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MAR 26 1986
JOHN P. HEHMAN, Clerk

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

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FEB 1 1984
JOHN P. HEHMAN, Clerk

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UNITED STATES OF AMERICA,

Plaintiff,

-vs-

Criminal Action
No. 82 80242

NELLIE BELL KASSIM, et al.

Defendants.

Proceedings had and testimony taken in the above-entitled matter, before the HONORABLE ANNA DIGGS TAYLOR, U. S. District Judge, at 211 U.S. Courthouse and Federal Building, Detroit, Michigan, on Thursday, October 28, 1982.

APPEARANCES:

ELLEN DENNIS, AUSA
and JAMES McCARTHY, AUSA
Appearing on behalf of Government.

D3, D4, D17, D18, D19, D24

KENNETH ROBINSON,
On behalf of Defendant Krebs.

ELIZABETH E. MONTGOMERY, RPR, CSR
Official Court Reporter
(313) 961-5965

750

A Yes.

MS. DENNIS: That's all, your Honor.

MR. ROBINSON: Could the doctor come down and I'll call -- dould we finish Dr. Heimlick today?

THE COURT: We have a Judges' meeting at 4:30.

D R . H E N R Y H E I M L I C K ,

was thereupon called as a witness herein, and after having been first duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. ROBINSON

Q Would you please tell us your name and age and profession.

A I'm Dr. Henry Heimlick. I am 62. I am a Thorasic Surgeon. That's a chest surgeon, a scientist, a writer and lecturer.

Q Doctor, I have just been advised that the Court is going to have to break at 4:30 today. Do you have -- can you be here in the morning or would it be better for you to come back tomorrow afternoon?

A Well, I could stay over until the morning.

Q We appreciate it.

A It would be difficult in the afternoon.
Q Doctor, would you please tell us your educational background?
A I attended Cornell University where I got my B. A. degree. Then Cornell Medical College in New York City for my M. D. degree. Did graduate work at Columbia University Medical College in New York City and graduated from med school in 1943.

I then went to the United States Navy as -- I'm sorry I took a nine month internship at Boston City Hospital, and then went into the United States Navy during world War II. I volunteered for extra hazardous duty in the Navy, and I ended up in a guerilla Army in northwest China behind Japanese lines in inner Mongolia.

Q Did you practice medicine then behind the lines?
A Yes, I did. I practiced in a mud hut or wherever we'd have to be.
Q And following the end of the war and your return to the States, what did you do next in your profession?
A What, when I came back to the States, I then sought additional training in surgery. I took a neuro surgery residency at the Veteran's Administration Hospital in New York. I went from there to Mt.

Sinai hospital in New York, and took a general surgical residency. I then continued at Bellevue Hospital as a general surgical residency also in New York; and then took a chest surgery residency, Thorasic Hospital at Traybough (ph.) Hospital and General Hospital, all in New York City.

Q And when did you finish all of those surgery schools?

A I finished the surgical training in 1950.

Q Now, on the completion of the surgery training, did there come a time that you did any clinical type work as a physician?

A Yes, I -- at that time, from 1950 on I have always both practiced medicine and surgery and had a teaching position or several teaching positions in universities or major hospitals. I -- from 1950, while I was still in New York City, I had an attending position at Mt. Sinai hospital at Montaburn (ph.) Hospital, Southside, Philadelphia, Albert Einstein Medical College and New York Medical College in New York City.

At the same time I should say, being the young surgeon and just -- I worked -- in order to work as a doctor in Saks 34 street, a department store in New York City and also I worked for a

health center called the Hotel Health Center. That was for members of the union of the hotels for several years, which I was doing teaching and graduately building up my practice.

I also continued with research during that time, and in the early 1950's did develop an operation for replacement of the esophagus. The esophagus is the tube that carries your food from your throat down to your stomach. Either brought by birth defects by people swallowing or children particularly caustic substance, drain cleaners, lye and so forth which block the esophagus and these people are unable to swallow food and they're fed through a rubber tube inserted into their stomach.

And at that time I had the concept of making a new esophagus using a part of the patients own stomach and develop that operation with a surgical research laboratory. And that was one of my first scientific pieces of work. And that operation is now -- is a standard procedure in many of the surgical ethics.

Q You created a standard for medicine?

A Oh yes.

As a matter of fact beyond that, at that time there was no such field as esophagus surgery

or an interest in the esophagus as the organ.
Q When you say you worked for a couple of years in 1950 at the Hotel Center, did you have occasion to examine patient's complaining of low back problems?
A Yes, I had patients complaining of all sorts of problems and with the hotel worker they were very common because you had people lifting heavy bags and equipment and so forth.
Q Did you have occasion to prescribe any medication with narcotics any time for back pain?
A Schedule II medication, we usually prescribed for back pain were aspirin or a combination of aspirin and Codeine.
Q Codeine is what is known as a controlled substance these days?
A Yes, Codeine is a Morphine derivative.
Q Could you tell us just generally about the type of physical examination you gave in 1950 at the Hotel Health Center for back patient's who had an examination by you?
A Well, at that clinic we had a pretty good turnover of patient's and some would come in for a thorough examination and go through a whole routine or would be sent to a hospital for treatment. But we also had the everyday visits to the clinic. And in that

instance I would examine the patient within the time that was available and prescribe accordingly.

Q And when you examined patients back in 1950 for lower back problems, did you use x-rays to examine for back problems?

A No, I think if we took an x-ray every time a patient came with a back problem we'd be taking them forever. It was known then that x-ray, except for very specific types of back problems are really not very helpful. The person is arthritic or has strained his back and is examined and found out there's reason to believe it's a chronic complaint where he's been working and seen many times by doctors. You would treat the complaint. We were treating patient's who needed treatment at that time and had to go back to work or to whatever they were doing.

Q Doctor, I'm going to skip ahead a little bit to the 70's and then I'm dropping back into some of the things you have done since the 50's when you developed the surgery on the throat.

I'm going to show you exhibit 37, I think. My numbering system is becoming -- if I give this a duplicate number, may I change it later?

THE COURT: Yes.

Q (By Mr. Robinson): Doctor I'm going to show you 38. This appears to be a Heimlick Maneuver. Are you familiar with this?

A Yes indeed.

Q What is the Heimlick Maneuver and who is the creature who created it?

A Well, it was my development. The Heimlick Maneuver is the means for saving the life of a patient who is choking, usually on food, choking to death; although in the case of children, young children will put objects in their mouth or a small piece of material and can choke to death on that. And I became aware in the early 70's that the children who did that on food was the leading cause of accidental death. And therefore looked into what was being done and found that the things were taught weren't correct, and did some research and realized, along with the background I had in chest surgery, that there would be enough air in the lungs so that if you could push upward on the diaphragm to compress that air you could cause enough air and that would carry the object out of the throat and out of the air way.

And after doing substansial research on

that, published it in a medical journal and began saving lives. And therefore became well known -- it was named Heimlick Maneuver in the American Medical Journal in 1975.

Q Doctor Heimlick, here again in reference to your scientific method which you have developed called the Heimlick Maneuver, was a standard again created for reviving choking or drowning victims since 1975 by your experience?

A That's correct.

Q So Doctor, at least in those two instances, is it fair to say in your lifetime as a physician back to 1943, at least on two instances you assisted the medical profession at one point to give credit in creating a new standard of medical therapy and assistance to patients?

A Yes. I'd like to say in regard to esophagus, that prior to that time there was not a particular interest in the esophagus. And since it has become a specialized field as a result of showing that it was an organ that should be treated specifically and so there are now standards for treatment of the disease of the esophagus as a result.

Q Can you tell us whether you had occasion to become a fellow in any physicians' association or

diplomate in any of the boards?

A Yes. After I finished my training I became licensed in the State of New York and subsequently another state, practiced medicine in surgery. I passed the examination and became a diplomate of the American Board of Surgery and on the Board of Thoraxic Surgery, Chest Surgery.

I am a fellow of the American College of Surgeons since that time. A fellow of the American College of Chest Physicians. I also have honorary teaching positions that have developed since that time. Professor of surgery at the University of Laplata.

Q Laplata, Maryland?

A Laplata, Maryland.

Q In reference to teaching positions, did you once have a teaching position at the medical school named Xavier?

A At present, until the past five years, I'm a professor of advanced clincal sciences at Xavier University in Cincinnati and Director of the Heimlick Institute at Xaview University in Cincinnati. And prior to that I -- after leaving New York I became, Director of Surgery at the Jewish Hospital in Cincinnati and have an

appointment as Associate Clinical Professor at the University of Cincinnati] Medical College, which I still possess, of surgery.

Q Doctor, to summarize before I go into other areas, is it fair to say you have experience as a physician in the residency obviously, is that correct?

A Yes. I actually formed the residency which had been slipping at the Jewish Hospital in Cincinnati and brought it to the point where it was again recognized and established residency and trained residents at the time I was lecturing at the other institutions.

Q The residency follows the medical school degree, is that correct?

A Yes. Actually you go from medical school. You then take an internship and if you want specialized or advanced training, you take a residency which can last, depending on the field, from three to five years.

Q Can a doctor become a licensed physician after finishing medical school without going through the residency?

A Yes, he can be licensed in most states. It varies by state. But in states yes, a one year internship

is required at which time and during the course that you can take license examinations, but you get your license, in most states, on completion of an internship. The residency is additional.

Q In your experience doctor, as a physician and as a Professor at the medical schools and the creator of the residency program at the Jewish Hospital in Cincinnati, what is the purpose, from your experience, of a residency program?

A Well, the residency program is to, for a doctor who is interested in expanding his knowledge and experience to get training under the direction of experienced teachers and physicians or surgeons.

As a matter of fact, at the present time there exists a residency in family practice so that it is not whatever area you're going into but it's advanced training that entitles a man to take a residency.

