Jim Leventhal's Cross-Examination of an Adverse Party[1]

Complete Transcript with Notes from Patrick Malone

The Court: The Plaintiff may call the next witness.

Mr. Leventhal: At this time, we will call the defendant, Dr. Perez, on cross-examination, pursuant to the Rules of Civil Procedure.

The Court: Very well. Dr. Perez.

Jesus Jaime Perez, MD., having been first duly sworn to tell the truth, was examined and testified upon his oath as follows:

Mr. Leventhal: Your Honor, I would request that the Court instruct the jury on the difference between calling somebody on cross versus direct.

[This is an optional prelude that heightens the drama and highlights for the jury the examiner's right to lead this witness on direct. A less experienced judge might have floundered. This one delivers a smooth and well-taken instruction that sets the table for any leading questioning that the examiner wants to do.]

The Court: The purpose of calling somebody on cross-examination, is largely to be allowed to question them using leading questions. As you will see, you've seen leading questions on cross-examination of other witnesses; but basically, the plaintiff has the right to do that. That does not make Dr. Perez the plaintiff's witness. It simply means, that the plaintiff is using this opportunity to question him in a certain way, that arguably the plaintiff feels is appropriate to present her case.

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1. *Epperly v. Perez*, Case No. 08CV165, 13th Judicial District, Colorado, January 15, 2009.

The defendant, Dr. Perez, also has the right to be examined by his own attorney in the same fashion. You will see some of those same types of questions. Later on, Ms. Doig will be examining Dr. Perez on direct examination; which is the same way that the plaintiff has been presenting questions, which means questions that call for a story. You will see those different types of questioning here. You are to evaluate the testimony of. Dr. Perez like any other witnesses, regardless of who calls him. Okay.

Mr. Leventhal: Thank you, Judge.

Cross-Examination by Mr. Leventhal:

Q: Good afternoon, sir.

A: Good afternoon.

Q: Could you tell the jury your name.

A: Jesus Jaime Perez.

Q: And you go by James Perez?

A: James, correct.

Q: You are a physician?

A: Yes.

Q: Your medical specialty is what?

A: Family medicine.

Q: You practice where?

A: Burlington, Colorado.

Q: Tell the jury a little bit about your educational training and background, please.

A: My training consists of going to high school there in Burlington, Colorado. Going to college in Fort Collins, CSU, to be specific. I majored in microbiology, graduated with honors. I was in the premed program, and ended up going to medical school at CU

in Denver, where I did my four-year medical school training. Through my medical school training, primary care became a calling to me. I was interested in taking care of all aspects of patient care, from pediatrics to geriatrics. And so, through my internship and rotation at the hospital, I very quickly figured that that was really what I loved to do, and that was my calling. So, after finishing my four years at CU medical school, I was fortunate enough to get in through the Greeley Family Medicine Program. Greeley at that time was one of the top primary care medicine residency trainings for specific emphasis in rural medicine.

Q: Okay. You did—so, did you do a residency in family practice?

A: Yes.

Q: How long was your residency?

A: The residency is three years in length.

Q: So, you completed three years of intense training in how to take care of patients that you could see in family practice?

A: Yes.

[So far, this has sounded much like a direct examination by the doctor's own lawyer, or the kind of questions that might be asked at a "soft" deposition. But now watch as the cross-examiner moves from general training to specific training in the key subject of evaluating chest pain.]

Q: You heard some witnesses testify as medical students, third year, second year medical students, part of the training was evaluation of chest pain?

A: Yes.

Q: You had that same training; didn't you?

A: Yes.

Q: And, in fact, you had the same training that Dr. Magorien said that he teaches, and Dr. Duran, and Dr. von Elten say they teach, and they took when they were studying to become family practice doctors?

A: That's correct.

[Note how the cross-examiner frames what otherwise could be abstract "standard of care" into the concrete "how you were trained in medical school." He also quickly links to the experts who have already testified for the plaintiff, who put the abstract standard into the concrete "what I teach." Now the cross-examiner marches directly into the heart of the case, the failure of the defendant to consider the aorta as part of the chest pain evaluation.]

Q: That training included, that when you evaluate somebody for chest pain, you look at worst first; page 8 right?

A: You look at life-threatening conditions, yes.

["Worst first" is a pithy way to put the diagnostic priority rule. Any time the cross-examiner can frame a "rule" with two or three words, is good.]

Q: That when you're evaluating somebody for chest pain, you have to consider the aorta?

A: Yes.

Q: That is part of your training; isn't it?

A: Yes.

[Having set up and validated a simple rule, the cross-examiner sets up some additional training background that he will return to later.]

Q: You also work at the emergency room at Kit Carson Memorial Hospital; don't you?

A: I rotate with three other physicians to cover the emergency room, yes.

Q: You have a contract with the hospital to do that?

A: It is part of my job description, yes.

Q: Tell the jury about your contract to provide emergency room service at Kit Carson Hospital, when you first entered into that contract, and what it requires?

A: The contract came about at the end of my third year. I basically agreed to become a hospital employee. And in the contract,

there is a job description that talks about how many hours we anticipate to do in clinical care; that we will practice OB, that we will do surgical OB; that we will do certain procedures; and we will also rotate in a fair fashion with the other physicians there covering the emergency room, since there is no full-time emergency room staff.

Q: Okay. And so, in order to work in the emergency room, you were required to be ACLS certified; weren't you?

A: That is correct.

Q: Can you tell the jury what ACLS stands for?

A: Advanced Cardiac Life Support.

Q: You have to actually study the test materials and then take a test?

A: Correct.

Q: You have to be recertified every how many years?

A: It is every two years.

Q: In addition to—and that is so that you can provide appropriate care for a patient that comes in with chest pain?

[Here is a minor quibble with an otherwise brilliant cross-examination. This section on ACLS certification could have been moved to a place just before the examiner starts quoting from the ACLS training book. That would have made the ACLS literature impeachment a bit stronger by making the nexus more obvious. Sometimes lawyers reflexively put all of their "training and qualifications" material into a preliminary section of the examination without tying it into specific substance of the case.]

A: That's correct.

Q: Right. You also had—to become an emergency room doctor, you had to become a ATLS certified?

A: Correct.

Q: And what does "ATLS" stand for?

A: Advanced Trauma Life Support.

Q: And again, there are materials to study, and you studied those materials and took the test, and you are ATLS certified?

A: That's correct.

Q: o, the types of patients that you've seen in the emergency room in Burlington include—it is not unusual for you actually to see chest pain patients, is it?

A: I see chest pain patients on a regular basis.

Q: It is one of the most common presentations, probably after headache, that people are seen for in the emergency room?

A: Yes, very close to low back pain, too.

Q: You've seen patients coming off the freeway who have been in accidents, trauma patients?

A: Unfortunately, yes.

Q: You see all patients that emergency room doctors see?

A: Yes.

Q: In fact, you believe that the standard of care for diagnosing a patient who presents in the emergency room for chest pain is the same, whether that doctor seeing him is a family practice doctor or an emergency room doctor?

A: In the initial evaluation of a patient through the emergency room, yes.

[The next question is a natural follow-through to the prior one, but one many lawyers don't follow because of the bad indoctrination so many of us get to "not ask one question too many" and to "save the point for closing." The next question is obviously important to validate the plaintiff's expert having a similar, but not the same, specialty as the defendant. Technically it doesn't have to be asked. The examiner has just established that the "standard of care" for family medicine doctors and emergency doctors in evaluating a chest pain patient in the ER is the same. So this next question is only necessary if the examiner wants

the jury to understand the key points as they're being made, which every trial lawyer who wants to conduct an effective cross-examination should want.]

Q: So, it was fair to have an emergency room doctor come and evaluate your care and testify in this case. That was fair to you; wasn't it?

A: Yes.

Q: Just as it is fair to have a family practice doctor, or anybody who understands the principles of evaluating a patient with chest pain?

A: Yes.

[More questions that tie the witness's training to his job duties to what happened to the patient in this case. You can see the relentless progression of logic.]

Q: Part of your job was to be able to recognize signs and symptoms of problems with the aorta, right?

A: That's correct.

Q: That was part of your duty to Mr. Epperly and any other patient that comes in with chest pain?

A: Yes.

[The cross-examiner begins a series of questions that close another escape route. In Rules of Road, this is the "not important" escape for violating a Rule. Here the lack of testing for what turned out to be wrong with the patient *was* important.]

Q: I want to begin with what is not contested in this case. You admit that Mr. Epperly died from an aortic dissection; don't you?

A: That's correct.

Q: You admit that when you saw Mr. Epperly on September 19, 2003, that he was, in fact, experiencing an aortic dissection?

A: In hindsight, with all of the information we have, with the autopsy report that we have in front of us; more than likely, yes.

Q: You admitted that you done a CT on the nineteenth, had you ordered a CT examination at the Kit Carson Hospital, more likely than not, Mr. Epperly's aortic dissection actually would have been diagnosed?

A: Again, in hindsight, that is probably yes.

Q: In fact, you told us that was probable?

A: Probable, yes.

[Nothing wrong with having the witness repeat a favorable admission.]

Q: And had that been diagnosed on the nineteenth, that more likely than not, Mr. Epperly would have survived?

A: The probability would be in his favor, yes.

Q: You also admit that the signs and symptoms that Mr. Epperly presented with—the new onset or acute onset of chest pain that day, and the pain radiating from his chest to his back—that those signs and symptoms that he was telling you about were, in fact, from this aortic dissection that he was experiencing at that time?

A: With the information that we have now, in hindsight, yes.

[Note the cross-examiner's self-discipline in not taking the witness's bait about "hindsight." It would have been easy to take a detour into what was knowable only by hindsight versus what could have been known with a better examination or testing at the time. But hindsight is where the witness wants to go, not the examiner, not yet, and so the attorney continues to set out the basic admissions that frame the case.]

