THE STATE OF OHIO,)
) SS: RICHARD M. MARKUS, J.
COUNTY OF CUYAHOGA.)

IN THE COURT OF COMMON PLEAS
(CIVIL BRANCH)

GERALDINE FRANKHAUSER, Executrix of the Estate of Joseph J. Frankhauser, Deceased,	)	
Plaintiff,	)	
vs.	)	Case No. CV-05-560742
SANDRA S. CHISAR, D.O., et al.,	)	
Defendants.	)	

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EXCERPT OF TRANSCRIPT OF PROCEEDINGS

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Whereupon, the following proceedings were had in Courtroom No. 3-A, The Old Courthouse, Cleveland, Ohio, before the Honorable **Richard M. Markus,** and a jury, on **Tuesday, April 11th, 2006,** upon the pleadings filed heretofore.

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APPEARANCES:

Hermann, Cahn & Schneider LLP, by:
Kerry S. Volsky, Esq.,

On behalf of the Plaintiff.

Roetzel & Andress, by:
R. Mark Jones, Esq.,
James P. Myers, Esq.,

On behalf of Defendants University Emergency Specialists, Inc., and Ewald E. Kundtz, III, M.D.

Weston, Hurd, Fallon, Paisley & Howley, by:
Beverly A. Harris, Esq.,

On behalf of Defendants Emergency Professional Services, Inc., and Sandra S. Chisar, D.O.

Reminger & Reminger, by:
Thomas B. Kilbane, Esq.,
Bethanie Ricketts, Esq.,

On behalf of Defendants USHC Physicians, Inc., and Robert Cirino, M.D.

Angela R. Cudo, RPR
Official Court Reporter
Cuyahoga County, Ohio

TUESDAY AFTERNOON SESSION

APRIL 11, 2006

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Thereupon, the Plaintiff, to further maintain the issues on her part to be maintained, called as a witness, ROBERT CIRINO, who, being first duly sworn, was examined and testified as follows:

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CROSS-EXAMINATION OF ROBERT CIRINO

BY MR. VOLSKY:

Q. Good afternoon, Doctor.

A. Good afternoon, Mr. Volsky.

Q. Please tell the jury who you are.

A. Robert Cirino, M.D.

Q. Where did you live, sir?

A. Live in Solon, Ohio.

Q. And what is your occupation?

A. I'm a physician.

Q. And what is your specialty, sir?

A. Specialist in internal medicine.

MR. VOLSKY: Your Honor, if you could indulge me one second.

THE COURT: Certainly.

Q. (BY MR. VOLSKY) Where do you practice, sir?

A. Practiced that day at University Suburban Health Care Center.
Q. What type of practice do you have?
A. I have three practices; inpatient internal medicine at University Hospitals, my regular ambulatory practice at that building, and a teaching practice at University Hospitals.
Q. Do you work for USHC, Inc.?
A. Yes.
Q. What does USHC, Inc. stand for?
A. The same as the health center, University Suburban Health Center.
Q. Was that corporation your employer when you provided medical care to Joe Frankhauser in June of 2002?
A. Yes, it was.
Q. Do you have privileges to admit patients at any hospitals?
A. Yes, I do.
Q. Which ones?
A. At University Hospitals in Cleveland.
Q. If Joe Frankhauser as your patient needed admission to the hospital, he would have gone to University Hospitals?
A. He could have gone to University Hospitals, yes.
Q. Well, if you were admitting him you would have put

him in University Hospitals; would you have not?
A. Yes.
Q. How did Joe become a patient of yours?
A. Well, we can get patients either that call and are referred to us by somebody else or on the recommendation of a current patient.
Q. Sir, I'm asking about Joe Frankhauser. How did he become a patient of yours?
A. Well, I found out later that his previous physician had retired and moved to the VA. There was some recommendation by his oncologist that he needed an internist, and that a friend or neighbor of the family had recommended our office and that somebody in our office was unable to see him, so they ended up with me.
Q. Doctor, I see you don't have Joe's medical chart in front of you. If you feel that that would be helpful in your testimony, please feel free to refer to it.
A. Okay.
Q. How long had Joe been a patient of yours?
A. Approximately a year and a half.
Q. Please explain what your role was as Joe's internist.
A. Same role as it is for many other patients who come by. To help take care of them.
Q. When is the first time you took care of Joe?
A. I believe it was in the summer of 2000.

Q. Did you do an overall examination of him the first time?
A. His first examination happened to be a protracted visit, yes.
Q. Did you make up a problem list of Joe's health problems?
A. Yes, I did.
Q. Doctor, am I correct that Joe's cholesterol at the time was about 220?
A. His cholesterol was drawn previous to him coming to my office that day.
Q. And what does the latest lab work show as far as what his cholesterol was?
A. 220.
Q. That's elevated, isn't it?
A. It depends. In 2002 the recommendations had been between 200 and 209 for somebody's cholesterol. But there are many several different breakdowns in the cholesterol products. So 220 is above 200.
Q. Doctor, didn't you write a letter to Joe Frankhauser after you did this initial evaluation -- did you write him a letter summarizing what you found in this protracted physical you did the first time?
A. Yes, I did.
Q. And do you remember writing that letter that Joe's

cholesterol should be less than 200?
A. Yes, I did.
Q. Okay. So what are you trying to tell us that it's 200 or 209 when you wrote a letter to Joe telling him it should be below 200?
A. Just what it says; the cholesterol is 209, is above 200, and that I recommended it be around 200 or less.
Q. I'm sorry, Dr. Cirino, I didn't hear your answer to my question as to why you wrote to Joe on December 30th, 2000 that it should be less than 200 and you told this jury that back in that time it was 200 to 209.
A. Because they're both correct.
Q. What were his triglycerides?
A. I believe they were 266, but we could refer to that and find the exact number.
Q. That is also elevated, isn't it?
A. That is elevated.
Q. What are triglycerides?
A. Triglycerides are the fats that are in the blood. They change with each meal, they change if you're fasting and what you've just eaten and how long they've been in your body. They change whether somebody has diabetes and whether somebody is on certain medications.
Q. They should be less than 130?
A. That depends when they're drawn, Mr. Volsky.

Q. Did you say that in your letter to Mr. Frankhauser, that it depends when it's drawn? Didn't you say for someone without a history of heart disease these should be less than 200, meaning the cholesterol, and 130 triglycerides to begin with; is that what you wrote to Mr. Frankhauser?

A. That is what is written. A number less than 130 implies a fasting triglycerides value.

Q. What was his good cholesterol?

A. Good cholesterol could not be determined from those labs that were available.

Q. Isn't it important to know the ratio between the good and bad cholesterol?

A. I think it's important to know that.

Q. I've heard, you know, that it's supposed to be 4:1 ratio. You're supposed to have four times -- one-fourth good cholesterol to 4 bad cholesterols. Is that fair?

A. No.

Q. Please tell us what it is.

A. You look at the total cholesterol ratio divided by the HDL.

Q. That's the good cholesterol?

A. HDL is the good cholesterol.

Q. But you didn't have that ratio between the good and bad cholesterol, did you?

A. No, I did not.
Q. So how did you know whether or not Joe's ratio of good cholesterol to bad cholesterol was dangerously low?
A. You cannot infer it from those unless you use a formula to take out the triglycerides and figure what the remaining LDL, which is the bad cholesterol, and HDL, which is the good cholesterol, are left.
Q. You didn't have any information to make that determination, did you?
A. No, I did not.
Q. Am I correct that the problem list that you made, you made a problem list of all the things wrong with Joe based on his first evaluation; did you not?
A. I did.
Q. And that's so you would have it for future reference so you could take care of this patient long term and always remember what type of problem list he has so that you can always consider it; isn't that fair?
A. Yes, it is.
Q. Am I correct that that problem list that you made on Joe's first visit included something which you wrote in your own handwriting; hyperlipidemia? Isn't that on the list?
A. Yes, it is.
Q. What does that mean, hyperlipidemia?

A. Hyperlipidemia is any single blood cholesterol value over 200.

Q. But you decided not to put him on cholesterol lowering medications; isn't that true?

A. Appropriately so.

Q. What was the game plan as far as his cholesterol?

A. I mentioned this in the letter also. That whenever you see somebody that has an initial value that's elevated, the very first step is either redraw the blood cholesterol or explain to people the dietary and exercise factors that could possibly lower cholesterol. It's exceedingly unusual that somebody who has a cholesterol value 10% over normal immediately be put on cholesterol lowering medications if that was the only value you had to base that on. So he was written a letter that suggested various dietary changes and some aerobic exercise changes that would help to lower it.

Q. Are you done with your answer, sir?

A. I am.

Q. Thank you. Your letter on December 30th to Joe said, It may be good at some point, about six months, to check a fasting cholesterol profile including a good and bad cholesterol. What did that mean?

A. Exactly what it says.

Q. Can you explain it to the jury what a fasting

cholesterol is. I know that's what it says, but, you know, people don't quite understand it as well as you do.

A. Okay. If I request that somebody come in for a fasting cholesterol, they'll generally not to have eaten from the night before until the morning or day they come. If they come in later in the day, they might have just missed breakfast and lunch.

Q. Now, that was in December 2000 that you talked about doing a fasting cholesterol check, the ratio of the good and bad cholesterol?

A. Yes.

Q. How many times did you see Joe in your office between December 2000 and June 18, 2002 when he passed away?

A. It was a total of four times, I believe.

Q. So as of June 2002 when Joe died, one and a half years later of a heart attack from a cholesterol laden plaque in his arteries, had you ever checked Joe's cholesterol like you had planned?

A. No.

Q. Did you ever find out what Joe's good cholesterol was?

A. Yes.

Q. Yes?

A. Yes.

Q. And how did you do that?

A. Looked on the computer.
Q. Excuse me?
A. Looked on the computer.
Q. Did he have other blood lab work done from the time that you saw him in December of 2000 until he passed away?
A. I believe he had other blood tests, yes.
Q. Were they in your records?
A. No, they're not in the records. They're in a computer because they're University Hospitals records. They're not my own records.
Q. Did you ever put him on cholesterol lowering medicine?
A. No, I did not.
Q. Did you know how old Joe was?
A. Yes, I do.
Q. How old was he?
A. Well, at the time I last saw him he was 70 years old.
Q. As a person ages would you agree with me that the increased risk in age, that fact alone without any other risk factors, puts that person at increased risk for heart disease?
A. Age is a risk factor in heart disease.
Q. So you agree with that statement?
A. Age is a risk factor in heart disease, yes.
Q. A 50-year-old is at an increased risk than a

40-year-old?

A. The debate between the earliest when it becomes a bigger risk factor at 10, 20, 30, now it's between 40 and 50, it's hard to put an exact number on any decade in life. In general, the older you get the more likely it is that age plays a role.

Q. A 60-year-old is at increased risk than a 50-year-old. Would you agree with that?

A. Yes.

Q. You would agree with a lot of people in their 50s are having heart problems and even more in their 60s?

A. There are more 60-year-olds than 50-year-olds in the country, so that would be a completely true statement.

Q. Is that the reason why there are more, the reason there are more 60-year-olds having heart problems is because there are more of them or because they're at greater risk?

A. That would be the math on that if the denominator and enumerator are both larger, then yes.

Q. A 70-year-old is at increased risk than a 60-year-old, would you agree with that?

A. Okay.

Q. There are a lot of people in their 60s having heart problems and even more in their 70s. Wouldn't you agree?

A. Okay.

Q. Did you know that Joe was a pack-a-day-smoker for 40 years?
A. Yes.
Q. 40-year pack-a-day is a significant smoking history?
A. Yes.
Q. Even though he quit 12 years before, it's a significant problem?
A. It is very significant that he quit for 12 years also.
Q. For 40 years he had smoked a pack a day. That does damage to your cardiovascular system along the way, doesn't it?
A. During the time that you're smoking, yes, it can.
Q. Did you know that Joe had a sister and mother who each had hypertension?
A. I knew he had a sister with hypertension and a mother.
Q. That Joe's mother had died of a CVA, or a stroke, did you know that?
A. Yes, I did.
Q. What is a CVA?
A. Technically the letters CVA stand for cerebrovascular accident. It's a general term for people that have a stroke.
Three different kinds of strokes. It

could be anabolic stroke that is due to irregular heartbeat, due to bleed in the head, and one of the three could be due to a clot that's in the brain.

Q. Do you know which kind Joe's mother had?

A. No, I do not.

Q. Did you know Joe's dad died of congestive heart failure?

A. Yes.

Q. That's a heart problem, right?

A. That's a heart problem.

Q. Did you know Joe's dad had suffered a major heart attack years before he died?

A. I believe he had acute coronary disease.

Q. Did you know that he had a heart attack years before he died?

A. I'm not sure that I did.

Q. The fact that Joe's dad had died of a heart problem and his mother had died from a stroke, was that a concerning family history as far as Joe was concerned?

A. No.

Q. Why not?

A. When you look at family history, what you're really looking for for acute coronary heart disease is a first degree relative; brother, sister, mother or father, who has premature coronary disease, age less than 55, and was

a non-smoker, because that make a difference. So neither his parents were below the age of 55 when they had a stroke, heart attack, acute coronary disease, or congestive heart failure.

Q. Well, Joe was as old or as close to as old as his parents when they had that problem. Isn't that important?

A. Well, it may be of interest. You can make no determination on that when it's well accepted that the risk factor is premature coronary disease age less than 55.

Q. Given the fact that Joe was 70 years old with a family history we've described, the fact he smoked a pack a day for 40 years and had elevated cholesterol, how would you describe Joe's cardiac risk at that time?

A. Well, let's see, Mr. Frankhauser was a gentleman at the age of 70. Men and women have almost equal risk of heart disease, especially after menopause in women their risk goes up tremendously. For both sexes, age of 70 we established is greater than 60 or 40 or 30 or 20 or 10. The risk factor for a smoker. The risk factor is smoking when you're an active smoker. The longer you have not smoked the less a risk it is for you for other complications of tobacco-related disease such as things in the lung, esophagus, et cetera. When you have stopped smoking, you no longer have the daily irritant from the

tobacco that's working on your heart. What's already been done is done. But the heart has a tremendous capacity to remodel, and therefore it's current smoking that is the risk factor.