Q Have you, in your experience of 39 years, since you finished medical school in 1943, that what you learned you learned and apply certain standards and tests in your residency in a medical school environment that are not what necessarily what you do in a clinical university environment, such as when you were working down there at the Hotel?

A Hotel Center.
Q Hotel Center. Is there a difference in what you do in using your skills and learning in a residency and training to apply the skills and judgment at the place such as the Hotel Health Center?
A Well, I'd like to answer that more broadly, if I can. That was just one type of practice. But obviously you learn what you do in the residency and you utilize it to the best of your ability in your residency training. Because it is a major hospital, only major hospital's are accredited for certain types of residency training or medical school or medical college or medical centers.

You start of by learning as much as you can. You're rather free in ordering tests and seeing how they come out and as part of your training, the medical school has the facility and the finances for that.

Well, then when you get out, there are different types of practices. Some people will remain in a medical school atmosphere and will continue that way seeking out only very complicated cases that carry their interest and are discussed at conferences.

But there are other aspects. I guess

the farthest at Boston City hospital. When I got there I had to use my mind, my hands and my mind and whatever experience I had accumulated. And that was in a mud hut or wherever you happened to be. The same, I guess for any military surgeon. He has to do what happens on the field. He can't wait to do all of the things that he would do in a teaching hospital. Then there are the different shades between that. You may have a doctor in his private office and he is seeing more patients generally than one sees in a residency at a time, at least for him as an individual.

Now, if he is practicing very average medicine, where he can take an hour with one patient and doing a lot of tests and so forth, that's another type of medicine that's practiced.

You mentioned the Hotel Center. In that type of center you have got 4 or 5 or 6 patients every hour and you are not there as their whole physician entity. You are there to see is there anything in this patient that requires emergency treatment. If you determine there is, you send that patient to an emergency hospital, emergency departments in a hospital or if they need hospitalization for surgery you might send them for

that. But the majority of your patients certainly in the health center are coming in for that which is bothering them at the moment. And you have to treat them with that in mind. In fact, you want to help your patient and you want to -- at the same time you try not to miss anything, but you do have to carry them over. You can't just send them out and say go to another hospital for this minor complaint.

Q And in your doing that, as long ago as 1950 when you saw the patient with pain in the lower back complaint that you diagnosed, you testified, I believe, that you would prescribe a form of aspirin with Codeine, a narcotic 32 years ago?

A If I determine while going over them and checking them, that I felt that was the thing that could tide them over and get them over their illness or maintain them as a result of their pain.

Q From your experience, is the dialogue between patient and physician important in that examination. What is discussed?

A Yes, very definitely. You ask a patient certain leading questions. First you hear that what the patient has to say, then you ask questions that can lead you to a diagnosis. Then you have to call on

your judgment. You also examine the patient. You examine the patient. If it's a back pain, and from that you then call into play your judgment from the thing you have learned in your training and in your experience, and deal with it accordingly.

Q Doctor have you had occasion in the past 15 years or so to lecture the residents in various hospitals or to lecture physicians in society, such as the American Medical Association and be a speaker commenting on what you have done as a physician?

A I have lectured and continue to lecture. I have always lectured at different medical clinics and hospitals. As a matter of fact, I was thinking of being here in Detroit from Cincinnati, I lectured some years ago at the Grace Hospital and another hospital -- I don't recall which one it was -- on two different occasions and have attended medical meetings here as well.

Q Have you had occasion to testify in litigations and court cases before as an expert?

A Yes, I have.

Q Testify as a physician as an expert in the field of medicine?

A Yes.

Q Now, doctor, can you tell us some of the -- we have

to do these things in court neatly -- things but have you had occasion to have various awards presented to you from presidents on down for your accomplishments?

A I have had, yes.

Q Could you just list a few?

A I had several commendations when I was in the Navy. I received honorary degrees in the last few years from Delphi (ph.) University in New York, Doctor of Science, Doctor of Science from Willmington College in Ohio, and I have always been interested in the lecturing in teaching both the public, as well as medical students and residents in the medical profession. And I did develop a film. On My Operation which, in the 1960's, won a bronze medallion at the International Film Festival. And that's something which I still am very pleased about, though it's not a medical award.

I am very much interested now in teaching medicine to the public and have appeared on television quite a few times to do that on the Today Show, Good Morning America, Johnny Carson, and so -- it's light, but I feel that it's important that the public understand medicine. And in keeping with this I developed a program, a one

minute cartoon shown on television, Doctor Heimlich's emergency lessons for people. It teachs children medicine, and I was pleased it won a national Emmy award after it was on 6 months starting 12 years ago.

Q Now, doctor as a physician and teacher have you had the -- during your career as physician and teacher, to witness what is taught in residency programs at various universities and what is taught in the medical school, the medical schools and what physicians put into practice when they're out there in the real world?

A Yes, I have been fortunate in seeing the various aspects of medical practice. It's been interesting to do so. I have operated at different hospital's, at Boston Children's Hospital for example, and I would stay a few days to follow the patients and lecture to the residents; answer students at the same time. I lectured this year at the -- for example the American Osteopathic Association which is the largest group, really percentage wise of general family doctors. So that I have gotten and had contact really with all different levels of medical practices and the scientific aspects as well.

Q Doctor, approximately how many journals have you published articles for in your career for purposes of discussing various medical views that have been published?

A I'm sure I have published more than one hundred medical scientific papers and medical journals and I have also published a book for surgeons, Post Operative Thoraxic surgery some years ago. More recently I published a book for the public called Dr. Heimlick's Home Guide to Emergency Medical Situations, which again is to teach medicine to the public. And I have done other types of popular writing and interviews as well. My interests have extended beyond the medical surgical.

Q Can you tell us whether you put in a practice to writing, lecturing and teaching the practice of medicine, it's the theme that there is a place for treatment in that you treat the immediate problem the patient brings to you. That's one of the standards that you have lectured on, if a person comes to complain of pain, you deal with that problem then and there?

A One thing I have been trying to do, I never feel the public has to know more about medicine. The doctor has the background and knows about it, but I

feel the public should know better every day medicine answers and television programs. I don't know if it comes in this area, it's about 8 states which originates in Cincinnati. And once a month I go to that for just that purpose to say so much on television, that is this gigantic machine that costs five hundred million dollars or whatever, and very complicated and what is now, I feel that it is important to get down to the basics, to what hurts, where does it hurt, how do you treat it, both to yourself and what the doctor should know.

Q Doctor, what you know of university atmosphere of the medical school or residency program would you describe -- what is the term, a full work up for the patient in that hospital atmosphere generally entail?

A Well, in a full work, your talking about a medical school major hospital type of thing in a teaching program?

Q Yes.

A Of course in the teaching program it's much more extensive than the doctor who is practicing in the hospital. The doctor practicing in the hospital will hopefully stick to those -- that are apparent to the patient at that moment. But in a teaching

program a resident or medical student has to learn out right, of things to do whether they are essential at that point or not. He has to know to do something so that he says that he doesn't get a positive result in a large number of cases and might not do it again in the future. So a full work up includes all types and varieties of blood tests, x-rays as well as the history and the examination of the patients.

MR. ROBINSON: May I ask one more question, your Honor?

THE COURT: Well, go ahead.

Q (By Mr. Robinson) Doctor, have you ever heard of a drug or medication called Pyribenzamine?

A Yes.

Q And have you ever heard of a pain relief medication called Talwin?

A Talwin, of course.

Q Yes. Could you tell me whether in your 39 years as a physician all these things you have ever discussed, you have ever heard don't prescribed PBZ, is what I'm going to call it and Talwin because it may be addictive to addicts on the street.

Have you ever heard that in the

residency programs or lectures you participated in across the world in 39 years of medicine?

A No, I have not.

Q Did you know, that -- did you know, until I met you and discussed your testimony last night that there is a journal, or journal articles written in September of 1980, which someone may show you later, that suggests that if an addict gets Talwin and PBZ and takes the capsules and breaks them down and melts them and heats them and injects them into their body, they can get a Heroin high. Did you know that before it was discussed with you last night?

A No, I have not.

Q Have you ever heard that it had been a standard of medicine that a physician should not prescribe those two medicines at the same time?

A No, I never heard that. In fact, I might say I think they have commonly been prescribed at the same time because the complaint that cross one or the other frequently requires both.

Q Doctor, are you familiar with the reputation of the University of Michigan Medical school?

A Yes, it's one of the world leaders.

Q And are you familiar with Ryan Krebs over there on

the wall?
A Yes, I certainly am.
Q How many years have you been knowing Ryan Krebs?
A A little over ten years.
Q And this is your son, right here?
A That's my son, yes.
Q You have been knowing him about 29 years?
A Yes, just about.
Q And can you tell us whether your son and Ryan Krebs went to college together?
A Yes, they certainly did.
Q And you had an opportunity, since those days, to get to know Ryan Krebs?
A I certainly did.
Q Have you had an opportunity, over the past ten years, to meet with and get to know Ryan Krebs and form an opinion as to his honesty and integrity?
A I most certainly have.
Q What is your opinion?
A As to Ryan, he's an -- in his integrity, he's a marvelous young man. I would say he's like my son. He's absolutely honest, and I just can't conceive of him straying. I know him very well because of my son's close friends, he was interested in medicine; and I therefore, took a particular

interest in him.
Q Can you tell us when your sons birthdate is, by the way?
A Pardon.
Q What day of the year was your son born?
A December 11.
Q Do you recall December 11, 1981, almost a year ago, whether Ryan Krebs came down to see you and your son in Cincinnati, on the birthday weekend?
A Yes.
Q Was there a tennis tournament?
A Yes, it was the Davis Cup Tournament at the coliseum.
Q Did you attend any of the --
A (Interposing) Yes, I did.
Q Can you tell us whether your son and Ryan Krebs attended?
A Yes.
Q They were both there?
A Yes.
Q That would be Saturday or Sunday?
A I was there one day and I honestly cannot recall, but I think it was mostly Saturday. But I know that Ryan was with Phillip for those three days, from Phillip telling me that.

