the chest, but it's --
A. Yes.
Q. -- between your chest and your back, right?
A. That's correct.
Q. It's not out in the front with nothing in the back, right?
A. That's correct.
Q. So, it lines up pretty much between the shoulder blades as to where it's physically located, correct?
A. That's right.
Q. And the severe pain that she has between her shoulder blades, based on all the history she gave you, there was nothing to say that that could not have been the heart that was exhibiting the pain in her system, correct?

A. But if you will --
Q. Correct? Correct?
A. That is--
Q. Correct?
A. That is a possibility.
Q. Okay.
A. Can I answer further?
Q. You'll have your opportunity to explain your side. I'm just trying to get something through here. You have -- in addition to that eight out of ten, you have chest midsternal pressure -- pressure. Now, would you agree with me that pressure or tightness in the chest can be a sign of a cardiac problem?
A. It is a possibility. It can also be a sign of multiple other problems that are going on including respiratory type problems.
Q. Right. And -- so, respiratory; it could be bronchitis?
A. Yes.
Q. Could be perhaps pneumonia?
A. Yes.
Q. Could it be a PE?
A. Yes
Q. And it could be a heart problem?
A. That's in the line of possibilities.
Q. Now, somebody could have a heart problem that could be fatal, right?
A. Yes.
Q. What's it take to order an EKG?
A. I would have to circle the order and give it to the secretary to get ordered.
Q. Okay. And the secretary gives it to the nurse, and the nurse puts the 12 leads on the patient, plugs them in and runs off the strips to determine what the EKG is showing for that patient's heart, right?
A. That's correct.
Q. And this is a fairly -- this is a – totally risk free to the patient, isn't it?
A. Yes.
Q. And it is inexpensive, correct?
A. I don't know the cost.
Q. Okay. Cost certainly should not be a factor that you would take into account, right?
A. Right.
Q. Okay. And it is reliable in the sense that it can give you information, more information about the status of that person's heart and heart rhythm, right?
A. That's correct.
Q. And it doesn't take very long to do, does it?
A. No.
Q. And it's all right there in the ER. I mean, they can do it with no difficulty at all in the ER. It's not like you got to go across the street or I didn't ask about certain risk factors around the corner. Right?
A. That's right.
Q. Isn't it true, Doctor, that you never even considered ordering an EKG on Mrs. Kamianka?
A. I did not consider ordering an EKG because was not indicated in this presentation.
Q. Well, you keep talking about presentation, and I'd like to ask you about that. Isn't the patient's presentation based in part on your observations and the information you gather?
A. Yes, it is.
Q. As a matter of fact, that's a large part of the presentation, as you call it, right?
A. Yes.
Q. So, if you don't know anything about certain risk factors or history in that patient – for example, the risk factors she had for coronary artery disease -- that's because you didn't ask about it, right?
A. I didn't ask about certain risk factors because of the complaints, the history and physical and the nurse's notes that were obtained in the department that morning.
Q. In other words, because she came in complaining of chest pain you decided not to ask her about a history of CAD or heart disease or chest pain?

A. She was not only complaining of chest pain, but if you take the entire context of her complaints, it was not a cardiac presentation.
Q. My point being, Doctor, that presentation is dependent on you and what you do or say to a great extent, right?
A. To a great extent.
Q. And you can't necessarily rely on a patient to offer information about her history or her prior episodes of chest pain or her prior family history, you can't rely on a patient because the patient doesn't know what is important for you to evaluate, correct?
A. That's correct.
Q. That's why it's up to you to gather the information and ask the questions to get this stuff so you can put it in the context of what's going on with that patient, right?
A. Yes. And those questions that are asked are guided by the examination and the interview or the history obtained from the patient.
Q. And it's your testimony in this case that that presentation, as you call it, didn't fit the diagnosis of something that could be cardiac in nature, right?
A. That is right.
Q. Well, what does the term rule out mean in medicine?
A. Rule out means that you consider something and then do further testing to say that that diagnosis or that disease is not present.
Q. Okay. So, it's a -- it's -- it's an evaluation and testing to exclude a particular thing as the source of the problem?
A. That's right.
Q. Okay. For example, if somebody has a biopsy and it comes back negative, they don't have cancer; I mean, it's a way of saying, okay, we have tested, and we found that there's no cancer in this patient or in their liver or whatever it may be, right?
A. Yes.
Q. And for heart problems, the cardiac catheterization seems to be, I think you would agree the gold standard for the testing and evaluation of whether somebody has coronary artery disease, correct?
A. Yes.
Q. So that would be an example of a test that rules in or rules out cardiac -- coronary artery disease in a patient, right?
A. Yes, it is.
Q. But in your practice, you certainly don't order the cardiac catheterization as the first line of testing for a cardiac problem, do you?
A. No, I would not.
Q. The fact of the matter is the first thing you would do is get an EKG, right?
A. If it was indicated, according to the patient's presentation, then, I would, yes.
Q. And then you would follow that or at the same time get blood studies done to evaluate whether or not there is any evidence of a cardiac enzyme elevation, right?
A. Yes.
Q. Now, are you capable of interpreting an EKG?
A. Yes, I am.
Q. And I'm sure that you have probably ordered thousands of EKGs in the emergency room in your career, right?
A. Yes.
Q. And an EKG is certainly a test that can help to rule in or rule out a potential cardiac problem, right?
A. Yes, it is.
Q. And if a patient has past damage to their heart, some damage in the form of a scar or necrotic tissue from some other event previously, an EKG can show that abnormality, right?
A. It can. It does not always.
Q. I understand. Depends pretty much on how significant that is, right?
A. Yes, that's right.
Q. And whether it interrupts or affects the conductivity of the heart electrically on the EKG, right?
A. Yes.

Q. Likewise, if somebody has ischemia, acute ischemia, they come in, and they have got chest pain, they have got chest pressure, and they have got what amounts to closing or narrowing of the arteries, the coronary arteries, that's going to show up in an EKG, isn't it?
A. Not all the time, but it can.
Q. But it certainly can?
A. Yes.
Q. And if it does, it gives you another piece of the puzzle to say we better look further on that, correct?
A. Yes.
Q. And if that EKG came back in a positive or abnormal fashion, regardless of the enzymes, you may go to yet another test, like a stress test, correct?
A. Are you saying I would go to a stress test if there were abnormalities on the EKG, is that the question?
Q. If there are abnormalities in the preliminary testing for EKG and enzymes, one or the other, particularly the EKG, it may result in going to the next level which would be a stress test?
A. It may.
Q. All right. And it may lead to a cardiac catheterization, which would be diagnostic of CAD, right?
A. That's correct.
Q. Now, would you agree as a general proposition that people who experience chest pain for any period of time should, in fact, get it evaluated; that's a good piece of medical advice to the general public?
A. Yes, it is.
Q. Why is it important for a person with chest pain to go to the hospital?
A. To have that chest pain evaluated.
Q. Is it also to determine what that physical condition is that's causing the chest pain?
A. That would be part of the evaluation.
Q. Is it also because chest pain can be a sign of something that is more serious that could occur?
A. It depends on the context of what's going on
at that time, but it can be an indicator of something more serious going on.
Q. And it's also because chest pain and whatever it represents can be successfully treated, right?
A. Yes, it can.
Q. And if it is chest pain caused by ischemia, for example, that would be a harbinger or something that would perhaps be more serious later on like an MI, right?
A. That's correct.
Q. And if it's caused -- if the chest pain is caused by ischemia, would you agree that it can be successfully treated and an MI or heart attack can in many instances be avoided altogether?
A. Yes, that's right.
Q. Now, as I understand it, No Name Hospital has a chest pain protocol; is that right?
A. I believe you're referring to a nursing protocol if I'm correct.
Q. Well, but No Name Hospital for the emergency room nurses gives them a protocol saying if somebody comes in with a chief complaint of chest pain this is what you should do?
A. They have multiple protocols for different presentations. Chest pain would be one of those.
Q. Okay. And all I'm talking about right now is chest pain, not appendicitis or anything else. And is Exhibit 26 a complete copy of the guidelines of care for -- or protocol for chest pain?
A. Yes, it is.
Q. And you say this applies to nurses because they need to have this to guide them through their work; is that right?
A. I'm not sure you can say they need to have this. This is present so that if they have a patient presenting with this complaint, then they will have guideline that they can use to guide their workup that patient in the emergency department.
Q. Right. And would it be fair to say that from your perspective anyway you don't think this applies to physicians?
A. No. This applies to the nursing staff.
Q. And I assume that it applies to nurses because they are not as well trained as doctors so they may need a little bit of guidance to deal with the potential risk associated with a complaint of chest pain, right?
A. Well, I wouldn't say that the nurses are less trained. I would say they are trained in a different venue. So, these guidelines are to help them in the workup of that patient.
Q. But isn't it true, Doctor, that if appropriate you even follow these guidelines?
A. I'm not sure I understand the question. Are you saying that I should --I'm bound by these guidelines?

Q. No, I didn't say that. I said, isn't it true that you, in fact, follow these guidelines if appropriate under the circumstances?
A. I don't follow nursing guidelines.
Q. I'm sorry?
A. I don't follow -- I don't use nursing guidelines in my workup of patients.
Q. Well, I'm going to draw your attention to page 23 of your deposition at line 12. It says, guidelines -- I'm sorry, line 11: That you are to follow those guidelines? That was the question. Answer: Guidelines are guidelines. They're used as a reference. So if you -- if you are saying, well they're binding and you have to follow them, that's not correct.
Question: But it is suggested by the Clinic Health System that you consult those and follow them if appropriate; is that right?
Answer: If appropriate, that's correct. That's what you testified to under oath in this case, did you not?
A. In that deposition at that time, you were referring to physician guidelines from the Clinic. I don't believe that you were referring to the nursing guidelines that we're talking about at No Name.
Q. I'm sorry to differ. One of the things you also do in your work that you --
MR. SMITH: Objection, Your Honor, the -- objection.
THE COURT: Sustained.
BY MR. AUGUST:
Q. One of the things you also do is give courses every once in awhile to emergency medical technicians; is that right?
A. I don't give courses. I do continuing medical education for paramedics.
Q. All right. I'm sorry I called them courses. You give talks that are substantive for the benefit of emergency medical technicians, correct?
A. That's correct.
Q. And I assume that you talk to them about a variety of subjects, correct?
A. Yes.
Q. And I assume you also tell them about how to deal with a patient that has chest pain complaints, right?
A. Yes,
Q. And I assume you also are aware of the fact that emergency medical technicians do EKGs on these patients even in their homes or in the truck or on the way to the hospital, correct?
A. Yes.
Q. Do you tell emergency medical technicians if there's chest pain you don't always have to do an EKG?
A. No, I don't tell them that.
Q. Okay. The fact of the matter is you teach them that if there's a chest pain complaint get an EKG as a matter of course, correct?
A. No. They -- paramedics do not always get an EKG. They do have monitors on the trucks, and they will typically place the patient on monitors, However, emergency medical technicians and paramedics are guided by a set of guidelines according to their training.
Q. Their guidelines are different than physicians?
A. And nurses.
Q. Okay. Now, when Mrs. Kamianka checked in, her chief complaints, as we said, was back pain, chest pain, vomiting and arm pain; and I believe you indicated that you got a history of cough and post tussive vomiting; is that right?
A. That is correct.
Q. Now, was the coughing the reason why you elected not to get an EKG on Mrs. Kamianka for her chest pain complaint?
A. Coughing was part of that, in my judgment, but I took in context all of the complaints and all of the history that Mrs. Kamianka was giving me at that time; and as a result of that, I, I did not elect to get an EKG at that time.
Q. What about a cough rules out a cardiac problem in a patient?
A. Cough in itself does not rule out a cardiac problem.
Q. As a matter of fact, Doctor, you're not suggesting to this jury that a person who has a cough can't have a heart attack or can't have heart disease, are you?
A. No, I'm not,

Q. Well, was another one of these various reasons the fact that there was yellow sputum that she apparently had coughed up, was that another part?
A. That is another part in the history that the patient gave to me.
Q. Is yellow sputum something that rules out or excludes a cardiac cause for the complaints of chest pain?
A. No, it does not.
Q. A person who has a cough and productive yellow sputum certainly can still have a heart attack or heart disease, right?
A. That is a possibility.
Q. Was it the pain that was between her shoulder blades that led you to believe that this complaint didn't need or require an EKG?
A. Pain between the shoulder blades is an atypical type of presentation for cardiac ischemia or coronary artery disease, but that in itself did not lead me away from getting an EKG.
Q. Well, but pain between the shoulder blades certainly doesn't rule out a heart problem, does it?
A. No, it doesn't.
Q. And a person can have an MI or heart disease and still have pain between the shoulder blades, right?
A. Yes, they can.
Q. As a matter of fact, you talk about it as an atypical presentation for heart disease; is that what you said in so many words?
A. That's exactly what I said.
Q. Well, you are aware of the fact that women more often present with atypical or different kinds of presentations than men, right?
A. Yes, women can.
Q. Was it the cervical spine scoliosis on x-ray that caused you to think that this was not cardiac in origin?
A. No. It was part of the entire workup, history and physical exam that I did. That was part of it, but that in itself did not eliminate me from getting an EKG.
Q. And I didn't say in itself. This is one of a list of things that you believe pointed you in a direction other than her heart?
A. But what you're doing is taking each one specifically and singling it out; and I'm saying that I took all of those in context as an entire presentation of the patient and as such did not order an EKG.
Q. Well, wouldn't it be fair to say that for all of those things that we have just listed, put them altogether, that a patient who has all of those things still can have a heart attack?
A. That's a possibility. All things are possible.
Q. And they still can have heart disease?
A. Yes, they can.
Q. And the chest pain they present with can be perfectly consistent with heart disease or heart attack?
A. Are you referring specifically to Mrs. Kamianka?
Q. I'm talking about a patient who comes in with those things that you said pointed away from cardiac despite the presence of chest pain.
A. She had chest pressure. Most of her pain was between the back and down the right arm.
Q. Which as you acknowledged earlier can be from the heart, right?
A. It's a possibility.
Q. None of the things that you found as factors leading you away from chest pain would rule out cardiac as a cause, would they?
A. That's correct.
Q. And anyone of these or all of these things could be in a person who still has heart disease or is going through a heart attack, right?
A. Yes, it can.
Q. So what about Mrs. Kamianka's presentation makes it okay not to do an EKG?
A. Well, you're saying that with this presentation that I'm obligated to rule out a cardiac origin. I'm saying that that is not the case. The patient presented with these symptoms, and I'm saying that there's no evidence in those symptoms that the patient had ischemic cardiac disease. The presentation was one of bronchitis and an infectious upper respiratory disease; and as such, I'm not obligated to rule out a cardiac origin.
Q. Well, let's just see. The log sheet that you have up there shows as one of her complaints chest pain, correct?
A. That's correct.