Q: You also admit that had you ordered a CT on the twenty-third, when you saw him, that more likely than not, the aortic dissection that he had, which started on the nineteenth, would have been diagnosed?

A: More than likely, yes.

Q: And that more likely than not, had you made the diagnosis on the twenty-third, in the morning when you saw him, that he would have received appropriate care and would have survived?

A: The probability of survival would be, again, in his favor, yes.

[The whole case has now been mostly admitted. The only surviving defense is whether the diagnosis could and should have been made at the time, or only through "hindsight."

Now watch a very adroit use of professional literature. Of course, Fed. R. Evid. 803(18) and its state rule analogs require that lawyers not start spouting quotations from books until they have been established by the witness or some other source as "reliable authority." Too many lawyers go through the groundwork abruptly, asking only the "magic words" question without dwelling on what it means to be a "reliable authority." Here, the witness's use of the very book establishes its authority.]

Q: I, throughout this case, have used a textbook of medicine called Harrison's Principles of Medicine. And I represented that this was a textbook you had on your desk in your office?

A: I have that in my office.

Q: Not always on your desk.

A: It fluctuates.

Q: This is a textbook that a reliable authority, in fact, it is one of the basic textbooks of medicine that almost everybody has who practices medicine, family medicine at least?

A: It was one of the primary books, yes.

Q: You had it in there, because you used it as a reference book?

A: I will rely on it at times, yes. I don't do that on a daily basis; but yes, I have used it as a resource, if I need to use it.

Q: And you admit this is the textbook in effect at the time—and this is the fifteenth edition, 2001. This was a 2003 case.

[Having locked in the reliability of the book with five questions where a less skilled advocate would have used one or two, the examiner now

publishes the key quotation. This is usually best done by showing the quotation on a screen or poster board at the same time the examiner reads the text aloud. (Inviting the witness to read the text aloud is often a prelude to a garbled, unintelligible recitation.)]

A: That is correct.

Q: Would you tell the jury why a chest X-ray is insufficient, a chest X-ray is not sufficient to exclude the diagnosis of an aortic dissection?

[Asking a "why" question at this point posed a risk, but not a large one. The witness has just agreed that the authoritative textbook which he keeps in his office and uses from time to time taught that a chest X-ray is not enough to find an aortic dissection. The witness could now respond that he disagrees with the textbook, but instead gives a valuable admission that is all the more strong for being put in his words, not the lawyer's.]

A: It doesn't have the appropriate sensitivity, meaning, you could have a normal chest X-ray, and miss an aortic dissection.

[The examiner now brings the literature quotation down to this case.]

Q: You knew that when you saw Mr. Epperly and you ordered the chest X-ray, that that was not the test to run, if you were going to exclude or rule out aortic dissection; didn't you?

A: If I was going to be looking for aortic dissection, I would have ordered a CAT Scan.

Q: Now, Mr. Epperly came into your office on the nineteenth, and he came into your office at the clinic, which is directly across the street from the hospital; isn't it?

A: That's correct.

Q: It is what, fifty feet from the hospital? Fifty yards from the hospital?

A: The length of a street, plus maybe a quarter of a block.

[Does it matter exactly how far the doctor's office is from the hospital, which is already established as "directly across the street"? No. The extra question is worth asking because it helps establish vivid detail about the proximity.]

Q: When he came in, he didn't have an appointment?

A: No, he came in unassigned.

Q: This is the first time you ever saw Mr. Epperly; right?

A: That's correct.

Q: And when he came in, he reported to your nurse that he had severe chest pain; right?

A: He reported that he had chest pain.

Q: Okay. That took him to the top of the list, even though you had other patients who had appointments. Other patients who had scheduled appointments, whether it was days or weeks in advance, Mr. Epperly became the priority; didn't he?

A: Like many other patients before him and after him, that present to the clinic with a complaint of chest pain, yes, he took priority.

Q: And tell the jury why—let me ask you this. When Mr. Epperly presented with chest pain, did he have left arm pain?

A: That was not given in the history.

Q: Did he have a report of crushing chest pain? We have heard the classic signs of a heart attack are crushing chest pain, radiating to the left arm. Did he have crushing chest pain, radiating to the left arm?

A: He had chest pain, described as a pressure.

Q: Not this classic presentation, crushing chest pain radiating to the left arm?

A: Chest pain with pressure would be also presentation of a heart attack.

Q: Not classic presentation, but consistent with a heart attack?

A: It was consistent. And if you look at some books, it can be classic.

[It's not clear why the examiner and the witness have digressed into what types of chest pain symptoms amount to "classic" descriptions of heart attack pain, since the patient didn't have a heart attack. But now the examiner brings it back to something important: that a chest pain description of this type puts the patient at "the top of the list" to be seen by the doctor. This kind of detail is useful because every juror has had the experience of waiting forever in a doctor's waiting room, so a condition that sends someone to the top of the heap is impressive.]

Q: So, then, because he complained of chest pain, he goes to the top of the list which means that he was seen before the other patients?

A: That's correct.

Q: Is that because when somebody complains of chest pain, it is possible that they may have an immediately life-threatening condition?

A: They would be—potentially, yes, in serious danger or trouble.

Q: In serious danger or trouble of dying immediately?

A: Correct.

Q: Right?

A: Correct.

Q: Okay. And so, he goes to the top of the list. And when you saw him, you then asked him what his history was; right?

A: Yes.

Q: You learned that he had this sudden onset of pain while he was walking that day?

A: He said a new onset of chest pain, not sudden. That is very important to verify. You have been talking about the standard of care throughout your whole presentation here. And I believe that I provided the standard of care. And to me, there is a big difference between sudden onset and a new onset.

Q: Okay.

A: Because on an regular basis, we do get patients with new onset chest pain. When we cover the emergency room, that is one of the top reasons why we see somebody at two o'clock in the morning; they have a new onset of chest pain.

[The thus far compliant witness thus far now begins to defend himself, on the narrow difference between "new onset" and "sudden onset" of chest pain. A less skilled cross-examiner, hung up on receiving a discursive answer to a yes/no question, would have complained that the witness was saying too much, and would thereby lose control of the encounter and look weak. Instead, this cross-examiner calmly moves to take apart the new/sudden distinction.]

Q: Okay. Well, so, then are you saying that because this was new—let me ask you this: What is the difference, Mr. Epperly said he had experienced chest pain that morning, right?

A: Correct.

Q: What time did he experience the chest pain?

A: He said in the a.m. I did not get the exact time from him.

Q: Okay. Well—and was—when you say in the a.m., did it start at 6:00 a.m. and gradually build up, or did you ask him, was this sudden, or was this something that gradually came over several hours?

A: The question was: When did it start, and it was in the a.m.

Q: So, do you have an answer then as to whether this was sudden? Start, you know, ten minutes ago, and I'm here—started an hour ago, and I'm here. Do you have an answer about whether that was sudden, or did you just know it was new?

A: I knew it was a new onset.

Q: You can't—you're not telling the jury, because you didn't ask the question about whether it was sudden, that you determined it was not sudden?

A: When the patient has a sudden onset, most of the time, like when he tells you other history, he will tell you it came on

suddenly. In his case, he said that it was this—in the a.m., in the morning.

Q: Did you ask him?

A: I asked him when it started, and he said in the a.m.

Q: Did you ask him whether it was sudden?

A: I don't recall.

[Without a good deposition that closed this escape path, the cross-examiner would have been on difficult ground if the witness had a new memory of in fact having posed the critical question to the patient. Now with the critical admission that the witness couldn't recall having asked that question, the cross-examiner can underscore the point, which deflates the witness's only attempt so far in the examination to defend himself. The next few questions lock in the admission.]

Q: So, as you sit here, you don't know whether he had a sudden onset of chest pain?

A: I can't recall. I am not going to make up a story on that I knew it was a new onset, started in the morning.

Q: Okay. So, Mr. Epperly comes in and tells you that he had a new onset of chest pain that started the very morning he came in to see you; right?

A: Yes.

Q: It may have been sudden, you don't know?

A: Potentially.

Q: Okay. And he told you that it was a chest pain, and he told you that it was radiating to his back?

A: That's correct.

Q: Not just to his—it was radiating to his mid-back, and to his low back?

A: When he came in, his presentation of the chest pain radiating to the back and low back pain, he had a history of low back

pain. When he presented to the clinic on the nineteenth, his primary source of pain, or the one that he focused on the most, was actually his low back. That was one of the reasons he got the Torado1 injection, was for the back pain, which was more severe than the chest pain.

Q: But you wrote chest pain, radiating to the mid-back, and low back pain; right?

A: Chest pain, radiating to the back, and low back pain; yes.

Q: All right. At that point, even though he didn't have left arm pain, and even though it was not what some folks describe as classic for a heart attack, you immediately hooked him up to an EKG?

A: That's a standard of care.

Q: That is because, even though the presentation may not be classic, his presentation fit a patient who may be having a heart attack, and it is important to rule it out as soon as possible; right?

A: That's correct.

A: SO, you gave him an EKG in your office. And the EKG, you interpreted as normal; right?

A: Yes.

Q: And EKG can, if a patient has had a heart attack, show evidence of heart attack on the tracing, true?

A: Yes.

Q: Does it look like little gravestones on the tracing, if somebody has had a heart attack?

[The only point of the question is to show the witness and the jury that the examiner knows something about reading an EKG, which helps advance his own credibility.]

A: That is a classic presentation of a massive myocardial infarction, the tombstone sign, yes.

Q: And sometimes it could show ischemic heart disease, by an elevation of something called the ST wave?

A: Yes.

Q: But he had neither. He was a normal presentation on the EKG?

A: EKG was normal, yes.

Q: But that in and of itself does not rule out that he's either had a heart attack, or that he's in the process of having a heart attack; does it?

A: It is part of the process of working him up.

Q: But not the whole process?

A: It is the initial process.