Q Now, doctor Heimlick you referred to the Heimlick Institute which was a part of the Xavier Medical School, is that correct?

A Xavier University, not medical school.

Q What is the purpose of the Heimlick Institute?

A Well, my work has been broadened involving many things of an innovative nature. A proscriptive.

You -- we spoke of the Heimlick Maneuver which has become more public than other things such as the esophagus operation.

I also had the opportunity, in the mid 60's, or in the early 60's to develop what is known to the medical profession as the Heimlick Chest Drainage valve and that severe small gadget, really just a little plastic valve which, when I was in charge in a -- I had one guerilla American soldier -- just 12 Americans. And there were a few hundred Chinese guerillas. I had one man shot in the chest and he was the one man I felt I had lost that perhaps something could be done about it because there was no way to treat a wound of the chest at that time. And the Heimlick Chest Drainage valve came about after I had finished my chest surgical training and was practicing and teaching. It was a means of introducing the tube through the bullet

hole with a valve on it which enabled a person to survive. That was credited with saving hundreds of lives of Vietnam and has since that time.

I mentioned this to show different work I have been involved in. I'm working now and I say the Heimlick Institute for improving the domestic economy through world peace. So the Heimlick Institute can be defined as an institution that tries to prevent medical, sociological and international tragedies, and act in a humanitarian way.

Q I'll ask two questions and then I'll be done with the area.

First doctor, based on your knowledge of Ryan Krebs and your opinion of him and knowledge of the medical school and the undergraduate school, his internship in Michigan, residency program he was in, and your opinion that you have given about his integrity, did there come a time in December following that weekend of your son's birthday, that weekend, that you made a decision to offer Ryan Krebs a job with the Heimlick Institute?

A Yes. I would like to say I met Ryan Krebs as I said over a -- a little over ten years ago. I used to see him when I would visit Phillip at the

college and we talked.

I was impressed with his intelligence and his decency. And I followed his career. He got into an excellent medical school, which means he had both a good background and good marks. He went to school at the University of Texas in Dallas, and that gave me another inkling to support my judgment as to his qualifications. Then I did find, as I was following him, that he had his internship at the University of Michigan Medical Center which is truly one of the very best. You don't get in there unless you are a special type of person.

I was impressed with his dedication to people and to medicine because he was willing to take the extra years, to take a residency in internal medicine and to advance his knowledge and experience and guidance. And I was impressed with the fact that he had been accepted into that program and been able to advance right through it at the University of Michigan.

After he was visiting in Cincinnati on that weekend in December, I spoke to my son or asked him to get in touch with Ryan and asked Dr. Krebs to come and head the direction of the -- to

act as Associate Director, and head the direction and the running of the research and medical work at the at the Heimlick Institute. I was informed that -- Phil informed me that he had already had been offered a position at the Scripts Clinic in Loyola, California, which is one of the finest in the country. And I suspected that probably that is where he would choose to go. But I wasn't sure. But I would say that he would be be welcome to work at the Heimlick Institute at any time he should so desire.

Q Doctor, would the credibility of your institute and the need for credibility for carrying on your work, notwithstanding these charges he is welcome there if he gets through this mess?

A He is most welcome, yes. I think he'd be a great asset.

Ryan is a dedicated young man, and I just can't accept any of the things charged against him. He's not that kind. And I came here from Cincinnati, to make that known, and I might say now, that I have to be here for an extra day. I came yesterday. I would certainly do so if need be.

THE COURT: The Court is in recess. Do

not discuss our case or read any articles, if there should be any, or listen to any program or broadcast if there should be any concerning our case.

(Adjournment.)

C E R T I F I C A T E

I, ELIZABETH E. MONTGOMERY, Official Court Reporter, in and for the United States District Court in the Eastern District of Michigan, Southern Division, do hereby certify that I reported stenographically the foregoing proceedings at the time and place hereinbefore set forth; that the same was thereafter reduced to typewritten form under my supervision by means of computer-assisted transcription; and I do further certify that this is a true and correct transcription of my stenographic notes so taken.

Elizabeth E. Montgomery

ELIZABETH E. MONTGOMERY, RPR, CSR
Official Court Reporter

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UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

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UNITED STATES OF AMERICA,

Plaintiff,

-vs-

Criminal Action
No. 82-80242

NELLIE BELL KASSIM, et al,

Defendant.

Proceedings had and testimony taken in the above-entitled matter, before the HONORABLE ANNA DIGGS TAYLOR, U. S. District Judge, at 211 U.S. Courthouse and Federal Building, Detroit, Michigan, on Friday, October 29, 1982.

APPEARANCES:

ELLEN DENNIS and JAMES McCARTHY, AUSA
On behalf of the Government.

KENNETH ROBINSON, ESQ.
On behalf of Defendant Krebs.

D3, D4, D17
D8, D19, D22,
D24, D21,
D5, D11

JAMES HOWARTH, ESQ.
On behalf of Defendant Levine.

DAVID WRIGHT, ESQ.
On behalf of Defendant Danner.

RICHARD J. AMBER, JR., ESQ.
On behalf of Defendant Curry.

(Continued).

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Appearances (Continued):

EDWARD WISHNOW,
On behalf of Defendant Ricks.

WILLIAM WOODARD, ESQ.
On behalf of Defendant Hicks.

DONALD FERRIS, ESQ.
On behalf of Defendant Zellner.

DENNIS SNYDER, ESQ.
On behalf of Defendant Fields.

SANFORD ROSENTHAL, ESQ.
On behalf of Defendant Iczkovitz.

RICHARD ROTH, ESQ.
On behalf of Defendant Scotch Castle Pharmacy

ELIZABETH E. MONTGOMERY, RPR, CSR
Official Court Reporter
(313) 961-5965

I N D E X

Detroit, Michigan 48226

Friday, October 29, 1982

(9:00 a.m.)

- - -

THE COURT: Good morning, ladies and gentlemen.

You are still under oath, Doctor.

D R. H E N R Y H E I M L I C K

having been previously sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

DIRECT EXAMINATION CONTINUED

BY MR. ROBINSON:

Q Dr. Heimlick, other than your experiences, which you outlined in detail yesterday, do you still have hospital privileges and a practice along with all of these other things you do?

A Yes, I do.

Q And tell us, please, what some of those functions in that practice are that you presently have regarding patients?

A Well, I'm practicing primarily in consultation for various conditions. But also, particularly in regard to treating patients with a new method I developed for providing oxygen to people with

chronic lung disease or heart disease. Any patient that needs oxygen formerly has been tied down to a tank or machine through a tube going into their nose which delivers the oxygen.

Through studies done over a period of years in our research laboratories, I was able to show that if you give the oxygen through a very tiny, tiny little plastic tube, a plastic tube put in the windpipe, the trachea under here, just the lowest part of the neck, that you save so much oxygen and you save, you use four times less oxygen than if you give it through the nose, because if you give the oxygen through the nose, there's a way around the nose and mouth and the patient has to suck the oxygen down into the lungs.

We found in our studies, original studies and it has been proven in the patients that treated over the last, little more than two and a quarter years with this method, that a -- they save so much oxygen by having it delivered this way -- this procedure which takes about five minutes actually, that a small tank, a six pound tank that can be carried like a camera case will last the patient a whole day, at least say 6 to 12 hours, depending on how much they use. So that these

patients who were formerly tied down to the leash or to the tank, are now free to move about and live within the framework of a fairly normal life. They can travel and work, some of them, and enjoy themselves.

So, I am now seeing patients primarily for this purpose and I'm providing this care both in a hospital in Cincinnati and also, I received a grant from a foundation, a foundation that is particularly interested in the people of West Virginia, and I received a grant to provide this to the people of West Virginia who have black lung disease, a great many of them, as well as their families who may have emphysema or other chronic lung disease or heart disease. So I have been traveling once a month to West Virginia to provide this for these people.

Q Doctor, is it fair to say that in your 38 years as a physician all of the things you have described you have become familiar with the standards of practicing medicine at the universities, in residencies and hospitals and in clinical situations as well as having listed at least three innovative standards that you have come up with yourself?

A That's correct.

MR. ROBINSON: Your Honor, I offer the doctor as an expert at this time, in the field of medicine.

MR. McCARTHY: No objection, your Honor.

THE COURT: He is.

Q (By Mr. Robinson): Doctor, are you familiar with the Physicians Desk Reference, the PDR? You are familiar with that?

A Oh, yes.

Q Can you tell us whether or not, in your opinion as a physician with reasonable medical certainty, it is authoritative or not to physicians both in the practice of medicine, in hospitals and residencies and universities?

A It is both authoritative and widely used. Probably one of the most widely used sources of medication.

Q Doctor, assume that you're a physician and that you are prescribing a medication which is listed in the PDR and that you want to see what the warnings, contraindications and indications are for that medication and you refer to the PDR, would it be reasonable to expect a physician to rely upon what is said in that PDR, to use in his judgment in prescribing that medication?

A I would say so, yes.
Q Do you feel that -- say there were two medications such as PBZ and Talwin in the Physicians Desk Reference and the physician was unaware that if you put the two together and you're an addict and you do what I was telling you yesterday, you can put them together, melt them down, inject it and get what is called a Heroin high, would you expect -- if the PDR doesn't tell a physician that that combination is possible, would you expect the physician to know that in his judgment?
A I'm sorry. It went on a while.
Q I'm -- I do that.

In other words, you have got a PDR that refers to Talwin and a PDR that refers to PBZ.

A Yes.
Q And that if you read the two in the PDR and you are talking about tablet form of each of the medications and there's no reference, and there's no reference in the PDR from the drug manufacturer who made those two drugs, or no editorials about it from the drug companies in the PDR indicating that you shouldn't mix the two at any time as a prescription to the patient, at the same time, would you expect the physician to go out and *do any*

kind of biological or research work before he had prescribed PBZ and Talwin, or would you expect him to rely on what the PDR shows the contraindications and indications are?