Q. And the No Name Hospital patient information sheet shows chest pain as one of her chief complaints, correct?
A. That's correct.
Q. And your listing as the first chief complaint or one of the chief complaints is chest pain, correct?
A. That's correct.
Q. And the nurse noted from the assessment chest pain as one of the chief complaints, right?
A. Yes.
Q. And described chest pressure and pain in the history, correct?
A. Yes. Can I make a clarification?
Q. And then there is further an order for the chest x-ray and the clinical history given for that is chest pain, correct?
A. Yes. Can I make a clarification about that,
Mr. August?
Q. About which?
A. About the multiple areas of chest pain that you're talking about.
Q. Sure.
A. The -- let's just take the last one for instance. The order for the chest x-ray as indicated as chest pain that is put in by a clerk in the emergency department who's taking the information off of the nurse's notes. The log is entered by a registrar who is in the front of the emergency department and is again taking that information off of the nurse's note. So, most of this is coming from one source which would be the nurse's notes or my chart. It's not significant that each of those different individuals are getting a history of chest pain from the patient. That is not the case.
Q. And I never said that, Doctor. The fact of the matter is it's coming from the medical people who have taken the history and recorded the chief complaints, that's you and Nurse Deitrick?
A. That's correct.
Q. And two of the references we identified here are from your record and Nurse Deitrick's record and say the chief complaint includes chest pain, right?
A. Yes. And you're taking that totally out of context as chest pain itself.
Q. All right. Up there in signs and symptoms, what does it say for Mrs. Kamianka?
A. Where are you pointing to, sir?
Q. Signs and symptoms. What does it say here for signs and symptoms relating to Mrs. Kamianka?
A. Pain in chest. And, again, that --
Q. Thank you.
A. -- is entered by the clerk who puts the order for the chest x-ray in, yeah.
Q. Now; if all of these things that we have talked about caused you to conclude that an EKG really didn't have to be done on her, tell me this: What does a patient need to have at a minimum to get an EKG when they come in with chest pain if you're the one covering the ER?
A. Well, the patient certainly wouldn't present with a productive cough, that she coughs so hard she would be throwing up and causing the chest pain. That is not the presentation that would lead me to get an EKG.
Q. Can a patient who comes in with a productive cough that's coughing hard, coughing enough to vomit, can that patient still have a heart attack?
A. All things are possible.
Q. Can they still have heart attack or heart disease when their complaints include chest pain?
A. Yes, they can.
Q. And that's pretty important to rule out if you have a means of doing it so easily accessible to you in the emergency room, isn't it? Isn't it?
A. To order that test, you need to have an indication as to why that test needs to be ordered and that was not present in this case.
Q. Truth is, Doctor, you never even thought or considered a cardiac cause for Mrs. Kamianka's chest pain complaints, did you?
A. It was in the differential when I initially evaluated the patient; but as I got further history and physical exam, it went further and further down the list, and I did not work that part of the differential up.
Q. Isn't that failure to even consider it the reason you don't even remember if she was on a heart monitor in the emergency room that morning?
A. I'm not sure I understand that question.
Q. Well, haven't you already testified in this case that you don't even remember if she was on a heart monitor that morning?

A. That's correct. I don't recall that.
Q. And isn't the reason you don't remember she was even on the heart monitor that morning is because it wasn't even in your thought process that she could have a cardiac problem at the core or the root of her chest pain complaints? Isn't that the reason why you don't even remember if she was on a heart monitor?
A. No. That has nothing to do with it.
Q. And isn't it also the case that you don't ever remember ever looking at any heart monitoring strips or heart monitor information about Mrs. Kamianka's heart rate, heart rhythm, things that would show up on a heart monitor?
A. That's correct. I testified to that previously.
Q. In fact, Doctor, isn't it true that once Mrs. Kamianka mentioned the fact that she had been to her family doctor and had a diagnosis of bronchitis some weeks before that you presumed the same diagnosis and operated accordingly? Isn't that true?
A. No, absolutely not. I based my treatment upon my interview with the patient, upon the history that obtained, upon my physical exam and the treatment of the patient in the emergency department. I did not base my -- I do not base my treatments and evaluations upon another physician.
Q. Doctor, you learned about Mrs. Kamianka's death not long after it happened, right?
A. That's correct.
Q. In fact, you got a call at home from the ER -- or ED director, correct?
A. Yes, that's right.
Q. And that call concerned you quite a bit, didn't it?
A. Yes, it did.
Q. And isn't that why you requested a copy of the
autopsy from the coroner's office only days later, on
November 20th?
A. Yes, I did.
Q. And in that letter didn't you indicate to the coroner that this was your patient?
A. Yes, in the emergency department.
Q. And you have reviewed the autopsy since then, haven't you?
A. Yes, I have.
Q. You don't have any reason to disagree with the coroner about what her cause of death was, do you?
A. No, I don't.
Q. And you have looked at that autopsy?
A. Yes, I have some time ago.
Q. And you are familiar both from your review as well as the other testimony in this case that Mrs. Kamianka was not found to have any bronchitis on autopsy, right?
A. I don't know that that was specifically looked for in the autopsy. I may be incorrect about that.
Q. Do you have anything to tell this jury that says that there was evidence of bronchitis in Mrs. Kamianka on autopsy?
A. No, I don't.
Q. So, there is no reported pathological basis to say Mrs. Kamianka had bronchitis on autopsy, right?
A. That's correct, but they may not have investigated that during the autopsy.
Q. As of November 2002, Doctor, is it true and did you agree that cardiovascular disease was the number one killer of women in the United States?
A. Yes, I believe that it was.
MR. AUGUST: Thank you very much.
THE COURT: Thank you Mr. August.
Doctor, you may step down.
Ladies and Gentlemen, we're going to take our morning break. Break for about 25 minutes. During this time you can go downstairs, get a cup of coffee if you'd like. Please don't discuss the case among yourselves or with anyone else. Don't form or express any opinions until you hear all the evidence.
All rise for the jury.
(Thereupon, a recess was had.)

4. CLOSING STATEMENTS AND JURY DECISION

AFTERNOON SESSION
WEDNESDAY. OCTOBER 5. 2005
(Thereupon, the following
proceedings were had out of the
presence of the jury.)
THE COURT: Did counsel have
an opportunity to look at the interrogatories
and the instructions?
MS. REID: I did, Your
Honor.
THE COURT: Are they still
with --
MR. AUGUST: I don't know.
MS. REID: They look fine
to me.
THE COURT: If you want to
come up here and just take a look at them.
MR. AUGUST: I don't
anticipate a problem.
(Thereupon, the following
proceedings were had in open court
and in the presence of the jury.)
THE COURT: Thank you, John.
Good afternoon, Ladies and Gentlemen. We're
ready to resume closing argument.
Mr. Jones, you may make your closing
argument.
MR. JONES: Thank you very
much, Your Honor.
CLOSING ARGUMENT ON BEHALF OF DR. MADISON
MR. JONES: Good afternoon,
folks. Now, it's not my place in this closing
argument to tell you what the facts are. You
have heard a lot of testimony. You're going
to see the exhibits, and some of you have seen
blown up here. But what the facts are in this
case are what you will determine they are when
you go back into the deliberation room.
So, I'm not going to stand up here
and say, well, this is what the facts are,
this is what you should believe, and this is
what you shouldn't believe. It's also not my
place up here in closing argument to tell you
who you should believe and who you shouldn't
believe. Again, you know, you heard from the

instructions, that's really the job that a jury is best suited for is to determine what they have heard they believe and what they have seen they believe.

So, my closing argument isn't going to be that. What I'm -- what I'm going to try to do as briefly as I can is give you a framework. Actually, two frameworks to go back into deliberations with and if you feel it's appropriate use these frameworks to sort of see how the facts that you find fit.

One framework is the model I think that Mr. August has been presenting in this case and which he confirmed for us in his closing argument and the other is a framework that we tried to use in presenting Dr. Madison's defense. So, just to give you an idea of what it is I'm going to try to do in the next few minutes.

Everything has a context. I don't think -- you know, Mr. August said a number of times let's use our common sense and, you know, that's true, but everything has a context. Nothing stands alone or very few things at least in this world stand on their own. So, I'm going to try to give you some context, too.

First, I want to thank you on behalf of Dr. Madison and myself for being so attentive. It has been a relatively long trial. I have done this for a number of years, and this is a relatively long one. It has taken us longer to put this case on than I think we anticipated originally, which taxes your patience, and you have been great. So, I want to thank you first.

Also, you know, in the course of any trial, I have done this long enough that I may have done something that you felt, I don't know, maybe wasn't appropriate. You may have seen me whispering or you may have seen something going on. I want to first say if I did anything that you felt was inappropriate, please, that is something you should hold me responsible for, not Dr. Madison. I have tried not to do that. I've tried to be respectful to everyone in the courtroom, but I don't know what you're all thinking all the time. I

wouldn't try to pretend that I do.
Dr. Madison you have seen testify, and he is just a wonderful fellow. And I -- he's lived with this case, with me for a number of years, and I would hate to have something that I may have done which you may take wrongly-- or rightly I suppose, as some bad reflection on Dr. Madison. Because he's testified a couple of times in this case and you really ought to judge him based upon his testimony and how he presented himself to you in this case.
I do want to mention one thing; and that is -- I do have one thing to apologize for. Dr. Smead, reading Dr. Smead's discovery deposition, that is nothing any lawyer, believe me, relishes doing. It is -- well, at least having heard the instructions, maybe the reading of a deposition is a little more exciting than that, but it's not much more exciting than that. Unfortunately, as you heard, Dr. Little testified -- this case was originally scheduled to be tried several weeks ago and that trial date had to be changed and I still thought I could get Dr. Smead in here on Friday as the first witness because of his trip, as you heard, to Guatemala this week for his missionary work, and that didn't work out. So, I had to read his deposition. And that's one of those things -- you know, you have seen a number of, obviously, witnesses who took time out of their practices or whatever else they have to do and came and testified, and that's what we all prefer. But the instructions are that you are to take the testimony of a deposition or a video or a live witness the same; and I know that can be difficult when I have read a deposition. Unfortunately, Dr. Smead like many experts isn't able to wait around a couple of days to testify like Dr. Marcus did. He has obviously other things going on. So, I do want to -- I do want to mention that. I would have liked to have called Dr. Smead live for you to see his testimony.
All right. So, the first issue is standard of care. What's the standard of care? What a reasonable physician -- in this case, when I am representing Dr. Madison -- a

reasonable emergency room physician would do under the same or similar circumstances. And it is important to understand that two physicians have seen Mrs. Kamianka within this two month period, and Mr. August is right, it is important to us that two very qualified, very well-experienced physicians in two different specialties saw Mrs. Kamianka under similar circumstances, not identical, but similar circumstances, and came to the same conclusion that this was not a cardiac problem.

We also had Nurse Deitrick who -- who has testified, again, by reading, but she is a nurse, and she had the same impression. So not only do we have two different doctors in two different specialties at two different times, we also have a nurse who is -- is looking at Mrs. Kamianka -- bless you -- when she came into the emergency room. And, and you heard a nurse is, she's responsible for making an initial assessment, too; and if it's suspicious of a cardiac problem, she has certain things to sort of put in place, which she did not because, as she testified, she didn't think it was a cardiac problem.

The case that Mr. August is putting on is that somehow, you know, once led down the primrose path by Dr. Little saying that this was bronchitis everybody just sort of stopped in lockstep and got behind Dr. Little; and when Dr. Little was wrong about that diagnosis, which I don't think he was, but that's their position, and so we all sort of got behind him in the wrong diagnosis. And that's not what happened.

From the testimony in this case, it's clear that each of these folks did their own complete assessment of what was going on with Mrs. Kamianka when she was being seen. So, whether it's described as a chest tightness and a cough and congestion or whether it's chest pressure with cough and other problems or whether it's a chest pain, however -- whatever words you want to use, the fact that they each had to assess how to put that complaint, which was one of a number of complaints each time, into context, into the

context of the presentation, and a presentation just isn't an appearance of somebody. A presentation involves looking at the patient, doing a history, talking with the patient, doing a physical examination treating the patient and seeing how that patient responds to treatment. It's all of that is a presentation.

Okay. So, it's not just, oh, the presentation, he looked okay she's nothing going on, nothing serious there. That's not what these doctors did, and it's not what the nurse did either.

These are the folks, the medical folks who actually had that opportunity in this relevant time period to sit down with Mrs. Kamianka, to talk with her, to observe her responses, to -- to lay hands on her, to touch her. The experts in these cases, it's impossible. They don't have the patient in front of them. They never do. That is a limitation of every expert, no matter who calls the expert. So, that's why the testimony of the doctors, an understanding from their records and their testimony, what happened is so important in these cases.

But because we have several people who have seen Mrs. Kamianka during this relevant period of time, they all came to essentially the same conclusion about what was going on for her, Mr. August has tried mightily in his case to -- to say everybody just sort of, you know, got in lockstep behind Dr. Little, and that's not -- not what the case is really all about.

Let's talk about what really medical decision making is about because if we -- take a look at this. It's very high tech here, I know.

