ORIGINAL

State of Ohio,)
) SS:
County of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

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COPY

Geraldine Frankhauser,)
)
Plaintiff,)
)
vs.) Case No. 502423
)
Solon Medical Center, et al.,)
)
Defendants.)

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Deposition of Robert Cirino, M.D., a defendant herein, called by the plaintiff for cross-examination, pursuant to the Ohio Rules of Civil Procedure, taken before Constance Versagi, Court Reporter and Notary Public in and for the State of Ohio, at the offices of Robert Cirino, M.D., 1611 South Green Road, South Euclid, Ohio, on Thursday, January 15, 2004, commencing at 2:11 p.m.

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APPEARANCES:

On behalf of the Plaintiff:

Kerry S. Volsky, Esq.
Hermann, Cahn & Schneider
500 Erieview Tower
Cleveland, Ohio 44114
216-781-5515

On behalf of the Defendant Sandra Chisar, M.D.:

Warren Rosman, Esq.
Weston, Hurd, Fallon, Paisley & Howley
2500 Terminal Tower
Cleveland, Ohio 44113
216-241-6602

On behalf of the Defendant University Hospitals:

Anne M. Kordas, Esq.
Tucker, Ellis & West
1150 Huntington Building
Cleveland, Ohio 44115
216-696-3215

On behalf of the Defendant Dr. Kundtz:

R. Mark Jones, Esq.
Roetzel & Andress
1375 East Ninth Street
Cleveland, Ohio 44114
216-623-0150

On behalf of the Defendant Solon Medical Center:

Juliana S. Gall, Esq.
Hanna, Campbell & Powell
3737 Embassy Parkway
Akron, Ohio 44334
330-670-7300

APPEARANCES CON'T:

On behalf of the Defendant Robert Cirino, M.D.:

Thomas Kilbane, Esq.
Reminger & Reminger
1400 Midland Building
Cleveland, Ohio 44115
216-687-1311

Also Present:

Geraldine Frankhauser

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ROBERT CIRINO, M.D.

of lawful age, being first duly sworn, as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION

By Mr. Volsky:

Q State your name for the record, please.

A Robert Cirino.

Q Dr. Cirino, my name is Kerry Volsky. We just met. We are here today to take your deposition in the case filed on behalf of the Frankhauser beneficiaries. I'm here to ask you questions here today. My intention is not to confuse you in any way. If you don't understand my question, please say so. I'll be glad to rephrase the question or do whatever else I can to make myself clear, okay?

A Yes.

Q You have to answer orally. Given the size of the room you have to keep your voice up so everybody can hear. We have to talk one at a time so Connie can take down what you and I are saying. If you forget, we will remind you, okay?

A Yes.

MR. ROSMAN: If I can pop in for one second. Dr. Cirino, my hearing is terrible. I've got both hearing aids in. I'm trying my hardest.

You really do have to speak up.

MR. KILBANE: Warren, maybe you ought to move closer.

MR. ROSMAN: I'm going to see how it is. If it isn't good, I'll move closer.

Q We're going to assume that if you answer a question, you understood what I was asking you. So you have to make sure you understand; is that fair?

A Yes.

Q What is your business address?

A 1611 South Green Road.

Q What city is that, South Euclid?

A South Euclid.

Q What is your home address?

A 29395 North Park Boulevard.

Q What city is that?

A Solon.

Q How long have you lived there?

A Three years.

Q Do you have any present intention of moving?

A No.

Q Doctor, what is your present professional relationship with USHC Physicians, Inc.?

A I'm employed by USHC.

Q How long have you been an employee of that

corporation?
A About four years now.
Q Do you have any type of compensation with that corporation, any type of contract with that corporation?
A Yes.
Q Do you have an employment contract?
A Yes.
Q Do you know who the shareholders of that corporation are?
A Myself and my partners.
Q So you have the same relationship to the corporation as all the other doctors working in the physical plant here?
A No. We're our own group.
Q I mean within your own group?
A Yes.
Q All of the doctors in that group are employees of that group and also shareholders?
A Yes.
Q Who are the officers of that corporation?
A We have four officers, a president.
Q Who is that?
A Stephen Rudolph.
Q What are the other officers?

A All the other officers are vice-presidents.
Q Who are they?
A The rest of my partners.
Q Are you a vice president also?
A I would be a vice president, yes.
Q How many shareholders physician are there in the group?
A We were at 10. We recently lost one. We are currently at nine.
Q Are you all equal shareholders?
A Yes.
Q You had the same relationship back in June 2002; is that correct?
A Yes.

MR. VOLSKY: Tom, we spoke off the record, you are going to provide me with all the insurance information?

MR. KILBANE: Yes.

Q Thanks.

Doctor, in reviewing the CV that was provided to me, I want to ask you some questions about some of the items you had listed.

Tell me about the program in clinical effectiveness certificate you received from the Harvard School of Public Health in 1993?

A It is an enrichment course taken in Boston for matters of public health, ethics, and statistics.
Q Did it have anything to do directly with your practice in internal medicine?
A No.
Q How long was the program?
A About two-and-a-half months.
Q Why did you decide to do that program?
A Enrichment.
Q You started in private practice in 1995; is that right?
A Yes.
Q In Chagrin Falls?
A Yes, it was.
Q Did you practice with anyone, or by yourself at that time?
A By myself.
Q Could you describe your practice during those two years?
A Meager. I was just starting out.
Q You were open for business, taking new patients, trying to build a practice?
A Yes.
Q Why did you leave that practice in Chagrin Falls?
A I was transferred.

Q By whom?
A By the people that I worked for at that time.
Q Who did you work for at that time?
A The UPCP physicians.
Q Is that the same one as -- what was the name of that corporation?
A UPCP.
Q All these initials get me confused.
A I understand.
Q Who were the physicians in that group?
A There is currently over 200 of them.
Q We're not going to go through them all.
You were an employee of that corporation back in 1995?
A Yes.
Q They set you up to start a practice in Chagrin Falls?
A Yes.
Q You did that for a couple of years, then they transferred you to Chardon in 1996; is that right?
A Yes.
Q You continued to work for them from 1996 to 1999; is that right?
A Yes.
Q Were you an employee of that corporation?

A Yes.
Q Practicing in internal medicine at that time?
A Yes.
Q Any subspecialties you were practicing at that time?
A No.
Q Now when you were in Chardon, did you practice with others, or by yourself?
A By myself.
Q That was the same type of practice, you had an office, you just attempted to get patients to practice internal medicine with?
A Yes.
Q Why did you leave in 1999?
A Because I was by myself.
Q You joined USHC Physicians, Inc. in 1999?
A Yes.
Q Do you remember when?
A Probably July 1st.
Q Did you come in as a partner on the same terms as the other physicians at that time?
A No.
Q Please explain to me what your original relationship was with that corporation when you first came there?

A An employee, but not a shareholder.
Q How long were you an employee, not a shareholder?
A It was either one year or two years.
Q Then you became a shareholder a couple years later?
A Yes.
Q Was that an equal shareholder with the other physicians?
A Yes, it was.
Q Originally you were a salaried employee?
A Yes.
Q When did you first receive the academic appointment at Case Western Reserve described in your CV?
A It would have been in the year 1993, 1994 academic year.
Q Are you still an assistant clinical professor?
A Yes, I am.
Q The CV that was provided by your counsel to me, do you know whether that is current or not?
A If I see the date on it.
Q Glad to show it to you.
A It would look to be.
Q I am sorry, if I hear your answer, you still are an assistant clinical professor at this time?
A Yes, I am.
Q Under the awards and appointments on your CV, it

lists that you've been an attending physician, general medicine and ambulatory practice at UH since 1994.

Can you please tell me what that is, and what would have been your job responsibilities?

A I precepted one of the clinics down there in the ambulatory medicine for people who do not have a physician.

Q What exactly is ambulatory medicine?

A Not inpatient medicine.

Q It's like a clinic?

A It is a clinic.

Q How often do you precept?

A Every Thursday for that entire time.

Q Are you compensated for those services?

A No, I'm not.

Q What is the primary care track program medical student core clerkship of which you are a clinical preceptor?

A A third year medical student will have some real life experience in a clinician's office. That is what I do.

Q They come to your office here on Green Road?

A Yes, they do.

Q So they just track you and follow you and see what

you do in your practice?
A Yes, they do.
Q When did you become Board certified in internal medicine?
A I believe 1993.
Q Did you pass the first time?
A Yes, I did.
Q Do you have any subspecialty certifications?
A No, I do not.
Q Do you have any other Board certifications of any kind?
A No, I do not.
Q Do you have any post doctoral training in emergency medicine?
A No, I do not. No.
Q Do you have any post doctoral training in cardiac care?
A No, I do not.
Q Have you ever had your deposition taken before today?
A Yes.
Q Can you tell me in what context you've had your deposition taken?
A I had a deposition several times as a witness.
Q A treating doctor witness?