A I think that he would rely both on what the PDR shows and his knowledge.

Q On his knowledge?

A Yes.

Q I believe you testified yesterday that your knowledge is all of the things you have done in your life, until you talked to me about this case you were unaware that there can be harmful affects to an addict if he uses PBZ and Talwin together.

You didn't know that until I discussed it with you?

A I didn't know that. I still don't know that you said there could be harmful affects. I'm not sure of that.

Q Doctor, you testified yesterday about in 1950 working in the -- a hotel -- I can't remember that --

A It's called the Hotel Health Center and it was the hotel union employees clinic.

Q All right, keeping that in mind, let me give you a hypothetical.

Assume that a patient comes to a clinic in 1981 in a city, Detroit for example, and they complain of a lower back problem. And they come in and they see a physician, they complain of the back problem, the physician has the blood pressure taken, height, weight, pulse, listens to whether there's a problem in the lungs, has the patient sit on a table or lean over a table and do certain exercises, examines the small part of the back where the complaint is and feels for tenderness or muscular problems and that physician diagnoses on that visit, which takes from 10 to 15 minutes in a clinic atmosphere, that there is a back problem or muscular problem with the back and prescribes Talwin.

Can you tell us whether or not your examination in 1950, where people were complaining about some of these things were any different than that I just gave you in the hypothetical?

A If you're talking about my clinic and I worked in the 50's, the hotel clinic where it was a single visit walk-in situation, then that was the type of treatment that certainly is usual and very common also in doctors' offices.

Q And have you talked, or heard talk in your time at

the University during the years while a doctor, any different standard in that kind of environment in dealing with a patient who complains of that problem, who has limited resources and who has pain.

Did you treat him and diagnose him that way?

A I'm not aware of any such discussion.

Q Again your diagnosis in the 1950's when there was pain that you felt was sufficient to require a narcotic. I believe you testified you prescribed Aspirin with Codeine, which was a controlled substance, is that right?

A Aspirin or it's equivalent or Aspirin and Codeine.

Q All right. Well, I'll give you the other hypothetical.

Assume that the doctor sits behind a desk and a patient comes in complaining of a back problem and the doctor doesn't get out of his chair, asks the patient what he wants, the patient tells him and the doctor writes out a prescription for Talwin.

That would breach the standard of care, wouldn't it?

A I would say if that's the first time the doctor *has*

seen the patient, yes. If it's a patient who has been coming back and he knows the patient and has been treating the ailment, then it is conceivable.

Q And of course under the circumstances such as that, you'd have to listen to what the patient says and what the doctor says and then believe which ever person you wish to believe before you can decide what really happened.

Would that be a fair statement?

A You mean --

Q (Interposing) In other words, the patient comes in and says the -- pretend the patient who says that is an FBI agent and he says that doctor so and so did that, and the doctor says that is not true, I did something else. You are not here to give an opinion on who you believe are you?

A No, I'm not.

Q But when you testified earlier on Dr. Krebs character you listed it as pretty high as I recall?

A Yes, if the doctor were Dr. Krebs, I would accept his word.

Q Now, Doctor, I believe there was a time in the past where you were called down to a pharmacy or to someone or someone in your office allegedly had forged a prescription in your name, or someone had

presented a prescription with your name on it to a pharmacist that you had to sign it, is that true?

A The situation was that I was called by a pharmacist in Cincinnati who said that he had just filled out a prescription for two people for Diluadid, which is a Morphine type narcotic drug, and that is my signature and my number, my drug regulation number was on the prescription. It was written on a hospital prescription blank and the patient's name was, or supposedly the patient's name had been put on it and the pharmacist said that when these people came in they called my office and this was -- it happened after five p.m. and usually no one is in my office after five p.m., or if it were after five p.m. whenever, and that somebody in my office said this is a patient of Dr. Heimlick and he did write the prescription and gave her name and it was not -- it was the name of someone who hadn't worked for me for a year and the druggist had filled the prescription and it was obviously a forged prescription because I had not written it, and the druggist informed me that he was going to turn it in.

Q Doctor, from your experience as a physician dealing with medicine, obviously, can you tell us whether

or not there's been literature and things you have been familiar with in the universities and journals and medical schools that indicates in the practice of medicine the private practice of medicine, particularly there is what is called extensive tests being done to the detriment of the patient's financial posture?

A There's been a lot of information coming out in the medical literature to that regard, not only to the patient's detriment but to the detriment of the third party payee, such as insurance companies. There have been medical studies that show there are excess examinations being done.

Q Can you tell us whether or not there has been some suggestion in some of that information that has been discussed, that one of the reasons is the physicians' fear of malpractice so they create a paper trail to suggest they did everything conceivable in treating the patient?

A Yes, that is one of the reasons and I think some doctors have good reason to do that.

There has been so much increase in malpractice in the last period of years, malpractice suits, and such large awards being given, that doctors in order to protect themselves

from that standpoint, rather than as part of the patient's treatment will frequently order many tests that are beyond the need of the patient.

Q Without reference to any specific drug or medication or narcotic in the PDR, would you say with reasonable medical certainty that if a drug is listed in the PDR as one that can be prescribed in this country by a physician, that it has to have a legitimate medical purpose?

A I would say that is true.

Q And most of what you do these days, as I understand it, is try to develop new methods to further the cause of medicine and to educate the public on what medicine should be doing, is that a fair statement, through lectures and research?

A I'm educating in treatment of patients in general, yes.

MR. ROBINSON: That is all I have, your Honor. Thank you.

THE COURT: Doctor.

THE WITNESS: Yes, your Honor.

THE COURT: A patient of apparent low economic -- a Black inner city patient who comes to a clinic which bears the title Medical Clinic and is required to pay $30 in cash in advance and tells

the doctor about his pain; does your profession recognize a lesser standard of care to save the third party payment as possibly -- is the determination made in your profession that this is not the time to make the tests or --

THE WITNESS: (Interposing) I would hate to think that the reason that anyone was not properly tested was because they were an inner city Black patient.

In fact, in my office today the manager of my office is --

THE COURT: I just want an answer to that question --

THE WITNESS: I'd just like to --

THE COURT: (Interposing) -- is the same standard of care applied?

THE WITNESS: Unfortunately in many instances it is not applied, and I'm aware of this because --

THE COURT: And does your profession recognize two standards of care, or more than two standards of care for patients on their presumed ability to pay, or their presumed attachment to the third party patient?

THE WITNESS: I know I do not recognize

two standards of care because it is on ability to pay. And I'm sure that there are doctors who do and doctors who don't.

I have been in some very excellent clinics and I have seen some even in hospitals that are not as good. They vary.

THE COURT: Thank you, that is all.

THE WITNESS: If I might, your Honor, just to add that in my office the manager in my office is a man who happens to be Black who was the assistant.

THE COURT: I thought that's what you were going to tell me.

THE WITNESS: I'm not saying it for that purpose, but was the Assistant Commissioner of Health in the City of Cincinnati and Assistant Head of the CETA project before it closed and was very much aware of what happened in the inner city.

CROSS EXAMINATION

BY MR. MCCARTHY:

Q Doctor, when you worked in the hotel clinic in the '50's, would it be fair to say that most of the patients that you saw come in were walk-in patients with an immediate problem that you treat so that they could go back to work or better, to see their

regular doctor?
A Most were that time, yes.
Q And on some occasions, while you were working in that particular facility you would refer persons to surgeons or other specialists during the course of your practice?
A Yes, I would.
Q During the time you were in that facility in treating persons for lower back problems, would you say that you treated all of those patients alike in terms of your diagnosis and treatment?
A No, I don't think so. I would say necessarily no two patients should be treated alike.
Q Would it be fair to say that there are many different causes of lower back pain and many different types of low back pain?
A Yes, there are.
Q Could you describe some of those for us, please?
A Well, there are the lower back pain due to injury or strain, lifting, bending over. There are those due to chronic conditions, such as arthritis; there are some due to kidney disease and other general diseases.
Q Now, what type -- what different types of treatment would you use for those different types of

problems, at least during that time?

A I can only speak of that time by the way.

Q I understand. I don't mean to ask you about different times?

A What sort of -- would you repeat the question.

Q Yes.

During the '50's while you were working in that facility and would see persons with back problems, lower back problems with the different causes that you have already described for us, what different types of treatment would you use for those individuals?

A Well, if it were a patient where I suspected there were kidney problems and that person's kidneys had not been worked up, I would then recommend them for further work up from that standpoint. For example, if it were an obvious acute injury and my questioning and examination brought that out I would then treat them accordingly with medication.

Q Now, let's talk about the person who would come in with an acute injury to your facility back in the '50's and say they had strained their back and they were in pain from lifting something heavy in the store that day, and you would have made an examination and determined that it was a muscle

strain and treated them with Aspirin or with Aspirin and Codeine. Now, let's say that the same person came back two weeks later with the same complaint and said it wasn't any better. What would you have done in that situation?

A Again, it would depend on my questioning of the patient. Had they strained themselves a little more? Was it diminishing somewhat, was it increasing, were there any other signs that I didn't know about. It would depend on those findings.

Q What would you do in a situation where the person came in two weeks to four weeks later, said that they hadn't reinjured their back but it wasn't any better than on the first visit and that Aspirin with Codeine was very helpful and could they have it again?

A I would say if there were a patient who had a sufficiently serious injury and that if I were, if I expected that injury to persist, then I would treat them again with medication. If it had been a very minor injury. I would have expected it. If I would expect that it should have cleared up I might then do further examinations or tests.

Q What type of further examination and testings would

you have done?

A I would examine the back probably. I would particularly ask some questions. If it was something where I suspected it could be more serious than just the injury, I might get an x-ray.