We have, in any presentation, decision making going on by the medical personnel, whether it's a nurse or whether it's a doctor, but this -- this sort of triad of things that go into medical decision making are that framework to talk about what a doctor is doing in evaluating a patient. And I'm going to deal with Dr. Madison and the emergency room in this regard. They have a history

You have heard about a physical exam, and this treatment response which becomes so important in a case like this. These are the points that play into medical decision making.
Mr. August has said in his closing, and I think he's tried to say in his opening and-and through some of his witness, that, you know, our defense is it's medical judgment and that medical judgment, you can't be questioned. I mean, because how can you question a judgment? Well, of course, that's not what we have been doing, folks. There are appropriate ways to evaluate patients and make decisions within the medical treatment context, and there are inappropriate ways, and that's what this case is about.
What the plaintiffs' framework is a very simple framework. Mr. August has said this right upfront. I think it was clear from the presentation of the case. Their framework is chest pain get an EKG, period. There's no medical decision at all. There's no reason he didn't do a history, do a physical exam, try to treat the patient and see how she responds. You just get the EKG. That's the only thing that means anything. And, you know, even Dr. Florra and his brainless medicine, which he agrees with me, and Mr. August just admitted, that it's a no-brainer according to Dr. Florra. There was all this other discussion, there's all of this going on at the same time. It's not brainless medicine in any way.
You cannot remove a complaint from the context of the patient's presentation in the emergency room. And that is Dr. -- in a very simple way, Dr. Madison's model or framework, that you have to put any complaint within the context. No single complaint will dictate the care. It's just not that simple.
Mr. August and perhaps Dr. Florra will try to make it that simple, but it is -- it is not. If there's anything that you learn in eight plus days of trial in a case like this, I hope you take away that nothing is that simple.
There's a threshold question when a patient has within their complaints presenting to the emergency room something about chest

pain, tightness, pressure, however it's described, there is this threshold question: and the threshold question is, is some other complaint the patient had, something else they have going on, does that explain the chest pain or is the cause of the chest pain really unclear? And, so, you have to take the context to make that threshold question answer.

It's abundantly clear right off the bat as to the fact that there's no explanation for this chest pain. Well, we would agree. You get that history that there's no other explanation. What's been going on? Nothing I just, you know, have this sharp pain; nothing has been going on; I mean, I -- you know, you do a physical examination, you do you know, decide. You know, there's no other explanation for this, yeah, we will get an EKG; I don't think there's any dispute about that. I don't think Dr. Madison has disputed it. I don't think Dr. Smead disputed it. Nobody is going to dispute that. But that's not the presentation of Mrs. Kamianka to the emergency room in the early morning hours of November 6th of 2002.

A point in listening to Mr. August's closing which I think is really important is the difference between cardiac disease -- again, you know, you're going to see Mr. August has already done this and his witnesses have done it, and I anticipate he may do it again in his opportunity to talk to you last because he gets a chance to talk to you after we sit down. He gets the last word. In an attempt to make this such a simple case we just sort of confuse the language of medicine. Cardiac disease, the patient had cardiac disease. The patient had cardiac ischemia. The patient had a myocardial infarction. Each one of those is a distinctly different medical entity. And Mr. August in the presentation of this case has tried to confuse that every chance he gets because there is no doubt Mrs. Kamianka had coronary artery disease, cardiac disease, as do, unfortunately, it's not a nice thing to think about, but you heard the testimony, most of us do. I think everybody

here is getting a little further in life, maybe there's a couple of people in their 20s that hopefully don't have much going on, but most of us into our 20s and into our 30s and into our 40s are developing coronary artery disease, that plaque, that plaque, okay. So that's undisputed.

And, now, the plaintiffs and Mr. August in his case wants to say, well, she had cardiac disease, so you have to worry about ischemia, so you have to worry about a myocardial infarction. No, no, no. Almost everybody of a certain age coming into the emergency room a doctor knows the patient has got some cardiac disease, some plaque somewhere. And you heard so much testimony about the underlying plaque, the atherosclerotic disease, the coronary artery disease that she had was minimum, was not enough to impede flow, was not enough to cause ischemia and that sort of thing.

So, the next step is cardiac ischemia. That's where our issue is in this case. Was there enough of a decrease in blood flow through the left anterior descending artery when Mrs. Kamianka was in the emergency room that morning that there was a decrease in the amount of oxygenated blood getting to the heart muscle itself? Was that causing symptoms? That's cardiac ischemia. Okay?

The disease -- the cardiac disease has gotten so bad that now we have this occlusion causing decreased blood flow, less oxygen to the muscle, pain. Okay?

The last is a myocardial infarction, and that is the complete disconnect of all oxygenated blood getting to a particular part of the heart muscle. That's sort of the end stage of things. So, you've got to be very careful. It's not that simple. It doesn't matter what Mr. August says about how simple a case this is. It is not that simple. You've got to be paying very close attention to how the language of medicine is being used in a case like this. Because there is no dispute that Mrs. Kamianka had cardiac disease. There is a question about whether or not she had coronary ischemia during the

presentation at the emergency room. And there's a big question about what was going on as far as any myocardial infarctions. I'm going to get back to that a little bit, but you have to understand that to sort of put a -- understand how information is coming to you and how it's being presented.

Let's see. I went back to the office last night and, and tried to figure out a way to talk about this case in terms of this framework that Mr. August has for Mr. Kamianka's case. It's simple. Chest pain, you get an EKG, and how he addresses all of the actual presentation of this witness, the facts of the presentation of this witness versus what Dr. Madison has done and tried to do it in a -- in a fairly straightforward and, and organized way.

So if we're going to -- if we are going to concentrate on the chest pain, that's it; this lady came in with chest pain. That's her overriding symptom. I don't think that's true. But let's assume that that is the case.

So, the first thing I say is if you focus on the chest pain as the complaint. So, we will accept that for this argument. How do you add up the presentation? How does the plaintiff, how does Mr. August on behalf of Mr. Kamianka do it? He uses Dr. Florra's equation, the brainless medicine equation, chest pain equals EKG. That's how he does it.

Why does he do that? Because chest pain with anyone symptom does not eliminate the possibility of ischemia. How often during the presentation of the plaintiffs' case did Mr. August ask a Witness, Doctor, wouldn't you agree that having chest pain in a 39-year-old female does not eliminate the possibility of this coronary ischemia? Well, of course not. You can -- you can be a 39-year-old female and have coronary artery ischemia from underlying coronary artery disease. Nobody disputed that. So, Mr. August gets up and says, well, you'd admit that chest pain with bronchitis a month ago as history, that doesn't eliminate the possibility of ischemia, does it? Well, of course not on its own the -- taking chest pain and one bit of history; no.

And, he says, oh, well, chest pain plus improvement with that antibiotic treatment after that bronchitis a month ago, that doesn't eliminate the possibility of ischemia, does it? No, you're right, Mr. August, it does not. Nor does the worsening when you get off the antibiotics if you still got chest pain. Well You know if you talk about it, no, that alone, that is not going to eliminate it.

Or the fact that the patient has got scoliosis seen on the x-ray; no, you can have scoliosis and you can have coronary artery disease with ischemia, Mr. August. Or, you know, you can have a cough causing chest pain and you can still have ischemia, can't you; well, yes, if you just look at that one thing, yeah, you can still have it; it would be unusual, but you could.

Post tussive vomiting, the same with the yellowish sputum, the absence of left arm pain, the absence with sweating, the absence with worsening with exertion, you take anyone of those things and say, well, if you have got chest pain and one of those things, wouldn't you agree that you haven't eliminated or ruled out the possibility of ischemia; and everybody who is honest is going to say, you know, you're right, you're right, Mr. August. So, that's the plaintiffs' case.

Let's take each one of these things one at a time, connect them with chest pain as the only complaint and say, yeah, that doesn't eliminate ischemia. You've got a duty to eliminate ischemia when that patient is in the emergency room, Doctor; you're negligent; you're at fault for this lady dying 12 hours later. That's the simple case that Mr. August is trying to convince you of.

He does the same thing when you talk about -- explaining away the physical exam. If you got chest pain and the vital signs are normal that doesn't eliminate ischemia; well, you know, you're right. You can have normal vital signs and still have ischemia. Oh, and the chest tenderness on -- on feeling the chest wall that doesn't eliminate. I think he -- from Rosen's they put up like 15 percent

of patients can still have chest tenderness, you're right. I'm not disputing that. Or wheezes or the normal heart sounds or the normal chest x-ray. Absolutely. Take anyone of those individually with chest pain and you're not going to eliminate the possibility of ischemia.

You know, you get down then to the treatment response for this case. It's undisputed, even Dr. Florra admitted this, the lungs improved with the aerosol treatment.

Well, you know, a lung problem isn't going to improve any breathing if they've got an underlying coronary ischemia causing the patient's problem. But, nonetheless, the lung improved. Can you have lung improvement and still end up and have ischemia

Sure, absolutely. The same with pain improving with Tylenol. Tylenol doesn't address coronary pain. You heard that over and over again. So, yeah, sure, I mean, you know the pain is responding to the Tylenol but, you know, can I say that -- that because she had chest pain and Tylenol response that there's no ischemia? No, I can't say that.

And, and, you know, Dr. Florra got a little silly a couple of times. And at one point, I actually had said I didn't appreciate him being silly, but there was one thing that I thought was sort of silly: He agreed with me. And that is, in what he is saying, in the testimony he's giving you, that he's asking you to take back to that deliberation room and talk about is this -- all of this talk about isn't this consistent with coronary artery disease and coronary ischemia, isn't that consistent with it, and I said, well, Doctor, the way you are using that term, I stubbed my toe is consistent with a coronary ischemia.

He said, oh, yes, it is. Oh, yes, it is.

That's because I can stub my toe, walk into the emergency room and have coronary ischemia that -- you know, so you want to play that game with the stakes involved in this case, I think it's insulting.

I told you I wouldn't tell you my opinion about credibility of witnesses. I just violated my own rule. That testimony

speaks volumes about what Dr. Florra's approach to this case is.
What does Dr. Madison say? What is his case? It's not as simple a case, folks. I, I -- you know, I wish -- I wish a very simple case could be created. I don't create the cases. This is the facts of the case. What's his equation, that is, Dr. Madison's? You take the history, the physical exam, and the treatment response and you make a reasonable medical decision making the diagnosis of what's going on with the patient. S~---w.bat'"-- you do is you take, okay, we will start -- we are still playing this game with chest pain is the only thing we have in this case. Okay, chest pain, okay, then let's add things. Well, let's add everything. Let's add everything else we have coming into this case because this is the contest of this pain.
It's not just the patient coming in with chest pain. She's 39 years old, 39-year-old female. Nobody disputed that 39-year old females are at much less risk for coronary artery disease and ischemia and myocardial infarctions, all three of those than older women and men. Bronchitis a month ago. That's a relevant piece of history. Nobody disputed that that's a relevant piece of history. She improved with antibiotics from that bronchitis. Everybody agrees that, you know, if you're having problems and you're given antibiotics and you improve that's not coronary artery disease.
Worsening when she went off the antibiotics. When she finished those antibiotics, the cough and the congestion came back. The scoliosis, you know, Mr. August seems to think, well, the patient never complained of back pain or any other problem in her upper back that we can ever find. Well, you know, that's true; I don't see anything in there. Although, I don't think that I have any evidence that she had any prior history of coughing that hard, vomiting -- I mean, she did vomit once with a cough before. You know, every -- every one of these incidence has its own little life. And

how hard somebody strains and what you may pull or what may be aggravated by it is an issue. We're not hanging our case on scoliosis in the ER. It's one of the many things that are involved in this presentation. Cough causes the chest pain. You know, short of calling Dr. Madison a liar, that's not an issue. The doctor's dictation, she indicates, not I am assuming from her prior bronchitis history from Dr. Little's office, no. She indicates that when she coughs -- when she coughs, she gets a very sharp pain both in the front of the chest and the back. Cough is causing this pain. It's a severe pain. It's enough to bring her to the emergency room because her doctor's office isn't open yet in the morning, she's been throwing up with it, yeah. We don't dispute any of that. But to dispute that she had a cough is inconceivable to me and that the cough was causing this pain. You are calling Dr. Madison a liar. And you're not calling him a liar today on the stand when he's trying to defend his reputation. You're calling him a liar back at 6:30 in the morning on November 6th, 2002, because that's when that was dictated.

Post tussive vomiting. You know, witnesses came in here and said, well, it wasn't post tussive vomiting. It's vomiting because of chest pain. Well, Dr. Madison was there talking to Mrs. Kamianka, asking her questions about what's going on, and she indicated that she was coughing so hard she threw up. That's post tussive vomiting. That's not I was so -- I had so much pain I got nauseous and threw up. There's a world of difference.

Yellowish sputum. Everybody agrees that yellowish sputum is not an indication of underlying coronary artery disease. Indication, not consistent With, of course, God knows we all can have yellowish sputum and still have coronary ischemia, but it's not an indication of coronary artery disease, but she had it.

These absent findings, absent left arm pain, absent sweating, absent worsening

with exertion, those are the things that are the typical presentation for coronary artery disease that would -- that would raise the red flag. Oh, you know, this chest pain has got some other things going on. And not only is this, you know, sort of by, we know this by absence. We know by an absolute fact from what even Mr. Kamianka has testified to she did not have these things. She didn't have any of this. And, in fact, not only absent worsening with exertion; I mean, there was some substantial exertion in this case. One part of which was not known by Dr. Madison because there wasn't that kind of questioning about it, what she had been doing the night before with her husband, but we do know that she drove herself to the hospital; we know that she walked in; we know that after talking with Nurse Deitrick and doing triage she walked back to the room; we know she walked to and from radiology to get a chest film; and not once did she complain, man, that really wore me out. You know, my chest pain is a lot worse when I'm walking around. That's exertion.

And Mr. August and his experts want to tell you, you know, not only does she have coronary artery disease, she's got ischemia, okay. Remember, we're going onto the next one. Ischemia, or maybe even an MI, maybe even myocardial infarction, a total occlusion at this time, and she has absolutely no evidence of worsening. Put more demand on the heart, if that blood flow is, is being compromised, why isn't she having a worsening of chest pain if the chest pain is from that problem?

