IN THE CIRCUIT COURT OF THE TWELFTH JUDICIAL CIRCUIT
WILL COUNTY, ILLINOIS

BRENDA GRAMELSPACHER, Special Administrator of the Estate of JEFFREY T. ELDER, Deceased,	)	
Plaintiff,	)	
v.	)	No. 08 L 827
PROVENA HOSPITALS d/b/a PROVENA SAINT JOSEPH MEDICAL CENTER, KIRKEITH LERTSBURAPA, M.D., JONG-YOON YI, M.D., and CARDIOLOGY ASSOCIATES OF NORTHERN ILLINOIS ILLINOIS, LLC d/b/a HEARTLAND CARDIOVASCULAR CENTER, LLC, ANDREW ZWOLSKI, M.D., PRAIRIE EMERGENCY SERVICES, S.C., AHMED HUSSAIN, M.D., and INTERNAL MEDICINE & FAMILY PRACTICE, S.C.,	)	
Defendants.	)	

PLAINTIFFS' RESPONSE TO DEFENDANTS' OBJECTIONS TO HIGH/LOW AGREEMENTS

NOW COMES the Plaintiff, Brenda Gramelspacher, by and through her attorneys, Cirignani, Heller & Harman, LLP, and in response to the Defendants Yi, Lertsburapa, and Cardiology Associates of Northern Illinois ("Cardiology Defendants"), and Ahmed Hussain, M.D., and Internal Medicine & Family Practice ("Internist Defendants"), objections to the high/low agreements entered into between Plaintiff and Defendants

Provena St. Joe's Medical Center ("Provena") and Andrew Zwolski, M.D. ("Zwolski"), state as follows:[1]

Statement of the Case

This case is about a forty-three year old man who went to Provena with chest pains, needed a test to save his life, never got that test, and died. Why this happened is the reason for the lawsuit and the reason for these high/low agreements.

Facts of the Case

On August 8, 2008, at 5:20AM, Jeffery Elder arrives at Provena by ambulance complaining of sudden onset of chest pain. *Ex. 1, MR 683-684.* The Defendant Dr. Zwolski orders a CT scan of the chest. *Id.* At 6:55AM, the hospital radiologist reports that the scan shows that Mr. Elder's aorta on the ascending portion of the artery is "dilated" – that is, it is enlarged. *Ex. 2, Zwolski Deposition, pp. 61-63, 72-73.* Given Mr. Elder's signs and symptoms, Defendant Zwolski knows that this could mean that the aorta is being torn apart, that it's enlarged because blood is getting in-between the layers that make up the artery. *Id.* The medical term for this condition is *aortic dissection* (hereinafter, "AD") and it is a medical emergency that needs immediate surgical repair. *Ex. 3, Zwolski Deposition, pp. 34-36.*

To confirm the diagnosis of AD, the radiologist recommends a CT scan with contrast to visualize and confirm the aortic tearing. *Ex. 2, Zwolski Deposition, pp. 61-63, 68.* There is

[1] Though the Cardiology and Internist Defendants make slightly different arguments in their pleadings, for the convenience of the Court, Plaintiff will file this single response.

a CT machine in the ER and Mr. Elder already has an IV in place for the contrast; however, rather than complete the CT, Defendant Zwolski chooses to admit the patient and to delay the testing until he is in his regular room. *Ex. 4, Anderson-Melnick Deposition, pp. 16-19; Zwolski, 56-57, 74-78*

He writes an order for this, and then calls Defendant Hussain, an internist, and gives him the key information: patient with chest pains, enlarged aorta, needs CT scan with contrast to rule out AD, and asks Defendant Hussain to admit Mr. Elder and take over as attending doctor. *Ex. 5, Zwolski Deposition, pp. 87-93, 106-111; Hussain Deposition, pp. 51-55, 60-61.* Defendant Hussain agrees. *Id.* Defendant Zwolski next calls Defendant Yi, a cardiologist, and gives him the same information and asks that he or someone from his medical group, act as cardiac consultant on the case. *Ex. 6, Zwolski Deposition, pp. 96-103; Yi Deposition, pp. 41-49, 55-57, 60-61, 65-66.* Dr. Yi agrees. *Id.* Defendant Zwolski goes home. *Ex. 7, Zwolski Deposition, pp. 112-113.*

At about 7:05AM, Mr. Elder is admitted and transferred from the ER to a cardiac floor. He is seen and evaluated there by two floor nurses, neither of whom see, enter, or complete Defendant Zwolski's order for the CT scan with contrast. *Ex. 8, Flint Deposition, pp. 27-32; Ortega Deposition, pp. 45-47.*

At 9:30AM, Dr. Hussain calls the hospital about Mr. Elder and gives verbal orders to his nurses, but doesn't check on the status of the CT scan with contrast. *Ex. 1, MR 722, and Ex. 9, Hussain Deposition, pp. 62-64.* He does the exact same thing at 10:15AM. *Id.*

At about 11:00AM, Mr. Elder is seen by Defendant Lertsburapa, one of Dr. Yi's colleagues. *Ex. 10, Lertsburapa Deposition, pp. 49-56, 67-85*. Defendant Lertsburapa knows nothing about Defendant Zwolski's order for a CT scan with contrast, doesn't check on the results of any test, and although like the others he suspects an AD and knows that it's presence means a medical emergency, he chooses a different test, but not to rule out an AD, but simply to get more information . *Id.* The other test he orders is one that is less sensitive than a CT scan for AD and takes longer to perform. *Id.* Despite this, he doesn't order the test done STAT—immediately—and its results are not delivered to Defendant Lertsburapa until almost 1:00PM. *Id.*

At about 1:00PM, Defendant Lertsburapa is told that Mr. Elder does indeed have an AD. *Id.* Although Defendant Lertsburapa now tries to get a surgeon to fix the tear emergently, none of the hospital surgeons are available. *Ex. 11, Lertsburapa Deposition, pp. 85-99, 101-106.* Calls to outside hospitals finally locate a doctor at Loyola but before Mr. Elder can be transferred, he arrests and dies. *Id.*

Summary of Damages

Jeffery Elder was the father of four children, three of whom were minors at the time of his death (one was a baby). *Ex. 12, Complaint.* Mr. Elder was also employed at the time by Caterpillar and has lost earnings in the range of $1.7 million to $2.3 million. *Ex. 13, 213 Interrogatory Answers, Radke.*

Summary of Defenses

Defendant Zwolski: Defendant Zwolski says it wasn't his fault that the CT with contrast was never done because he left an order for it to be done and had transferred responsibility for following up on the test results to Defendants Hussain and Yi. *Ex. 13, Zwolski Deposition, pp. 85-86.*

Defendant Hussain: Defendant Hussain says it wasn't his fault that the CT with contrast was never done because Defendant Zwolski told him that Defendant Yi (or someone from that group) had accepted responsibility for following up on the test results. *Ex. 14, Hussain Deposition, pp. 51-52, 61.*

Defendant Yi: Defendant Yi says it wasn't his fault that the CT with contrast was never done because Defendant Zwolski told him that he, Defendant Zwolski, would retain responsibility for following up on the test results. *Ex. 15, Yi Deposition, pp. 71-75, 78-83.*

Defendant Lertsburapa: Defendant Lertsburapa says it wasn't his fault that CT didn't get done because it didn't matter that the CT with contrast was never done. He says that by the time he got involved, he ordered a different test that confirmed the diagnosis, making the CT moot *See, supra, Ex. 10, Lertsburapa Deposition excerpts.*

Defendant Provena: Defendant Provena says it is not its fault that CT didn't get done because if any one of Defendants Zwolski, Yi, and Lertsburapa had done what the standard of care required of them, the CT would have been ordered and completed before Mr. Elder ever left the emergency room.

Summary of Settlement Discussions

With the above facts known and completely discovered, in August of last year, undersigned Plaintiff's counsel approached *all* defendants and asked them if they would be willing to mediate the case for settlement. *Ex.16, Affidavit of William A. Cirignani.* Defendants Zwolski and Provena said yes, but the Cardiologist and Internist Defendants said no, saying that they wanted to see Plaintiff's expert disclosures before discussing settlement. *Id.*

In October of 2011, Plaintiff filed its expert disclosures and once again asked *all* Defendants to submit to mediation. *Id.* Once again, Defendants Zwolski and Provena said yes, but the Cardiologist and Internist Defendants again said no, this time saying simply that they felt they had a defensible case. *Id.*

In November of 2011, Plaintiff approached Defendants Zwolski and Provena separately about entering into high/low agreements with Plaintiff. *Id.* There were many discussions during which Plaintiff repeatedly indicated that all high/low agreements under consideration were not to be hidden from the non-settling Defendants. *Id.* Indeed, undersigned counsel even insisted that before final agreement was reached on any high/low deals, that counsel for Defendants Provena and Zwolski engage the non-settling Defendants one more time about a global settlement. *Id.* Though not privy to these conversations, undersigned counsel was told that this was done and that once again the non-settling defendants preferred to stay that way. *Id.*

Negotiations over the exact terms of the high/low agreements were then hashed out over the next several months, the hashing out of which was well-known to the non-settling Defendants. *Id*. Finally, last month agreements were reached. The exact agreements have been attached. *Id.*

Argument

Combined, the non-settling defendants make three arguments against the high/low agreements in this case. The first argument is made by the Internist Defendants alone and says that the agreements must fail because of they don't equitably apportion the damages amongst all defendants. *See Internist Objection, generally and p. 4.* The second argument is made by the Cardiology Defendants alone and says that the agreements must fail because they are Mary Carter agreements in disguise. *See Cardiologist Defendants' Objection, generally and p. 3.* The third argument is made by both of the non-settling defendants and states that the high/low agreements must fail because they don't allocate the settlement amounts between the wrongful death and survivorship claims. *Id.* Each argument will be taken in turn.

1. In this Joint and Several Liability Case the Goal of Equitable Apportioning Has Been Met

The Internist Defendants argue that the present high/low agreements are bad faith agreements because the settlement amounts do not fairly reflect the amount of each party's pro rata fault. This argument is specious. In medical malpractice cases where liability is joint and several, as here, fault is never apportioned. *Fultz v Peart,* 144 Ill. App. 3d 364, 494

N.E.2d 212, 225 (5th Dist. 1986)(with suits against joint tortfeasors it would be improper for a jury to apportion damages based on any degree of relative fault). Because a guilty defendant is responsible for the *whole* of plaintiff's injury there cannot, by definition, be unfairness to the non-settling defendants no matter how much they may have to pay after verdict. *Best v. Taylor Mach. Works,* 179 Ill.2d 367, 423, 689 N.E.2d 1057, 1084 (Ill. 1997)(each joint tortfeasor is responsible for the whole verdict).

In the present case—just as there is in every case where one tortfeasor settles in a joint and several liability scenario—there are only two possible outcomes for the non-settling defendant: the defendant either wins and pays nothing, or he loses and is liable for *up to the whole* verdict. *Id.* There is no in-between, no apportionment amongst tortfeasors. The only relief from this result is *not* a rejection of the settlement agreement as the Internist Defendants argue, but a right to a set-off. *Johnson v. United Airlines,* 203 Ill.2d. 121, 784 N.E.2d 812, 817 (Ill. 2003).

Despite this, the Internist Defendants insist that the high/low agreements should be rejected, not seeing the irony of their request: if the high/low agreements were rejected, a loss at trial means that the Internist Defendants would still be liable for the whole verdict but would then not have the guarantee of a set-off that comes from a *pre-trial* settlement. This is true because nothing in the law requires Plaintiff to apportion damages amongst tortfeasors after a verdict. *See Best,* 689 N.E.2d at 1084. She can, if she chooses, collect her whole damages from whomever she wants. *Id.* For example, she could collect completely from the Internist Defendants alone and because the Internist Defendants have not filed for

contribution from their fellow tortfeasors, they would have no way of softening that result. A pre-trial settlement, however, gives the Internist Defendants a set-off. These high/low agreements thus actually help the Internist Defendants, not hurt them.[2]

Nonetheless, the Internist Defendants persist in arguing that the amount of the high/low settlements warrants their rejection. Although the Internist Defendants cite several cases where the amount of settlement is a factor considered in whether a settlement was reached in good faith, all of those cases were decided in a legal context where fault was apportionable. *See, Bowers,* 272 Ill.App.3d 606 (1 Dist. 1995)(a construction accident case); *Stickler*, 303 Ill.App3d 689 (1st. Dist. 1999)(a construction accident case); *Warsing,* 271 Ill.App.3d 556 (2nd Dist. 1995)(a construction accident case); and *Johnson,* 203 Ill.2d. 121 (Ill. 2003)(an air disaster case). While Plaintiff concedes that the language of "fault apportionment" is cited in medical cases, a close review of those cases shows that not a one of them actually apply it the way Internist Defendants would have this court apply it. *See, e.g., Johnson v. Belleville Radiologists*, 221 Ill.App.3d 100, 581 N.E.2d 750 (5th Dist. 1991); and *Pritchard v. Swedish American Hospital,* 199 Ill.App.990, 557 N.E.2d 988 (2nd Dist. 1990). Indeed, it is Plaintiff's position that taken together, the case law expresses, albeit in strained ways, the logical proposition that the amount of settlement should have *no* weight in a good faith analysis when liability is joint and several.

---

[2] The Internist Defendants also doesn't seem to see that the *high* portions of the high/low agreements give them protection from an excess verdict, protection they wouldn't have at all if these were straight settlement and dismissal agreements.

Nevertheless, even if it's assumed for the sake of argument that the settlement amount is somehow relevant, both high/low agreements in this case provide for substantial sums of money to be paid in order to cap the settling defendants liability—a healthy set-off of $1,750,000.00 to be precise. The Internist Defendants don't argue that this amount is nominal (and therefore suspect), only that it is inadequate. It is inadequate, they say, because they can imagine a jury verdict for ten million dollars. Let's assume that this is indeed a possibility.

Defendant Zwolski has one million in coverage and has agreed to pay half of that million now and three hundred and fifty thousand dollars later if he loses and the verdict is high enough. Even with a ten million dollar verdict, how much more do the Internist Defendants think Defendant Zwolski should pay in settlement? All of his coverage? If this view were accepted, then in cases where a verdict is likely to exceed available insurance coverage no defendant would be allowed to settle within policy limits lest they expose the non-settling defendants to greater liability. The Internist Defendants make essentially the same argument about Provena.

With Provena, the Internist Defendants are surprisingly frank when they characterize the hospital as the deep pocket. True enough. But then they go on to argue that as the deep pocket, Provena must not be allowed to cap its liability since to do so exposes non-settling defendants to potentially greater liability, thereby making the same argument they made about Zwolski. Under the high/low agreement with Provena, the hospital has agreed to pay Plaintiff one and quarter million dollars now and an additional seven

hundred and fifty thousand more if it loses and the verdict is high enough. Even with deep pockets and the possibility of a ten million dollar verdict how is this amount not good enough? Is there any amount good enough? Not surprisingly, the Internist Defendants don't cite law for these unique arguments against settlement. It's not surprising because Illinois law actually says the *opposite*:

> [A] party refusing to settle a case on agreed terms * * * always risks that he will be exposed to enhanced liability by that refusal. This is implicit in the very nature of a settlement: a party either compromises in return for the certainty of a fixed result, or gambles that he will obtain a more advantageous result by taking his case to trial, knowing that he risks losing by that gamble.

Johnson v. Belleville Radiologists, 221 Ill. App. 3d 100, 581 N.E.2d 750, 756 (5th Dist. 1991). The *Johnson* court when on to say that enhancing the liability of non-settling defendants is *not* bad faith.[3] *Id.* at 756-757.

While the Internist Defendants want the Court to stay focused on the possibility of a ten million dollar verdict and how that puts them at risk, another problem with this argument (other than the inappropriateness of even considering pro rata fault) is that predicting jury results can be a fool's game. Could a Will County jury award ten million dollars in this case? Sure, it's possible, but it's also possible that they could award only one million dollars, or even nothing at all. Indeed, the factors determining jury awards are unpredictable and myriad: the relative abilities of counsel, the appearance and potential

[3] The Internist Defendants also make the argument that these high/low agreements were reached for the purpose of forcing the remaining Defendants to settle. Even if this were true, it is not bad faith. *Johnson*, 581 N.E.2d at 755-756.

jury appeal of the parties, evidentiary rulings, the makeup of the jury, and the jury's attitude toward the type of the case involved. *Johnson,* 581 N.E.2d at 754. This is why courts have generally frowned on the use of the "ratio" method for testing a pretrial settlement for good faith. As one court put it, "[i]t is virtually impossible to use an unknown factor; i.e., the jury's verdict, to test good faith prior to trial." *Id.* at 752.

The point is no matter what possible verdict is reached, the settlements here are not nominal settlements, but substantial amounts of money that have a reasonable relation to the defendants available coverage and potential liability. Indeed, in considering the totality of the circumstances surrounding settlement it is apparent that these agreements were made in good faith. Certainly both of the Defendants are potentially liable under the facts of this case, and since they are jointly and severally liable for the entire loss, they have a legitimate interest in limiting this liability. Similarly, plaintiff knows that there is no such thing as a slam dunk, that any medical malpractice case can be lost, and thus has an interest in protecting against a defense verdict. So long as there is no fraud or other public policy implications, these high/low agreements are the perfect vehicles for protecting both side's interests and should be upheld.

2. These Agreements Are Not Mary Carter Agreements

Mary Carter agreements are high/low agreements with a twist in that they provide for repayment of the low *if* the verdict is high enough. *Banovz v. Rantanen*, 271 Ill.App.3d 910, 913, 649 N.E.2d 977, 980-981 (5th Dist. 1995). The problem with this arrangement is that where once the defendant would have fought to keep damages low, after settlement he

now works to make damages high. *Id. at* 913-915, 649 N.E.2d at 980-981. This realignment of incentive is a distortion from the norm and is prohibited unless disclosed to the fact finder. *Id.*

The present high/low agreements do not contain payback provisions and thus are not Mary Carter agreements. It is Plaintiff's position that the language of the agreements is clear on this point, and that in any event, as the Cardiology Defendants point out in their objection, Plaintiff and settling defendants have repeatedly stated their intentions clearly. *Robertson v. Belleville Anesthesia Associates,* 213 Ill.App.3d 47, 571 N.E.2d 1131, 1134-1135 (5th Dist. 1991) (it's permissible for court to accept the word of the attorney's as to the meaning of the agreement). Moreover, by their nature, the high/low agreements in this case preserve the defense motive to win, and if they don't win, to keep damages as low as possible. Indeed, it is only through a vigorous defense can either settling Defendant hope to avoid paying anything beyond the low. Thus, none of the concerns present in a Mary Carter agreement are present here.

Still, the Cardiology Defendants argue that despite the absence of a payback provision, and despite the incentive to keep damages low, the priority of execution proviso in the high/low agreements gives settling Defendants unnatural incentive to work against the non-settling defendants.[4] A review of the facts shows that this is simply not the case.

[4] The priority of execution provision provides that Plaintiff will collect any verdict in excess of the low from the non-settling defendants first, then Provena, and then finally Defendant Zwolski.

First, as should be evident by the depositions excerpts submitted, the settling Defendants were pointing fingers at the non-settling Defendants, and vice versa, long before these high/low agreements were negotiated. Indeed, the stated reason why the Cardiology Defendants have refused to settle was because they believed fault lied with Defendant Zwolski and the hospital, not with them. It is disingenuous at the very least to now argue that the settling Defendants had no intention of pointing the finger back at the Cardiology Defendants until they cut these high/low deals.

Nonetheless, even if the settling Defendants weren't already motivated to keep the non-settling Defendants in the case, the assumption underlying the Cardiology Defendants' argument is that a defendant's natural incentive is to work *for* a co-defendant. But this is false, and to see that it is false one need look no further than the objections filed by the Internist Defendants, who spend their entire brief arguing that the settling Defendants shouldn't be allowed to settle! Where in those arguments is the defense comity that hopes for a co-defendant's protection or release from liability that the Cardiology Defendants imply exists absent these high/low agreements? The truth is, in a joint and several world no defendant wants another defendant out of the case, lest there be one less wallet to share from.

As should be clear, any incentive that the settling Defendants may have to see that the non-settling defendants are held liable is an incentive created and existing outside of these high/low agreements, and thus not a consideration in this bad faith analysis. Indeed, even the priority of execution proviso that has raised the ire of the Cardiology Defendants

is a right the high/low agreements didn't create. As noted earlier, it has long been the law of Illinois that when liability is joint and several plaintiff has the right to execute her judgement in any order she wishes. *Best,* 698 N.E.2d at 1084 ("significantly, under this doctrine, the plaintiff may recover compensation for the full amount of the injury from any one of defendants responsible for the injury.") The fact that she formalizes these choices ahead of time as part of the high/low agreement cannot render the agreement one made in bad faith. *Jachera v. Blake Funeral Homes*, 189 Ill.App.3d 281, 545 N.E.2d 314 (1st Dist. 1989). The *Jachera* case involves a high-low settlement under very similar facts.

As here, in *Jachera,* the plaintiff entered into a high/low agreement where payment of the high was conditioned upon the plaintiff seeking satisfaction of any judgment beyond the low from co-defendants first. In *Jachera* pursuit of the co-defendant's money was to come from the plaintiff's good faith effort to prosecute whatever claims he had against the co-defendant's insurance companies before seeking the high. The remaining co-defendant complained that this provision was, on its face, bad faith. The appellate court disagreed, holding: "[The plaintiff's] right to pursue [the claims against the insurance companies] always existed, and was not created by the settlement." *Id.* at 287, 545 N.E.2d at 318.

The same is true here. The high-low agreements in this case did not create plaintiff's right to execute against whomever she wants and in any order—the law of Illinois did that—and it can hardly be bad faith for Plaintiff to exercise this right, even if non-settling Defendants don't the manner in which it is exercised. The agreements should be upheld.

3. The Settlements Are Divided Equally Between the Claims

Plaintiff and the settling defendants have the right to choose how settlements are apportioned amongst wrongful death and survivorship claims. *Johnson*, 581 N.E.2d at 756-757. While this apportionment is reviewable by the court, the non-settling defendants do not get a say on the matter. *Id.* Here, it was the settling parties' intention to split the settlements equally between the two claims. In this case there are substantial losses under both claims—one to two million in income loss, and the loss of society of four children, three of whom were minor at the time of death—and there is no rational basis to suggest that one claim deserves a higher percentage of contribution to it than another.

Although both the Cardiology and Internist Defendants seem to suggest that because this division is not stated in the Agreements, the Agreements must fail. This is not true. Ultimately, apportionment is within the sound discretion of this Court and its ruling will bind the parties. *Readel v. Towne,* 302 Ill.App3d 714, 706 N.E.2d 99, 102-103 (2nd Dist. 1999). As such, there is no need for the documents to state an apportionment amount; however, if the Court so required, the settling parties could easy amend the documents to conform with the Court's rulings.

Finally, the Cardiology Defendants want the apportionment decision postponed, deferred to the trial judge. Why the trial judge would be in a better position to decide apportionment than the present Court is unexplained. Perhaps they mean to argue that apportionment must await a verdict, but even then they do not suggest how such procedure is superior to the usual process.

The Cardiologist Defendants do not cite any authority for this novel proposition, and indeed, to postpone apportionment would harm the Plaintiff. Distribution of money to the next of kin differs under these claims. With survivorship claims, money must run through probate; wrongful death claims do not. Currently, a probate estate has been opened for the purpose of processing settlement money, and structured settlements have been arranged that have to be funded by July 15, 2012. Delay, especially delay without legal precedent or purpose would frustrate this process and put at risk the agreements themselves. Indeed, to allow the Cardiologist Defendants to impose this restriction is to grant them a power to affect settlements that the Contribution Act prohibits:

> [A]ppellant's argument would take from appellee and those in appellee's position the ability to settle their own cases, and would rather effectively place veto power over any settlement in the hands of the hardest bargainer. [I]t seems contradictory to allow one litigant to hold others hostage to its own intransigence.

Johnson, 581 N.E.2d at 756.

Accordingly, the Court should enter an order apportioning settlement equally between claims or in any way that the court deems just.

Respectfully submitted,

By: _____
William A. Cirignani

CIRIGNANI, HELLER & HARMAN, LLP
Attorneys for the Plaintiff
150 South Wacker Drive, Suite 2600
Chicago, IL 60606
312-346-8700
ID# 6211973

EXHIBIT 1

PROVENA Saint Joseph Medical Center
333 North Madison Street, Joliet, Illinois 60435

4222

Patient ID: DC0026793332
Patient Name: ELDER,JEFFREY Age: 43 Sex: M
Registration Date: 08/04/2008 0533
Chief Complaint: CHEST PAIN
Medical Record Number: DC01688027
Time Seen by clinician: 0530.

PREHOSPITAL CARE: The patient arrived via ambulance. The patient was treated according to EMS protocols. Refer to EMS run sheet for medications, dosages and/or additional care given.
The patient's condition upon arrival was fair.

HPI: The patient presents with complaints of waking up with chest pain. The patient says that he woke up with chest pain about an hour PTA. The patient says that it is a pressure that it radiating into the neck, is associated with shortness of breath, LH, sweatiness, and palpitations. The patient says that he has never had this before. The patient describes the pain as a burning. The patient says that he has not been having any abd pain. The patient has an odor of alcohol on the breath. The patient says that he has not been having and leg swelling, no calf cramping. The patient has a strong odor of alcohol on the breath, says that he was drinking last night. The patient says that the pain was a 9/10. The patient says that he has a 4/10 pain now after two NTG SL en route

PMH: denies

CURRENT MEDICATION: The nursing notes were reviewed.
ALLERGIES: The nursing notes were reviewed for patient allergies.

PFSH: The patient lives with their family. The patient lives in the local area. The patient is a non-smoker. The patient has no history of alcohol abuse. There is a family history of CAD on his father's side.

REVIEW OF SYSTEMS:
GENERAL: No fever or chills.
EYES: No significant pain or recent change in vision.
ENT: Ears: No significant earache. Nose: No significant discharge or epistaxis. Throat: No sore throat.
NEUROLOGICAL: No local weakness or significant headache. No recent change in level of function or speech.
CARDIAC: As noted above.
RESPIRATORY: No significant dyspnea, cough, or wheezing.
GASTROINTESTINAL: No significant abdominal pain, vomiting or diarrhea. No bloody stools or melena.
GENITOURINARY: No dysuria or hematuria.
MUSCULOSKELETAL: No significant joint pain or swelling.
SKIN: No rash or itching.

PHYSICAL EXAM: Vital Signs: The nursing notes were reviewed. The patient is alert and cooperative.
The patient appears to be adequately hydrated.
EYES: Pupils reactive. Conjunctivae pink. The sclera is anicteric.
OROPHARYNX: Mucous membranes are moist, the tongue is normal and the pharynx is benign.
LUNGS: Clear to auscultation and breath sounds equal.
HEART: Regular rate and rhythm. No murmurs, gallops or rubs.
ABDOMEN: Soft, nontender. No masses or hepatosplenomegaly.
NEUROLOGICAL: Alert and cooperative. Sensory and motor functions intact.
EXTREMITY EXAM: There is no calf tenderness.
There is no pedal edema.

DIFFERENTIAL DIAGNOSIS: MI, angina, PE, pneumonia, gastritis, esophagitis

LAB():
CBC: No clinically significant abnormality.
BASIC METABOLIC PANEL: No clinically significant abnormality.
CARDIAC ENZYMES: Reviewed enzyme panel, which was within normal limits.

X-RAY(1): CHEST: bilateral chronic pneumothoraces vs blebs, suggested CT CT CHest (no contrast) blebs, and possible dilated ascending aorta.
EKG: Rate: <100 Rhythm: normal sinus rhythm Interpretation: J point elevation V2-V4.
CARDIAC MONITOR: A cardiac monitor was attached and the patient's cardiac rhythm was continuously monitored. The tracings showed normal sinus rhythm as reviewed by the emergency physician.
PULSE OXIMETRY: The test was performed on room air.99% INTERPRETATION: within normal limits for this patient.

INTERVENTION:
OXYGEN: 2 liters, nasal cannula.
IV: normal saline.
MEDICATIONS: The patient says that he had 4/10 pain after the 2 SL NTG given PTA. The patient was given a GI cocktail and the pain went down further to a 1/10. The patient was given NTP, Lovenox .
CONSULT:. board call medicine was consulted by phone and will admit the patient.
CONSULT:. Cardiologist was consulted by phone and will follow-up with the patient in the hospital.

DIAGNOSIS: Chest (Thorax) Pain, 786.50

Possible Thoracic Aortic Aneurysm, 441.2

DISPOSITION:
ADMIT: The patient was admitted to a monitored bed. The patient's condition was stable.

Dr. Andrew Zwolski, M.D. 031
Mon Aug 04, 2008

ADDENDUM:
Called to the floor to see the patient . Pt in code blue , bradycardic no blood pressure . Pt in the process of transfer for aortic dissection but arrested prior to transfer . Pt intubated c 8-0 ett c good air exchange and bs bilaterl . Code care turned over to cardiology at the bedside .
Daniel J. Knight D. O. (4364)
Mon Aug 04, 2008 09:03 pm

PROVENA
Saint Joseph Medical Center
WE ARE BUILDING **EXCELLENCE**

DC0026793332 DOB: 04/19/65
ELDER, JEFFREY
Hussain, Ahmed M.D.

DC01688027
08/04/08
M 43
D01S0422-2

☐ **STAT**

DO NOT USE ABBREVIATIONS: U, IU, Q.D., Q.O.D., Trailing zero, Lack of leading zero, MS, MSO_4, $MgSO_4$

DATE & TIME	PROGRESS	DATE & TIME	PHYSICIAN'S ORDERS
	Date: _____ **Time:** _____		**Date:** _____ **Time:** _____
	Generic substitute will be dispensed unless otherwise specified		Patient Status: ☐ Admit as an Inpatient ☐ Place in Observation ☐ Medical/Surgical Bed ☐ ICU Bed ☐ Telemetry Bed ☐ Isolation ☐ Other _____
	Allergies:		8/4/08 0930 no allergies 23 hr observation Cardiac enzymes x 2 q 6h Cardiac diet Act as tol 1st dose PRN Morphine 1 to 2 mg q 3h prn Heart Card Consult. T.O. Dr Hussain
			8/4/08 10:15 1. give Morphine 2mg IVP q 3h/PRN for severe pain 2. give morphine 1mg IV. q 3h/PRN for moderate pain T.O Dr Hussain / Glenn 8/4/08

EXHIBIT 2

very common reading whatsoever in order to discuss, you know, how can we get more information about what this etiology is that you've specified here in your report, and we talked and we found at that time noncontrast CTs since we were looking at lung pathology would be adequate.

Q. In fact, in the X-ray report, the radiologist suggests CT of the chest to further characterize what was going on; is that right?

MS. SWATEK: Where is that?

MR. CIRIGNANI: If you go to the pink tab, it would be the first document.

MS. MITCHELL: If you give me the page number for that?

BY MR. CIRIGNANI:

Q. Page 742 of Group Exhibit Number 2.

A. Yes. What you just said is true.

Q. In any event, you ordered the CT scan, and that revealed a dilated ascending aorta, correct?

MS. SWATEK: Do you have the page number for that?

BY MR. CIRIGNANI:

Q. Sure. It's right following that one.

A. Yes.

Q. And you understood that one of the possible diagnoses from that CT scan result was an aortic dissection, correct?

A. Among the possibilities.

Q. I understand. You also understood that the radiologist had recommended a CT with contrast to determine the specific cause of the dilated aorta, correct?