When you look at the cholesterol, you have not mentioned what also was in the very first note, which was that Mr. Frankhauser was just coming off chemotherapy. He initially weighed somewhere between 210 and 220 pounds. He had lost almost 50 pounds. He weighed 165 pounds at the lowest weight he was at. He was just regaining some of the weight. Would it be unusual that he had cholesterol that was slightly elevated after having gone through several years of recovering from esophageal cancer? I would suggest that that answer is no. During the time that he was treated, we know that his cholesterol was in the 100s, 133, 150s, 170s. The 220 value Mr. Volsky has picked out is the highest value that was there. It was also the most recent value. So appropriately, according to what we practice, recommendations for exercise and diet now that he had gained a little bit of weight back but he was still not back to his upper weight. He was still about 24 pounds less than when he was before the surgery.

Q. Doctor, will you answer my question now?

A. You asked me about the risk factors and what that

means for Mr. Frankhauser. So far we have that he's a 70-year-old male; that he's a former smoker, not a current smoker; that he had one hyperlipidemia value of 220 that was drawn prior to him coming in; that because of the changes in his body after surgery he had lost a significant amount of weight already and was just starting to gain it back. We also know that he did not have high blood pressure, he did not have diabetes, and the most important risk factor of all is he had no previous coronary disease as mentioned in the letter. So basically gave him a risk of a 70-year-old man, which would have been the same as a 70-year-old woman, and his age and sex.

Q. Doctor, do you remember I had asked you on Page 34 of your deposition on Line 2 I asked you, Given his family history, his pack-a-day-40-year smoking history and hyperlipidemia, how would you describe Mr. Frankhauser's cardiac risk at that time? And your answer was, Average for an adult male. Do you remember that?

A. I think we just established that.

Q. Did you mean the same as an adult male who was 30?

A. We were talking specifically about Mr. Frankhauser. We were talking about Mr. Frankhauser at that time.

Q. When you say that he was at average risk for an average adult male, adult males are all different ages, aren't they? There are some adults that are 30 and

there's some adults that are 80. Wouldn't you agree with that?

A. I agree that some adults are 30 and some are 80. But you had asked about Mr. Frankhauser.

Q. When you answered it was average for an adult male, are you telling us what you meant is an average adult male that is 70 years old?

A. Yes.

Q. So the fact he smoked for 40 years didn't put him at any greater risk than the average adult male who was 70 who never smoked in his life?

A. Smoking plays a role in people's health. Not just their coronary artery syndrome, but their lungs, their blood vessels, their blood pressure, many other things. What you also need to know is when you stop smoking, these things have the ability to change. They have very little capacity to change in the lungs, they have some capacity to change in the heart, and they have some capacity to change in the great blood vessels. So it is more important to Mr. Frankhauser that he had stopped smoking almost 12 years before I had met him.

Q. Are you a greater expert in cardiology and the heart than Dr. Garrett?

A. I am not.

Q. Do you have any special training in cardiology that

has allowed you to render such opinions and medical analyses regarding the recoverability of heart tissue after the withdrawal of smoking after the man put that poison in his body a pack a day for 40 years?

A. I merely said the body has the capacity to change. I did not quantify it.

Q. But to some extent, those arteries and the cholesterol in them, there's damage done that can't be undone when somebody smokes for 40 years. Wouldn't you agree with that?

A. There's honestly no way to know that.

Q. How do you know it gets better?

A. You have to look at what happens to people throughout their lifetime.

Q. Have you done studies in that area?

A. I've not done any studies in that area.

Q. You knew that Joe had a cancerous tumor removed from his ear?

A. Yes, I believe I did.

Q. And you knew he had esophageal cancer?

A. Yes, I did.

Q. Did you know whether Joe continued to go to specialists, doctors for the ear cancer and esophageal cancer, who followed him to make sure his cancer had not come back?

A. I believe so.
Q. Was there any sign that his skin cancer had come back?
A. I don't believe so.
Q. You received periodic updates from those doctors, didn't you?
A. I only received periodic updates from Dr. Levitan for the esophagus.
Q. Not Dr. Lynch?
A. I did not receive from Dr. Lynch.
Q. Dr. Lynch is one of the top doctors in town, isn't he, in his specialty?
A. Okay.
Q. Isn't he?
A. He does a very specialized procedure called MOHS, M-O-H-S surgery, were you peel off layer by layer cell by cell the tissue layers of skin cancer. There's very few people that do that.
Q. Dr. Clayman is a very well-respected surgeon in town that did Joe's surgery?
A. Dr. Clayman is retired now.
Q. Back then.
A. She's a cardiothoracic surgeon, yes.
Q. What was her reputation?
A. Tough.

Q. Good surgeon?
A. Good surgeon.
Q. Excellent reputation?
A. Excellent reputation.
Q. Dr. Levitan is an oncologist. Excellent reputation?
A. I know Dr. Levitan. Yes.
Q. Do you agree he has an excellent reputation in the city?
A. Yes.
Q. Gerry and Joe were trying to go to the top doctors in town. Wouldn't you agree with that?
A. Yes.
Q. You got letters and reports from Dr. Levitan, the cancer specialist, every time Joe saw him, didn't you?
A. Yes.
Q. And Dr. Levitan?
A. I'll take that back. If there were other times that he saw him, how would I know that?
Q. I understand. You regularly got reports from Dr. Levitan as to how Joe was doing?
A. I did.
Q. Did you receive a letter from Dr. Levitan dated May 2nd, 2002?
A. Yes. Can I see my own records now?
Q. Yes. Please feel free.

A. Okay. Mr. Volsky, you asked about one that was in May.

Q. Yes. May 2nd, 2002.

A. Yes.

Q. This is the second page of that letter, isn't it?

A. Yes, it is.

Q. And you have a little notation at the top of the first page. Is that the day you received it?

A. The day I put on the letter is the date I read it and receive it.

Q. What is that day?

A. May 1st, 2002.

Q. That was about a month to a month and a half before Joe died; is that right?

A. That would have been one month.

Q. Am I correct that that report from Dr. Levitan said that a CT Scan -- which is like a sophisticated x-ray, would you agree with that?

A. CT Scan is a three-dimensional x-ray.

Q. It showed a problem in Joe's lung, didn't it?

A. Yes, it did.

Q. It also says that the radiologist -- that's a person who interprets the CT Scans and the x-rays, specialist?

A. Yes, it is.

Q. That radiologist interpreted that CAT Scan and said

that the lesion could possibly represent an endobronchial lesion, couldn't it?

A. What we're reading here, understand please, is Dr. Levitan's interpretation of the radiologist's interpretation of the actual scan.

Q. And Dr. Levitan says the radiologist has said that it could possibly represent an endobronchial lesion. Do you have any reason to dispute or question that the radiologist actually said that and that Dr. Levitan read the report and is now indicating in his letter what the radiologist told him?

A. Yes, that is what the radiologist had said. It's not on this page.

Q. That could possibly -- Endobronchial lesion is what?

A. The inside of most everything is endo. The outside is the ecto. So as you breathe in, air will go down the inside of your trachea, then your bronchial tubes and the bronchi continue to divide. Endobronchial lesion could be any lesion inside one of the windpipes, or the main bronchus, or any of the bronchi underneath it.

Q. Okay. To us lay people, we're talking about cancer of the lung, aren't we?

A. Not necessarily. An endobronchial lesion could occur arising from any source. It may be in the lung, but it might be metastatic from somewhere else. It may be

arising from the lung itself. Endobronchial lesion could also be any sort of infection, inflammation, blood cancer, lymphomatous tissue. There's actually quite an array of things. That's why it's called endobronchial lesion. That's not definitive to anything.

Q. Could have been a metastatic tumor from esophageal cancer?

A. It could have.

Q. Dr. Levitan goes on to tell you, I'm quoting, I am concerned about the possibility that Mr. Frankhauser may have either a pulmonary neoplasm. What is a pulmonary neoplasm?

A. Typical lung cancer arising from the lung itself.

Q. Or metastatic disease from his esophageal cancer. What would that be?

A. Metastases is the word for when cancer reoccurs or occurs in a place than the original tumor.

Q. But Dr. Levitan goes on in his record, doesn't he, and says it could be a pneumonia, doesn't he?

A. He says the CT could be consistent with pneumonia.

Q. And he will give Joe a treatment of antibiotics and repeat the CAT Scan in a month?

A. This is true.

Q. A concerning letter, wouldn't you agree?

A. I would say so.

Q. Especially when Joe had such a deadly type of cancer where most people who get it die within five years. Wouldn't you agree with that?

A. I agree.

Q. And Joe was out four years at that time since his cancer had been treated in 1998; is that true?

A. He was treated in 1998, yes.

Q. Doctor, what is the next thing you found out about Joe based on his medical chart? Please look at your chart.

THE COURT: Mr. Volsky, we're going to take a break in about five minutes. You tell us when it's good.

MR. VOLSKY: Okay, Your Honor. Thank you.

A. June 17, 2002.

Q. (BY MR. VOLSKY) Is that this page that's blown up here?

A. Yes, it is.

MR. VOLSKY: Can you see it, Your Honor?

THE COURT: That's fine.

Q. (BY MR. VOLSKY) So what is the next thing you hear about Joe after getting that concerning letter?

A. The entry from June 17th, 2002.

Q. And that's about a month after getting that concerning letter from Dr. Levitan that Joe's cancer might

be back?
A. Yes, it is.
Q. And what is it that's in the note? What is it that's the next thing you hear about Joe Frankhauser after getting that letter?
A. There's a message that was left at our office.
Q. Okay. What does that message say?
A. Says, Phone, CP, chest pain, with pain radiating down both arms. Will go to the ER.
Q. And underneath that there is a note with the date June 18th and your handwriting; is that right?
A. Yes, it is.
Q. That is a note on your record about your telephone conversation with Dr. Kundtz the day before, correct?
A. It is.
Q. Please read for us what your note says.
A. I spoke with ER physician, negative EKG during pain. Give sublingual nitroglycerin as trial. Follow up in office for G.I. evaluation. Had CT, labs 4/02. Positive pulmonary nodule.
Q. What does that mean, Had CT -- what does that say?
A. Labs.
Q. Labs 4/02. That's April '02?
A. Yes.
Q. What does that say?

A. Positive.
Q. Positive pulmonary nodule?
A. Pulmonary nodule.
Q. The possible cancer?
A. Yes.
Q. Do you recall the conversation you had with Dr. Kundtz that day?
A. Yes, I do in some part.
Q. Why don't you tell me everything you remember about that conversation.

THE COURT: That will be a fairly long answer. Why don't we take a break before we do that. We're going to take another -- Well, let's make this another ten-minute break since you had a ten-minute break earlier. While you're out of the room keep in mind the instructions.

Rise for the jury.

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(Thereupon, a recess was had.)

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THE COURT: I think I should explain to the jury, as far as I can tell, we are on schedule, so things are moving along as we can expect. In terms of the overall time schedule, if our anticipation is appropriate, indeed it's

possible we might finish slightly earlier than that.

All right. You may proceed.

MR. VOLSKY: Thank you, Your Honor.

Q. (BY MR. VOLSKY) Dr. Cirino, before we broke I had asked you to tell me everything you remember about your conversation with Dr. Kundtz. Would you please do that.

A. Yes. I remember he had called. I was paged. I answered the page. I spoke with him. Identified myself. These were things that would be true. He let me know a little bit about what was going on at the time of that visit, as is often the case. Talked in a vague sort of presentation, you know, could we have some follow up. You know, could I see him. Did I know him. Could I take care of him. Nothing very specific in that regard.

Q. Did he tell you they couldn't come up with anything definite?

A. I can't quote those were his words, no.

Q. Did he inform you of the findings he had at that point in time?

A. I believe he told me about an EKG or chest x-ray or blood test, yes.

Q. Did he tell you that that patient had come in to the emergency room with chest pain?

A. I don't believe he did.

Q. Did he tell you that he had heartburn symptoms that had been gradually worsening over a month and now were severe enough that he had come to the emergency room?
A. He may have said those things. I don't have any direct recollection that those were the exact words that Dr. Kundtz used.
Q. But your recollection is that he told you about some chest discomfort that was not very well-characterized?
A. I believe what we heard so far was epigastric discomfort.
Q. That's pretty well-characterized, wouldn't you say?
A. Epigastric? How could that be well-characterized? That involves too many things.
Q. Because it's a certain type of chest discomfort?
A. Epigastric is the area that's below your xiphoid process, which is the arrow point at the bottom of your sternum there. So it's neither entirely in the abdomen nor is it entirely in the chest. That's why it's called epigastric.
Q. Doctor, on Page 51 of your deposition on Line 20 I asked you the question, Do you recall the conversation you had with Dr. Kundtz that day? And you answered, I do recall some elements of it. And then I asked you, Why don't you tell me everything that you remember about that conversation. And you answered, That there was some --

There was this idea of some 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.

Do you remember that answer?

A. That sounds reasonable. Yes.

Q. So at that point, closer to the time this happened, you told me that Dr. Cirino had told you about chest discomfort, not epigastric discomfort.

THE COURT: Excuse me, this is Dr. Cirino.

Q. (BY MR. VOLSKY) I apologize. Dr. Kundtz told you that at the time. You said that Dr. Kundtz told you that there was some chest discomfort, you didn't talk about it that time that it was epigastric discomfort now that you just distinguished there's a difference between epigastric discomfort down here and chest discomfort up here.

A. Exactly what I said; epigastric is midway between the two. Neither completely in the abdomen nor completely in the chest. It's certainly reasonable that chest or abdomen or epigastric can all mean the same thing at certain times depending what the context and the situation might be.