The physical exam, the chest tenderness, that's a musculoskeletal response. The normal vital signs. You know, most people who are in significant coronary ischemia or MI don't have normal vital signs. That's the evidence in the case. She had wheezes. There's no disputing that she had wheezes. You don't get wheezes from coronary artery disease. You don't get wheezes from coronary artery ischemia. You don't get wheezes from having an MI. You get wheezes because you

have an upper respiratory illness.
Normal heart sounds. You know,
you're right, you can't listen to the heart
and say, oh, I listened to the heart, I can
hear coronary artery disease. Well, of course
not. You can't hear the plaque, okay.
However, if you have got a plaque as
significant enough to cause a significant
amount of ischemia to cause this kind of chest
pain, the heart gets irritated -- you heard
the testimony -- you can very well have
abnormal heart sounds, abnormal rhythms. You
don't have to, but you can.
Normal chest x-ray. You can't take
an x-ray of the heart and say, oh, I see
coronary artery disease in that x-ray. No,
you can't. But if you have had coronary
ischemia, significant coronary ischemia or an
MI long enough, you heard the testimony about
congestive heart failure, the pumping of the
heart isn't working right, fluid backs up in
the lungs and you get changes on the chest
film and that would raise a suspicion of
what's going on with the heart. That wasn't
there. That's not in this case. And then
what -- I'm not sure we really made that clear
in this case and then she had this response to
treatment. If she is having coronary artery
ischemia or an MI getting an aerosol breathing
treatment is not going to improve her.
It's not going to improve her pain.
. If her lung function is normal,
getting an aerosol treatment isn't going to
cause an improvement in the lung function; and
even Dr. Florra admitted she had an
improvement in her lung function with the
aerosol treatment. Why? Well, according to
the plaintiff, there's nothing wrong with her
lungs. She has got no airway illness. Why
would there be an improvement? And pain
improved with Tylenol. Well, you know, she
took some Motrin at home and the pain didn't
really improve, don't know how much. She took
Tylenol and pain is improving when she's
coughing. That's why we get that down from
eight over ten, whatever that means. Dr.
Madison was talking about the subjective nature
of pain and what's right for you may not be

eight for the next person or for me, but you get sort of this idea, the important part is she's improving.

If the coronary artery ischemia -- there's significant coronary artery ischemia or an MI, Tylenol isn't going to help that pain, folks. Everybody who was asked that question admitted as much.

So, I wish that this analysis was as simple as Mr. August' and his experts looking at chest pain and saying, well, it doesn't really matter, any of this other stuff, because any of these other things are consistent with coronary artery disease or coronary artery ischemia. How can you win? mean, how can you attack an opinion like that? It's just -- it's brainless.

Dr. Madison and Dr. Smead in their testimony as emergency room physicians were telling you in this triad of medical treatment, decision making, history, physical, treatment, response, when you look at the full picture and you take the complaint of chest pain in context, this is not coronary ischemia. There is no clinical manifestation. Dr. Madison said a couple times there was no clinical manifestation of that. Could she have it; yes. We have never disputed that she could have it. But a doctor has to have some clinical manifestation of that to make a diagnosis, and she didn't.

Diagnosis of bronchitis under these circumstances is fully appropriate, certainly within the standard of care diagnosis of this case. The fact that Mrs. Kamianka passed away 12 hours after she was sent home from the emergency room bears no relevance to this analysis that Dr. Madison had. Dr. Madison did not have the autopsy to work from. And Mr. August today still says how can you say this is reasonable decision making when she died 12 hours later? He still wants to say, look back at what happened, how can you say that's reasonable? He gives -- he gives lip service to don't look at the standard of care issues retrospectively, but he still does, and he's still insinuating that you should, and that's just not fair, and it's not the law.

Risk factors. You know, when this case started in opening statement, Mr. August said Mrs. Kamianka had five known and understood risk factors for coronary artery disease when she was seen by Dr. Little and Dr. Madison in her presentation -- five. There was smoking. There was family history. There was increased cholesterol. There was obesity. Then there was birth control pills. What happened to those five risk factors by the end of this case, folks?

Well, Dr. Florra said, well, you know, the whole thing about birth control pills, you know, that's -- we all understand the veins in the legs, that's, you know, one thing, but back in 2002, it wasn't really understood that there was any increased risk with birth control pills. He's not critical of that. This -- this whole cholesterol business, 204, which is I think four or five points above the normal range for a patient, which was non-fasting and all these other things that you have heard about, I mean, it's not a significant risk factor in this case. It's certainly nothing that Dr. Madison could have gotten from the patient according to the plaintiffs' case.

The obesity. You know, there's this whole thing. She was, as I said in opening statement, she's a little overweight. There's no doubt about that. But obesity means a very specific thing to an emergency room physician in evaluating a patient. And, you know, there was isn't playing a part in this evaluation at all. So, what are we left with as far as risk factors? We have smoking. Well, we can get rid of smoking. Smoking is not really focused on by the plaintiff in this case because smoking is a risk factor for pretty much everything. Unfortunately, too many people, and they're all at risk for -- you name it including bronchitis. They have more respiratory illnesses as well as being at risk for coronary artery disease. So, what does it come down to? It comes down to this family history and whether Dr. Madison was obligated to ask a family history with this presentation. Well, you know, nobody said that you

ask a family history under all circumstances. Dr. Florra is the one that said you got to ask family history in the emergency room setting with a patient who presents with chest pain. That's because this whole thing is chest pain, EKG, you know, it doesn't matter the context; it doesn't matter what else is going on, the history, the physical exam, how she's responding to treatment, none of that makes a darn bit of difference, so chest pain, you got to do all of this; and that's not true. Remember the Rosen's that I confronted him with. It's talking about a brief history and a -- and a -- and a brief exam. I mean, this is not the, the 20 minute time to sit down with your family doctor and go through everything. This is an emergency room presentation.

But if we look at the family history even closer, I mean, I'm not contesting that her brother -- a brother died at the age of 32 of coronary artery disease and an MI. I will accept that. We have no evidence otherwise. I mean, that's fine. We don't have any evidence to confirm it, but we have no evidence otherwise, so we accept it. But that's one brother of four other siblings. She had neither mother nor father with this problem.

It's a relatively - and Dr. Little was talking about this primarily because he's the one that got that history. It's a relative risk factor and no pun intended there. It's just -- it's -- you know, if she had both brothers or both of her parents, Proximate cause. Again, I said in then, it's -- those risks multiply in family history. What is even most telling about this is from the pathology. We know for an absolute fact, everybody agrees, Mrs. Kamianka had about the amount of coronary artery disease you would expect of a woman her age. So, the plaintiff, Mr. August, he wants to say, whoa, brother died at the age of 32, you know, bells, alarms, everybody's got -- this lady has got to have coronary artery disease significant to be causing ischemia in her and, man, we all have got to jump through hoops

about this. When, in fact, one of the absolute undisputable facts that we have is that the plaque that she had -- and that's what her risk Factor is for, that plaque development, no matter what it was, she didn't have a really significant amount of it, no more than you would expect of any other 39-year-old woman.

So, you know -- again, you've got to take all of this and put it in the appropriate context in analyzing all of the issues in this case.

Proximate cause. Again, I said in opening statement I don't really understand the testimony about the pathology. I was very upfront about it. I said that Dr. Madison and I are not going to contest the pathology in this case. I didn't call a pathologist. You know, I asked very few questions of the pathologists because I don't really, there -- they're -- they clearly have different opinions about things that I don't fully understand. So, you know, to put it on that, very simple -- you know, I don't have the burden of proof of that. Mr. August does.

As far as I'm concerned the pathology in this case is something that, you know, hopefully, together, as a group in deliberations, you can figure it out. But what I do know is that Dr. Brains testified, when I was asking her questions, and I had a diagram that I did on the grease board which can't show you. We had to erase it to put Dr. Blood's numbers up for you, so I had to get it erased. But she had said that, okay, we got this 20 percent or so minimal amount of coronary artery disease, but it's not enough to cause symptoms, That's not the kind, you know, you need to have 65 to 70 percent or so to be causing symptoms.

She said at the time of Mrs. Kamianka's death 12 hours later there was this thrombus, this clot, that occluded the artery completely. And she said, as did Dr. Smead from his testimony, that that can happen like very quickly, okay, or it can happen over a period of hours. And, so, the question is from Dr. Brains's testimony, as much as I can

understand, it's an open issue as to how much of her coronary artery was or was not occluded when she was in the emergency room. I'll leave it to you to try to figure out from Dr. Brains's testimony compared to Dr. Flocker's and what you look at in this case, whether you can figure that out.
But I do find it interesting that Mr. August is, you know, calling Dr. Flocker sort of this hired gun, big expense, big named guy from New York on his defense of Dr. Little, but all of a sudden Dr. Flocker is some kind of cardiac pathology genius when it comes to, you know, what he said about what was going on in the ER that day about the thrombus. I mean, how can you play both ends of that game? Okay, well, okay, yeah, he's right on that. He's a hired whore for Dr. Little, but, boy, he's a genius when it comes to what he says about what is going on in the ER.
The other thing that I don't understand, and you heard the testimony, you may be able to figure it out, is Dr. Flocker said that he thought that there was a myocardial infarction -- remember, that's the very end of a process -- one or two days before she died. If she was having a total occlusion of -- of her coronary artery to cause cell death, and chest pain is a manifestation of that, then she should have had chest pain for more than a day or two from this myocardial infarction. And what we have as the earliest complaint of any chest pain was the evening before, certainly less than 24 hours. I mean, even looking at it in the broadest sense, I cannot reconcile that particular opinion with the facts in the case.
So, again, the point for Dr. Madison's defense though is it doesn't really matter whether or not she had some disease, whether she had some development of thrombus of whatever degree at the time she was in the emergency room. The issue is was it clinically manifesting itself that it was there. The case is it wasn't. She wasn't having the symptoms you would expect to see of somebody with that problem, and that's a standard of care issue, looking at it

prospectively from Dr. Madison's point of view that morning.
Very briefly, I, I want thank you again for all the attention in this case. It hasn't been easy. I have tried to not obfuscate this case. If I have done that, it was unintentional. But the facts are what you folks are going to find them to be when you go back.
You got the law with you when you go back there to apply whatever facts you find. Dr. Madison has walked into this trial. He knows, you know, we are in a situation where a patient died within 12 hours of him having seen her in the emergency room. He knows how difficult that can be for jurors to say, gee, didn't something have to be wrong, and yet Dr. Madison has been steadfast about defending this case. He has been here every day. He has listened as carefully as we all can to the testimony in this case, and he has confidence, as do I, that when you go back into the deliberation room, have a chance to talk to each other about all of your impressions, about what went on in this case and what was said, have a chance to look at the exhibits in this case, that you will be able to come back into this courtroom when you are done and give Dr. Madison the defense verdict that he should get in this case. And, again, thank you very much
Thank you, Your Honor. I am done.
THE COURT: Thank you, Mr. Jones, on behalf of Dr. Madison.
The defense on behalf of Dr. Little (the PCP) may deliver your closing argument.
MR. KANE: Thank you, Your Honor.

CLOSING ARGUMENT ON BEHALF OF DR. LITTLE (the PCP)
Good afternoon, Ladies and Gentlemen.
Truth. That's what we are here to find. That's the purpose of this whole process, and we want you to find the truth.
And in order to find the truth, you have to consider all of the facts. I will tell you I have tried very hard to bring you all the facts so that you can find the truth.

know Chris who has helped me try this case has tried hard to bring you all of the facts. try to do that for a couple reasons. First of all, because I don't want to be accused of obfuscating, which until a few minutes ago I don't think I ever knew what it meant. Now that I heard what it meant, I don't think it was very nice to say. That wasn't nice. I'm not trying to do that. I'm not trying to confuse or complicate these issues.

The truth is I want you to see the truth. Let me tell you why. When I was a young lawyer, which seems like a long time ago now, I was getting ready to try I think my second case -- I think I lost the first one. As I was getting ready for the second one, I said I think I better go to somebody and find out what I am doing wrong. So, I went to a old lawyer in our office. And I said to him, I'm getting ready to try this case, here's what it's about, how do I Win, what do I do, hoping to hear from him the secrets of cross-examination or the brilliant techniques that you use to win a case. You know what he told me? He said, you know, Tom, what's the truth of the matter? I said to him what do you mean? He said, Tom, if you find out what the truth of the matter is, you find out what actually happened, what the medical truths are, what the science of medicine shows us about the case, and you show that to the jury. They will get it right. They will find the truth, and you will win the case. And ¥you know what, he was right. And that's why I have tried very hard in this case not to overstate, not to misstate and not to take things out of context. Because if you look at the facts of this case, you will find the truth.

The truth-Dr. Little met the standard of care; and he met the standard of care because when she came in on September 5th, 2002, she didn't look like she was having a heart attack. Her presentation was one, if you look at it in total, of a patient who is suffering from bronchitis. And she looked like she was suffering from bronchitis because she was. She wasn't having a heart attack,

and working her up for cardiac disease
wouldn't have produced a diagnosis.
And, Ladies and Gentlemen, that is
the truth of the matter.
Now, I want to go through the issues
in this case. I want to highlight the truth.
At times I want to contrast it with how the
picture has been painted by the plaintiffs in
this case. So let's look at it and let's not
-- I know everybody is sick of these records.
And if I could ask you to raise your hands and
ask if you need to see it again, I would, but
I can't. And because I've got an obligation
to defend Dr. Little, I feel obligated to go
through it again, but let's look at facts of
this case, not picking out the first two
things here, but looking at the total exchange
between Dr. Little in his office and Anna
Kamianka. What did he learn? He learned that
she had chest pain, that she was congested and
coughing up yellow sputum and hadn't slept
last night.
She wanted to be seen that day, but
she didn't want to come until after work.
When she got there, she said that her chest
was tight, but there was cough with phlegm,
and she had had it for two or three days.
He then went in and saw her himself,
and he learned that she had back pain
yesterday; she didn't think anything of it.
She said it got worse -- but she had tightness
in her chest and that it was worse when she
coughed. She also told him that her chest
pain wasn't exertional, which means it didn't
get worse when she was exerting herself. He
did a physical examination.
And Ladies and Gentlemen, I talked
Dr. Little about the examination of the heart,
and I tried very hard to not take things out
of context. If you will remember, before I
asked him about this, I said, will this
listening to the heart tell you anything about
whether this patient has coronary artery
disease, meaning whether or not there was
plaque forming in the vessel, and his answer
was, no, it doesn't help at all with that.
My follow up question was if she's
having an acute coronary event, she's actually

having a heart attack, can it help sometimes show whether there's a heart attack or not. His answer was, yes, it can help under those circumstances. And -- and, again, I'm reminding you of that because there was a suggestion that somehow, you know, we were trying to say that she didn't have coronary artery disease because she didn't have abnormal heart sounds, and that's not what I said, and that's not the context that I raised that.

Ladies and Gentlemen, at the end of this visit Dr. Little diagnosed her with bronchitis, and he did that because coronary artery disease doesn't get worse when you cough and coronary artery disease gets worse when you exert yourself. If you're having a heart attack, that heart is being deprived of blood, it gets worse when you move around and you exercise and you do things like go to work and act as a cashier and a waitress, delivering things and taking people to their seats. It wasn't exertional. And if it was exertional, that would point you to cardiac disease, but it wasn't.