A. Yes, that's documented here.

Q. According to the CT scan report, the one that you're looking at, the results of the CT scan were discussed with you, correct?

A. Yes, they were.

Q. The report says that the results were discussed with you at 6:55 AM. First off, that's what the report says, right?

A. Yes.

Q. Do you have any reason to disagree with that time?

A. No.

Q. Was this the first time, 6:55 AM, that you heard the results of the CT scan?

MS. SWATEK: Or saw the results?

BY MR. CIRIGNANI:

Q. Let me strike that. Let me start over. Was this the first time that you became aware of the results of the CT scan?

A. I don't know.

Q. Was there any other way?

A. The reason why I specify I don't know is because pneumothoraces or pneumothoraxes where the lungs are partially collapsed is a situation that also sometimes, even though it says chronic, but a pneumothorax sometimes may be life threatening in and of itself.

A pneumothorax also is something where it needs to be treated usually using thoracotomy or decompression of the space, sometimes using chest tubes, which is a procedure that I would have to do in the emergency room; so I'm not sure if I might have looked at the scan before I heard

the radiology call me back with the results or not just for my own assessment saying wait, are these big pneumothoraxes that I might just tell the nurses to start getting the equipment together to do this.

I don't know. I might have reviewed the CAT scan on my own beforehand, you know, or this might have been the first, but my guess is that I probably reviewed it beforehand just because I would have had the heads-up trying to see if there was further procedures that I had to do right then and there so --

Q. All right. Let me see if I understand what you told me. We know based upon the records that you had a conversation about the results of the CT scan with Dr. Fagan at 6:55 AM, right?

A. Yes.

Q. But it's possible per your custom and practice in situations like this that you may have actually looked at the CT scan itself prior to hearing what the radiologist's interpretation was, right?

A. With my own less than expertise, I, yes.
Q. I understand. I understand that. But that would have given you some information prior to talking to Dr. Fagan? That's the only thing I'm trying to get at.
A. True.
Q. Okay. In your phone conversation, I presume that -- strike that.
It says the discussion with Dr. Zwolski at 6:55. Was that by phone or in person?
A. It would be by phone.
Q. Okay. I assume in your phone conversation with Dr. Fagan you discussed the possibility of an aortic dissection; is that fair?
A. I don't recall.
Q. Okay. But as we talked about earlier, given the results of a dilated aorta, an aortic dissection was on your list of possible conditions causing it, right?
A. Yes, that then becomes part of the differential.

Q. So you understood that it was possible that Mr. Elder was a medical emergency at that point?
A. You know, I think at the time, you know, considering the patient's reasonably stable condition at the time of getting the test and stuff like that and his course during the emergency room, you know, the other possibilities still being entertained, that, yes, that was among the possible diagnoses, although still other diagnoses were very possible as well, such as an aortic aneurysm that might have been long-standing. It could have been a chronic issue in and of itself.
Q. But you had no way as you're sitting there -- strike that.
You had no way at the time that you were treating Mr. Elder to know whether it was a chronic, long-standing, or emergency dissection; is that fair?
A. Without prior comparison tests and stuff like that that would have established that that was there, I would not have been able to know if it was chronic or acute, although it's still possible either way.

Q. Certainly the symptomatology was acute, right?
MS. SWATEK: I object to form.
THE WITNESS: What do you mean by acute?
BY MR. CIRIGNANI:
Q. He had no history of this type of chest pain before. He came in with acute, sudden experience of chest pain that caused him to come in?
A. He came in with a new complaint, yes.
Q. So as far as the signs and symptoms go, that was acute, right? You knew that?
A. The signs and symptoms were new.
Q. Okay. All right. So sudden appearing does not qualify to -- strike that. Acute -- strike that.
I use the term acute to mean sudden. Do you mean it to mean something else?
A. Yes, I think honestly a lot of

people use acute rather loosely, you know, an acute pneumonia versus a chronic pneumonia. An acute would be just a more recent one versus chronic where it's a long-standing process.
Q. Fair enough. But other than comparing previous CTs or X-rays that may or may not have --
A. Or prior history.
Q. -- or prior history?
A. Known prior history.
Q. Another way beyond comparing prior history or old CTs or old X-rays to determine whether or not you're dealing with an acute dissection versus a chronic aneurysm would be to do a CT with angio, correct?
A. Yes.
Q. And, in fact, in response to the CT results, Dr. Fagan recommended CT angiography, correct?
A. Yes.
Q. What else did you and Dr. Fagan discuss during the phone conversation?

A. I don't have any specific recollection.
Q. Okay. So as you sit here today, do you have any recollection of discussing the possibility or using the terms aortic dissection?
A. Not specifically.
Q. You understood that the dilation of the aorta was in the ascending portion of the aorta, correct?
A. Let me look back. Yes.
Q. All right. Okay. Just so that I don't miss anything, is there anything else that you can recall as you sit here regarding your conversation with Dr. Fagan?
A. I know where I was sitting in the emergency room, but aside from that, not from the contents of the conversation, no.
Q. I'm focusing on the content of the conversation.
A. Nothing as far as the content of the conversation.
Q. All right. You, in fact, ordered a CT angiography for Mr. Elder, correct?

A. Yes, yes.
Q. If we look at the physician order tab, blue, dark blue, the first document, it says physician orders?
A. Yes.
Q. In fact, above that it says ED physician admission orders, correct?
A. Yes.
Q. Regardless of what the title of the document is, your signature is in two spots on it. These are your orders, correct?
A. Yes.
Q. And one of the orders you wrote in the middle of the page and circled is CT angio of chest. Rule out aortic aneurysm. I believe it says once in room. Did I read that correctly?
A. Yes.
Q. And then that's your initials AZ there, right?
A. Yes.
Q. Okay. That's an order for a CT angio of the chest, is it not?
A. Yes.

Q. And it's fair to say that you specifically ordered the CT to rule out an aortic aneurysm or an aortic dissection, correct?
A. Essentially the reason for that phrase in this context, rule out aortic aneurysm, that is calling attention to that area for the technicians, for nurses, for the radiologists, specifically for them to focus on that part of the chest and that part of the anatomy because that's where we want answers.
Q. Okay. I mean, but one of the things that you had in your mind as an emergency room doctor on your list of differential diagnoses is aortic aneurysm or aortic dissection, right?
A. Yes.
Q. So it's reasonable to write out rule that out, look here to see what's going on there, right?
A. Yes.
Q. Okay. Now, this document says that you gave the order for the CT with angio at

6:30 AM, right?
A. I wrote the order at about that time, yes.
Q. And that was before you talked to Dr. Fagan, correct?
A. That would lead me to believe that maybe I did look at the noncontrast CT at the time.
Q. That was going to be my next question. It's fair to say that you already had put aortic dissection on your list of possible causes before you even heard from Dr. Fagan regarding the CT scan results, right?
A. Dissection/aneurysm, yes.
Q. Okay. For our purposes, though, the CT scan with angio would have uncovered a dissection or an aneurysm, correct?
A. Yes.
Q. So, regardless, in your mind, one of the things you were concerned about is is that there was blood going into the layers of the aorta, right?
A. It was one of the concerns.

Q. I understand that. But that was one of the reasons why even before talking to Dr. Fagan you ordered the CT with angio; is that right?
A. Yes.
Q. Okay. When did you expect the order for the CT with angio to be completed?
A. Well, this document here is normally yellow in color is what we fill out once we try and start moving the patient on to care -- further care up on the floor. It's a three-hour order sheet with the intention that these orders will be carried out within the next three hours.
This is an order sheet which is -- it's used as like a bridge between the emergency orders in the emergency room and then further orders that are given by the admitting physicians once they're on the floor, so it's -- the intention is to be like a bridge between the two.
Q. Okay. So is it fair to say then that your expectation was that the CT angio would be completed within three hours of

writing that order?
A. The CT angio itself would be completed by then?
Q. Yes.
A. Ordered at least by then.
Q. Well, I'm completely confused. If this is a three-hour order sheet, it's not taken -- it doesn't mean that you're given three hours in which to write orders, does it? It means three hours to get the orders done?
A. No, no, no. No, orders in the intention that within three hours this is going to be an order that is entered in the computer, and at least the patient is on his way getting it done, such as the same way as let's say, for an example, let's say the admission for a GI bleed and anemia. Okay? I would put a three-hour order for transfuse two units of blood if the blood was too low.
Truly within reason putting in that much blood as long as a patient is stable over an hour or two, you know, could actually cause some harm. At least the --

the procedure itself, the study, whatever else, at least it would be entered so that it's at least initiated by the end of those three hours.
Q. Okay.
MS. SWATEK: We're going to take a break.
THE VIDEOGRAPHER: Pardon me, Bill. I'm sorry. We're going to need to do it anyway in that we're at the end of the tape as well, so this will be the end of tape number 1. We're going off the record at 1:56 PM.
(Whereupon a short break was had from 1:56 PM to 2:02 PM.)
THE VIDEOGRAPHER: Good afternoon. We're going back on the record. This will be the beginning of tape number 2. It is 2:02 PM. Please proceed.
BY MR. CIRIGNANI:
Q. Doctor, my question to you had been when did you expect your order for a CT angio to be completed, and I meant CT actually done and interpreted, and it's my

understanding that your expectation was that the CT angio order would be entered and the start of the process to getting it done sometime within the three hours, right?
A. No. When this document arrives on the floor with the patient, you know, this is seen by nursing staff, this is seen by unit secretaries, and when this arrives on the floor, it gives them a guidance as to what the next step is, so I would assume that very soon after arrival to floor orders are getting entered.
Q. All right. So let me ask the question again then: When did you expect your order for the CT angio to be completed?
A. To be completed within an hour or two of them getting to the floor because this should have been entered immediately.
Q. When you say it should have been entered immediately, you mean the order for the CT angio should have been entered immediately once the patient got to the monitored bed or to the floor where he was being admitted to?

EXHIBIT 3

Q. And that's generally because they're in the best position to make judgments about the patient; wouldn't you agree?
A. Yes.
Q. You'd agree that a doctor's judgment is never allowed to needlessly endanger that patient, correct?
MS. SWATEK: I'm going to object to form again.
THE WITNESS: That a doctor's judgment is never allowed to needlessly endanger, would that -- are you trying to tell me that there might be someone who might say, no, Doctor, we're not going to do that?
BY MR. CIRIGNANI:
Q. No. Just as a physician, when you're making judgments, the judgments that you make are not allowed to needlessly endanger a patient; wouldn't you agree?
MS. SWATEK: I'm going to object as an incomplete hypothetical and a mischaracterization of the law. You can

answer, if you can.
THE WITNESS: Yes. The question honestly confuses me. It doesn't allow doctors to? The judgments that we make in the emergency room there's -- as I make those decisions on my patient, there's not someone there saying stop, we're not going to do that.
BY MR. CIRIGNANI:
Q. Well, presumably yourself is what I'm talking about. I'm not talking about other people stopping you. I'm talking about you.
A. I am my own judge, admittedly.
Q. Can you think of a situation where you would needlessly endanger a patient of yours?
A. No.
Q. So even when using your bedside judgment, you'd agree that as a physician you should not be needlessly endangering your patient; would you agree?
A. I try the hell -- I'm sorry. I try the heck most not to, yes.

Q. Doctor, you'd agree that an acute ascending aortic dissection is a medical emergency, correct?
A. Yes, it is.
Q. And you would agree that thousands of people die every year from aortic dissections, correct?
A. I wouldn't know the numbers.
Q. You'd agree that the reason it's a medical emergency is because if the dissection is not repaired, the patient could die, correct?
A. That's known to happen, yes.
Q. And, in fact, it often happens very quickly after the dissection develops; wouldn't you agree?
MS. SWATEK: Objection, foundation.
THE WITNESS: That I don't know, but it is thought to be an emergent situation that has to be resolved as quickly as possible.
BY MR. CIRIGNANI:
Q. You would agree that as a general rule emergency room doctors must know which

medical conditions can kill quickly, if not treated right away, right?
A. Yes.
Q. For example, a doctor must know that a cut to a carotid artery can kill quickly if not treated right away, right?
A. Yes.
Q. I think in this case -- strike that. I'll leave that alone. And you would agree that in such cases a doctor must do everything he reasonably can to treat his patient in time to deal with that condition before it hurts them, right?
A. Yes.
Q. When it comes to diagnosing patients, guessing at a diagnosis is not allowed, correct?
MS. SWATEK: I'm going to object to relevance and misstating the law with this line of questioning as well as form.
MR. SCHULTZ: Join.
MS. MITCHELL: I'm going to join in form.
THE WITNESS: A lot of guessing

EXHIBIT 4

A. E 000690.
Q. First off, when we're looking at that page, that's a computerized document, right?
A. Correct.
Q. I take it that that's -- the information that's contained in that document is information that is put in by nurses or doctors who are in the emergency department taking care of the patient for whom this document applies?
A. This document is strictly RN based, RN driven.
Q. Okay. This document is page 5 of 5 pages. It's called EDM patient record.
A. Correct.
Q. What does EDM stand for?
A. Emergency department --
Q. I don't know either. I figured the first two.
A. Meditech.
Q. But the EDM patient record is a portion of the patient's chart where the input is from the nurses only; is that

right?
A. Correct.
Q. Okay. And the input is via a computer terminal of some sort?
A. Correct.
Q. And then what we have before us is a printout from whatever is put into the computer; is that right?
A. Correct.
Q. Okay. And you're pointing me to page 690 which is the fifth page of that EDM patient record. Tell me what you were going to show me.
A. The significance is my -- if you look under patient notes in the center and it's entered by me at 6:38 AM, August 4th, 2008, to CT scan per cart.
Q. Okay.
A. So that means he's off the unit in the CAT scan.
Q. All right. Looking at patient notes, there's one that says in X-ray and that's at 05:53, right?
A. Correct.

Q. So at 5:53 in the morning, he was getting a chest X-ray, correct?
A. Correct.
Q. Did that take place in the emergency department?
A. It's -- yes, it's in our department.
Q. Portable chest X-ray machine or is there just a separate room?
A. He went to the department. He actually went to the department which is on our unit. He didn't like leave -- exit any doors out of the unit to go to X-ray.
Q. So when you say our unit, you mean the emergency department unit?
A. Correct.
Q. And as part of the emergency department unit at Provena Saint Joseph's Medical Center, there is a room that is capable of taking chest X-rays?
A. Correct.
Q. Or the equipment's in there for that purpose that allows people to do it, correct?

A. Correct.
Q. And that's where he went for his chest X-ray?
A. Correct.
Q. So he never left the emergency department for the chest X-ray?
A. Correct.
Q. But for the CT scan, he would have had to have left the room?
A. Well, he left the room for X-ray. He left his physical room.
Q. His physical room within the ER?
A. Within the ER.
Q. Okay.
A. And then he went to X-ray at 5:53, and then at 6:38 he went to CAT scan which is in our ER department he had to leave his room to go to, but it's physically on our department. We have our own CAT scan department.
Q. Very interesting. Okay. Let's break -- I'm trying to make sure you and I have the terminology the same so when we talk about this it makes sense.

When you talk about room, we're talking about a small cubicle size space with a bed where the patient is kept inside what would be the broader emergency department, right?
A. Correct.
Q. Okay. Inside the broader emergency department, there are rooms for patients, right?
A. Correct.
Q. Then there's probably, I'm guessing, an examination area or, I'm sorry, a place for nurses or nursing center?
A. The nurses' station.
Q. Station. Thank you. That's the word I was looking for. But in addition to that, what I hear you telling me is there are also separate rooms -- one for X-ray, and there's a separate room for CT scans, correct?
A. Correct.
Q. Okay. So that if a patient whose part of the emergency department needs a chest X-ray, he may have to leave his room,

but he doesn't have to leave the emergency department, true?
A. Correct.
Q. He's -- how far is the -- generally speaking, how far are the, for example, the room that contains the CT scan machine? How far is it from where the patients are kept in their rooms?
A. Depending on where their room is at.
Q. Okay. Give me a sense of what the longest it would be. I mean, how many minutes would it to take to transport a patient from an ER room to a CT scan room?
A. 30 seconds.
Q. Okay. So not very long?
A. No.
Q. Okay. All right. Okay. So when this note says that he is to CT scan per cart, what does cart mean?
A. He's on our ER cart. He wasn't ambulatory. He wasn't in a wheelchair. He was on our ER cart transferred to their department.

Q. So to get a CT scan, he never left his bed, the bed was rolled into the CT scan room?
A. Correct.
Q. Okay. And he was in the CT scan room then at 6:38?
A. Correct.
Q. Okay. So let's go back to -- I don't know if we need to go back to it, but I had asked you why you looked at the CT scan itself, and you had told me something about that was the time at which he was being endorsed over or something?
MR. SCHULTZ: And just so we're clear, the report. You said the CT scan.
BY MR. CIRIGNANI:
Q. Did I? I apologize. CT scan report. I take it you never looked at the CT scan itself?
A. No, sir. I was at home already by then.
Q. Okay. Is that something that you would typically do as a nurse anyways, look at the actual scans?

A. If it's something that is visible to my naked eye, I would be curious and look it up.
Q. But as far as your responsibilities professionally, that's not something that you as a nurse would undertake, fair?
A. Correct.
Q. So obviously what I think is going on is that there's a shift change, and you are actually leaving the emergency department, and you're finishing your shift and endorsing or transferring patients over to another nurse at a time when Mr. Elder is getting a CT scan?
A. Correct.
Q. Did you -- would you have wheeled Mr. Elder over to the CT scan room?
A. I have transferred patients to the CT room, but in this specific case, I did not that I recall. I did not.
Q. Let's talk about that for a second. Obviously you had an opportunity to treat a patient by the name of Jeffrey Elder, correct?

foundation. I'm going to ask you something:
BY MR. CIRIGNANI:
Q. As an emergency room doctor, do you believe that you have the training and qualifications to answer the question as to what treatment is needed for an acute aortic dissection?
A. What treatment is needed?
Q. Yes.
A. The treatment that's needed is surgery.
Q. So you know that?
A. True.
Q. And that's something you learned in medical school, I presume, or somewhere in your training; is that right?
A. Right, yes.
Q. And you'd agree that the surgery that's needed is emergency surgery, correct?
MS. SWATEK: I will object to foundation and incomplete hypothetical in that situation.
THE WITNESS: Yes.
MR. CIRIGNANI: Thank you.

BY MR. CIRIGNANI:
Q. You were first contacted about Mr. Elder at 5:30 AM on August 4th, 2008, correct? That's the time that I have. Now, let me just pause and say this: I have tabs on the records so if you turn to the yellow tab that says emergency room, you should be able to find your records. They may not be in the order that you're used to seeing them, but if you flip through there, you will be able to find them.
A. I got it.
Q. The time seen by clinician, 5:30 AM; does that seem right to you?
A. Yes.
Q. You knew at the time that you saw him that his chief complaint was chest pain, correct?
A. Yes.
Q. Patients with chest pain trigger a particular assessment protocol at Provena; isn't that right?
A. We do have a chest pain care map, if that's what you're referring to.

Q. That's exactly what I'm referring to. In fact, I think Provena uses -- it's the care map system, right?
A. I don't know the specific name. I just know the care map system, yes.
Q. Fair enough. If you turn to page 694 of that same section --
A. I'm there.
Q. -- that's the care map document that lists the protocol that would typically occur with a patient who comes into the emergency room complaining of chest pain; is that right?
A. Yes.
Q. Under this system, the assessment of a patient's chest pain begins with the nurses even before you see the patient, right?
A. Yes.
Q. Now, the reason that this protocol is triggered is because chest pain can be a sign of a condition that can be quickly fatal; agreed?
A. I don't think that's the sole

intent, but I think that's among the intentions.
Q. Okay. Now, an IV line would have been inserted in Mr. Elder before you even saw him, correct, by the nurses?
MS. MITCHELL: Objection, foundation.
THE WITNESS: Not necessarily.
BY MR. CIRIGNANI:
Q. In this case according to your records, an IV with saline was inserted in the emergency department, right?
A. Well, I know that it was. I'm just not sure of the time. Actually, it says prior to admission here, I'm sorry, if you look at page 695 at the bottom.
Q. So PTA, and you're talking now about a box that says time IV solution, size, type, et cetera, there, right?
A. Yes.
Q. And it says PTA prior to admission. So at some point in the emergency department he received an IV line; is that fair?
MS. SWATEK: I'll object.

Mischaracterization of testimony.
MS. MITCHELL: Join.
BY MR. CIRIGNANI:
Q. Well, do you mean prior to admission to the emergency room?
A. PTA is commonly used for prior to admission or prior to entry, so this would be honestly something that EMS would have done in the field.
Q. Admission has two potential meanings here. It means admission to the emergency room when EMS drops him off or admission to the hospital, and under your understanding of the record, when it says PTA is that it would have been inserted prior to coming to the hospital at all; is that right?
A. Yes.
Q. Okay. Now, we talked about this a bit earlier. One of the conditions that you looked for and tried to rule out with Mr. Elder was a myocardial infarction, correct?
A. Tried to work up because in truth a

workup for a myocardial infarction sometimes is not complete in the emergency room.
Q. Okay. But in this situation, the things that you did reasonably ruled out myocardial infarction in Mr. Elder; is that true?
A. No.
Q. Okay. Do you believe that Mr. Elder had a myocardial infarction?
A. No, I don't.
Q. All right. And you don't based upon the information that you gained during your course of treatment of Mr. Elder; is that right?
A. No. The reason why I know that, and I'll be specific about this, is for a myocardial infarction, it is possible that all of our initial testing is negative that takes place in the emergency room. Six, eight hours later repeat cardiac enzymes may actually show that there was, in fact, some heart damage, so that might actually be a diagnosis that takes place up on the floor; so, you know, commonly, my common practice

with patients, I don't tell them that no, you have never had a heart attack and no, you don't have one right now. I say it's still a possibility, although our tests thus far look good.
Q. Okay. Fair enough. Besides a myocardial infarction, you had listed on your differential diagnosis list angina, PE, which I presume to be pulmonary embolism?
A. Pulmonary embolism.
Q. Pneumonia, gastritis, and esophagitis; is that right?
A. Yes.
Q. Now, one of the tests that you ordered presumably in an attempt to try to figure out what was going on with Mr. Elder was a chest X-ray; is that right?
A. Yes, it was.
Q. Okay. Tell me why you ordered the chest X-ray.
A. Chest X-ray is a physical way to try and take a look -- it's a modality trying to take an early look inside the chest to see if there might be anything that

might be apparent that would indicate what the source of the problem might be.
Q. Was it intended to look for or confirm or rule out any of the specific diagnoses you had listed there?
A. No.
Q. No. Okay. In any event, the chest X-ray report showed possible chronic pneumothoraces. I don't know how to say that.
A. Pneumothoraces, yes.
Q. And from my general reading of the medical records apparently, and this may not be the case and you can tell me, that led you to order the CT scan of the chest; is that right?
A. That result came back from radiology.
Q. Which result?
A. The X-ray, chronic pneumothoraces, and I do remember in this specific case calling radiology, and just for clarification, that's a little bit of an unusual reading. You know, that's not a

Q. I understand that. But that was one of the reasons why even before talking to Dr. Fagan you ordered the CT with angio; is that right?
A. Yes.
Q. Okay. When did you expect the order for the CT with angio to be completed?
A. Well, this document here is normally yellow in color is what we fill out once we try and start moving the patient on to care -- further care up on the floor. It's a three-hour order sheet with the intention that these orders will be carried out within the next three hours.
This is an order sheet which is -- it's used as like a bridge between the emergency orders in the emergency room and then further orders that are given by the admitting physicians once they're on the floor, so it's -- the intention is to be like a bridge between the two.
Q. Okay. So is it fair to say then that your expectation was that the CT angio would be completed within three hours of

writing that order?
A. The CT angio itself would be completed by then?
Q. Yes.
A. Ordered at least by then.
Q. Well, I'm completely confused. If this is a three-hour order sheet, it's not taken -- it doesn't mean that you're given three hours in which to write orders, does it? It means three hours to get the orders done?
A. No, no, no. No, orders in the intention that within three hours this is going to be an order that is entered in the computer, and at least the patient is on his way getting it done, such as the same way as let's say, for an example, let's say the admission for a GI bleed and anemia. Okay? I would put a three-hour order for transfuse two units of blood if the blood was too low.
Truly within reason putting in that much blood as long as a patient is stable over an hour or two, you know, could actually cause some harm. At least the --

the procedure itself, the study, whatever else, at least it would be entered so that it's at least initiated by the end of those three hours.
Q. Okay.
MS. SWATEK: We're going to take a break.
THE VIDEOGRAPHER: Pardon me, Bill. I'm sorry. We're going to need to do it anyway in that we're at the end of the tape as well, so this will be the end of tape number 1. We're going off the record at 1:56 PM.
(Whereupon a short break was had from 1:56 PM to 2:02 PM.)
THE VIDEOGRAPHER: Good afternoon. We're going back on the record. This will be the beginning of tape number 2. It is 2:02 PM. Please proceed.
BY MR. CIRIGNANI:
Q. Doctor, my question to you had been when did you expect your order for a CT angio to be completed, and I meant CT actually done and interpreted, and it's my

understanding that your expectation was that the CT angio order would be entered and the start of the process to getting it done sometime within the three hours, right?
A. No. When this document arrives on the floor with the patient, you know, this is seen by nursing staff, this is seen by unit secretaries, and when this arrives on the floor, it gives them a guidance as to what the next step is, so I would assume that very soon after arrival to floor orders are getting entered.
Q. All right. So let me ask the question again then: When did you expect your order for the CT angio to be completed?
A. To be completed within an hour or two of them getting to the floor because this should have been entered immediately.
Q. When you say it should have been entered immediately, you mean the order for the CT angio should have been entered immediately once the patient got to the monitored bed or to the floor where he was being admitted to?

A. As soon as it, yes, is possible being that this is the item that the floor uses to guide their care at the time.
Q. When you say this is the item, you are talking about the document that's called physician orders or ED physician admission orders, right?
A. Right.
Q. Okay. So it's your expectation that the CT angio would have been completed an hour or two after the patient got to the floor; is that right?
A. Barring technical difficulties with the CAT scanner going down, you know.
Q. Assuming all things equal.
A. Assuming it's done as efficiently as possible, that's reasonable.
Q. The term stat means to do something without delay, correct?
A. Yes.
Q. You could have ordered the CT angio stat if you had wanted to, right?
A. I could have written that as well.
Q. All right. Beyond writing it, you

could have ordered that it be done stat which is without delay, correct? We'll talk about the reasons.
A. Yes.
Q. Let me just ask the question again because I talked over you, and I apologize. You could have ordered the CT angio done stat, without delay, correct?
A. Yes.
Q. Okay. Dr. Fagan in his deposition said that a patient who already has an IV line -- strike that.
Dr. Fagan said that with a patient who already has an IV line in place he can do a complete CT angio up through interpretation in 45 minutes to an hour. Do you have any reason to dispute that?
MS. SWATEK: I'll object to incomplete presentation of testimony.
THE WITNESS: The only way that I would further specify that, that is, that any delay in getting the patient into the radiology suite where they can get that done, you know, yes.

BY MR. CIRIGNANI:
Q. Fair enough. Okay. If you had ordered a CT stat -- strike that.
If you had ordered the CT angio to be done stat, you'd agree that its results would have been known no later than 8:00 AM, right?
MS. SWATEK: I'm going to object. Incomplete hypothetical.
MR. SCHULTZ: Join.
MS. MITCHELL: And calls for speculation.
MS. SWATEK: Join.
THE WITNESS: Yeah, I don't know.
BY MR. CIRIGNANI:
Q. What don't you know? I mean, if it takes 45 minutes to an hour for him to read it from beginning to end and you order it stat without delay, presumably the patient would be transferred to radiology, how long does it take to get to radiology?
A. Well, you'd still have to, you know, first of all, the delay in the orders being processed, the delay in the order

actually being realized by the radiology department.
By the time the tech there clears the table for the next patient, you know, there's a lot of variables, so even a stat study, there's a lot of variable still where timing is not absolute.
Q. Okay. So at Provena Hospital a stat order can be delayed by how long?
A. I wouldn't know.
MS. SWATEK: I would object to speculation and incomplete hypothetical.
MR. SCHULTZ: Join.
BY MR. CIRIGNANI:
Q. I mean, just tell me. A stat radiology order, how long in your experience at Provena Hospital are stat radiology orders often delayed?
A. It's variable.
Q. Okay. Give me a sense. What is the longest you've seen?
A. It would be a guess in truth. I have had it before --
MS. SWATEK: I will object to this

EXHIBIT 5

an hour and a half?
MS. SWATEK: I'll object to speculation. If you can answer, go ahead.
MR. SCHULTZ: Join.
THE WITNESS: I can't answer. I don't know.
BY MR. CIRIGNANI:
Q. Why didn't you order the CT angio stat?
A. The reason why I didn't order it as a stat, you know, I think it's a combination of factors. I think it was knowing the patient's seemingly stable clinical course in the emergency room, also assuming that it would have gotten entered as soon as the patient was up on the floor which there wasn't going to be too much more delay until that actually happened, and also, you know, also assuming that there would be, you know, adequate oversight from the cardiology group and even maybe Dr. Hussain too.
Q. Okay. Okay. So the reasons that you didn't order the CT angio stat was one, Mr. Elder appeared seemingly stable,

correct?
A. Yes.
Q. Two is that your assumption was that the order would be entered when he got to the floor right away -- strike that. Let me rephrase that.
Two is that your assumption was that the order would be entered right away once he got to the floor, right?
A. Yes.
Q. Three is your assumption was that there would be somebody else caring for Mr. Elder including Dr. Hussain or somebody from the cardiology group that would provide oversight, correct?
A. Yes.
Q. Is there any other reasons why you didn't order it stat?
A. Not that I can recall.
Q. While in the emergency room, you consulted with two other doctors, correct? Let me show you the page I'm looking at for that information. If you go back to the emergency room records, go right to the

first document that's typed.
A. Yes.
Q. Turn to the second page which is page 684 of Group Exhibit Number 2.
A. Yes.
Q. And under medication it says consult colon, and then another one says consult colon; do you see that?
A. Yes.
Q. The first consult says: Board call medicine was consulted by phone and will admit the patient, right? That's what it says?
A. Yes.
Q. Can you tell me what that means?
A. Board call medicine would be family practice or internal medicine, a physician who was on call to take unassigned patients, meaning patients who come into the emergency room and they don't have their own private physician, and yet the person needs a physician obviously to help coordinate their care and therefore an intern, that would be Dr. Hussain, he was the one who was assigned

for whatever that time frame was that this admission was called in to.
Q. So that would have been Dr. Hussain, correct? That's the person you would have spoken to?
A. I didn't specify here, but I understand that's who it was.
Q. Okay. Do you have any recollection or can you tell from the records what time that call was made to the internal medicine department to have Mr. Elder admitted?
A. No.
Q. Can you recall what was said to the internal medicine department in order to get him admitted -- what you said?
MS. SWATEK: I'll object to mischaracterization of testimony.
BY MR. CIRIGNANI:
Q. All right. Let's stop for a minute. I assume when it says consulted by phone, that's you making the consultation by phone; am I incorrect?
A. You're not incorrect.
Q. Okay. So if you pick up the phone,

you call the internal medicine department, you say I need a patient of mine here in the emergency room admitted to the hospital, what do you tell them?
A. I'm not talking to the department in general. I'm talking to the physician himself.
Q. So you're talking to Dr. Hussain. What do you tell Dr. Hussain or what did you tell Dr. Hussain in this case?
A. Specific recollection, what I commonly do, though, honestly, is that this whole medical record here that we see, my note, my common practice honestly is to tell him the contents of that, you know. Also to tell him too where we stand in the workup as far as what's been done so far, what's still yet to be done, the thought processes as far as possible diagnoses in order -- you know, in order to give him a grasp as far as what's going on with the patient.
Q. Okay.
A. Yes.
Q. When you say you tell him what's in

these notes, you're talking about the typewritten pages which is pages 683 and 684?
A. Yes.
Q. Okay. By the way, just a small digression, at the top it says X-ray chest; do you see that?
A. X-ray chest, yes.
Q. At the top of the second page?
A. Yes.
Q. Okay. And then it says at the end of that sentence and possible dilated ascending aorta, right?
A. Yes.
Q. You'd agree that it wasn't possible, it was a confirmed dilating ascending aorta, right?
A. Yes.
Q. So that's not correct when you wrote possible there, right?
A. Yes, no, yes. Yes, dilated ascending aorta would have been sufficient without using the word possible.
Q. All right. So if I understand

correctly, you don't have any specific recollection of what you told Dr. Hussain in this case except that your custom and practice would be to give a summary version of what's contained in the notes that we talked about on page 683 and 684; is that right?
A. Commonly these conversations would be about as long as it takes for me honestly to have read off this because I tend to be rather detailed.
Q. Would you literally read him your notes?
A. No, but it still remains in my mind as far as, you know, the assessment, the HPI, the physical exam findings, the laboratory results.
Q. Okay. And then you would have told him as well what the plan was, where they stood as far as what your orders were in going forward?
A. Yes.
Q. Would you have told him that you had ordered the CT angio?