Q. So what he told you about was this idea of some sort of chest discomfort that wasn't very well-characterized?

A. Okay.

Q. Is that right?
A. Well, we'll have to take that, as that was my deposition at that time.
Q. That was your recollection at the time?
A. I'm sure it was my recollection at the time.
Q. Okay. Do you recall that Joe's prior esophageal cancer was discussed at that time?
A. No, I can't say that I do.
Q. Have you told us everything you remember was discussed?
A. I can't say that I have. There might be some other prompt or something else that will help me remember something else. But in general, when I'm called, I usually hear a little bit about the presenting symptoms and a little bit about the lab work and that's what I recall.
Q. I'm just asking you so that we don't have any misunderstanding later. As you sit here now, can you remember anything else about your conversation with Dr. Kundtz?
A. I don't remember any words that were used, but I'm sure there were other things that we discussed.
Q. Now, Dr. Kundtz told us before that he thought that the two of you very definitely discussed the fact he had had esophageal cancer and there was this recent ominous --

potentially ominous letter from Dr. Levitan about this pulmonary nodule that you write about in the summary of your conversation with Dr. Kundtz. Is that correct?

A. Well, it may not be entirely correct. First of all, Dr. Kundtz couldn't remember everything that he talked about, and in fact recollected very little about it. I don't blame him. There was nothing written down there at the time. At the time I received this phone call I was at home. So I'm not sure how much I knew about what I had previously read the month before on Mr. Frankhauser. This note was written when I got to the office the next morning.

Q. I see. So it could have been after your conversation with Dr. Kundtz you came in, looked at the chart and then said, I see this letter from Dr. Levitan about a pulmonary nodule?

A. That's hypothetically correct.

Q. You don't remember either way?

A. Well, no. I do remember that I was at home when I got this particular telephone call, so I could not have had the chart at the time.

Q. You might have remembered getting this alarming letter from Dr. Levitan a month before indicating that Joe's cancer might be back. You might have remembered that at the time of your discussion with Dr. Kundtz,

wouldn't you agree?

A. I would like to say that I can remember every letter I get about every patient that comes in to see me, but I can't honestly quite say that I would have known that at the time that I spoke with Dr. Kundtz. If I did, I would certainly tell you.

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

A. No. I think it's more fair to say that when I got to the office the next morning I did look it up.

Q. Doctor, you received eventually another letter from Dr. Levitan, the cancer doctor, with good news, didn't you?

A. Eventually I did.

Q. This letter from Dr. Levitan is dated June 13, 2002; is that right?

A. It is dated June 13, 2002.

Q. So it was written five days before you saw Joe on June 18th, fair?

A. No. It was actually dictated 6/22/2002 at 9:45 in the morning.

Q. Fair enough. Fair enough.

A. So it would have been I had already seen Mr. Frankhauser.

Q. So is it fair to say Mr. Frankhauser had seen Dr. Levitan on the 13th when he dictated the letter and put

the 13th at the top? Would your agree with that, or do we have to look at Dr. Levitan's office records to show when his appointment was?

A. I have no doubt his appointment might have been on 6/13/2002, but this was not dictated until 6/22/2002 at 9:45 a.m.

Q. I understand. The letter said after a course of antibiotics Joe had another CAT Scan of his chest and the abnormality that Dr. Levitan suspected was cancer was now gone. Is that a fair characterization of what Dr. Levitan told you?

A. Dr. Levitan wrote this letter, dictated this letter, and I received it on June 30, 2002.

Q. Thank you. That wasn't at all my question. My question was that this letter said that after a course of antibiotics Joe had another CAT Scan of his chest and the abnormality that Dr. Levitan suspected might be cancer was now gone?

A. It says the previously described upper right lobe infiltrate has cleared.

Q. So am I correct, yes, the letter says after a course of antibiotics Joe had another CAT Scan of his chest and the cancer that Dr. Levitan suspected was gone?

A. Yes.

Q. Thank you. It will go a lot faster if you answer my

questions, sir.

The fact that it was gone probably meant it was pneumonia that was cleared up by the antibiotics but definitely not cancer. Would you agree with that?

A. Well, it says that the right upper lobe infiltrate has cleared. It was not called pneumonia in the first place. That was one of the things on the list that was there. He was given an antibiotic. That was probably six weeks before that. So the CT Scan stands for what it is. It says whatever was there before had cleared.

Q. Cancer doesn't vanish on CT Scans, does it?

A. If you know that.

Q. Doctor, will you answer my question. A CT Scan, if the nodule vanishes that means it wasn't cancer. Would you agree with that, yes or no?

A. In general, if you're suspecting cancer and there's a change in the CT Scan, yes, it can mean that it was either not cancer in the first place, but you can't say. A CT Scan is a radiographic tool. It doesn't tell you for sure what it is. It does say something has changed.

Q. Doctor, I'm sorry if I'm a little frustrated. It's been a long day so I guess I'm getting a little frustrated that I can't get a straight answer.

This is what he says; that a CT Scan of the chest performed April 9 shows an ill-defined density

that was possibly an endobronchial lesion. Doesn't it say that?

A. Yes.

Q. I prescribed a course of Biaxin antibiotic therapy and arranged for repeat CT Scan of the chest, right?

A. Yes.

Q. On June 3 he underwent the CT Scan of the chest.

A. Yes.

Q. This was read and in comparison with the prior study. The previously described right upper lobe infiltrate has cleared. Right. So it's no longer there in the lung?

A. Correct.

Q. No hilar or adenopathy. There is no evidence of recurrent or metastatic malignancy.

Doesn't that mean Dr. Levitan has concluded that based on the fact this thing was gone after the course of antibiotics that it wasn't cancer?

A. That is his conclusion.

Q. Okay. That took five minutes.

THE COURT: Excuse me. Please don't make remarks. Just ask questions.

MR. VOLSKY: I'm sorry, Your Honor.

Q. (BY MR. VOLSKY) Doctor, when did you receive that letter?

A. June 30, 2002.

Q. So when you got that letter Joe was already dead; is that right?
A. That is correct.
Q. You never learned before his death that the worrisome abnormality suspected to be cancer was in fact not cancer?
A. No, I did not.
Q. So when you were talking to Dr. Kundtz on that fateful day, cancer was still suspected as far as you knew?
A. As far as I knew.
Q. You made a note of your conversation with Dr. Kundtz in your records, correct?
A. Yes.
Q. And your note summarizing your conversation said that Joe was coming in for a G.I. evaluation, not a G.I. heart evaluation; isn't that true?
A. It said G.I. evaluation. It did not say limited to G.I. evaluation.
Q. It did not say limited to G.I. evaluation?
A. I don't believe limited was in there.
Q. No, limited wasn't in there. Are you telling me that statement you wrote, follow up for a G.I. evaluation, meant he's coming in for an evaluation but it's not limited to a G.I. evaluation?
A. It says just what it says. It says follow up in the

office for a G.I. evaluation.
Q. Thank you. Let's get back to your conversation with Dr. Kundtz. Did you discuss that the EKG was negative?
A. I would say so, yes.
Q. Did you discuss that the blood enzyme test was negative?
A. I did not write it down there, but I would suggest that if we talked about the EKG then we probably talked about the enzyme tests.
Q. Your note says that an EKG was done during pain and it was negative. We've talked about the significance of an EKG being negative during pain.
A. Yes.
Q. So you would agree that you were aware that Dr. Kundtz was giving tests to determine if Joe's problem was his heart?
A. I was writing down what my recollection of the previous night's conversation was.
Q. Okay. Using all your training and experience, Doctor, if you write down negative EKG, you know that that means that Dr. Kundtz was considering a heart problem, was doing tests to consider a heart problem?
A. That would be a reasonable consideration.
Q. Thank you. You are fairly certain that Dr. Kundtz discussed with you the things that had to do with your

heart -- with Joe's heart, aren't you?

A. Well, if we spoke about an EKG and blood work, we were speaking of the heart, yes.

Q. You talked in general about various causes that could be the cause of Joe's problems, did you not?

A. How much we talked about, I'm not quite sure.

Q. And you discussed the possibility of cardiac or heart cause to the complaints, didn't you?

A. I think what we discussed was this was after the visit was nearing its end, so we were speaking about the EKG and speaking about the blood work and obviously some of that was done with regard to heart issue.

THE COURT: Again, let me suggest, please listen to the specific question. If it is one that calls for a yes or no answer, begin your answer with yes, or no, or I don't know, or I can't answer. But you're welcome to give further explanation, but it's easier for us if you begin with a response that is direct.

THE WITNESS: Okay.

THE COURT: Thank you.

Q. (BY MR. VOLSKY) Doctor, on Page 61 of your deposition I asked you a very simple question. Question, Did you discuss cardiac as being a possible cause? And you answered, I think I answered before when you asked the

same question that since we had discussed the EKG and blood levels, yes, we had discussed some cardiac causes. Is that correct?

A. I think that's what I just repeated here.

Q. You knew that based on Dr. Kundtz's evaluation that he could not come up with anything definite; is that true?

A. I believe so.

Q. And nothing had been ruled in or ruled out by him?

A. Okay.

Q. Is that true?

A. Yes.

Q. That's a different answer than okay.

THE COURT: Don't argue with the witness. Just ask questions.

Q. (BY MR. VOLSKY) What did you mean okay when you answered when then you answered yes?

A. Okay and yes might mean the same thing when you come up with -- I'm sorry. Can you ask the question again?

Q. Well, okay to me means if you say so and yes means yes. Did you mean a difference in your answers of okay and the next time yes?

A. What was the original question?

Q. We'll move on.

So nothing had been ruled in or ruled out?

A. Nothing had been ruled in or ruled out, yes.

Q. Which means it had not been confirmed, no diagnosis or condition had been confirmed, and none had been excluded?

A. Okay.

Q. Doctor, wouldn't you agree that in your experience whenever you get called by an emergency department physician they generally don't have time to definitely rule in or rule out anything specific in such a limited visit?

A. Well, that's not quite true.

Q. What is true?

A. If somebody comes in with pneumonia and they have an x-ray that shows pneumonia and they give antibiotics, they've essentially ruled that in. I'm certain there are people that come into the emergency room that may not have a definitive answer.

Q. Dr. Kundtz told us about how busy he is and it's not his job to figure out what the patient's problem is all the time, the not life-threatening ones.

A. If that's what Dr. Kundtz spoke for himself.

Q. Would you agree?

A. If that's what Dr. Kundtz says, that's fine.

Q. Is that what you expect from an emergency department physician?

A. I expect an emergency department physician is going

to look at a patient, take care of the patient, take a history, do whatever testing he feels is necessary and come up with whatever decision he can make.

Q. The exception would be that to -- I'm talking about a person with chest pain symptoms. The exception would be that if the first EKG or blood enzyme shows that the patient has had a heart attack, then the emergency room physician can make that diagnosis immediately and get that patient care. Would you agree with that?

A. That would be a fairly easy thing, yes.

Q. But short of that, you understood that Dr. Kundtz was not in a position to make a final determination as to whether or not a potential heart problem was the cause of Joe's symptoms with only one EKG and one blood enzyme test? You understood that, right?

A. Yes, I do.

Q. You would agree with me that heartburn or epigastric pain and discomfort can be associated with too little blood to the heart?

A. That's one of the many things that it can be associated with, yes.

Q. Okay. You knew that the EKGs and blood enzymes that were not spread out over hours and repeated at least two more times could not eliminate the possibility that Joe was having either a heart attack or unstable angina in the

University Hospitals emergency room?

A. I couldn't have known that.

Q. You couldn't have known what?

A. I couldn't have known everything that went on with the visit. I knew that there was an EKG and I knew there were some enzymes and there was no diagnosis made, so I guess everything was still possible.

Q. Everything was still on the table?

A. Okay. Yes.

Q. What is a differential?

A. A differential in medicine is where you think about all the possible and probable causes of anything that comes in.

Q. A heart problem was still on the differential when Joe walked out of the emergency room at University Hospitals that night, wasn't it?

A. I suppose that's true, yes.

Q. Now, when you got off the phone with Dr. Kundtz at some point you put down in the chart if you claimed -- and I have no reason to dispute you -- you were home when you got the call, you came to the office in the morning and that's why it's dated the next day, but you put down in Joe's records so there would be an accurate reflection of the important parts of your conversation with Dr. Kundtz; is that right?

A. Yes.
Q. And that's where your summary of that conversation included quote, Follow up in office for a G.I. evaluation, end of quote; is that right?
A. Yes, it is.
Q. If you understood after talking to Dr. Kundtz that nothing had been ruled in or out, including his heart, why did you write that he was coming in for a G.I. evaluation?
A. Well, at the time I wrote down what I felt was what I got out of the conversation.
Q. Was it your understanding of the conversation with Dr. Kundtz that you two had agreed that heart had been excluded as a possibility and that what the two of you had agreed to was that you would follow up and perform a G.I. evaluation?
A. I think we can both agree, Dr. Kundtz and I, that Mr. Frankhauser would follow up in the office to determine what would be done there. I'm sure I would start all over again and take a history and physical and try to come up with a plan.
Q. Then why would you write down for G.I. evaluation?
A. Maybe to remind myself what happened the night before. Perfectly reasonable.
Q. A G.I. evaluation is much different than a chest pain evaluation. Wouldn't agree with that?

A. You're speaking of a gentleman who had both organs in the same place.

Q. Are you saying and trying to tell this jury under oath that when you said G.I. evaluation is because Joe had some G.I. in his chest that that included a heart evaluation?

A. I didn't say that, nor does that imply that, nor is that limited to that.

Q. Is that your testimony that when you wrote G.I. evaluation it included a heart evaluation because Joe had G.I. in his chest?

A. No.

Q. Okay. Doctor, you're the one that decided to write follow up for G.I. evaluation. That's your decision-making process?

A. Yes.

Q. Are you telling us you were going to do an open-ended evaluation including the heart and consider every possibility without any bias towards the cause being G.I. in nature?

A. No. Well, you can say that you would like to believe that you don't have any bias for anybody under any circumstances. We all know that things that you hear, read about, see, may influence some of the things you will do. So you take that part and then you do your own part.