He also learned she was 39, and she was a woman. He knew those things. And we all know -- in fact, plaintiffs' experts have agreed that it's unusual, it's less likely in young people who are women; and Ladies and Gentlemen, everyone agrees that coronary artery disease, cardiac ischemia, it doesn't make you cough up phlegm. Bronchitis does. The truth of the matter is this lady had bronchitis and Dr. Little made the appropriate diagnosis.

Now, because he's a good and careful doctor he wrote himself a reminder. If she doesn't get better, if these problems get worse, if they change, if they persist or recur, consider doing a stress test, because we think we have a diagnosis, we're very comfortable with it, but if it doesn't resolve with treatment, then we need to continue thinking.

You also heard testimony he considered a number of life-threatening things, all of which he ruled out. Lung

cancer, pulmonary embolism, a thoracic aneurysm. He ruled all of those things out with just history and physical examination. And the truth is that's how medicine is practiced. You cannot work up, and there is no reason to work up every potentially life-threatening thing even if you don't think it's there. You just don't do it. That's not how medicine is practiced.

Now, I want to contrast the picture of this woman who comes in with a productive cough, that hurts more when she coughs, it's not exertional, with the picture that seems to have been painted in plaintiffs' opening, if you can remember back that far. Remember what he talked about. He started this whole discussion about this visit off by talking about how -- and he wasn't there. He wasn't on the phone. But he said when she called she said she really, really, really needed to be seen that day. He talked about this overwhelming sense of urgency to get seen. Well, let's put it into context to be fair to the facts of this case. She did have some sense of urgency, but it was to be seen that day. She wasn't a patient who came in clutching her chest dying from a heart attack. She was a lady who said, I was up last night coughing; I am going to work; I don't want to come in until I am done with work, but I do want to be seen today; and that's the truth. That's the presentation.

It wasn't just chest pain. It was all of these things. And he keeps talking about this presentation like it was chest pain and that was her complaint. She had a multitude of complaints, and that's what doctors do is they look at the multitude of complaints and they make a judgment about what they think it is. And if they have a diagnosis like bronchitis that explains all of those things, you don't work up some remote problem.

He also told you -- Mr. Jones stole my thunder -- remember in opening statement she came in with five risk factors. The truth is -- you heard his experts; we have heard all the testimony. His own experts, Dr. Florra,

Dr. Morgan, they both said she
really has two, smoking and family history.
The other thing if you'll remember and it
struck me as odd when he said it, he got to
the close of his opening statement, Ladies and
Gentlemen, if it walks like a duck, quacks
like a duck that it must be a duck, and I
think his point was this is just -- this is,
like Mr. Jones pointed out, this is a
no-brainer. Well, Ladies and Gentlemen his
own expert, Dr. Morgan, who he
chose to be his expert, who he invited and
paid to come to the courtroom to testify,
said, in truth, she probably did have
bronchitis and this was an atypical -- meaning
not typical presentation for cardiac disease,
and it went from being this no-brainer where
it's walking and quacking like a duck to being
an atypical presentation. And did you see how
things changed over the course of the week?
Then all of a sudden it became, well, there's
two things going on at once. She may have had
bronchitis, but you should have been thinking
cardiac anyway.
Ladies and Gentlemen, the truth of
this case is that Dr. Morgan in
part was right. This was atypical. It was
atypical because it wasn't a heart attack.
Now, as it relates to the standard of
care, plaintiffs really only have one
criticism. Their criticism was he failed to
more strongly consider cardiac disease, and he
failed to do an EKG, and he failed to do a
stress test. Those are the criticisms you
have heard from the plaintiffs. But, despite
the fact that his experts, the ones that he
must -- and you heard the jury instructions --
he has to prove this case through expert
testimony. He can't just make something up or
throw it out there and expect you to follow
it. It has to come from an expert. I want to
talk about what his expert said.
Failure to do an EKG, failure to do a
stress test. But there was a lot of
discussion of other things, and I want to talk
about them. First of all, there was all this
communication to the patient, what should the
patient be told, was the patient told enough.

Remember what Dr. Morgan said.
He had no criticisms of the communication given to this patient.
Mr. August' expert doesn't have a problem with what this patient was told. Only Mr. August. And that's not good enough to reach a verdict against Dr. Little.
The blood pressure not being taken.
Well, first after all, the blood pressure was taken. You heard Dr. Little. If it wasn't on the chart, he takes it himself. Because it's usually on the chart, he doesn't think~ to record it when he dictates, but he said I would have checked the blood pressure. That's what I did, and it would have been normal.
The second thing to think about, Ladies and Gentlemen, is what did Dr. Morgan say about the blood pressure, what did Dr. Marcus say? Nothing. No criticisms of a failure to do a blood pressure. And the second part of it -- and keep in mind, to prove this case he has to prove that there was a deviation from the standard of care, and he has to prove that that deviation caused the injury in this case.
There is not a single piece of testimony from any Witness, even any hypothetical question, that doing a blood pressure would have resulted in a diagnosis of anything. There is no testimony to support any criticism of the failure to do a blood pressure in this case.
Another issue that we spent tons of time on that goes absolutely nowhere is did this patient get a letter after her first visit about the cholesterol level of 204. Do you remember how much time Mr. August spent talking about this with Dr. Little? Try and think of how much time he spent with Dr. Morgan talking about it. You're going to think about it for a long time because there was none. The truth is Dr. Morgan came in here and had no criticisms of the failure of this patient to get a letter.
And the other thing that's not fair about that, to put it in the context, whether she got a letter or not, there is proof in

this chart from, I think it's May 13th of '02 where she was reoffered labs. And Dr. Little told you, and common sense will tell you, that of course he discussed the labs that were done the last time and encouraged her to repeat them because of the abnormality.

There is also a question of whether she should have been told, you know, about maybe he's considering a stress test. Ladies and Gentlemen, the truth is you don't tell the patient every single thing that goes through your mind. He didn't tell her that you might have a pulmonary embolism when he's comfortable that you don't. You tell them what you think they have. You give them instructions, if you don't get better, come back in three to five days; if this gets worse, come back sooner. And you expect that the patient will do that.

Now, there's been this whole suggestion that somehow we have said the patient doesn't have the right to know. Of course the patient does. If the patient says, Doctor, I know you said this is bronchitis, but is there anything else that it might be that I should look out for, you tell her. Dr. Little wasn't trying to hold anything back from her.

He's being a good doctor. He's a careful doctor. You heard from Mr. Kamianka. He's the kind of guy that took time, answered questions. The Kamiankas liked him.

Ladies and Gentlemen, let's talk about the second issue whether she was having a heart attack, whether tests would have resulted in the diagnosis of treatable coronary artery disease or treatable cardiac ischemic disease. Ladies and Gentlemen, the truth of this case is -- and, and I think it's overwhelming -- she was not. And again, it can be disorienting. I admit that when I first opened this case it was disorienting.

So, I'll put it up. This is not an exhibit. It will not go back with you. So, I'll give it to you one more time to look at. Almost nine full weeks went between these two visits. And the truth is -- and I called Dr. Flocker. He is a wonderful doctor, incredibly

well-trained, and he testified that based on his review of the slides -- and I'll remind you, I'm the only one who actually showed you the slides. I'm the only one who actually brought you a cardiac pathologist who specializes in looking at cardiac slides. And he said the oldest possible time that there is evidence of an infarct, evidence that there was ischemic injury to this woman's heart, the oldest that it's possibly there is six weeks. He thinks the oldest part was within four to six weeks, and then he talked about some recent changes, the ones immediately prior to her death.

The other testimony you heard was from Dr. Brains. And she says that there may be injury that's greater than six weeks or greater than four weeks. I'm going to show to you in a minute, but the truth is she was not having a heart attack. She developed it subsequently. Nobody understands why, even Dr. Flocker, Dr. Brains, with their training can't answer exactly what caused this woman's cardiac ischemia. They think it was spasm, but there's no proof of it. I want to remind you of what Dr. Flocker said. It was by videotape, so I'm going to read it to you in case it got lost.

Doctor, let's categorize your opinions very briefly and then we will finish. Do you have an opinion to a reasonable degree of medical probability whether Mrs. Kamianka had a myocardial infarction that would date back to September 5th, 2002?

Answer: I do.

Question: What is your opinion?

She did not.

Do you have an opinion to a reasonable degree of medical probability whether she had any significant coronary artery disease that would date back to September 5th, 2002?

I do.

What is your opinion?

She did not.

Do you have an opinion to a reasonable degree of medical probability whether the performance of an EKG would have

produced any abnormalities?
I do.
What is your opinion?
She did not.
Do you have an opinion to a reasonable degree of medical Probability whether a stress test, if it were performed in September of 2002, would have helped make the diagnosis of ischemic heart disease or coronary artery disease?
I do.
What is your opinion?
It would not.
Do you have an opinion to a reasonable degree of medical probability whether a cardiac catheterization would have led to the diagnosis of any clinically significant cardiac disease or coronary artery disease?
I do.
What is your opinion?
That it would not.
Do you have an opinion to a reasonable degree of medical probability what the cause of death of Mrs. Kamianka was?
I do.
What is your opinion?
Sudden cardiac arrhythmia related to acute ischemic disease and myocardial infarction.
Do you have an opinion to a reasonable degree of medical probability whether anyone could have predicted on September 5th, 2002, that Anna Kamianka would go onto die from a heart attack or myocardial infarction on November 6th, 2002?
To my knowledge, there's no way that anyone could predict that.
That was how I ended my direct examination. It was followed by 45 minutes of cross-examination that did not move him from that position one bit.
And Mr. August has not produced any testimony from anyone that can date myocardial injury back this far; and because she wasn't having a heart attack, it couldn't have been diagnosed.
Now, let's talk about the testimony

that he did give. Let's start *off* with Dr. Marcus. Just a preview for you, I'm actually going to show you his testimony. I don't want to be accused of taking it out of context. His theory in this case is based on Dr. Brains, but let me tell you what he says. He says, I think there was an occlusion of the septal branch, and he tells you that there are no septal branches on this picture, but I'll remind you, even though she made fun of my picture, Dr. Brains who came in said, oh, yeah, those are septals; they travel on the surface of the heart and then they go down. But Dr. Marcus thinks that what happened is that there was a septal branch of this bigger artery, the LAD, that occluded. He believes it occluded sometime prior to six weeks and that he would defer to the pathologist about how long it was. And he thinks that that's what caused that scar. And he thinks that because there was this septal infarct and a scar, that if an EKG -- actually, I don't think he said EKG. I think he said a stress test would have been positive. Let's look at what he actually said.

This is from his trial testimony,

okay. She did not have thrombosis of the LAD when she saw Dr. Little on September 5th, correct?

Oh, I think she did.

So you think she had an acute thrombosis of the LAD?

Yes. She had -- she had clot forming in the LAD because the septal branches come *off* the LAD and she ended up at autopsy having a gray scar. In other words, a well-formed scar which must -- which had to have occurred more than six weeks before her death.

And this is where I asked him about the board.

Okay. Let's do it this way. First of all, are there any septal branches on here?

Well, you can see -- and I was pointing to the board -- you can see what's presented there are the arteries on the surface of the heart. When we're talking about the septal branches, they come *off* the undersurface of the left anterior descending

and penetrate the muscle and go into the
septum.
Okay.
Answer: They don't force the surface
of the heart.
Then I asked him: Would you defer to
a pathologist on the timing of and how long
prior in advance of the death the areas of
infarct seen on autopsy occurred? Would you
defer to a pathologist
Yes.
But let's look at the pathologist
that Mr. August called for you. And I think a
minute ago when you were talking to Mr. August
you said in fact you couldn't tell whether
they were older than four or six or eight
weeks, correct?
That's correct.
It could be as old as four, as six,
could be as old as eight; you just can't tell.
Answer: Or even more. Could be
beyond.
Okay. And, in fact, it might have
been as recent as four weeks?
Could be, yes.
Ladies and Gentlemen, that means that
the infarct could have occurred any time
between four weeks and the time of her death.
But she goes on.
So, in fact, this infarct may only be
as old as four weeks according to what you
just told us?
Yes.
Okay, or it might be as old as six
weeks?
That's correct.
Or it may be even older?
That's correct.
But you cannot say to any degree of
probability that there was infarct present
when this patient saw Dr. Little on September
25th, 2002, correct?
I cannot say other than to say what I
have already said about that.
And then I stood in front of the
board and pointed to different dates after
September 5th and said maybe there; it may
not, that's correct. May have occurred on

this date; that's correct. May have occurred on this date; that's correct. May have occurred on this date; that's correct. Maybe even on this date; that's correct.
Moving on forward. Now Dr. Flocker, you have heard and read his testimony. He believes that the oldest area of infarct dates back to the period of time between four and six weeks. You're familiar with that.
Yes.
Now, you are not saying that he's wrong. You're just saying that you have a different opinion.
That's correct.
And, in fact, because he's a cardiac pathologist you would pay attention to what he says.
Now, let's talk about Dr. Marcus and his opinion that there must have been occlusion of a septal branch of the LAD. Now, again, he's deferring to a pathologist. He wasn't there. He didn't see the heart. That's his theory, that it must have been there and that's how it would have been diagnosed.
Well, let me show you what he said.
Well, you know that Dr. Brains testified that when they did this autopsy they would have been looking for occlusion of any of the coronary arteries including the septal branch. Do you know that?
Answer: I don't know whether there was any specific mention of the septal branches or dissected out the septal branches. There's no mention of that in the --
Question: Well, her testimony is that they would have looked, that that's their routine, and that they didn't find any. Would you defer to her or do you think she's wrong or making it up?
Well, these are -- these are arteries on the surface. I would not -- or not on the surface. They are penetrating arteries that are within the muscle. I don't think that's a routine evaluation. It's not a routine.
So, his thing is it's not there, because if it's there, it doesn't make sense.
Well, would you defer to Dr. Brains

who is the coroner who is responsible for?
Sure, setting up policies for her
pathologists, sure.
Okay. And if, in fact, they did look
for occlusion or abnormalities in the septal
branch and didn't find any, would that be
inconsistent with your opinion that she had a
clot in the septal branch that lysed itself
and just disappeared?
Answer: It didn't lyse itself. She
went on to have a septal infarct. What I'm
saying is its origin was in the left anterior
descending. That process occurred within the
arte~ involved the septal branch. It's a
bystander of the process occurring in the
artery. It's a branch.
But you know that when Dr. Brains and
her staffed looked at the coronary artery,
they found plaque, and they found the mbug of
different ages.
Okay.
But none of the thrombus dated back
to September 5th.
Answer: The scar sure did.
But none of the thrombus was that
old.
I don't know that they said any part
of the organized thrombus was not back to
September. There was well organized thrombus
of different ages.
So, his opinion it's not there
because -- or it's diagnosable because, you
know, it's there and Dr. Brains just didn't
look for it.
Well, let's look at what Dr. Brains
said. There's no pathologic evidence of what
caused that old scar in the septum; is that
correct?
That's correct.
It could be due to something like
spasm of the coronary arteries; is that
correct.
Yes, that's correct.
There was no evidence though that
there was any occlusion of the coronary
arteries that would have caused that septal
scar, correct?
That is correct.