A. In this case?
Q. Yes.
A. Yes, I would. The reason why is because it would have been a little bit unusual for us to stop at just -- actually, I would have to justify why is it that I did a noncontrast CT of the chest, you know, and it would have been saying hey, look, we were looking for lung pathology because of the pneumothoraces, and therefore we found something else now when we were looking for lung pathology that now leads us back to the direction of well, the aorta's in play now too as far as an issue.
Q. Okay. So you would have told Dr. Hussain about the fact that you ordered a CT angio, correct?
A. Yes.
Q. What role was Dr. Hussain going to play in the care and treatment of Mr. Elder other than admission?
A. As the admitting physician, he would be oversight of the patient care from a general standpoint. He's not a

specialist. He would oversee the care during the course of the patient's stay in the hospital, and potentially, if necessary, also perhaps be the first follow-up once they leave the hospital too.
Q. Okay. Did you tell Dr. Hussain that you had had a conversation with a cardiologist or anything to deal with the cardiology consult?
A. If I had already spoken to cardiology by that time, I would have told him that I have already spoken to cardiology, you know. I don't know the timing of that in truth, yes.
Q. If you hadn't spoken to cardiology, would you have told him that you were intending to speak to cardiology?
A. That or sometimes to the attending that I call the board doc will sometimes say hey, would you mind calling this group or that group too, in which case I add that to my list of things to do, so it could go either way. Hussain would have said call cardiology, and I would have said it would

have been a good idea to call cardiology and I got a phone call after that already, either way.
Q. Based upon what we see in the records, it's apparent that the responsibility to call cardiology in whatever way it came to you was yours, right?
A. I'm sorry. Say that again.
Q. The responsibility to call cardiology, however it came to you, whether an order to Dr. Hussain or your own decision, ultimately that responsibility remained yours, right?
A. Yes.
Q. Okay. And you undertook that by contacting somebody from Heartland Cardiovascular Group; is that right?
A. Yes, Heartland Cardiology, yes.
Q. And I presume that references the second consult that is on page 684 where it says cardiology was consulted by phone?
A. Yes.
Q. Cardiologists. Okay. Do you

recall -- strike that.
Tell me a little bit about how you chose who to call. Is there a list in the emergency department?
A. Yes, there is.
Q. As I understand the hospital policy is they create a list of consults for you to contact; is that right?
A. Yes because the names change day to day.
Q. And so you would have called a cardiology group, not a specific doctor; is that right?
A. Right.
Q. And in this case it ended up being Heartland Cardiovascular Group; is that right?
A. Yes.
Q. And when you called that group, it's my understanding that you got an answering service initially?
A. I don't make that initial phone call. Essentially --
Q. Fair enough.

A. Essentially I tell the secretary I need to talk to Heartland Cardiology. The secretary makes the phone call and talks to the -- and the next time I hear or the next time I'm actually on the phone is with the cardiologist themselves.
Q. Fair enough. Fair enough. So at some point you instructed the receptionist or the nurse in the emergency department to make that call, and at some point a cardiologist calls you back?
A. Yes.
Q. And it ends up being Dr. Yi, correct?
A. Yes.
Q. Now, the information that I have says that the call from Dr. Yi happened at 7:05 AM. Does that seem to be about right to you?
A. The information that you have?
Q. I have it from Dr. Yi's logs as far as the phone call goes.
A. That's reasonable.
Q. Does --

contrast CT, so therefore I had to explain the thought processes involved behind that for both of them, so I do recall that.
Q. Okay. And the thought process behind that was the dilated aorta which was shown on the first CT and that needed follow-up, right?
A. Still needed follow-up.
Q. What else? Can you remember anything else?
A. Not specifically, no.
Q. All right. You admitted Mr. Elder to a monitored bed in the hospital, right?
A. Yes.
Q. And that means he was physically transferred from the emergency department to another room, correct?
A. Yes.
Q. Now, according to the nursing records, he arrived at the monitored bed or the regular floor at 7:45 AM. Does that seem about right to you?
A. I wouldn't know personally, but, yes, that seems about right.

Q. You would have no reason to think that the time in the records that says 7:45 is wrong?
A. No.
Q. Once he was transferred out of the emergency department, did you have any more responsibility for his care in any way?
A. No.
Q. Who did?
MS. MITCHELL: Objection, foundation.
BY MR. CIRIGNANI:
Q. I assume you know who's taking care of Mr. Elder, don't you?
A. Theoretically Dr. Hussain and the cardiology group or Dr. Yi or whoever I spoke to.
Q. Not theoretically, you have a responsibility as an emergency room doctor to make a transfer of care of your patients, right?
A. Yes.
Q. Okay. And in this case you transferred the patient to a monitored bed,

and my question is to whom did you transfer his care?
A. To Dr. Yi and to Dr. Hussain.
Q. And how did you make the transfer of responsibility to these other doctors?
A. That would have been with a phone call informing them of the patient and the situation and where we're at as far as the workup.
Q. And we talked about as much as you could remember regarding your conversations to them, right?
A. Yes.
Q. Okay. Did you have any understanding as to when Dr. Yi would see the patient when you finished your conversation with the cardiologist?
A. It would be an assumption, but being that it was towards the beginning of the day, rather promptly.
Q. Do you have any recollection of him saying anything to you about I'll be right in or anything like that?
A. No.

Q. So you just assumed based upon what you described to him, what you told him, and all the thought processes that you had that he would see him promptly?
A. Yes.
Q. Who was responsible for following up with the CT angio that you ordered?
A. Part of the reason why I had to specify to both Dr. Hussain and the cardiologist, Dr. Yi, the noncontrast CT and then the contrast CT, it would end up being either the two of them in truth because I would have told them hey, this is still something that has to be done, and therefore the responsibility for following up on it would be theirs.
Q. Okay. Was that responsibility made clear to either of those or both of those doctors by you?
A. I would tend to think I probably did make it clear. I do not recall the specific, you know, sentences back and forth.
Q. Give me a sense of your custom and

practice. What would you say to them? I've ordered the CT scan. I'm not following up. You're following up. How would you say that?
A. Custom and practice in this situation would have been so I'm going to be ordering a CT angio of the chest and specifically just like I wrote once he gets to the floor.
Q. But --
A. And there usually -- it would be out of normality for them to say Dr. Zwolski, please follow that from the emergency room. It's actually assumed that if it's a floor test, it's going to be followed by the doctors that are responsible for him on the floor.
Q. Okay. So in your conversations with Dr. Hussain and Dr. Yi, you would have explained to them that you have already entered an order for a CT angio to be done when the patient gets to the room; is that right?
A. Yes.

Q. And by saying when he's in the room, you have essentially communicated by custom and practice to these two doctors that the responsibility is no longer yours to follow up on the CT scan?
A. Yes.
Q. Do you know when Mr. Elder was actually seen by a cardiologist in this case?
MS. SWATEK: Objection. He's testified that he hasn't reviewed the chart.
BY MR. CIRIGNANI:
Q. Okay. I take it you don't know?
A. I know he was seen before he died. That's all I know.
Q. Other than the next steps that you wrote about in your records, in your orders, were you relying upon Dr. Yi and Dr. Hussain both to determine the next steps with Mr. Elder?
A. Give me some time frame here. Once I've already spoken to them?
Q. Right.
A. And told them what the clinical

picture is as far as where our workup is still yet to be done?
Q. Let me rephrase the question.
A. Thank you.
Q. It's my understanding that in your conversations with Dr. Hussain and Dr. Yi, you would have told them the things that you were still going to do or the things you were still going to order, right?
A. Yes.
Q. Beyond that, that is, the response to the results of those things, et cetera, I presume that you relied upon Dr. Hussain and Dr. Yi to follow up on that and to be responsible; is that right?
A. Yes.
Q. If Dr. Yi had asked you to get the CT scan done -- strike that.
If Dr. Yi had asked you to get the CT with angio done stat, would you have done so?
A. Stat as in like in the emergency room, with me there?
Q. Stat meaning without delay.

A. If he specified stat, it would have been carried over as an order.
Q. Let me rephrase the question. Let me just make sure that we're understanding each other. You would agree with me that the order that you entered to do the CT angio on Mr. Elder was not entered stat, correct?
A. Right.
Q. If Dr. Yi had said I want the CT angio done stat, would you then have amended your order to make it stat?
A. Yes.
Q. In this case the CT with angio that you ordered was never done. Do you know why?
A. I don't.
Q. Did you make any attempts to follow up on getting it done?
A. I wasn't physically present in the hospital to do so, so no, I didn't.
Q. Tell me about that. When did you leave your shift?
A. I don't have specific recollection.

based on the history and physical exam, then I would do the workup and if needed refer to the specialist.
Q. Okay. In your career as an internal medicine doctor, have you ever had a patient come into your office who ultimately was diagnosed with an aortic dissection?
A. No.
Q. Have you ever had a patient ever that has had an aortic dissection?
A. I don't recall.
Q. If I asked you about treatment for aortic dissection, would you defer to a cardiologist?
A. Yes, I would.
Q. Is it your view that treatment of aortic dissections is not within the purview of the duties of an internal medicine doctor?
MR. STAMOS: I'm sorry, purview of the duties. I'm not sure what you mean by that.

BY MR. CIRIGNANI:
Q. Let me rephrase that. It was a bit wordy. Is it your view that the treatment of aortic dissections is not within the duties of an internal medicine doctor?
A. It's beyond our internist expertise.
Q. Okay. When were you first contacted about Mr. Elder? Can you give me a little bit more precise -- I know it was in August of 2008, but do you remember which day or what time?
MR. STAMOS: If you need to look at the chart at any time, you may.
THE WITNESS: August 4.
BY MR. CIRIGNANI:
Q. Okay, 2008. What time were you contacted?
A. Contacted, like physically seeing the patient, you mean or --
Q. No, sir. When was the first time you even heard about and asked to be involved in his care?
A. It was August 4. The exact time I

don't recall.
Q. It was sometime in the morning of August 4th?
A. Right.
Q. And is it fair to say that the first contact -- first time that you ever even heard about Mr. Elder was when you received a phone call from the emergency room doctor, Dr. Zwolski?
A. Yes.
Q. Okay. And the substance of that phone call, is it what you told me earlier, in the early part of this deposition?
A. Yes, for the chest pain.
Q. So, I'm sorry, and I apologize for doing this, but can we go through that again? Can you tell me precisely what Dr. Zwolski told you when he called you?
A. He said there's a young gentleman came with the chest pain and I already spoke to cardiology and he has some abnormal aorta, abnormal aorta.
Q. So he told you that the patient was young, that the patient had chest pain?

A. That the patient's chest pain was relieved by some medication he said, I don't remember what was that, and then he said he's talking to the cardiologist.
Q. So Dr. Zwolski said that he, Dr. Zwolski, was going to talk to the cardiologist?
MR. STAMOS: Was already talking to the cardiologist.
THE WITNESS: Was already talking. He said he already spoke to the cardiologist.
BY MR. CIRIGNANI:
Q. Okay. So let me clarify that. At the time that you first became aware of Mr. Elder's existence and his need for care was through a phone call by the emergency room doctor, right?
A. Yes.
Q. And in that phone call, that emergency room doctor, Dr. Zwolski, told you that he had already spoken to the cardiologist?
A. Right.

Q. Okay. He also told you that Mr. Elder had an abnormal aorta?
A. Yes.
Q. Did he describe specifically to you what that abnormality was?
A. No. I don't remember.
Q. Okay.
A. It was -- I don't remember.
Q. The purpose of the phone call was to ask you to admit the patient to the hospital?
A. I mean, I was on call like internist on call, so normally they're admitted under internist, but sometimes, you know, they do it with the cardiology also.
Q. Did he ask you to admit the patient?
A. He said he will -- he will admit the patient.
Q. Is he admitting him under your name as the attending or is he admitting him under the cardiologist that he already talked to?
A. I'm not sure what was his -- once

the patient comes to the floor, that's when we find out who was the attending.
Q. Okay. At that point in time, what did you understand your responsibilities to be regarding that patient, Mr. Elder?
A. My understanding was because, you know, there's already the subspecialists involved and the care has been initiated, and then when the patient -- normally in a normal practice like when the patient comes to the floor and we see the patient, history taking, examination, and, you know, continuation of care.
Q. So, I'm sorry, I'm not really sure I follow. The question was is what did you understand your responsibilities to be towards Mr. Elder at the time that you received the phone call from the emergency room doctor, Dr. Zwolski; and you told me that there was a specialist involved already, and that care was initiated and that your expectation then was to see him on the floor?
A. My expectation was, yes, once he

arrives to the floor, once -- my expectation was to see him when he arrives.
Q. So was it your understanding then that you were to have no further involvement in his care until he was transferred to the floor?
A. If they call from the ER, then whenever they call, we respond.
Q. Absent getting called on Mr. Elder, was it your understanding that you were to have no further responsibility for his care until he reached the floor?
A. I believe if there is anything, any kind of -- anything needed, normally we get called from the ER or called from the floor.
Q. I understand that. But other than when they call you from the floor to ask you to do something, was it your expectation that you were not going to have any further responsibility for him until he reached the floor?
MR. STAMOS: I think you're misunderstanding each other for some reason. I think what he's telling you he doesn't do

anything unless they call him in that time frame, unless I'm wrong. I don't mean to put words in your mouth, so I don't know what you mean beyond that.
THE WITNESS: Yes.
BY MR. CIRIGNANI:
Q. Okay. Let me ask you something. Was it your expectation that you would be involved in Mr. Elder's care at some point after this phone call with Dr. Zwolski?
A. Yes, my expectation was.
Q. And what was your expectation with regards to when you would be involved in his care?
A. The moment the patient arrives to the floor or depends wherever he goes.
Q. But unless you're called before that, you would not be calling up with any orders or instructions regarding that patient, right?
A. Calling? We don't know where to call. There are several --
Q. So let me ask it a different way: So after the emergency room doctor,

Dr. Zwolski, called you but before Mr. Elder reached the floor, you would have no responsibility unless somebody called and asked you?

MR. STAMOS: When you say no responsibility, I mean, I don't know what you mean. I'm afraid that word might mean something different than the way you're using it than the way he's hearing it.

BY MR. CIRIGNANI:

Q. I understand what you're saying. Okay. When I talk about responsibility, I'm talking about making patient treatment and care decisions for Mr. Elder. Okay? Do you understand that? I just want to get the definition right.

MR. STAMOS: In this context, when he's using that word, that's how he means it.

BY MR. CIRIGNANI:

Q. Do you understand what I mean?

A. If I'm involved in the care, so, you know, whenever I get call, I have to respond.

Q. I got that. I'm trying to figure out whether or not between the time when the emergency room department called you but before Mr. Elder was brought to the regular floor, you felt that you needed to be making decisions or judgments regarding Mr. Elder's care other than when they call you and ask you?

A. Yes, if there is anything needed emergent.

Q. Okay. Outside of the situation where anything is needed emergently or they call you, basically you would have done -- anticipated not doing anything until you saw him on the floor?

MR. STAMOS: He said not saw him before. Now he said when he's called by the floor.

THE WITNESS: Called by the floor.

BY MR. CIRIGNANI:

Q. I thought you're talking about the emergency department.

A. Called by the floor.

Q. Okay. So it just seems to me then

that your primary function was to be the admitting physician, and unless you were called, you really didn't intend or anticipate having any involvement in Mr. Elder's care; is that right?

MR. STAMOS: Wait. Stop for a second. You've asked this now three or four or five times. He's described exactly what he understood his role to be. He was going to get a call from the floor and respond at that time when the patient got there, and then he talked about following up on the floor for continuity of care, so it's pretty unfair for you to say that you were going to be the attending and not be responsible for his care.

MR. CIRIGNANI: I'm not trying to be unfair. I'm just not as smart as you.

MR. STAMOS: I don't think that at all. I think it's quite the opposite. So the bottom line is, though, he has answered that question a number of times, and I ask you not to ask that same question again.

MR. CIRIGNANI: Just so that I can

clarify and make sure that I understand it, and I appreciate that you understand it and Dr. Hussain understands it, Maybe everybody in this room does, but I'm not sure that I do.

MR. STAMOS: Why don't you ask him?

MR. CIRIGNANI: I am. I'm going to give it a shot.

MR. STAMOS: Ask him for the fourth time what did you understand your role to be.

BY MR. CIRIGNANI:

Q. Hold on. Let me think what I want to ask him now. So after the phone call from the emergency department, it was your expectation that you would be involved in Mr. Elder's care only when either the emergency department called you or when you were called from the floor?

A. I would be involved in the care because he's admitted under my name if it, you know, because that's the standard of care. We go and we print our list and then we see all of the patients.

I mean, if they don't call doesn't mean that I'm not going to see the patient because I get the list from the hospital.

Q. Okay. And when did you anticipate seeing the patient -- after you were called and told he was on the floor?

A. Yes. It depends, but like, you know, it depends, not exact time because sometimes, you know, the patients arrive at different time. Sometimes we have the office and then we see the patient in the office and then go back.

Q. Okay. So I take it then that with respect to any care that Mr. Elder needed between the time that the emergency room doctor called you and the time that you were called and told he was on the floor, you anticipated that being taken care of by the emergency room doctor and the cardiologist?

A. Yes.

Q. Now, earlier you told me -- strike that.

Let's do this: Do you have

entries in the progress notes section of the chart? It's not that long.

A. Yes.

Q. Would you tell me -- would you direct me to -- in the lower right corner of the chart, there's a page number that starts with the letter E. Could you tell me what page number you are on?

A. 047.

Q. Above that, the dark number, E-000722?

A. 000722.

Q. And I take it that your note is the top note?

A. Yes.

Q. Or is it both notes? Is the entire page your notes?

A. Yes, that's the phone orders. This is return by probably the nurse. You mean this writing?

Q. Okay. I'm sorry. Let me break it down. There's two entries on page 722, correct?

A. Uh-huh.

Q. There's one that's timed at 9:30 AM, and one that's timed at 10:15 AM, correct?

A. Yes.

Q. Okay. Are either of those notes your handwriting?

A. No.

Q. Okay. I take it then that those are a nurse or somebody else's notes that received orders or information from you by phone?

A. Yes.

Q. Okay. So both of those orders are telephone orders?

A. Yes.

Q. And that's what the TO means down at the bottom next to your name, right?

A. Yes, telephone order.

Q. Got it. So it's fair to say that at least at 9:30 and at 10:15 you had not yet seen Mr. Elder; is that fair?

A. Yes.

Q. Can you tell me when did you actually first see Mr. Elder, if you did?

A. It was on the 4th around 2:00 PM.

Q. What page are you looking at?

A. 728.

Q. All right. On page 728 which note -- what does 728 contain that indicates that you had seen him in person?

A. There's a note from me.

Q. And is that the upper left note that doesn't have a time? It says 8/4/08. There's no time there, right?

A. No, there's no time. You're right.

Q. And then I take it --

A. Sometimes it's in the afternoon so --

Q. Okay. Could you read that note for me, please?

A. 43-year-old male --

Q. What's above the 43-year-old male?

A. Medicine.

Q. So medicine is underlined, and then it says 43-year-old male?

A. Chest pain, aortic dissection, discuss with cardiology and CV surgery. Plan per CV surgery.

EXHIBIT 6

A. I don't recall myself in truth.
Q. Okay. Now, Dr. Yi when we took his deposition said that he did not order the CT angio stat because you told him that you had already ordered the test. Did you tell him that you had already ordered the CT angio in that conversation?
A. I don't recall specifically, but I probably would have, being that the same process that I would have had to go through with Dr. Hussain, I had to -- you know, I did a noncontrast CT looking for lung pathology, but hey, we found something different, something about the aorta; and I would have explained the same process to Dr. Yi as well, so therefore, yes, I'm going to be putting in an order or already have put in an order for a CT angio of the chest.
Q. As you sit here today, you don't recall specifically what you told him, but you would have told him about your intention to order a CT with angio, correct?
MS. SWATEK: Objection, mischaracterization of testimony.

BY MR. CIRIGNANI:
Q. I'm trying to get a sense because there's two different timings here, okay, what Dr. Yi said was that you told him that you had already ordered the test. Okay? Does that sound right to you?
A. Yes.
Q. Okay. And as we talked about earlier, the order for the CT angio was put on the order sheet at 6:30 which would have been before you made this phone call or this phone call came to you, right?
A. Yes.
Q. Dr. Yi also told us that you told him that Mr. Elder was actually on his way to radiology to get the CT angio when you were talking to him. Did you tell him that?
MS. MITCHELL: I'm going to object to the fact that that mischaracterizes Dr. Yi's deposition testimony.
MR. CIRIGNANI: Oh, I had a feeling you were going to say that, so let's take a look at his testimony.
MS. SWATEK: I'll join. I also set

forth that there were several different answers by Dr. Yi during his deposition regarding that topic, and to take out one of the question-and-answer sessions regarding that topic would mischaracterize the content of the dep.
MS. MITCHELL: I join in that, and I would object to just showing this witness one page, one set of questions from Dr. Yi.
MR. CIRIGNANI: You can show him anything you want to show him, counsel. What is the objection? The objection is showing him documents? What's the objection?
MS. SWATEK: The objection is showing him a document that mischaracterizes --
MR. CIRIGNANI: Mischaracterization of whatever. Okay. Let's get to the question. Let me read a little testimony from Dr. Yi. Okay? Here's the question?
MS. MITCHELL: Page number and line number, please.

BY MR. CIRIGNANI:
Q. Page 78, line 10.
"QUESTION: Did you suspect after talking to Dr. Zwolski that Mr. Elder may have had a dissection?
"ANSWER: I remember this that Dr. Zwolski told me that the patient has aneurysm and patient is going back to radiology for I believe the CT angiogram.
"QUESTION: Doctor, would it be fair to say that it was your understanding when you talked to Dr. Zwolski that Mr. Elder was already scheduled for the test that would tell you and the other doctors whether or not there was a dissection?
"ANSWER: Yes.
"QUESTION: Did Dr. Zwolski tell you a CT scan with angiogram has already been ordered and it's going to get done to figure out whether or not there's a dissection? Was that information conveyed to you?

"ANSWER: Yes.
"QUESTION: Would it be fair to say that during your phone conversation with Dr. Zwolski you knew a dissection was on the differential -- strike that.
I didn't want to read that question. Hold on. Let me read from page 85.
On page 85 here's the question to Dr. Yi. Line 11.
Did Dr. Zwolski tell you that the CT scan with angio had already been done?
"ANSWER: That wasn't the impression that I got.
"QUESTION: Based on what Dr. Zwolski told you, were you under the impression that Mr. Elder was on the way to radiology to get the CT scan with angio?
"ANSWER: Yes.
Okay. So here's my question for you. I'm left with the impression that Dr. Yi believed that you told him that

Mr. Elder was on the way to radiology. Did you say that or not?
A. I would say --
MS. MITCHELL: I would object to the form and the fact that it mischaracterizes other portions of Dr. Yi's deposition testimony.
MS. SWATEK: I'll join in that.
BY MR. CIRIGNANI:
Q. The question is: Did you say that or not?
A. It's consistent with what I wrote.
Q. So my question is: Did you tell Dr. Yi that Mr. Elder was, in fact, on the way to radiology or not?
A. I would have to say no.
Q. Okay. Dr. Yi also said that you had agreed to call his group with the results of the CT angio. Did you agree to do that?
A. That is also inconsistent with what I wrote, no.
Q. So the answer is no?
A. No.

Q. Now, Dr. Yi also said that he did not follow up on the CT angio test because you said that you would do it. Did you say that?
MS. MITCHELL: I'm going to object to the form, foundation, and that mischaracterizes Dr. Yi's deposition testimony.
MR. CIRIGNANI: Did you say that?
THE WITNESS: That's inconsistent with what I wrote. The answer would have to be no.
BY MR. CIRIGNANI:
Q. Dr. Yi also said that you requested a routine rather than a stat cardiac consult for Mr. Elder; is that true?
A. We commonly don't specify over the phone routine versus stat, so that would not be true.
Q. When you call a cardiology consult in a case like this with chest pains, who would make the decision whether it's stat or whether it's routine -- you or the cardiologist?

A. Both. It would be a team approach, you know, yes.
Q. Dr. Yi said that you never mentioned directly or indirectly that Mr. Elder may have an aortic dissection; is that true?
A. I would be surprised if I didn't. The reason why is because of the need for further testing that we were both aware of.
Q. Tell me what else you can, if you have any -- strike that. Do you have any other memories of the conversation -- strike that.
Tell me what you remember about the conversation you had with Dr. Yi.
A. Specifically I don't remember talking to Dr. Yi. I remember it was a cardiologist at the time, and it proves to be Dr. Yi, but aside from that, though, I do recall because I had to do it twice, both for Dr. Hussain and also for the cardiologist who was on, that I did feel that I had to justify why I went from chest X-ray to a noncontrast CT and then to a

phone call -- strike that.
At 7:06 when you received a page about a patient at Saint Joseph who needed a cardiologist, could you easily figure out what Heartland cardiologist you needed to call who was going to be in the hospital that day?
MR. MANGAN: Object to the form of that question. Go ahead.
THE WITNESS: I guess, yes, if I make phone call.
BY MR. HARMAN:
Q. It would be fair to say it would require you making one phone call to determine what cardiologist was going to be at Saint Joseph on August 4th, 2008, correct?
A. I'm not sure what one phone call, but I can make a phone call to find the people.
Q. On August 4th, 2008, if you wanted to figure out which one of your partners was going to be at Provena Saint Joe, would you call your office?

A. Probably office is not open yet.
Q. Okay. If you wanted to find out which one of your partners was going to be at Provena Saint Joe on the morning of August 4th, 2008, how would you go about doing that?
A. I have to call the people around who whether they already start working that day maybe. I'm not sure actually around 7:00 o'clock whether I can find somebody to be able to tell me who is going to be at Saint Joe.
Q. Is it your testimony that at or about 7:05 you did not have the ability to figure out which one of your partners was going to be at Provena Saint Joe Medical Center that morning?
MR. MANGAN: Object to the form of the question.
THE WITNESS: I did not say that.
BY MR. HARMAN:
Q. Doctor, in your opinion, did you have the ability on the morning of August 4th, 2008 to figure out which one of your

partners was going to be at Saint Joe Medical Center that day?
A. I could make a phone call, but whether I could get the answer is not certain.
Q. Well, as of August 4th, 2008, did you have Dr. Lertsburapa's phone number?
A. No.
Q. As of August 4th, 2008, did you have any of your partners' phone numbers?
A. Their personal cell phone number?
Q. Yes, sir.
A. No.
Q. Well, if you wanted to get ahold of one of your partners in your cardiology practice on August 4th, 2008, is it your testimony that you didn't have those people's cell phone numbers?
A. I will find them through the pager, pager number, not with the cell phone.
Q. If you wanted to get ahold of one of your partners as of August 4th, 2008, did you have their pager numbers?
A. Yes.

Q. When you received the page on the morning of August 4th, 2008, did you know which one of your partners was going to be at Provena that day?
A. No.
Q. As of 7:06 AM when you received the page concerning Mr. Elder, was there one of your partners actually in the hospital at that time?
A. I'm not sure.
Q. When you do rounds at Provena Saint Joe Medical Center, what time do you usually start in the morning?
A. It depends on each individual. Some people might start at 7:00 o'clock. Some people might start at 7:30. Some people might start 8:00 o'clock. Most all of them start from 8:00 o'clock. Some of the people who had earlier case will be there earlier.
Q. It would be fair to say that by 8:00 o'clock there's usually a Heartland cardiologist at Provena doing rounds, correct?

A. Yes.
Q. On the morning of August 4th, 2008 before you received the page concerning Mr. Elder, was it your intention to go directly from your house to Morris Hospital or did you have some kind of errands to do or drop the kids off at school or anything like that?
A. I was planning to go to Morris Hospital directly.
Q. Would there have been anything that would have physically prevented you from leaving your house and going directly to Provena Saint Joe Medical Center to see Mr. Elder?
A. Physically?
Q. Yes, sir.
A. No.
Q. Did you have any emergency cases or emergency pages from Morris Hospital on the morning of August 4th, 2008?
A. I do not recall.
Q. After you received the page at approximately 7:06 from the emergency room

at Provena Saint Joseph Medical Center, at some point did you return the page, i.e., call the emergency room?
A. Yes.
Q. How much time transpired between when you received the page at approximately 7:05 or 7:06 and when you were speaking with someone from the emergency room at Provena Saint Joe's?
A. Probably a few minutes.
Q. Okay. Would it be fair to say -- strike that.
Is it your opinion that you answered the page concerning Mr. Elder in prompt fashion, i.e., four or five minutes?
A. Yes.
Q. Did you call the emergency room from your cell phone or from your land line at your house in Hinsdale?
A. I do not recall.
Q. When you called the emergency room, did you know to ask for Dr. Zwolski or did you just generally call the emergency room and say this is Dr. Yi, I've been paged?

How did that work, sir?
A. When you get the call from emergency room, you call back the number and they will triage me to the physician who paged me.
Q. When you called -- strike that.
When you called the emergency room on the morning of August 4th, 2008, were you put through in prompt fashion to Dr. Zwolski?
A. I do not recall.
Q. In other words, when you called ER, did you have to sit there on hold for 5 minutes or 10 minutes or did you get to Dr. Zwolski relatively quickly?
A. I do not recall.
Q. When you spoke with Dr. Zwolski, were you still at your home in Hinsdale?
A. Yes.
Q. Did you have only one phone conversation with Dr. Zwolski concerning Mr. Elder on August 4th, 2008?
A. Yes.
Q. Approximately how long was the one

phone conversation you had with Dr. Zwolski on the morning of August 4th, 2008?
A. I'm not sure.
Q. Can you give me any estimate of any kind as to how long the phone conversation was with Dr. Zwolski concerning Mr. Elder?
A. About five, seven minutes.
Q. The five- to seven-minute phone conversation that you had with Dr. Zwolski concerning Mr. Elder on the morning of August 4th, 2008, to your knowledge, was anyone privy to that conversation other than you and Dr. Zwolski?
MR. MANGAN: Just object to the form. You mean on the line?
BY MR. HARMAN:
Q. I mean anything. Was anyone else on the line to your knowledge? Was your wife standing next to you? Did he say I have a nurse clinician next to me? To your knowledge, did anyone overhear or on the line directly or indirectly between -- the conversation between you and Zwolski, sir?
A. I'm not sure.