Q: SO, when he's in your clinic, you also gave him some, what was it, Maalox or some type of antacid drink?

A: Correct

Q: You heard Rana Epperly say that he threw that up; is that correct?

A: Yes.

Q: So, he wasn't feeling good, right?

A: No. He didn't look good, no.

Q: You also gave him a shot of Toradol, and it says IM, which means into a muscle.

[Always translating any technical words into plain English—"into a muscle" is better than "intra-muscular"—keeps the examination on a clear path.]

A: That's correct. That was for his low back pain.

Q: But Toradol doesn't just affect the low back, it is not a drug that says, I'm only going to touch the low back. When you put it in the muscle, it will help if you have pain anywhere.

A: That's correct. But it was intended to help with the pain of his low back pain.

Q: In fact, if have you chest pain or mid-back pain, or whatever, the Toradol predictably will diminish pain, wherever it is.

A: The Toradol as a pain killer will affect the entire body, yes.

Q: But the Toradol doesn't, if the pain subsides, rule out a heart attack; will it?

A: I did that for patient comfort.

Q: I understand that. But the Toradol don't rule out if he's having a heart attack?

A: No, it just makes the patient more comfortable.

Q: But you still have a concern he may have a immediately life-threatening problem?

A: You continue with the work up, yes.

Q: You know, have you heard the expression "masking symptoms"?

A: Yes.

[More non-leading questions enable the cross-examiner to make his point through the witness's words.]

Q: With regard to the administration of pain medications, what does that mean?

A: If you give them a high enough pain medication, you could take any pain away.

[The witness has given a less-than-clear definition of what it means for a medication to "mask symptoms," so the examiner gives his own definition.]

Q: One of the great things about the body is, that the pain is a warning sign not just to patients, but also to the doctors, so that they know what to look for?

A: That's correct. That's the reason that I gave him 30 milligrams of Toradol, rather than a narcotic such as Morphine or Demerol.

Q: One of the things you're required to do, is not just recognize he's in pain, but do a history of him and find out where the pain is, whether it is sudden onset, how severe it is, and does it radiate; is that correct?

A: That's correct.

Q: You did find out that he had severe pain, and that it was chest, and low back. The low back, you said, was the most severe, and that it radiated to his mid-back; right?

A: That's correct.

Q: But are you telling the jury, you didn't determine whether this was sudden, and that is somehow important to this case?

[It doesn't hurt to underline again the key point that the doctor had failed in his job to get an accurate history.]

A: The sudden onset of chest pain was not documented. I did not pick that up. It was a new onset. He did describe it as new onset. If he would have described it as sudden onset, that would have made a big difference, yes.

[The witness tries to push the blame for no "sudden onset" description onto the patient, and the cross-examiner shows he is instantly ready for the point.]

Q: But you're the doctor. You're the one that understands the significance. He comes in and says: I got this pain this morning, and I'm here, and I'm concerned. That's basically what he said, right?

A: Yes.

Q: And you're the doctor. You're saying that if he had told you it was a sudden onset, that it would have made a big difference. What stopped you from asking him whether it was sudden?

[Is this risky? Not much. The attorney has already established that (1) the "sudden" nature of the pain would be key to know and (2) the witness didn't recall asking about it specifically, so another non-leading question that basically asks "why didn't you ask if it was sudden" is not one that

leaves the witness any escape option, except to develop a new and non-credible memory that he did in fact ask the question.]

A: In getting the history, I asked: When did it start? I asked the severity of it. That's where the eight out often came from. I asked: Does it go anywhere? In that, the patient will usually elicit—if it is there, they will tell me it was a sudden onset.

Q: I understand you don't have that written down, and you don't know whether he said sudden or not; but what stopped you from asking him anything?

[Good cross-examiners listen carefully to each answer. The witness did not directly answer the question, so asking it again keeps the witness on the hook. Persistence then pays off in the next few questions when the examiner gets the witness to admit that if he had asked the key question, he would have taken an entirely different path with the patient.]

A: I just knew it started that morning.

Q: But there was no reason that you couldn't have asked him: Was this sudden?

A: I could have asked him, yes.

Q: You're saying if you had asked him that question and he said it was sudden—we have no reason to suggest that he wouldn't have said that because you heard what he said to Rana—all of a sudden, I'm walking down the street, and it felt like I had one of our horses stomp on my chest. Are you telling the jury, if he had said it was sudden, it would have made, in your words, "a big difference"?

A: Yes.

Q: Are you telling the jury that if he had said it was sudden, you would have worked him up for an aortic dissection?

A: According to the standard of care and everything that you've been seeing, yes.

Q: Let me ask you this question, sir. [You] made the determination that working him up in your clinic was not enough. You

had to take him across the street. Did you personally walk him across the street?

A: Yes, I did.

Q: When you got across the street, you took him to the emergency room, and he filled out some forms. Were those filled out before you saw him, or did you go right in?

A: What forms are you talking about?

Q: Well, there are some hospital record forms that talked about his address and phone number and things like that. Did you go right into the emergency room with him without filling out the forms?

A: I had called the nurses to give them advanced notice that I was going to be coming over with a patient. And in the process of going over, he did get checked in by the nurse. The nurse asked him the questions to fill in the emergency room encounter.

Q: How quickly was he hooked up to another EKG in the emergency room?

A: I can't recall the exact time, but it would have been within thirty minutes.

Q: Then in addition to the EKG—in addition to the EKG, you also administered some blood tests?

A: That's correct.

Q: One of the blood tests was a troponin level; is that correct?

A: That's correct.

Q: Tell the jury what troponin is, and why you give a patient who you want to exclude heart attack a troponin test?

[Here is another safe "why" question—asking the witness to explain why he did what he did when there are limited options for the witness to answer. The question invites the witness to explain things as a doctor would, and so the witness takes the bait.]

A: Troponin is an enzyme that is located within the cells of the heart, that is not found in the bloodstream, unless damage to the heart has occurred. When that happens, it leaks that enzyme out, and we are able to detect it in the bloodstream.

Q: Pretty sensitive; isn't it?

A: Yes.

Q: But sometimes it takes a while for troponin, the troponin test to actually become positive; doesn't it?

A: It could take up to four hours, sometimes.

Q: In fact, what you typically do, if you're concerned about a heart attack, is administer a troponin test, and even if it is negative, you wait about four hours, and then give those again?

A: You can, yes.

Q: But you didn't do that this time, did you?

A: There was enough time that had lapsed, with his presentation, I would have expected the troponin to have been elevated.

Q: When you brought him into the emergency room, you then filled out a history from him; didn't you?

A: Yes.

Q: Exhibit 50, which you have in the book in front of you, and I have up here, this is the emergency room record, and it says "chest pain". Is there a specific form that is used in the emergency room when a patient comes in with chest pain?

A: The one you're looking at there.

Q: SO, there are different forms for different presentations?

A: Headaches, chest pain, kidney problems, yes.

Q: Okay. And it says: Chief complaint chest pain. Did you circle "chest pain"?

A: Yes.

Q: And it says: Started this a.m., is that handwriting?

A: That's correct.

Q: Pressure, eight out of ten. Now, is ten—when you explain the pain scale of one to ten, what do you tell patients?

A: I tell them to base it upon a one—zero to ten scale. Zero is no pain, and ten is the worst pain ever.

Q: So, eight out of ten is worst, very severe pain; isn't it?

A: Moderate to severe, yes.

Q: Moderate would be four, five. If ten is the worst pain ever, wouldn't eight out often be close?

A: Four, 1 would say, would be mild to moderate. Eight would be moderate to severe.

Q: But the instructions that you give the patient were, zero is no pain, ten is the worst pain ever?

A: That's correct.

Q: And so he hit 80 percent of the worst pain ever?

A: It was significant. This is a pressure, eight out of ten, no shortness of breath.

Q: Now, one thing that happens when you have a heart attack, is you can have shortness of breath, true?

A: You may or may not.

Q: No diaphoresis. Would you tell the jury what diaphoresis is?

A: Sweating.

Q: Plus LBP. That means, he also had low back pain?

A: That's correct.

Q: Now, as far as the description of the pain, you have, this is a pressure, eight out of ten was the pain to describe the chest pain radiating to his mid-back; wasn't it?

A: That's correct.

Q: The low back pain, what was that, ten out of ten?

A: It was more severe, yes.

Q: More severe than an eight?

A: His complaint to the clinic when he showed up with the chest pain radiating to the back, and his low back pain, his low back pain was more severe.

A: Okay.

Q: He told you this pain was constant, and you checked constant, and it was still present. And then, under location of pain, you drew an arrow, and you drew those boxes; right?

A: Correct.

Q: The boxes are not on the form, you actually drew them on there; didn't you?

A: Yes.

Q: And you drew a pressure right to the middle of the chest, and right underneath that is the heart, and coming off of the heart, is what?

A: The aorta.

Q: You drew a line also to the mid-back, and you wrote the word "radiation" on top?

A: That's correct.

Q: And radiation, right through the mid-back and right under that little diagram in the mid-back; is what?

A: The aorta, along with the trachea, the esophagus, and part of the lung.

Q: Then you drew another line to the low back, and does the aorta go under that as well?

A: At the low back, no.

Q: Now, under here you have got, "onset during rest"; is that significant?

A: Can be.

Q: And in fact, if a patient has an aortic dissection, that does not have to happen when they are working out. It could just happen when they are asleep, or at rest, or whatever?

A: Also, with other chest pain, we have a lot of cardiac patients that come in with chest pain at rest. It actually wakes them up. They were sleeping.

Q: You put the number eight out often when seen in the emergency department, E.D. It is still eight out of ten, it has not gone down?

A: Right. This was immediately on arriving to the emergency room, you start to fill these forms out. These are getting filled as the nurses are taking the information from the patient for that emergency room encounter.

Q: But this is not the nurse, because this is your handwriting?