A No.
Q What kind of witness?
A An expert witness.
Q How often have you served as an expert witness?
A Approximately 10 times over the past 10 years.
Q Have you ever had your deposition taken before as a treating physician?
A I believe so.
Q In these cases you served as an expert witness, you said it was about 10 times, were those malpractice cases?
A Yes, they were.
Q Can you tell me who the lawyers were that retained you to serve as an expert witness?
A I believe early on it was Arter & Hadden.
Q Who at Arter & Hadden?
A Kris Treu.
Q Anybody else?
A I don't believe so.
Q Any other law firm that retains you as an expert witness?
A One that is -- I'm sorry, it ends in Farchione. Sutter, O'Connell & Farchione maybe.
Q Yup. Mannion would be upset with you. You didn't include him.

Who in that firm retained you as an expert?
A Colleen Petrello.
Q Do you remember how many times you served as an expert witness for Miss Petrello?
A Perhaps twice.
Q Can you tell me what those cases were about?
A This is going back some. I believe one was a case of pulmonary embolism. I'm having some difficulty thinking of the other one. It was some time ago.
Q What about the cases on behalf of Kris Treu, do you remember what those were about, how many times you were asked to be an expert by Kris?
A This was in the early, mid 1990's, probably twice.
Q Do you remember what those cases were about?
A I vaguely remember something about medication infiltration from an I.V. site.
Q Do you remember the other case, what it was about?
A I think it was about administering eye drops.
Q Anyone else you've been retained as an expert witness by?
A Probably there is one more. John Wolanin. He's a private person.
Q Did he represent the plaintiff or the defendant?
A The plaintiff.
Q Do you remember what that case was about?

A I believe it was about a fractured wrist.
Q Have you ever been a plaintiff's expert other than this one case for Mr. Wolanin?
A No.
Q All other times it's been on behalf of the defendant; is that right?
A Yes.
Q Do you remember any of the plaintiff's lawyers involved on the other side of those cases?
A I'm sorry, I don't.
Q Do you remember what year or years the cases involving Miss Petrello were?
A It was in the 2000's.
Q Have you ever been sued for malpractice other than this case?
MR. KILBANE: Objection. Go ahead.
A I was named in a suit, yes.
Q When was that?
A 1993.
Q What was that case about?
A I was a resident physician in the intensive care and one of the patients there had something happen with his spine. I was named along with everybody else.
Q He sustained a spinal injury in the ICU?

A Something along those lines.
Q Who represented you in that case?
A I believe the hospital attorneys.
Q Do you remember who it was?
A I probably don't.
Q Do you remember the name of the plaintiff?
A Trinko.
Q Trinco, T-R-I-N-C-O?
A K-O maybe.
Q First name?
A I'm sorry.
Q Was that a Cleveland case, while you were at University Hospitals, or was it at one of your other residencies?
A No, my residency was here. I may be mixing up a name or the issue. I was dismissed from the case.
Q Did you ever give deposition testimony in that case?
A I don't think so.
Q Have you ever testified live in a courtroom?
A Yes.
Q When was that?
A It was that case.
Q In the Trinko case?
A Yes.

Q Have you ever testified live in a courtroom in any of the cases that you served as an expert witness?
A No.
Q So your only time testifying live was in that case in which you were named in the lawsuit?
A Yes.
Q Doctor, if you have a medical question that needs to be researched, are there any internal medicine textbooks or sources that you normally refer to?
A Depending on the question, there may be many different sources.
Q Is there one you use most typically?
A Not really.
Q Which ones do you use most often?
A I use several on-line sources.
Q What are those?
A Up-to-date, Harrison's on-line, Scientific American on-line.
Q Harrison's on-line, is that somehow affiliated with the book?
A I believe so.
Q Do you own Harrison's?
A Yes, I do.
Q Do you use it as a resource?
A Occasionally.

Q Do you have textbooks in your personal library?
A Yes.
Q What textbooks do you have in internal medicine?
A I probably have over 100 books.
Q What have you reviewed in preparation for your deposition here today?
A These records here in front of me.
Q Can I see what you have?
A Certainly.
Q What you've handed me is essentially three volumes of medical records relating to Joseph Frankhauser; is that correct?
A Yes.
Q When were you provided this information?
A Last week.
Q When did you review this information?
A Over the past week.
Q Do you know how Joseph Frankhauser first became a patient of yours?
A Yes.
Q Tell me how.
A I believe he was referred to me from his retiring from practice physician.
Q Who was that?
A Daniel Wolpaw.

Q How did you know Dr. Wolpaw?
A I worked with him in the clinic I attended.
Q Am I correct that the first time you saw Mr. Frankhauser was December 22, 2000? Please feel free to refer to your chart.
A Yes.
Q When seeing a patient for the first time, what was your practice as to what documents the patient would fill out at the initial visit?
A Registration form.
Q Would he or she prepare a detailed patient history?
A No.
Q Any other information or documents that the patient would fill out the first time they would come to see you as a treating doctor?
A I don't believe so.
Q Did Mr. Frankhauser fill out the document that you just described?
A Actually it goes into a computer, so it's not a written form.
Q I see.
A Name and address.
Q Just background information?
A Background information.
Q Is it medical information at all?

A No. Demographics.
Q That is the only thing you believe that Mr. Frankhauser filled out?
A I think so.
Q Did you receive or obtain any prior medical or hospital records of Mr. Frankhauser at the time of your initial examination?
A No.
Q Did you ever get the patient chart from his prior physician?
A No.
Q Included in the copy of Mr. Fankhauser's office chart that has been provided is something called patient information; do you see that page?
A Yes.
Q Who filled in the top part of that form?
A The demographic portion?
Q Yes.
A I don't recognize the handwriting. Could be one of my medical assistants or the patient himself. I'm not sure.
Q Who wrote in the words under allergies?
A I did.
Q Who prepared the problem list?
A I did.

Q Did you ever get grades in penmanship?
A Yes.
Q How were they?
A Pretty good.
Q You're kidding?
A No.
Q How did you obtain the patient's history which allowed you to prepare this problem list?
A From the patient.
Q So you took a verbal history from him at that time?
A Yes, I did.
Q Was that verbal history memorialized anywhere else other than the creation of the problem list?
A No.
Q Would you please read for me everything written in that problem list?

MR. KILBANE: Let me give you a caveat for reading anything. You probably are going to have him read a lot of his notes.

MR. VOLSKY: You bet.

MR. KILBANE: To make life easier for our court reporter, we have a tendency to read faster than we speak. That can be a challenge for her, especially with the medical terms. Read it slowly and read it verbatim. He just wants you to

read it at this point.

A Certainly. 12/00 psoriasis, (Lynch.) S/P melanoma (ear) EOCA, (Clayman) S/P EO/partial gastrectomy. S/P XRT/CMTX (Levitan). Colon polyps (Chak). Hyperlipidemia, gout, S/P BIH. Presbycusis, acne rosacea.

Q Lynch in parenthesis, does that mean he treated for that with Dr. Lynch?

A Yes.

Q The third reference I assume you are referring to esophageal cancer, Dr. Clayman was his treating surgeon; is that right?

A Yes.

Q The Levitan reference has to do with the treatment for the esophageal cancer; am I correct?

A Yes.

Q Do you know when Dr. Chak found or treated Mr. Frankhauser for colon polyps?

A I would have to look at the notes.

Q What notes?

A The notes of his colonoscopy.

Q You have status post BIH, what is that?

A Bilateral inguinal hernia.

Q What are the last two things?

A Presbycusis, hard of hearing. Acne rosacea, mild

blushing infection of the nose.
Q How did you determine that the patient had hyperlipidemia?
A By the laboratory result.
Q What laboratory result did you have which allowed you to list that as on the problem list in December of 2000?
A Only the one that he had previously drawn, either a month or several months before that.
Q You had access to that laboratory result?
A Only via the computer.
Q I see. It wouldn't become part of his chart necessarily. There was one laboratory result in here?
A I copied it down off the computer. It's on the next page. That was scratch writing.
MR. KILBANE: On the preprinted form you just went past, if you look in the top right-hand corner.
A I was writing off the computer screen.
Q Do you have access to all University Hospitals lab work that is done?
A Not all the time.
Q How does that work?
A After one to three years it's culled out. You are

no longer able to bring it up.
Q But if Dr. Levitan ordered blood labs during the time that you were also treating the patient, as long as it was within a year or two, you would have access to those labs on the computer?
A Most of the time. It depends where they were drawn at.
Q Did you prepare this problem list at the time that you were first talking to Mr. Frankhauser?
A Yes.
Q There is another preprinted sheet with USHC Physicians at the top, at the very bottom right-hand corner it says waiver XIS, do you see that page? I think you are open to it.
A Yes.
Q What is this document?
MR. JONES: Can I see what you are referring to?
MR. VOLSKY: Yes. At the very bottom. You got it?
MR. JONES: Yes.
Q Can you tell me about what this document is?
A I believe it's for uncovered Medicare services.
Q As far as getting a signature from the patient to pay for services not covered under Medicare; is

that what you are saying?
A I believe so.
Q What is the list of services on the left for?
A Those are some of the possible preventative medicine diagnostic codes from Medicare.
Q The numbers to the right, is that the charges for those services?
A Yes.
Q So it's kind of to show the patient the type of things that he might be responsible for?
A A generic typical idea, yes.
Q Any reason why Dr. King's name is at the top left?
A We all shared the same Medicare number, so we all have the same sheets. No particular reason that day.
Q Now the notations you referred to are the lab values up in the right-hand top part of the form; is that right?
A Yes.
Q Do you know when you attained these lab values?
A Either while he was there, or soon after that day.
Q Please tell me what you wrote and what the abbreviations and numbers signify?
A There is an upward curving line that has several numbers on it; 139, 100 and 14 across the top. Is

sodium chloride and BUN number. There is a creatinine, which is 1.1. Glucose which is 79, and the rest didn't copy well.