Q. Dr. Zwolski asked you for a cardiac consultation on Mr. Elder, correct?
MR. MANGAN: Objection, vague. Go ahead.
THE WITNESS: What do you mean by that? I'm not certain what you're asking.
BY MR. HARMAN:
Q. Doctor, you are a cardiologist and for a living physicians call you in for consults; is that correct?
A. Right.
Q. Did Dr. Zwolski ask you for a cardiac consultation or Mr. Elder on the morning of August 4th, 2008?
A. Yes.
Q. Do you have any understanding as to why you received the page for the cardiac consult for Mr. Elder as opposed to some other physician in your group?
A. Probably because I was on call that night.
Q. Okay. And being the on-call physician -- well, strike that.
Can you tell me how the on-call

system worked for Heartland Cardiology? Would there be one cardiologist who would be on call for all three hospitals or would there be multiple cardiologists on call? Could you just give me the breakdown of that, please?
A. We have primary call physicians cover all three hospitals, and then we have a backup interventional cardiologist, we have backup electrophysiologist, so three physicians going on call.
Q. I want to make sure I have this correct. There would be a physician on call for general cardiology and then also on call would be an interventional cardiologist and an electrophysiology person; is that correct?
A. Yes.
Q. Would it work like this? The general cardiologist would get all the pages, and then he or she would determine if what was needed was the interventional person or the electrophysiology person?
A. Yes.

Q. So the -- strike that.
The general cardiologist on call for Heartland would, in essence, screen what type of consult was needed preliminarily over the phone, and then if it was clear, an interventional was needed or electrophysiology, they would call the other person? Is that how it worked?
A. Yes.
Q. When would you go off call?
A. 7:00 AM.
Q. So the phone call -- strike that.
The phone call in this case if it came in at 7:05 or 7:06 was right at about the change of shift for Heartland Cardiology, correct?
A. Yes.
Q. All right. Would it be the situation that the on call wouldn't change at exactly 7:00 o'clock, it might be a little bit before, a little bit after? Is that what would happen?
A. Possible.
Q. Doctor, it says that you were paged

at 7:06, and technically you went off call at 7:00 o'clock.
What's your understanding, if any, as to how you ended up with the call then as opposed to the person who was on call for the day shift at Heartland?
A. Ask me again.
Q. All right. At 7:00 o'clock a different Heartland person would be on call; is that correct?
A. Technically, yes.
Q. And if technically at exactly 7:00 o'clock a different Heartland person would be on call, the day shift, for lack of a better word, cardiologist shouldn't have gotten the call. You were the night shift. You got it in this case. Is that just because it's not precisely at 7:00? I mean, how did that happen, sir?
A. I'm not sure.
Q. Do you have any criticisms of the paging service in this case?
A. What do you mean by that?
Q. Did the paging service in your

opinion call the right doctor at Heartland i.e., you, for Mr. Elder?
MR. MANGAN: I'm going to object to foundation. Go ahead.
THE WITNESS: Technically, no.
BY MR. HARMAN:
Q. Okay. Who was supposed to get paged with the consult for Mr. Elder?
A. I'm not certain.
Q. It's your testimony that -- well, strike that.
When you say technically you weren't supposed to get the call -- strike that.
Doctor, do you have any criticisms in this case of the paging service?
MR. MANGAN: Again I'm going to object to the form of the question.
THE WITNESS: I'm not sure what you mean by criticizing paging system.
BY MR. HARMAN:
Q. Well, in your opinion, do you blame the paging service in any way for the fact

that Mr. Elder didn't see a Heartland cardiologist until 10:30 or 11:00 AM in the morning?
MR. MANGAN: I'm going to object on the basis of form, foundation.
MR. HARMAN: If he doesn't and you will stipulate that he doesn't, I'll move on, John.
MR. MANGAN: He doesn't have an opinion? Yes, he doesn't have an opinion.
THE WITNESS: I'm not sure. I don't have an opinion on that.
MR. HARMAN: Fair enough.
BY MR. HARMAN:
Q. Did you speak to anyone at any time from the paging service concerning why you got the page on the morning of August 4th as opposed to the cardiologist who was on call for the day shift?
A. No.
Q. Specifically on the morning of -- strike that.
After you got the page at about 7:06, is the next communication of any kind

you had with anyone when you called the ER?
A. Ask me again.
Q. Sure. You get the page at 7:05 or 7:06. Is the next communication of any kind you had with anyone when you were on the phone with the ER at Saint Joe's?
A. I'm not sure what you're asking.
Q. All right. Doctor, there's a time frame in between when you see your pager and when you're on the phone with the emergency room at Saint Joe's. In between those two time periods, did you talk to anyone?
A. No.
THE VIDEOGRAPHER: Jim, we'll need to take just a moment to change tapes.
MR. HARMAN: Okay. Thanks.
THE VIDEOGRAPHER: This will be the end of tape number 1. We are going off the record at 4:07 PM.
(Whereupon a short break was had from 4:07 PM to 4:07 PM)
THE VIDEOGRAPHER: We are going back on the record. This is the beginning of tape number 2. The time is 4:07 PM.

Please proceed.
BY MR. HARMAN:
Q. Did Dr. Zwolski request a stat cardiac consult?
MR. MANGAN: Object to the form of the question, vague.
THE WITNESS: No.
BY MR. HARMAN:
Q. Is it your testimony that Dr. Zwolski requested a routine cardiac consult?
MR. MANGAN: Objection, vague.
THE WITNESS: Yes.
BY MR. HARMAN:
Q. A routine cardiac consult means that a cardiologist will be in the hospital to see the patient that day; is that correct?
A. Yes.
Q. All right. You would agree that when you talked to the emergency room doctor like you did -- do you need to answer that?
A. I'm fine.
Q. Are you sure?

A. Yes.
Q. Okay. Strike that. Did Dr. Zwolski tell you that Mr. Elder had a dilated aorta?
A. Yes.
Q. Did Dr. Zwolski tell you that Mr. Elder had a dilated ascending aorta?
A. I do not recall.
Q. Did you ask Dr. Zwolski what part of Mr. Elder's aorta was dilated?
A. I do not recall.
Q. Would it be fair to say that you learned during your phone conversation with Dr. Zwolski that the dilated aorta was in the thoracic aorta, correct?
A. Yes.
Q. All right. So it would be fair to say when you talked to Dr. Zwolski you knew that the dilated aorta was not a dilated abdominal aorta, correct?
A. Yes.
Q. Did Dr. Zwolski tell you the size of the aortic dilatation?
A. I do not recall.

Q. Did you ask Dr. Zwolski how dilated the aorta was?
A. I do not recall.
Q. You would agree the standard of care would have required you as a cardiologist to independently determine during the phone conversation whether or not Mr. Zwolski needed an urgent consultation, true?
MR. MANGAN: Objection, vague and incomplete.
THE WITNESS: Ask me again.
BY MR. HARMAN:
Q. Sure. Doctor, it's your testimony that Dr. Zwolski told you to -- strike that.
It's your testimony that Dr. Zwolski told you a routine cardiac consult was needed and requested for Mr. Elder, correct?
A. I still don't understand your question.
Q. All right. I'm going to ask a different one. I'm not jumping around. I'm going to ask you a different question.

Okay?
A. Sure.
Q. You would agree that as a cardiologist you reasonably rely on emergency room physicians to let you know whether or not you need to come in and see the patient urgently, correct?
MR. SCHULTZ: Objection, form.
THE WITNESS: I have no opinion on that.
BY MR. HARMAN:
Q. Doctor, do you at least in part rely on the emergency room doctor to determine whether or not you need to come in right away to see the patient; is that fair?
A. In part, yes.
Q. Did Dr. Zwolski use the actual words routine consult?
A. I do not recall.
Q. It would be fair to say -- strike that.
It's your testimony that Dr. Zwolski made it clear to you that Mr. Elder was to be a routine cardiac

consult, correct?
A. I do not recall.
Q. Doctor, in your opinion, was there any ambiguity of any kind that Mr. Elder was to be a routine cardiac consult?
A. At that time I do not recall.
Q. You would agree that as a cardiologist when you get a phone call like in this case you have to ask a series of questions of the emergency room doctor to determine whether or not the patient needs to be seen immediately, correct?
MR. MANGAN: Objection, form, vague, incomplete. Go ahead.
THE WITNESS: Yes.
BY MR. HARMAN:
Q. And is it your testimony in this case that when you talked to Dr. Zwolski, you asked a series of questions to reasonably determine as best you can over the phone whether or not Mr. Elder needed to be seen right away by a cardiologist?
A. I do not recall.
Q. You would agree the standard of

care would have required you to ask a series of questions to reasonably determine whether or not Mr. Zwolski needed to be seen urgently or right away, correct?
A. Yes, yes.
Q. The aorta at the level of the pulmonary artery on the CT scan that was available as of the time you talked to Dr. Zwolski was 4.9 centimeters -- strike that.
You would agree an aorta at the level of the pulmonary artery that's 4.9 centimeters is severely dilated, true?
MR. MANGAN: Objection, vague and incomplete.
THE WITNESS: No.
BY MR. HARMAN:
Q. How would you characterize an aorta that's 4.9 centimeters at the pulmonary artery -- normal, moderately dilated, minimally dilated, tremendously dilated? How would you characterize that, Doctor?
MR. MANGAN: Objection, form.
THE WITNESS: Probably moderate to

severe.
BY MR. HARMAN:
Q. Have you ever reviewed the CT scan that was done on the morning of August 4th, 2008 on Mr. Elder?
A. No.
Q. And in preparation for -- strike that.
Have you ever looked at the echo that was done on Mr. Elder?
A. No.
Q. Have you ever had any conversations with Dr. Hussain concerning Mr. Elder?
A. No.
Q. You know who Dr. Hussain is?
A. Yes.
Q. Is the only physician that you spoke to on the morning of August 4th, 2008 from the emergency room concerning Mr. Elder was that Dr. Zwolski?
A. Yes.
Q. Did you talk to any nurses or nurse practitioners concerning Mr. Elder on the morning of August 4th, 2008?

A. I do not recall.
Q. Did Dr. Zwolski characterize in any way how dilated Mr. Elder's aorta was?
MR. MANGAN: Objection, asked and answered. Go ahead.
THE WITNESS: I do not recall.
BY MR. HARMAN:
Q. Doctor, you have been kind enough to tell me that Dr. Zwolski did not tell you the exact number, 4.9 centimeters, for the dilatation. Did Dr. Zwolski characterize without using numbers the degree of dilatation of Mr. Elder's aorta?
A. If I may be -- correction. I did not say Dr. Zwolski did not tell me the size. I said I do not recall.
Q. Okay. Dr. Zwolski could have told you that the aorta was 4.9 centimeters, you just don't remember; is that fair?
MR. MANGAN: Object to the form. Go ahead.
THE WITNESS: Correct.
BY MR. HARMAN:
Q. Dr. Zwolski -- strike that. You

know for a fact, though, that you didn't ask Dr. Zwolski how big is that dilated aorta; is that correct, sir?
A. No.
MR. MANGAN: Object to --
THE WITNESS: I said I do not recall.
BY MR. HARMAN:
Q. It's your testimony even after reviewing the record in this case you don't know one way or the other whether you asked Dr. Zwolski the size of the aorta, correct?
MR. MANGAN: Objection, asked and answered many times now.
THE WITNESS: I do not recall whether he told me the size of the aneurysm at that time or not.
BY MR. HARMAN:
Q. I appreciate that. My question was different. Doctor, can you tell me one way or another whether or not you asked Dr. Zwolski how big Mr. Elder's aorta was?
MR. MANGAN: Objection, asked and answered.

THE WITNESS: Whether I asked him?
BY MR. HARMAN:
Q. Yes, sir.
A. I do not recall.
Q. Did Dr. Zwolski tell you that Mr. Elder's chief complaint was chest pain?
A. Yes.
Q. It would be fair to say during the phone conversation with Dr. Zwolski you knew Mr. Elder had a chief complaint of chest pain, and he had a dilated aorta, true?
A. Yes.
Q. Did Dr. Zwolski tell you that the chest pain in Mr. Elder had sudden onset?
A. I do not recall.
Q. And, Doctor, when I ask you these questions did he tell you, if he said precisely those words, please tell me. If he said something real close that gave you essentially that information, please tell me. Okay?
A. Sure.
Q. Did Dr. Zwolski tell you in so many words that the chest pain that brought

Mr. Elder to the hospital was acute chest pain, it hadn't been ongoing for years or days or months, it happened that morning?
MR. MANGAN: I'll object to the form. Go ahead.
THE WITNESS: I do not recall.
BY MR. HARMAN:
Q. Did you ask Dr. Zwolski whether or not the chest pain that brought Mr. Elder to the emergency room was of sudden onset?
A. I do not recall.
Q. You would agree the standard of care would have required you to ascertain to some degree whether or not this chest pain was a new symptom for Mr. Elder, true?
A. Yes.
Q. Did Dr. Zwolski tell you that the chest pain Mr. Elder came to the ER with was a nine out of ten, that it was severe chest pain?
A. I do not recall.
Q. Did you ask the emergency room doctor how severe the chest pain was that brought Mr. Elder to the emergency room?

A. I do not recall.
Q. You would agree the standard of care would have required you to generally ascertain how severe the chest pain was that brought Mr. Elder to the emergency room, correct?
MR. MANGAN: Object to the form. Go ahead.
THE WITNESS: Yes.
BY MR. HARMAN:
Q. Okay. Did Dr. Zwolski tell you that Mr. Elder had no prior history of chest pain prior to when he came to -- strike that.
Did Dr. Zwolski tell you or inform you in any way that Mr. Elder had no history of chest pain?
A. I do not recall.
Q. Did you attempt to find out over the phone whether or not Mr. Elder had a prior history of chest pain?
A. I do not recall.
Q. Did Dr. Zwolski tell you that as of 7:00 o'clock Mr. Elder still had chest pain,

that the chest pain was ongoing?
A. I do not recall.
Q. You would agree the standard of care would have required you to ascertain whether or not the chest pain was still there and whether or not Mr. Elder had a history of chest pain, correct?
A. Yes.
Q. With reference to -- strike that.
Did Dr. Zwolski tell you that Mr. Elder still had chest pain despite the fact that he had been given oxygen and nitroglycerin?
A. I do not recall.
Q. Did you ask Dr. Zwolski if this chest pain was relieved by nitroglycerin?
A. I do not recall.
Q. Did Dr. Zwolski tell you that an MI had been reasonably ruled out?
A. Yes.
Q. And Dr. Zwolski told you that Mr. Elder's 12-lead EKG was normal, and that the cardiac enzymes were normal, true?
A. I do not recall.

EXHIBIT 7

Q. Then how --
A. I was doing an overnight, I know that, and this was still, you know, one of the cases remaining for that overnight, so I probably, and it's a guess, I probably would have left the hospital probably within an hour or two of this whole happening, you know, because commonly when I do an overnight, I'm usually there till about anywhere from 7:00 to 9:00 o'clock, sometimes a little bit later, after the shift is over.
Q. Okay.
A. And part of the reason for signing that off to the doctors who were going to be responsible on the floor is yes, I can go home and go to sleep because I know that and I trust that they will follow that.
Q. Okay. Is there any records that would tell when you left the hospital on that day?
A. No.
Q. All right. So I take it then that you did not make any attempts to follow up

on getting the CT with angio done before you left the hospital; is that fair?
A. That's fair.
Q. You would agree that someone involved in Mr. Elder's care breached the standard of care in not getting the CT angio done as you ordered, right?
MS. SWATEK: I'm going to object to foundation.
MR. SCHULTZ: Join.
MS. MITCHELL: And form, join.
BY MR. CIRIGNANI:
Q. Right?
A. I would really rather not make judgments on other physicians' care.
Q. Well, I say this respectfully. I know you would rather not, but I'm asking you a question that unless there's a valid objection or a reason not to answer, you're required to answer.
MS. SWATEK: No, I think it is a valid objection. He's an emergency room physician. There's no other care provider involved in this case who is an emergency

room physician. I object to him rendering a standard-of-care opinion regarding a different specialty.
BY MR. CIRIGNANI:
Q. At Provena Hospital in 2008, was it within the standard of care to not follow a physician's order for anybody?
MS. SWATEK: I'm going to object to incomplete hypothetical, and I'm going to object to lack of foundation and lack of specification in that question.
MR. SCHULTZ: Join.
MS. MITCHELL: Join.
MR. CIRIGNANI: You can answer the question.
MS. SWATEK: Do you understand the question?
THE WITNESS: It's not -- you know, rephrase one more time.
MR. CIRIGNANI: Would you read my question back, please, Diane.
(Record read as requested.)
MS. SWATEK: I'm going to object

that that's not specified relative to what type of standard of care. I'm going to instruct him not to answer that question.
MS. MITCHELL: I actually thought he asked to rephrase it, not repeat it, but maybe I misheard him.
BY MR. CIRIGNANI:
Q. Do you want me to rephrase it? What do you want? Your lawyer is instructing you not to answer that question. Do you want me to rephrase the question? Here let me rephrase it.
From an emergency room doctor's perspective only, is it within the standard of care to not follow a physician's order?
MS. SWATEK: Are you asking him it's not standard of care for an emergency room physician to follow another emergency room physician's order?
MR. CIRIGNANI: No, I'm not. I'm asking him whether or not it's within the standard of care for nurses or other doctors or other medical personnel to not follow an order that you give.

EXHIBIT 8

puts the orders in and the chart is finished or she's finished with the physician orders portion of the chart, it's my understanding that the chart goes on a rack of some sort or it goes somewhere where you as the nurse can access it; is that your understanding?
A. Yes.
Q. Okay. Where does it go?
A. There's a rack that's located right by where she works next to the desk.
Q. Okay. Is that what you as the registered nurse in charge of Mr. Elder would have gone to --
A. Uh-huh.
Q. -- after the initial assessment was done by Nurse Ortega was go to his chart?
A. Yes.
Q. And would you have reviewed the physician orders?
A. Yes.
Q. And would you have checked to see if those were implemented, that is, put into the computer?
A. Yes.

Q. Okay. How would you do that?
A. There's a part on the computer that you could check, but most of the time I would just verbally go up to the unit secretary, and she makes a special mark. She'll check off the orders that were put in, and then I go through and I'll say are you sure you put this order in the computer? I don't see a checkmark here. Let's make sure we don't forget this or something, so it's really me and her discussing the page together.
Q. Okay. I got you. And that's sort of the way that mistakes are not made?
A. Yeah. She'll sign it all off.
Q. And that was something that you would do right at the outset as soon as the patient comes up, right, is your first opportunity?
A. Uh-huh.
Q. Is that a yes?
A. Yes.
Q. Because you understand that it's important to look at the physician orders

from the emergency department right at the outset of his admission to the regular floor in case something needs to be done -- something that needs to be done -- strike that.
And that's because you understand that orders from the emergency department doctor that come up with the patient need to be done on an efficient basis, right?
A. Yes.
Q. Okay. When we were talking, you were pointing to it. It's the one that I know that you know about. It's the issue that we've been talking about in this case quite a bit. Let's just jump right to it.
There is on page 740 an order from the emergency department physician for Mr. Elder to receive a CT with contrast. Agreed?
A. Uh-huh, yes.
Q. There's no checkmark around that, right?
A. Right.

Q. And that would indicate to you that if there's no checkmark that it had not been entered into the computer, correct?
A. Correct.
Q. So if you had been following the procedure that you described for me, that should have been an order that you would have drawn the unit secretary's attention to and said something about getting it done, right?
A. Yes.
Q. As you sit here today, do you have a recollection of doing that?
A. No, and as I sit here today, I've never read that order on that page right there.
Q. So what you're saying is that as you sit here today you don't have a recollection of ever seeing that order?
A. I've never seen that order, yes.
Q. Okay. How do you know that you never saw that order?
A. I just know.
Q. Okay. And I don't mean -- I

honestly don't mean this -- I'm not trying to be impertinent or rude, so I'm going to sound that way anyways, but I don't want it to be.

You had told me earlier that you had no memory of this case other than what's in the records, right?

A. Right.

Q. So I'm looking at the record, and I'm seeing an order that you now say that you don't remember seeing, so can you explain to me --

A. Well, that day I did not recall seeing this. Now I've seen it after the fact that I've been able to review the chart.

Q. Okay.

A. But that day I did not see this order. I'm assuming it's at the desk, and the unit secretary is taking care of it and doing her part while I'm taking care of the patients.

Q. Okay. The unit secretary said that when she gets an order for a CT scan that

what she does before she can put it in the computer is get a questionnaire that's necessary that has to be filled out by the patient through the nurse. Have you ever seen one of those forms before?

A. I have, yes.

Q. So you know what she's talking about?

A. Yes.

Q. Are they a special color, do you know?

A. They've been different colors.

Q. I'm just wondering, something that you wouldn't miss if she put it on top of the chart when you went to go grab the chart, right?

A. Right.

Q. And if you saw that on top of the chart, what would you do with it? If you came to the patient's chart, Mr. Elder's chart, and on top of that chart was a questionnaire for a CT scan, what would you do?

A. I would take the questionnaire and

go in his room and ask him the questions and complete it.

Q. Okay. As you sit here today, do you have any recollection of doing that in Mr. Elder's case?

A. No recollection. No recollection of getting a CT paper.

Q. Okay. And assuming that you had gotten the CT paper and you asked him the questions and you filled it out, what would you then do with that document?

A. I would bring it back to the unit secretary and hand it to her.

Q. Okay. The order for a CT scan that's written there was never completed. You understand that, right?

A. Yes.

Q. Do you have any explanation as to how that order never got completed?

A. I don't have an explanation, but I can tell you that I've never seen a CT angio of the chest once the patient's in the room. I have never ever seen anything like that before, an order.

Q. So what you're talking about never having seen is specifically the type of procedure that's listed there?

A. Uh-huh.

Q. Is that a yes?

A. Yes.

Q. Okay. So as a floor nurse in your career since 2002 or 2006 up until today, the only time that you have ever seen a CT angio of a patient that needed to get done while they're on the regular floor is this one right here?

A. Uh-huh.

Q. Yes?

A. Yes. Sorry.

Q. That's okay. That's okay. I do it. I find myself doing it in the middle of a deposition, and I've been doing this for 20 years. I know that you don't know how it didn't get entered. I'm going to ask you based upon your experience as a nurse to speculate. Do you have any ideas as to how it might have happened?

MR. SCHULTZ: I object to the form

Q. And he's an emergency room doctor?
A. Yes, I was told that.
Q. Okay. Did you not know that before you were told that?
A. I would have -- these are emergency room physician orders, so I would assume that that's him, an emergency room doctor.
Q. All right. Patients on the telemetry floor sometimes get admitted from the emergency department, correct?
A. Yes.
Q. Okay. You indicated earlier that you reviewed at least a CT scan. Did you review -- strike that. Let me just ask the question.
You have the record in front of you. Can you tell me if that particular order was ever followed? Was a CT with angio ever performed on Mr. Elder?
A. No. I was told that this morning.
Q. Okay. From everything that you have looked at in the medical record -- from everything you have looked at in the medical record, you'd agree with me that there's no

indication that the CT angio was ever performed on Mr. Elder, correct?
A. Yes.
Q. So it's fair to say that that particular order that's written right there was never followed, correct?
A. Correct.
Q. Do you have any explanation as to why -- strike that. Let me go back to the actual language of the order. It says there, and I quote, and you tell me when I'm done if I'm reading it right. I quote, CT angio of chest. Rule out aortic aneurysm once in room, end quote. Would you agree that I read the order correctly?
A. Yes.
Q. Okay. Do you have any explanation for why that order was not followed once he was in his room?
A. No.
Q. Okay. Is it your view today that the responsibility for following that order would have fallen to Nurse Flint?
A. Yes.

Q. Okay. So I take it then that my job is to talk to Ms. Flint next; is that fair?
MR. SCHULTZ: I object to the form of that question. That was unnecessary.
BY MR. CIRIGNANI:
Q. That was a stupid question. Let me see here. Have you ever heard anyone say anything critical at any time anywhere with anybody except your attorneys of the care that Mr. Elder received?
A. Could you rephrase that.
Q. Sure. Have you ever heard anybody say anything critical of the care Mr. Elder received from anyone anywhere at any time other than your lawyers?
A. Um --
Q. I'm sorry. Did you answer that?
A. No.
Q. Okay.
A. Can I discuss that with you.
MR. SCHULTZ: If you want to take a break, we will take a break.
THE WITNESS: Take a break.

MR. CIRIGNANI: I'm almost done. We can take a break. That's fine. Let's do it.
THE VIDEOGRAPHER: We are going off the record at 11:05 AM.
(Whereupon a short break was had from 11:05 AM to 11:08 AM)
THE VIDEOGRAPHER: We're back on the record at 11:08 AM.
BY MR. CIRIGNANI:
Q. Nurse Ortega, I left off by asking the question: Have you ever heard anybody anywhere offer criticisms of the care that Mr. Elder received, and I excepted from that question your attorney. I'm asking you the question again. Have you ever heard anybody criticize the care that Mr. Elder received?
A. No.
MR. SCHULTZ: What did you say you excepted? She said no. She said no.
MR. CIRIGNANI: The court reporter said she said um, so it wasn't really clear whether she said no so --
MR. SCHULTZ: I'm not sure that the

EXHIBIT 9

I mean, if they don't call doesn't mean that I'm not going to see the patient because I get the list from the hospital.

Q. Okay. And when did you anticipate seeing the patient -- after you were called and told he was on the floor?

A. Yes. It depends, but like, you know, it depends, not exact time because sometimes, you know, the patients arrive at different time. Sometimes we have the office and then we see the patient in the office and then go back.

Q. Okay. So I take it then that with respect to any care that Mr. Elder needed between the time that the emergency room doctor called you and the time that you were called and told he was on the floor, you anticipated that being taken care of by the emergency room doctor and the cardiologist?

A. Yes.

Q. Now, earlier you told me -- strike that.

Let's do this: Do you have

entries in the progress notes section of the chart? It's not that long.

A. Yes.

Q. Would you tell me -- would you direct me to -- in the lower right corner of the chart, there's a page number that starts with the letter E. Could you tell me what page number you are on?

A. 047.

Q. Above that, the dark number, E-000722?

A. 000722.

Q. And I take it that your note is the top note?

A. Yes.

Q. Or is it both notes? Is the entire page your notes?

A. Yes, that's the phone orders. This is return by probably the nurse. You mean this writing?

Q. Okay. I'm sorry. Let me break it down. There's two entries on page 722, correct?

A. Uh-huh.

Q. There's one that's timed at 9:30 AM, and one that's timed at 10:15 AM, correct?

A. Yes.

Q. Okay. Are either of those notes your handwriting?

A. No.

Q. Okay. I take it then that those are a nurse or somebody else's notes that received orders or information from you by phone?

A. Yes.

Q. Okay. So both of those orders are telephone orders?

A. Yes.

Q. And that's what the TO means down at the bottom next to your name, right?

A. Yes, telephone order.

Q. Got it. So it's fair to say that at least at 9:30 and at 10:15 you had not yet seen Mr. Elder; is that fair?

A. Yes.

Q. Can you tell me when did you actually first see Mr. Elder, if you did?

A. It was on the 4th around 2:00 PM.

Q. What page are you looking at?

A. 728.

Q. All right. On page 728 which note -- what does 728 contain that indicates that you had seen him in person?

A. There's a note from me.

Q. And is that the upper left note that doesn't have a time? It says 8/4/08. There's no time there, right?

A. No, there's no time. You're right.

Q. And then I take it --

A. Sometimes it's in the afternoon so --

Q. Okay. Could you read that note for me, please?

A. 43-year-old male --

Q. What's above the 43-year-old male?

A. Medicine.

Q. So medicine is underlined, and then it says 43-year-old male?

A. Chest pain, aortic dissection, discuss with cardiology and CV surgery. Plan per CV surgery.

EXHIBIT 10

Q. And what did you do when you got to the floor?
A. Entered the EMR, the electronic medical records.
Q. So you looked at essentially his chart?
A. Correct.
Q. This was done electronically?
A. Correct.
Q. At that point then, did you see that there was a CT scan done?
A. Yes.
Q. Okay. After you reviewed his chart, and we will talk about that in a minute, the things that you saw in there, but after you reviewed his chart -- strike that.
Did you review his entire chart then for that admission?
A. Everything that was in the EMR. I don't remember if I looked at every sheet of the actual paper chart.
Q. I guess what I'm asking, you understood that Mr. Elder had come to the

hospital into the emergency room of Saint Joseph's Medical Center, right?
A. Correct.
Q. Did you see him in the emergency room?
A. No, I did not.
Q. What room was he in? I mean, not room number. Was he on a regular floor?
A. Yes, he was.
Q. So he had already been released from the emergency room and brought to a floor?
A. Correct.
Q. Was it a cardiac floor?
A. Yes, I believe that was the cardiac floor.
Q. Okay. So when you go see him, he is -- who's caring for him at the time that you go see him? What doctor?
A. You mean who had seen him before me?
Q. Well, we know that the emergency doctor saw him, right?
A. Correct.

Q. Because he came in through the emergency room, again, we'll talk about that, but then he was transferred to the regular room. Was there any doctor there when you got there?
A. No.
Q. And you were being called as a consult, correct?
A. Correct.
Q. Do you know who was in charge of his care, to whom you would have made a report?
A. The attending physician?
Q. Attending physician.
A. I believe Dr. Hussein as far as I can remember.
Q. Do you know if Dr. Hussein was in the hospital at the time that you saw Mr. Elder?
A. I do not know if he was in the hospital at that time.
Q. Okay. You get down to the floor, you review his medical chart, and so you would have available to you for review

everything that was in the chart for that day, correct?
A. Correct.
Q. And then what did you do after you reviewed the chart?
A. I went to speak and interview Mr. Elder.
Q. Okay. All right. Now, according to the chart, that occurred about 11:00 AM. Not about 11:00 AM, it occurred at 11:00 AM; is that your recollection?
A. It occurred a little bit between 10:30 to 11:00 when I was in his room.
Q. All right. When you fill out a medical chart and you put a time on the chart, does that time reflect the time that you arrive, the time that you do examinations, or the time that you're entering the note in the chart?
A. The time I'm entering the note.
Q. Is that standard of care to use the time that you're entering the note?
A. Yes, unless you had come back, let's say, later in the day because the

patient may not have been there, and I would usually say late entry for when I saw him earlier.

Q. Fair enough. After you had -- strike that.

When you were first told about Mr. Elder having chest pains and here's his room number, did you view him as a medical emergency?

A. Before I went to see him?

Q. Yes.

A. No.

Q. After you got to the floor and reviewed his chart, did you view him as a medical emergency?

A. No.

Q. Why not?

A. Previously from the review of the chart, some of the history suggested that this may be one of the many chest pain patients we have which leads to no significant diagnosis of, let's say, heart attack or, you know, pulmonary embolism and such.

Q. Okay. You would have known at the time, though, that he had a dilated aorta, right?

A. Correct.

Q. And so that certainly is abnormal, correct?

A. Correct.

Q. And that gives rise to a suspicion at least of something that you would put on your differential would be an aortic dissection, correct?