You can't say whether she was
suffering -- had or was suffering from an
acute bronchitis on the day she saw Dr. Little;
is that correct.
In September?
Yes.
No, I cannot say.
And she continues on about the septal
branches. This is talking about Dr. Sleesman,
the doctor who actually did the autopsy.
Now, when he looked at Mrs.
Kamianka's heart, he should have been looking
for an occlusion or abnormalities in any of
the coronary arteries.
That's what he should have done, yes.
And that's what you believe he did.
Yes.
And because of the presence of scar
in the septum, you would anticipate that he
will look for any abnormalities in the
arteries that would be perfusing the septum?
Correct.
And in this case, the autopsy doesn't
indicate that there is any abnormalities of
the septal branch of the LAD; is that correct?
That's correct.
But you would have expected that he
would have when he examined this heart looked
for any abnormalities of the' septal branch of
the LAD.
Yes, whatever he could see with his
naked eye he would have looked at.
But, particularly, in the face of a
septal scar, it's your expectation and your
testimony here today that he would have looked
at the septal branch of the LAD that would
have perfused the area of the heart, correct?
Yes, I would -- he would have looked
at everything, yes.
And if he looked at it and found any
abnormalities, you would expect that there
would be a slide from that, true?
Yes.
And there would be some description
on gross examination that he found some type
of abnormality in the septal branch of the
LAD?
Yes.

There is no mention of any
abnormalities of the septal branch of the LAD
in this autopsy, correct?
Answer: That's correct.
Final question: So, it's fair for us
to assume, and it's your testimony, that the
septal branch of the LAD was examined and
found to be normal?
Yes.
Ladies and Gentlemen, the reason that
I took the time to go through testimony is
because Mr. Jones keeps scaring me when he
says after all these years of doing this kind
of work that he doesn't understand the
pathology issues in this case, my concern is
that you don't or didn't the first time
through, but what's important about what those
witnesses said and I tried to iust show for
you, is that Dr. Marcus believes there could
have been diagnosis made because there was
occlusion of the septal branch that caused
this scar. And the truth is, his testimony is
based on the pathology findings of Dr. Paltry
and her findings and her testimony on the
stand do not support his opinions. She can't
say there was occlusion of the septal branch.
She can't say there was scar. She can't say
there was ischemia. And because those
findings weren't present, Dr. Marcus, who said
he deferred to a pathologist, can't say that a
stress test here or here or here or here would
have made a diagnosis of coronary artery
disease or ischemic heart disease.
Now, he made some comments about the
scar. Ladies and Gentlemen, let me remind you
because, again, I immersed myself in this
medicine till it's now getting second nature
to me, but let me reinforce it. Dr. Brains
when she testified, Mr. August asked her about
this gray scar, and he seemed to try to make
the point that if there's gray scar it must be
old;-it must date a long way back. Well,
remember what she said. She said some people
scar to gray; some people scar to white. It
takes place at different rates; and I can't
really say what the importance of a gray scar
is.
And to be fair to the facts of this

case, I don't want you to take my word for it. This is her testimony.
You talked about the different people's healing response. Some people heal to gray, and that's a mature scar, right?
Yes.
Some people go onto mature to form a white scar?
That's correct.
So, based on your understanding of the fact that this car is gray doesn't mean that -- because you don't know that this lady's healing response, whether this was a fully mature scar or whether this was on its way to becoming white?
That's correct.
The truth is she doesn't know anything about the fact that it's gray or white. It could be gray as a final scar, could be white. It doesn't make any sense.
I'll remind you that Dr. Flocker when he testified that a gray scar would be an immature scar, and that would be consistent with an infarct that was four to six weeks old.
As long as I've got this page out, I will show you, there seems to have been some discussion from Mr. August whether Dr. Flocker can weigh in on this case because he's not a forensic pathologist. You'll remember back to opening statement when he tried to paint his picture of this case, he seemed to make a big deal about the fact that Dr. Flocker, although he's got an incredible CV, isn't a forensic pathologist. Let's see what his expert says.
Okay. Now, you certainly don't doubt, Doctor, or don't dispute Dr. Flocker has the ability and the qualifications to offer opinions about the cause of death and the timing of infarcts in this case?
No, I don't.
So the fact that he's not a forensic pathologist doesn't mean anything at all, does it?
No, it does not.
Ladies and Gentlemen, I think any argument that Dr. Flocker is not to be believed in this case we can put to rest.

The truth is this man is the founding member, the founding editor of the Journal of Cardiovascular Pathology. He's lectured around the world. He's lectured in this country. He's published over 200 peer reviewed articles, written countless book chapters and teaches both pathologists and cardiologists because he has a position not only in the department of pathology at his teaching hospital but also in the department of cardiology.

When you heard the jury instructions a few minutes ago, the Judge told you you're going to see the instructions on credibility. One of the things you're going to see is that you are permitted to weigh his ability to know these things, his intelligence, his training, his expertise. Ladies and Gentlemen, this man is incredibly well-qualified to testify in this case.

Now, interestingly -- and there's been a little obfuscating in this case - Mr. August keeps saying do the EKG; the EKG would have made the diagnosis. Well, he doesn't really distinguish whether it would have made the diagnosis here or here. There's a method to that. And the method to that is he's produced testimony from a number of people, including Dr. Flocker, that an EKG might have been positive on this date; and he's produced Dr. Marcus who said it would have. There has been no testimony from any witness in this case that simply an EKG would have made the diagnosis back here.

The testimony from his expert -- and I can show you -- this is the testimony of Dr. Morgan. Let's see what he says about whether an EKG would have been diagnostic on September 5th.

Now, let's just assume for a moment that an EKG had been done on Mrs. Kamianka on September 5th, 2002, by Dr. Little. Assume that, in fact, happened. Do you have an opinion based on reasonable medical certainty and/or probability as to what the likely results of the EKG would have been for Mrs. Kamianka on that day?

And his compelling response is: I do

not.
Ladies and Gentlemen, that means that his own expert witness concedes -- and that was Mr. August' question by the way -- that he can't say that an EKG done on this date would have made the diagnosis.
Now, to be fair to the facts of this case, because I don't want to take things out of context, he also said that whether it was abnormal or not, a stress test should have been done; but my point is to show to you that Mr. August is blurring things a little bit here; and when he said to you in closing argument, do an EKG, it would have made the diagnosis, his own witnesses don't support that as it relates to Dr. Little.
Ladies and Gentlemen as it relates to the issue of whether she was having a heart attack or whether there was injury to the heart that could have been diagnosed, the best they can say is from Dr. Brains who says maybe; and maybe is not good enough. We have heard countless times since we walked into this courtroom that he has the burden of proof, that you can't find against Dr. Little on either the standard of care or proximate cause unless he proves that that EKG or that stress test would have been positive. And Ladies and Gentlemen, he has not.
Another thing that he just said in opening statement that, frankly, Ladies and Gentlemen, is outrageous, he made a comment that, well, if there's infarct here, according to Dr. Brains, there must have been some ischemia sometime before that, and he stopped there, but what he did was try to suggest to you that there would have been ischemia, even though there wasn't death that would have produced a diagnosis, Ladies and Gentlemen, the reason that I think thaws outrageous is not a single witness, not a single one, not Dr. Marcus, not Dr. Brains, not Dr. Morgan, no one that the defendants have called supports that in any fashion, Ladies and Gentlemen. We're talking about obfuscation. That's not fair. And that's what is taking place here. Because he just raised an issue that his own experts

won't support.
Now, let's talk briefly about the credibility of the experts. Talk about Dr. Marcus from Harvard. It's been awhile since you heard him testify, but let's talk about him. Again, I encourage you, when you go back, look at the credibility instruction that you got. He's a cardiologist. To be fair, he sees some patients that he treats for cardiology problems that he provides primary care to, but as a cardiologist, he spent his life looking at and worrying about diseases of the heart. Of course, when he sees a patient with chest tightness, his reflex is to think that ifs cardiac. The truth is he can't fairly assess the care of a primary care provider who didn't do cardiology training. I suspect, Ladies and Gentlemen, you got a pulmonologist to look at this case, they would say, should have done a VQ scan and ruled out a pulmonary embolism. If you looked at -- sent it to an oncologist, he might look at it and say, hey, she might have lung cancer; you have got to do a spiral CT of the chest. The truth is it's not fair to ask a cardiologist to comment on the standard of care for somebody who's not.
The other thing I think that you will remember about Dr. Marcus is he wasn't here the way my experts were, to answer questions fairly whether they were brought by the plaintiff or the defendant. He was great. He was very accommodating to Mr. August. As soon as me or Mr. Jones asked him questions, he dug in and he fought, and that's because he was here as an advocate. He was here to try and win, to try to make sure that you understood his opinions instead of doing what an expert should fairly do, which is to come here and say here are my opinions. You know, I don't have a stake in this. I don't care whether we win or lose. I'm just telling you what I think.
One of the things you're going to see in that credibility instruction is you're allowed to consider the frankness or lack thereof of the witness. Ladies and Gentlemen, I think if you remember Dr. Marcus was not

frank with the defendants in this case.
Let's talk about Dr.
Morgan. Did you notice, Ladies
and Gentlemen, a little bit like Dr. Blood who
does this all the time he seemed familiar with
all the lawyers. The reason he's familiar
with all the lawyers is he does this all of
the time. He used to spend 60 percent of his
time seeing patients, and the remaining 40
percent of his time doing medical/legal
reviews and providing testimony in court
cases. Then what happened? The legislature
and in their wisdom changed the rules for what
it takes to be an expert. They said you can't
just see patients 60 percent of the time.
You've got to see patients 75 percent of the
time. So, you know what Dr.
Morgan did? He started seeing
patients more so that he can stay qualified as
an expert. He told you he does this now 25
percent of his time, and he told you that the
overwhelming majority of the reviews that he
does is on behalf of the plaintiffs.
Ladies and Gentlemen, I think one of
the things when we're talking about
credibility of anyone in this courtroom that I
can't let pass is he wrote a report in this
case, and you heard Chris ask him about it.
When he wrote this report, he put, by his
errors in management, Dr. Little and his
employees are responsible for this patients
death. The conduct of Dr. Little rises to the
level of conscious disregard for the rights
and safety of this patient which had great
probability of causing harm.
Ladies and Gentlemen, when he came in
here and testified, what did he say? He said,
well, I don't really believe that. And Chris
said, well, why did you put this in your
report; and the answer was -- and it speaks to
his credibility -- the answer, I'll remind you
was Mr. August asked me to.
Ladies and Gentlemen, experts are
supposed to reach their conclusions on their
own. They're not supposed to do what the
lawyers tell them. And that's why -- Dr.
Morgan, an entertaining little
witness, can't be believed in this case. He's

got a bias; and he has proved that he will do things at the lawyer's request.
Now, the last witness I want to talk about in terms of credibility, plaintiffs brought was Dr. Brains. And Ladies and Gentlemen, I didn't mean any disrespect to Dr. Brains; and I hope none of you thought that I was suggesting it. My only point in talking to Dr. Brains as the coroner is against the backdrop of Mr. August' opening statement. He made this big deal about how she is coroner and threw it around like the fact that she's coroner means that somehow she's got special qualifications. My only point was to show you what a coroner is.. What it turns out is all you have to do is be a doctor, be in practice two years, run for the position of coroner and get more votes than anybody else. I didn't mean to disrespect her or say that she wasn't a good physician. She's probably a wonderful coroner. She's probably a great administrator. She's got this program for grief counselors. But my point with Dr. Brains is she does not have the training and the experience looking at pathology from the heart that Dr. Flocker does.
Dr. Flocker studied it. He's done research. He's gotten grants. Dr. Brains, no disrespect to her, a lot of her time is spent hiring and firing employees, making sure her department runs smoothly, making sure she sets a budget, sets policies, and that's why Dr. Flocker has more weight in this case.
Now, to make sure we are complete, to be fair, I also want to talk about my experts. You will remember Dr. Haines who was the first one that you saw in this case. Dr. Haines, he's done this 12 times total. He's testified at trial one time before, and that was on behalf of a plaintiff.
Dr. Haines has reviewed cases for me in the past; and I will tell you, the last time I sent him a case, you heard him testify, he looked at the case and said, Tom, I think your doctor deviated from the standard of care. Ladies and Gentlemen, I chose him because he's a straight shooter, because he tells me things like that. He doesn't tell me

what I want him to. He doesn't put things in his report because I want him to. He looks at the facts and says whether he thinks it met the standard of care.

I also picked him, Ladies and Gentlemen, because he is a full professor at the University of Marvelous. He's incredibly well-trained, and that's why I chose him, because I wanted to bring to you high quality physicians who came in and told you straight what they thought about the case.

I will also talk briefly about Dr. Flocker. Ladies and Gentlemen, I don't know what else to say. I don't know how I could have found any more qualified expert to talk about the issues in this case. I didn't just go and get a doctor who reads the Journal of Cardiovascular Pathology. I got a doctor who founded the Journal of Cardiovascular Pathology and spent ten years as the editor deciding what articles would be published in that journal. He made some comment that he's some high-priced expert from New York City. Ladies and Gentlemen, don't get distracted by that. He charges for his testimony. Dr. Marcus charges for his testimony. All of these physicians have to charge for the time that they spend away from their office. Ladies and Gentlemen, in the final analysis, Dr. Marcus charged more to come here. Now, to be fair, he's $3,500 a day. Dr. Flocker is four. Dr. Marcus is here for two days. Maybe it wasn't his fault. But if we're talking about money and the cost of doing these reviews as some way to say Dr. Flocker is making this up, that's not fair either.