Q There are some other numbers and letters to the right?

A UA which is uric acid, 7.0. Cholesterol, CHO, 221. TG, triglyceride, 266. PSA, 1.3.

Q Based on your standard practice, do you believe there are any other records or documents relating to this patient filled out on the December 22nd of 2002 visit that is not in the chart in front of you, other than the office note that we're going to get to?

A Only what would have between entered into the computer demographic-wise.

Q No other significant medical information?

A No.

Q If you would refer to your office note, please. Who filled out the top information on that sheet for December 22, 2000?

A Again, looks like the same handwriting as patient information. My guess would be the medical assistant.

Q Who is your medical assistant?

MR. KILBANE: Now we're back in

2000.

Q I believe the initials are JR?

A That would have been Julie Reich.

Q R-E-I-C-H-T?

A I don't believe there is a T at the end.

Q When you say medical assistant, what is her education and training?

A Medical assistant training.

Q Not a nurse?

A Not a nurse.

Q Is that a two year certificate degree you get to be a medical assistant?

A I'm not sure.

Q What does CCNPT stand for?

A Can you tell me where you are looking?

Q Right under weight.

A CC, chief complaint, new patient.

Q New patient, got you.

Was the medical assistant's involvement in the care just to get this type of information that was written here?

A Yes.

Q Doctor, now I would like you to go through and read for us what this note says in its entirety. To the extent you can, do it in the order in which you

wrote it, if you know.

A That would not be possible. There is most likely a lot of skipping around that occurs.

Q Why don't you go through it in any organized way that you find appropriate.

A 12-22-00. Weight: 189. Pulse, P: 64. BP, 120/80. CC:NPT, new patient. MPFFT, met patient for first time. SUFS, see updated front sheet. Former, Dr. Wolpaw.

Q What is the front sheet? Is that the patient information sheet?

A Um-hum.

MR. KILBANE: So the transcript is clear later when we read it, do you want him to translate these abbreviations as we go?

MR. VOLSKY: Absolutely.

MR. KILBANE: I didn't want the record be at odds with what is here, because he's not dictating verbatim. He's going to translate for you.

Q Right.

A Until he moved to VA. Longstanding association with Ireland Cancer Center for esophageal carcinoma. Doing remarkably well. No chest pain/shortness of breath. No side effects status

post XRT.
Q Meaning what?
A X-ray therapy. Never has had thyroid rechecked after XRT. Bowels are okay. No prostate symptoms. Only new complaint is increased elbow pain, fell on it at golf course. Right elbow/fall. Former Dr. Wolpaw patient, Douglas Moore.
Q Patient Douglas who?
A Former Dr. Wolpaw patient, Douglas Moore is the name of the clinic.
Q How do you spell Moore?
A M-O-O-R-E.
Q Thank you.
A Continuing down the left margin. Social history, alcohol/rare. Tobacco, quit 12 years ago, pack per day times 40 years. Under that family history. Sister/hypertension, osteoarthritis. Sister/healthy. Mother/died of CVA, stroke, obesity, high blood pressure. Father died of congestive heart failure, ASCBD. Son/healthy.

Prevention, colonoscopy. Was down to 165 (was 213) prior to chemotherapy. Would like to weigh around 190. Flu shot 2001. DRE, digital rectal exam, Dr. Levitan this year.

Back up to the examination. Vital signs noted. Alert and oriented times three. Normal cephalic, atraumatic. Pupils equal, round and reactive to light and accomodation/extraocular movement intact, naris/without discharge. Oropharynx/benign. Tympanic membranes/normal bilateral. External auditory canals clear. No ACPCPA nodes, meaning lymph node tracts. No thyromegaly. No JVD or bruits. Skin, acne rosacea. Psoriasis plaque on scalp. Actinokeratosis on left forearm. Psoriasis plaque also on right calf. Chest clear to ascultation and percussion. No wheezing or crackles. Cardiovascular regular rate and rhythm, S1, S2 without murmur, gallop or rub. Spine, normal curvature. Negative straight leg raise, negative log roll. Negative SI joint tenderness.

Abdomen, normal active bowel sounds, soft, nontender. No hepatosplenomegaly. No rebound or guarding. No general adenopathy. Extremities, no clubbing, cyanosis, or edema. Normal distal pulses. Deep tendon reflexes 2 plus throughout.

Back up on the right-hand side, musculoskeletal; right elbow normal range of motion. No bursal swelling. Mild tenderness at

lateral epicondyle.

Impression: Hyperlipidemia, tendinitis, GERD, gout.

Plan: Labs reviewed from University Hospitals. Advise on decrease eggs and decrease uric acid. Increase exercise. Advise on diet/saturated fats. EKG in the future. Refuse blood work today. Will need to check TSH at some point. Range of motion for elbow, Tylenol okay. Try to avoid NSAIDs. Recheck three months, based on labs. Signature.

Q What is over to the left at the bottom?

A Check uric acid, check cholesterol.

Q You said something about THS?

A TSH.

Q I'm sorry. What is that?

A Thyroid stimulating hormone.

Q What was the significance, if any, of this patient's family's cardiovascular history?

A Could you be more specific?

Q Did it have any significance to your care and treatment of him?

A It's part of the initial information that is there.

Q Does it put him at increased risk for cardiovascular disease?

A Not necessarily.
Q Given his family history, his 40 pack-year smoking history and hyperlipidemia, how would you describe Mr. Frankhauser's cardiac risk at that time?
A Average for an adult male.
Q How would you describe his overall health at the time?
A Fairly good.
Q He was an active individual?
A Appeared to be.
Q Were you aware that he was still working as an accountant?
A I'm not sure.
Q Were you aware that he was physically active playing golf and tennis?
A I did write there that he injured his elbow at the golf course.
Q Did you ever become aware he began playing baseball again?
A Not directly.
Q Did he have any active or ongoing health problems?
A At this time?
Q Yes.
A Follow-up of his esophageal cancer.
Q Do you recall any other discussions, events, or

treatment rendered on this visit, other than what is reflected in the chart?

A Nothing offhand.

Q Do you recall whether or not Mrs. Frankhauser was with him this visit?

A I honestly can't remember.

Q Now the chart includes a letter that you wrote to Mr. Frankhauser dated December 30th; is that right?

A Yes.

Q It indicates at the top that this letter was mailed on January 3, 2001?

A Yes.

Q Do you know how it was mailed, since this copy did not have a full address on Mr. Frankhauser?

A In an envelope.

Q But his address wasn't on here?

A Right. It would have been on the outside of the envelope.

Q Now your next involvement with Mr. Frankhauser was on March 23, 2001; is that right?

A Yes.

Q Again I'm going to ask you to please read the entire entry.

A 3-23-01. Weight: 191. Blood pressure: 130 over 80. Chief complaint: Right elbow pain.

Occasional twinge of right elbow pain with lying down or occasionally with use. No further injury. Works with outstretched arm on typing machine. Right-handed. Also with post nasal drip. Vital signs noted, positive chorisa.

Q What is that?

A Redness to the eye. Tympanic membranes normal bilaterally. External auditory canals, large amount of cerumen removed from right. Oropharynx benign. Naris clear discharge. No AC nodes. Chest clear to auscultation and percussion. No wheezing or crackles. Right elbow: Normal appearance, full range of motion. Tender with hand grip at posterolateral elbow and pronation. That is turning the hand over. Lateral epicondritis. Post nasal drip and sinusitis was the impression. Plan; Duratus GP one half tablet, p.o. day or twice a day as needed. Sample was given. Celebrex, 200 milligrams, q day, as needed. Sample was given. With food only. If no relief, consider MRI, local injection, ortho (wants to play golf.) Tennis elbow band. Recheck as needed for this. Signature.

Q Am I correct this visit was only related to the elbow problem and some nasal discharge?