A. On the differential, correct.

Q. And I understand it's not a confirmed diagnosis yet, but when you see a dilated aorta, one of the reasonable possibilities for that is an aortic dissection, correct?

A. Correct.

Q. Okay. And that's something that you would have had in your head at the time that you saw Mr. Elder, correct?

A. Yes.

Q. And you understood that an aortic dissection if that were present could be a

medical emergency, correct?

A. Correct, that's present.

Q. All right. But then you also viewed him as it being possible that he might have other cardiac conditions and not an aortic dissection; is that right?

A. Correct.

Q. The enzymes had been done by the time that you got down there, and those were all negative for an -- and an EKG were all negative for myocardial infarction, correct?

A. Correct.

Q. And so that while it's not definitive, that makes an MI pretty much -- certainly makes it less likely of a diagnosis, correct?

A. Yes, an acute MI.

Q. Fair enough. From the information that I have in this case, before you got involved, an ER doctor contacted a Dr. Yi, Y-I, at 7:05 AM about Mr. Elder. Are you aware of that?

A. I just knew somebody from our group was talked to, but I didn't know exactly who

or when.

Q. I mean, it's fair to say that at the time that you first heard about Mr. Elder and went and saw her, the only information you had was information that he had chest pain, his room number, and then the information that was in the chart; is that correct?

A. Correct.

Q. Is Dr. Yi a member of your Heartland Cardiovascular?

A. Yes.

Q. Is he still as we sit here today?

A. Yes.

Q. And it's fair to say that you never talked to Dr. Yi? In fact, you didn't even know that it was Dr. Yi who had been involved in Mr. Elder's care in any way prior to your involvement?

A. Correct.

Q. According to the call sheets from Heartland Cardiovascular and the interrogatory answers, Dr. Yi was called at 7:05 AM. Were you on duty at 7:05 AM?

(Whereupon a short break was had from 3:05 PM to 3:12 PM.)

THE VIDEOGRAPHER: We're going back on the record. This will be the beginning of tape number 2. It is 3:12 PM. Please proceed.

BY MR. CIRIGNANI:

Q. Doctor, in Group Exhibit Number 2, there are colored tabs. There's a purple tab called progress notes. If you would flip to that tab and then in the lower right corner, there are page numbers with the beginning with the letter E dash. Would you turn to page 724.

A. Okay.

MR. MANGAN: And there's another number which I would ask you to read because I don't have your e-numbers.

MR. CIRIGNANI: Sure. Right below that is page 49.

MR. MANGAN: 49. Thank you.

BY MR. CIRIGNANI:

Q. It's fair to say that all of that information written on that page is your

handwriting, correct?

A. Correct.

Q. And that is an entry made by you on August 4th, 2008 at approximately 11:00 AM after you had completed your evaluation of Mr. Elder; is that fair?

A. Yes.

Q. At the top left column, it says cardiology consult, and then it says cardiology, and then in parentheses it says consult dictated, right?

A. Right.

Q. And that I believe refers to -- now, if you hold your finger there and flip to the green tab that says consult -- consultation, I should say?

A. Yes.

Q. The very first document there is a dictated report by you, correct?

A. Correct.

Q. And that's two pages long or actually three pages, to be technical, but two substantive pages; is that fair?

A. Correct.

Q. Okay. I take it that the dictated report is not a separate evaluation, it's just a dictation of the same evaluation that we saw in your handwritten report on page 724; is that correct?

A. Yes.

Q. So I know it doesn't contain exactly the same information, but it's not a separate new different evaluation, is it?

A. No, it's not a separate evaluation.

Q. Okay. So taken together, that should -- we should be able to see your thought process at the time that you finished your evaluation of Mr. Elder on August 4th, 2008 at about 11:00 AM; is that correct?

A. Correct.

Q. Okay. I'm going to work off the handwritten one on page 724 in the progress notes. If there's something else that -- if you want to look at the typewritten of course, I don't care. I mean, we'll look at whatever one you feel comfortable looking at to get the information.

In the right column under physician orders, you have things listed there by numbers -- 1, 2, 3, and 4, correct?

A. Right.

Q. Number 1 says CT chest with contrast; indication, rule out dissection, correct?

A. Correct.

Q. Did I read that right? Okay. So it would be fair to say -- and this is what I think we talked about a little bit earlier -- that based upon the earlier CT exam, one of the diagnoses on your differential was a possible aortic dissection, correct?

A. Correct.

Q. And you wanted to do a CT -- another CT scan, this one with contrast, in order to rule in or rule out that dissection, correct?

A. Correct.

Q. Was that CT now -- strike that.

Sometimes I have seen reference to CT angiography, and I understand that

they're technically different, although they're very similar, are they not?
A. Compared to?
Q. The CT with contrast.
A. I think it's my understanding it's the same thing. You'd probably have to ask a radiologist but --
Q. If Dr. Fagan said that they're slightly different, but if he had gotten an order for a CT with contrast, he would have done an angiography, you would have no reason to think that's wrong, right?
A. I think that's fair, correct.
Q. All right. Was this CT that you ordered under number 1 there ever done?
A. It was not done.
Q. Do you know why not?
A. I do not know why not.
Q. Can you tell me what attempts, if any, that you made to follow up on getting it done on August 4th, 2008?
A. No attempts.
Q. Was it a breach of the standard of care to not make sure that the test that you

ordered was, in fact, done?
A. The diagnosis was made by the time so the CT of the chest became a moot point at that point.
Q. Okay. And that was because the diagnosis of aortic dissection was made by the TEE; is that correct?
A. TTE.
Q. Did I say TEE?
A. Yes.
Q. I'm sorry, TTE.
A. Transthoracic.
Q. I apologize. For our purposes today, from here on out, I'm going to call it an echo. When I say echo, I'm going to mean the TTE type. Okay?
A. Right.
Q. So it was not a breach of the standard of care to not insure that the CT angio or the CT with contrast was done because you had gotten a confirmed diagnosis of aortic dissection by the echo; is that correct?
A. Correct.

Q. Give me one second here. All right. If you would turn to -- there's a blue tab called physician orders. If you can flip to that?
A. Okay.
Q. The very first page, page 740 of Group Exhibit 2 at the top, it says ED physician admission orders. Do you see that?
A. Yes.
MR. MANGAN: Could I have the number?
MR. CIRIGNANI: Page 46.
MR. MANGAN: 46. Thank you.
BY MR. CIRIGNANI:
Q. And one of the orders on there that's circled and initialed is CT angio of chest, rule out aortic aneurysm once in room. Do you see that?
A. Yes, I do.
Q. Based upon this medical record, that appears to be an order from the emergency room doctor, correct?
A. Correct.

Q. And that order appears to have been entered prior to your arrival to see Mr. Elder, correct?
A. Correct.
Q. And I take it that it's fair to say that that CT was never done either, correct?
A. Correct.
Q. Do you have any information as to why that CT wasn't done?
A. I have no information.
Q. When you arrived to see Mr. Elder at 10:30ish time on the 4th of August, you had available to you this particular sheet that we're looking at now, the emergency room physician order sheet, correct?
A. I don't remember seeing the sheet.
Q. It would have been available to you, correct?
A. Probably if it was in the chart.
Q. Okay. But as you sit here today, you do not have a recollection of actually looking at that sheet?
A. Correct.
Q. I take it then that is it -- strike

that.
Is it fair to say that at the time that you evaluated Mr. Elder and entered the orders that we were looking at on page 724 that you were unaware that there had been a previous order for a CT angiogram?
A. That is correct. I was not aware of anyone ordering a CT angiogram before I did.
Q. Okay. Had you been aware that a previous CT angio had been ordered, would you have taken steps to find out -- to make sure that it got done?
A. If I had known someone had ordered it?
Q. Yes.
A. Yes.
Q. And that's because I take it -- I'm sorry?
A. Depending on the circumstances also, I'd probably see the patient first and see what exactly was going on.
Q. Okay. Fair enough. By the time

that you sat down to write your orders that are on page 724, you would have taken some step to say, you know, let's get that thing done that was ordered earlier, the CT angio, right?
A. Correct, if it had been ordered.
Q. And what would you have done?
A. Tell them to do the order that was written.
Q. Okay. So then let me ask you this question: As a practical matter, your orders essentially are pretty close to the same order for the same purpose, it's to do a CT of his chest with contrast in order to rule in or rule out an aortic dissection, right?
A. Correct.
Q. So at that point in time, your order would be essentially the same value as the earlier order, right?
A. Correct.
Q. So the point was let's get this done, right? It wouldn't have to be whose order you're getting done, it's just let's

get one done, right?
A. I believe so.
Q. All right. I mean, you wouldn't have said do a CT angio that was ordered earlier and then when you're done with that do a CT with contrast, would you?
A. No, I would have repeated it.
Q. They're essentially the same type of test?
A. Correct.
Q. And so given that, the whole point was just to make sure it got done, not to make sure whose order got followed, correct?
A. Correct.
Q. Okay. Now, you also ordered the echo, correct?
A. Correct.
Q. And, by the way, I meant to ask you this, you number your orders there. Was that intended to be the order in which they would be done or is it just happened to be a list?
A. It was an intention by me in terms of stepwise procedures to be done.

Q. So when you wrote the order that's listed the orders listed in one, two, three, and four on page 724, Group Exhibit Number 2, it was your intention that they be followed in that order, that the CT be done first, then the echo, and then the whatever, keep NPO, and then the stress study?
A. Correct.
Q. Who did you tell that to?
A. I didn't tell anyone. It was given as an order to the secretary on the floor.
Q. When you say it was given as an order to the secretary, you mean what you wrote here?
A. Correct.
Q. Okay. And so then you assumed that the person reading this would know that this is a stepwise order that is intended to be done in that order?
A. I assume they would enter all the orders in, but not necessarily in a certain order.
Q. I'm sorry. Let me just make sure that we're talking about the same thing.

It's my understanding that when you wrote the orders that you did for Mr. Elder, it was your intention that they be actually conducted, those tests, in the order in which they're written, that the CT be done before the echo and that the echo be done before the stress test, right?
A. Correct.
Q. But I also understand that you didn't tell any of the nurses or anybody else that that was your intention, correct?
A. Not initially.
Q. Okay. All right. You assumed that when they read the order that they would know that?
A. Correct.
Q. Okay. Then you just said to me that not initially. Did at some point you say that?
A. Then I realized perhaps they may not have assumed that it's the same way I thought it so I had called the stress lab to tell them don't do it until the CT scan is done.

Q. Okay. All right. What time did you do that? What time did you call the stress lab?
A. I don't remember. To my best recollection, probably 12:00 to 12:30.
Q. Okay. So what you just told me that you called the stress lab to tell them that you wanted it in a particular order, I didn't see that recorded anywhere in the record. Did you?
A. No, it's not in the record.
Q. So then that testimony you're giving me then is based upon your independent recollection?
A. Correct.
Q. Okay. Okay. Do you remember who it was that you spoke to in the stress lab?
A. One of the stress lab nurses. I don't remember which one.
Q. All right. And why was it that you wanted the CT done before the echo and the echo done before the stress test?
A. To, as it says, rule out any dissection, and you don't want to stress

someone to have something else going on.
Q. And you would agree that particularly with an aortic dissection a stress test is contraindicated?
A. Correct.
Q. Because it actually worsens the condition of a dissection?
A. Right.
Q. Okay. Now, one of the reasons that you ordered the echo that I see written there is to evaluate the valve size of the ascending aorta, correct?
A. Correct.
Q. Help me understand that. Is that literally to just understand the size of the valve or is that specifically diagnostic in the sense of wanting to know whether there's a dissection?
A. Just to confirm the size seen on the CT without contrast and to look at how his valve looked like.
Q. Okay. So it wasn't specifically for the purpose of ruling in a dissection, that was what the CT chest was for?

A. Correct.
Q. This was to give you more information?
A. Right.
Q. Got you. But it ended up evidently that the echo was able to diagnose or confirm your suspicions that he had an aortic dissection, correct?
A. Correct.
MR. MANGAN: Object to the form.
BY MR. CIRIGNANI:
Q. Now, you ordered the echo at 11:00 AM; is that right, I mean, according to the sheet?
A. Yes.
Q. Now, the echo wasn't done until 12:30 PM; is that correct?
A. I do not know what time it was started.
Q. Let's see if we can figure that out. The next page, if we turn the page, right from your entry on 724, on the next page we have an entry from a nurse -- I guess it says late entry, and I can't figure

out what that means. Anyhow, that entry seems to be 12:34 PM, right, 12:30 in the afternoon?
A. Correct.
Q. And it says patient arrived via cart from nuclear medicine for second part of stress test?
A. Correct.
Q. So nuclear, would that be where they would do just a portion of the stress test, the Myoview or something?
A. The actual scan.
Q. Okay. Okay. All right. But then later on it talks about echo technician here to do echocardiogram. Does that help you identify the time frame in which the echo may have been done? It's toward the bottom half.
It says -- just before your name, it says CT order not in computer, RN notified, echo technician here to do echocardiogram. Then Dr. Lertsburapa notified per echo technician that plaintiff has an aortic dissection.

A. To my best guess it was probably started a little after 12:30.
Q. Okay. All right. Are you qualified -- strike that.
Were you qualified at the time that you cared for Mr. Elder to interpret echocardiograms, a TTE specifically?
A. Yes.
Q. You could have called then an echo technician and had an echo done in front of you at 11:00 o'clock if you had wanted to?
A. Yes, if I wanted to.
Q. And that can be done pretty quickly, right?
A. Yes.
Q. I mean, certainly less than a half an hour?
MR. MANGAN: Objection, foundation.
THE WITNESS: Depending on the flow, but, yes, if I really needed it.
BY MR. CIRIGNANI:
Q. Okay. All right. Which means that you personally could have confirmed your suspicions or your differential diagnosis

that he might have had an aortic dissection if you had wanted to do it yourself, right?
MR. MANGAN: Object to the form.
THE WITNESS: You mean would I do the echo myself?
BY MR. CIRIGNANI:
Q. No, sir. I didn't mean that. You would have an echo technician do the echo, correct, but you would be able to be right there watching it?
A. Bedside, yes, that could have that can be done.
Q. All right. Okay. The order for the echo does not contain the word stat nor does the box above that say stat checked. Was it your intention that those examinations be done stat?
A. No, not initially.
Q. Why did you not order it stat?
A. Because of the -- my clinical suspicion at the time when I saw Mr. Elder in his room.
Q. So what was your clinical suspicion?

A. That he may have an aneurysm, but with his other history, going through the chart, there were other diagnoses which may have been higher on the list.
Q. Okay. So you in your mind as you looked at your differential diagnosis list thought that there were some diagnoses that would have been more likely than the dissecting aorta, correct?
A. Correct.
Q. But, nonetheless, you knew that an aortic dissection was possible in light of the earlier CT scan, and so you ordered tests to rule that out?
A. Correct.
Q. Okay. According to the note on page 725, the nurses' note we looked at that says that Dr. Lertsburapa notified per echo technician that plaintiff had an aortic dissection, so it's fair to say, is it not, that sometime around 12:30 or so in the afternoon you were notified that, in fact, he had an aortic dissection, correct?
A. It was closer to -- closer to 1:00.

If I remember, it was around 12:45.
Q. Okay. All right. And, again, I didn't see any notes in the record by you indicating when you received that. The only one I saw is this one. So from based upon your independent memory, it was about 12:45?
A. Correct.
Q. Now, I understand from other documents, other recordkeeping that once you -- the aortic dissection was confirmed that you then tried to get emergent surgical management of that dissection; is that correct?
A. Correct.
Q. It's my understanding that you started trying to find a surgeon to do emergency surgery on Mr. Elder at about 2:00 PM; is that correct?
A. No, approximately 1:00 PM.
Q. All right. Let's take a look at page 730. Let me just make sure that's right. Hold on. Let me see. 728. I'm sorry. All right. If you look at the bottom half of the page 728, the note that's

entered at 2:00 PM?
A. Yes.
Q. It's dated August 4th, 2008 at 2:00 PM, correct?
A. Correct.
Q. And that's all your note, correct?
A. Correct.
Q. In the left column, would you read that for me?
A. Ativan 2 milligrams IV.
Q. Hold on. Hold on. I don't know where you're reading from.
MR. FETZER: He's reading the order side.
BY MR. CIRIGNANI:
Q. I'm sorry. Not that side, the left side. I apologize. Let's do the left side first on the progress, and then we'll read the order side. Okay?
A. From my note, correct?
Q. From your note.
A. Cardiology: Patient transferred for possible acute dissection seen on echo. Patient with chest pain but not as bad as

last night. CVOR consulted.
Q. Stop there. CVOR is cardiovascular surgeon, is it not?
A. Correct.
Q. So had you by this point in time at 2:00 o'clock already spoken to a cardiovascular surgeon?
A. Not the surgeon, the physician assistant.
Q. Okay. Okay. All right. Let's break that down for one second, and I will have you read the right side in a moment. First off, can you tell me real quickly it says patient transferred. Where was patient transferred to?
A. To the ICU or CCU.
Q. Okay. So now that he has a confirmed aortic dissection, you understand it's an acute dissection, you understand that he's in serious trouble and needs to be in the ICU, correct?
A. Correct.
Q. Now, it says here that you told me that you contacted a cardiovascular surgeon,

but you talked to the physician assistant for those surgeon or surgeons, correct?
A. Correct.
Q. Okay. Who did you talk to?
A. The physician assistant's name is Bill. I don't remember his last name.
Q. So what group was it?
A. I'm not aware of the surgical group name, but it was Dr. Altergott and Foy's group.
Q. And that's a group that was located -- officed -- or strike that. That was a group that was attending Saint Joseph's Medical Center, correct?
A. Correct.
Q. And that would be naturally the first group that you would contact would be the group that normally operates there and is operating there?
A. Correct.
Q. And it's your testimony that you contacted a physician assistant about 1:00 o'clock; is that right?
A. 1:00 o'clock or maybe ten minutes

EXHIBIT 11

If I remember, it was around 12:45.
Q. Okay. All right. And, again, I didn't see any notes in the record by you indicating when you received that. The only one I saw is this one. So from based upon your independent memory, it was about 12:45?
A. Correct.
Q. Now, I understand from other documents, other recordkeeping that once you -- the aortic dissection was confirmed that you then tried to get emergent surgical management of that dissection; is that correct?
A. Correct.
Q. It's my understanding that you started trying to find a surgeon to do emergency surgery on Mr. Elder at about 2:00 PM; is that correct?
A. No, approximately 1:00 PM.
Q. All right. Let's take a look at page 730. Let me just make sure that's right. Hold on. Let me see. 728. I'm sorry. All right. If you look at the bottom half of the page 728, the note that's

entered at 2:00 PM?
A. Yes.
Q. It's dated August 4th, 2008 at 2:00 PM, correct?
A. Correct.
Q. And that's all your note, correct?
A. Correct.
Q. In the left column, would you read that for me?
A. Ativan 2 milligrams IV.
Q. Hold on. Hold on. I don't know where you're reading from.
MR. FETZER: He's reading the order side.
BY MR. CIRIGNANI:
Q. I'm sorry. Not that side, the left side. I apologize. Let's do the left side first on the progress, and then we'll read the order side. Okay?
A. From my note, correct?
Q. From your note.
A. Cardiology: Patient transferred for possible acute dissection seen on echo. Patient with chest pain but not as bad as

last night. CVOR consulted.
Q. Stop there. CVOR is cardiovascular surgeon, is it not?
A. Correct.
Q. So had you by this point in time at 2:00 o'clock already spoken to a cardiovascular surgeon?
A. Not the surgeon, the physician assistant.
Q. Okay. Okay. All right. Let's break that down for one second, and I will have you read the right side in a moment. First off, can you tell me real quickly it says patient transferred. Where was patient transferred to?
A. To the ICU or CCU.
Q. Okay. So now that he has a confirmed aortic dissection, you understand it's an acute dissection, you understand that he's in serious trouble and needs to be in the ICU, correct?
A. Correct.
Q. Now, it says here that you told me that you contacted a cardiovascular surgeon,

but you talked to the physician assistant for those surgeon or surgeons, correct?
A. Correct.
Q. Okay. Who did you talk to?
A. The physician assistant's name is Bill. I don't remember his last name.
Q. So what group was it?
A. I'm not aware of the surgical group name, but it was Dr. Altergott and Foy's group.
Q. And that's a group that was located -- officed -- or strike that. That was a group that was attending Saint Joseph's Medical Center, correct?
A. Correct.
Q. And that would be naturally the first group that you would contact would be the group that normally operates there and is operating there?
A. Correct.
Q. And it's your testimony that you contacted a physician assistant about 1:00 o'clock; is that right?
A. 1:00 o'clock or maybe ten minutes

after.
Q. Essentially as soon as you were made aware that he had a dissection, you got on the phone and you called the surgeon saying I've got a patient who needs surgery, correct?
A. Correct.
Q. You talked to the physician assistant whose name is Bill. What did you tell him, and what did he tell you?
A. I told him that we had someone who had an aortic dissection and needs to go to surgery. I don't remember any other important information from the conversation. I think he came to see him in the ICU.
Q. I'm sorry. Who came? Somebody came to see Mr. Elder in the ICU?
A. No.
Q. The physician assistant did?
A. Correct.
Q. I didn't see an entry from a physician assistant in the chart, did you, or maybe I'm wrong?
A. I think it's this entry on 727.

Q. So the previous page?
A. CV surg, 136.
Q. I got it. Okay. I see. All right. I don't see a time for that entry, do you?
A. 13:36.
Q. Oh, that is 13. My type is bad. So about 1:36 PM which would follow if you made the phone call at about 1:00 or so?
A. He probably saw him and then wrote the note.
Q. Give me one second here. So at this point in time after you called the physician assistant you said that -- I'm sorry, I lost my train of thought there.
You told him about the dissection, you told him that your patient needed emergency surgery, correct? Is that a yes?
A. Yes.
Q. Okay. And what did he say back to you?
A. He said he would talk to Dr. Altergott, and that was the initial

conversation.
Q. Okay. That was the one that took place around 1:00 o'clockish?
A. Between 1:00 and 1:30, correct.
Q. Okay. Let me see if I got the sequence of events right. At 12:45 you're notified that he, in fact -- that Mr. Elder, in fact, has an aortic dissection, correct?
A. Correct.
Q. Then you pick up the phone sometime around 1:00 o'clock to call Dr. Altergott's group, and you speak to his physician assistant named Bill?
A. Correct.
Q. And in that conversation, you tell him that you need this emergency surgery, and he tells you that he'll notify Dr. Altergott?
A. Correct. Can I just add that I don't remember if I spoke to him on the phone or whether he actually was in the ICU.
Q. Okay. Fair enough. Okay. All right. You found him somehow?
A. Correct.

Q. Okay. And then apparently the physician assistant went ahead and saw Dr. Elder, I mean, Mr. Elder and evaluated him at approximately 1:36; is that fair?
A. Yes.
Q. So what did the physician -- other than tell you he's going to talk to the doctor or mention it to the doctor, did he tell you that he was going to do anything else?
A. I had asked whether we needed to do any further imaging, and I think Bill had told me that he said that was not necessary at that point.
Q. Okay. All right. What else? Anything else?
A. He told me Dr. Foy wasn't available, but I don't remember if that was when we first had discussed the case or afterwards.
Q. You mean afterwards, after he died?
A. No, after like an hour had passed. I don't remember.
Q. So I take it that you had a couple

of conversations then with Bill?
A. Probably maybe two.
Q. All right. One when you first contacted him, and then a subsequent one at some point?
A. Correct.
Q. And you're not sure whether it was the initial or the subsequent conversation in which it was mentioned that Dr. Foy was not available?
A. Correct.
Q. What did Dr. -- how do you pronounce his name?
A. Altergott.
Q. It is Altergott. What about Dr. Altergott? What were you told about his availability?
A. Initially I don't remember Bill saying anything about his not being available. I had assumed he was around.
Q. Okay. Okay. So help me understand your thought process at this point in time. You're trying to get your patient emergency surgery to repair his dissection, you

know -- you called the group. Do you think that the group is handling it or --
A. I assumed Bill and the surgical group were handling it because he had ordered some, you know, blood work, blood banked to be ready, some labs, I think, and that was how it started.
Q. Okay. So do you view -- strike that.
Is it your understanding then of events that you had passed off the care of Mr. Elder to Bill and the physicians in that group?
MR. MANGAN: Object to the form. Go ahead.
THE WITNESS: Passed off preparation for surgical care. Medically I was still managing.
BY MR. CIRIGNANI:
Q. Okay. Okay. Fair enough. So you were going to continue to medically manage, which means to try to control his blood pressure primarily, right?
A. Correct.

Q. Okay. Until he can actually get into surgery, right?
A. Correct.
Q. But as far as getting him into surgery and preparing him for surgery, you believed at this point in time when you talked to Bill at some time between 1:00 and 1:30 that that was being taken care of by them?
A. Correct.
Q. Okay. At some point then did you find out that they, in fact, were not going to be able to do the surgery?
A. I didn't find out that they weren't able to. I found out they were concerned whether they would get to him in time.
Q. Tell me about that. Explain that to me.
A. As I think there's a note I had written where Dr. Altergott actually called me from the operating room.
Q. Okay.
A. Discussing his concerns about perhaps transferring Mr. Elder as he was

still tied up in his case.
Q. And that was -- let me see if I have my notes -- that was sometime about 2:25, correct?
A. Correct.
Q. And I think your note is on page 732. Let me see. Right. Page 732?
A. Correct.
Q. Now, that note was entered at 4:35, but it actually refers to your earlier conversations, and it specifically has the time within the note at which those calls occurred, correct?
A. Yes.
Q. All right. Okay. So you're thinking -- sometime around 1:30ish you're thinking that preparation is underway to get Mr. Elder into surgery, and then at about 2:25 you're notified by the cardiovascular surgeon that, in fact, he's thinking that you're going to have to transfer him somewhere because he may not be able to get to him in time; is that right?
A. Correct.

Q. Let me just go back in time a little bit. At 11:00 AM, after you had finished your evaluation of Mr. Elder, you understood that one of the distinct possibilities was that he had an aortic dissection, correct?
A. Correct.
Q. You could have, if you had wanted to, notify the surgeons at that point in time of a possible aortic dissection, correct?
A. I could have.
Q. Okay. Why didn't you?
A. Again, my suspicion was low at that time, and they wouldn't take him unless he had some sort of diagnosis to surgery.
Q. Okay. Right. Fair enough. You still needed the diagnosis in order to actually get the surgery done, correct?
A. Correct.
Q. But you could have called them and asked them or let them know to prepare them or to find out if they were going to have slots available, correct?

A. I could have, but normally I don't do that.
Q. Okay. I take it then from everything that you've told me that if you had had a confirmed diagnosis of aortic dissection by CT when you walked in to see Mr. Elder that you would have not entered all those orders, but you would have immediately got on the phone as you did later to try to get him into surgery; is that fair?
A. Did you say if I had results of a CT scan before I saw him?
Q. Correct.
A. I probably wouldn't have seen him in that case.
Q. Okay. Let's see if I can -- I think we're saying the same thing, but let me be sure. If I recall, you were basically told that he has chest pains, go see this patient. When you had walked into that patient's or onto the cardiac floor and you picked up his chart and in that chart was a CT scan with contrast that confirmed the

diagnosis of aortic dissection, you would have gotten on the phone with the surgeon to get him into surgery, correct?
A. Provided no one had done it already.
Q. Fair enough. Okay. In this case a stress test -- a resting stress test which -- let's talk about our terms for a minute.
Some stress tests are done by putting a person on a treadmill and making them exercise, correct?
A. Yes.
Q. Other stress tests are done medically by giving medications that stresses their heart, and they test it that way, correct?
A. Yes.
Q. In this case, Mr. Elder had the resting or medical stress test at about 3:00 PM, correct?
A. No. He had that done probably before he had the echo done. I would assume, I'm guessing on the time, probably

noon or maybe a little before.
Q. All right. Let's see. Okay. All right. So it's your understanding, and I don't have it at my fingertips, I thought that the -- let me just see. Hold on a second. I think I remember now where I saw that at.
It is your understanding that the stress test -- the nontreadmill stress test was done on Mr. Elder sometime on or after 12:30, but before the echo but before the echo; is that correct?
MR. MANGAN: Object to the form of the question. Misstates the testimony.
BY MR. CIRIGNANI:
Q. All right. That's what I'm asking him.
A. He didn't have a stress test. He had a resting portion of a stress test.
Q. Okay. Just sitting there?
A. Correct.
Q. No medication given, just to see what his baseline would be?
A. Just a tracer.

EXHIBIT 12

IN THE CIRCUIT COURT OF THE TWELFTH JUDICIAL CIRCUIT
WILL COUNTY, ILLINOIS

BRENDA GRAMELSPACHER, Special Administrator of the Estate of JEFFREY T. ELDER, Deceased,	)	
Plaintiff,	)	
v.	)	No. 08 L 827
PROVENA HOSPITALS d/b/a PROVENA SAINT JOSEPH MEDICAL CENTER, KIRKEITH LERTSBURAPA, M.D., JONG-YOON YI, M.D., and CARDIOLOGY ASSOCIATES OF NORTHERN ILLINOIS ILLINOIS, LLC d/b/a HEARTLAND CARDIOVASCULAR CENTER, LLC, ANDREW ZWOLSKI, M.D., PRAIRIE EMERGENCY SERVICES, S.C., AHMED HUSSAIN, M.D., and INTERNAL MEDICINE & FAMILY PRACTICE, S.C.,	)	
Defendants.	)	

FIFTH AMENDED COMPLAINT AT LAW

NOW COMES the Plaintiff, Brenda Gramelspacher, Special Administrator of the Estate of Jeffrey T. Elder, Deceased, by and through her attorneys, Cirignani, Heller & Harman, LLP, complaining of the Defendants, Provena Hospitals d/b/a Provena Saint Joseph Medical Center, Kirkeith Lertsburapa, M.D., Jong-Yoon Yi, M.D. and Cardiology Associates of Northern Illinois, LLC d/b/a Heartland Cardiovascular Center, LLC, Andrew Zwolski, M.D., Prairie Emergency Services, S.C., Ahmed Hussain, M.D. and Internal Medicine & Family Practice, S.C., stating as follows:

1. In August 2008 and at all relevant times herein, Defendant Provena Hospitals (hereinafter referred to as "Provena") was a non-profit corporation organized and existing under the laws of the State of Illinois, providing medical services and facilities as a hospital, commonly known as Provena Saint Joseph Medical Center, by and through its agents and employees, for the care and treatment of the patients admitted therein in the City of Joliet, County of Will and State of Illinois.

2. In August 2008 and at all relevant times herein, Defendant Cardiology Associates of Northern Illinois, LLC d/b/a Heartland Cardiovascular Center LLC (hereinafter referred to as "Heartland") was an Illinois corporation providing cardiology services for the care and treatment of patients, by and through its agents and employees, in the County of Will and State of Illinois.

3. In August 2008 and at all relevant times herein, Defendant Kirkeith Lertsburapa, M.D. (hereinafter referred to as "Lertsburapa") was a physician duly licensed under the laws of the State of Illinois and was engaged in the practice of cardiology in Will County, Illinois.

4. In August 2008 and at all relevant times herein, Defendant Jong-Yoon Yi, M.D. (hereinafter referred to as "Yi") was a physician duly licensed under the laws of the State of Illinois and was engaged in the practice of cardiology in Will County, Illinois.

5. In August 2008 and at all relevant times herein, Defendant Prairie Emergency Services, S.C. (hereinafter referred to as "Prairie") was an Illinois corporation providing emergency medicine services for the care and treatment of patients, by and through its agents and employees, in the County of Will and State of Illinois.