Q What if that same person came with the same complaints once a month for six months and each time the complaint didn't change at all. It was the same, hadn't gotten any better, hadn't gotten any worse and they liked the Aspirin and Codeine and could they have it again?

A Well you know, in a clinic setting of that type, frequently you don't see -- of the type I was in, you don't see the same patient time after time. You might see a patient and they might see somebody else in the interim and you go by what you see at the moment. And just as the patient coming into a doctors' office wasn't treatment for a specific problem and you suspect there is nothing additionally serious about that problem, within limits you just continue giving the treatment. I think there's an extent at which you would stop or a point at which you would re-evaluate your findings, but of the vast majority of people treated in doctors' offices, not only are there no

physical findings, despite all of the tests a very vast majority and I'm sure equally so in clinics that are -- things that are related to psychoneurotic problems and pains resulting from that and stress as much as anything physical.

In that case, if you feel you have that type of a patient then you would continue the treatment on an on-going basis when you saw that patient again. You would know that from your discussions that there is nothing that you can treat in any other manner. If you suspect there is, of course, then you might want to --

Q In a clinic type situation as you have described where a patient doesn't necessarily see the doctor, the same doctor on each visit, would it be fair to say that the files that were kept, the charts that are kept for that patient in that particular clinic are fairly important?

A I think charts should be kept as well as possible, yes.

Q And what sort of information should be in a patient's chart in a situation where the same doctor won't see the same patient every time?

A The complaints, the findings and the medication.

Q Why is that important?

A So that the next doctor will know what the treatment was.

Q When you were treating patients in the '50's for back problems, would you be able to say whether you treated as many as 90 to 95 percent of patients with those complaints in the same fashion, with the same diagnosis and treatment?

A I really can't say at this date, but my back problems -- well my aching back. During World War II when you wanted to get out of doing something -- I suppose it's still that way, you had an aching back. It's the most vague type of complaint, the most difficult thing to pin anything down on, and it's one of the common things that people will complain about when there are no physical findings. It is just something that -- when you can put your finger on something is very rare. There are specific back findings, a fracture -- that a break of the bone, or as I say arthritis or something, but it really is something that drives most of your first line of defense doctors crazy. Many patients come in and have back pain and you cannot pin it down. It may be due to overweight. It may be due to stress but not very frequently can you say this back pain is due to such a such a situation. And

many people are even operated on for their backs for a specific problem and when the problem exists. It is one of the vague areas to say, a heart attack.

Q Would it be fair to say that complaints of backache are frequently used as excuses to get out of work in auto plants?

A I don't know about in auto plants, but it is frequently used to get out of work, yes. I would say the reason is because it's so difficult to pin it down.

Q Would it also be fair to say that most persons who have back pain recover pretty much on their own with the passage of time and rest?

A That is hard to say. You say most, and I don't know exactly what that means. There are people who go on for years and years with their back pain and I would say if I were open that would be a guess. I don't have any figures on this. I would say that most commonly people with back pain it just continues on and on for years. And it doesn't go away. I think the acute back pain of someone who has played a game of tennis or lifted a barrel or something might go away.

Q Would you recommend the use of the constant use of

Talwin for chronic back pain?

A I think it is a very common medication for that purpose. I don't -- as I say I have never treated back pain with Talwin because I don't treat that type of situation anymore, but I know that it is one of the common medications used by doctors throughout the country for the treatment of back pain.

Q Yesterday I believe Mr. Robinson referred to an article to you in the journal of American Medical Association dated September 12, 1980 entitled T's and Blues. Do you recall reviewing that article yesterday?

A I didn't review that article.

Q Well, would you accept the Journal of American Medicine as an authoritative source?

A Generally the American Medical Association.

Q Yes?

A Yes.

Q Would you agree with the following statement that soon after the introduction of Pentazocine, Talwin in 1967, as a narcotic to the analgesics without known abuse potential it became apparent that the drug was being abused and that it was addictive? Would you agree or disagree with that

statement?

A I would like to see the statement and what went with it, if I may.

Q All right. I will hand you a copy of the two-page article entitled T's and Blues from the Journal of the American Medical Association, September 12, 1980 Volume 244 number 11 page 1224 and 1225.

A I'd like to comment on that. Could you repeat the question.

Q Do you see the statement. I believe it's in the first paragraph and underlined, that talks about the year 1967 when Talwin was introduced?

A The statement you read. Shall I read it again?

Q Please?

A You read that soon after the introduction of pentazocine, which is Talwin, N196P as a non narcotic analgesic without known abuse potential it became apparent that the drug was being abused and that it was addictive.

I believe that is all you read. I might say that without reading through the entire article, I hesitate to comment on all of it, but I will comment on that and I also think we ought to understand that when we have an article in the Journal of the American Medical Association that

simply means that the doctor is writing for the Journal and expressing his opinion and findings and that the Journal of the American Medical Association, if you will look in the front portion, states that it is not responsible. The American Medical Association, nor the Journal of the American Medical Association are responsible for the writings therein. They are simply reporting someone elses work. Is that understood?

Q Well, if it wasn't before, it is now. Thank you.

A Okay. Then you said soon after the introduction of pentazocine in 1967 as a non-narcotic analgesic without known abuse potential it became apparent that the drug was being abused and it was addictive and this thing refers to another article published in the New York State Medical Journal in 1971. I think it goes on to say abuse was limited to the medical community and patients and street abuse was unpopular until recently.

This may have been due, in part, to its mild narcotic antagonistic and that would be unplesant on regular Heroin users because the drug Talwin actually acts against Heroin and the affects of Heroin, for example. So that I think that that clarifies it a little further that the abuse was

limited to the medical community. That means that the doctors were perhaps prescribing it and it began having reports of psychiatric disturbances associated with pentazocine use and abuse including disphoria depression, confusion and hallucinations either while under the influence of the drug or during withdrawal.

Now, I should really read the whole thing but I don't know.

Q Please do.

A Shall I?

Q Please do.

Doctor, have you had a chance now to review T's and Blues article in its entirety?

A I have.

Q I would ask you for a moment to turn to the second page of that article and look to the middle paragraph, I believe there's several sentences underlined in red. I'd like you to read that part that's underlined in red outloud and tell us whether you agree or disagree with the statement made there?

A It says much of pentazocine and trimanomine is obtained through legal prescriptions. Prescribing physicians should be aware of the abuse of these

two drugs particularly since pentazocine in tablet form is often considered of low abuse potential.

Umh, I don't know that there's anything to agree or disagree with. I think he's stating a fact of his opinion.

Q Is there anything else that you have read in that article in either of the two pages that you would like to comment on that I haven't asked you about or that you haven't already explained?

A Well I think that I'd like to comment on the thrust of the article.

What this author is saying, he is advising doctors that this Talwin is a fairly commonly proscribed drug. It's not a drug, it's a medication. And that the reason for writing the article apparently, is to make the physicians aware that these two drugs are being used by some narcotic -- by some drug users, narcotic addiction to mix the tablets together and inject them into their veins, which is not the way the drug is supposed to be used. It's suppose to be taken as a tablet by mouth as an Aspirin tablet. And really the primary point as I can see of this article is he is saying at this time is becoming a common abuse of the drug that narcotics addicts are

obtaining this drug which is supposed -- the two drugs which are supposed to be taken by mouth, and mixing them and injecting them into the bloodstream. And as a result those physicians who take care of narcotics addicts should be aware that complications can arise from this misuse of these two drugs. Such as ulcers on the skin and complications in the lungs from the material getting into the lung. And he is advising the physicians that if you are taking care of narcotics addicts and they have these complications, they may very well be misusing these two drugs.

He also speaks of the treatment. If you find a person who has been taking the drugs in the vein this way, he says that pentazocine addiction -- that's Talwin addiction is associated with a mild narcotic like withdrawal symptom. That means consisting of restlessness, insomnia, irritability and so forth. In other words, he is saying it is not a narcotic, but when you withdraw the drug after it's been taken in the vein there are mild symptoms that are similar to those of the minimal symptoms of narcotics addiction. And he goes on to say that in the treatment of such addiction to this drug being taken in the vein, hospitalization is

usually unnecessary; and he also goes on to say for many patients where the drug is being withdrawn no supportive medication is required. I think that's what he's trying to point out.

Q Would you say that he's also trying to point out to physicians in general, that they should be aware of or be suspicious if one patient is consistently getting Talwin and Pyribenzamine?

A I -- you mean if this doctor should be suspicious if he prescribes it.

Q Given the fact that that article talks about the high abuse potential of the two.

A Repeat your question.

Q I'm not sure that I can repeat it.

Do you believe that it's a fair -- would it be a fair statement that that article is also, in addition to warning doctors that they should be suspicious of addiction type persons who may be abusing Talwin and Pyribenzamine, that physicians in general should be very aware of or concerned about the fact, or concerned about the situation in which they may be over a long period of time, prescribing for certain of their regular patients, addiction or not, Talwin and Pyribenzamine?

A No, you use the word suspicious, the doctor should

be suspicious. I don't see that anywhere here.

What he's saying is that if a person does choose to mix these two tablets and injects it into the veins and you see such a patient and you are treating such a patient, you should be aware that they can have lung complications that should be treated and ulcers on the skin that should be treated; and that if you want to cure that patient of the addiction that you can withdraw the drug without giving any other medication or hospitalization and the withdrawal symptoms are not severe enough to warrant necessarily hospitalization or treatment. In fact they go on to say that there's a -- it is controversial as to whether Methadone should be used in the case of a person addicted to injectiona with the other two drugs. And he points out that the reason there is a controversy, Methadone is used for withdrawal, to help an addict get over withdrawal of Heroin because Heroin is so much more severe a drug than Methadone. But here he is pointing out that Methadone is a much more severe drug than the medications that we are talking about given intravenously and therefore it would be unwise to give the Methadone, in order to try to cure the

person. And I think he is pointing out that this can be done and that doctors should not abuse the prescription of these two drugs.