You do what you think is the best thing to do.
Q. If you weren't really thinking that the problem was G.I. and none other, why would you write down after following up in office for G.I. evaluation this reference to the CT lab and the labs of April 2 indicating a positive pulmonary nodule which could have been a sign of the return of his esophageal cancer?
A. Well, actually I thought it was a good idea since I didn't have them at the time I spoke with Dr. Kundtz to look at the records and see what was in there.
Q. And that's what you were putting two and two together with? You indicated you were going to do a G.I. evaluation because you looked in Joe's chart and you saw Dr. Levitan's letter and you said, uh-oh, he's got epigastric pain and he's in the emergency room and now he's got this pulmonary nodule that Dr. Levitan thinks could be cancer, and you started thinking, uh-oh, this guy's cancer's back. Isn't that true?
A. Well, not only that. I mean, first of all, it would be ridiculous that I didn't consider those things. If you have that information, you must use it. You can't ignore it. But that still doesn't limit you from looking at what else is going on.
Q. Did you write down Dr. Kundtz hasn't ruled out heart so I better look at the heart, too?

A. I don't think I would write that down. I did not write that down.

Q. Okay. When Joe walked in your office that day you're thinking G.I. and you're thinking pulmonary nodule and you're thinking uh-oh, this guy's cancer's back. Wasn't that at the forefront of your thinking?

A. I can't say it is, Mr. Volsky. I don't know how you can ask me that.

Q. It certainly was in the forefront of your thinking when you wrote that note, wouldn't you agree with that?

A. What I wrote there was exactly what it says. It was a conversation from the night before and in looking up some labs. I had to use the information I had at hand. It's part of your tools to find out what's going on.

Q. It's okay to write in and remind yourself as long as when you come in you're going to consider everything and not just do a G.I. evaluation.

A. It doesn't say limited to G.I. evaluation.

Q. It sure looks like it says it to me.

A. I'm sorry. It does not.

THE COURT: That will go out. Do not make comments. Just ask questions.

MR. VOLSKY: I'm sorry, Your Honor.

Q. (BY MR. VOLSKY) So it is your testimony you continue to insist you were planning to do an assessment and

consider everything including heart?
A. Yes.
Q. Dr. Kundtz's testified that he told you he thought Joe's problem was G.I. Is that your recollection?
A. That could be my recollection.
Q. Well, could be your recollection is not the issue. Do you have a recollection?
A. Are you speaking of Dr. Kundtz's conversation with me or his recollection of the visit with Mr. Frankhauser?
Q. That's a fair question. In his conversation with you.
A. We mentioned a couple of different things. I don't think there was any definitive answer made either way.
Q. You don't recall him telling you he thought Joe's problem was G.I.?
A. Dr. Kundtz already testified that he didn't recall the conversation very well.

THE COURT: The question was not about what Dr. Kundtz testified. The question was about your conversation with him that evening. Whether he was right, wrong, confused or whatever. Please try to answer that question.

Q. (BY MR. VOLSKY) Do you guys understand you guys aren't a tag team. You have to answer the questions as to what you remember.

A. That's what I'm trying to remember.
Q. It's different than what Dr. Kundtz said. I'm asking you do you remember him telling you that he thought that Joe's problem was G.I.?
A. I could remember it that way, yes.
Q. Dr. Kundtz has also testified that even though he thought it was G.I. he knew that heart problem was still a possibility and that he expected that since he was referring Joe back to you that you would do your own evaluation and come to your own conclusion as to what the problem was. Was that your understanding of what you had agreed to do?
A. Yes, I believe that's what I intend to do anytime I get a phone call.
Q. Dr. Kundtz testified that he believed that you would do your own assessment and make your own evaluation as to whether or not a heart workup was needed. Was that your understanding?
A. That would be my understanding.
Q. You understood, did you not, when Joe and Gerry walked into your office that day Joe's life was potentially in your hands?
A. I don't want to be dramatic about it. Anytime somebody comes in you try your best to do what you can do. So I'm not sure that it was at that kind of level that we

were thinking at that time. I could be wrong.
Q. That's because you weren't really thinking about the fact that he could have a life-threatening condition, acute coronary syndrome; isn't it true?
A. It's only partially true. It's one of many different life-threatening decisions.
Q. Were you aware that Dr. Kundtz on his differential had two things at the top of his list; G.I. and heart?
A. Yes.
Q. Were those two that were at the top of your differential?
A. I believe so.
Q. You were the captain of the ship at that point, that is to say you were in charge of assessing Joe and figuring out what was wrong with him to the best of your ability. Would you agree with that?
A. I don't like the cliche captain of the ship. I do try to use all the available information to try to help somebody, yes.
Q. You understand that Joe was now in your hands to figure out what was wrong with him?
A. I understand Joe was in for an office visit that morning and was in the emergency room the night before and we were going to try to figure out what was wrong with him.

Q. Would you agree that each physician who sees a patient after a prior emergency department visit where no diagnosis has been made is absolutely responsible for determining what's going on with the patient himself to the best of his or her ability?

A. You should always determine what you're trying to figure out to the best of your ability.

Q. I want you to assume that your expert, Dr. Dell, is going to come into this courtroom and testify that you were allowed to rely on Dr. Kundtz's assessment because Dr. Kundtz was your eyes and ears. Assuming that he comes in and says that, do you agree or disagree with him?

A. Same as I have testified to already; you can't ignore something that somebody else tells you. You still have to make your own determination about what's going on. That's the only fair way to do it.

Q. Do you agree that in general all internal medicine specialists, such as yourself, should take care -- who take care of a patient who has been discharged from an emergency department and told to follow up with their own doctor know that when they evaluate that patient they should not take anything for granted and should do their own history, do their own physical examination and make their own assessment?

A. I think we've already discussed that several times.

Whenever somebody comes in you use all the available information. Yes, you take your own history, yes, your own physical examination, and then try to figure out what to do, yes.

Q. Now, there's a note in Joe's chart with the date June 17th, the day he was seen by Dr. Kundtz in the emergency department at University Hospitals, that says quote -- Let me come over and point it out -- in parentheses, phone, chest pain with pain radiating down both arms. Will go to UH, University Hospitals, emergency room. Is that in there?

A. Yes, it is.

Q. Who wrote that?

A. It would be the medical assistant.

Q. Somebody in your office?

A. Somebody in my office.

Q. It wasn't written by you?

A. It was not written by me.

Q. Do you know when Joe or somebody had phoned your office to let you know about Joe's symptoms and the fact they were going to the emergency room at University Hospitals?

A. I'm going to figure either that day or the next day when I pulled the chart to write my own note.

Q. You would agree you knew about this note at the time

you wrote about your discussion with Dr. Kundtz because it was sitting right there right above where you wrote?

A. Yes. They're proximal to each other.

Q. And you would have obviously seen that when you went to write your note about the conversation with Dr. Kundtz?

A. Yes.

Q. Okay. So you admit when Joe Frankhauser came into your office that day you knew that he had had chest pain which had radiated down both arms?

A. I knew that note was there, yes.

Q. Do you agree with your own expert, Dr. Moss -- and I want you to assume that he testifies -- that if you knew that Joe had chest pain which radiated to his arms you needed to ask the questions necessary to see if Joe's symptoms could have been caused by too little blood to the heart?

MR. KILBANE: Objection whether that is the testimony of that witness if that witness is going to appear. Until they're here --

THE COURT: The question is do you agree with that statement.

A. Yes.

Q. (BY MR. VOLSKY) Doctor, can chest pain which radiates down the arms be caused by too little blood to the heart?

A. That's one possibility, yes.
Q. Doctor, can we agree that since heart had not been definitively ruled out by Dr. Kundtz and remained at the top of his list of possible causes of Joe's symptoms, or on the differential, you had an obligation to consider and assess whether or not heart was the cause of Joe's symptoms?
A. Two parts to your question I believe. One was that it was on his differential or whether it was on the top, and the second was should I make my own decision based on that. The first question I believe was I'm aware that Dr. Kundtz was thinking about those two things. And the second question is still the same answer; yes, use the available information, you have to try to find out what's going on. If something is ruled in or ruled out, you still need to make that determination.
Q. You agree you had an obligation to consider and assess whether or not heart was the cause of Joe's symptoms when he came to see you on the 18th?
A. Yes, among other things.
Q. Can we agree that if someone is working up a cardiac or heart problem that the doctor would want to know as much information as they possibly could about the symptoms that the patient was having?
A. Yes.

Q. Doctor, do you agree that starting in medical school doctors are trained on how to do an assessment of a patient complaining of chest pain?

A. The first two years of medical school are mainly book learning. It's not until the third and fourth year that you get some real life patient experience, so it's at that time you start to do your clinical mode.

Q. Are you aware of the seven or so factors that help a physician determine whether or not the problem is a potentially deadly heart condition?

A. I suppose so.

Q. What does quality of chest pain mean?

A. Quality would be the nature of the pain.

Q. Is the quality of the pain important to know about in a chest pain patient?

A. Yes.

Q. Why?

A. Well, it can help make you determine if there's anything that's going on that will lead you down one way or another to help figure out the problem.

Q. Is the location of where it hurts important to know in a chest pain patient?

A. I would say so. Again, you have to understand that most of these are not very specific. That's why there are so many different ones. You use a little bit of

everything to help figure out what is going on.
Q. Is whether or not the pain radiates into another part of the body important to know about in a chest pain patient?
A. Again, it's important with the caveat that there is only a few times when it absolutely means something and then there's many times that it doesn't mean as much and there's sometimes that it doesn't mean anything at all.
Q. It means enough to be one of the seven factors that you learn to ask about when deciding whether it's ischemic cardiac disease, isn't it?
A. I suppose that's why you need seven different things to come up with an answer.
Q. No question. There is no silver bullet. But there are seven areas that you're supposed to try to elicit as much information as you can in order to try to pinpoint the cause as coronary ischemia; is that correct?
A. I'd like to think that every history can come to that conclusion. So if you like to use those things as one way of trying to figure out the information, that is the way to do so.
Q. Well, I'm not using those things. That's what you're taught in your second two years of medical school and you use throughout your training; isn't that true?
A. Use throughout your life.

Q. Absolutely. And pain which radiates and where it radiates is one of the seven factors?

A. Again, there is about radiation pain and you have to know where it is and where it goes and how that can help play a role in what you're trying to find out.

Q. Is the intensity of the pain important to know about in a chest pain patient?

A. I suppose. I don't think I can rank order the seven things and you're going to get me to say which is most important. That's again why you use all seven or parts of the seven to try to figure out what you can.

Q. Is the frequency or how often the pain occurs important to know in a chest pain patient?

A. Again, some elements of frequency are going to be important, some elements are going to be less important, and it really depends on the answers to the questions.

Q. But you got to ask the questions?

A. You have to ask some of the questions. I don't mean to say that anybody that comes in with chest pain we have a little sheet that has seven things on it that you ask all those things and write down that answer one at a time. You have a conversation with people. You sit down, try to talk about what's happening and in there you'll work in a little bit of everything.

Q. But if you ask the questions and you continue to not

be sure, you better keep asking more questions to get more information of the seven factors. Would you agree with that?

A. Not necessarily, no. At some point when you've asked so many questions and you're still having trouble -- and I'm just talking about any condition now -- coming up with an answer, you might try something else.

Q. What are associated symptoms in a chest pain patient?

A. Associated symptoms would be -- We've heard this before those that don't necessarily have to do -- Specifically if we're talking about the heart, these include sweating, and radiation, the breathing, any other symptoms either on the skin, on the chest, on the chest muscle, on the back.

Q. I didn't hear you mention shortness of breath.

A. I said in the chest.

Q. Okay.

A. I thought that was going to be another question for me.

Q. You're anticipating. Shortness of breath is a symptom, an associated symptom, consistent with coronary ischemia?

A. Sometimes it is.

Q. What are precipitating factors in a chest pain patient?

A. I'm afraid there are quite a few. Be anything from emotional distress, to physical exertion, to cold air, to we've spoken about meals, we've talked about physical activity, and we've talked about having no exertion leading up to this.

Q. And you agree that having chest pain after a big meal can be associated with coronary ischemia?

A. It could be consistent with it, but it's certainly not unique to it.

Q. Would it be important to know when the serious pain started in a chest pain patient?

A. Again, you try to figure out everything that you can based on the information that you're getting.

Q. Doctor, do you have a recollection of this office visit with Joe Frankhauser?

A. Yes, I do.

Q. Do you remember whether or not Gerry was present during the whole visit?

A. At this point I do.

Q. At this point you do. What is your recollection?

A. She was there for the visit.

Q. She was there for the whole visit?

A. Yes.

Q. What history do you recall being given?

A. What history do I recall being given?

Q. Yes.
A. Not only what is written down in the note that is there, but the history about what brought them to my office that morning.
Q. Well, tell me. What do you recall about the history you were given.
A. The history that I was given started off with the visit, came in the room, talked about again what had happened the evening before, asked about the problem at hand and tried to find out a little bit about what was going on and what had led up to that and then started to get some responses and wrote down what I felt was appropriate, and that's the part obviously that I'll remember a little bit better.
Q. Well, I'm going to ask you, you just gave me a very nice overview, but I'm asking you in detail to tell us everything that you remember that happened in that visit as far as what history you got.
A. Okay. With the caveat that I wish I could remember every single thing that went on, but I can't.
Q. Let me stop you for one second. I don't mean to interrupt but your answer has brought to mind another question. You said you remember this visit. Do you remember every aspect of the visit?
A. No way to remember every aspect of the visit.

Q. I'm trying to get the jury to understand what you're testifying based on, and I'm not implying that you should remember everything about the visit because you see hundreds and hundreds of patients and I understand you can't remember every detail about the conversation. So as you tell me you do remember it but you go and grab your office chart, I need you to explain to us what you're testifying to based on what's written down as compared to what you really in your mind's eye remember about this office visit.