6. In August 2008, and at all relevant times herein, Defendant Andrew Zwolski, M.D. (hereinafter referred to as "Zwolski") was a physician duly licensed under the laws of the State of Illinois and was engaged in the practice of emergency medicine in Will County, Illinois.

7. In August 2008 and at all relevant times herein, Defendant Internal Medicine & Family Practice, S.C. (hereinafter referred to as "IMFP") was an Illinois corporation providing internal medicine services for the care and treatment of patients, by and through its agents and employees, in the County of Will and State of Illinois.

8. In August 2008 and at all relevant times herein, Defendant Ahmed Hussain, M.D. (hereinafter referred to as "Hussain") was a physician duly licensed under the laws of the State of Illinois and was engaged in the practice of internal medicine in Will County, Illinois.

9. On August 4, 2008 at 5:20 a.m., Jeffrey T. Elder (hereinafter referred to as "Todd") presented to Provena Saint Joseph Medical Center with chest pain.

10. In the Emergency Department of Provena Saint Joseph Medical Center, Todd came under the care of Defendant Zwolski.

11. On August 4, 2008 at or about 6:55 a.m., a CT scan of the chest without contrast was performed.

12. The CT scan was interpreted by Brian Fagan, M.D.

13. Dr. Fagan indicated to Defendant Zwolski that there was a possibility of a dilated ascending aorta.

14. Dr. Fagan recommended that CT angiography be done.

15. Defendant Zwolski ordered CT angiography of the chest.

16. On August 4, 2008 at or about 7:00 a.m., Defendant Zwolski spoke with Defendant Yi.

17. On August 4, 2008 at or about 7:00 a.m., Todd was admitted to Provena St. Joseph Medical Center.

18. On August 4, 2008 at or about 7:00 a.m., Todd came under the care of Defendant Hussain.

19. On August 4, 2008 at or about 9:30 a.m., Defendant Hussain ordered a cardiology consultation.

20. On August 4, 2008 at or before 11:00 a.m., Todd was seen by Defendant Lertsburapa.

21. Defendant Lertsburapa ordered an echocardiogram.

22. The echo technician for the echocardiogram informed Defendant Lertsburapa that the echocardiogram indicated there was an aortic dissection.

23. On August 4, 2008 at or about 4:12 p.m., Todd died at Provena Saint Joseph Medical Center from complications of the ascending aortic dissection.

24. Todd left surviving him: his wife Shelly Elder, and his children, Brandon Elder, Logan Elder, Lanie Elder and Tessa Elder.

25. By reason of the death of Todd, his wife Shelly Elder, and his children, Brandon Elder, Logan Elder, Lanie Elder and Tessa Elder, have been deprived of his comfort, society, companionship and protection and have sustained pecuniary damages, all to their great loss and damage.

26. The Plaintiff, Brenda Gramelspacher, is the Special Administrator of the Estate of Jeffrey T. Elder.

COUNT I
KIRKEITH LERTSBURAPA, M.D. (Wrongful Death Action)

27. Plaintiff adopts and incorporates paragraphs 1-26 inclusive of this Complaint at Law as though fully set forth herein.

28. There was a duty on the part of Defendant Lertsburapa to diagnose and treat Todd in accordance with accepted standards of prevailing cardiology practice and opinion in Will County, Illinois.

29. After assuming the care and treatment of Todd, Defendant Lertsburapa was guilty of one or more of the following wrongful acts and/or omissions in treating Todd:

a. Negligently and carelessly failed to inquire about the reason his consultation was requested;

b. Negligently and carelessly failed to see Todd immediately after being notified of the consultation request;

c. Negligently and carelessly failed to directly supervise the care of Todd;

d. Negligently and carelessly failed to timely diagnose Todd's ascending aortic dissection;

e. Negligently and carelessly failed to timely treat Todd's ascending aortic dissection; and

f. Negligently and carelessly failed to timely contact a cardiovascular surgeon.

30. As a direct and proximate result of one or more of the aforementioned acts and/or omissions of Defendant Lertsburapa, Todd died.

31. Plaintiff brings this action under 740 ILCS 180/1 & 2 governing wrongful death actions.

WHEREFORE, Plaintiff asks for judgment against Defendant Lertsburapa in an amount in excess of Fifty Thousand Dollars ($50,000.00).

COUNT II
KIRKEITH LERTSBURAPA, M.D. (Survival Action)

32. Plaintiff adopts and incorporate paragraphs 1-26 inclusive of this Complaint at Law as though fully set forth herein.

33. Plaintiff adopts and incorporates paragraphs 28-29 inclusive of this Complaint at Law as though fully set forth herein.

34. As a direct and proximate result of one or more of the aforementioned acts and/or omissions of Defendant Lertsburapa, Todd's aortic dissection was not timely diagnosed and treated and Todd experienced permanent physical and neurological injury, pain and suffering, pecuniary loss and irreversible damage to his body.

35. Plaintiff brings this action pursuant to 755 ILCS 5/27-6, governing survival of actions.

WHEREFORE, Plaintiff asks for judgment against Defendant Lertsburapa in an amount in excess of Fifty Thousand Dollars ($50,000.00).

COUNT III
JONG-YOON YI, M.D. (Wrongful Death Action)

36. Plaintiff adopts and incorporates paragraphs 1-26 inclusive of this Complaint at Law as though fully set forth herein.

37. There was a duty on the part of Defendant Yi to diagnose and treat Todd in accordance with accepted standards of prevailing cardiology practice and opinion in Will County, Illinois.

38. After assuming the care and treatment of Todd, Defendant Yi was guilty of one or more of the following wrongful acts and/or omissions in treating Todd:

a. Negligently and carelessly failed to inquire about the reason his consultation was requested;

b. Negligently and carelessly failed to see Todd immediately after being notified of the consultation request;

c. Negligently and carelessly failed to directly supervise the care of Todd;

d. Negligently and carelessly failed to timely diagnose Todd's ascending aortic dissection;

e. Negligently and carelessly failed to timely treat Todd's ascending aortic dissection;

f. Negligently and carelessly failed to timely contact a cardiovascular surgeon;

g. Negligently and carelessly failed to follow-up on the CT angiogram which was ordered; and

h. Negligently and carelessly failed to ensure that Todd was seen immediately upon notification of the consultation request.

39. As a direct and proximate result of one or more of the aforementioned acts and/or omissions of Defendant Yi, Todd died.

40. Plaintiff brings this action under 740 ILCS 180/1 & 2 governing wrongful death actions.

WHEREFORE, Plaintiff asks for judgment against Defendant Yi in an amount in excess of Fifty Thousand Dollars ($50,000.00).

COUNT IV
JONG-YOON YI, M.D. (Survival Action)

41. Plaintiff adopts and incorporate paragraphs 1-26 inclusive of this Complaint at Law as though fully set forth herein.

42. Plaintiff adopts and incorporates paragraphs 37-38 inclusive of this Complaint at Law as though fully set forth herein.

43. As a direct and proximate result of one or more of the aforementioned acts and/or omissions of Defendant Yi, Todd's aortic dissection was not timely diagnosed and treated and Todd experienced permanent physical and neurological injury, pain and suffering, pecuniary loss and irreversible damage to his body.

44. Plaintiff brings this action pursuant to 755 ILCS 5/27-6, governing survival of actions.

WHEREFORE, Plaintiff asks for judgment against Defendant Yi in an amount in excess of Fifty Thousand Dollars ($50,000.00).

COUNT V
CARDIOLOGY ASSOCIATES OF NORTHERN ILLINOIS, LLC d/b/a HEARTLAND CARDIOVASCULAR CENTER, LLC (Wrongful Death Action)

45. Plaintiff adopts and incorporates paragraphs 1-26 inclusive of this Complaint at Law as though fully set forth herein.

46. At all relevant times herein, Defendant Lertsburapa, Defendant Yi and Ellen Lukawski, R.N. were agents and/or employees of Defendant Heartland.

47. At all relevant times herein while Defendant Lertsburapa, Defendant Yi and Ellen Lukawski, R.N. were rendering care and treatment to Todd, they were acting within the scope of their employment with Defendant Heartland.

48. There was a duty on the part of Defendant Heartland, by and through its agents and/or employees, including but not limited to Defendant Lertsburapa, Defendant Yi and Ellen Lukawski,

R.N., to diagnose and treat Todd in accordance with accepted standards of prevailing cardiology and nursing practice and opinion in Will County, Illinois.

49. After assuming the care and treatment of Todd, Defendant Heartland, by and through its agents and/or employees, including but not limited to Defendant Lertsburapa and Defendant Yi, was guilty of one or more of the following wrongful acts and/or omissions in treating Todd:

a. Negligently and carelessly failed to inquire about the reason his consultation was requested;

b. Negligently and carelessly failed to see Todd immediately after being notified of the consultation request;

c. Negligently and carelessly failed to directly supervise the care of Todd;

d. Negligently and carelessly failed to have the CT scan of the chest with contrast performed in a timely manner;

e. Negligently and carelessly failed to ensure that Todd was seen immediately upon notification of the consultation request;

f. Negligently and carelessly failed to timely diagnose Todd's ascending aortic dissection;

g. Negligently and carelessly failed to timely treat Todd's ascending aortic dissection;

h. Negligently and carelessly failed to timely contact a cardiovascular surgeon; and

i. Negligently and carelessly failed to follow-up on the CT angiogram which was ordered.

50. As a direct and proximate result of one or more of the aforementioned acts and/or omissions of Defendant Heartland, by and through its agents and/or employees, including but not limited to Defendant Lertsburapa and Defendant Yi, Todd died.

51. Plaintiff brings this action under 740 ILCS 180/1 & 2 governing wrongful death actions.

WHEREFORE, Plaintiff asks for judgment against Defendant Heartland in an amount in excess of Fifty Thousand Dollars ($50,000.00).

COUNT VI
CARDIOLOGY ASSOCIATES OF NORTHERN ILLINOIS, LLC d/b/a HEARTLAND CARDIOVASCULAR CENTER, LLC (Survival Action)

52. Plaintiff adopts and incorporates paragraphs 1-26 inclusive of this Complaint at Law as though fully set forth herein.

53. Plaintiff adopts and incorporates paragraphs 46-49 inclusive of this Complaint at Law as though fully set forth herein.

54. As a direct and proximate result of one or more of the aforementioned acts and/or omissions of Defendant Heartland, by and through its agents and/or employees, including but not limited to Defendant Lersburapa and Defendant Yi, Todd's aortic dissection was not timely diagnosed and treated and Todd experienced permanent physical and neurological injury, pain and suffering, pecuniary loss and irreversible damage to his body.

55. Plaintiff brings this action pursuant to 755 ILCS 5/27-6, governing survival of actions.

WHEREFORE, Plaintiff asks for judgment against Defendant Heartland in an amount in excess of Fifty Thousand Dollars ($50,000.00).

COUNT VII
ANDREW ZWOLSKI, M.D. (Wrongful Death Action)

56. Plaintiff adopts and incorporates paragraphs 1-26 inclusive of this Complaint at Law as though fully set forth herein.

57. There was a duty on the part of Defendant Zwolski to diagnose and treat Todd in accordance with accepted standards of prevailing emergency medicine practice and opinion in Will County, Illinois.

58. After assuming the care and treatment of Todd, Defendant Zwolski was guilty of one or more of the following wrongful acts and/or omissions in treating Todd:

a. Negligently and carelessly failed to order CT angiography or aCT of the chest with contrast to be done immediately;

b. Negligently and carelessly failed to send Mr. Elder directly to the radiology department for CT angiography;

c. Negligently and carelessly failed to discontinue the Lovenox after being informed of the chest CT results.;

d. Negligently and carelessly failed to accurately report the results of the chest CT to Defendant Yi;

e. Negligently and carelessly informed Defendant Yi that Todd was on his way to have a CT angiogram or CT of the chest with contrast; and

f. Negligently and carelessly failed to inform Defendant Yi that Todd needed to be seen immediately by a cardiologist.

59. As a direct and proximate result of one or more of the aforementioned acts and/or omissions of Defendant Zwolski, Todd died.

60. Plaintiff brings this action under 740 ILCS 180/1 & 2 governing wrongful death actions.

WHEREFORE, Plaintiff asks for judgment against Defendant Zwolski in an amount in excess of Fifty Thousand Dollars ($50,000.00).

COUNT VIII
ANDREW ZWOLSKI, M.D. (Survival Action)

61. Plaintiff adopts and incorporate paragraphs 1-26 inclusive of this Complaint at Law as though fully set forth herein.

62. Plaintiff adopts and incorporates paragraphs 57-58 inclusive of this Complaint at Law as though fully set forth herein.

63. As a direct and proximate result of one or more of the aforementioned acts and/or omissions of Defendant Zwolski, Todd's aortic dissection was not timely diagnosed and treated and Todd experienced permanent physical and neurological injury, pain and suffering, pecuniary loss and irreversible damage to his body.

64. Plaintiff brings this action pursuant to 755 ILCS 5/27-6, governing survival of actions.

WHEREFORE, Plaintiff asks for judgment against Defendant Zwolski in an amount in excess of Fifty Thousand Dollars ($50,000.00).

COUNT IX
PRAIRIE EMERGENCY SERVICES, S.C. (Wrongful Death Action)

65. Plaintiff adopts and incorporates paragraphs 1-26 inclusive of this Complaint at Law as though fully set forth herein.

66. Plaintiff adopts and incorporates paragraphs 57-58 inclusive of this Complaint at Law as though fully set forth herein.

67. At all relevant times herein, Defendant Zwolski was an agent and/or employee of Defendant Prairie.

68. At all relevant times herein while Defendant Zwolski was rendering care and treatment to Todd, he was acting within the scope of his employment with Defendant Prairie.

69. As a direct and proximate result of one or more of the aforementioned acts and/or omissions of Defendant Prairie, by and through its agent and/or employee Defendant, Zwolski, Todd died.

70. Plaintiff brings this action under 740 ILCS 180/1 & 2 governing wrongful death actions.

WHEREFORE, Plaintiff asks for judgment against Defendant Prairie in an amount in excess of Fifty Thousand Dollars ($50,000.00).

COUNT X
PRAIRIE EMERGENCY SERVICES, S.C. (Survival Action)

71. Plaintiff adopts and incorporates paragraphs 1-26 inclusive of this Complaint at Law as though fully set forth herein.

72. Plaintiff adopts and incorporates paragraphs 57-58 inclusive of this Complaint at Law as though fully set forth herein.

73. Plaintiff adopts and incorporates paragraphs 67-68 inclusive of this Complaint at Law as though fully set forth herein.

74. As a direct and proximate result of one or more of the aforementioned acts and/or omissions of Defendant Prairie, by and through its agent and/or employee, Defendant Zwolski, Todd's aortic dissection was not timely diagnosed and treated and Todd experienced permanent physical and neurological injury, pain and suffering, pecuniary loss and irreversible damage to his body.

75. Plaintiff brings this action pursuant to 755 ILCS 5/27-6, governing survival of actions.

WHEREFORE, Plaintiff asks for judgment against Defendant Prairie in an amount in excess of Fifty Thousand Dollars ($50,000.00).

COUNT XI
PROVENA HOSPITALS d/b/a PROVENA SAINT JOSEPH MEDICAL CENTER.
(Wrongful Death Action)

76. Plaintiff adopts and incorporates paragraphs 1-26 inclusive of this Complaint at Law as though fully set forth herein.

77. On August 4, 2008 and at all relevant times herein, Defendant Zwolski, Dr. Fagan, Defendant Yi, Defendant Lertsburapa, Defendant Hussain, the nursing personnel, medical personnel and administrative personnel at Saint Joseph Medical Center were agents and/or employees of Defendant Provena.

78. In the alternative, on August 4, 2008 and at all relevant times herein, Defendant Provena held out to Todd that Defendant Zwolski, Dr. Fagan, Defendant Yi, Defendant Lertsburapa, Defendant Hussain, the nursing personnel, medical personnel and administrative personnel at Saint Joseph Medical

Center were agents of Defendant Provena; Todd relied upon this representation; and this reliance was reasonable.

79. On August 4, 2008 and at all relevant times herein while Defendant Zwolski, Dr. Fagan, Defendant Yi, Defendant Lertsburapa, Defendant Hussain, and the nursing personnel, medical personnel, unit secretaries and administrative personnel at Saint Joseph Medical Center rendering care and treatment to Todd, they were acting within the scope of their agency or employment with Defendant Provena.

80. There was a duty on the part of Defendant Provena by and through its agents and/or employees, Defendant Zwolski, Dr. Fagan, Defendant Yi, Defendant Lertsburapa, Defendant Hussain, nursing personnel, medical personnel, unit secretaries and administrative personnel, to diagnose and treat Todd in accordance with accepted standards of prevailing hospital practice and opinion in Will County, Illinois.

81. After assuming the care and treatment of Todd, Defendant Provena, by and through its agents and/or employees, Defendant Zwolski, Dr. Fagan, Defendant Yi, Defendant Lertsburapa, Defendant Hussain, nursing personnel, medical personnel, unit secretaries and administrative personnel, was guilty of one or more of the following wrongful acts and/or omissions in treating Todd:

a. Negligently and carelessly failed to have the CT scan of the chest with contrast or CT angiography performed in a timely manner;

b. Negligently and carelessly failed to notify the radiology department of Dr. Zwolski's order for a CT of the chest with contrast or CT angiography;

c. Negligently and carelessly failed to enter Dr. Zwolski's order for a CT scan of the chest with contrast or CT angiography into the system;

d. Negligently and carelessly failed to follow Dr. Zwolski's order for a CT scan of the chest with contrast or CT angiography;

e. Negligently and carelessly managed, maintained, controlled, owned and operated Provena Saint Joseph Medical Center Illinois in such a manner that caused Todd to be injured;

f. Lertsburapa and Yi negligently and carelessly failed to inquire about the reason his consultation was requested;

g. Lertsburapa and Yi negligently and carelessly failed to see Todd immediately after being notified of the consultation request;

h. Lertsburapa and Yi negligently and carelessly failed to directly supervise the care of Todd;

i. Lertsburapa and Yi negligently and carelessly failed to timely diagnose Todd's ascending aortic dissection;

j. Lertsburapa and Yi negligently and carelessly failed to timely treat Todd's ascending aortic dissection;

k. Lertsburapa and Yi negligently and carelessly failed to timely contact a cardiovascular surgeon;

l. Yi negligently and carelessly failed to follow-up on the CT angiogram which was ordered; and

m. Yi negligently and carelessly failed to ensure that Todd was seen immediately upon notification of the consultation request.

n. Zwolski negligently and carelessly failed to order CT angiography or aCT of the chest with contrast to be done immediately;

o. Zwolski negligently and carelessly failed to send Mr. Elder directly to the radiology department for CT angiography;

p. Zwolski negligently and carelessly failed to discontinue the Lovenox after being informed of the chest CT results.;

q. Zwolski negligently and carelessly failed to accurately report the results of the chest CT to Defendant Yi;

r. Zwolski negligently and carelessly informed Defendant Yi that Todd was on his way to have a CT angiogram or CT of the chest with contrast;

s. Zwolski negligently and carelessly failed to inform Defendant Yi that Todd needed to be seen immediately by a cardiologist;

t. Hussain negligently and carelessly failed to recognize that Todd's condition was a cardiac surgical emergency;

u. Hussain negligently and carelessly failed to ensure that the CT chest with contrast was done in a timely manner;

v. Hussain negligently and carelessly failed to ensure that Todd was seen promptly by a cardiologist; and

w. Hussain negligently and carelessly failed to adequately supervise Todd's care to make sure the care he needed was done as expeditiously as possible.

82. As a direct and proximate result of one or more of the aforementioned acts and/or omissions of Defendant Provena, by and through its agents and/or employees, Defendant Zwolski, Dr. Fagan, Defendant Yi, Defendant Lertsburapa, Defendant Hussain, nursing personnel, medical personnel, unit secretaries and administrative personnel, Todd died.

83. Plaintiff brings this action under 740 ILCS 180/1 & 2 governing wrongful death actions.

WHEREFORE, Plaintiff asks for judgment against Defendant Provena in an amount in excess of Fifty Thousand Dollars ($50,000.00).

COUNT XII
PROVENA HOSPITALS d/b/a PROVENA SAINT JOSEPH MEDICAL CENTER
(Survival Action)

84. Plaintiff adopts and incorporates paragraphs 1-26 inclusive of this Complaint at Law as though fully set forth herein.

85. Plaintiff adopts and incorporates paragraphs 77-81 inclusive of this Complaint at Law as though fully set forth herein.

86. As a direct and proximate result of one or more of the aforementioned acts and/or omissions of Defendant Provena, by and through its agents and/or employees Defendant Zwolski, Dr. Fagan, Defendant Yi, Defendant Lertsburapa, Defendant Hussain, nursing personnel, medical personnel, unit secretaries and administrative personnel, Defendant Provena, Todd's aortic dissection

was not timely diagnosed and treated and Todd experienced permanent physical and neurological injury, pain and suffering, pecuniary loss and irreversible damage to his body.

87. Plaintiff brings this action pursuant to 755 ILCS 5/27-6, governing survival of actions.

WHEREFORE, Plaintiff asks for judgment against Defendant Provena in an amount in excess of Fifty Thousand Dollars ($50,000.00).

COUNT XIII
AHMED HUSSAIN, M.D. (Wrongful Death Action)

88. Plaintiff adopts and incorporates paragraphs 1-26 inclusive of this Complaint at Law as though fully set forth herein.

89. There was a duty on the part of Defendant Hussain to diagnose and treat Todd in accordance with accepted standards of prevailing emergency medicine practice and opinion in Will County, Illinois.

90. After assuming the care and treatment of Todd, Defendant Hussain was guilty of one or more of the following wrongful acts and/or omissions in treating Todd:

a. Negligently and carelessly failed to recognize that Todd's condition was a cardiac surgical emergency;

b. Negligently and carelessly failed to ensure that the CT chest with contrast was done in a timely manner;

c. Negligently and carelessly failed to ensure that Todd was seen promptly by a cardiologist; and

d. Negligently and carelessly failed to adequately supervise Todd's care to make sure the care he needed was done as expeditiously as possible.

91. As a direct and proximate result of one or more of the aforementioned acts and/or omissions of Defendant Hussain, Todd died.

92. Plaintiff brings this action under 740 ILCS 180/1 & 2 governing wrongful death actions.

WHEREFORE, Plaintiff asks for judgment against Defendant Hussain in an amount in excess of Fifty Thousand Dollars ($50,000.00).

COUNT XIV
AHMED HUSSAIN, M.D. (Survival Action)

93. Plaintiff adopts and incorporate paragraphs 1-26 inclusive of this Complaint at Law as though fully set forth herein.

94. Plaintiff adopts and incorporates paragraphs 89-90 inclusive of this Complaint at Law as though fully set forth herein.

95. As a direct and proximate result of one or more of the aforementioned acts and/or omissions of Defendant Hussain, Todd's aortic dissection was not timely diagnosed and treated and Todd experienced permanent physical and neurological injury, pain and suffering, pecuniary loss and irreversible damage to his body.

96. Plaintiff brings this action pursuant to 755 ILCS 5/27-6, governing survival of actions.

WHEREFORE, Plaintiff asks for judgment against Defendant Hussain in an amount in excess of Fifty Thousand Dollars ($50,000.00).

COUNT XV
INTERNAL MEDICINE & FAMILY PRACTICE, S.C. (Wrongful Death Action)

97. Plaintiff adopts and incorporates paragraphs 1-26 inclusive of this Complaint at Law as though fully set forth herein.

98. Plaintiff adopts and incorporates paragraphs 89-90 inclusive of this Complaint at Law as though fully set forth herein.

99. At all relevant times herein, Defendant Hussain was an agent and/or employee of Defendant IMFP.

100. At all relevant times herein while Defendant Hussain was rendering care and treatment to Todd, he was acting within the scope of his employment with Defendant IMFP.

101. As a direct and proximate result of one or more of the aforementioned acts and/or omissions of Defendant IMFP, by and through its agent and/or employee Defendant, Hussain, Todd died.

102. Plaintiff brings this action under 740 ILCS 180/1 & 2 governing wrongful death actions.

WHEREFORE, Plaintiff asks for judgment against Defendant IMFP in an amount in excess of Fifty Thousand Dollars ($50,000.00).

COUNT XVI
INTERNAL MEDICINE & FAMILY PRACTICE, S.C. (Survival Action)

103. Plaintiff adopts and incorporates paragraphs 1-26 inclusive of this Complaint at Law as though fully set forth herein.

104. Plaintiff adopts and incorporates paragraphs 89-90 inclusive of this Complaint at Law as though fully set forth herein.

105. Plaintiff adopts and incorporates paragraphs 99-100 inclusive of this Complaint at Law as though fully set forth herein.

106. As a direct and proximate result of one or more of the aforementioned acts and/or omissions of Defendant IMFP, by and through its agent and/or employee, Defendant Hussain, Todd's aortic dissection was not timely diagnosed and treated and Todd experienced permanent physical and neurological injury, pain and suffering, pecuniary loss and irreversible damage to his body.

107. Plaintiff brings this action pursuant to 755 ILCS 5/27-6, governing survival of actions.

WHEREFORE, Plaintiff asks for judgment against Defendant IMFP in an amount in excess of Fifty Thousand Dollars ($50,000.00).

Respectfully submitted,

By: _____

Deborah A. Alroth

CIRIGNANI, HELLER & HARMAN, LLP
Attorneys for Plaintiff
150 South Wacker Drive
Suite 2600
Chicago, IL 60606
312-346-8700
ARDC#6229422

IN THE CIRCUIT COURT OF WILL COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

BRENDA GRAMELSPACHER, Special Administrator of the Estate of JEFFREY T. ELDER, Deceased,	)	
Plaintiff,	)	
v.	)	No. 08 L 827
PROVENA HOSPITALS d/b/a PROVENA SAINT JOSEPH MEDICAL CENTER, KIRKEITH LERTSBURAPA, M.D., JONG-YOON YI, M.D., and CARDIOLOGY ASSOCIATES OF NORTHERN ILLINOIS ILLINOIS, LLC d/b/a HEARTLAND CARDIOVASCULAR CENTER, LLC, ANDREW ZWOLSKI, M.D., PRAIRIE EMERGENCY SERVICES, S.C., AHMED HUSSAIN, M.D., and INTERNAL MEDICINE & FAMILY PRACTICE, S.C.,	)	
Defendants.	)	

ATTORNEY'S AFFIDAVIT

I, William A. Cirignani, an attorney, on oath, do hereby state that in the case of *Elder v. Provena Hospitals et al.*:

I have consulted with a physician whom I reasonably believe:

a. Is knowledgeable in the relevant issues involved in this action;

b. Practices in the same area of medicine that is at issue in this action;

c. Is qualified by experience in the subject of this case;

d. Has either practiced or taught within the last six years;

e. Meets the expert witness standards set forth in paragraphs (a) through (d) of 735 ILCS 5/8-2501.

The physician has determined in a written report, after a review of the medical records, that there is a reasonable and meritorious cause for the filing of this action against Ahmed Hussain, M.D.

I have concluded on the basis of the reviewing physician's review and consultation, that there is a reasonable and meritorious cause for the filing of this action against Ahmed Hussain, M.D. and Internal Medicine & Family Practice, S.C.

I further certify, pursuant to Illinois Supreme Court Rule 222(b), that Plaintiff seeks money damages in excess of $50,000.00.

William A. Cirignani

SUBSCRIBED and SWORN
to before me this 16th day of December, 2010.

NOTARY PUBLIC

CIRIGNANI, HELLER & HARMAN, LLP
Attorneys for the Plaintiff
150 S. Wacker Drive
Suite 2600
Chicago, IL 60606
312-346-8700
ARDC#6211973

December 1, 2010

Stanley J. Heller
Cirignani, Heller and Harman
150 S. Wacker Drive
Suite 2600
Chicago, Illinois 60606

Re: Jeffrey Todd Elder

Dear Mr. Heller:

At your request I have reviewed the medical records of Jeffrey Todd Elder from St. Joseph Medical Center, August 4, 2008 along with the depositions of Dr. Altergott, Trisha Christenson, Dr. Fagan, Dr. Foy, Dr. Hussain, Dr. Lertsburapa, Ellen Lukawski, R.N., Linda Ortega, R.N., William Shell, Dr. Yi, and Dr. Zwolski.

I am an actively practicing physician licensed to practice medicine in the State of Connecticut. I have been practicing internal medicine for more than six years. I am Board-certified in internal medicine. I am familiar with the medical issues involved in this case.

Based upon my review the material it is my opinion that Ahmed Hussain, M.D. fell below the standard of care in his care and treatment of Mr. Elder.

Dr. Hussain was Mr. Elder's attending physician for the admission of August 4, 2008. The records and depositions indicate that Dr. Hussain was notified of the admission of Mr. Elder and of his role as attending physician about 7:00 a.m. on August 4. While the depositions are not precise on the point, it is clear that Dr. Hussain spoke to the emergency room physician, Dr. Zwolski, and at least knew that Mr. Elder presented to the emergency room with acute chest pain, that he was a 43 year-old male and that he had a dilated aorta. Even if this was the only information Dr. Hussain received, it was sufficient for him to recognize that an acute aortic root dissection was a significant possibility and that this was a potential cardiovascular surgical emergency. Dr. Hussain's responsibility was to supervise Mr. Elder's care to make sure that everything necessary was done in as expeditious a manner as possible under the circumstances. However, Mr. Elder's evaluation was not done in a prompt and expeditious manner. A CT scan of the chest with contrast that was to be done upon admission to the floor was never done, and the cardiology consult that had been requested was not carried out promptly. This resulted in a substantial delay in diagnosis of the aortic dissection and implementation of surgical intervention.

For these reasons, I believe there is a meritorious basis for an action against Dr. Hussain. My opinions are based on the limited records that are available to me at this time. As more materials become available my opinions may be subject to expansion and/or modification.

Very truly yours,

IN THE CIRCUIT COURT OF WILL COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

BRENDA GRAMELSPACHER, Special Administrator of the Estate of JEFFREY T. ELDER, Deceased,	)	
Plaintiff,	)	
v.	)	No. 08 L 827
PROVENA HOSPITALS d/b/a PROVENA SAINT JOSEPH MEDICAL CENTER, KIRKEITH LERTSBURAPA, M.D., JONG-YOON YI, M.D., and CARDIOLOGY ASSOCIATES OF NORTHERN ILLINOIS ILLINOIS, LLC d/b/a HEARTLAND CARDIOVASCULAR CENTER, LLC, ANDREW ZWOLSKI, M.D., and PRAIRIE EMERGENCY SERVICES, S.C.,	)	
Defendants.	)	
AHMED HUSSAIN, M.D. and INTERNAL MEDICINE & FAMILY PRACTICE, S.C.,	)	
Respondents in Discovery.	)	

ATTORNEY'S AFFIDAVIT

I, William A. Cirignani, an attorney, on oath, do hereby state that in the case of *Elder v. Provena Hospitals et al.*:

I have consulted with a physician whom I reasonably believe:

a. Is knowledgeable in the relevant issues involved in this action;

b. Practices in the same area of medicine that is at issue in this action;

c. Is qualified by experience in the subject of this case;

d. Has either practiced or taught within the last six years;

e. Meets the expert witness standards set forth in paragraphs (a) through (d) of 735 ILCS 5/8-2501.

The physician has determined in a written report, after a review of the medical records, that there is a reasonable and meritorious cause for the filing of this action against Andrew Zwolski, M.D.