Ladies and Gentlemen, something else you should know about Dr. Flocker when you assess his credibility. The first time I met Dr. Flocker and the reason that I picked him to review this case, is the first time I met him was when I was sitting on the opposite side of the table from him and took his deposition; and at the end of that deposition, I concluded this is a really well-trained expert who really knows what he's talking about. And that's why I said to myself, next time I have an issue involving cardiac pathology, I'm

going to him.
Something else you should know about him is I have sent him other cases because I'm impressed with him as a witness. There have been other occasions, and you heard him testify, where I sent him a case, he looked at the slides, he told me what he thought, it wasn't helpful to the defense. He didn't say, well, tell me what you want, Tom, and I'll write your report and help you defend the case. He said, hey, this is what I see; I can't help you.
Ladies and Gentlemen, the next subject I'm going to touch on is one that every defense lawyer hates to touch on, and it's the damages in this case. And the reason that we all hate to touch on it is it's a catch 22. And let me tell you why it's a catch 22. If I stand up here and talk about damages and -- let me see if Mr. August is surprised or not -- I'm going to put up his boards. The reason we don't like to talk about it, the reason it's a catch 22 is because if we talk about damages he can jump up and stand up here and say, Ladies and Gentlemen, Mr. Kane is talking about damages, he must think he's losing. Let me tell you first *off* that is absolutely the last reason in the world that I am talking about damages in the case. I'm talking about damages in this case because if I don't he's going to jump up and say, Ladies and Gentlemen, at least Mr. Kane and I agree on one thing. We agree that this is a reasonable number, and we must agree because if Mr. Kane didn't think that was reasonable I'm sure he would have stood up and told you. The truth is I've got to comment on it, not that I want to. I certainly don't want you to think that we are losing or that I'm worried about you reaching a verdict, but I have to comment on it one way or the other. First of all, let me point something out. And I don't know why Mr. August has this listed here. You're going to see in the jury instructions that the Judge is going to give you, this exact same language is going to be there, except there's going to be nothing

about parents or next of kin; and that's because they don't have a claim in this case. You're not here to reach a verdict for the parents and next of kin. This is just misleading. This is not part of your deliberations. And, in fairness, he should have crossed them out.

The second thing that you should know about your job is it's to provide reasonable compensation, to fairly compensate this family if you ever get to a verdict even though I don't think you should do it. You should understand about Mr. August, when he offers you this guidance, his job is not to reach fair and reasonable compensation. His job is to get everything he possibly can for his client. I will tell you when plaintiffs' lawyers sit down and come up with a number, they try and pick as big a number as they can that they can look at the jury with a straight face and ask for it and not run the risk of losing their credibility or offending the jury.

So, Ladies and Gentlemen, when he puts this as a reasonable number, don't take him at face value. It's your job to determine whether this is a reasonable number. And in fairness -- again, to be fair to the composite of the facts of this case, he put an expert witness on the stand, Dr. Blood, who we all know well, and the reason that we don't call anybody to oppose him is we're not here arguing about how he calculates his numbers. Keep in mind, he didn't come here to say she would have lost these numbers. He didn't come here to say she would have worked until 55 or 62 or 67. That's not his role. All his role is to say if she were to work that long this is what it would cost to replace her services. We're not arguing about that. We can change the rate of interest that he uses to calculate this number and come up with different numbers, but that's -- that's -- he's not saying that she lost this. He's saying if she would have worked that long, that's what she's lost.

Again, to be fair to this case, he offered alternate numbers to this. He offered

a number to her work life expectancy, which would have been $276,000; and he offered another number if she worked to 65, which she would have worked towards. And if we were being fair to the facts of this case, we would have laid out those possibilities because they're -- it's up to you to determine whether she would have worked to 55 or 62 or 67. And in fairness, this is a little bit presumptuous for Mr. August to put that out. That's your job to determine how long you think she would have worked based on the facts of this case. And he -- this number calculates her working to 67 years old. Ladies and Gentlemen, his own experts testified that she only would have lived to her 70s. So, he's got poor Mrs. Kamianka working till the day she dies just about.

The last comment I will make about damages and value in this case is when you go back, if you ever get there -- and, Ladies and Gentlemen, you shouldn't; you really shouldn't in this case, not with the problems he has in his case. If you ever get there, though, think about money, think about value. And I guess one of the units of value that I think about when I think about money is I think about my home, and the average value of a home in Cuyahoga County is something like $130,000. For most of us, that's the biggest purchase we ever make, and we work for 30 years, most of us, to pay that $130,000 house *off*. We go to work every day, and we do it for 30 years, and it's the biggest check we write every month. And just if you go back and you ever get there, and you shouldn't, think of the value of money. Don't let him get 'you talking about millions of dollars unless you get there on your own. That's for you to decide.

Now, one of the things that occurred to me as I was listening to this case, and in particular the closing argument was that you can tell a lot about the strength of the quality of a case by how a lawyer presents it to you. If you got a really good case, Ladies and Gentlemen, you go right to the issues. You talk about the issues. You don't get caught up in extraneous issues. You be fair

to the facts. You don't take things out of context. You don't overstate. You don't mischaracterize, and you don't waste time. When you got a case and you are working around some issues, you got some problems, you do all of those things. I just want to go to -- and I made a list from the last eight or ten days or however long it's about been. I'm not going to talk about them.

First of all, I heard it in his closing argument today. He talked about there's a red light in medicine; and if you go through the red light, then you made a mistake. It's a little bit misleading, Ladies and Gentlemen, because when you go back and deliberate, one of the things you're going to see is he has to prove two issues. He has to prove that the doctor went through the red light; and the fact that he went through the red light is not enough, okay, not that Dr. Little did in this case or not even "that Dr. Madison did in this case, but that's not enough; you got to go through the red light and you got to cause an injury to somebody. That's why it's not a fair analogy. He didn't bring that second part up to you; and he didn't remind you that this analogy stops a little bit short, but he's got to prove both issues. He's got to prove there was a mistake and that it caused injury.

And, Ladies and Gentlemen, at risk of sounding like a broken record, he hasn't even gotten close to proving the second two issues, not that he's gotten close to the first either.

Let's go through just some of the things where I don't think he was fair to the facts of this case. Was it fair when he in opening statement said she called a d said he -- she really, really needed to be seen? Was it fair when he said if it walks like a duck and quacks like a duck, it's a duck, when his own expert witness came in and told you this is an atypical presentation? Was it fair in opening statement when he said Dr. Little, he diagnosed bronchitis, and Dr. Madison just latched onto it?

Ladies and Gentlemen, the testimony

of Dr. Madison was he did his own independent evaluation and did not base his opinions and his evaluation of this patient on something Dr. Little did.

Was it fair in opening statement when he stood up here and said, and the defendants are going to try to blame the plaintiff for what happened here? Ladies and Gentlemen, I have been sitting here trying to pay close attention. I know I never said it. I know none of my witnesses ever said it. I suspect strongly that none of Mr. Jones's witnesses have said that. We're not blaming Mrs. Kamianka, and it was unfair to say that we were.

You know, he made this comment the patient wasn't told she was at risk for coronary artery disease. This patient was told from the day she walked into his practice and the day Dr. Little sat down and made out a family tree and sat and talked to her about what happened to her family and different issues and they identified that the brother had had a heart attack, they had a discussion at that point that she was at an increased risk for coronary artery disease; and it wasn't fair for him to suggest that the patient wasn't aware of that.

We talked about it, the blood pressure not being done. That wasn't fair. There's no criticism of that. We all know it was done. And talked about whether there was a letter about the cholesterol. Ladies and Gentlemen, his own experts don't criticize that. It's not fair for him to stand up and make a big deal about it when his own experts don't.

One of my favorites was, do you remember when he put Dr. Marcus on the stand and said, well, Dr. Marcus, isn't there evidence of a chronic cough, do you remember that, put it up on the thing, chronic cough. Mr. Jones got up two minutes later and said what's at the beginning of that sentence, denies shortness of breath, chest pain, chronic cough. It's not fair to suggest here was a chronic cough when the very same sentence says that there wasn't.

Was it fair in opening statement when he said this patient lived a sedentary lifestyle and she wasn't active and that's why -- it's another risk factor? Was it fair against that backdrop of Dr. Florra and Dr. Morgan both saying, no, she wasn't sedentary, that's not a risk factor? Mr. Kamianka from the stand said, no, she wasn't sedentary.

Mr. August claimed in opening statement that she was. He claims she had another risk factor. Was that fair? Was it fair when he said this big deal in opening statement that Dr. Flocker is not a forensic pathologist who we know from his own expert, Dr. Brains, who he called, it's not a big deal, even she admits it's not a big deal. Was it fair when he kept making a big deal about the cost of the lab suggesting that, oh, they must not have been offered because there's no way she would have turned them down because of cost without also putting it against the backdrop of a woman who made about $15,000 a year and had never gotten a mammogram despite the fact that it was recommended? If he was being fair to the facts of this case, he would have admitted that, yeah, it's a possibility because an extra $40 or $80 or whatever it is, that's a lot of money when you make $15,000 a year. You know, was it fair when he made this comment about how she religious -- religious she was about coming for her annual visit without also being fair to the facts and saying, in all fairness, she came every year; we don't know whether it was because she was concerned about her healthcare or whether she simply wanted to get her oral contraceptives renewed? Is it fair when he's talking about Dr. Flocker with all his qualifications and suggested that somehow he's not an appropriate expert for this case?

Was it fair when he said a few minutes ago in his closing argument that maybe there was ischemia that preceded the death or the muscle injury that Dr. Brains said must have been greater than six weeks even though not a single expert supports that?

Ladies and Gentlemen, the reason you say things like that in closing argument when you don't have a witness who supports it, when you know there's no testimony to stand on, is because you know you have got a huge hole in your case. It's because you know that this lady didn't present looking like she was having a heart attack, having symptoms of a heart attack or ischemic disease; and it's because he knows that on the issues on this case he loses. His case is based on the premise that she had diagnosable and treatable coronary artery disease going back to September 5th, 2002. And the problem is he hasn't proven that there was disease that could have been diagnosed. And, Ladies and Gentlemen, that's why he's dealing these things that are unfair.

Now, you're going to see here in about two minutes, I'm going to sit down and I don't get to talk again, but Mr. August does. He's going to say lots of things, he will probably say Mr. Kane is a terrible guy, how dare he attack me. A couple things, first of all, he said I obfuscate, which I don't think is very fair, but it's only fair that it be thrown right back at him. The second thing is -- and this happens in these cases -- he's going to be getting up and say, well, if you don't have the facts, argue the law; and if you don't have the facts -- or the law, argue the facts; and if you don't have either, pick on the other lawyer, beat him up. Ladies and Gentlemen, that's not what I'm doing here. I hope you don't think that's what I'm doing. What I'm doing is pointing out to you how this case was brought to you and pointing out that you have to look at all of the facts. You have to put them in context. And if you don't, that's not fair.

The truth is Mr. August, you have .seen him on his feet all week, he's a very good lawyer. He's smooth. He's polished. He should be an anchor on network 1V. I mean, he looks the part. He's terrific at it, Ladies and Gentlemen, but the truth is he hasn't been fair to the facts in this case. He hasn't brought you all the facts, Ladies and

Gentlemen. And when he stands up and gets to argue and I don't get to respond. I want you to challenge him. I want you in your mind to make him explain why would he do all these things, why would he not be fair. And another thing, and I think he should answer for you, is why if Dr. Flocker is wrong and this death of the muscle was not four to six weeks old, why not go and consult a cardiac pathologist, have him look at the slides and say this is what Dr. Brains said, and I agree with it completely. He had every right to do that. He had every opportunity to do that. Ladies and Gentlemen, he didn't produce that testimony for you. And he can say, well, Dr. Brains is good enough.

Ladies and Gentlemen, he knows that I'm going to get up and say I've got a cardiac pathologist; he doesn't; and he could have put this all to an end by getting a cardiac pathologist who would say, no, no, no, no, I'm a cardiac pathologist and Dr. Flocker is wrong. He decided not to do that, Ladies and Gentlemen. I think he should answer for you why he didn't.

Ladies and Gentlemen, I'm going to ask you to go back and deliberate, and I'm not going to tell you don't deliberate. I want you to go back, I want you to look at these exhibits. I want you to talk, and I want you to talk about your memory of the testimony, and I want you to remember the things that all the lawyers have told you, and I want you to remember the things that I told you and tried to show you in this closing argument. I want you to do those things because, Ladies and Gentlemen, if you do, you will find the truth of the matter in this case, and you will return a verdict for Dr. Ken Little.