A: This is my handwriting, but I'm telling you all of this is happening at once.

Q: Okay. Then the next page of this, which is page 2, describes the physical exam; right?

A: That correct.

Q: That exam, there are little checkmarks. Did you make those checkmarks'?

A: Yes.

Q: You fill out the EKG monitoring strip, "result NSR" means what?

A: Normal sinus rhythm.

Q: That is a normal test, right?

A: It is showing a normal sinus rhythm, right.

Q: In fact, you checked off: Reviewed by me, normal sinus rhythm, normal intervals, normal access, normal QRS—which are the Q waves—normal ST segments.

A: That's correct.

Q: Then the chest X-ray, you have: Chest X-ray reviewed by me. As I told the jury, you did the initial review of the chest X-ray'?

A: Yes.

Q: And that was normal?

A: Yes.

Q: And KUB, which is another film you ordered,

A: Yes.

Q: And then there was an ultrasound, which was normal?

A: Read as normal, yes.

Q: The CBC, you read as normal. And then it says, except, and you have this slightly elevated Lipase?

A: Correct.

Q: You do agree, it is only slightly elevated; don't you?

A: There is no dispute on that. Yes.

Q: All of these other tests. Troponin are normal. KCK, another enzyme to determine if there is any muscle damage. All of those are normal, right?

A: That's correct.

Q: Then under clinical impression, it says chest pain, pericardial. And the word "pericardial" means?

A: It is anterior to the heart.

Q: There is a section here for acute aortic dissection, but that's not circled; is it?

A: No.

Q: You do admit, that virtually every textbook of medicine that deals with the evaluation of chest pain, says you must include aortic dissection within the differential, especially when you're dealing with a middle-aged man; true?

A: Chest pain in general, you would have to consider aortic dissection.

Q: In this case, we saw the diagram of the aorta, and it is sort of a candy-cane-type figure. If there is an aortic dissection, the pain can, in fact, as you heard from Dr. Magorien, Dr. Duran, and Dr. von Elten, radiate from the chest right to the back; true'?

A: True. And also, like your textbooks and journals, it could also radiate to the jaw, radiate to other body parts, cause signs and symptoms of a stroke, cause hoarse voice, cause problems swallowing. There is a multitude of symptoms. It is not that just that simple, of radiation to the back.

Q: You knew when you saw Mr. Epperly, that he had signs and symptoms which were consistent with aortic dissection; didn't you?

A: Knew or know?

Q: You knew at the time that Mr. Epperly had this new onset of chest pain that morning, that it was severe, that it radiated to his back; and you knew at that time, that he had signs and symptoms which were consistent with aortic dissection. Whether he had one or not, you didn't know, but you knew that they were consistent with aortic dissection?

A: That would be a no.

Q: You didn't know that?

A: No. No. Could I expand on that a little bit?

[The witness remains under control, as shown by his asking permission to expand his answer. The cross-examiner shows fairness and control by postponing, but not denying, the witness's desire to explain.]

Q: In a minute. Do you remember giving a deposition in this case?

A: Yes.

Mr. Leventhal: May I approach the witness, Your Honor.

The Court: You may. You may do so.

Q: (by Mr. Leventhal) Doctor, I'm going to hand you the original of your deposition.

The Court: The record will reflect the seal has been broken on the original.

[Another mark of a skilled cross-examiner is not rushing through the foundation for impeachment with a deposition. Stretching the foundational point here heightens suspense because everyone knows that a critical juncture has been reached.]

Q: (by Mr. Leventhal) This deposition was taken November 14, 2006; do you remember giving that deposition, sir?

A: Yes.

Q: Do you remember that when you gave the deposition, that you were under oath?

A: Yes.

Q: Do you remember that I told you that not only—and you were aware, that not only were you giving a deposition that was being taken down by a court reporter, but you were also videotaped?

A: That's correct.

Q: And I told you that if you changed your testimony during the deposition or at trial, that change could be pointed out to the jury, for them to consider whether you were telling the truth?

A: Yes.

Q: I want you to turn—and you also had an opportunity to make corrections to that deposition; didn't you?

A: Yes.

Q: But you made no corrections, did you?

A: No.

Q: I want you to turn to page 115 of your deposition. I want you to read to yourself from line 2 through line 17. Just read that to yourself, quietly. Megan I would like for you to play for the jury, please, line 2 through line 17. (Dr. Perez' Video Deposition and text, from November 14, 2006, was played, from page 115 line 2 to page 115 line 17, to the jury.)

Q: (by Mr. Leventhal) That was your testimony, wasn't it?

A: I still hold to it. You're reading into it maybe the wrong way. In the general differential, when people present with chest pain, the general differential of aortic dissection would be included. Above, I was telling you in my presentation, the patient, Mr. Epperly, at that point, no.

Q: Are you then saying to this jury, that Mr. Epperly told you he had a new onset of chest pain that morning, eight out of ten, radiating to his back, that he did not—is it your testimony now, that he did not have signs and symptoms consistent with aortic dissection when you saw him?

A: I've had many patients present with his similar symptoms, that have been through the same work-up he has, and they did not receive a CAT Scan. When we see a patient with a chief complaint of chest pain, whether it radiates or not, you are going to have in the big differential, the list that books will spit out at you, the ones that you carry with you at all times, aortic aneurysm or aortic dissection would be there. Very quickly, as you assess the patient, you tailor a differential that is specific for that patient.

Q: Now, would you answer my question, sir. Would you like me to repeat it?

[The witness has strayed beyond the question to try out his defense. Again, rather than moving to strike the answer as non-responsive, which involves the judge and shows weakness, the cross-examiner instead simply asks the witness to return to the question asked.]

A: Go ahead.

Q: Are you telling the jury when you saw Mr. Epperly, who told you that he had a new onset, maybe sudden, of chest pain, eight out of ten, radiating to his back, that he did not have signs and symptoms consistent with aortic dissection?

A: For my tailored differential diagnosis for him at that point, no. If that would have been part of the tailored differential diagnosis for him, a CT would have been ordered.

Q: Turn to page 143 of your deposition, please. I want you to look at lines 8 through 12. Read those to yourself. Megan, please, play for the jury lines 8 through 12.

[Dr. Perez' Video Deposition with text was played from page 143 line 8 to page 143 line 12 to the jury.]

Q: That was your testimony at the time under oath, true?

A: True.

Q: Now, you took him across the street. You get the EKG. You did the chest X-ray. You did no tests. You did no tests which would have ruled out aortic dissection; true?

A: There was no test done to rule out an aortic dissection, true.

Q: There was a CT Scan in the hospital; wasn't there? A CT Scanner?

A: Yes.

Q: And if you wanted to order a CT for Mr. Epperly with contrast, that could have been done?

A: If an indication was present for a CT, a CT would have been done, and could have been done, yes.

Q: The only risk to Mr. Epperly, was a very small, as you described it, minimal amount of radiation?

A: Correct.

Q: What would it have taken, a couple of minutes?

A: About five.

Q: Five minutes?

A: Five or ten minutes.

Q: SO a five-minute CT Scan, and Mr. Epperly would be alive today, right?

A: With what we know today, in hindsight, he probably would be alive today, yes.

[The witness had already admitted, early in the examination, that a CT scan would have saved the patient's life. But here, adding the new detail about the amount of time a CT scan would have taken makes the repetition fresh and non-boring: Not just that a CT scan would have saved his life, but a five-minute CT.]

Q: I have shown you the book which says that the signs and symptoms are consistent, you must rule it out and do it immediately, and that chest X-ray is not enough. But there is almost an identical statement in the ACLS book; isn't there?

[The question about the ACLS book circles back to the witness's training as ACLS-certified.]

A: You see that multiple times. The key phrases are, "if" there are signs and symptoms that are consistent, "if".

Q: SO, the ACLS book, let me make sure I get this exactly right. Given Mr. Epperly's presentation, given his age, and given the fact that he was a smoker, that part of a work-up would be required for you to do, would be to work him up for the possibility of an aortic aneurysm or rupture under the ACLS book, true?

A: If it is indicated, yes.

Q: Actually, what the ACLS book says, for a patient like him, chest pain radiating to the back, they have to be worked up for an aortic aneurysm; that is what it says, doesn't it?

A: No. It is their recommendation. There are hundreds of thousands of patients that have chest pain radiating to the back, that do not get CAT Scans.

[The witness has just made a seemingly strong point, putting the patient among "hundreds of thousands" of others who don't get CT scans. This could have stopped a lesser examiner cold, but Leventhal is ready, because the key difference goes back to chronic pain versus sudden, new pain.]

Q: But we are not talking about just chest pain radiating to the back. We're not talking about somebody that has had it for months or years. As you put it twenty minutes ago, if he told you that it was sudden, you would have given him a CAT Scan?

A: That would have made a big difference, yes.

Q: Basically, what you're telling the jury is: If you had asked Mr. Epperly, was this sudden? And knowing what you know today, he would have said, yes; he would be alive today.

A: In hindsight, if he would have conveyed the information, if I would have asked him, if he would have said "sudden". it would have a dramatic difference.

Q: Dramatic is an understatement; isn't it? He would be alive?

A: Yes, potentially.

Q: You don't know whether you asked him. You can't say sit there and say, he didn't tell you that it was sudden. All you know, is that you didn't write it down?

A: All I know, is that started that morning.

[Now the examiner asks the witness the ultimate question. Rather than using lawyer talk—"you breached the standard of care"—he uses the more forceful and direct, "your care was substandard."]

Q: Do you admit then, if in fact Mr. Epperly told you, in addition to the fact that it started that morning—do you admit to this jury, if he told you that, your care was substandard?

A: My care would have been modified to include a CT in the work-up, if I would have gotten the sudden component of the chest pain.

[Note how the witness has dodged the most damning admission, making only the lesser admission that his care would have changed. The examiner persists and then finally obtains the damning admission.]