I have concluded on the basis of the reviewing physician's review and consultation, that there is a reasonable and meritorious cause for the filing of this action against Andrew Zwolski, M.D. and Prairie Emergency Services, S.C.

I further certify, pursuant to Illinois Supreme Court Rule 222(b), that Plaintiff seeks money damages in excess of $50,000.00.

William A. Cirignani

SUBSCRIBED and SWORN
to before me this 15th day of October 2010.

NOTARY PUBLIC

Official Seal
Susan G Shellhammer
Notary Public State of Illinois
My Commission Expires 08/26/2013

CIRIGNANI, HELLER & HARMAN, LLP
Attorneys for the Plaintiff
150 S. Wacker Drive
Suite 2600
Chicago, IL 60606
312-346-8700
ARDC#6211973

October 15, 2010

William A. Cirignani
150 S. Wacker Drive
Suite 2600
Chicago, IL 60606

Re: Jeffery Todd Elder

Dear Mr. Cirignani:

Thank you for asking me to review the care of Jeffery Elder. I have reviewed the medical records of from Provena St. Joseph Medical Center for August 4, 2008, as well the depositions of Dr. Zwolski, Dr. Yi, Dr. Fagan, Dr. Lertsburapa and Nurse Lukawski. I am currently an emergency physician licensed to practice medicine in the state of Massachusetts. I have been practicing as an emergency medicine physician in excess of six years, am board certified in emergency medicine and experienced in the diagnosis and treatment of the medical issues involved in this case.

Mr. Elder was a 43-year old male who presented to the emergency department at 05:20 with chest pain. A CT of the chest without contrast was done and at 06:55 the radiologist informed the emergency physician, Dr. Zwolski, that there was an abnormal ascending aorta measuring 4.9 centimeters in diameter and that a CT scan of the chest with contrast should be done because of the possibility of an acute aortic dissection.

Dr. Zwolski's note indicates that "cardiologist was consulted by phone and will follow up with the patient in the hospital." The records indicate that the patient was admitted to the hospital shortly after 07:00, and that the telephone conversation with the cardiologist, Dr. Yi, occurred shortly after 7:00 a.m.

A CT scan with contrast was ordered by Dr. Zwolski with instructions to have it performed upon the patient's arrival on the floor. According to the records this CT was never done.

Dr. Lertsburapa saw the patient at 11:00, re-ordered the CT scan with contrast and ordered an echocardiogram. The timing of the echocardiogram is not documented but it showed intimal flap which is indicative of an aortic dissection. The echocardiogrphy technologist informed Dr. Lertsburapa of this finding who then called the cardiovascular surgery service and a resident physician saw the patient at 13:36. However by that time both surgeons capable of performing this surgery were unavailable as they were actively operating on other patients. The decision was made to transfer the patient to Loyola Medical Center rather than to await the arrival of another surgeon. Prior to being able to be transferred, Mr. Elder went into cardiac arrest and could not be resuscitated.

The telephone communication between Dr. Zwolski and Dr. Yi occurred at approximately 7:00 AM. Neither physician has a specific recollection of the details of the conversation. If, however, Dr. Yi's version is substantially correct—that Dr. Zwolski essentially communicated only a request for a routine cardiac consultation—then Dr. Zwolski failed to comply with the standard of care in not informing him of the potential for an acute aortic dissection. This would have lead to a delay in the appearance of Drs. Yi or Lertsburapa evaluating Mr. Elder which would have been caused by Dr Zwolski's negligence.

Dr. Zwolski additionally fell below the standard of care when he ordered the CT angiography to be performed upon the patient's arrival on the floor. The standard of care required that if the reason for performing a CT angiography of the chest is to rule out the diagnosis of acute thoracic aortic dissection that it be done from the emergency department where a positive result can be acted on in an expeditious fashion. There was no reasonable explanation for transferring Mr. Elder to the floor prior to the performance of the CT.

Last, Dr. Zwolski fell below the standard of care by administering Lovenox to a patient who was being worked up for aortic dissection. For obvious reasons, anticoagulation is contraindicated in the presence of an acute aortic dissection as it would not allow normal clotting of blood which could stop or delay the dissection from propagating.

Because of Dr. Zwolski's deviations from the standard of care, the diagnosis of Mr. Elder's acute aortic dissection was significantly delayed. This delay, in my view, prevented him from getting the life-saving surgery he needed in a timely manner and contributed to his death.

FILED

IN THE CIRCUIT COURT OF WILL COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

2008 OCT 14 AM 8:37

CLERK, CIRCUIT COURT
WILL COUNTY, ILLINOIS

BRENDA GRAMELSPACHER, Special Administrator of the Estate of JEFFREY T. ELDER, Deceased,	)	
Plaintiff,	)	
v.	)	No. 08 L 827
PROVENA HOSPITALS d/b/a PROVENA SAINT JOSEPH MEDICAL CENTER, KIRKEITH LERTSBURAPA, M.D., and CARDIOLOGY ASSOCIATES OF NORTHERN ILLINOIS, LLC d/b/a HEARTLAND CARDIOVASCULAR CENTER, LLC,	)	
Defendants.	)	

ATTORNEY'S AFFIDAVIT

I, Deborah A. Alroth, an attorney, on oath, do hereby state that in the case of *Elder v. Provena Hospitals et al.*:

I have consulted with a physician whom I reasonably believe:

a. Is knowledgeable in the relevant issues involved in this action;

b. Practices in the same area of medicine that is at issue in this action;

c. Is qualified by experience in the subject of this case;

d. Has either practiced or taught within the last six years;

e. Meets the expert witness standards set forth in paragraphs (a) through (d) of 735 ILCS 5/8-2501.

The physician has determined in a written report, after a review of the medical records, that there is a reasonable and meritorious cause for the filing of this action against Kirkeith Lertsburapa, M.D. and personnel at Provena Saint Joseph Medical Center.

I have concluded on the basis of the reviewing physician's review and consultation, that there is a reasonable and meritorious cause for the filing of this action against Provena Hospitals d/b/a Provena Saint Joseph Medical Center, Kirkeith Lertsburapa, M.D. and Cardiology Associates of Northern Illinois, LLC d/b/a Heartland Cardiovascular Center, LLC.

I further certify, pursuant to Illinois Supreme Court Rule 222(b), that plaintiff seeks money damages in excess of $50,000.00.

Deborah A. Alroth

SUBSCRIBED and SWORN
to before me this 10th day of October 2008.

NOTARY PUBLIC

Official Seal
Kimberly Lugo
Notary Public State of Illinois
My Commission Expires 11/29/2010

CIRIGNANI, HELLER & HARMAN, LLP
Attorneys for the Plaintiff
150 S. Wacker Drive
Suite 2600
Chicago, IL 60606
312-346-8700
ARDC#6229422

Joel Kahn, M.D.
2935 Long Ridge Court
West Bloomfield, MI 48323

September 17, 2008

Stanley J. Heller
150 S. Wacker Drive
Suite 2600
Chicago, IL 60606

Re: Jeffery Todd Elder

Dear Mr. Heller:

At your request I reviewed the medical records of Jeffrey Elder from Provena St. Joseph Medical Center for August 4, 2008. I am a physician licenced to practice medicine in the state of Michigan. My license number is 4301047704. I am board certified in both internal medicine and cardiology. I am experienced in th types of cardiologic issues involved in this case..

Mr. Elder was a 43-year old male who presented to the emergency room at 05:20 with chest pain. A CT of the chest without contrast was done and at 06:55 the radiologist told the ER doctor, Dr. Zwolski that there was an abnormal ascending aorta measuring 4.9 centimeters in diameter and that a CT scan of the chest with contrast should be done because of the possibility of an acute aortic dissection.

Dr. Zwolski's note indicates that "cardiologist was consulted by phone and will follow up with the patient in the hospital." Since the records indicate that the patient was "admitted" to the hospital shortly after 07:00 and was on the floor at approximately 08:00, the ER telephone conversation with the cardiologist, Dr. Lertsburapa probably occurred shortly after 7:00 a.m.

A CT scan with contrast was ordered by Dr. Zwolski with instructions to have it performed upon the patient's arrival on the floor. According to the records this CT was never done. There is reference in the records to the fact that the order was lost in the system.

Dr. Lertsburapa saw the patient at 11:00, re-ordered the CT scan with contrast and ordered an echocardiogram. The timing of the echocardiogram is not documented but it showed intimal flap, indicating an aortic dissection. The echo tech told this to Dr. Lertsburapa. Dr. Lertsburapa called cardiovascular surgery and a resident physician saw the patient at 13:36. However by that time both surgeons capable of performing surgery were in the process of cases. A decision was made to transfer the patient to Loyola Medical Center rather than to await the arrival of another surgeon but at approximately 15:30 the patient arrested. He could not be resuscitated.

In the type of situation present here, it would be customary for the ER physician to tell the cardiologist the reason for the consultation. If he did not, the standard of care would require the cardiologist to inquire as to the reason for the consultation. Therefore I assume for the purposes of this initial letter that the emergency room physician told Dr. Lertsburapa that an acute aortic dissection was suspected based upon the CT scan. Assuming this to be the case, in my opinion Dr. Lertsburapa fell below the standard of care for not immediately seeing the patient and directly supervising his care in a potentially emergent life-threatening situation. It was below the standard of care for Dr. Lertsburapa to arrive at approximately 11:00, 3 to 4 hours or so after the initial contact. Because of this delay in his appearance the testing required to confirm the presence of an

aortic dissection did not occur until probably between noon and 1:00 p.m. By that time many hours had been wasted and needed emergency surgical assistance was not available.

It is also my opinion that Provena St. Joseph Hospital through its employees failed to have the ER physician's order for a CT scan with contrast done in a timely manner.

Because of the deviations from the standard of care indicated above by Dr. Lertsburapa and by the hospital, there was a critical delay in diagnosis of Mr. Elder's acute aortic dissection. Had the diagnosis been made as it should have been, by roughly 09:00 in the morning, there would have been ample time to clear an operating room and have a cardio- thoracic surgeon available for successful repair of the aortic dissection.

Very truly yours,

Joel Kahn, M.D.

IN THE CIRCUIT COURT OF WILL COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

BRENDA GRAMELSPACHER, Special Administrator of the Estate of JEFFREY T. ELDER, Deceased,	)	
Plaintiff,	)	
v.	)	No. No. 08 L 827
PROVENA HOSPITALS d/b/a PROVENA SAINT JOSEPH MEDICAL CENTER, KIRKEITH LERTSBURAPA, M.D., JONG-YOON YI, M.D., and CARDIOLOGY ASSOCIATES OF NORTHERN ILLINOIS ILLINOIS, LLC d/b/a HEARTLAND CARDIOVASCULAR CENTER, LLC,	)	
Defendants.	)	
ANDREW ZWOLSKI, M.D. and PRAIRIE EMERGENCY SERVICES, S.C.,	)	
Respondents in Discovery.	)	

FILED
2010 MAY 27 AM 9:47
CLERK, CIRCUIT COURT
WILL COUNTY, ILLINOIS

ATTORNEY'S AFFIDAVIT

I, Amanda Ghagar, an attorney, on oath, do hereby state that in the case of *Elder v. Provena Hospitals et al.*:

I have consulted with a physician whom I reasonably believe:

a. Is knowledgeable in the relevant issues involved in this action;

b. Practices in the same area of medicine that is at issue in this action;

c. Is qualified by experience in the subject of this case;

d. Has either practiced or taught within the last six years;

e. Meets the expert witness standards set forth in paragraphs (a) through (d) of 735 ILCS 5/8-2501.

The physician has determined in a written report, after a review of the medical records, that there is a reasonable and meritorious cause for the filing of this action against Jong-Yoon Yi, M.D.

I have concluded on the basis of the reviewing physician's review and consultation, that there is a reasonable and meritorious cause for the filing of this action against Jong-Yoon Yi, M.D.

I further certify, pursuant to Illinois Supreme Court Rule 222(b), that plaintiff seeks money damages in excess of $50,000.00.

Amanda Ghagar

SUBSCRIBED and SWORN
to before me this 24th day of May 2010.

NOTARY PUBLIC

Official Seal
Susan G Shellhammer
Notary Public State of Illinois
My Commission Expires 08/26/2013

CIRIGNANI, HELLER & HARMAN, LLP
Attorneys for the Plaintiff
150 S. Wacker Drive
Suite 2600
Chicago, IL 60606
312-346-8700
ARDC#6299845

May 15, 2010

Stanley J. Heller
150 S. Wacker Drive
Suite 2600
Chicago, IL 60606

Re: Jeffery Todd Elder

Dear Mr. Heller:

I previously provided you an opinion letter in this case. A copy of the letter is attached and incorporated by reference. The essence of my criticism of the cardiology care was that there was a four hour delay from notification to a cardiologist of a patient with the possibility of an acute aortic dissection to the appearance of a cardiologist to attend the patient's emergency situation. At the time I wrote my initial letter, it appeared from the records that a single cardiologist was involved, namely Dr. Lertsburapa. Additional information provided to me in the form of an interrogatory response indicates that a second cardiologist, Dr. Yi, was involved and that Dr. Yi was the cardiologist who spoke to the emergency room physician, Dr. Zwolski on the telephone at or about 7:00 a.m.

It is therefore my opinion that Dr. Yi fell below the standard of care in failing to either see Mr. Elder immediately upon receiving the call from Dr. Zwolski or to make sure that another cardiologist in his group saw Mr. Elder immediately.

EXHIBIT 13

Vocational Evaluation Report

On

Jeffrey Todd Elder

Submitted by:

James J. Radke, MS, CRC, LCPC, CEA

September 22, 2011

ASSOCIATES FOR CAREER TRANSITION

INTRODUCTION:

I have been asked to evaluate the vocational-economic losses of Mr. Elder. It is noted that Mr. Elder has passed away on August 5, 2008 while he was hospitalized at Provena St.Joseph's Medical Center in Joliet, IL. It is noted that Mr. Elder was a manager at Catepillar and had been promoted recently. He was earning a base salary of $62,556 at the time of his death with medical, life, disability and pension benefits. In addition, he was entitled to a bonus depending upon the company performance of approximately 14% of his salary.

VOCATIONAL:

Mr. Elder was a senior associate engineer at the time of hiring in 2006. Mr. Elder was hired at Catepillar in 2006, and he was then quickly promoted to a different pay grade along with a raise in 2008. There were no disciplinary records in his personnel file.

He earned $70,456 in 2007 indicating that he qualified and received some incentive pay for his and company's performance in that year. In the new pay grade that Mr. Elder is in, he would receive 14% of his salary times the company performance factor which historically has been 1.0.

ECONOMIC:

I have calculated the vocational-economic losses of Mr. Elder from the point of his death to my estimated of the date of adjudication, 1-15-2012. From the point of his death in 2008, I have calculated losses for this partial year. These are listed on page 2 of the enclosed appendix. I did not calculate any raise in wages from 2009 based upon the input from the Director of Human Resources, Ms. Tamara Holman at the Joliet Catepillar facility. However, I used the data from the Bureau of Labor Statistics, Employer Cost Index (ECI)) to calculate the growth of wages in 2010 and 2011. In reviewing the data from the ECI, I have found that the increase in wages for all private sector workers was 1.6% in each of those two years. Thus, I have increased the wages by that amount in both 2010 and 2011. I have increased wages by 1.8% in 2012.

I have noted in the deposition of Ms. Holman that the historical average of the incentive "factor" of the company has been 1.0. I note however that there have been significant recessionary pressures in the last 3 years. However, I assumed that there was no bonus in 2009, and I have reduced the incentive factor to 0.75 for 2010, but I have increased this to 1.0 for 2011 since the company reported strong profits. I have not assumed any bonus for 2009 when the wages were frozen. Thus the wages for 2010 and 2011 are estimated here to be $70,230 and $73,614 respectively which includes the incentive amounts.

In regards to the employee benefits, I have used data from the Bureau of Labor Statistics in their benefits' study which provided employer costs based upon several different factors. Specifically, I used private sector workers with more than 500 employees. Taking this information into account as well as noting his employee benefits of health care, life, disability and pension, I find that the total benefit amount was 20.48% excluding the pension amounts. Ms. Holman also noted that the company pension contribution stating in 2020 would be zero. Thus, in the future benefits' area starting in 2020, I have adjusted the benefit amount for this consideration.

I have computed estimated past losses using an potential settlement date of January 15, 2012, I find using the data noted above that there is $292,945 of past losses including both wages/incentives as well as benefits.

Regarding future losses, page 3 of the enclosed profile indicates the wage and incentive amount separately. I have used the wages noted previously of $65,736, and I have used the incentive compensation based on the 14% of his wages times the historical rate of 1.0 for an amount of $9,203. I have used the employee benefits of 20.48% as noted previously.

In regards to the calculation of *future wages or damages*, I have computed three different scenarios of possible losses. The first assumes the normal worklife expectancy; I have also used his worklife expectancy of 18.09 years as given in the Skoog and Ciecka tables for a person with his education and age. The second scenario assumes a retirement of age 65, and the last one assumes a retirement age of 67.

It should be noted that it is important to apply the present cash value adjustments to the basic dollar amounts. The first factor in this calculation is that of the interest rate. It is general practice that government securities are used because of their safety. The interest rate used here is a government security that measures *real* interest rates, the Treasury Inflation Protected Securities (TIPS). I used the 10 year bonds and I have determined their real, blended yield is approximately 0.07%.

I also used the data from the Social Security's Board of Trustees. They predict that the real interest rate from now until the date of retirement in 2026, 2028 or 2030 would be 2.84 percent. If I average the real interest rates from the TIPS and the Social Security Board of Trustee's, I find that the real prospective interest rate would be 1.46%.

Regarding the second major factor in the analysis, growth of compensation, I used a 25 year average of *real* growth of wages and benefits as given by the Bureau of Labor of Statistics. This figure is 1.21% for the period of time from 1986 to 2010. The predicted real growth of wages from the Social Security is 1.17%. The average of these 2 figures is 1.19%. Noting the present real growth

of wage compensation and the real discount rate, I have determined that the differential would be 0.27%.

Using the data noted above, I find that for the first scenario there are future losses of $1,517,718; these are then reduced to present cash value of $1,359,240. This is then combined with past losses of $293,915 to equal $1,652,422 of total vocational-economic losses. For the second possibility, I have assumed that he would work until age 65. Thus, I would have the same past losses of $293,915, but the future unadjusted losses would be $1,915,765. These are then reduced to $1,666,245; this combined with past losses to equal $1,960,160. For the third or age 67 retirement age scenario, I find that again $293,915 of past losses, but with unadjusted losses of $2,163,709. These losses are reduced to $1,853,159 for combined losses of $2,147,074.

Lastly, it is noted that Mr. Elder would lose considerable pension benefits because he would not at work where the company would be providing significant pension contributions. I have computed his pension losses according to the company pension equity plan in light of various retirement ages. I find that if Mr. Elder would retire at age of 61.33, he would lose an additional $106,835 in pension disbursements. If he would have worked continuously with the company until age 65, he would lose $150,420 of pension disbursements. Further, if he would work until age 67 continuously, he would lose $166,257 in pension amounts. These calculations were taken from the Catepillar Pension Equity Program.

Thus, he would have the following vocational-economic losses:

- Age 61.33 retirement: $1,769,780 ($1,652,422 plus $106,835)
- Age 65 retirement: $2,125,776 ($1,975,356 plus $150,420) and
- Age 67 retirement: $2,366,134 ($2,147,074 plus $166,257)

I reserve the right to update this report if additional information becomes available.

Respectfully submitted:

James J. Radke

James J. Radke, MS, CRC, LCPC, CEA

James J. Radke
Associates for Career Transition
3710 Commercial Avenue, Suite1
Northbrook, IL 60062
847-205-1301 jradke-act@comcast.net 847-715-9341

Personal Injury Economic Damages Report
Plaintiff: Jeffrey Elder

Report Produced On 9/23/2011

Case Information

Trial or Settlement Date: 1/15/2012
Compound Interest Rate: 0 (for Past Damages)
Injury Date: 8/5/2008
Discount Rate: 0.0146 (for Future Damages)

Present Value of Future Damages Computed Monthly
Present Value Computed Using Compound Interest

Plaintiff Information

Sex: Male
Birth Date: 5/11/1965
Worklife Expectancy*: 18.09 Years
Life Expectancy**: 34.99 Years
Race: White
Age at Injury: 43.24
Retirement Age: 61.33
Expected Age at Death: 78.23

Damages Summary

	Future Values		Present Values	
Type of Damage	Past	Future	Past	Future
Lost Income	$ 234,459	$ 1,263,760	$ 234,459	$ 1,129,918
Lost Fringe Benefits	59,456	265,615	59,456	239,202
Lost Household Services				
Medical Costs				
Other Costs				
Total Damages	$ 293,915	$ 1,529,375	$ 293,915	$ 1,369,120
Grand Total Damages	$ 1,823,290		$ 1,663,035	

* Work Life from The Markov (Increment-Decrement) Model of Labor Force Activity: New Results Beyond Work-Life Expectancies. Gary Skoog and James Ciecka, Journal of Legal Economics, Spring-Summer 2001, Vol. 11, Number 1, for men active in the work force, with some college but no degree.

** Life Expectancy information from United States life tables, 2006. by Elizabeth Arias, Ph.D.; Brian L. Rostron, Ph.D.; and Betzaida Tejeda-Vera, B.S. Division of Vital Statistics, National Vital Statistics Reports, Vol. 58, No. 21, June 28, 2010

Detail of Pre-Trial Lost Income
Plaintiff: Jeffrey Elder

Projected Earnings of the Plaintiff - Injury to Trial

Annual Earnings of the Plaintiff Before the Injury: $

From	To	Occupation	Income	Fringes	Growth*
08/05/2008	12/31/2008		$ 25,365	$ 6,894	0.9%
01/01/2009	12/31/2009		62,556	17,003	2.5%
01/01/2010	12/31/2010		70,230	17,275	2.1%
01/01/2011	12/31/2011		73,614	17,551	2.1%
01/01/2012	01/15/2012		2,694	733	2.1%
		Totals:	$ 234,459	$ 59,456	

True

Evaluation of Pre-Trial Lost Income by Year

Year Ending	Lost Earnings	Present Value Lost Earnings	Lost Fringe Benefits	Present Value Lost Fringes
12/31/2008	$ 25,365	$ 25,365	$ 6,894	$ 6,894
12/31/2009	62,556	62,556	17,003	17,003
12/31/2010	70,230	70,230	17,275	17,275
12/31/2011	73,614	73,614	17,551	17,551
01/15/2012	2,694	2,694	733	733
Totals	$ 234,459	$ 234,459	$ 59,456	$ 59,456

Detail of Future Lost Income
Plaintiff: Jeffrey Elder

What the Plaintiff Would Have Earned in the Future

From	To	Occupation	Annual Earnings	Fringe Benefits	Growth Rate	Discount Rate
01/15/2012	12/31/2019	Manager	$ 65,736	$ 17,893	1.19%	1.46%
01/15/2012	09/07/2026	Manager	9,203		1.19%	1.46%
01/01/2020	09/07/2026	Manager	81,745	16,741	1.19%	1.46%

James J. Radke
Associates for Career Transition
3710 Commercial Avenue, Suite1
Northbrook, IL 60062
847-205-1301 jradke-act@comcast.net 847-715-9341

Personal Injury Economic Damages Report
Plaintiff: Jeffrey Elder

Report Produced On 9/23/2011

Case Information

Trial or Settlement Date: 1/15/2012
Compound Interest Rate: 0 (for Past Damages)
Injury Date: 8/5/2008
Discount Rate: 0.0146 (for Future Damages)

Present Value of Future Damages Computed Monthly
Present Value Computed Using Compound Interest

Plaintiff Information

Sex: Male
Birth Date: 5/11/1965
WorkLife Expectancy: 21.75 Years
Life Expectancy*: 34.99 Years
Race: White
Age at Injury: 43.24
Retirement Age: 64.99
Expected Age at Death: 78.23

Damages Summary

	Future Values		Present Values	
Type of Damage	Past	Future	Past	Future
Lost Income	$ 234,459	$ 1,637,208	$ 234,459	$ 1,423,363
Lost Fringe Benefits	59,456	296,991	59,456	258,078
Lost Household Services				
Medical Costs				
Other Costs				
Total Damages	$ 293,915	$ 1,934,199	$ 293,915	$ 1,681,441
Grand Total Damages	$ 2,228,114		$ 1,975,356	

* Life Expectancy information from United States life tables, 2006, by Elizabeth Arias, Ph.D.; Brian L. Rostron, Ph.D.; and Betzaida Tejeda-Vera, B.S. Division of Vital Statistics, National Vital Statistics Reports, Vol. 58, No. 21, June 28, 2010

Detail of Pre-Trial Lost Income
Plaintiff: Jeffrey Elder

Projected Earnings of the Plaintiff - Injury to Trial

Annual Earnings of the Plaintiff Before the Injury: $

From	To	Occupation	Income	Fringes	Growth*
08/05/2008	12/31/2008		$ 25,365	$ 6,894	0.9%
01/01/2009	12/31/2009		62,556	17,003	2.5%
01/01/2010	12/31/2010		70,230	17,275	2.1%
01/01/2011	12/31/2011		73,614	17,551	2.1%
01/01/2012	01/15/2012		2,694	733	2.1%
		Totals:	$ 234,459	$ 59,456	

True

Evaluation of Pre-Trial Lost Income by Year

Year Ending	Lost Earnings	Present Value Lost Earnings	Lost Fringe Benefits	Present Value Lost Fringes
12/31/2008	$ 25,365	$ 25,365	$ 6,894	$ 6,894
12/31/2009	62,556	62,556	17,003	17,003
12/31/2010	70,230	70,230	17,275	17,275
12/31/2011	73,614	73,614	17,551	17,551
01/15/2012	2,694	2,694	733	733
Totals	$ 234,459	$ 234,459	$ 59,456	$ 59,456

Detail of Future Lost Income
Plaintiff: Jeffrey Elder

What the Plaintiff Would Have Earned in the Future

From	To	Occupation	Annual Earnings	Fringe Benefits	Growth Rate	Discount Rate
01/15/2012	12/31/2019	Manager	$ 65,736	$ 13,463	1.19%	1.46%
01/15/2012	05/06/2030	Manager	9,203		1.19%	1.46%
01/01/2020	05/06/2030	Manager	81,745	16,741	1.19%	1.46%

James J. Radke
Associates for Career Transition
3710 Commercial Avenue, Suite1
Northbrook, IL 60062
847-205-1301 jradke-act@comcast.net 847-715-9341

Personal Injury Economic Damages Report
Plaintiff: Jeffrey Elder

Report Produced On 9/23/2011

Case Information

Trial or Settlement Date: 1/15/2012
Compound Interest Rate: 0 (for Past Damages)
Injury Date: 8/5/2008
Discount Rate: 0.0146 (for Future Damages)

Present Value of Future Damages Computed Monthly
Present Value Computed Using Compound Interest

Plaintiff Information

Sex: Male
Birth Date: 5/11/1965
Worklife Expectancy: 23.76 Years
Life Expectancy*: 34.99 Years
Race: White
Age at Injury: 43.24
Retirement Age: 67.00
Expected Age at Death: 78.23

Damages Summary

	Future Values		Present Values	
Type of Damage	Past	Future	Past	Future
Lost Income	$ 234,459	$ 1,850,161	$ 234,459	$ 1,583,908
Lost Fringe Benefits	59,456	372,617	59,456	322,054
Lost Household Services				
Medical Costs				
Other Costs				
Total Damages	$ 293,915	$ 2,222,778	$ 293,915	$ 1,905,962
Grand Total Damages	$ 2,516,693		$ 2,199,877	

* Life Expectancy information from United States life tables, 2006. by Elizabeth Arias, Ph.D.; Brian L. Rostron, Ph.D.; and Betzaida Tejeda-Vera, B.S. Division of Vital Statistics, National Vital Statistics Reports, Vol. 58, No. 21, June 28, 2010

Detail of Pre-Trial Lost Income
Plaintiff: Jeffrey Elder

Projected Earnings of the Plaintiff - Injury to Trial

Annual Earnings of the Plaintiff Before the Injury: $

From	To	Occupation	Income	Fringes	Growth*
08/05/2008	12/31/2008		$ 25,365	$ 6,894	0.9%
01/01/2009	12/31/2009		62,556	17,003	2.5%
01/01/2010	12/31/2010		70,230	17,275	2.1%
01/01/2011	12/31/2011		73,614	17,551	2.1%
01/01/2012	01/15/2012		2,694	733	2.1%
		Totals:	$ 234,459	$ 59,456	

True

Evaluation of Pre-Trial Lost Income by Year

Year Ending	Lost Earnings	Present Value Lost Earnings	Lost Fringe Benefits	Present Value Lost Fringes
12/31/2008	$ 25,365	$ 25,365	$ 6,894	$ 6,894
12/31/2009	62,556	62,556	17,003	17,003
12/31/2010	70,230	70,230	17,275	17,275
12/31/2011	73,614	73,614	17,551	17,551
01/15/2012	2,694	2,694	733	733
Totals	$ 234,459	$ 234,459	$ 59,456	$ 59,456

Detail of Future Lost Income
Plaintiff: Jeffrey Elder

What the Plaintiff Would Have Earned in the Future

From	To	Occupation	Annual Earnings	Fringe Benefits	Growth Rate	Discount Rate
01/15/2012	12/31/2019	Manager	$ 65,736	$ 17,893	1.19%	1.46%
01/15/2012	05/12/2032	Manager	9,203		1.19%	1.46%
01/01/2020	05/12/2032	Manager	81,745	16,741	1.19%	1.46%

Evaluation of Future Lost Income by Year
Plaintiff: Jeffrey Elder

Year Ending	Plaintiff Would Have Earned		Plaintiff Will Earn Instead		Difference (Totals)	Present Value of Loss
	Earnings	Fringes	Earnings	Fringes		
01/15/2013	$ 74,939	$ 17,893	$	$	$ 92,832	$ 92,103
01/15/2014	75,831	18,106			93,937	91,848
01/15/2015	76,734	18,321			95,055	91,592
01/15/2016	77,647	18,539			96,186	91,347
01/15/2017	78,571	18,760			97,331	91,092
01/15/2018	79,506	18,983			98,489	90,845
01/15/2019	80,452	19,209			99,661	90,588
01/15/2020	81,798	19,332			101,130	90,587
01/15/2021	92,835	16,940			109,775	96,913
01/15/2022	93,939	17,142			111,081	98,637
01/15/2023	95,057	17,346			112,403	96,381
01/15/2024	96,188	17,552			113,740	96,119
01/15/2025	97,333	17,761			115,094	95,846
01/15/2026	98,491	17,972			116,463	95,591
01/15/2027	99,663	18,186			117,849	95,320
01/15/2028	100,849	18,402			119,251	95,061
01/15/2029	102,049	18,621			120,670	94,794
01/15/2030	103,263	18,843			122,106	94,529
01/15/2031	104,492	19,067			123,559	94,277
01/15/2032	105,736	19,294			125,030	94,009
05/12/2032	34,788	6,348			41,136	30,483
Totals	$ 1,850,161	$ 372,617	$	$	$ 2,222,778	$ 1,905,962

Real Interest Rate and Real Wage Growth Forecasts from the Social Security Administration Trustees' Report