A Yes.
Q Were there any other health issues discussed on this visit?
A There could have been.
Q You don't recall any?
A I don't recall.
Q You have no information or anything in writing which would evidence any other topics or complaints or problems?
A No.
Q Do you recall anything about this office visit other than what appears in the office note?
A Not particularly.
Q Your next involvement was June 11th of 2001; is that right?
A Yes.
Q Would you please read that entire entry?
A Certainly. Temperature: 97.8. Chief complaint: URI, several days of sneezing, drainage, cough nonproductive, but yellow green nasal discharge. Vital signs noted, positive chorisa.
Q What is that?
A Redness to the eye.
Q I'm sorry, I asked you that before.
A That's okay. Tympanic membrane normal

bilaterally. External auditory canal clear. Naris, copious drainage, oropharynx posterior streaking. No AC nodes.

Goes to the next page. Dated again, 6-11-01. Chest clear to auscultation and percussion. No wheezing. No sinus tenderness. Impression: Sinusitis. Plan: Tequin 400 milligrams, every day for five days. Sample given. Allegra D, one twice daily. Sample given. Aspirin or Tylenol okay. Recheck as needed. In the margin going to Montana next week.

Q What does it say under the date up at the top?

A Continued.

Q This visit was related only to an upper respiratory infection?

A Yes.

Q You are unaware of other health issues that were discussed?

A Unaware.

Q You have no recall of this visit beyond what appears in the note?

A Not in particular.

Q Anything generally that you recall?

A Many things transpire during a visit.

Q If you remember anything, I want to hear about it.

A If there was anything specific I would let you know.
Q In reviewing the chart, since the prior visit you had received a copy of an outpatient note from Mr. Frankhauser's treating oncologist, Dr. Levitan, dated 4-23-01. Would you refer to that, please?
A Certainly.
Q Prior to receiving this note or letter from Dr. Levitan, what information did you have concerning this patient's history of esophageal cancer, treatment and follow-up care he had received?
A I believe this was one of the very first documents I received.
Q So, are you aware of any other documentation or medical records or anything dealing with Mr. Frankhauser's prior medical problems, before receiving this note from Dr. Levitan dated April 23, 2001?
A This is my entire chart.
Q Did you at any time speak to Dr. Levitan about Mr. Frankhauser at any time, including after his death?
A I believe I called his office to inform him of his death.

Q Did you remember talking to Dr. Levitan about his death?
A I don't believe he was in at that time.
Q So what did you do?
A I left a message with his secretary.
Q Did you speak to Dr. Levitan about Mr. Frankhauser at any time?
A I don't believe so.
Q Am I correct you didn't ever receive any other records or documents concerning Mr. Frankhauser's care, treatment and follow-up for esophageal carcinoma other than a copy of the office notes sent by Dr. Levitan, which are included in the patient chart?
A Yes.
Q Did you ever speak personally at any time, including after Mr. Frankhauser's death, with Dr. Chak?
A Yes.
Q Please tell me about that.
A I called him to try to arrange the upper endoscopy.
Q That was days before his death. We're talking in June of 2002?
A It would have been the same day I saw him.
Q Tell me about that conversation.

A I asked him if he could do an upper endoscopy on Mr. Frankhauser.
Q He agreed to do that?
A Yes.
Q Did you tell him why?
A Yes.
Q What did you tell him?
A That he felt like he had something stuck in his throat.
Q Anything else you told him?
A He probably knew the history as well as I, or better than I, having treated him for a longer period of time.
Q My question is just did you provide him with any other information other than what you just described?
A Perhaps I gave him some for information.
Q Did you recall?
A The details, not exactly.
Q Please understand I'm trying to find out what you remember and what you don't.
A I understand.
Q If you don't remember, that is okay.

Did you ever have any other conversation with Dr. Chak at any time concerning

Mr. Frankhauser, even after his death?
A Yes, after his death I let him know also he had passed away.
Q Did you speak to Dr. Chak about it?
A I did speak to Dr. Chak.
Q Please tell me everything you remember about that conversation.
A I asked him what the endoscopy had showed. Let him know he had passed away.
Q Did you know the cause of death at the time you found out he passed away?
A No.
Q Did you discuss anything else with Dr. Chak concerning the circumstances surrounding Mr. Frankhauser's death?
A I can't recall.
Q Did you ever receive any records relating to the care rendered to this patient by Dr. Chak, other than the EGD procedure report dated June 20, 2002 which is in the patient's chart?
A I believe that is all that I have from Dr. Chak, along with the pathology report.
Q Did you ever speak personally at any time with Dr. Clayman about Mr. Frankhauser?
A I don't believe so.

Q What about Dr. Daniel Wolpaw, did you ever speak to him about Mr. Frankhauser at any time?
A I didn't see him very much after that. Perhaps not.
Q I'm not talking just at the end, at any time?
A That's what I meant.
Q Dr. William Lynch was also a treating doctor for the psoriasis; is that right?
A Yes.
Q Do you remember ever speaking to Dr. Lynch about Mr. Frankhauser?
A I don't believe so.
Q Dr. Donald Shina, do you know who Dr. Shina is?
A I know who Dr. Shina is.
Q What is his specialty?
A Radiation oncology.
Q Did you ever talk to Dr. Shina about Mr. Frankhauser in any way you recall?
A No.
Q You next saw the patient on October 31, 2001?
A Yes.
Q Once again I ask that you read the entire note for me.
A Certainly. 10-31-01. Weight, 185 and a half pounds. Temperature, 36.8. Sick visit.

Q What happened to the BP, there a slash through it?
A Slash.
Q What does that mean?
A Crossed out. Sick visit, drainage from nose times several days to week with low grade fever. Cough, nonproductive. No chest pain, or shortness of breath. Throat, sick. Vital signs noted.
Q Is that throat is okay?
A Throat is okay. I'm sorry. Vital signs noted. Alert and oriented times three. No chorisa. Tympanic membranes normal bilateral. EAC's clear of cerumen. Naris, clear, to white discharge. O/P, oropharynx is benign. Sinus tenderness bilateral frontal with decreased transillumination. Chest clear to auscultation and percussion. No wheezing or crackles.

Impression: Sinusitis. Plan: Increase fluids, Tequin 400 milligrams, five day course of therapy. Given samples. Helped the last time. No allergy symptoms. Will also use Zephrex LA, one half to one tablet p.o. twice daily, number 20, prescription. No refills. Tylenol p.r.n., recheck as needed. In the left-hand margin, CT scan negative, (saw Dr. Levitan last week, had flu shot.)

Q Again this visit was only related to an upper respiratory infection or sinusitis problem?
A That is what he made the appointment for.
Q Your diagnosis was sinusitis?
A Yes, it was.
Q Any other health issues discussed that you recall?
A There could have been.
Q Do you remember any?
A Not offhand.
Q Any recall of this visit beyond what appears in the note?
A Well, evidently if I had written in the left-hand margin some things about CT scan, there was probably several other things we talked about that day.
Q Do you remember what they were?
A Again, not specifically.
Q Would you assume that it dealt with the follow-up for the esophageal cancer?
A That could have been one of the things.
Q Any other things that you recall being discussed or any problems?
A Again there could have been several other things.
Q I'm trying to find out what you remember.
A Again, nothing in particular.

Q Your next entry in the chart documents a phone call to the office on June 17, 2002; is that correct?
A Yes, it is.
Q Are you aware of any contact between Mr. Frankhauser and you or your office between October 31, 2001 and June 17, 2002?
A I don't believe so.
Q Are you aware of any health problems or treatment Mr. Frankhauser received between those two dates?
A Yes.
Q What are you referring to?
A I received a letter from Dr. Levitan on 11-1-01.
Q What is the date of that letter?
A The date of the letter is 10-25-01. In addition, on 5-13-02 I received a letter from Dr. Levitan, dated 5-2-02.
Q You also received a letter that was dated 6-13-02, you did not read it until 6-30-02; is that right?
A I did not receive it until 6-30-02.
Q As far as this reference in your chart on June 17, 2002, do you know, or can you tell from the note of the phone call, whether or not you spoke to Mr. or Mrs. Frankhauser on that day?
A I cannot tell from the note. I don't believe it was I who spoke with either.