Q: I get that part. I want to know whether you admit it. You told me, if you got the information that it was a sudden onset of chest pain, that you would have done a CT?

A: It—

Q: My question is, sir, if in fact you did get that information, if in fact Mr. Epperly said exactly what he told Rana, when she said that she heard, when she was in the emergency room, it came on while he was walking, felt like a—like his Belgian stepped on his chest. If he told you that and you didn't do a CT, do you admit to this jury, that your care was substandard?

A: If it was sudden, and I did not do a CT, a CT should have been included in the work up.

Q: So you admit it?

A: From a sudden standpoint?

Q: Yes.

A: It should have been included in the work up.

Q: And do you admit, sir, that because patients who come in, they might not even know what the aorta is. And even if they do, they may not know what is a sign of a problem with the aorta, that was your job, not Mr. Epperly's job, to ask him if it was sudden.

[Having received the critical admission, the examiner closes off the one tiny escape still remaining, that it could be the patient's fault for not saying "sudden."]

A: Yes, I'm not blaming anybody for that. In the history of pain, there was a new onset of chest pain.

Q: But it was your job to ask him, because it was so important to you, it was your job to ask him if it was sudden, not Mr. Epperly's job to tell you, it's your job to ask him.

A: Yes, I'm not blaming Mr. Epperly.

Q: Do you know why the ACLS was published?

A: As recommendation guidelines to work up chest pain and other cardiac issues.

Q: Actually, it was published, and I believe that these are your words: To provide a certain standard of care for patients. Do you remember saying that?

A: I read it.

Q: Well, but you read it—

A: What I had said, yes, correct.

Q: —but—

A: Yes, I read it, yes.

Q: One of the purposes, and the main purpose of the ACLS, was so patients' problems would not be missed. That was one of the reasons, right?

A: To do a complete work up, yes.

Q: In fact your word was: It gives you a standard, your words, a standard to follow.

A: Yes.

Q: And the reason for that is so that patients' problems would not be missed; right?

A: Yes.

Q: That's one of the reasons for the ACLS guidelines?

A: They are guidelines to help you, yes, in medical decision making.

Q: And in fact it provides a standard approach for patients who present with certain signs and symptoms; doesn't it?

A: Yes.

Q: And what it does, it takes away the judgment of the physician, so that the patient can't say—so the physician can't say, yes, he has chest pain. He has pain radiating down his arms, and all of these problems, but in m)! judgment, it is not a heart attack, it is something else. The ACLS took away that judgment to make sure that physicians weren't missing a problem, true?

A: ACLS guidelines are guidelines. The book when you certify every two years they tell you, these are not intended to serve the position of the physician, but they are there as guidelines.

Q: My question, sir, was: The ACLS took away the judgment, to make sure that physicians were not missing a problem; true?

A: You still need to use your medical judgment.

Q: Turn to page 114, please, of your deposition. I'm sorry, page 111. On page 111 I asked you virtually the same questions that I asked you now.

Line 10: Did you know why the ACLS was ever published?

Your answer: To provide a certain standard of care for patients.

Question: So patients' problems would not be missed. That is one of the reasons; right? Answer: It gives you a standard to follow, yes.

Question, by me: So patients' problems weren't missed, right?

Answer: That is one.

Question: That is one of the reasons for the ACLS guidelines?

Answer: You would hope so.

In fact, it provides a standardized approach to patients who present for certain signs and symptoms, doesn't it?

You said: Yes.

And question: ACLS does?

Answer, you said: Yes.

And my question to you: And what it does is takes away the judgment of a physician, so that a physician can't say, well, gee, he's got chest pain, he's got radiating down his arm, he's got all of these problems, but in my judgment, it is not a heart attack, it is something else. The ACLS took away that judgment to make sure physicians were not missing a problem, true?

And your answer was: They were there to try and make that not happen, yeah, to lessen the risk, correct.

A: To lessen the risk, yes.

Q: You looked at the chest X-ray and you read it as normal. You didn't have a radiologist in the hospital at the time that you looked at the chest X-ray, did you?

A: No.

Q: What is the situation with radiologists at Kit Carson, if you need one to read a film STAT, or immediately, what do you do?

A: In 2003, you could scan it or digitize it and send it over the internet. The radiologist stated that is not appropriate for them. It affects the quality of the read, and they could not stand behind the read, but they would still read it for you with the understanding that they may change the reading once they see it in person.

Q: So, this was a Friday. September 19 was a Friday, and you didn't digitize it or try to scan it and send it over the internet?

A: No, the X-ray looked normal to me.

Q: Okay. But you did discharge Mr. Epperly—

A: Yes.

Q: —on the nineteenth. And you heard Mrs. Epperly tell the jury, that Mr. Epperly didn't want to go home?

A: He did not voice that. There was no comment made about him not wanting to leave. If anything, Mrs. Epperly did a very good job of convincing him to let me finish the work up.

Q: He never said anything, it feel like I'm dying, or there is something wrong; he didn't use those words?

A: Not directly with him. The first time I had heard those words. was the first time he came in after the aortic dissection ruptured, his wife told me those words, her husband had felt, or the premonition of doom or dying.

Q: You heard Mrs. Epperly say and it is in her posting fourteen days, or thirteen days after Mr. Epperly's death, you told them this was not life threatening, or words to that affect, and that she heard you say that at least three times. Do you admit saying that to them?

A: As I had told you in my deposition, I do not recall. I would have to rely on the recent information. She typed this out thirteen or fourteen days after the event. I would have to give her the benefit of the doubt. This memory of thirteen days out, is better than six years out.

Q: Then you think that you probably did say that because that is what she wrote?

[The witness has made the concession, but the cross-examiner stretches the point to make it clear to the jury.]

A: Again, I probably don't recall, but with her information there, I would have to give her the benefit of the doubt.

Q: Given the fact that aortic dissection is within the differential, you didn't put it in, but you admit it would be, how do you tell somebody it is not life threatening before you do a CT Scan?

[Another non-leading question is safe here because it replows old ground, and the question produces a dramatic concession, albeit hedged with the "hindsight" defense.]

A: It was based on my initial history and examination of Mr. Epperly. If I said that that is what it would be based upon. In hindsight, with what we know today, we obviously know that is very wrong.

[Now that the witness has come back to his only defense of "hindsight," the examiner punctures the defense by going to the rules set out in the literature.]

Q: One of the reasons you don't want to look at things in hindsight, you don't want to be faced with a misdiagnosis which costs a patient their life; right?

A: Correct.

Q: One of the reasons for the rules, if the signs and symptoms are consistent with aortic dissection, you must work it up so that you don't wind up looking at something in hindsight and saying, Oh, no. Oh, my God. I missed it. That is the purpose of the rule, to be sure that don't happen; right?

A: Designed to help assess them. It is not perfect. That is why they call it the art of medicine.

Q: It is actually only perfect if the doctor follows the rule. But if he breaks the rule, things like this happen; true?

A: Even if the doctor follows the rules, you could still have bad outcomes.

Q: But not in this case. Because if you had followed the rule which says, that if the patient's history or examination is consistent

with aortic dissection, the imaging studies to evaluate the patient must be pursued; if you had done that and you had done the CT, he would be alive?

A: Would probably be alive. There is no guarantee on that.

[Again, persistent polite questioning leaves the witness's hindsight defense looking weak.]

Q: On Monday, the twenty-second, you met with Dr. Harrington?

A: Correct. During my hospital rounds, 1would routinely go to the radiology reading room where the radiologists gather in the mornings to read the films that had occurred from last week and over the weekend.

Q: Was there typically a radiologist there on a Friday?

A: If they were there, they were in there in the morning, and they would leave by around noon. But it didn't necessarily mean they would have to be there. Their schedule, I don't keep track of, so.

Q: You met with Dr. Harrington, who actually came in, drove in to do a shift at Kit Carson?

A: Yes.

Q: How many days a week would she do that?

A: Again, I—once, twice a week. I'm not quite sure. I couldn't tell you.

Q: Dr. Harrington and you discussed the X-ray. Tell the jury what Dr. Harrington said to you about the X-ray?

A: I presented the case to her. I wanted to take a look at the X-rays. The way that she read the X-ray was normal. She made a comment about how the aorta was tortuous. but that can be a norn1aI variant. That is the way that she described it to me.

Q: You also knew that it could be a normal variant in an older person, but for someone Mr. Epperly's age, it would be unusual for the aorta to look tortuous?

A: It's still within a normal variant, and this is her words. not mine.

Q: Was my statement true?

A: About what?

Q: That you knew, on September 22, 2003, that it was not unusual for an aorta to look tortious in an older person, older than forty-one, someone in their sixties to seventies; but that it was unusual, may still be within a normal range, but it was unusual for it to look tortuous in a forty-one-year-old?

A: It was more likely to be unusual in an older person than a younger person, yes.

Q: You said that you presented the case to her. Did you give her the medical record to review?

A: It was a verbal presentation. I don't carry medical records with me.

Q: So, you didn't have the medical records when she was doing this. She would just have your verbal presentation?

A: Correct.

Q: Did you document what you told her anywhere?

A: We don't routinely do that, no.

Q: And what did you tell her?

A: I told her that a forty-one-year-old male, chest pain, come in. I had told her the work up we did. I said, would you mind taking a look at the X-rays, the KUB, and ultrasound, and see if you agree with all of the initial readings.

Q: Is that your best recollection of what you told her?

A: That is not the exact words, but the gist of it, yes.

Q: SO, is it correct that she didn't see the diagram which shows the chest pain radiating to the back?

A: No.

Q: Was my statement correct?

A: She did not see the diagram, no. Radiologist usually, all they get is an X-ray with a patient's name, date of birth, and maybe one word on a complaint, and that is it.

Q: What you told her was, this was a forty-one-year-old man with chest pain, but you didn't tell her about the back pain?