A. I'd be glad to tell you that.

Q. Please.

A. Because this is the office that I currently practice at, every day I go into the same room that I was in for this particular visit, so you're obviously going to remember some things that aren't only here. When you write something down, that will also determine what you were talking about. No matter what is written down, that led up to something being asked, something being said. Would you like me to go through the note?

Q. I would like you to tell us everything that you specifically remember, not speculate and guess might have happened or based on your custom and practice. I want to find out what you remember happened in this visit, the one that Gerry was at this whole visit. Is that right?

A. Yes.

Q. Okay.

A. Here's the things I remember because I wrote them down. This was a sick visit, so it was noted as a sick visit. Means it wasn't a prescheduled visit. So that I knew. I had known because of the phone call from the day before.

I wrote down three days feeling food stuck in throat. So if I wrote that down that means I had been asking questions and remember asking questions about things that have to do with the upper chest. They would be pains or pressures or swallowing because what I ended up writing down was a summation of those things.

I asked various different frequency and associated symptoms, and the ones that I wrote down I felt at the time were most pertinent going on. So that I remember also.

I remember doing an examination because I wrote it down. Doesn't mean that's the only examination I did, but those were the key points that were there.

I remember forming an impression because that's what we did at the end of every visit. I specifically remember looking up some of the labs from the night before since I really did not have a copy. All I had was what Dr. Kundtz would have told me. Talked about

some medications.

I excused myself to make a phone call to a physician. I remember that. I remember having to come back, explain everything again and then for follow up. So those things I can recall.

Q. Do you remember any specific questions that you asked Joe about his symptoms?

A. I'd like to remember exactly what specific questions, but I'm afraid that's outside of anybody's real knowledge.

Q. Very good. Okay. But Gerry Frankhauser was a witness to what happened in this visit, wasn't she?

A. Yes.

Q. Wasn't she?

A. Yes.

Q. Yes.

MR. VOLSKY: Your Honor, can we approach?

THE COURT: All right.

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(Thereupon, a discussion was had between Court and Counsel outside the hearing of the jury and off the record.)

- - -

THE COURT: It's approximately 20 minutes after, and there are some scheduling issues that

do not concern you, so we're going to recess early. You get ten minutes off today.

While you're out of the room, again, keep in mind the instructions. As we go along that gets harder because obviously you're hearing more information and with that more information you feel you're ready to discuss things. But you're really not ready to discuss things until the case is concluded and it's submitted to the jury. Among other things, you've not heard all the evidence, you're not heard my instructions of law which are critical to your evaluation, and you've not had the chance to discuss it with each other, which is extremely important.

I remind you again that when you're in the hallway you should recognize that the participants in the trial will not discuss anything with you, and again you should not try to encourage that. I'm sure you don't. I also remind you that you're not permitted to go out and look for other information. It's very tempting to say, gee, this fellow said this, this fellow said that, I'm going to look it up. Don't do it. Don't look it up. Don't read a book. Don't call anybody on the phone. Don't read anything on the internet. This

is the only place you'll get any information to decide this case.

See you tomorrow morning at 9:00.

Rise for the jury, please.

- - -

(Thereupon, proceedings were adjourned to 9:00 a.m., on Wednesday, April 12th, 2006, at which time the following proceedings were had:)

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WEDNESDAY MORNING SESSION

APRIL 12, 2006

MARKUS, J.: Mr. Volsky, do I understand you're continuing with your questions of Dr. Cirino?

MR. VOLSKY: Yes, Your Honor, that's correct.

THE COURT: Dr. Cirino, would you kindly return to the stand.

- - -

CONTINUED CROSS-EXAMINATION OF ROBERT CIRINO

BY MR. VOLSKY:

Q. Good morning, sir.

A. Good morning, Mr. Volsky.

Q. Doctor, at the end of yesterday, if you recall, I asked you a couple of times to tell us everything you specifically remember about this office visit with Joe and Gerry. Did you think of anything now that you've thought about it overnight and I assume talked to your lawyers since we last spoke.

MR. KILBANE: Objection.

Q. (BY MR. VOLSKY) Anything, anything more you remember with this office visit?

A. Just the things I had mentioned yesterday.

Q. Okay. Now, yesterday you said something about asking

questions about the upper chest. Do you remember saying that yesterday?

A. Not exactly.

Q. You don't remember?

A. I remember what we were talking about. I don't remember upper chest being used.

Q. I asked Karen to take notes of all the things you are thinking. One of the things she had written down is about upper chest.

MR. KILBANE: Objection.

Q. (BY MR. VOLSKY) Do you remember talking to the Frankhausers about the upper chest?

A. Yes.

Q. Okay.

A. How's that?

Q. That's fine. That's fine. What did that mean?

A. Symptoms related to the upper chest, yes.

Q. Like what? What questions did you ask about the upper chest?

A. Like what's going on. You know, tell me a little bit about what your problem is. And I might not have used the word problem. I'm not sure of the exact wording, but obviously when somebody's coming in with something you're trying to figure out, you try to ask a bunch of questions that just helps them lend them get an answer. You hear

what they say, you use their body language or verbal clues to try to figure things out.

Q. And I think your note, you know, talks about asking about a couple things about the upper chest. Does that include the throat when you're talking upper chest?

A. Oh, yes. I would believe so.

Q. All right. That's what I want to clarify. Just for the jury's help, I hope you can read it, Mr. Kilbane has been kind enough for us to use your interpretation of your note so the jury can see and perhaps easier read. I'm going to --

THE COURT: I'd rather you not have a conversation with jurors even if it's about mechanics. I'll ask the jurors to tell me if they have a problem and we'll do what we can. It's better that you not have discussions with the jurors. That could be misunderstood. So it's better that you tell me if there's a problem and try to help.

MR. VOLSKY: I apologize. I should have done the same. I'm sorry.

THE COURT: Let's move on.

MR. VOLSKY: Okay.

Q. (BY MR. VOLSKY) When you talked to Dr. Kundtz he was telling you about epigastric discomfort; is that right?

A. Yes.
Q. And that's different? That's the lower chest or down below, correct?
A. Okay. And that's really an okay rather than a yes or a no, because epigastric means above the gastric, and gastric is the stomach, and so it means anything in the stomach or above. So when your stomach's in the normal place, epigastric would be including the chest and epigastric itself. In this particular situation it is also the chest.
Q. Fair enough. Was your understanding in talking to Dr. Kundtz when he described epigastric pain that he was talking the upper chest, the lower chest, or the whole chest?
A. I would have to say the whole chest.
Q. Okay. Now, you said yesterday that at some point you remember getting a phone call and you excused yourself and you came back and you said you explained it again. What did you mean by that?
A. I'm sorry, explained what again?
Q. I don't know. That's what I'm asking you. You said that you came back from the phone call, and spoke to the Frankhausers --
A. Picked up the conversation.
Q. Excuse me, let me finish, then you can have whatever

opportunity you want to answer.

You came back into the room after leaving the room and you used the words I came back to the Frankhausers and explained it again, and I don't understand what you explained again.

A. I'm not sure where we were at that point in time of the visit when I had mentioned that. Whenever I excuse myself I try to ask the last thing again when I come back in the room so we can pick up where I left off.

Q. Fair enough. Did you ask a lot of questions to try to figure out the cause of his symptoms?

A. I believe so, yes.

Q. Do you remember your lawyer saying in opening statement that the patient has the responsibility to tell the doctor what problems he or she is having? Do you remember that part?

A. Yes.

Q. When it comes to chest pain, doesn't the doctor have the responsibility to ask the important questions that they have learned since medical school to find out about the chest pain?

A. I feel they're shared responsibility. When you're having a conversation it's not a lecture, so you're not only saying one thing. The patient isn't only saying one thing. You meet in the middle.

Q. You wouldn't expect a patient to know what the significance of the features of the chest pain is which make it more like ischemic in origin or esophageal or any other problem, do you?

A. My only expectation is only to try to get down to what they really feel.

Q. If you want to get information about the quality of the pain, or, you know, the frequency of the pain, or, you know, any of those six or seven factors that we have talked about, I'm sorry to say over and over again, those are things that the doctor knows are significant that the patient doesn't know. Wouldn't you agree with that?

A. Not entirely. We really like to hear from the person themselves.

Q. If you feel you don't have enough information, isn't it your job to ask more questions to get the information from the patient so that you're comfortable you can make a decision as to what's wrong?

A. Yes. That is what a history taking is all about. Trying to help facilitate getting an answer.

Q. Since you're trying to get to the bottom of Joe's problem to the best of your ability, what do you recall specifically as you sit here today were the questions you put to Joe and what were the answers?

A. I said, you know, what does this feel like to you

and, you know, how is it affecting you, and can you tell me a little bit about what's been going on. And the answers were, you know, feels like food stuck in my throat. So that to me was a fairly significant response. It's fairly significant and specific. So again, the idea is well, what is it all about? It's not something very specific. It tells me a little bit about it. I don't understand, help me out here.

Then there's questions about, you know, is it associated with nausea, does it make you feel like you want to throw up. And then the next thing is when people have food stuck in their throat or that sensation it's really important because the sensation, that stays there for much longer than it might be there. It might increase the gastric juices, so there are questions with what does it feel like. I mean, do you feel this? Do you feel, you know, heartburn symptoms?

You know, what can happen if people do have food stuck in their throat is they can aspirate it. Meaning if it's sitting there you can easily throw it back into your chest, too, and in your lungs and that can cause other problems such as breathing, fever, infections. It's a very common cause of aspiration where, you know, the old went down the wrong hole saying. We all know what an uncomfortable sensation that is. So those questions were

asked.

Q. Those were the questions that were asked. Any others that you remember?

A. Well, you know, what other things, you know, are associated with this, and then obviously asked about, you know, how it relates to breathing, and that is is it worse with breathing, is it better with breathing, does it make you breathe harder, is there anything that can provoke it into that. And those questions were asked also. And following from that is, you know, again, how does it affect you? What does it feel like?

Q. Is it fair to characterize what you've just told us as a review of the feeling of this epigastric discomfort and food stuck in the throat?

A. It's a review of the chest, yes.

Q. It's a G.I. question? All the questions you asked are related to gastrointestinal, weren't they?

A. No, Mr. Volsky, not exactly. When you ask about things like fever, when you ask things about worse with deep breathing, obviously you're not limited to just the gastrointestinal things.

Q. Fair enough. Most of the things you just mentioned; the food stuck in the throat, the extra salivation, the possible extra gastric excretions, all those things are geared toward the G.I. evaluation; is that fair?

A. All those things are geared towards the patient's response.

Q. I'm asking a more specific question. Certainly it's a patient response. You ask a question, and Joe responded to it?

A. Yes.

Q. But each of your questions was trying to elicit information about a G.I. related issue?

A. Most of the questions were based on the previous answer by the patient himself.

Q. Do you remember any of Joe's responses to your questions other than it feels like food stuck in the throat?

A. Well, if I put down these things --

Q. I don't mean to interrupt, but I want to regear my question. I don't mean to be rude. I don't want you to testify based on your assumption based on your chart. Right now I'm asking your recollection, what you recall, any answers that Joe gave you.

A. My recollection is very small if only because in my office anyway Mr. Frankhauser was a man of very few words.

Q. Would you say that's true of Gerry Frankhauser, was she a woman of very few words?

A. Well, I mean, there's nothing incredible to say about that.

Q. But it's your testimony that it was Joe Frankhauser who responded to your open-ended question, How are you feeling, Joe? What's the problem? It's your testimony that he said, It feels like food stuck in my throat, rather than you testifying -- I'm sorry, you saying to him, Joe, does it feel like food stuck in your throat? Are you sure that it was Joe that said that?

A. Here's what I'm certain of; between the two of us, we agreed that it felt like food stuck in his throat because that was his response, yes.

Q. Okay. Please try and answer my specific question. Is it your testimony that you are sure sitting there under oath that Joe Frankhauser answered your open-ended question something like, What's bothering you, Joe, what's the problem, Joe Frankhauser characterized it as food stuck in his throat rather than you characterizing it that way and asking him, Does it feel like food stuck in your throat?

A. The same answer, Mr. Volsky. When you're having the conversation, that was what came up and that is what was answered. I can't say it any other way.

Q. Okay. Then I'll ask you a specific question. Are you sure whether or not you said does it feel like food stuck in your throat, or Joe offered that answer as an explanation for his symptoms?

A. I'm not certain exactly how it came out. I know that was the end result.

Q. Fair enough. If Mrs. Frankhauser -- I want you to assume that Mrs. Frankhauser is going to testify that you asked Joe, Joe, what's the problem? And he said, I've got pain in my chest. And you said, Does it feel like food stuck in your throat? And he shrugged his shoulders and said, Yes. Would you have any reason to dispute her testimony on that issue?

A. You're asking me to assume that I asked a question about chest pain?

Q. No. I'm asking you to assume there is going to be testimony from Mrs. Frankhauser and her testimony is going to be what happened was that she came in, you came in afterwards, you had a little discussion about something else, and then you said an open-ended question, Joe, what's the problem? He said, I've got pain, and he grabbed his chest and said, I've got pain in my chest. And then you asked him, Does it feel like food stuck in your throat? And Joe then shrugged his shoulders and said, Yes. Would you dispute that version of the facts if that's what Mrs. Frankhauser testifies to?

A. Whatever Mrs. Frankhauser testifies to is fine. What I would say what happened is exactly what I've said, and I really mean to say that as what happened. That is, if

somebody says, I feel like it's food stuck in my throat, whether you put your hand here or here (indicating), I don't think it makes any difference. If the response was, Chest pain, I would have asked or recorded different questions than what's actually there. So in partnering with the patient, I asked the questions that seemed appropriate at that time for him, and that is what happened.

Q. Dr. Cirino, with all due respect, I appreciate and thank you for your answer, but I think you're dancing around my question which is a very direct one. Would you dispute that it was you that suggested the symptom it feels like -- does it feel like food stuck in your throat?

MR. KILBANE: Objection.

Q. (BY MR. VOLSKY) Do you dispute that?

THE COURT: Overruled. You may answer.