Q You have no recollection of speaking to them?
A That would be correct.
Q Is it your assumption that it was the person who wrote this in the chart that spoke to either Mr. or Mrs. Frankhauser?
A It could well have been.
Q Is that the normal practice?
A Several different practices. Sometimes people may call, ask to speak with me. Sometimes they leave a message on the phone. Sometimes they speak with the assistant who will come to me, ask a question, go back to the patient, give them some sort of idea what to do. Could have been any one of those three. There is no way to tell.
Q Under all three of those scenarios, is it the standard practice of the office for -- if it was the medical assistant, that is what we're talking about here, the JR initial again, Miss Reich?
A Yes.
Q Under each of those scenarios would it be standard practice for Miss Reich to inform you if there was a phone massage or she spoke to the patient, what the call was about before putting it in the chart?
A There is no standard. Most of the time people work together to communicate things that happen in the

office that day.
Q Do you have recollection of the circumstances surrounding this phone call?
A Not in particular.
Q So as you sit here today, do you know whether or not you were aware that they had called with these complaints and that they were going to the University Hospitals emergency room?
A The same question I just answered. Unsure which of those scenarios was played out that day.
Q Do you know when you first learned that Mr. Frankhauser had been complaining of chest pain with pain radiating down both arms, was going to the University Hospitals emergency room?
A Would have between the time of 6-17 and 6-18-02.
Q Do you know how you learned of that event?
A Again, from the 6-17 event that transpired in the office that day, 6-18 from the emergency room.
Q Would it be standard practice if Miss Reich entered a notation like this in the chart, that she would leave the chart out so that you would see it?
A I don't believe there is any standard for that. We do like to document a lot of different things in the course of a day.
Q Is it possible under the procedures in your office

that she would have entered in the chart, then put the chart away?

A Anything is possible. Is that probable, I'm not sure. I don't think.

Q What would be probable based on normal routine?

A That she might have asked me about this, what to do. Then that message was transmitted back.

Q What is the significance of pain radiating down both arms in a chest pain patient?

MR. KILBANE: Objection. Go ahead.

A It's uncertain. It's a very nonspecific complaint.

Q Did you ever become aware that Mr. Frankhauser had been to the Solon facility emergency room on June 18th -- I'm sorry, June 16, 2002?

A Before he passed away I do not believe so.

Q You didn't know that?

A I don't believe so.

Q How did you learn after his death?

A By looking at these notes.

Q Which notes are you referring to?

A The notes I have in front of me.

Q I see you are talking about you didn't know that until the last week or so?

A No, obviously it had come out before then in conversations. This was the first time I was

actually able to see that visit.
Q Did you know before this lawsuit was filed that Mr. Frankhauser had been to the Solon emergency facility on June 16, 2002?
A I'm honestly not quite sure that I knew that.
Q So I'm correct that you, prior to this lawsuit, were unaware that the Solon emergency room doctor wanted Mr. Frankhauser seen by his primary care physician as soon as possible for the workup of both GI and cardiac?
A I don't know how I would have known that.
Q Do you remember receiving a call from a Dr. Kundtz from the University Hospitals emergency room?
A I believe so.
Q Did you know Dr. Kundtz before that call?
A Probably just in interacting with patients, but not any different than any other emergency room physician.
Q Did you know who he was?
A I knew he was an emergency room physician.
Q Because he told you, or because you knew beforehand that he was working in the University Hospitals emergency room?
A I'm not quite sure that makes any sense.
Q Then I'm not asking the question properly.

I'm trying to understand whether when he called up and said I am Dr. Kundtz, did you know who that was?

A Well, he worked in the emergency room.

Q You knew that?

A Well, if the number on your pager in the emergency room number, we're all too familiar with that.

Q Would you have known Dr. Kundtz if you had to identify him at that time?

A Even if I had to identify him today, I'm not quite sure I would know who he is.

Q Fair enough.

How common is it for an emergency room doctor who worked up a chest pain patient to call that patient's primary care physician, to discuss the results and agree upon a plan?

MR. ROSMAN: Objection.

A I can't speak for other emergency room physicians, but I would say some of the time.

Q Do you recall the conversation you had with Dr. Kundtz that day?

A I do recall some elements of it.

Q Why don't you tell me everything that you remember about the conversation.

A That there was this idea of some sort of chest

discomfort that was not very well characterized. That they couldn't come up with anything definite on. He called to inform me of the findings they had at that point in time.

Q Do you remember what findings he told you about?

A I believe he told me about his electrocardiogram. Most likely a chest x-ray. The blood work.

Q What did he tell you about each of those things?

A That they were normal.

Q Did he tell you what specifically Mr. Frankhauser's complaints were in the emergency room?

A Again, mentioned vague type of epigastric sort of discomfort.

Q Did he mention that the pain was also radiating up to his arms bilaterally?

A He could have.

Q Do you recall whether he did or not?

A Specifically, it's very difficult to remember every exact detail.

Q I'm not intending to imply that you should. I'm trying to find out if you remember one way or the other, okay?

A Certainly.

Q I take if from your prior answers that he did not tell you that the patient had been to the Solon

emergency room with similar complaints the day before?

A It's very likely he didn't mention that, or there is also a small possibility he could have mentioned that.

Q You don't remember one way or the other?

A Not definitively.

Q What did Dr. Kundtz tell you about the EKG results?

A That they were negative.

Q Anything else that you recall?

A Not much.

Q What was Dr. Kundtz, based on your understanding, attempting to accomplish by performing an EKG and doing the lab work?

MR. JONES: Objection.

A Communication.

Q Was he trying to rule out anything specifically?

MR. JONES: Objection.

MR. KILBANE: Objection.

A I'm sure he was doing a good job of assessing the patient and his symptoms.

Q Why would you do an EKG?

MR. JONES: Objection.

MR. KILBANE: Objection.

A EKG is quite honestly done many times when people

present to the emergency room with almost any complaint, quite often.

Q Were any enzyme tests done to attempt to rule out myocardial infarction?

A I believe so.

Q Did he inform you of his differential diagnosis?

A I'm probably sure he discussed a number of different things.

Q What do you recall that he discussed?

A Again, history of esophageal carcinoma. The fact of the vagueness and that could lead to a number of different possibilities, none which are very specific. He obviously mentioned about the EKG that was done was negative. Fairly certain he mentioned about things that have to do with the heart.

Q That was one of the things he was attempting to determine, whether it was a cardiac issue?

MR. JONES: Objection.

A Perhaps.

Q Was that your understanding, based on your conversation with Dr. Kundtz?

A Again the conversation is sort of a summary of everything that might go on during the visit. I can't speak for Dr. Kundtz and his assessment at

the time.

Q What I'm asking you is your recollection. Rather I'm not asking you to assume what Dr. Kundtz thought. I'm asking you to characterize your understanding of your discussions with Dr. Kundtz.

My question is, during that discussion, did you reach a conclusion as to what Dr. Kundtz's differential diagnosis was?

A No, no conclusion was reached.

Q You don't recall him indicating to you his diagnosis was atypical chest pain?

A Atypical chest pain is a very generic diagnosis for anything in the chest. That is why it's called atypical.

Q If you would, please read for me the first note at that the bottom of this page dated 6-18-02.

A Yes. Spoke with ER (negative EKG during pain.) Give sublingual nitroglycerin as trial; follow-up in office for GI evaluation. Had CT/labs, April '02/positive pulmonary nodule.

Q Who prescribed the nitroglycerin?

A If there was nitroglycerin prescribed, obviously it would have to come from the person who is actually seeing the patient that the time, if that was the case.

Q Do you recall discussing with Dr. Kundtz prescribing nitroglycerin for Mr. Frankhauser?
A Again, that very well could have come up during the conversation. That is a fairly typical thing to do in some cases.
Q The fact that you knew that -- it talks gives sub --
A Lingual.
Q Nitroglycerin. When you phrase it that way, do you know what you meant, is that a recommendation that you had to Dr. Kundtz?
A That is unlikely that somebody on the telephone would tell someone who is actually seeing the patient and assessing him and treating him what the therapy should be.
Q I'm trying to ask you if you can interpret the note. Tell me whether you putting it the way you did means anything to you as to who ordered it and whether it was discussed?
A Again, since obviously these events happened the day before, I don't take the person's chart home with me every night, not knowing who, like now, we'll be getting a call from and such, the tenses of the verb could be from the night before or in recollection and such. Could equally be gave

sublingual nitroglycerin as a trial. I think it's an inconsequential part of it.

Q Did you and Dr. Kundtz discuss the value of giving nitroglycerin to this patient?

A It's possible we could have discussed that in general as one might normally do in that type of situation where you are uncertain what exactly is going on.

MR. KILBANE: We've been going an hour and a half. Is this a logical stopping point?

MR. VOLSKY: Not quite.

MR. KILBANE: He has to return a page.

THE WITNESS: I'll be fine.

Q You're posing your answers in terms of maybe and could be. I'm really asking you if you recall. If you don't, you tell me you don't.

Do you recall discussions with Dr. Kundtz this issue of prescribing nitroglycerin to this patient?

A Again the exact circumstances probably can't possibly be rendered for sure. It was a while ago. It happened when there wasn't immediate documentation available. Documentation helps you

to remember most of what goes on during the time.
Q Do you recall one way or the other? If you don't, tell me you don't.
A Again, the subject of nitroglycerin came up, there had to be some recollection. Specifically I'm not sure.
Q Why would nitroglycerin be given in this type of patient, with these types of complaints?
A There is probably a couple of different reasons. One is if you are looking for a response to treatment, it might help to know what is going on a little bit better. Not a very good diagnostic test. Certainly not a reliable one.
Q Do you know why the nitroglycerin was prescribed to this patient?
A If one is trying to determine whether there was chest pain that was due to certain etiology, you might give a nitroglycerin tablet, see if there is any response to it. See if there is any likelihood there can be something for instance like esophageal spasm, something cardiac, or some other reason.
Q Is it your testimony that nitroglycerin is given for esophageal spasm?
A Sometimes nitroglycerin is given for esophageal spasm.