A: The back pain would have more than likely have been included, yes.

Q: Do you know whether you told her about the back pain?

A: I would imagine so, yes.

Q: Do you know?

A: I would have to say, yes.

Q: Actually, you don't know whether you said back pain or not, just like you don't know whether you said this is not life threatening to the Epperlys. It's a long time.

A: You learn, when you regurgitate histories, to keep things in mind. And this radiation to the back, would have been included in the presentation to Dr. Harrington.

Q: Did you tell Dr. Harrington that Mr. Epperly did not have health insurance?

A: I don't recall if I discussed health insurance with her or not. Usually, from my standpoint, it doesn't make an issue whether they have health insurance or not.

Q: In fact, you have no recollection of telling, no reason to have told Dr. Harrington that Mr. Epperly didn't have health insurance; did you?

A: That would not affect the decision as to what to do, if there is anything else to do, no.

Q: I'm not asking that. I'm not asking whether it would affect the decision. I'm asking you whether you concede that there was no reason for you to tell the radiologist that this man did not have insurance?

A: We don't usually discuss insurance issues with radiologists. We discuss the case. We don't normally bring up, Oh, they have Blue Cross Blue Shield, or uninsured, they are on Medicaid. We don't usually discuss that, no.

Q: You never had a discussion with Mr. Epperly where he said, I don't want to pay for expensive tests; did you?

A: No.

Q: That is clear in your mind. He never said, I don't want the CT Scan, I don't want tests, because I can't afford them. Those words or anything like it never came out of his mouth, true?

A: Correct.

Q: You were aware when Dr. Harrington told you that it appears tortuous, that it means that it may be a little unusual; right?

A: Twisted, yes.

Q: You knew that one reason that a patient can have an aorta that appears to be kind of twisted, or unusual, is an aortic dissection?

A: It can be, yes.

Q: So, you knew when you saw him, saw Mr. Epperly, when you were talking to Dr. Harrington, that signs and symptoms which were consistent with an aortic aneurysm, or problems with the aortYou knew that. The doctor is telling you, the radiologist is telling you, that the aorta looks tortious. And that can happen when there is dissection. You knew that. You didn't need her to tell you to do an additional study. That was your job; true?

A: I did not know that. If I had known that, I

Q: You did not know what?

A: What you were saying, that I knew that he had aortic dissection. That I knew that he needed—had I knew that, I would not have requested or required her recommendation to get a CT. If I had known that, I would have got a CT that Friday.

Q: I'm sorry, you misunderstood me. I apologize if it was not clear. Let me restart. When you were talking to Dr. Harrington, you knew that Mr. Epperly had signs and symptoms that would have been consistent with an aortic dissection—you didn't know he had one—but you knew that he fell within the general differential; right?

A: Again, when you assess the patient initially, in the general differential, you would have aortic dissection in place. With his modified differential, when I did his history and assessment, it was no longer there. If it was still there, I would have ordered the CAT Scan on Friday.

Q: I want you to, if you would please, turn to Page 142 of your deposition. I want you to read to yourself Page 142 Line 6, through Page 144 Line 6. Megan, would you please play for the jury Page 142 Line 6 through Page 144 Line 6.

Ms. Doig: Your Honor, if I could have a minute to read through this, there are a number of objections. I want to be sure that—

The Court: If you will hold off until we deal with those.

Ms. Doig: No objection. (Dr. Perez' Video Deposition with text was played from page 142 line 6 to page 144 line 6.)

Q: So, you're not blaming Dr. Harrington for the misdiagnosis; are you?

A: No, not directly.

Q: —or indirectly. It was your job to put it together. It was your job to recognize and put this whole picture together. She pointed out the tortuosity. It was your job to determine what to do with it. It was not her fault; is it?

A: She failed to make additional recommendations that then she supposedly verbalized in her deposition that had happened between her and I; but no, she is not directly responsible, and I'm not directly blaming her, no.

Q: She didn't need to. As I had pointed out, she didn't need to make those recommendations. You knew that a CT was the only way to rule it out; right?

A: CT is the way to rule out aortic dissection, yes.

[The examiner makes sure the witness does not shift the blame elsewhere.]

Q: You knew that. You didn't need her to tell you that, right?

A: Correct.

Q: You knew the signs and symptoms of an aortic dissection. You didn't need her to tell you that?

A: No.

Q: Correct?

A: Correct.

Q: You knew that after she told that you the aorta looked different for a forty-one-year-old man, tortuous, you knew it could be aortic dissection, you didn't need her to tell you that; right?

A: It could, yes.

Q: I have shown the jury this on several occasions, but these are your words; aren't they? Even if there is just a chance that someone may have a life-threatening condition, you want to rule that out, so that they don't die while you're thinking it may be something else; right? And you said, Correct. That is the standard of care, isn't it? Answer: That is the way that you approach patients. Those were your words, weren't they?

[The witness is asked to reaffirm in his own words that life-threatening conditions must be ruled out to comply with the standard of care. This sets up the next line of questions, where the witness is forced to disagree

with his own official summary of the case read to the jury at the start of the trial.]

A: That's correct.

Q: At the beginning of this trial, the Court read an instruction for the jury. Bear with me for a moment. I want to get a copy of that. It set forth your position in this case, in the instructions, and I'm asking the Court to take judicial notice of that, because it is now part of the trial.

The Court: This was the joint statement of the case?

Mr. Leventhal: Right. We've prepared the upper part, and defense prepared this part.

The Court: Understood.

Q: (by Mr. Leventhal) It says, although Dr. Perez did consider an aortic dissection, based upon Mr. Eppley's presentation, the probability of this diagnosis was not sufficient to warrant additional testing. That's your official position in this case, now, can you tell me how you take that position, and at the same time say, even if there is—or agree, that even if there is just a chance that someone may have a life-threatening condition, you want to rule that out so they don't die, while you're thinking that it may be something else. The probability was not high enough? But if there is chance they may have it, you rule it out. They just don't fit; do they?

[The witness is forced to walk back his attorney's official description of the case which used the term "probability" unwisely.]

A: What I would correct that statement to, with regard to the probability, when you are assessing a patient with chest pain, with or without radiation, you will make within the first few minutes of that patient's encounter, a differential diagnosis, that if it includes an aortic dissection, you would do a CT; if it don't, you would not.

Q: Doctor, it is a little late to correct the statement, because it became part of the case when it was read to the jury. It is your official position in this case. So, tell the jury, by percentages, what the probability was. Was it 10 percent? Was it 20 percent? We have heard probability when we talked earlier with the jury, that probability begins at 51 percent. What was the probability that Mr. Epperly was having an aortic dissection when you saw him, that was not high enough to justify a five-minute CT? Two percent, five percent, ten percent, what was it?

A: Based upon the books and literature provided, that you provide, it would be one percent or less.

[The witness's answer finally puts the examiner back on the ropes, as he has no ready rejoinder to the assertion that the patient had a one percent or less chance of having the fatal condition. But watch the examiner recover with more questions.]

Q: That's true of any patient, even with classic signs and symptoms; right?

A: Right.

Q: In fact, the books that we provide are all chest pain patients, not chest pain patients with radiation to the back, not chest pain patients when you start limiting it down to a forty-one-year-old man. Do you know what this probability was for him?

A: Precise, no, I don't.

Q: But you do admit that there was a chance?

A: There is always a chance, always. There is always a possibility. I mean, that is the uncertainty of medicine.

Q: I'm not talking about always. I'm not talking about the situation where one of these people here, there is always a chance they may be in the process of having an aortic dissection, or I might be. I'm talking about a person that presents with a new onset of chest pain—as he described it, sudden, radiating to his back, right where the aorta is—that person, certainly at the

minimum, had a chance that they were in the process of suffering an aortic dissection; true?

A: The possibility is there; yes.

Q: So, when you, given your admission, and given your statement in the deposition, that the standard of care is to rule it out so that they don't die while you're thinking it is something else, and you didn't do that, you admit to the jury that your care, because there was a chance that this man was having an aortic dissection, given his presentation, that because you didn't rule it out, don't you admit that your care was substandard, truthfully?

A: In my heart, I still believe that the care provided for Mr. Epperly was appropriate.

[The witness still won't admit his care was substandard. But watch how the examiner persists.]

Q: We heard, and there was a discussion during jury selection, that a doctor can exercise his judgment; but he shouldn't do that until after he does all of the tests. You exercised your judgment before you got the CT; didn't you?

A: Correct.

Q: That was before you got the critical tests?

A: Meaning the CAT Scan?

Q: Yes.

A: Yes.

[Now the examiner comes back to the issue of taking away any chance of finding out if the patient had the life-threatening issue, but adds to it a new element: the failure to disclose the option of a further test to the patient.]

Q: So, you took away any chance of finding out whether Mr. Epperly had this life-threatening problem, by making the decision for him, without telling him, without giving him the option that he shouldn't have a CT; right?

A: Based upon his history and his physical examination, yes.

Q: His history did not rule out an aortic aneurysm; did it?

A: Again, with the presentation, the new onset, not knowing if it was sudden, that plays a role.

[Recess]

Q: Did his history rule out aortic aneurysm?

A: His history made it less of a chance, yes. It made it less of a probability.

Q: What part of the history makes it less of a probability? He says, I have this chest pain radiating to my back, it came on this morning. Even if he didn't say that it was sudden, and there was good evidence that he did. Even if he didn't say it was sudden, what part of that reduces the chance that it is not an aortic dissection or aneurysm?

A: The classic symptoms that you talk about, the sudden onset, the tearing sensation, and the relentlessness.

Q: It was relentless—it never went away. It was constant in your office. It was the same at the hospital. It was the same four days later.

A: It improved at the hospital, and when he presented to the clinic on the twenty-third, it was still the same as when he left the hospital, but it was not in the same condition that he presented on Friday.

Q: Doctor, when he was in the hospital and you said that it improved, you had just given him Toradol; correct?