A. I won't dispute any testimony. All I can say is that it came up that food was stuck in the throat. I agreed with that, and that's what happened.

Q. (BY MR. VOLSKY) When you say you agreed with that, you seem to be implying that Joe said it feels like food stuck in his throat. And I'm asking you would you deny Mrs. Frankhauser's testimony that those words never came out of Joe's mouth, they were your characterization?

MR. KILBANE: Objection. Asked and

answered.

THE COURT: Overruled.

A. My characterization is that if Mr. Frankhauser was asked directly was food stuck in your throat, the answer is yes.

Q. (BY MR. VOLSKY) I honestly don't think it's that hard.

THE COURT: Go to the next question rather than arguing with the witness.

MR. VOLSKY: Okay.

Q. (BY MR. VOLSKY) Do you know whether or not you said it was food stuck -- Do you know whether or not what actually happened was you suggested to Joe, Joe, does it feel like food stuck in your throat, or was it to an open-ended question, Joe, what's your symptoms, what's bothering you, and Joe is the one that characterized it was food stuck in his throat? Do you know which one it was?

A. I think it would be the latter.

Q. But you don't know?

A. This is the best that I can remember from here.

Q. You don't remember. Okay.

Let's talk a little bit about this record.

MR. VOLSKY: May I approach over here, Your Honor?

THE COURT: Yes.

MR. VOLSKY: Thank you.

Q. (BY MR. VOLSKY) Doctor, who wrote this note?

A. I did.

Q. You did. When did you write that note?

A. During the course of the visit.

Q. And you wrote that whole note during the course of the visit?

A. Sometime there and right afterwards.

Q. Okay. There's a line up here; is that right?

A. Yes.

Q. And there's an initial there. That isn't yours?

A. That's correct.

Q. Whose is that?

A. The medical assistant.

Q. And the medical assistant is the one who put in the date; am I right?

A. Yes.

Q. And the weight and the blood pressure and the pulse. That's part of their normal job before you come in the room?

A. Yes.

Q. Then there's this chief complaint with a question mark chest pain?

A. Yes.

Q. Is that right?
A. Yes.
Q. Okay. What does chief complaint mean?
A. The main reason for the visit.
Q. It's the main reason the person's coming to see you?
A. Yes.
Q. Doctor, I assume when you made this note you would write down the significant items that you felt were important to you making the ultimate assessment as to what you felt Joe's problems were?
A. Yes.
Q. Doctor, please read for us what your note says as far as the history you got from Joe himself that day.
A. Three days of feeling food stuck in throat without nausea, vomiting, increase in salivation, fever. Worse with deep breath. Asymptomatic. Vital signs noted.

Do you want me to keep going?

Q. If there's more history that you got from Joe, please tell us.
A. That's the historical information.
Q. Joe had been telling you he'd been having this problem for three days, correct?
A. Yes.
Q. And he told you it felt like food stuck in his throat; is that right?

A. Yes.
Q. Doctor, was the symptom of feeling like food stuck in his throat a vague symptom that was not well-characterized?
A. I would say that's a little bit more specific than everything else.
Q. Okay. Didn't you tell us that in that conversation with Dr. Kundtz that was the case, that Joe had given symptoms to Dr. Kundtz that were not very well-characterized?
A. Yes.
Q. So this was a brand-new symptom, one that Dr. Kundtz had not told you about; is that true?
A. I believe so, yes.
Q. Do you agree -- Did you ask Joe about the vague symptoms that he had told Dr. Kundtz about the next day since this was somewhat of a more specific complaint?
A. Well, I believe so, yes.
Q. Is there anything in the record about things that Joe told you about the vague complaints that he had made to Dr. Kundtz the day before?
A. Well, in the second line about the nausea and vomiting, obviously those are symptoms that can be related to different things, so yes.
Q. Okay. But, you know, Dr. Kundtz told you that he

had, you know, this epigastric pain and that it had been radiating to his arms and all these vague symptoms that he couldn't really make sure he had a handle of. Are you telling me that that whole discussion and the whole evaluation by Dr. Kundtz and him telling you about all these vague symptoms are limited as far as your discussion with Joe that you put in your record that it's nausea and vomiting?

A. No, I don't think it's limited to that.

Q. Well, what else is there in that that goes over and discusses, you know, the vague symptoms and the things that Dr. Kundtz talked about with Joe throughout that whole emergency visit of two or three hours that he concluded were vague and unable to get a handle of? Where is that discussion and your attempt to elicit information to make those types of symptoms less vague than they were to Dr. Kundtz?

A. Fair. When you ask this many different questions, if you look at what's there, I mean, when you go from nausea to breathing to fever, you're thinking about other systemic things, too.

Q. Did Joe complain the day before about nausea and fever to Dr. Kundtz? Did Dr. Kundtz tell you that?

A. I'm not sure if he did or not.

Q. This is the page before of your office chart for Joe

Frankhauser?

A. Yes, it is.

Q. When you saw him and you had this discussion and whoever said it, you know, this food stuck in the throat thing, did you say to him, Wait a minute, Joe, my nurse wrote down in your chart when you called yesterday to tell us that you were going to the University Hospitals emergency room the day before that it felt like chest pain that was radiating down into your arms? Did you ask Joe about that inconsistency between food stuck in your throat and what was right in your record already, this complaint that scared the heck out of him to such an extent that he went to the emergency room with chest pain with pain radiating down his arms?

A. Well, first of all, that was a message, so I had to take that into consideration; and second, it's not inconceivable at all that that could be the same symptoms that we were talking about that day.

Q. Well, you'd sure want to ask the questions so you don't assume it. You want to make sure that it is and it isn't just conceivable? Isn't that the word you just used; conceivable?

A. Yes.

Q. You want to find out whether or not it's conceivable, but this guy's got a potentially life-threatening

condition and it's your job as captain of the ship to find out what the problem is. Don't you think you needed to ask about that inconsistency and say, Wait a minute, Joe, I got to ask you more than do you have more saliva and do you have trouble swallowing. You got this chest pain radiating to your arms, you've only had one EKG, you've only had one enzyme test, we haven't ruled out even a heart attack yet --

THE COURT: Are you finished with the explanation?

MR. VOLSKY: Almost.

THE COURT: Please come to the question.

Q. (BY MR. VOLSKY) -- and we haven't ruled out unstable angina. Let's talk about that. Did you go into that with Joe?

THE COURT: The jury will disregard the lengthy comments by the lawyer preceding the question. Now we have the question.

Q. (BY MR. VOLSKY) Thank you. Would you like me to repeat it, Doctor?

A. Okay.

Q. Okay. Did you have this discussion of Joe saying when he came up with this new symptom that you had heard for the first time, you know, about food being stuck in his throat, did you ask him about the potential

inconsistency caused by the vague symptoms that Dr. Kundtz told you about and your own record that said you had chest pain radiating down the arm?

A. You are assuming they are inconsistent when in fact they could be entirely consistent. If anybody has had food stuck in their throat or anything like food stuck in their throat or anything go down the wrong hole, you know that's a very obnoxious symptom.

Q. They could be consistent. But chest pain with pain radiating down the arms could be consistent with coronary ischemia, can't it?

A. That's one of the symptoms.

Q. When you get an answer to a question that puts you in one direction, you don't just stop and assume that's it. Your job as captain of the ship is to look at all the possible things including potentially life-threatening problems like coronary ischemia, isn't it?

A. That's one of the things.

Q. You knew when Joe came into your office that Dr. Kundtz had put at the top of his list two things; gastrointestinal and heart, because he had done heart checks and was concerned about the heart, right?

A. Yes.

Q. Okay. But you wrote after talking to Dr. Kundtz that you're going to follow up for a G.I. evaluation, and isn't

that what you did, a G.I. evaluation?
A. That's one of the things that I did.
Q. Is there anything in your handwritten note getting any more details about Joe's symptoms in his arms?
A. Symptoms, no.
Q. Now, we talked yesterday about the seven or so factors that doctors learn since medical school to ask a chest pain patient. Joe was a chest pain patient, wasn't he?
A. Okay. Yes.
Q. Okay. Remember we discussed the seven or so things; the quality of the pain, the location of the pain, the radiation of the pain, the intensity of the pain, the frequency of the pain, the associated symptoms, and the precipitating factors. Those are all things you learn to find out about in an attempt to decide whether a chest pain is a coronary ischemic chest pain, true?
A. Yes, as well as any other chest pain.
Q. Did you ask him about the quality of his chest pain?
A. If the quality was feeling like food stuck in the throat, then that is a quality.
Q. Did you ask him about the location of the chest pain?
A. Yes.
Q. You knew that the pain radiated to both his arms because your nurse wrote that in the chart, right?

A. I knew that note was there, yes.
Q. But did you ask him what the radiation to his arms felt like?
A. I can't recall.
Q. Did you ask him whether it felt like heaviness or numbness or just pain?
A. I can't recall.
Q. Is it in your records?
A. No.
Q. Did you ask him about the intensity of the pain? Joe, how bad was this pain?
A. Yes.
Q. Is it in the records?
A. Well, again, if the feeling was, you know, without nausea and vomiting but it felt like food stuck in the throat, that's a very uncomfortable symptom, so that is a measure of intensity, yes.
Q. It's an uncomfortable symptom. That's the assessment and the detail in which you got the intensity, it's uncomfortable?
A. Yes.
Q. Did you ask him how often the pain occurred? Was it constant? Did it come and go? Did you ask him those kinds of questions?
A. I may have asked him those questions.

Q. Is it in the records?
A. What's in the record was that it was three days' worth of this feeling.
Q. Did you ask him if there were any associated symptoms with the chest pain?
A. Yes. I asked him all the things about breathing, sweating, nausea, all the things that we've already mentioned, yes.
Q. Did you ask him whether there were any precipitating factors like did it come on after eating or did it come on after physical activity?
A. Well, again, if I asked with deep breathing, that would include the questions about physical activity. If you're talking about food stuck in the throat, we're obviously mentioning about eating.
Q. It's your testimony that when you asked him about deep breathing, that's as good to you an amount of information as, Joe, were you playing golf when the pain came on, or, Were you physically active when the pain came on? Don't you think that would be a more specific question than just asking him about heavy breaths, does it hurt when you take a heavy breath?
A. Well, no. I think what you're really getting at is what was written down was not a specific answer, but my general thinking about what was going. Whatever cause,

deep breathing, whether it's playing golf or eating or whatever, when deep breathing was occurring was it making a difference.

Q. Or you could have just asked him does it hurt when you take a deep breath?

A. I'm sure that that could be one of the questions, too.

Q. What does it say in there about that? What is it about the deep breathing that it specifically says in the chart? Can you point me to it, please?

A. About the deep breathing?

Q. Yes.

A. Worse with deep breathing.

Q. Where does it say that; worse with deep breathing? That doesn't say worse with deep breathing. What does that say?

A. I'm sorry. First of all, all of this was prefaced with a without sign. So the only difference is salivation. So without nausea. Without vomiting. There was increased salivation.

Q. Without salivation, without increased salivation?

A. No. That was the only one that had a different arrow there.

Q. Your record doesn't say increased. This is characterizing the arrow?

A. That's the interpretation there.
Q. That could be read without nausea, without vomiting, without increased salivation, without fever.
A. Without worse with deep breath. That was all the same sentence here.
Q. But you said and tried to tell the jury that your questions about deep breathing was an indirect way of asking about his activity and because he would have been breathing deeply with activity that was the focus of your question. But it's very interesting, your chart doesn't say without worse with deep breathing. Your chart says without worse with deep breath. One breath. So what this is saying is it didn't hurt more when he took a deep breath. Isn't that what you wrote?
A. That's what I wrote. Breath and breathing. That doesn't necessarily mean two different things.
Q. Oh, Doctor, there's a big difference between it not hurting with one deep breath than it doesn't hurt with deep breathing when you're running around playing golf or basketball. Aren't those two different things?
A. In both of those you're breathing deeply.
Q. That wasn't the intent of your record, was it? Are you really trying to tell this jury your writing down here without worse with deep breath had to do with your attempt to find out whether he had chest pain with physical

activity?
A. That was the culmination of what I wrote down, yes.
Q. Doctor, where in the records does it indicate that you got a response to a question that you asked Joe, What were you doing when this problem first came on?
A. There's nothing in the record there.
Q. Where in the record does it say, Joe, did you have another major experience, something worse than the other times, and what were you doing if it came back a second time? Did you elicit that kind of information from Joe?
A. No.
THE COURT: Excuse me, I didn't hear it. Was there an objection?
MR. KILBANE: No.
THE COURT: I heard something. I was trying to respond if there was something. Go ahead.
Q. (BY MR. VOLSKY) Wouldn't you like to have known when the pain first started?
A. Yes.
Q. Wouldn't you liked to have known how the pain changed between when the pain started three days before, according to your record, and when you saw him?
A. Yes.
Q. Is that in there? Is there any attempt to find out

how the condition changed over the three days or whether it got worse at certain times and better at certain times? Is there anything like that in the record that shows that?

A. It's not in the record.

Q. Wouldn't you have liked to have known that?

A. Yes.

Q. Wouldn't you have liked to have known if the pain came back, it went away, and it came back, and if so, what were you doing when it came back?

A. Yes.

Q. Okay. And you didn't find that out, either, did you?

A. Again, there was -- when you ask, if this is what they're telling us, you have to go by what they're saying.

Q. But, you know, you have patients. Some patients are good at explaining and others just aren't good at explaining. They're incapable of expressing as well as other people what their symptoms are and what the problem is. And if they're not telling you the information you need to know, it's not their responsibility to know it's important. They're doing the best they can. They're there to get help. Isn't your job as captain of the ship with your medical training and your experience to elicit the information that's going to be helpful for you to diagnosis the problem?

A. Yes, with this caveat; first of all, I have no reason

to disbelieve Mr. Frankhauser when he comes in and talks about his symptoms. If Mr. Frankhauser felt that those were the symptoms that were important and those were the answers he's giving, history is a partnership. You talk with people, you try to elicit what's going on. If that's what somebody's telling you, I'm not going to disbelieve them. I'm going to, you know, help facilitate what's going on.