Q Will you say that -- let's say you saw a patient's chart where one doctor prescribed Talwin and Pyribenzamine approximately once a month for 78 months for the same person. Would you be suspicious at that point, having read that article, that perhaps there was an abuse problem going on with that patient?

MR. ROBINSON: For the record I object. There's no evidence in this case, hypothetically that the doctor had -- the doctor in this case had read that article. In fact he denied it. So I think that should be clear to the Court and jury that that hypothetical should not apply to Dr. Krebs.

THE COURT: Well did the hypothetical say reading the article --

MR. ROBINSON: Assuming Dr. Krebs had read that article. Doctor Krebs had not read that article.

Q (By Mr. McCarthy): Let me try one more time, Doctor. If you saw a patient's chart that the same patient had received from the same doctor for a

period of let's say six months, once a month, A prescription for 50 Talwin and a prescription for Pyribenzamine, should that doctor be suspicious of possible abuse by that patient. Would any bells go off or lights go off in a doctor's head or should they?

A What do you mean by abuse by that patient?

Q That perhaps those controlled substances are not being used for the purpose that they were prescribed.

A I think if the doctor was prescribing it because of the symptoms of the patient, I would have to know what symptoms that patient had. In other words if you're telling me a perfectly well patient comes in and has no complaints and the doctor is prescribing the two medications, that is one thing. But it would depend. Now for example, there are conditions -- in fact in Cincinnati a very prominent and fine doctor was brought up on charges of using large doses, huge doses, tremendous doses of Demerol, which is a narcotic, an addicting substance, to treat a man who happened to be a very well known radio announcer who is now in another city and the charges were dropped when it was shown that there are certain conditions where huge doses

of Demerol are required. The only thing that will relieve a patient's pain and certain patients decompose the Demerol because of the physical condition. And so there's no way to say that because a patient has prescribed for him certain medication, that the doctor should think it is being abused. I think if he thought it was being abused, he would not have prescribed the medication.

Q Doctor, you talked yesterday about how much you enjoyed teaching and making the public aware of medicine in general.

That is a fair statement?

A Yes.

Q Have you done any teaching in the area of drug abuse?

A No, I have not. But I think it would be a good subject.

Q Let us know what show it's going to be on. We'll all watch.

Assume that the patient comes to a doctor, complains of chronic back pain that they have had for a two to three year period, resulting from a fall from a horse which caused something known as a fused spine. And also assume that that

patient said to you that her doctor, her own doctor was treating her with heat, rest antiinflamatory drugs, perhaps some muscle relaxants and wouldn't give her anything stronger. Would it be a standard of practice to prescribe for that patient Percodan without at least first contacting that patient's own doctor and finding out what that doctor had done and reviewing that doctor's file?

A I think it depends on the circumstances of treatment. As I mentioned yesterday there are different circumstances in which you can treat a patient. If you're in a private office and a patient comes in you know, and gives you permission to call that other doctor, and of course you cannot obtain medical information without the patient's permission.

Q Would it be fair to say that the doctor should ask for an opportunity to review the case with the patient's earlier physician?

A It depends on --

Q Is that your standard?

A Well, it depends on that doctor's evaluation of the patient. If the doctor assumes and believes that that patient is describing something that is the truth and the symptoms are such and the patient *has*

been treated in that way, I think in general you have to assume the patient coming to you is telling you the truth and is coming to you for treatment and if you were to take every patient that comes through and say I wonder if his patient is lying to me and should I treat this patient or should I call some of the other people or other doctors you just wouldn't be able to treat anybody. So if you give me a hypothetical situation I can't andwer it.

Q So you can't say whether -- at least as I have given you the hypothetical so far that meets or does not meet any standard and I would say that if the doctor who is doing the treatment believes what you told me about the patient and feels that the patient has been under another doctor's treatment has induced a fused spine, has pain, as a result of the injury and has not been helped by the other doctor, then the doctor who is doing to present treatment must use his judgment or her judgment and decide how to treat that patient?

A Shall I relieve the symptoms by giving something the other doctor has given or should I just say I'm not about to treat you until -- you know, come back and I'll treat to get follow up examination, that were done elsewhere. It just depends on the

circumstances.

Q Doctor, can you tell us what Percodan is?

A I'm not an authority by any means on this type of medication. It does relieve pain.

Q Are you aware at all of the addict potential or anything like that?

A I would have to look it up in the PDR or its equivalent.

Q Let's try a different hypothetical for a moment?

If a patient came in in 1980 said that he had lower back pain off and on since 1973 as a result of a strain from lifting something heavy in an automobile plant and the patient now being in his mid 20's, said that he was getting Talwin from his regular doctor for that pain, but that he wanted more and his regular doctor wouldn't give him anymore than he was already giving him, would it meet the standard of practice in the field of medicine to prescribe Talwin for that patient without first talking to the regular doctor?

A It depends on whether it is your intent to thoroughly work up this patient.

Q Is this patient coming to you as a family physician or coming to you, in a major hospital setting. are going to follow this patient and treats all of his

illnesses or are you treating that patient for his present complaints?

A Now, that would have to be decided. It would depend on that situation.

Q How do you know that. How do you know which of those two situations it is when a patient comes in?

A Well, I think it depends on where you are treating the patient. The patient comes into a doctor's office. He assumes that that doctor is going to follow him perhaps for the rest of his life and the doctor assumes that as well in the usual private practice.

If you're in a hospital or medical school setting you have a clinic. And I have worked in many clinics of this type. Then you also assume that the patients will come in there you are going to treat them, you yourself, are going to treat them. And in most clinics of that type now you will find they have the patient referred back to the same doctor each time, if possible. You're going to have a continuity of treatment.

If you're in a situation such as I described in the clinic I was in at the Hotel Union in New York, then you are seeing the patient for that thing and that is what you are treating at

that moment and you have to relieve that patient and you might follow him on and off for a few times. But you are not solely his total physician.

Q So basically you can't say whether that -- the conditions that I described in that hypothetical meets the standard of medical practice.

A So far back --

Q (Interposing) I'll try it again.

A All right.

Q If a patient comes to you, say a patient in his mid 20's that he had sprained his back back in 1973 and was coming to you in 1980, strained his back in an auto plant in his home town which is 60 miles away from your clinic, and also he was treated by a doctor in his home town and was receiving Talwin on a regular basis from that doctor but he wanted more Talwin. He wasn't getting enough from his own doctor to relieve the pain and wanted more from you. Would it meet the standard of medical practice to prescribe Talwin for that patient without at least first contacting that patient's regular doctor?

A It would depend on whether I believed that patient and what he was telling me and whether I then felt that my diagnosis was equivalent to the other

doctor and whether the pain that was described was in fact so severe that his dosage should be increased. I'm not an expert on Talwin, but it is an analgesic. It is a non-narcotic. It is a relatively mild drug or medication I should say, and if I were giving back in the '50's Aspirin and Codeine under those circumstances and another doctor had given it and I felt this patient really is in discomfort and must be tided over now I would say go home until I can get your records and suffer. I'd say this is what I think you should be treated with.

Q If the person in that circumstance where they were in what you believed to be legitimate immediate discomfort would you consider any alternative therapies or prescriptions other than Talwin?

A I said --

Q (Interposing) before that person could get back to their regular physician?

A I certainly would consider everything I knew of in the medication.

Q Specifically with respect to back problems what else would you consider in addition to or in lieu of Talwin?

A Well again, I'm not an expert on back problems

today. Talwin was not in existence when I was treating this type of problem. But I -- if I were I might be aware of other things that could be as good or not as good, you know, or alternatives as a possibility. But I would still use the Judgments. If it were Talwin was a good drug or medication for this particular patient that is what I would prescribe.

Q Have you ever prescribed Talwin for a back pain?

A I don't want to say yes or no. I do have patients in the hospital for other causes, and it is conceivable that they would have back pain, and generally now we have residents in the hospital where I work and I know that they would surely prescribe Talwin for back pain if one of these patients had it and I may have in the course of events; but I really don't recall a specific incident.

Q Would it be within the standard of practice in the field of medicine to prescribe for a patient such controlled drugs as Talwin, Ambenyl, Tussionex, Emperin No.4 without performing anymore examination on the patient other than the patients being weighed, having their height taken and their blood pressure taken?

A I would say if that were all you had, if that were the only information the answer is no I would not prescribe. If I had asked certain questions that led me to feel that a medication was indicated, then I would order it.

Q Now doctor, at this time I'd like to hand you Government Exhibit 20, -- DW-20, DW-21, DW-25, DW-22, DW-23, DW-24, DWD, 25 and I'd ask you to take a moment and look these different six over, then I'll ask you a few questions about them.

Doctor, now referring to each of these exhibits by the letters and numbers on the yellow sticker, can you tell us what's --

A Well, that contain prescription blanks with certain medications on them, and a signature.

Q Referring to the different envelopes with the different prescription blanks in them, can you relate to us the number on the yellow sticker with the prescription that's written on the blanks inside as well as the name on the bottom of the prescription pad?

A You want me to read what is written on the prescription blank after I give you the number, is that correct?

Q Please?

A DW-20, Pyribenzamine, 50 milligrams No. 1, PO, by mouth. KW6H, that's every six hours. Preludin, 30 tablets. Tussionex one teaspoon -- this is DW-21. Tussionex, one teaspoon, KW8 hours, preludin, 8 ounces. These are all signed with the name Ryan Krebs.

DW-22 Percodan, No. 1 PO 6 hours preludin is if necessary. No. 50, Ryan Krebs.

DW-23 Ambenyl, X -- EXP. No. 1 teaspoon, KW 8 hours are preludin. 8 ounces, Ryan Krebs.

Desoxyn, I'm sorry. DW-24, Desoxyn 15 milligram, one PO, by mouth, KW day, it each day. No. 30 tablets. Dr. Ryan Krebs. DW-25 Talwin 50 milligrams, No. 1 PO, KW 6H preludin one by mouth every 6 hours every night, 50 tablets, Ryan Krebs M.D.