A: Toradol lasts four to six hours. maximum. When I saw him on Tuesday, it was much later.

Q: But you gave it, and he came in on Tuesday, you're saying it was improved. Let's see what you wrote for Tuesday. Let's go to page 25—exhibit 25, page 8, please. This is the note that you dictated at that time, right?

A: Correct.

Q: Within minutes of seeing him?

A: Yes.

Q: So you write, patient presents today for follow-up on his chest pain. Since his last visit, he continues with the pain, pretty much constant. There all of the time. It does not worsen or improve. Activity does not make it any worse. Can you show me where in the note it says that it is the same improved chest pain that it was after—when he left the emergency room?

A: If it would have been worse, he would have told me he was worse.

Q: I didn't ask you that, sir. It says, is the same. Right? You would assume the same as when he left the emergency room, not the same as when he had the first encounter on Friday. Did you ask him to rate the chest pain on a scale of one to ten'!

A: No.

Q: So, did you ask him, and the chest pain was eight out of ten, because he said it is the same. Are you saying, that if he had said it was the same, you would have done a CT?

A: Probably not. The other thing that you notice with him, an improvement in his general exam when I had initially saw him on Friday, he was standing, pacing about in the exam room. Tuesday, he was sitting in the chair, his legs crossed, giving me this information. He was appearing and looking much more comfortable.

Q: I have a question about that. I have a question. If a chest X-ray, which is a radiographic study that looks into the chest, right in the area where the aorta is, is not sufficient to rule out an aortic dissection; how can you claim that by looking at him, that you can make the decision that he didn't have an aortic dissection?

A: I'm claiming, by looking at him, that he was improved.

Q: Are you telling the jury that because he was improved, you decided not to do a CT? Because that's what you told us in your deposition. You saw a man who comes in that morning, says: Follow-up on chest pain. Since his last visit continues with the pain, pretty much constant. There all of the time. Are you saying because he looked improved, which you didn't note, that you decided not to do a CT?

A: On my general exam. General is just looking at the patient. General is unremarkable, rather than standing, pacing, looking uncomfortable.

Q: Turn to exhibit 1, page 20 for me, please.

A: Exhibit 1, page 20.

Q: Doctor, that is the note that you dictated after Mr. Epperly died. At this point, you knew you had missed an aortic dissection.

A: The diagnosis became more apparent with the chest X-ray, yes.

Q: You knew you had missed it. That was what was going on the whole time. You knew you missed it, and you wrote this note.

A: I had dictated events of the ER and the history, yes.

Q: And it was your opportunity to document that, not only what you saw, but your reason for not working him up, not doing the CT; right?

A: To document the events of the things that took place.

Q: Part of this note—would you enlarge the bottom part for the jury, please. Says: I saw him as a follow-up again today in the clinic. I noted that he was doing about the same, no worse, no better. He had taken it easy over the weekend, not really doing much activity. He had cut back on his coffee intake. He had been drinking twenty pots of coffee a day, and cut back down to two cups. There were no overall significant changes. That was dictated the night that he died.

A: Yes.

Q: When you dictated that, you didn't write in there that he was improved from when you first saw him, did you?

A: No.

Q: The twenty pots of coffee a day, you're not claiming the reason that you failed to do a CT Scan, was because he had this history of coffee intake; are you?

A: The coffee no, by itself, no.

Q: Do you agree when you have a person like this, that about 50 percent of the time, only about 50 percent of the time, there is a description of this tearing pain when there is an aortic dissection; is that your understanding of the literature?

A: That is what has been brought up, yes.

Q: You knew that in 2003, just because you don't have a history that the patient had tearing pain, does not mean that they are not having an aortic dissection; you knew that, didn't you?

A: There are many variables in the presentation, yes.

Q: So, you're not going to claim—you're not going to say that because he didn't have tearing pain, that was an excuse for not doing a CT, that is not going to be your defense, right?

A: It played a role, yeah. It played a role in my decision making, yes.

Q: Is that the reason that you didn't do a CT?

A: That was part of it, again, you look at the total picture.

Q: But you knew that 50 percent of the patients will have no tearing pain. In fact, Doctor, after you saw Mr. Epperly, and after he died, you saw a man who just had chest pain, no back pain, and you decided to send him for a CT, and what did you find?

A: I didn't follow up myself, personally. I was consulted on it. He had a connective tissue disorder consistent with Marfan's. They are at higher risk for aortic dissections. He had a CT done, and an aortic dissection or aneurysm was detected.

Q: And that not only didn't have tearing pain, he didn't have pain radiating to his back; right?

A: Correct.

Q: And that man, who you saw after Mr. Epperly, he had a history of connective tissue disease, and didn't have the tearing pain, didn't have radiation to his back; but because there was a chance he may have an aortic dissection, you sent him for CT, it was identified, and he survived; true?

A: Correct. He had a CT done, and the priority was his Marfan's syndrome, the connective tissue disorder that greatly increases the risk of aortic dissection.

Q: Mr. Epperly was a smoker, doesn't that increase the risk of aortic dissection?

A: It increases the risk of coronary artery disease, arterial sclerosis. But based upon the literature that you have, there is no direct link to smoking.

Q: You're not claiming because he was a smoker, that is somehow an excuse for not doing a CT?

A: Smoking will play a role, maybe, in heart disease, but not directly in aortic dissection.

Q: The approach to a patient is a step-by-step approach; is it not?

A: Yes.

Q: And the first thing that you do, is rule out heart disease, heart attack; right?

A: Correct.

Q: You were aware that an EKG generally will not rule out aortic dissection; correct?

A: In general, yes.

Q: But sometimes, an EKG will reveal an aortic dissection, if the dissection starts at the aortic valve, coronary artery?

A: If it affects the valves that feed the heart, yes.

Mr. Leventhal: Your Honor, may we approach the bench for a moment. Before we go into this, I would like the Court's permission to do something.

The Court: It may be time to take a break. Okay. We'll go ahead and take a brief recess, in any event, let's go for about fifteen minutes or so. We will stand in recess. You're welcome to step out.

[A recess was then taken. The following proceedings were had, out of the presence of the jury.]

The Court: Court is back in session, 08CR165 All parties and counsel are present. The jury is not present. Are we going to be ready to go, or are we going to need to make some adjustments before we resume?

Mr. Leventhal: What happened, I had requested to approach the bench. I did that because before I asked Dr. Perez about his evaluation on Monday, and the fact that he did not work up Mr. Epperly for MI on Monday, and that his expert believes that that was substandard care on his part, I had wanted to clear that with the Court. I had, during the testimony of Dr. von Elten, pointed out to the Court, that when Dr. von Elten had—I believe it was both Dr. von Elten and Dr. Duran—said that—and Dr. Perez admitted, that during the work up an MI—when you do an EKG, while in most cases, the EKG will be normal for an aortic dissection, the aortic dissection can be abnormal? depending on where the dissection starts.

The Court: The EKG can be abnormal?

Mr. Leventhal: I mean EKG.

The Court: I may be confused.

Mr. Leventhal: Sure. It also goes to this step-by-step approach. You start with heart attack and move to aortic dissection. There are many reasons why, when the doctor says that his care was

appropriate, it wasn't. His own expert says that it was not appropriate. I could wait until Dr. Watz is on the witness stand. Or I just want permission, if I decide to do this with Dr. Perez, that I don't get in trouble for doing it, and I don't cause a mistrial.

The Court: Ms. Doig?

Ms. Doig: Well, I object to those types of questions. I think we need to hear what Dr. Watz actually says on the witness stand, before any reference is made to what he says. Do you know what I mean?

The Court: Well, I do.

Ms. Doig: I mean, he said one thing in his deposition, I don't think that he will testify inconsistently with his deposition. But I may choose not to even go to the twenty-third, and then there would be no questions about that, because it might be beyond the scope. My argument, frankly, I have not even thought about all of that. That is next week, in my mind, mentally. My argument, though, is consistent with what I have been saying before. Before that, there is no evidence that an aorta —an EKG on the twenty-third, would have led to a CT, which would have made a difference in the ultimate outcome. You know, whether or not an EKG is normal or not normal, there is still no evidence that a CT should have been ordered on the twenty-third, due to a further additional cardiac work up.

Mr. Leventhal: I already have his expert saying that a CT should have ordered on the twenty-third. That's a given. Those people say that, but the issue is, whether or not an additional cardiac work-up should have been done on the twenty-third.

Mr. Leventhal: The semantics that we are going to be presenting to the Court, as Ms. Doig is saying, that in order for me to get this in, I have to show that an EKG would have revealed an aortic dissection. In order for her to make that statement, she has to ask you to … the holdings in People versus Ramirez. People versus Ramirez does not require that for evidence to

be presented, that there is a 100 percent certainty that a test would be positive and show evidence of an aortic dissection. People versus Ramirez does not require it to even be probable. It only requires that there be a possibility. And in this case, even without Ramirez, because we are dealing with medicine. All we have to do is show that it is possible that an EKG would have revealed this, and that it was substandard care for him not to do an MI work-up and do an EKG; and because of that, an opportunity was missed. For her to suggest that she might not even ask the doctor those questions, I think, once again, we get the doctor on the witness stand, and he says that in his opinion the care was appropriate, within the standard of care, and he can be cross-examined. I think the cross-examination cannot be limited, because she chooses to cut off his care on the nineteenth. and not include the twenty-third.

The Court: Presumably, you could call him as an adverse witness for that, I would presume.

Mr. Leventhal: Absolutely, and I would.

The Court: I mean, I've done it for a while. I've not read Dr. Watz' deposition. First, let me make sure I have access to it. I think it is among the exhibits, but I want to be sure of that.

Mr. Leventhal: We could give you a copy if you don't have it. It looks like exhibit 47.