Q. What did you ask him to try to make an assessment as to whether or not his chest pain, which was radiating to his arms, could have been caused by coronary ischemia?

A. Again, when we start to ask what's going on, people have plenty of opportunity to say what is happening with them to help me to help ask something a little bit more specific.

Q. And rather than it come out of Joe's mouth at the time he was in your office, he already did tell you, he already did tell you what his symptoms were. The day before he had chest pain radiating down his arms and he was going to the emergency room. That's part of the responsibility. Didn't they live up to their responsibility, not only their responsibility, the courtesy to call you and let you know that they weren't going to make their appointment they had scheduled with you on Wednesday, that they were going Monday to the

hospital and to let you know, right?
A. Yes.
Q. And it didn't have to come out of Joe's mouth at the time you saw him on the 18th because it came out of their mouths on the 17th and was right in the chart. He had chest pain with pain radiating down his arms. Is that right?
A. Yes. That was the message that was left.
THE COURT: I didn't hear the rest of the answer.
A. Yes. That was the message that was left.
Q. (BY MR. VOLSKY) Okay.
THE COURT: All right.
Q. (BY MR. VOLSKY) Now, you said I think before that, you know, Joe came in and he said it was food stuck in his throat. What if Joe had come into that office visit and said, Doc, I have chest pain with pain radiating down my arms? If that's what he had told you, wouldn't you have done a thorough workup of the questions that you've learned since medical school to ask about coronary ischemia?
A. Hypothetical question is if that's what would have happened, then of course, I would listen to the patient and try to follow up on their symptoms.
Q. Okay. Why didn't you listen to the patient in a

phone message where he called in and told you he had chest pain with pain radiating down his arms? Did you not have an obligation at that point to work up the heart and a chance of a coronary ischemia just as if Joe had walked into your office the day of your office visit and said, I got chest pain with pain radiating down my arms?

A. You're asking two different things. The first is what if that would have happened. The second is when you have the opportunity to actually speak with somebody, you weigh what they're telling you even if there was this message that was there. I had the opportunity to hear it from Mr. Frankhauser the next day.

Q. You don't feel you had an obligation to say, Wait a minute, Joe, I got a record here that says you had chest pain radiating down your arms and I've talked to Dr. Kundtz and he told me that you have these vague symptoms and now you're giving me a very specific symptom. I need to check into all these things and make sure I get the information to assess the whole picture, the whole picture, the whole picture, rather than follow up for a G.I. evaluation. Wouldn't you agree with that?

THE COURT: Objection will be sustained.

I think you covered the subject, Mr. Volsky.

Let's go on to something else, please.

Q. (BY MR. VOLSKY) Isn't it true, Doctor, when Joe and

Gerry walked into your office that you had already made up your mind that Joe had a G.I. problem and that's why you wrote it down in your notes that he's coming in for a G.I. evaluation?

A. The answer to that is no.

Q. Isn't it true that that is precisely what you did, a G.I. evaluation without any attempt to evaluate whether or not his symptoms could have been from his heart?

A. That is not true.

Q. Doctor, were you even aware that Joe Frankhauser had been to two emergency rooms two days in a row?

A. No, I was not.

Q. You didn't know after asking Joe all the necessary questions and trying to get as much information as you could, as you already have told us that a good internist tries to do, that Joe had been to the Solon emergency department two days before when this new severe symptom started?

A. No, I did not know he was there.

Q. Why was it that you didn't know that Joe had been to the emergency department at Solon only two days before when you had Joe sitting there right there in your office and you were trying to get to the bottom of what his problem was?

A. Well, obviously, Mr. Frankhauser knew that but I did

not.

Q. Doctor, I'm going to refer you to Page 50 of your deposition. Do you remember that I asked you, Did you know before this lawsuit was filed that Mr. Frankhauser had been to the Solon emergency facility on June 16, 2002? And your answer was, I'm honestly not quite sure that I knew that. Then I asked you, 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 G.I. and cardiac? And your answer was, I don't know how I would have known that. Is that correct?

A. Yes, it is.

Q. You didn't know how you would have known that? With all due respect, Doctor, how about getting a complete history, that's how you could have learned that Joe Frankhauser's problems first started two days before and sent him to the emergency room? Would you agree with that?

MR. KILBANE: Objection.

THE COURT: Overruled.

A. No. When you take a history you have to have at least some expectation that when you're talking with somebody you might actually get answers that help you. If somebody does not give you that information, how in the

world would you know for sure if anything else significant happened? If there was opportunity for them to say such a thing, why not?

Q. (BY MR. VOLSKY) Doctor, in taking that history of a chest pain patient in a patient that you know has had chest pain and pain radiating down his arms, don't you think that you would ask questions to Joe like, Joe, when did this really bad pain start? Is that an appropriate question to ask somebody to get a history?

A. That's an appropriate question.

MR. KILBANE: Objection. Your Honor, can I approach?

THE COURT: All right.

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(Thereupon, a discussion was had between Court and Counsel outside the hearing of the jury and off the record.)

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Q. (BY MR. VOLSKY) Doctor, if you had asked Joe Frankhauser the question of what did it feel like when the pain started and how bad was it, you would have gotten an answer that would have told you that it was on Sunday night after a meal, wouldn't you have?

A. I don't know that, Mr. Volsky, because that's a

hypothetical question. But I have no reason to disbelieve that Mr. Frankhauser wouldn't have said something if that's what he was feeling.

Q. He can only say it if it's in response to the appropriate question that you've been learned to ask?

A. No, that is not true. When you let people talk about their symptoms there's no reason to believe that they would not say anything that they felt was important.

Q. Don't you think you should have asked him, Joe, did you get any treatment when that problem got really bad the first time?

A. If that didn't come up or they didn't bring it up, I couldn't have known that.

Q. You could have asked them.

A. I'm not sure that that's correct.

Q. Wouldn't you agree that a doctor who is trying to get the whole picture of what the pain is and what the symptoms are and whether it's come and whether it's gone would be able to elicit from a patient that he had been to two emergency rooms two days in a row if the doctor was doing his job?

A. Again, it's not just the doctor doing his job, but you have to let people say what is going on with them.

Q. It's Joe and Gerry Frankhauser's fault?

A. It's nobody's fault. There was no reason to believe

that he wouldn't have brought up going somewhere else or another symptom. There was nothing that limited him from not saying that.

Q. Nothing other than all your questions and your total focus was on saliva, did it hurt when you took a deep breath, his throat, those were the questions and that was the information that you put in the chart?

A. Mr. Volsky, that does not limit him from saying anything.

Q. Isn't it true that you did ask the questions you asked based on the information in your chart and then you did an examination of Joe, didn't you?

A. Yes.

Q. And you looked in his mouth to see whether there was excess secretions and salivation; is that right?

A. Yes.

Q. Do you remember you pushed on his chest in an examination? Do you remember that?

A. I probably did, yes.

Q. Okay. And do you remember that after doing that rather than asking more questions you looked at Gerry and Joe and you said, I think we got to call Dr. Chak, the G.I. doctor, and make sure and we're going to have him look down your throat?

A. I finished the examination first.

Q. Okay. You finished the examination, didn't ask any more questions, and said after getting the information about G.I., no, swallowing, no, this here, it hurts, you know, and do your examination and then rather than asking more questions about the heart or anything else you were going to call Dr. Chak, and you got up and you went right to the phone to call Dr. Chak to arrange for an appointment as soon as possible for him to stick a tube down Joe's throat to see what was going on in his esophagus; isn't that true?

A. Not exactly. Mr. Volsky skipped over the part about listening to his heart and lungs, and going over about pressing on the chest, then there was some conversation, about, you know, what this might be about, then I had to find out that was Dr. Chak who actually knew Mr. Frankhauser and did this. So we had to talk about that for a little bit, too. Then I was excused again and came back in and then we talked a little bit more, then I went back out and called Dr. Chak at that point in time.

Q. Okay. And you told Dr. Chak on the phone that Joe had told you that it felt like food stuck in the throat, and you reminded Dr. Chak that Joe had esophageal cancer before and you wanted Dr. Chak to look at the esophagus and see what was going on?

A. No, that's not quite correct. I called Dr. Chak

because Mr. Frankhauser had known Dr. Chak and Dr. Chak had remembered Mr. Frankhauser and told me that, you know, there was this problem in the past where Joe needed something after surgery where there was food getting caught in the throat. So he knew that. And he also said, Mr. Frankhauser's I think due for a colonoscopy also.

Q. You mentioned Dr. Chak knew and remembered that Joe had had a problem with food stuck in his throat before. That was right after his surgery the first time four years before he had some swallowing problems. Did you know that?

A. I looked back later in the records, and it was in '99.

Q. 1999. Well, '99 is when he had a stricture as a result of the anastomosis, they had connected the two sides, and that's a known complication of that kind of a surgery that you can get some scar tissue and stuff that gets in the esophagus and it's called a stricture, correct?

A. Thank you. Yes.

Q. And the doctor has to go in and kind of push it apart and stretch it a little bit, and that's what Dr. Chak did; is that right?

A. Yes, did.

Q. And that was in 1999?

A. Yes, it was.
Q. And we're in 2002, and you're unaware that he had any food in the throat problems for almost three years -- would you agree with that -- based on his records?
A. Well, based on his records.
Q. Okay. I just didn't want to leave a misconception that this --
THE COURT: Excuse me. We're not asking what you would want. Ask questions.
Q. (BY MR. VOLSKY) There was a large time gap from when he had his stricture problem closer to his surgery from today; isn't that correct?
A. That's not unusual. Yes.
Q. And he went to Dr. Chak, right?
A. Yes, he did.
Q. And he went there because you believed that that was his problem?
A. I believed that that is what was happening at the time, yes.
Q. And you were concerned that his cancer was back?
A. I only wasn't concerned about that. Again, when people say that they have this sensation or feeling, it puts them at risk every time they swallow something or might be able to aspirate something. And whether it was cancer or stricture or inflammation or, you know, anything

that might have been coming back up, you have the responsibility to do something about that.

Q. Okay. And you also had the first letter from Dr. Levitan that had raised this issue that Joe might have his metastatic cancer back?

A. Yes, I had that information.

Q. And that was concerning to you?

A. Again, if you use all of the available information, you put these things in context, the patient, this is what his complaint was, the other doctor tells you something about epigastric, you have a CT Scan that shows there might be a possible recurrence, you have a patient who confirms these particular symptoms, you don't have anything else that's strongly related to those symptoms as that, you take all that information together and, you know, I think it would be foolish if I did not pursue those things.

Q. Okay. Doesn't Dr. Levitan's report from April, which you had read by that time --

A. Yes.

Q. -- say that have Joe was going to have another CT Scan in a month?

A. Yes.

Q. It also said it was possible that the problem was pneumonia?

A. Yes.
Q. It was more than a month later when Joe came into your office that day?
A. Yes.
Q. Did you ask Joe whether he had had another CT Scan?
A. No, I did not.
Q. Did you ask him whether he had seen Dr. Levitan again within the last month?
A. I don't believe so.
Q. Did you ask him whether or not Dr. Levitan was still worried that it was cancer?
A. No, I did not.
Q. Did you call Dr. Levitan to find out whether there was still any evidence that he had cancer on his next CT Scan?
A. No, I didn't.
Q. So when Gerry and Joe walked out of your office you were still under this impression he had a spot on his lung consistent with metastatic esophageal cancer?
A. Again, there wasn't anything to suggest otherwise.
Q. Unless you got the information and asked the right questions of Joe or called Dr. Levitan?
A. Again, there was nothing limiting Mr. Frankhauser from saying anything. There was no cap on what he was allowed to say or not allowed to say.

Q. It's Joe's job to tell you that the CT Scan is clear and Dr. Levitan gave him a clean bill of health? He's supposed to know to tell you that?

A. If Mr. Frankhauser knew that, yes, he's entitled to be able to tell me that.

Q. Doctor, this is a man and a woman who have frankly gone from one emergency room and was told that it was G.I., and another emergency room and was told it's G.I., now they've come to your office, you have done your evaluation, you tell them it's G.I., I got to call Dr. Chak. Do you think they were under a little stress, and do you think they were thinking as clearly as you as the objective doctor as to what the important information was? Is that their job?

A. I can't say that it has to be a job. I'm just saying that there was no way that limited any opportunity for them to -- or Mr. Frankhauser to say anything about those things.

Q. And there was nothing limiting your opportunity to ask Joe whether he had any of this information or call Dr. Levitan?

A. Again, if that information was brought up, you know, it would have been very, you know, applicable to talk about it at that time.

Q. Doctor, something just occurred to me now after all

these years. You indicated before that you were able to get University Hospitals labs on the computer and you were able to call up information?

A. Yes.

Q. I assume that's also true of radiology reports?

A. No. Unfortunately, the Scanning Department was undergoing a major overhaul and I was limited to labs that had not been called out.

Q. Instead, you just put two and two together and figured it must have been his cancer without checking out could it be his heart? Is that true?

A. Again, there was no assumption that it was cancer at that point. It was following up on patient's symptoms.

Q. Well, you had a pretty strong indication that it was a strong consideration in your mind, because you took the time to write at the end of your note after speaking to Dr. Kundtz to remind yourself about this CT Scan and this suspicious pulmonary nodule, that would have been metastatic esophageal cancer; is that right?

A. Again, I was just trying to use the available information that I had.

Q. Did you ever consider getting Joe a stress test?

A. I might have.

Q. Do you remember whether it was a consideration or something that you thought about doing?

A. My actual consideration at that time was to try to find out what was going on based on the visit that he had and that whatever was coming -- we would have to re-evaluate whatever is going on based on those findings.
Q. Even though cardiac ischemia had clearly not been ruled out by Dr. Kundtz in the emergency room the day before, correct?
A. Yes.
Q. Don't you have partners in your medical group who are cardiologists?
A. No, I do not.
Q. None of them have a specialty in cardiology?
A. No, they don't.
Q. If you thought it was necessary, you could have arranged for Joe to get a stress test quickly, couldn't you have?
A. Semi.
Q. What does that mean?
A. Well, a stress test isn't available every day there, so I would have to go by whatever scheduling would be.
Q. Well, if it wasn't in the office there, you could have arranged for him to get a stress test somewhere within University Hospitals system, correct?
A. I have to go through the same things. As an outpatient, it's very difficult to arrange that.