Q Is that an appropriate use of that drug based on the PDR?
A Again, a lot of times you treat persons because they have symptoms, so you use medication that helps people. We can look in the PDR if you want for specific indications.
Q Do you know whether or not the PDR indicates a specific use of nitroglycerin for esophageal spasm?
A I would not know.
Q Have you ever prescribed for a patient nitroglycerin for esophageal spasm?
A I believe so.
Q It's also given to alleviate the symptoms of cardiac ischemia, is it not?
A Yes, it is.
Q Do you recall discussing with Dr. Kundtz the time frame in which he was going to tell the patient he needed to see you?
A Not exactly.
Q Do you recall why your note indicates that the patient was to follow-up in your office for a GI evaluation only?
MR. JONES: Objection. Doesn't say that.
A I don't believe it actually says that.

Q Says to follow-up in your office for a GI evaluation.
A Um-hum.
Q Why was it limited to a GI evaluation?
MR. JONES: Objection.
MR. KILBANE: Objection.
A I don't see where it says limited.
Q Where did it come from if you recall your discussions with Dr. Kundtz, which led to you indicating in your note that he was going to come to the office for a GI evaluation?
A I'm sorry, can you say that one more time?
Q Do you want to take a break?
MR. KILBANE: Yes. Are we halfway there, if we have 15 minutes.
MR. VOLSKY: Not 15 minutes. Way more than halfway.
MR. KILBANE: Let's take a break. You can return your page.
(Recess taken.)
Q Dr. Cirino, did Dr. Kundtz and you discuss in your telephone conversation the possible causes of Mr. Frankhauser's symptoms?
A I thought we covered that, sure.
Q Tell me what you remember being discussed as the

possible causes?
A I think we mentioned a number of different causes in what you called before a differential diagnosis.
Q Did you discuss the fact that it could be epigastric in nature?
A It's possible.
Q Do you remember whether you discussed it with Dr. Kundtz?
A Again, we spoke about many things quite a while ago. It's possible we could have spoken about that. You have to understand that direct recollection may not always be entirely possible.
Q I understand that. You have to understand that I am trying to get your answer as to whether you have a recollection. I'm asking you now whether you specifically recall discussing various possible causes for Mr. Frankhauser's symptoms with Dr. Kundtz, that is basically a yes I remember, or no, I don't remember, or no, we didn't.
A Again, there is -- I wish you could just answer yes or just answer no. It would be 100 percent on everything. Yes, in general we talked about the different causes.
Q Did you discuss cardiac as being a possible cause?
A I think I answered before when you asked the same

question, that since we hadn't discussed the EKG and the blood levels, yes, we had discussed some cardiac causes.

Q Do you know why your note says that the patient is to follow-up in office for a GI evaluation?

A As you recollect and reconstruct these things, at the time that was one of the things that needed still further attention.

Q Is it your testimony that Dr. Kundtz told you that he felt that the only workup needed was a GI evaluation?

A Again, I believe we had covered that, that there was no recollection here at all that anything was limited.

Q Dr. Kundtz did not indicate that he had ruled out coronary artery disease as a possible cause, did he?

A I can't speak for Dr. Kundtz.

Q I'm asking you what you recall about your conversation. Did he indicate to you that he had ruled out for himself coronary artery disease as a cause of Mr. Frankhauser's symptoms?

A I'm not sure that he could have said that.

Q I don't know what that answer means.

MR. KILBANE: He wants to know if you

have a recollection of that or not.
A Again, people don't talk in these definitive terms when they are communicating a visit and such. It's not like you repeat the entire visit between the two in this case physicians speaking. So, hardly any time can you definitively rule in or rule out anything in such a simple visit.
Q Did Dr. Kundtz indicate to you that he did not believe it was a coronary problem?
A I really couldn't say.
Q You don't remember him expressing any opinion one way or the other?
A No, I couldn't say what that opinion was.
Q We're going in circles.
A It's a circular question somewhat.
Q It seems a specific question.

Do you have a recollection of Dr. Kundtz indicating to you that he did not believe that Mr. Frankhauser's symptoms were coronary in nature?
A I'm sorry, there are too many negatives in there. The answer to that would have to be no, I can't recall when asked that way.
Q Do you recall discussing the issue of whether or not Mr. Frankhauser's problems were coronary in nature?

A I believe for the fourth time we might have mentioned about again the EKG, definitely the issue of some sort of coronary problem came up within a differential.

Q So coronary was still on the differential?

A Neither had anything been ruled in or ruled out.

Q It was still not ruled out yet, the coronary was still on the differential as a possibility?

MR. KILBANE: Objection.

A Again, I'm not sure there was a differential that was written down. This is again communication about possible causes of things that have to do with this visit. There are quite a number of possible causes.

Q When did you write this note dated 6-18-02 concerning your conversation with Dr. Kundtz?

A I believe it was 6-18-02.

Q Do you know when you spoke to Dr. Kundtz, was it on 6-18-02?

A If Mr. Frankhauser was in the emergency room and discharged from the emergency room on 6-17-02, then it would have been spoken with on 6-17-02.

Q You made the note the next date?

A I think we covered this. We don't bring every patient's chart home each evening. The only time

to document it would to be the next day.
Q Okay. I'm not casting aspersions on it. I'm trying to get an answer as to whether that is what you believe happened. That you got the call on the 17th, you believe it was in hours after -- other than office hours. When you got in the office the next day, you wrote it in the chart?
A Sounds perfectly reasonable.
Q Is that your testimony?
A Yes, it is.
Q Thank you.
Do you have an independent recollection of Mr. Frankhauser's office visit on 6-18-02 beyond what is in the note?
A Certainly.
Q You have an independent recollection of this visit?
A Yes.
Q Do you remember whether or not Mrs. Frankhauser was present during that whole visit?
A I can't be certain. I would think so.
Q Now what history do you recall being given that day, on the 18th of June 2002?
A I recall a lot from what I have here. In that there was some vague type of discomfort. It was not completely characterized. A lot of questions

asked to try to elucidate the cause of the symptoms.

Q What were the questions asked, what were the answers?

A Many of the questions asked had to do with items such as feeling of food stuck in the throat. What would cause the food stuck in the throat. What kind of food it was, when it was. How much it was. How long it lasted. Basically the sort of review of symptoms of the complaint of this feeling of epigastric discomfort.

Q Do you recall what answers Mr. Frankhauser gave as to all the questions that you just listed?

A I recall some of the answers that he gave.

Q Tell me what you recall.

A Again, if the question was posed what does it feel like, the answer was feels like food stuck in the throat. If the question was did you throw up, the answer was no. If the question was nausea, was that present, the answer was no. Was there fever, the answer was no. Was there a lot of excessive gastric juices in saliva, the answer was yes. Was it worse with a deep breath, the answer was no. Was he having any symptoms at the time I saw him, the answer was no. I'm sure there were others.

Q Did you discuss whether the symptoms he was telling you about now were any different that the symptoms he told you about previously?
A I'm not certain. Which do you mean previously?
Q Previously in the last few days?
A The last few days, again it would be reasonable that if I was asking about what had happened recently that these would be consistent with what he told everybody else.
Q Do you have a specific recollection one way or the other whether that was discussed?
A Again, what was discussed.
Q As to what type of symptoms he had complained of over the last several days?
A I guess I would say that he would have no reason to tell me any differently than he did anybody else.
Q That is the assumption you made?
A Certainly that is an assumption.
Q Did you ask him about what type of pains and problems he was having over the last several days, what he did about it?
A Well, of course.
Q Did you ask a question which elicited an answer he had been to the Solon emergency room the day before he had been to the University Hospitals emergency

room?
A I'm not sure if that came up.
Q So you had no information as to the recommendations which had been made by the emergency room doctor in the Solon emergency room two days before?
A If the patient himself hadn't volunteered that information, I would have really no other way of knowing.
Q Did you have any discussion about what medications he had taken?
A We talked about the Prilosec medication he was taking.
Q Did you talk about the nitroglycerin that was referenced in the prior note?
A I'm not sure that I knew any results and/or recommendations about the nitroglycerin as he came in that day.
Q Did you ask him whether he had taken nitroglycerin as prescribed in the note, as referenced in your note that same day?
A Again, A, I'm unsure he actually got the nitroglycerin because this is neither an order nor anything else. B, if there was a prescription, I neither knew if he actually got it, or took it.
Q Did you ask him?