Like eve body else here, including Mr. August, Mr. Kamianka, all the lawyers, I know this is hard, and I know you have worked hard. I know it probably hasn't been fun listening to repetitive testimony. There's no way around it in this case. I want you to know on behalf of myself, on behalf of my friend, colleague, Chris Reid, but most importantly, on behalf of Dr. Ken Little, I

thank you for your time and attention.
THE COURT: Thank you, Mr.
Kane.
Mr. August, you may argue.
MR. AUGUST:
Thank you.
FINAL CLOSING ARGUMENT ON BEHALF OF THE PLAINTIFF
Trust me, be brief. I'm as tired of sitting as you are.
I have never been accused of being so
unfair in my whole life, I have to admit, but
you are the ones to determine whether that's
true just like you're the ones to determine
the credibility of the witnesses and the
experts. It's very interesting that Mr.
Kane would say that Dr. Morgan
is some hired gun and that he is not a very
credible witness, but that was about 30
seconds after he said, hey, he was right about
that question concerning the results of the
EKG on 9/5. So, you know, take it for what
it's worth. Pick and choose. You know, he
was really very competent when he said I don't
know, and he read it to you, he showed it
right on the screen, I do not know what the
results of the EKG on 9/5/02 would be because
I'm not a cardiologist; I defer to the
cardiologist. So, he was very, very good and
competent then, but he wasn't when he didn't
like the answer that he got.
So, you know, put it in perspective;
and I think it's unfair for him to do that,
but be that as it may, you decide credibility.
So, you know, put it in perspective;
and I think it's unfair for him to do that,
but be that as it may, you decide credibility.
Economic losses. It's my duty. I am
absolutely duty bound to present to you In my
open close, as they call it, economic numbers
if this is about economics and damages. So,
to say that I did something wrong by
presenting economic numbers to you is
absolutely verboten. I mean, that's -- I have
to. But to compare the value of Mrs. Kamianka's life
to this man and to her three sons with a mortgage or a house or
a piece of property is beyond an insult; and I think you
all agree with that.
Now, let me just touch on a couple
of things. I'm going to address kind of both

counsel when I say Mr. Kane says that Dr.
Little is a good and careful doctor, and Mr.
Jones says that Dr. Madison is a good man- and
I think I said in the very beginning of this case it's not about whether they are nice guys
or whether they are good people. That's not what I'm talking about
If I run a red light that doesn't necessarily make me a bad driver.
It means I made a mistake at that one time,
but it doesn't reflect on my quality as a
human being or for that matter on my quality
as a driver. It means I made a mistake. I
had a lapse at that moment. So, to bring it
to a personal level is a cheap shot. This is
not about whether they are good people or bad
people. I never said this was about them
being bad people, nor did I say they were bad
doctors. They just made a mistake. That's
what this is all about.
All of this talk about it's an
atypical presentation, it's a -- you know,
it's -- you have got a million other things
going on here in this. document I have never
seen before from Mr. Jones, one thing that
nobody has ever really addressed, yeah, okay,
she had other symptoms, never denied that,
it's in the records, you have seen it 100
times, but on September 5, what did she come
In with? She came in with chest pain. That's
something that was kind of played down here
talking about all this causation testimony of
Dr. Flocker and Dr. Brains and so on and so on
and so on. Chest pain. That wasn't there
before ever in her whole life, and it's
consistent with occlusion or partial occlusion
of the coronary arteries.
The reason that Dr. Madison and his
counsel are not contesting the pathology is
not because Mr. Jones doesn't understand it.
He is a very smart man. I've tried cases
against him. He's a very talented lawyer.
He's never said anything like that in his
whole life. The reason he's not contesting
the pathology is because they can't. Because
both Dr. Brains and Dr. Flocker have made It
painfully clear that on 11/6/02, no question
it was diagnosable. And Mr. Kane says that
Dr. Flocker said it could have been
diagnosed- no, no, no, no he didn't say it
could have been. He said it would have been,

and he held that opinion to a reasonable degree of medical certainty.
I've got a lot of things, but I'm not going to say them. I would say this, however. Mr. Jones referred to Dr. Smead and the fact that he said, well, they had two different doctors in two different specialties, plus a nurse all saw the same thing and came to the same conclusion and, therefore, it's okay as if to say two wrongs make a right -- or in this case, three wrongs make a right. But I believe that Dr. Little and Dr. Madison are the people in charge in their respective environments. Dr. -- Dr. Madison does not defer to the nurse, I hope. He said he wouldn't, and I wouldn't expect him to, particularly if you remember the testimony of Nurse Deitrick she went through a preceptor ship where she shadowed somebody for a period of, she said, two to three months starting at the end of July and then went solo after that, which means that in this case she had been on her own as an ER nurse for about a month, give or take. So, maybe two weeks, maybe three weeks, four weeks, but that's about it, folks.
So is this something that Dr. Madison should -- someone Dr. Madison should defer to? I doubt. But when you get back there, I want you to look at the chart, and I'm not even going to put it on the screen because it would take time, there is something that's got a Bates stamp down at the bottom that's numbered 31, it's this checklist in the emergency room, and you will see this section here right under all these big black dots where there are all these things checked -- now, Nurse Deitrick came in here and testified in a deposition that, oh, yeah, yeah, yeah, yeah, I remember now, the pulse ox was 97 percent. How she remembered that is beyond me. And she said, oh, yeah, there was coughing; I forgot to write that down; and that's why it doesn't show up in the nursing assessment sheet. Well, if you look on this, there is a very detailed breakdown that she filled out in total and the very last question is cough, slash, sputum, the answer is none. She doesn't check a thing. She doesn't say a

thing about coughing.
So, you are the ones to assess credibility; and you assess credibility not on the basis of just their appearance, because some of them didn't actually appear, but on the basis of the records themselves.
I think in the end, Ladies and Gentlemen, that you have -- and I -- honestly, I don't believe that it is unfair or improper or not reflective of the evidence in this case. Two times in this woman's life she complained of chest pain. Two times. And we heard a lot of talk about how EKGs can be done easily and anywhere and very effectively. It was never done. I will remind you, chest pain, EKG; if there's pain in the chest, get the test.
Thank you very much.

JUDGE INSTRUCTIONS TO JURY:
THE COURT: Thank you, Mr. August, counsel.
Ladies and Gentlemen, a few closing remarks. The Court has given you the instructions on the law applicable to this case already. I will now instruct you on how to conduct your deliberations and prepare your verdict.
First, the selection of foreman or forewoman. When you go to the jury room, your first function will be to select one of your number to serve as foreman or forewoman. The person you select to preside over your deliberations does not have any greater power nor does this person's vote have any more importance than the others. He or she serves the purpose of helping to conduct your deliberations in an orderly manner and to give each of you the opportunity to express your opinions. One additional duty of the foreman/forewoman is to see to it that the verdict forms are returned to the Court after you have reached a verdict.
Now, the verdict forms, I will now read what the verdict forms say and caution you not to make any inference based on the order in which I read them. In addition to the instructions that go back, you will have

the interrogatories that I talked about earlier. These you will deal with first, and you will follow the instructions at the bottom of each interrogatory. Depending on how you decide these interrogatories will guide you when to reach the general verdict forms.
Here's the general verdict form. The first one, if you find for the plaintiff, we the jury being duly impaneled upon the concurrence of the undersigned jurors, being not less than three-fourths of the whole number thereof do hereby find in favor of the plaintiff, Mr. Kamianka, and assess damages in the amount of blank and against the defendants, Timothy Madison, MO, and/or Ken Little, DO, the instructions circle one name or both.
The next verdict form is a defense verdict form which states the following. We the jury being duly impaneled upon the concurrence of the undersigned jurors being not-less than three-fourths of the whole number thereof do hereby find in favor of the defendant, Timothy Madison, MO, and against the plaintiff, Mr. Kamianka. And the third verdict form is, we the jury being duly impaneled upon the concurrence of the undersigned jurors being not less than three-fourths of the whole number thereof do hereby find in favor of defendant, Ken H. Little, MO, and against the plaintiff, Mr. Kamianka. And on each of these general verdict forms is a signature line for the jurors. You reach these by following the instructions at the bottom of the interrogatories.
In order to conclude this case, it is necessary that at least six members of the jury agree -- agree upon a verdict. The members of the jury agreeing upon a verdict must sign their names to the form of verdict to which they have agreed. The foreman or forewoman need not be among the six jurors have agreed to reach a verdict. When you have reached and signed the verdict forms, you will then summon the bailiff who will return you the courtroom at which time your verdict will be announced in open court.
The Court cannot embody all the law

in any single part of these instructions. In considering one portion you must consider it in light of and in harmony with all the other instructions.

Circumstances in the case may arouse sympathy for one party or the other. Sympathy is a common human emotion. The law does expect you to be free of such normal reaction. However, the law and your oath as jurors require that you disregard sympathy for either party and not to permit it to influence your verdict.

Your initial conduct upon entering the jury room is a matter of importance. It is not wise to immediately express a determination insist upon a certain verdict because your sense of pride may be aroused. You may hesitate to give up your position if shown that it is not correct. Consult with one another in the jury room, deliberate with a view to reaching an agreement if you can do so without disturbing your individual judgment. Each of you must decide this case for yourself. You should do so only after a discussion of the case with your fellow jurors. Do not hesitate to change an opinion if convinced it is wrong. However, you should not surrender honest convictions concerning the weight of the evidence in order to be congenial or to reach a verdict solely because of the opinion of the jurors.

Alternates. Jurors selected as alternates are not permitted to participate in the jury deliberations unless one or more of the regular jurors is unable to complete the service due to an illness or other misfortune. We are pleased that that has not occurred in this case, so it will not be necessary for you gentlemen who served as alternates to deliberate in this case. Even though you will not be required to render further service in this case, the Court must restrict you from discussing this case with anyone or revealing to anyone how you would have voted. After the jury has returned its verdict and it is announced in court, you will be released from this restriction and at that time if you wish you may discuss this case. On behalf of

myself, I'd like to thank you for the time and attention and the sacrifice that both of you made in regards to sitting as alternates in this jury. If you provide your contact information to my bailiff, he will be able to contact you if you'd like to receive information once a verdict is reached.
Final closing arguments. The Court reminds you that the foreman and forewoman of the jury will be responsible for the return to the Court of the verdict forms and interrogatories. Until your verdict is announced in open court no juror is permitted to disclose to anyone the status of your deliberations or the nature of your verdict. This order must be strictly obeyed. After your verdict is returned and announced in court you may discuss the case with anybody.
All right. You
(Thereupon, the jury began its deliberations.)
(Thereupon, the following proceedings were had out of the presence of the jury.)
THE COURT:
may be seated.
If counsel for both parties can look over the exhibits and make sure that the proper exhibits that have been admitted into evidence are there and give those to John and nothing improper goes back and make sure that the medical records are restamped as joint
You are not required to do so. It is a matter of your own free choice.
I want to thank you and express my appreciation, express the appreciation of the citizens of this community for your service as jurors. By providing this service, you have contributed towards the continuing unique system of justice that we enjoy in this country.
Thank you very much. Ladies and Gentlemen, all rise for the jury.
Thank you, Your
exhibits between the defense and the plaintiff.
Is there anything else from the parties?

MR. JONES: No, Your Honor.
MR. AUGUST: No, Your Honor.
THE COURT: All right .. I'd
like to take this opportunity to thank counsel
for their professionalism. And please provide
your contact information to John should there
be a question. We will get right up with you
if there is one.
MR. JONES:
MR. AUGUST: Thanks, Your
Honor.
(Thereupon, Court was adjourned.)
Honor.
THURSDAY, OCTOBER 6,2005
AFTERNOON SESSION
(Thereupon, the following
proceedings were had in open court
and in the presence of the jury.)
THE COURT: Okay. Good
afternoon, Ladies and Gentlemen. It's my
understanding my bailiff has informed me you
have reached a verdict.
JURY FOREMAN: Yes.
THE COURT: Will the foreman
please hand the verdict forms over to John?
(Tendered.)
THE COURT: All right. With
respect to the interrogatories to the jury,
interrogatory number one: Has plaintiff,
Mr. Kamianka, proven by preponderance
of the evidence that defendant, Ken Little,
was negligent? The answer is no. This is
signed by all eight jurors.
Interrogatory number four: Has
plaintiff, Mr. Kamianka, proven by a
preponderance of the evidence that defendant,
Timothy Madison, was negligent? The answer is
no. This is signed by signed by seven jurors.
A general verdict form is signed in
favor of -- indicating, we the jury being duly
impaneled upon the concurrence of the
undersigned jurors being not less than
three-fourths of the whole number thereof, do
hereby find in favor of defendant, Ken
Little, MO, and against the plaintiff, Mr.
Kamianka. This is signed by all eight jurors.
The second verdict form: We the jury
being dually impaneled and sworn upon the

concurrence of the undersigned jurors being not less than three-fourths of the whole number thereof do hereby find in favor of the defendant, Timothy Madison, MO, and against the plaintiff, Mr. Kamianka. This is signed by seven jurors.
All right. Thank you very much, Ladies and Gentlemen, for resolving this matter. I'm going to dismiss you now. And if you have any questions, I'll meet with you in the jury room. If you would like to go, I understand that. You have put a lot of time into this case. But on behalf of all my colleagues down here at the Justice Center, I want to thank you very much for resolving this matter. And if you do have questions, I'll be happy to answer any in the back afterwards.
All rise for the jury.
One moment. Is there anything from the parties in terms of polling?
MR. AUGUST: I was going to ask for polling.
THE COURT: All right. I'm going to ask Juror Number Number 1, is this your verdict?
JUROR NO.1: Yes.
THE COURT: As to the defense verdict for Ken Little, Juror Number 1, is this your verdict?
JUROR NO.1: Yes.
THE COURT: Juror Number 2?
JUROR NO.2: Yes.
THE COURT: Juror Number 3?
JUROR NO.3: Yes.
THE COURT: Juror Number 4?
JUROR NO.4: Yes.
THE COURT: Juror Number 5?
JUROR NO.5: Yes.
THE COURT: Juror Number 6?
JUROR NO.6: Yes.
THE COURT: Juror Number 7?
JUROR NO.7: Yes.
THE COURT: Juror Number 8?
JUROR NO.8: Yes.
THE COURT: All right. As to the defense verdict in favor of Timothy Madison, MD, against plaintiff, Mr. Kamianka, Juror Number 1, is this your

verdict?
JUROR NO.1: Yes.
THE COURT: Juror Number 2,
is this your verdict?
JUROR NO.2: No.
THE COURT: Okay. Juror
Number 3,is this your verdict?
JUROR NO.3: Yes.
THE COURT: Your Number 4?
JUROR NO.4: Yes.
THE COURT: Juror Number 5?
JUROR NO.5: Yes.
THE COURT: Juror Number 6?
JUROR No.6: Yes.
THE COURT: Juror Number 7?
JUROR No.7: Yes.
THE COURT: All right. And
Juror Number 8?
JUROR NO.8: Yes.
THE COURT: All right.
Anything else from the parties?
MR. JONES: No, Your Honor.
MR. KANE: No, Your Honor.
MR. AUGUST: No, Your Honor.
THE COURT: Thank you
much.
All rise for the jury.
(Thereupon, the following
proceedings were had out of the
presence of the jury.)
THE COURT: Anything else
from the parties at this time?
MR. JONES: No, Your Honor.
MR. AUGUST: No, Your Honor.
MR. KANE: No, Your Honor.
THE COURT: All right.
Thank you very much.
(Thereupon, Court was adjourned.)
CERTIFICATE
I, Robert P. Man, Official
Court Reporter for the Court of Common
Pleas, Ohio, do hereby
certify that as such reporter I took down
in stenotype all of the proceedings had
said Court of Common Pleas in the
above-entitled cause; that I have
transcribed my said stenotype notes into
typewritten form, as appears in the

foregoing Transcript of Proceedings; that said transcript is a complete record of proceedings had in the trial of said cause and constitutes a true and correct Transcript of Proceedings had therein.