The Court: Is it on one of the discs? We will get it. I have a copy of it

Mr. Leventhal: Could I get the exhibit, I think the court reporter has it, which was exhibit 66, for use?

The Court: Yes, we have it. Are you talking about the Triple A Tragedy?

Mr. Leventhal: Yes.

The Court: I'm handing it to you.

Mr. Leventhal: Thank you. I am ready to go then.

THE COURT: I will take a look at that depo, and we will have to look at this argument. I might even wait until he testifies. Let me at least read the depo, and then we'll try to go forward. You may be seated, please. All right. (The following proceedings were had to a jury of six and two alternates.)

THE COURT: The jury has now returned to the courtroom. Dr. Perez, you're still under oath.

A: (by Mr. Leventhal) Doctor, I want to clarify one thing. That is, this chest pain, back pain that was eight out of ten refers to the chest pain and mid-back pain. The pain was higher than eight out often?

A: Correct.

Q: He had mid-back pain, eight out of ten, and chest pain eight out of ten, and low back pain higher?

A: More severe, yes.

Q: Can I ask that the court reporter make a note of this part of the transcript. I'm going to ask you to do something later with this. Doctor, you said that his history was not consistent with aortic dissection; do you recall him saying that?

A: Yes.

Q: And then you told us the thing that was missing, was sudden onset. If this were present, it would have made it consistent?

A: It would have made a big difference, yes.

Q: Now, you also told us that you give a lot of weight and a lot of credibility to the posting that Rana Epperly did on October 3, 2003, because it was within thirteen or fourteen days after Mr. Epperly's death?

A: Her memory, recollection, would be better than mine would be six years later on this subject, yes.

Q: I have exhibit 66 up, and it says—and this is an exhibit that is going to the jury—that on Friday, September 19, my husband

left the house to run some errands in town. At 11:00 a.m., I received a call from our doctor, stating that John had come into the office about chest pain, and he was being admitted to the ER for further tests. He told me, upon arrival, that it felt as if he had been kicked in the chest by one of our Belgian horses (large drafts weighing over one ton.) Had excruciating back pain, numb big toe, was dizzy, and saw stars. You saw that, didn't you, and heard her say that?

A: Yes.

Q: And that was consistent with sudden onset of chest pain; isn't it?

A: It's the way to describe the severity of the pain.

Q: Also, if he felt like he was kicked, and so, when you're kicked, you have a sudden onset of pain, right'?

A: It would go along as a substitute. When people come in with chest pain, they can also describe it as an elephant sitting on their chest, or a ton of bricks on their chest.

Q: That was not the description. The description was: He felt as if he had been kicked. So, assume for a moment that this is consistent with the sudden onset of chest pain, okay?

A: Okay.

Q: When Mr. Epperly came into the emergency room, he didn't know what tests he needed; did he?

A: No.

Q: He didn't know that he needed another EKG?

A: No.

Q: That was your decision?

A: Correct.

Q: He didn't know that he needed a blood test?

A: Correct.

Q: That was your decision?

A: Yes.

Q: He didn't know what to test in the blood? He didn't know that the enzymes needed to be tested, right?

A: I would assume so.

Q: That was your decision?

A: Yes.

Q: If the enzyme had been positive, it would have shown that he was in the process of having a heart attack, right?

A: Correct.

[The examiner returns to the core issue of whose job it is to ask the questions that elicit the key history.]

Q: SO, when you're going through and determining whether his presentation is consistent with a heart attack, you were the one who knows what information is critical to determine what is consistent and what is inconsistent, right?

A: I'm the one that takes the history, yes.

Q: Not just takes the history, but orders the tests?

A: Correct.

Q: SO, you have no reason to believe that John Epperly had any medical knowledge of what was important or unimportant in evaluating either his heart or his aorta; true?

A: True.

Q: And so, isn't it true, Doctor, that if the turning point of this whole case, the turning point of whether to do a CT Scan, is whether this is sudden, that it was your responsibility, your duty, to ask the question; isn't that true?

A: Yes, again, I do not blame Mr. Epperly for that.

Q: Just like it was your duty, your responsibility to order the troponin, and if you had not ordered the troponin, if you were to come to court, and this was a heart attack case, and you said that his history was not consistent, because he didn't have a positive troponin, but I didn't order it, that would be substandard care; wouldn't it?

A: If you did not order the troponin, and you were suspicious of a heart attack, yes.

Q: Just like in this case, by not asking Mr. Epperly whether this was sudden, and you have no reason to believe that he wouldn't have told you that it was sudden, right? I think that probably, if this is the history, he's walking down the street, and he has a sudden onset of chest pain, if you would have asked him, he would have said it was sudden, true?

[More relentless questioning further undermines the defense of "not sudden."]

A: He might have, yes.

Q: Probably would have. There is no reason to hold that back. He's in there, he's letting you stick holes in his arm, take X-rays, he's letting you hook him up to EKG; if you asked him a simple question, and said: Was this sudden? He probably would have told you that it was sudden.

A: The chances are good, yes.

Q: So, isn't it true, doctor, and don't you admit to this jury, by not asking the question, by not finding out that this was sudden—which is a life or death question in this case—that care was substandard? Don't you really admit that, sir?

A: By not asking the question, it did not warrant the CT Scan, so, yes, it did affect the outcome.

[The witness makes one admission but not the core one of substandard care, so the questioner returns.]

Q: Don't you admit, because you didn't ask the question, and because your whole decision on whether to do this CT was based upon that question, don't you really admit, that in this case, that since that question was so important, and because the answer was likely going to be, it was sudden, that that reflects substandard care on your part; isn't that true?

A: It reflect a substandard in the history taking.

Q: Is it the history that, in your mind—

A: Right.

Q: —is so important, about whether or not to do the CT. So, had you asked the question as you now admit that you were required to do, and you probably would have gotten the answer that it was sudden, it was substandard care, and cost this man his life; true?

A: Not having the sudden onset in the history affected the outcome with regard to ordering or not ordering a CT; and ultimately, yes, the death of Mr. Epperly.

Q: So, you agree with me, that your failure to ask the question, cost Mr. Epperly his life, and that was substandard care?

A: The failure of not asking him the question did affect the result on whether or not to order a CT, which then affected his life, yes.

Q: And that was substandard care, true?

A: Yes.

Mr. Leventhal: No further questions.

[Close to a brilliant cross. Leventhal chose his words extremely carefully, and ended up describing the event so persuasively that he seems to have convinced even the witness that his care was substandard. After this, the witness's lawyer made a game attempt on redirect at reviving the witness, but the corpse was cold.]

Closing Comments by Malone: "Was Your Care Substandard?" A Reprise

Let's do an instant replay of all the questions that directly asked the witness if his care was "substandard."

First try:

Q: Do you admit then, if in fact Mr. Epperly told you, in addition to the fact that it started that morning—do you admit to this jury, if he told you that, your care was substandard?

A: My care would have been modified to include a CT in the work-up, if I would have gotten the sudden component of the chest pain.

Second try, one question later:

Q: My question is, sir, if in fact you did get that information, if in fact Mr. Epperly said exactly what he told Rana, when she said that she heard, when she was in the emergency room, it came on while he was walking, felt like a—like his Belgian stepped on his chest. If he told you that and you didn't do a CT, do you admit to this jury, that your care was substandard?

A: If it was sudden, and I did not do a CT, a CT should have been included in the work up.

Q: So you admit it?

A: From a sudden standpoint?

Q: Yes.

A: It should have been included in the work up.

[That was pretty close to what the examiner was looking for, but the series of answers had so many qualifiers that it didn't feel like a clean admission.]

Third try (and the witness has revived his fight):

Q: So, when you, given your admission, and given your statement in the deposition, that the standard of care is to rule it out so that they don't die while you're thinking it is something else, and you didn't do that, you admit to the jury that your care, because there was a chance that this man was having an aortic dissection, given his presentation, that because you didn't rule it out, don't you admit that your care was substandard, truthfully?

A: In my heart, I still believe that the care provided for Mr. Epperly was appropriate.

[These next questions comprise a single stretch of examination that ended the questioning, but let's break it up into discrete times when the "substandard" question is asked.]

Fourth:

Q: So, isn't it true, doctor, and don't you admit to this jury, by not asking the question, by not finding out that this was sudden—which is a life or death question in this case—that care was substandard? Don't you really admit that, sir?

A: By not asking the question, it did not warrant the CT Scan, so, yes, it did affect the outcome.

Fifth:

A: Don't you admit, because you didn't ask the question, and because your whole decision on whether to do this CT was based upon that question, don't you really admit, that in this case, that since that question was so important, and because the answer was likely going to be, it was sudden, that that reflects substandard care on your part; isn't that true?

A: It reflect a substandard in the history taking.

[The witness has now admitted "substandard" on one aspect of his work.]

Sixth:

Q: Is it the history that, in your mind—

A: Right.

Q: —is so important, about whether or not to do the CT. So, had you asked the question as you now admit that you were required to do, and you probably would have gotten the answer that it was sudden, it was substandard care, and cost this man his life; true?

A: Not having the sudden onset in the history affected the outcome with regard to ordering or not ordering a CT; and ultimately, yes, the death of Mr. Epperly.

[The witness again retreats from the "substandard" admission, admitting causation but not directly answering the substandard question. So:

Seventh:

Q: So, you agree with me, that your failure to ask the question, cost Mr. Epperly his life, and that was substandard care?

A: The failure of not asking him the question did affect the result on whether or not to order a CT, which then affected his life, yes.

Eighth:

Q: And that was substandard care, true?

A: Yes.

In this last stretch, the witness admitted three times that not asking the right question in his examination of the patient had, as Leventhal put it, "cost Mr. Epperly his life," but avoided answering whether the care was substandard. Finally, he gave it up. How many questioners would have persisted this long? Most would have retreated long before the end, thinking that the early admissions were "close enough." As the old saying goes, "Close counts only in horseshoes."