Year	Growth Rate CPI	Growth Rate, Wages	Real Wage Differential	Interest Rate	Interest Rate - CPI Growth	Interest Rate - Wage Growth	Net Discount Rate, NDR	Real Interest Rate	Real Wage Growth
2005	3.50%	3.70%	0.20%	4.30%	0.80%	0.60%	0.58%	0.77%	0.19%
2006	2.20%	3.20%	5.00%	4.80%	1.60%	-0.20%	-0.19%	1.55%	1.74%
2007	2.60%	4.40%	1.60%	4.70%	1.90%	0.30%	0.29%	1.85%	1.56%
2008	4.30%	3.30%	-1.00%	3.60%	-0.70%	0.30%	0.29%	-0.67%	-0.96%
Avg 89-08	3.00%	4.08%	1.09%	6.23%	3.23%	2.15%	2.07%	3.14%	1.06%
Avg 94-08	2.55%	3.96%	1.40%	5.55%	2.96%	1.59%	1.55%	2.89%	1.33%
Avg 99-08	2.55%	3.95%	1.40%	5.00%	2.45%	1.05%	1.03%	2.39%	1.37%
Avg.04-08	2.88%	3.94%	1.06%	4.44%	1.56%	0.50%	0.49%	1.52%	1.03%

Real Interest Rates and Wage Growth Forecasts from Social Security Administration Trustees' Report

2009	-1.00%	0.70%	1.70%	3.00%	4.00%	2.30%	2.28%	4.04%	1.72%
2010	2.70%	3.40%	1.70%	4.00%	2.30%	0.60%	0.58%	2.26%	1.67%
2011	2.30%	4.10%	1.80%	5.00%	2.70%	0.90%	0.86%	2.64%	1.76%
2012	2.70%	4.10%	1.40%	5.70%	3.00%	1.60%	1.54%	2.92%	1.36%
2013	3.10%	4.20%	1.10%	6.00%	2.90%	1.80%	1.73%	2.81%	1.07%
2014	3.10%	4.10%	1.00%	6.00%	2.90%	1.90%	1.83%	2.81%	0.97%
2015	2.80%	4.20%	1.40%	5.70%	2.90%	1.50%	1.44%	2.82%	1.36%
2016	2.80%	3.70%	0.90%	5.60%	2.80%	1.90%	1.83%	2.72%	0.88%
2017	2.80%	3.80%	1.00%	5.60%	2.80%	1.80%	1.73%	2.72%	0.97%
2018	2.80%	3.90%	1.10%	5.70%	2.90%	1.80%	1.73%	2.82%	1.07%
Long Term	2.80%	3.90%	1.10%	5.70%	2.90%	1.80%	1.73%	2.82%	1.07%
09-18	2.31%	3.62%	1.31%	5.23%	2.92%	1.61%	1.56%	2.85%	1.28%
09-28	2.56%	3.76%	1.21%	5.47%	2.91%	1.71%	1.64%	2.84%	1.17%
09-38	2.64%	3.81%	1.17%	5.54%	2.91%	1.74%	1.67%	2.83%	1.14%
09-48	2.68%	3.83%	1.15%	5.58%	2.91%	1.75%	1.69%	2.83%	1.12%
09-58	2.70%	3.84%	1.14%	5.61%	2.90%	1.76%	1.70%	2.83%	1.11%
09-68	2.72%	3.85%	1.14%	5.62%	2.90%	1.77%	1.70%	2.83%	1.10%

Real Interest Rates and Real Wage Growth, recent History from Social Security Administration:
2008 Annual Report of the Board of Trustees of the Federal Old Age and Survivors Insurance and Disability Trust Funds

Year	Growth Rate CPI	Growth Rate Wages	Real Wage Differential	Interest Rate	Interest Rate - CPI Growth	Interest Rate - Wage Growth	Net Discount Rate (NDR)	Real Interest Rate	Real Wage Growth
1985	3.50%	6.00%	2.50%	10.80%	7.30%	4.80%	4.53%	7.05%	2.42%
1986	1.60%	4.60%	3.00%	8.00%	6.40%	3.40%	3.25%	6.30%	2.95%
1987	3.60%	4.60%	1.00%	8.40%	4.80%	3.80%	3.63%	4.63%	0.97%
1988	4.00%	5.30%	1.30%	8.80%	4.80%	3.50%	3.32%	4.62%	1.25%
1989	4.80%	3.90%	-0.90%	8.70%	3.90%	4.80%	4.62%	3.72%	-0.86%
1990	5.20%	5.10%	-0.10%	8.60%	3.40%	3.50%	3.33%	3.23%	-0.10%
1991	4.10%	3.00%	-1.10%	8.00%	3.90%	5.00%	4.85%	3.75%	-1.06%
1992	2.90%	4.90%	2.00%	7.10%	4.20%	2.20%	2.10%	4.08%	1.94%
1993	2.80%	1.90%	0.90%	6.10%	3.30%	4.20%	4.12%	3.21%	-0.88%
1994	2.50%	3.70%	1.20%	7.10%	4.60%	3.40%	3.28%	4.49%	1.17%
1995	2.90%	4.70%	1.80%	6.90%	4.00%	2.20%	2.10%	3.89%	1.75%
1996	2.90%	4.00%	1.10%	6.60%	3.70%	1.00%	2.50%	3.60%	1.07%
1997	2.30%	5.60%	3.30%	6.60%	4.30%	1.00%	0.95%	4.20%	3.23%
1998	1.30%	6.20%	4.90%	5.60%	4.30%	-0.60%	-0.56%	4.24%	4.84%
1999	2.20%	4.80%	2.60%	6.20%	2.70%	1.10%	1.05%	3.62%	2.54%
2000	3.50%	6.10%	2.60%	6.20%	2.70%	0.10%	0.09%	2.61%	2.51%
2001	2.70%	2.00%	-0.70%	5.20%	2.50%	3.20%	3.14%	2.43%	-0.68%
2002	1.40%	0.40%	-1.00%	4.90%	3.50%	4.50%	4.48%	3.45%	-0.99%
2003	2.20%	2.60%	0.40%	4.10%	1.90%	1.50%	1.46%	1.86%	0.39%
2004	2.60%	3.80%	1.20%	4.30%	1.70%	0.50%	0.48%	1.66%	1.17%

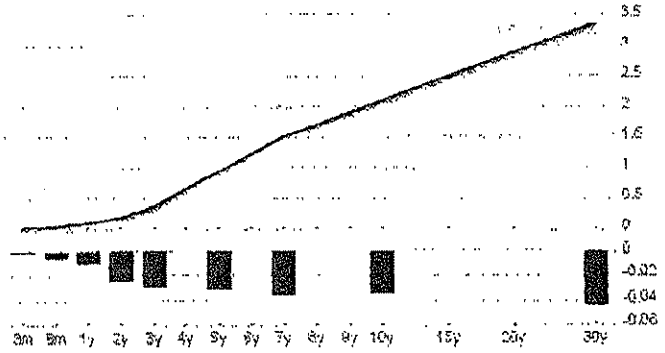
Government Bonds

U.S. UK Germany Japan Hong Kong Australia Brazil

U.S. Treasuries

	COUPON	MATURITY	PRICE/YIELD	PRICE/YIELD CHANGE	TIM
3-Month	0.000	12/15/2011	0.00 / 0.00	0.000 / 0.000	09/1
6-Month	0.000	03/15/2012	0.02 / 0.02	-0.005 / -0.005	09/1
12-Month	0.000	08/23/2012	0.07 / 0.07	-0.010 / -0.010	09/1
2-Year	0.125	08/31/2013	99-29½ / 0.17	0-01½ / -0.024	09/1
3-Year	0.250	09/15/2014	99-24+ / 0.33	0-02⅝ / -0.029	09/1
5-Year	1.000	08/31/2016	100-14 / 0.91	0-04¾ / -0.031	09/1
7-Year	1.500	08/31/2018	100-07 / 1.47	0-05½ / -0.036	09/1
10-Year	2.125	08/15/2021	100-22 / 2.05	0-09¾ / -0.034	09/1
30-Year	3.750	08/15/2041	108-08 / 3.31	0-27½ / -0.043	09/1

YIELD CURVE ■ CURRENT ■ PREVIOUS CLOSE



Inflation Indexed Treasury

	COUPON	MATURITY	PRICE/YIELD	PRICE/YIELD CHANGE	TIM
5-Year	0.125	04/15/2016	104-15¼ / -0.83	0-01⅝ / -0.013	09/1
10-Year	0.625	07/15/2021	109-14 / 0.07	0-03½ / -0.030	09/1
20-Year	2.500	01/15/2029	129-25+ / 0.67	0-21 / -0.036	09/1
30-Year	2.125	02/15/2041	127-03+ / 1.05	0-27+ / -0.030	09/1

Municipal Bonds

	CURRENT YLD	PREV YLD	CHANGE	26% EQ YLD	1 WK YLD	1 MO YLD	6 MO YL
1-Year	0.209%	0.204%	0.005%	0.280%	0.222%	0.176%	0.330
2-Year	0.316%	0.309%	0.007%	0.437%	0.314%	0.302%	0.699
5-Year	0.901%	0.903%	-0.002%	1.251%	0.826%	0.848%	1.772
7-Year	1.431%	1.435%	-0.004%	1.987%	1.403%	1.579%	2.369
10-Year	2.087%	2.087%	0.000%	2.898%	2.071%	2.270%	3.019
15-Year	2.940%	2.917%	0.023%	4.083%	2.889%	3.048%	3.809
20-Year	3.392%	3.393%	-0.002%	4.710%	3.386%	3.514%	4.265

Rates & Bonds

- Government Bonds
- Corporate Bonds
- Key Rates

Related Stories

U.A.E., Qatar Companies Might Sell $1 Billion in Project Bonds, HSBC Says
Updated 3 hours ago

Israeli Inflation-Linked Bonds Gain, 10-Year Falls as August Prices Rise
Updated 4 hours ago

Germany Rejects Using ECB Leverage to Increase European Rescue Fund's Size

Databases, Tables & Calculators by Subject

Change Output Options: From: 1986 To: 2011 GO
Include graphs
More Formatting Options

Data extracted on: September 18, 2011 (8:41:25 PM)

Major Sector Productivity and Costs Index

Series Id: PRS84006152
Duration: % change quarter ago, at annual rate
Measure: Real Hourly Compensation
Sector: Business

Download:
xls

Year	Qtr1	Qtr2	Qtr3	Qtr4	Annual
1986	2.5	6.1	2.1	2.4	3.3
1987	-2.5	-1.5	0.5	1.5	0.2
1988	4.6	0.7	0.7	-1.5	1.5
1989	-2.8	-4.2	-0.1	1.9	-1.6
1990	2.1	5.5	-0.2	-2.9	1.4
1991	1.2	5.8	1.9	1.8	1.5
1992	5.7	-0.1	3.8	-1.6	2.7
1993	-0.7	-0.9	0.0	-1.1	-0.2
1994	2.9	-3.4	-3.0	0.1	-0.6
1995	0.9	-1.3	0.8	2.1	-0.3
1996	0.4	0.6	1.4	-1.6	0.7
1997	0.1	2.3	2.8	5.7	1.1
1998	7.1	4.1	4.4	0.2	4.6
1999	6.4	-2.1	0.2	4.9	2.4
2000	11.0	-1.3	4.7	0.1	3.9
2001	5.5	-1.3	0.4	4.2	1.8
2002	2.4	0.7	0.2	-0.7	1.5
2003	2.4	8.5	1.7	1.5	2.5
2004	-4.5	2.4	3.7	0.0	0.7
2005	0.9	-1.0	-0.1	-0.8	0.5
2006	3.4	-2.2	-2.5	11.2	0.5
2007	0.0	-2.1	0.5	0.8	1.2
2008	1.1	-6.0	-2.8	12.1	-0.5
2009	-0.4	4.6	-0.9	-1.6	2.0
2010	0.0	2.9	0.7	-2.2	0.4
2011	0.1	-1.0			

Databases, Tables & Calculators by Subject

Change Output Options: From: 2001 To: 2011 GO

include graphs

More Formatting Options

Data extracted on: September 18, 2011 (8:40:34 PM)

Employment Cost Index

```
Series Id:      CIU1020000000000A (C)
Not Seasonally Adjusted
compensation:   Wages and salaries
sector:         All Civilian
periodicity:    12-month percent change
Industryocc:    All workers
```

Download:
xls

Year	Qtr1	Qtr2	Qtr3	Qtr4	Annual
2001	3.7	3.6	3.6	3.7	
2002	3.5	3.5	3.1	2.8	
2003	2.9	2.7	2.9	2.9	
2004	2.6	2.6	2.5	2.5	
2005	2.5	2.5	2.3	2.6	
2006	2.7	2.8	3.2	3.2	
2007	3.6	3.4	3.3	3.4	
2008	3.2	3.2	3.1	2.7	
2009	2.2	1.8	1.5	1.5	
2010	1.5	1.6	1.5	1.6	
2011	1.6	1.6			

C : See Footnote C on www.bls.gov/ect/cimagnote.htm.

EXHIBIT 14

an hour and a half?
MS. SWATEK: I'll object to speculation. If you can answer, go ahead.
MR. SCHULTZ: Join.
THE WITNESS: I can't answer. I don't know.
BY MR. CIRIGNANI:
Q. Why didn't you order the CT angio stat?
A. The reason why I didn't order it as a stat, you know, I think it's a combination of factors. I think it was knowing the patient's seemingly stable clinical course in the emergency room, also assuming that it would have gotten entered as soon as the patient was up on the floor which there wasn't going to be too much more delay until that actually happened, and also, you know, also assuming that there would be, you know, adequate oversight from the cardiology group and even maybe Dr. Hussain too.
Q. Okay. Okay. So the reasons that you didn't order the CT angio stat was one, Mr. Elder appeared seemingly stable,

correct?
A. Yes.
Q. Two is that your assumption was that the order would be entered when he got to the floor right away -- strike that. Let me rephrase that.
Two is that your assumption was that the order would be entered right away once he got to the floor, right?
A. Yes.
Q. Three is your assumption was that there would be somebody else caring for Mr. Elder including Dr. Hussain or somebody from the cardiology group that would provide oversight, correct?
A. Yes.
Q. Is there any other reasons why you didn't order it stat?
A. Not that I can recall.
Q. While in the emergency room, you consulted with two other doctors, correct? Let me show you the page I'm looking at for that information. If you go back to the emergency room records, go right to the

first document that's typed.
A. Yes.
Q. Turn to the second page which is page 684 of Group Exhibit Number 2.
A. Yes.
Q. And under medication it says consult colon, and then another one says consult colon; do you see that?
A. Yes.
Q. The first consult says: Board call medicine was consulted by phone and will admit the patient, right? That's what it says?
A. Yes.
Q. Can you tell me what that means?
A. Board call medicine would be family practice or internal medicine, a physician who was on call to take unassigned patients, meaning patients who come into the emergency room and they don't have their own private physician, and yet the person needs a physician obviously to help coordinate their care and therefore an intern, that would be Dr. Hussain, he was the one who was assigned

for whatever that time frame was that this admission was called in to.
Q. So that would have been Dr. Hussain, correct? That's the person you would have spoken to?
A. I didn't specify here, but I understand that's who it was.
Q. Okay. Do you have any recollection or can you tell from the records what time that call was made to the internal medicine department to have Mr. Elder admitted?
A. No.
Q. Can you recall what was said to the internal medicine department in order to get him admitted -- what you said?
MS. SWATEK: I'll object to mischaracterization of testimony.
BY MR. CIRIGNANI:
Q. All right. Let's stop for a minute. I assume when it says consulted by phone, that's you making the consultation by phone; am I incorrect?
A. You're not incorrect.
Q. Okay. So if you pick up the phone,

EXHIBIT 15

based on the history and physical exam, then I would do the workup and if needed refer to the specialist.
Q. Okay. In your career as an internal medicine doctor, have you ever had a patient come into your office who ultimately was diagnosed with an aortic dissection?
A. No.
Q. Have you ever had a patient ever that has had an aortic dissection?
A. I don't recall.
Q. If I asked you about treatment for aortic dissection, would you defer to a cardiologist?
A. Yes, I would.
Q. Is it your view that treatment of aortic dissections is not within the purview of the duties of an internal medicine doctor?
MR. STAMOS: I'm sorry, purview of the duties. I'm not sure what you mean by that.

BY MR. CIRIGNANI:
Q. Let me rephrase that. It was a bit wordy. Is it your view that the treatment of aortic dissections is not within the duties of an internal medicine doctor?
A. It's beyond our internist expertise.
Q. Okay. When were you first contacted about Mr. Elder? Can you give me a little bit more precise -- I know it was in August of 2008, but do you remember which day or what time?
MR. STAMOS: If you need to look at the chart at any time, you may.
THE WITNESS: August 4.
BY MR. CIRIGNANI:
Q. Okay, 2008. What time were you contacted?
A. Contacted, like physically seeing the patient, you mean or --
Q. No, sir. When was the first time you even heard about and asked to be involved in his care?
A. It was August 4. The exact time I

don't recall.
Q. It was sometime in the morning of August 4th?
A. Right.
Q. And is it fair to say that the first contact -- first time that you ever even heard about Mr. Elder was when you received a phone call from the emergency room doctor, Dr. Zwolski?
A. Yes.
Q. Okay. And the substance of that phone call, is it what you told me earlier, in the early part of this deposition?
A. Yes, for the chest pain.
Q. So, I'm sorry, and I apologize for doing this, but can we go through that again? Can you tell me precisely what Dr. Zwolski told you when he called you?
A. He said there's a young gentleman came with the chest pain and I already spoke to cardiology and he has some abnormal aorta, abnormal aorta.
Q. So he told you that the patient was young, that the patient had chest pain?

A. That the patient's chest pain was relieved by some medication he said, I don't remember what was that, and then he said he's talking to the cardiologist.
Q. So Dr. Zwolski said that he, Dr. Zwolski, was going to talk to the cardiologist?
MR. STAMOS: Was already talking to the cardiologist.
THE WITNESS: Was already talking. He said he already spoke to the cardiologist.
BY MR. CIRIGNANI:
Q. Okay. So let me clarify that. At the time that you first became aware of Mr. Elder's existence and his need for care was through a phone call by the emergency room doctor, right?
A. Yes.
Q. And in that phone call, that emergency room doctor, Dr. Zwolski, told you that he had already spoken to the cardiologist?
A. Right.

EXHIBIT 16

Q. Did you ask -- well, strike that.
It would be fair to say once the emergency room doctor told you an MI had reasonably been ruled out, then you really didn't need to ask what the enzymes were and what the EKG was, fair?
A. Not necessarily. You want to confirm that, just double-check to make sure that that was the case.
Q. Did you ask Dr. Zwolski if the 12-lead EKG was normal?
MR. MANGAN: Objection, asked and answered. Go ahead.
THE WITNESS: I do not recall.
BY MR. HARMAN:
Q. Did you ask Dr. Zwolski what the basis of his opinion was that a heart attack -- a myocardial infarction had reasonably been ruled out?
A. I do not recall.
Q. Did you ask Dr. Zwolski what the initial enzymes were?
A. Did I ask?
Q. Yes, sir.

A. I do not recall.
Q. So it would be fair to say during the phone conversation with Dr. Zwolski, you knew Mr. Elder had chest pain, a dilated aorta, and an MI had already reasonably been ruled out, correct?
A. Yes.
Q. With reference to your phone conversation with -- strike that.
Did Dr. Zwolski in your opinion based on what he told you in any way, either directly or indirectly, want you or one of the Heartland cardiologists to see Mr. Elder as soon as possible?
A. No.
Q. In your opinion, did Dr. Zwolski give you a thorough, complete, and adequate report on Mr. Elder?
A. I do not recall.
Q. Well, do you have any criticisms of the report that you received from Dr. Zwolski?
A. What do you mean by criticism?
Q. All right. Doctor, I assume it is

your testimony in this case that you did not facilitate a stat or urgent consult on Mr. Elder; is that correct?
MR. MANGAN: Object to the form of the question.
MR. SCHULTZ: Join.
THE WITNESS: Yes.
BY MR. HARMAN:
Q. And I assume it's your testimony in this case that your actions were reasonable and within the standard of care in not ordering or facilitating a stat or urgent consult, cardiac consult on Mr. Elder because -- well, strike that.
Doctor, why in your opinion after the phone conversation with the emergency room doctor didn't you have to get a stat cardiac consult for Mr. Elder?
MR. MANGAN: Object to the form. Go ahead.
THE WITNESS: Well, at the time I thought that I wasn't given probably any information that needs to be urgently a patient is to be seen.

BY MR. HARMAN:
Q. So it's your opinion that based on the information you were given by Dr. Zwolski there was nothing that led you to reasonably believe that Mr. Elder needed to see a cardiologist immediately; is that correct?
A. Yes.
Q. Did you receive any information -- strike that.
It would be fair to say that you personally made the decision as to whether or not Mr. Zwolski needed to see a cardiologist stat or as soon as possible, correct?
A. Ask me again.
Q. Sure. It would be fair to say that you made the decision on the morning of August 4th, 2008 that Mr. Elder did not need to be seen by a cardiologist immediately, correct?
MR. MANGAN: I just object to the form. Go ahead.
THE WITNESS: What do you mean by

immediately?
BY MR. HARMAN:
Q. Doctor, it would be fair to say that you made the decision on the morning of August 4th, 2008 that Mr. Elder did not need to be seen by a cardiologist as soon as possible; is that correct?
A. Yes.
Q. And it would be fair to say that the sole basis of your decision that Mr. Elder did not need to be seen by a cardiologist as soon as possible was the information that you received from the emergency room doctor, Dr. Zwolski, correct?
A. Yes.
Q. It would be fair to say that -- strike that.
Hypothetically, if Dr. Zwolski had requested a stat or emergent consult on Mr. Elder, you would have done that, true?
A. Yes.
Q. Hypothetically, if Dr. Zwolski had asked you or requested you for a stat or urgent consult on Mr. Elder, how would you

have done that? Would you have actually gone and done it yourself or would you have immediately called one of your partners and had them do it? How would you have done that?
A. I'm not sure.
Q. Okay. It would be fair to say that the reason you didn't do a stat or emergent consult on Mr. Elder is because the emergency room doctor, Dr. Zwolski, didn't ask you to do that, fair?
A. Yes.
Q. Would it be fair to say that the emergency room doctors, they're the ones who are right there seeing the patients, and they're the ones that you rely on real heavily to determine whether or not you as a cardiologist need to come in right away and see the patient, correct?
MR. SCHULTZ: Object to the form.
MR. MANGAN: I will object to the form of the question.
MR. HARMAN: You are objecting to that question, Mr. Mangan?

MR. MANGAN: I object to the form of the question.
BY MR. HARMAN:
Q. Do you remember the question, Doctor?
A. No.
Q. It would be fair to say that as a cardiologist you rely pretty heavily on the emergency room doctor to let you know whether or not that patient sitting in the emergency room needs to see you right away; is that fair?
MR. SCHULTZ: Same objection, form.
MR. MANGAN: Yes, join.
THE WITNESS: Yes.
BY MR. HARMAN:
Q. Do you have any idea why Dr. Zwolski -- well, strike that.
How did you know that Dr. Zwolski wanted a routine cardiac consult on Mr. Elder?
A. I do not recall.
Q. Doctor, one of the ways that you could know that Dr. Zwolski wanted a routine

cardiac consult would be that that's what he told you he wanted, true?
A. Possible, but I do not recall. Can I take a five-minute break?
MR. HARMAN: Sure. Absolutely.
THE VIDEOGRAPHER: We are going to go off the record at 4:33 PM.
(Whereupon a short break was had from 4:33 PM to 4:40 PM.)
THE VIDEOGRAPHER: We're back on the record at 4:40 PM. Please proceed.
BY MR. HARMAN:
Q. Did Dr. Zwolski tell you why he wanted a cardiac consult on Mr. Elder?
A. I believe because of the chest pain.
Q. Did you suspect that -- strike that. Hypothetically, if -- well, strike that.
Did Dr. Zwolski lead you to believe in any way, either directly or indirectly, that Mr. Elder may have a dissecting aneurysm?
A. Ask me again.

Q. Sure. I'm going to ask you a different question in fairness, and I'll get back to that one.
A. Sure.
Q. Did Dr. Zwolski tell you that he thought Mr. Elder may have a dissection?
A. No.
Q. Did Dr. Zwolski tell you that a dissection was on the differential diagnosis for Mr. Elder?
A. I don't think so.
Q. Did Dr. Zwolski lead you to believe in any way, either directly or indirectly, that Mr. Elder may have a dissection?
A. No.
Q. Sometimes emergency room doctors tell you I think this patient may have a dissection, please come in and see him right away; that happens, true?
A. Yes.
Q. Did you ask Dr. Zwolski what he thought was wrong with Mr. Elder?
A. I do not recall.
Q. Did Dr. Zwolski tell you what his

differential diagnosis was for Mr. Elder?
A. I do not recall.
Q. You knew over the phone that Mr. Elder was a patient with a chief complaint of chest pain and an MI had reasonably been ruled out and the aorta was dilated. Given that information, why didn't you order a stat consult for Mr. Elder -- strike that.
Did you suspect after talking to Dr. Zwolski that Mr. Elder may have a dissection?
A. I remember this that Dr. Zwolski told me that the patient has aneurysm and patient is going back to radiology for -- I believe for CT angiogram.
Q. Okay. Doctor, would it be fair to say that it was your understanding when you talked to Dr. Zwolski that Mr. Elder was already scheduled for the test that would tell you and the other doctors whether or not there was a dissection?
A. Yes.
Q. Would it be fair to say -- strike

that.
Did Dr. Zwolski tell you a CT scan with angiogram's already been ordered, and it's going to get done to figure out whether or not there was a dissection? Was that information conveyed to you?
A. Yes.
Q. It would be fair to say that during your phone conversation with Dr. Zwolski you knew a dissection was on the differential diagnosis because the test to determine whether or not it was there had already been ordered, true?
A. Yes.
Q. Would it be fair to say that Dr. Zwolski didn't come out and flat out tell you a dissection was on the differential diagnosis, but you knew that because he'd ordered the test to rule it in or rule it out; fair?
A. I might say so.
Q. After you hung up the phone with Dr. Zwolski, what did you do next?
A. I remember the conversation with

him telling him give us call once you get report of the CT angiogram.
Q. It's your testimony that you told Dr. Zwolski to call a Heartland cardiologist as soon as -- strike that.
Did you tell Dr. Zwolski to call you personally back with the results of the CT angiogram or did you tell Dr. Zwolski please call back a Heartland cardiologist as soon as the results came back? Which was it?
A. I did not say personally call me.
Q. Okay. Is it your testimony that you told Dr. Zwolski to call a Heartland cardiologist as soon as he got the results of the CT scan with angiogram?
A. I implied that.
Q. In your opinion, did you make it crystal clear to Dr. Zwolski that you wanted him to call a Heartland cardiologist as soon as he got the results of the CT scan angiogram back?
A. I implied that.
Q. I appreciate that. My question was

different. Doctor, in your opinion, did you make it very clear with no ambiguity to Dr. Zwolski that he was supposed to call back a Heartland cardiologist as soon as he got the results back of the CT scan with angio?
A. Yes.
Q. What words did you use that in your opinion made it crystal clear to Dr. Zwolski that he was supposed to call back a Heartland cardiologist once the results of the CT scan with angio came back?
A. I said once you get the result call us back.
Q. Okay. And -- strike that.
When you told Dr. Zwolski please call a Heartland cardiologist back when you get the results of the CT scan with angio, did he say yes, I'll do that?
A. Yes.
Q. Is it your testimony that during the phone conversation with Dr. Zwolski you knew Mr. Elder based on the preliminary CT scan, his history, and that an M -- strike

that.
Doctor, is it your testimony that you knew Mr. Elder might have a dissecting aortic aneurysm, but it was your understanding the test to determine that had been ordered and you told the ER doctor call us back as soon as you get the results and therefore you feel you complied with the standard of care?
MR. MANGAN: I'll object to the form. Go ahead.
THE WITNESS: Yes.
BY MR. HARMAN:
Q. It would be fair to say you didn't order a CT scan angio stat because it had already been ordered by the emergency room doctor, fair?
A. Yes.
Q. Was it your understanding -- strike that.
Doctor, was it your assumption that the CT scan with angio was being done on a stat basis and that your group would be getting a phone call shortly from

Dr. Zwolski about the results?
A. Yes.
Q. Did you give Dr. Zwolski the name of a particular Heartland cardiologist to call with the results of the CT scan?
A. No.
Q. Was it your assumption that when the results of the CT scan with angio came back that Dr. Zwolski would simply page whatever Heartland cardiologist was in the hospital at the time?
A. Triage nurse, triage pager, yes.
Q. Provena Saint Joe's Hospital, do they have a TV, again, in August of '08, where you can just look up and see what doctor is physically in the hospital?
A. Yes, they may have.
Q. Do you know one way or another? There's a name for this system. You know when you walk in the hospital, you scan your card and then the nurses, the ER doctors, et cetera, they can look up at a TV and see what doctor's physically there?
A. Yes, but my understanding is not

everybody is using that system.
Q. You said the triage pager -- strike that.
You testified that you assumed Dr. Zwolski would call the triage pager?
A. Yes.
Q. What is that?
A. That's basically daytime answering service.
Q. Okay. It's your testimony it was your assumption that Dr. Zwolski would simply page the Heartland cardiologist that was on call for the day shift and tell him or her about the results of the CT scan, correct?
A. Yes.
Q. It's your testimony that -- strike that.
Did Dr. Zwolski tell you that the CT scan with angio had been ordered stat?
A. I do not recall whether he said stat or not.
Q. Did Dr. Zwolski lead you to believe

EXHIBIT 17

IN THE CIRCUIT COURT OF THE TWELFTH JUDICIAL CIRCUIT
WILL COUNTY, ILLINOIS

BRENDA GRAMELSPACHER, Special Administrator of the Estate of JEFFREY T. ELDER, Deceased,	)	
Plaintiff,	)	
v.	)	No. 08 L 827
PROVENA HOSPITALS d/b/a PROVENA SAINT JOSEPH MEDICAL CENTER, et al.	)	
Defendants.	)	

AFFIDAVIT OF WILLIAM A. CIRIGNANI

The undersigned, William A. Cirignani, being duly sworn on oath, deposes and states as follows:

1. In August of 2011, I approached *all* defendants and asked them if they would be willing to mediate the case for settlement.

2. Defendants Zwolski and Provena said yes, but the Cardiologist and Internist Defendants said no, saying that they wanted to see Plaintiff's expert disclosures before discussing settlement.

3. In October of 2011, I filed plaintiff's expert disclosures and once again asked *all* Defendants to submit to mediation. Once again, Defendants Zwolski and Provena said yes, but the Cardiologist and Internist Defendants again said no, this time saying simply that they felt they had a defensible case.

4. In November of 2011, I approached Defendants Zwolski and Provena separately about entering into high/low agreements with Plaintiff. There were many discussions during which I repeatedly indicated that all high/low agreements under consideration were not to be hidden from the non-settling Defendants.

5. Furthermore, I insisted that before final agreement was reached on any high/low deals, that counsel for Defendants Provena and Zwolski engage the non-settling Defendants one more time about a global settlement. Though not privy to these conversations, undersigned counsel was told that this was done and that once again the non-settling defendants preferred to stay that way.

6. Negotiations over the exact terms of the high/low agreements were then hashed out over the next several months, the hashing out of which was well-known to the non-settling Defendants.

7. Finally, in June of 2012, agreements were reached. The exact agreements have been attached to this affidavit.

8. The Affiant says nothing further.

William A. Cirignani

SUBSCRIBED and SWORN
to before me this 5th day of July, 2012.

NOTARY PUBLIC

Official Seal
Susan G Shellhammer
Notary Public State of Illinois
My Commission Expires 08/26/2013