A I'm quite certain that when I'm asking somebody as I would normally do about various symptoms that have to do with the epigastric or chest pain, I would ask them if they received any prescriptions or took any prescriptions or were given any medicines, that would be fairly usual.
Q Do you remember asking that question?
A I can't say that I actually directly do.
Q Can you tell from your note whether there is any information in there that the issue of the receiving and taking of nitroglycerin and the patient's response to that medication, is at all referenced in the note that you wrote?
A Objectively there is no reference to it here.
Q You don't recall a discussion about Mr. Frankhauser taking three tablets of nitroglycerin because the directions weren't clear, you expressed that this was too much to take?
A I can't recall that.
Q Did you perform or order any test during this visit on June 18th?
A I asked him to have an upper endoscopy done.
Q Did you perform any other test?
A Not a test, no.
Q Did you do an examination?

A Did an examination.
Q Tell me about the examination that you did.
A Vital signs noted, not in distress, swallows normally. Abdomen, normal, active bowel sounds, soft, nontender, no rebound or guarding. Chest, clear to auscultation and percussion, no wheezing, no crackles. Cardiovascular, regular rate and rhythm, S1, S2. No tachycardia, no murmur, no gallop.
Q Did you arrive at a differential diagnosis?
MR. KILBANE: Objection. Go ahead.
A Most likely.
Q What was the differential diagnosis?
A Again, it would be difficult to reconstruct from my impression. Obviously dysphagia, esophageal carcinoma recurrence. I'm sure there were several other things.
Q What?
A I would be reconstructing this now of course. Other bronchial, epigastric, or cardiac problems.
Q Was coronary artery disease on your differential diagnosis?
A I'm sure there was some thought given to that.
Q Why would that be?
A Because as we previously discussed, had talked

about a negative EKG, a negative enzymatic test just the day before.

Q Would you agree that Mr. Frankhauser had symptoms which were consistent with cardiac ischemia?

MR. KILBANE: Objection.

A I don't believe so.

Q Why is that?

A Because again, as you see a patient, go through the litany of questions to try to help tease things out, you look for the typical responses. They weren't forthcoming.

Q What were the responses that you would have expected, if the symptoms were consistent with cardiac ischemia?

A I'm sure there is more than I can actually bring forth. Substernal crushing, chest pain with diaphoresis, shortness of breath, radiation, a number of different ideas.

Q Radiation where?

A Perhaps to the jaw. Perhaps to the left arm.

Q Did you ask Mr. Frankhauser whether he had experienced any shortness of breath in the last several days?

A I believe so.

Q Is it referenced in your note?

A Well, again the summary statement of -- talking about the statement with the deep breathing.
Q What does it say in there about deep breathing?
A Without prefaces this worse with deep breathing.
Q The symptoms were worse with deep breathing?
A No it was prefaced by the symbol S with a bar above it, which means without. The litany of things there, the only one that was negative was salivation, which has an arrow in a different direction.
Q Does your note indicate a response one way or the other as to whether or not the patient had been experiencing shortness of breath?
A Again, the only symptom I wrote down, which I would assume would be the one I felt most important at that time, is he did not have any worsening with deep breath.
Q If you had asked him have you experienced any shortness of breath in the last few days, if he had said yes, that would have significance to you, you would have the written it down?
MR. KILBANE: Objection. Go ahead.
A It's possible I could have wrote that down. If that was the response, that was the question. That is not what actually happened.

Q Would you read for me the entire office note of June 17, 2002?

A Certainly. June 18, '02. Weight, 184. Blood pressure, 118 over 90. Pulse, 62. Chief complaint: Question mark, chest pain. Sick visit. Three days after feeling food stuck in throat. Without nausea, vomiting, increased salivation, fever, worse with deep breath. Asymptomatic today. Vital signs noted. Not in distress. Swallows normally. Abdomen, normal active bowel sounds, soft, nontender, no rebound or guarding. Chest, clear to auscultation and percussion, no wheezing, no crackles. Cardiovascular, regular rate and rhythm, S1, S2. No tachycardia, no murmur, no gallop. Impression: Dysphagia, history of esophageal carcinoma. Plan: CT reviewed, labs reviewed, all normal for labs, troponin was normal, increased Prilosec to b.i.d., add Carofate 1 gram q.i.d. number 50 no refills. Discussed with Dr. Chak. Will do EGD this week. To set up follow-up from there. Return if recurs. Signature.

Q What does it mean to set up follow-up from there?

A Again, based on the results of the tests, whatever else might come up, or whatever those findings

would have shown, base your follow-up on your initial impression and maneuvers.

Q Did you have a plan if the EGD was totally normal?

A Certainly it would have gone back through everything and perhaps gotten more information. That is why I said to return.

Q Do you remember your discussion with Mr. and Mrs. Frankhauser during this office visit?

A I remember some things that occurred.

Q Tell me everything you remember about your conversation with them.

A That would probably be quite impossible. There is no way to recollect every single thing that can happen.

Q I'm asking what you do remember?

A I remember talking about some symptoms. I remember examining him. I remember talking to him about the potential plan of what is going to happen.

Q What did you tell him about the potential plan and what is going to happen?

A I said probably something along the lines of you know if you feel like you are having food stuck in the throat, obviously with the history being such with the esophagus, we better take a look down -- paraphrasing obviously -- better take a look down

there, make sure something isn't stuck or ulcerated. Something is going on with the esophagus. That seems to be what you are complaining about.

In the meantime, why don't we increase your stomach medicine. Add this other coating medicine to help relieve your symptoms. That I'll try to set everything up. That is probably in a nutshell what was going on.

Q Do you remember any discussion about that the problem could possibly be cardiac in nature?

A Again, nothing directly.

Q Did you discuss with Mr. and Mr. Frankhauser what they should do if Dr. Chak's EGD was normal?

A Again, the way I put it here, probably what I would normally do is, let's find out what is going on. If we get an answer with that, we will take it from there. If we don't get an answer from that, we will have to see. It's not likely that you can set up a 10 point plan based on a visit like this.

Q Do you remember any of the questions posed by the Frankhausers to you?

A I don't know if you mean something in specific. Obviously this is a recollection of the main points of what happened during that acute visit.

Q Did you ever have any contact again with Mr. or Mrs. Frankhauser after this office visit of June 18, 2002?
A I spoke with Mrs. Frankhauser.
Q When was that?
A At the time that Mr. Frankhauser was brought by the squad to Saint Vincent I believe it was.
Q Tell me everything you remember about that conversation.
A I'm certain I said something I was sorry to hear about what happened. That I probably asked some questions about what happened.
Q Do you remember what she said?
A Vaguely something about water. I don't know, a bird bath or something, that she found him with the hose still on. I seem to remember that in particular.
Q Anything else?
A I don't believe so.
Q How did you learn of Mr. Frankhauser's death?
A It was Solon Saint Vincent who called. I believe it was them.
Q Did you ever hear or learn the cause of death?
A Not until I received these records last week.
Q What is your understanding of the cause of death,

based on the records you reviewed?
A Cardiac tamponade.
Q Based on the patient's history, his family history, physical findings, was it reasonable to suspect that the patient's complaints could have been caused by coronary artery disease?
MR. JONES: Objection.
MR. KILBANE: Objection.
A I don't believe so. You mentioned the family history. There was no premature coronary disease. The second thing you mentioned, his examination.
Q His history, his family history and the physical findings?
A Family history there was no premature coronary disease. His history, there was nothing that suggested that based on his single presentation here. His examination, certainly nothing. Negative EKG, negative troponin level, nothing there. So, no more than I think I believe I said before the average man.
Q I believe we already agreed that Dr. Kundtz ordered certain tests such as the EKG and blood enzymes, in an attempt to rule out an acute MI as the cause of Mr. Frankhauser's atypical chest pain; can we agree on that?

MR. JONES: Objection.

A I believe so.

Q An acute MI was in fact ruled out; is that right?

MR. JONES: Objection.

MS. KORDAS: Objection.

A If that was the reason for doing that, those tests were negative, that is the best that medicine can do.

Q That is your understanding that an acute MI was ruled out at that time when Dr. Kundtz examined him on the 17th at University Hospitals?

MR. JONES: Objection.

MS. KORDAS: Objection.

A If you are being very deliberate about it, most of the time those kinds of tests rule out acute ischemia. That would be the more proper thing to say.

Q But not necessarily chronic ischemia?

A Very difficult to do that.

Q How do you do that?

A I think you have to have a number of different sources of historical factors, patient symptoms, exam findings, laboratory values, the like, to come to that conclusion.

Q Are there any tests that can be performed to help

you to determine whether or not somebody is suffering from chronic cardiac ischemia?

A There are a few tests that can be helpful for people. Sometimes they are not helpful. That is why you have to use all the information, and not just rely on a single entity.

Q What are those tests?

A If you are looking for something ischemic, you can consider something like one of the many different kinds of stress tests for instance.

Q Would you agree that based on the tests performed at the emergency room by Dr. Kundtz, chronic cardiac ischemia could not be ruled out as the cause of Mr. Frankhauser's symptoms?