Q Now doctor do you recognize the signatures on those prescription blanks at all?

A Do I recognize them.

Q Yes, sir?

A How do you mean.

Q Does it look familiar to you?

A Oh, no.

Q Now, assume for this hypothetical, that all of

those prescription blanks -- well let me ask you another questions first. Are there any patients' names or addresses on any of these prescription blanks?

A No there aren't.

Q Assume for this hypothetical that all of these prescription pads made out as to drug and signed in the name of a doctor are found in a doctors office in a clinic when the doctor is not there. Would such a preparation of prescription blanks in that nature be within the standard of practice in the field of medicine?

A It certainly would in a clinic. As a matter of fact in some hospital clinics I have worked in they have a stamp. It's just stamped on there. And for drugs, medication that you commonly use. It's just such a great turnover of these drugs that they are stamped in this way. In fact they are also ordered as to how treatment should -- what treatment should be given and these are frequently printed out and stamped and then you just have to check them and sign the appropriate ones.

Q Now in the clinics you have talked about where those particular prescriptions that, DW-20 through DW-25, those type of prescription blanks filled out

in those clinics for those particular controlled substances?

A I really couldn't tell you because I haven't been in a clinic since some of these substances have come into being.

Q When was the last time that you were in a clinic setting?

A I would say certainly well -- let's say, I was in charge obviously as Director of Surgery in the Jewish Hospital in Cincinnati which ended in 1977 or it was '77. Umh I was occasionally in such clinics.

Q Can you name for us the types of drugs that would have been on prescription pads filled out in advance at that time?

A Very frequently non-narcotic pain remedies, cough remedies,.

Q Non-controlled?

A Things where there was a constant turnover of patients who had certain very, very common complaints.

Q Can you give us any examples?

A Aspirin surely and we used to use very frequently in the days gone by, elixer of terpin hydrate, and Codeine, was a common remedy for a cough. It

depended on the clinics. If you were in a clinic that was Urinary, Urology Clinic, then some of the antibiotics that frequently were given for Urinary infections if you had a clinic with a large turnover you would have those available.

Q Now the ones that you talked about as having been in the settings you have seen or the drugs were any of those controlled substances?

A They would have to be or they wouldn't need a prescription.

Q Well do you know what I mean by the term controlled substance?

A Well define it, if you will.

Q Controlled substances are substances that by law fit into one of five schedules, controlled substance schedules; one being things like Heroin, going down to Schedule V something like Ambenyl, the higher the -- the lower the schedule number the higher the abuse potential. The lower the medical value, basically that would be about it?

A They are prescribed medications.

Q Well?

MR. ROBINSON: Your Honor, I object to controlled substance questions -- I have no problem with the doctor being asked about specific

medications.

THE COURT: I sustain the objection. He doesn't know what is a controlled substance.

MR. McCARTHY: Thank you, your Honor.

Q (By Mr. McCarthy): The prescribed prescription pads that we talked about things like Aspirin, would those also be signed in advance by the doctor or would they just have the medicine written on the pad in advance?

A Well very frequently they would be signed and given out as the patient left, by a nurse for example.

Q I'm not sure I understand your answer. Would the doctor write Aspirin on, let's say one hundred pads and sign his name to them and leave the patient area blank and leave that pad with the nurse and then as the doctor would see a patient and send that patient home, stop at the nurse and she'll give you the prescription?

A Have the nurse write the name on the prescription, yes.

Q That would be a standard practice?

A I would say so.

THE COURT: So the nurse would keep something equilalent to DW-20 through DW-25, the nurse would have those in blanks.

THE WITNESS: I think in a busy clinic or in a busy doctor's office.

THE COURT: How does she know to whom to give it?

THE WITNESS: Well, the doctor writes orders for the patient and only that patient gets it. It's basically a simple time-saving mechanism. And basically you have, I believe as we brought out in the last few minutes, no specific knowledge about there being anything different about controlled substances or about the specific drugs that are listed in Government's Exhibit DW-20 through DW-25. I really have no expertise on this drug particularly, though.

Q I would now hand you what has been marked as Government Exhibit DW-8. And it consists of a package of files. I would like you to take a moment to flip through the files and after you do so I'll ask you a few questions about them?

A Yes, the files contained within Government Exhibit DW-8 I have.

Q Could you describe for us briefly what you have seen in that exhibit?

A These are apparently patient history files that the patient would fill out.

Q Is there any medical type information contained in those files that you were able to see?
A There is an evaluation -- the right portion of the sheet there are some notes?
Q Can you tell us what those notes are?
A They are a description of some physical findings and complaints.
Q Is there any indication on those pages of a prescription for controlled or for medication -- let me try that one more time.

Any indication on those pages of any medications as well as the brief description sort of a medical problem.

A I don't know.
Q Any indications of medications?
A There are some abbreviations that I don't understand. This is a habit in medical circles to abbreviate. So, I can't be sure of that. I don't see any I recognize.
Q Can you tell us what type of -- what are the initials on there that say you don't understand, but can you tell us what initials they are?
A Well on this one I -- in this particular one I can recognize overweight and insomnia and then there is a P75 over 30. I assume it's the pulse, but I'm

not sure. I don't know what the over 30 is Preludin 75 milligrams, dispense 30.

MR. ROBINSON: I object. The doctor has stated a lack of expertise on controlled substances and those files contain controlled substances. He has a lack of knowledge of Dr. Krebs' writing. He doesn't identify his writing. He has no evidence that Dr. Krebs prepared those files and there's no predicate to ask that type of question.

THE COURT: No comment has been requested yet and he is still building an assumption and asked if he knows it.

MR. ROBINSON: My objection is he said he doesn't know about the controlled substances. He doesn't know about the writing, he doesn't know about the patients, and he doesn't know about the files. He's not here as an expert to testify on something -- no evidence other than an FBI handwriting and I object that you are asking an inappropriate opinion.

THE COURT: Overruled. He has been asked to comment substantially on prescriptions which we know are controlled substances.

Q (By Mr. McCarthy): In that particular file you said it had the indication of insomnia and

overweight and the P, 75-30. Do you see any name written on that page at all?

A There's a name that looks like it could be Krebs and above it it's a KWVA,30.

Q Assume that means Quaalude?

A What?

Q Quaalude, dispense 30.

Now is there any patient's name on that page, doctor?

A Yes.

Q What is the patient name?

A Ella Taylor.

Q Why don't you go to the next one?

A And there's another name there it says, likes like Larry Murphy or something like that.

Q Are those names actually. Is the name Larry Taylor written on the patient history or is that a separate piece of paper?

A Ella Taylor is on the patient's history and Larry Murphy and another one on Ella Taylor is on a separate piece of paper and there's an abbreviation on the Larry Murphy. I don't understand.

Q What abbreviation is that?

A PTAB.

Q Is there on the patient history sheet, is there any

patient history indicated?
A No, there isn't. Oh, yes there is just in the note below.
Q For the overweight insomnia?
A Yes.
Q Why don't you open one of the next files, Doctor. Can you describe for us what you see in that file?
A Again in that file we have history sheets, three history sheets, the patient's name and address. Letters on the top and some writing on the bottom.
Q Can you tell us what the letters on the top are?
THE COURT: Well, let's start with the name. Are all three history sheets for the same person.
THE WITNESS: Well it's three history sheets for the same person, one name.
THE COURT: What is the name?
THE WITNESS: Yes, they are.
THE COURT:: All right. What is the name.
THE WITNESS: Joe Brown.
THE COURT: All right.
Q (By Mr. McCarthy): Are there any initials at the bottom?
A Yes, there are.

Q Can you tell us what they are?
A It's difficult to make out. Likes like MSCBW then you are. I -- it's like URI, it's not clear but that I would understand as upper respiratory infection. I don't know whether the first letter is N and TCPB and T5 or 50. I think it's a B, 8 ounces and there's a signature on it.
Q Okay. Why don't you go to the next file. Is there a patient name in that file?
A Yes, there is.
Q What is the name in that file?
A George Johnson.
Q Any initials at the bottom?
A There are both a T, a B on the top and again it looks like MSCBB I see the five. Looks like dash 50. URI. And there's a B something. I -- well, maybe that's 8 ounces and there's a signature.
Q All right. In the remaining files that we haven't talked about yet that are in Exhibit DW-8, did you find any files in there that did not have patient names written on the history form at the top?
A I'd have to go through again. I don't recall.
Q Would you do that, please?
A Sure. Four do have the name written on top.
Q Of the four that don't have names at the top, are

there any initials at the bottom?
A Yes.
Q What are the initials, please?
A On this one it's MS something likes like BP overweight The 50, 50P75-30.
Q Is there a name signed on it?
A There's a name signed on it and I would not know the name if I didn't know who we were talking about but it could be Krebs.
Q I understand.
A But it's -- it's not written so that it can be read.
Q How about the others that you said don't have a patient's name on them. Did they also have initials at the bottom and a name that looks like - it could be Krebs?
A Yes.
Q With respect to those four files, where it appears that medication is indicated on patient's charts appears that there is a signature of a doctor it appears to be a patient history sheet without even a patient name or history on there, would you say that that, those four files are within the standards for medical care in the profession?
A I -- please explain, because I don't know what

these files indicate.
Q Well, that they are found in a doctor's office?
A Yes.
Q Just as they are already made out?
A Yes.
Q In a clinic?
A Yes.
Q And they are found in the form that they presently exist?
A Yes.
Q Is that the type of thing, putting a diagnosis on a piece of paper words like overweight, low back pain, writing the name of a doctor without there being anything else on the history sheet within the bounds of standard medical practice?
A If a doctor did that then it would not be in the bounds of standard medical practice.
Q Now yesterday I believe you said that you had known Dr. Krebs --
A (Interposing) I said by the way I noticed one of the charts here had or more had one of these had a name on the file folder.
Q We assume that all of the rest of them had patients named on them?
A No, the name on the file folder is not the same as

the patient name. There are so many. I don't know whether that indicates that these file folders, that these files were in folders that had patients names but I will say I will agree with you that if this is all there was and a doctor would write down a diagnosis and treatment it would not be within the standard.

Q Now just so we have the record straight, can you tell us the name that is on the file, that you just mentioned, as well as the patient name that is different from that that is inside the file?

A There's a Janet McFarland on the outside of this.

Q That is on the manila folder. On the manila folder and there's a Barbara Scott on the sheet inside?

There are also I might note tabs that were placed on all of these charts that are no longer there, that have been apparently removed.

Q Now I believe you testified yesterday, Doctor, that you had known Dr. Krebs for ten or so years?

A Yes, indeed.

Q And you had gotten to know him very well not only as your son's friend but really as your own friend as well. Also his medical career?

Q And you held him in such esteem that you offered him a position in Cincinnati at your institute, *is*

that right?
A That's right.
Q During the period of time from 1981 until late, or 1980 until late 1981 or early 1982 did you ever visit Dr. Krebs at any of the three clinics that he worked in the City of Detroit?
A No, I did not.
Q Did you visit any of those three clinics known as RNA or 7 Mile or Jefferson Medical Clinic at any time either before, during or after the time that Dr. Krebs was working there?
A No, I did not.

MR. McCARTHY: Your Honor, I have no additional questions at the present time, thank you.

MR. HOWARTH: Your Honor, I'll probably be brief if I can ask questions from here.

THE COURT: Certainly.

CROSS EXAMINATION

BY MR. HOWARTH:
Q Dr. Heimlick, is it possible that you have another son who is in the pharmacy business?
A Not that I know of.
Q I was afraid you were going to say that. No further questions.

MR. WRIGHT: No questions.

MR. AMBERG: No questions.

MR. FERRIS: No questions.

MR. ROBINSON: I have one.

REDIRECT EXAMINATION

BY MR. ROBINSON:

Q Dr. Heimlick the Court asked you questions before that relate to whether or not -- I got the impression from the questions that whether or not there's a different standard of care that you recognize in the medical profession for poor Black people in the city; and I got the impression that you were trying to explain an answer about the differences in medical treatment in the University atmosphere and residency atmosphere and hospital and some private practices and clinics in the inner city or with poor people. Would you tell us what you meant by your answer?

A That there are differences between them. There are -- well first of all let's talk about different types of clinics. I don't know that you can break it down into inner city necessarily or Black or white.

Most clinics I know of are mixed or if they are in a certain area they might have the race

or nationality. If you want to speak about inner city clinics, there are -- as there is in medicine in general, all levels. There are inner city clinics with some of the most dedicated doctors in the world. The fact that they will give up lucrative practices to work there indicates the dedication of some of the young men I have seen in such clinics. So I'm really speaking about the different level of treatment or different type of treatment depending on the site and atmosphere of the place itself.

There is a medical school treatment which I described yesterday which is very extensive and complete for teaching purposes; as excessive as far as the individual patient goes. But for teaching there are hospital clinics where they have certain types of hospital clinics and where perhaps one or more of a group of doctors are interested in certain types of disease and concentrate on that in the clinics and do extensive studies on certain diseases they are particularly involved with, significantly. There are clinics that are walk-in type clinics where that patient comes into the clinic and says I have a pain or I have this problem, help me. And the type of treatment *varies*

with that situation. And there are good doctors and there are bad doctors. I don't know what else I can say.

MR. ROBINSON: That is all. I have nothing additionally. Thank you, doctor.

THE COURT: Is it presumed in an inner city clinic when a patient comes and is required to pay $30.00 in advance to see a physician about pain, is it presumed that this is a one time walk-in obligation; that the doctor has to tide him over to go for other care elsewhere, or that there are not other resources to follow up or test whatever the patient's problem is? That is, is a patient who walks in and pays $30.00 in advance and complains of pain to a doctor, is he able to expect medical care or simply a medication and to use his wits and find true care elsewhere. Must he find an individual doctor's name posted or a hospital?

THE WITNESS: That's a very difficult --

THE COURT: (Interposing) are the standard of the profession such that only certain care is given in a clinic, and is it presumed, he is too poor to see through his care?

THE WITNESS: The word clinic I think is a little ambiguous, because we did refer to a

medical school clinic or to and outpatient clinic and so forth. It varies so, but If I can talk just to the point, perhaps of medical care and not use the word clinic which is too broad.

It varies extensively and varies with the doctor who is doing the treatment and the type of clinic. I know private doctors who, when you call for an appointment in their office, the nurse tells them that we want you to know that the initial visit is $150.00 to $200.00 which will include all of your blood tests, urinalysis, chest x-rays, etcetera, etcetera without knowing what is wrong with the patient. And if the patient can't put up then they'll say I'm sorry you will have to go elsewhere.

There are clinics such as the Mayo Clinic where, when you travel out there you go to spend days of examination and usually you travel out there with the doctors there already having received extensive records from your own doctor because you are going there for a complicated situation that your own doctors cannot treat. And then there are clinics and doctors offices where there is no alarming number of patients, where perhaps the amount paid is not enough to allow for

a whole hour or two with the patient. And they provide a service as well to people who have to get back to work, who have everyday complaints, and are to be treated.

I think perhaps the best explanation is if you took away anyone of these things what would you have? And there we would all like to have Mayo Clinics all over the country because it's a marvelous institution. For reasons that may be governmental, employment problems, overwhelming numbers of people in a certain area, the medical standards around the country cannot be, or has not been, I wish it were, Mayo Clinic standards. So you are either going to say every patient has to have that, and therefore these many millions of people cannot get any treatment or you have to divide them with what help you can to support them and carry them over their immediate illness.

Does that answer your questions, your Honor?

THE COURT: No.

Is there an obligation by the profession to see a patient through treatment of whatever type that patient may be able to afford or a third party provider. The standard of care does not provide

that --

THE WITNESS: (Interposing) I would say if you recognize a treatment that should warrant extensive work-up if you will, or what have you, that there should be places in every area where patients could be referred for that type of treatment.

Q (By Mr. Robinson): Doctor, is it fair to say that based on the Court's question that any such standard to refer a patient depends on the physician's at the clinic, judgment to determine whether that is indicated?

A That is correct.

Q Finally, Doctor --

A (Interposing) I think what is also important, is that you have to rely on the physician's judgment.

Q Doctor, from your experience -- let's take this case of Dr. Krebs where, according to Dr. Krebs' own testimony, he saw at least in the hundreds of patients not necessarily thousands, but in the hundreds over a 15 month period and to our knowledge in all of these cases not one patient who saw him complained of malpractice. Are you aware of the potential and ability of the patient to complain that their needs were not tended to *within*

the requirements of the standard. Don't they have the right to sue doctors and clinics?

A They surely can and they surely do.

Q And does that appear to you that based upon your experience with hundreds of patients visiting Dr. Krebs that not one has filed a complaint of malpractice indicates he was within the standard of care, at least for those patients in their judgment.

A I would say it certainly is -- apparently within the standards. I also say in line with what I said to the Judge, if Dr. Krebs were not there to treat these people, who would be there? Now it's my understanding he told me that he had answered an add in the newspaper and a doctor was needed in this area and he felt a doctor was needed in that area. Now he had the choice. He had the choice of opening a practice, which is for doctors a very lucrative thing to do. I have had a practice. I have never put that before the other things I had to do, I wanted to do. The scientific work as well, and all of that that you do either in your practice. So he had the choice. Shall I go down to this clinic or go into practice and build up a practice? And he made his choice and if he hadn't

made that choice I don't know what would you say these people would have had, the thousand or so he treated?

MR. ROBINSON: Thank you, doctor, I have no more questions.

RECROSS EXAMINATION

BY MR. McCARTHY:

Q Doctor, are you telling us that the standard of care for practice in the field of medicine is up to the judgment of the individual physician?

A No.

Q Is there?

A I'm saying the treatment of the patient is up to the judgment of the individual physician who should stay within the standard practice of medicine.

Q Did -- when Dr. Krebs told you about his answering an ad in the newspaper that a doctor was needed at the clinic, did he also tell you that he had indicated that the pay would be $100.00 per hour?

A No, I didn't know that.

MR. McCARTHY: No further questions, your Honor. Thank you.

REDIRECT EXAMINATION

BY MR. ROBINSON:

Q Did you know, that Dr. Krebs testified he was paid

$25.00 an hour?

A I didn't know that either; though that would be generally --

MR. ROBINSON: That is all. Thank you. I'm sorry we kept you so long.

I'm going to call Dr. Laufman now, your Honor. Was that our break for the morning? I'd just soon go on.

A L A N L A U F M A N

was thereupon called as a witness herein, and after having been first duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

THE COURT: You are a lawyer.

THE WITNESS: Yes, ma'am.

MR. ROBINSON: And a doctor

DIRECT EXAMINATION

BY MR. ROBINSON:

Q Tell us your name and educational background?

A My name is Alan Kerry Laufman. I grew up in Texas, went to the University of Pennsylvania in Philadelphia. I then attended Harvard Law School and earned a law degree and during that period I became a resident in the field of legal medicine and went on to earn a M.D. at the medical school

C E R T I F I C A T E

I, ELIZABETH E. MONTGOMERY, Official Court Reporter, in and for the United States District Court in the Eastern District of Michigan, Scuthern Division, do hereby certify that I reported stenographically the foregoing proceedings at the time and place hereinbefcre set forth; that the same was thereafter reduced to typewritten form under my supervision by means of computer-assisted transcription; and I do further certify that this is a true and correct transcription of my stenographic notes so taken.

Elizabeth E. Montgomery

ELIZABETH E. MONTGOMERY, RPR, CSR
Official Court Reporter