A Well, I think what I just briefly answered, any one day is very difficult to rule out a chronic problem.

Q Would you agree that the symptoms which brought Mr. Frankhauser to the University Hospitals emergency room can be associated with chronic cardiac ischemia?

A Again, difficult to say if the patient, just any patient, in particular here, the patient feels like it's epigastric, food stuck in the throat. It's difficult to rule out any chronic cardiac condition

based on those historical findings.
Q Did you ever rule out chronic cardiac ischemia as the cause of Mr. Frankhauser's symptoms?
A I don't think they were either ruled in or ruled out.
Q In a patient complaining of chest pain, which radiates down both arms, a working diagnosis of atypical chest pain is made, what type of workup does the standard of care require?
MR. JONES: Objection.
MR. KILBANE: Objection. Assuming it requires a workup.
MR. ROSMAN: Objection.
A The standards are not a concrete entity that one would look at. You might look at the arm pain as being more significant. You may look at the etiology of the arm pain. You may look at the chest pain as more significant. You may take them both together. There was so many different things that can occur. There can be no standard.
Q There is no standard of care as to what workup needs to be done in a patient such as this?
MR. JONES: Objection.
MS. KORDAS: Objection.
MR. KILBANE: Such as what?

Q Such as a patient complaining of chest pain that radiates down both arms. A working diagnosis of atypical chest pain is made.

MR. JONES: Objection.

MR. KILBANE: Objection. If you can answer the question based on those alone, Doctor, go ahead.

A Since your question is predominant symptom is bilateral arm pain, the working diagnosis, not actually being the symptom, or anything other than a diagnosis, the standard would be somewhere along the lines you should listen to the patient, examine what you think is appropriate. Order what you think is appropriate. Follow up on what you think is appropriate. That would be somewhat a direction to get started.

Q Would you agree with me that any condition on the differential in an atypical chest pain patient that can result in sudden death, even if it's not at the top of the list, must be ruled out at soon as possible?

MR. JONES: Objection.

MR. ROSMAN: Objection.

MR. KILBANE: Objection.

A I don't believe.

Q Why is that?

MR. JONES: Objection.

A In medicine sometimes the lists are exceedingly long. The amount of tests that one can order are exceedingly great. To say that the smaller chance of something more serious is a higher likelihood than someone that has symptoms that clearly go with their history, to supersede that, may not be in the patient's best interest all the time.

Q In Mr. Frankhauser's case, you were basically considering epigastric as a possibility, and cardiac as a possibility?

MR. KILBANE: Objection.

A Again, the patient himself claimed food stuck in the throat. If you look at the recent records of what I had available, he had a CT scan that had shown a new pulmonary nodule and a history of esophageal cancer. He obviously went through major surgery, radiation therapy, chemotherapy. He did not have a benign lesion, meaning that there was evidence of some spread through the muscle. So that it would not be in his best interest to think that with his set of symptoms, something that was very strongly in his history should be ignored.

Q What is that?

A The recurrence of esophageal carcinoma occurring in the esophagus, or at the esophagus/gastric juncture, again considering his symptoms over recent times that I'm not talking about just a few days, but the recent CT scan that he had had, that we had to look at.

Q Would it have made any difference in his outcome if the EGD was done in a week, rather than a couple days?

A At the time I think when someone says that there is food stuck in their throat, you kind of want to do something as soon as you can for somebody.

Q Is there any reason why this patient could not have undergone a stress test?

A Well, again, if there was a valid reason for ordering the stress test, that might suffice. However, again, you have to look at what he said, what happened, what was examined, what he complained about. Again, you have to look at the patient, say how can this be helped the best.

Q Do you know what he complained about at the Solon emergency room?

MR. KILBANE: Objection. Haven't we been through the whole emergency room at least a couple times?

Q You don't know what he complained about at the Solon emergency room because you didn't know he was there, right?
A That would be true.
Q Did you ever review the University Hospitals records as to what he specifically complained about at University Hospitals' emergency room?
A Again, before he passed away the only thing I had to review was what I put here, the hospital records speaking with the emergency room physician.
Q Your answer to my question is no?
A Can you ask me exactly what you asked again?
Q Yes, I can. Did you review the emergency room records from University Hospitals on or before June 18, 2002?
A There is no way I could have before June 18th. On June 18th, obviously nothing was prepared yet, so I couldn't have that day either.
Q You didn't know what he complained about to the people at the emergency room the day before --
MR. KILBANE: Objection.
Q -- is that true?
MR. JONES: Objection.
A Not really.
MR. KILBANE: The question was had he

reviewed the records?

MR. VOLSKY: I'm asking a different question.

MR. KILBANE: He talked to the patient, than he talked to the doctor.

Q Did you see what he complained about in the emergency room record?

MR. KILBANE: He answered no, the records weren't available.

Q Do you agree that in an atypical chest pain patient, with coronary artery disease risk factors, including a 40 pack-year smoking history, a family history of cardiovascular disease, and hyperlipidemia, the standard of care requires that coronary artery disease, including chronic cardiac ischemia must be ruled out?

MR. KILBANE: Objection.

MS. KORDAS: Objection.

A No, that would not be the standard.

Q Why not?

A Again, same thing we've been going through. You look at the person, you look at their symptoms, you look at their exam, you try to put a whole plan together for them. You look at the things such as their symptoms to help guide you along.

Q Did you at any point consider ordering a stress test?
A Again, if as part of what we were looking at on June 18th, if that had been more prolonged, it's possible that might have come up.
Q What do you mean if it had kept going along?
A Again, pretty much what was said and described was since a lot of your symptoms are pointing towards what you are telling me, food being stuck in the throat, esophageal pain, esophageal carcinoma, obviously we had increased the acid blocking medicine, new pulmonary nodule on CT scan, that was the priority at the time, because that was his complaint. That was what was most important at that point in time.
Q Looking back with hindsight, Doctor, what is your opinion today as to what medical condition was the cause of Mr. Frankhauser's symptoms on June 16th through the 18th?

MR. JONES: Objection.

MR. ROSMAN: Objection.

MR. KILBANE: Objection. If you have an opinion.

A I can't have an opinion on that because we have records of those things.

Q Well, I'm asking you seeing and having reviewed the records and reviewing the autopsy, as you sit here today, do you have an opinion as to what was causing his symptoms back then?

MS. KORDAS: Objection.

MR. JONES: Objection.

MR. KILBANE: Objection.

A The same answer to the autopsy report mentioned cardiac tamponade as probably the final cause of death.

Q Did you think those were cardiac symptoms he was suffering on June 18th?

MR. KILBANE: Objection.

MS. KORDAS: Objection.

MR. JONES: Objection.

A I can only go by what at the time, this is the kind of information that I got from him.

Q I understand. I'm asking you to look back with hindsight. Looking back, knowing everything you know, would you agree that the cause of his pain back on June 18th was probably the ischemia?

MS. KORDAS: Objection.

MR. KILBANE: Objection.

MR. ROSMAN: Objection.

MR. JONES: Objection.

A I can't say that because it's unclear. It's hard to take an autopsy finding and extrapolate backwards to symptoms.
Q Do you know of any evidence that Mr. Frankhauser had metastatic disease or cancer at the time of his death?
A When?
Q At the time of his death?
A At the time of his death I would have no knowledge. All I have is what I mentioned before.
Q Did he have any medical conditions which made his life expectancy any less than the average person his age?
MR. KILBANE: Objection. If you have an opinion, Doctor.
A That would only be opinionary. People who have cancer probably don't have as long a life span as everybody else.
Q Do you have any information as to the likelihood of Mr. Frankhauser having a recurrence of his cancer, given that he had been cancer free for so long?
A I don't believe the length of being cancer free figures as much in the longevity as the aggressiveness of the original tumor. I'm not an oncologist, nor a gastroenterologist to have much

to say.

Q You defer to the oncologist or expert in that area?

A Again, for cancer that makes sense.

MR. VOLSKY: Give me a minute.

(Recess taken.)

MR. VOLSKY: I have nothing further at this time.

MR. KILBANE: We would like to read it. She's going to type it, have you read it. Can we have more than 14 days, 30 days?

MR. VOLSKY: Sure, if I can get an unsigned copy.

(Deposition concluded at 4:30 p.m.)

(Signature not waived.)

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I have read the foregoing transcript from page 1 through 89 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

_____
Robert Cirino, M.D.

Subscribed and sworn to before me this _____ day of _____, 2004.

_____
Notary Public

My commission expires: _____.

State of Ohio,)
) SS: CERTIFICATE
County of Cuyahoga,)

I, Constance Versagi, Court Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, Robert Cirino, M.D., by me first duly sworn to testify the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy/computer in the presence of said witness, afterward transcribed, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified, and was completed without adjournment.

I do further certify that I am not a relative, counsel, or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 2nd day of February, 2004.

Constance Versagi, Court Reporter and
Notary Public in and for the State of Ohio.
My Commission expires January 14, 2008.