Q. If you felt that was important for this patient, you could have arranged for a quick stress test?
A. How quick is a matter of debate. Unlike other procedures, it's very rare you would bump someone else that has a stress test for another person because it's the same idea.
Q. Okay. But you didn't feel it was necessary to even try to get him a stress test; is that right?
A. My main focus at that point in time was based on the visit that we had, in lieu of any other important information that we came to together, we went ahead with the upper endoscopy.
Q. Doctor, you give physicals in your office all the time, don't you?
A. Yes.
Q. Does your office have an EKG machine?
A. Yes, it does.
Q. That's part of a standard physical. You give EKGs all the time?
A. Yes.
Q. How long does an EKG take?
A. I don't know. Three minutes.
Q. You didn't even take an EKG of Joe that day, did you?
A. No.
Q. Even though he had complained of chest pain radiating

down his arms, you didn't feel it was even necessary to do an EKG?

A. I had known he had an EKG the day before.

Q. That was then and this is now.

A. Yes.

Q. He could have had a totally different picture now, correct?

A. No. I can't say that.

Q. EKGs just because they are not negative once doesn't mean they're not going to be negative two or three hours later. That's why they do serial EKGs when they're worried about a chest pain patient; isn't that true?

A. That's true.

Q. Doctor, even if Joe's cancer had returned, what difference would a week or two make in delaying that diagnosis on how long Joe would have had to live?

A. Again, you're making the assumption that it was only the cancer that was important. And although that might have been one of the things, as I already mentioned, if there's something else that can happen, such as aspiration or rupture or anything else that might be important, those are equally impressive symptoms and carry a large amount of symptoms with it.

Q. Equally impressive is the number one killer of men Joe's age?

A. The number one killer of men Joe's age?
Q. Yes.
A. Is cancer.
Q. Doctor, we've had all kinds of experts in this case all readily concede the number one killer of men Joe's age is heart disease. I don't want to argue with you. You believe it to be cancer?
A. Well, that's what the census, the data, shows.
Q. Okay. The point is is that the possibility of some sort of esophageal rupture or life-threatening condition even in a guy with Joe's history, he was much more at risk of heart problem than any of those unusual events?
A. No. First of all, they were not -- they would not have been unusual for Joe Frankhauser. This gentleman had esophageal cancer, he had had previous problems with swallowing before his surgery, he had problems after his surgery. The risk of aspiration, pneumonia, rupture, are equally important and life-threatening situations if that were to persist.
Q. But you certainly had the obligation to get as much information as was necessary to evaluate the possibility that it was heart so that you could weigh the risks with as much information as possible so you could make an educated assessment. Do you agree with that?
A. I did make an educated assessment.

Q. When did you learn that Joe died?
A. The day that he passed away.
Q. Was it before or after you got the letter from Dr. Levitan that Joe did not have cancer?
A. It was before.
Q. Did you speak to Gerry Frankhauser after Joe's death?
A. Yes, I did.
Q. What was the purpose of that call?
A. Condolences.
Q. Do you recall speaking to Gerry about whether or not she should have an autopsy?
A. Again, when somebody passes away at home, it's not my jurisdiction whether people get an autopsy or not.
Q. Do you remember it being discussed in your conversation with Gerry Frankhauser?
A. I did not discuss autopsy.
Q. If Gerry Frankhauser testifies in this case -- I'm going to ask you to assume she testifies during the conversation you tried to talk her out of an autopsy three different times, would you disagree with that testimony?
A. Yes, I will. Yes, I do.
Q. Doctor, I want to take you back to -- My instinct is to show it to you. This isn't the one. I want to take you back to this one. That's the note of Joe and Gerry when they came to your office; isn't that right?

A. Yes, it is.
Q. Doctor, that might be the worst handwriting I've seen in 25 years of doing this. Would you agree with that?
THE COURT: I don't know how he can agree which handwritings you have seen.
MR. VOLSKY: Fair enough.
Q. (BY MR. VOLSKY) Do you agree that much of it is illegible to most of us other than you?
MR. KILBANE: Objection.
THE COURT: Sustained.
Q. (BY MR. VOLSKY) Do you think -- Have you found that people have trouble reading your handwriting?
A. It depends. I write in a pattern. When my medical assistants are there, they can read that. When people have looked at it for a while, they can look at and read that, too.
Q. Doctor, would you read for us the first line?
A. The first line in my writing?
Q. Yes.
A. Sick visit.
Q. Okay. I can see that sick visit.
What does the second line say?
A. 3 days.
Q. 3 days. That's days?
A. Yes, it is.

Q. Okay.
A. Of.
Q. What's that?
A. Feeling.
Q. Okay. Food I can read. Stuck in throat.
A. Uh-huh.
Q. Okay. Would you agree the food stuck in throat is pretty legible but that the first part really isn't?
MR. KILBANE: Objection.
THE COURT: Sustained.
Q. (BY MR. VOLSKY) Would you read the third line, please.
A. Without, S with a bar above it, N/V, nausea/vomiting, then up arrow for increased salivation, fever.
Q. Would you read the fifth line.
A. Fifth line. Vital signs noted. You said the fifth line? Vital signs noted. VS noted.
Q. Doctor, would you agree with me that on this fourth line there's a period halfway through that line?
A. Yes.
Q. Do you think that that is something that is legible to the average person?
MR. KILBANE: Objection.
THE COURT: Sustained.
Q. (BY MR. VOLSKY) Would you agree with me that there

is a period there after the second part of that line?
A. Yes.
Q. After the words asymptomatic today?
A. Yes.
Q. What does asymptomatic mean?
A. Is not current.
Q. Asymptomatic means not having any problem at the time?
A. Right at the moment.
Q. Okay. But you said asymptomatic today, which would mean the whole day?
A. Well, it was the morning, so not much of the day had gone by.
Q. Would you agree with me the words asymptomatic today are totally readable and legible, that anybody could read that?

MR. KILBANE: Objection.

THE COURT: Sustained.

Ladies and gentlemen, there has been no evidence in this case that the legibility of writing is a meaningful issue in the case.

Q. (BY MR. VOLSKY) Would you agree with me there's a difference in the style of the writing from the beginning of this fourth line and then a different style of writing with the words asymptomatic today?

MR. KILBANE: Objection.

THE COURT: You may answer that.

A. No.

Q. (BY MR. VOLSKY) This isn't something that is kind of like in your cryptic hieroglyphics or whatever your lawyer called it?

THE COURT: Why don't we call it his notes.

Q. (BY MR. VOLSKY) The style of your writing in your notes is different on the first half of this line than the second half. Would you agree with that?

A. No.

Q. The style of your writing after the words asymptomatic today is different than the rest of your writing in the rest of that note, isn't it?

A. No.

MR. KILBANE: Objection. Your Honor, can I approach?

THE COURT: All right. I'll listen to you.

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(Thereupon, a discussion was had between Court and Counsel outside the hearing of the jury and off the record.)

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Q. (BY MR. VOLSKY) Doctor, do you still feel that Joe Frankhauser was at average risk for an adult male for coronary ischemia or acute coronary syndrome?

A. I think that's what we mentioned yesterday.

Q. You still believe it as you sit here today?

A. From yesterday to today, yes.

Q. Doctor, will you at least admit that looking back with hindsight that Joe's pain on June 17th and June 16th and when you saw him on June 18th was caused by too little blood to his heart?

A. I can look back with hindsight only because we already have an autopsy result. But you cannot extrapolate people's symptoms based on an autopsy finding.

Q. You had the autopsy finding when I took your deposition way back when, didn't you?

A. To be honest, I'm not quite sure I had that at the time, but I think I did, yes. I think I did.

Q. And on Page 87, Line 18 --

A. That's right, yes.

Q. -- I asked you, 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? And you answered, I can't say that because it's unclear. It's hard to take an autopsy

finding and extrapolate backwards to symptoms.

Do you remember saying that?

A. I think I just said it right now.

Q. No. I think that you said that now looking back with hindsight you're able to say that it was the coronary ischemia that was causing his pain all along. Isn't that what you said?

A. I believe I said almost exactly what I said in the deposition.

Q. Let me ask you again then. As you sit here today with hindsight, would you concede that it was coronary ischemia all along that was causing Joe's symptoms?

A. Well, is not the only thing that was going on at the time. So when you have symptoms, they could be consistent with that and there could be other symptoms, too.

Q. And I understand that, and you considered those at the time. Now I'm asking you as you sit here today, knowing everything you know, you've seen the autopsy, you've seen the results, you've heard testimony, as you sit here today wasn't it the coronary ischemia causing his symptoms all along?

MR. KILBANE: Objection.

THE COURT: You may answer.

A. Well, you didn't mention the results of the endoscopy which I also didn't have before Mr. Frankhauser passed

away stating acute and chronic inflammation of the esophagus.

Q. (BY MR. VOLSKY) Dr. Chak stuck a tube down his throat with a camera and Dr. Chak in looking at it said there's nothing wrong, everything's fine. Wasn't that his assessment of looking right at the esophagus?

A. That was the -- What he found there was no stricture there. However, on his biopsy results he did find chronic and acute focal inflammation.

Q. You're saying when he took a piece of tissue and cut it into slides and put it on a microscope and put it up 100 times or whatever it was, he saw some cells in there, the pathologist, that there's chronic and acute inflammation. Are you telling me that microscopic chronic and acute inflammation was in fact a cause of Joe's symptoms on the 16th, 17th and 18th?

A. I can't speak for his symptoms on the 16th or the 17th. On the 18th perhaps. But when you have acute inflammation, that means something actively is going on. So very conceivably at least some of his symptoms were due to just what was found there.

Q. So you won't even concede after all this that it was his heart causing his symptoms all along?

A. No, I didn't say that.

Q. You take no responsibility for at least contributing

to Joe's death?
A. That's a very difficult question. Anytime somebody in your practice passes away, it's an entirely traumatic event. There's not one time that goes by when you don't feel some measure of sympathy, compassion, responsibility for any patient. Doesn't matter if you've known them one day. It doesn't matter if you've known them a lifetime.
Q. Doctor, am I correct that it is your testimony that you considered Joe's complaints to Dr. Kundtz that Dr. Kundtz told you about in the University Hospitals emergency room of heartburn and some vague complaints?
A. I'm sorry, can you ask that again, please?
Q. Of course. Am I correct that it's your testimony that you considered Joe's complaints as described to you by Dr. Kundtz on the telephone from the emergency room at University Hospitals of heartburn and these vague symptoms that he couldn't get a handle of?
A. Yes, I considered that.
Q. I want to ask you a hypothetical question. Do you understand what that is?
A. Yes, I do.
Q. Okay. Instead of those symptoms that Dr. Kundtz told you about, I want you to assume instead that you had been told by the emergency department physician that Joe's complaints were midsternal chest pain described as

squeezing and tightness which occurred after eating and lasted one and a half hours; that the pain was now gone but that the pain during that one and a half hours had radiated to his arms; he was short of breath and his arms felt heavy. If you assume that you were told on the phone by an emergency department physician of those symptoms, wouldn't you have wanted Joe Frankhauser hospitalized and worked up to rule out acute coronary syndrome?

MS. HARRIS: Objection, Your Honor.

THE COURT: Overruled. Overruled means that the question is permissible. The jury will decide what significance the answer will be. Sustained means you should not answer it.

A. Overall, if the different set of symptoms were given to me, I would make that decision based on what was happening at the time.

THE COURT: So you understand, he's not asking about your decision under your circumstance. He's asking under circumstances which you have said were not applicable. But he wants you to assume those circumstances and see what response, if any, you have to that.

A. Again, I would take the situation as it was presented to me at that time.

Q. (BY MR. VOLSKY) I want you to assume that is the

situation, that's what you're told by the emergency department doctor. What do you do?

A. You try to do the best that you can for the patient. So if you hear those symptoms, you might under the hypothetical situation say, okay, admit the patient if that's the emergency department physician's recommendation.

Q. What if the emergency department physician doesn't make those recommendations with those symptoms. You have a responsibility to do for the patient what you feel is right based on the information provide by the emergency department physician, don't you?

A. It's very difficult to when somebody else is actually seeing somebody and you're on the other end of the telephone saying what is going on there, anything else going on. That could happen. I would gather that that's a good responsibility to have. If the person who's actually seeing the patient has a specific recommendation that was to admit that patient, then hypothetically yes, I have no reason to disagree with them.

Q. What if they say I don't want to admit this patient, I want to send them home, and you have these symptoms told to you?

A. I have some reason or understanding why. That's fair.

Q. You don't blindly go by whatever the emergency department doctor recommends, do you?
A. When you're not actually seeing the patient, you have to rely on something. You have to rely on what you're given and what you may or may not know about the patient at the time.
Q. But you don't know this emergency department -- Let's assume you don't know the emergency room physician from Adam and that person gets on the phone and says, I got your patient in here, he's your patient and you've cared for him for years, and they're calling to get your input on the situation. Isn't it a joint responsibility of the two of you to make a decision what to do with a patient as far as further follow-up care?
A. Yes. I'd like to think we can help out.
Q. Okay. And this doctor says, You know, well, he's got midsternal chest pain, he describes it as squeezing and tightness. It occurred after eating. It lasted for an hour and a half. The pain was radiating to his arms and his arms felt heavy. If you were told those symptoms, wouldn't you want your patient who's in your hands to make sure that he goes into the hospital to make sure he doesn't have acute coronary syndrome going on?
A. Under that type of hypothetical I have no reason to believe I wouldn't suggest that that person needs to be

admitted. I mean, that's a hypothetical situation. That's a hypothetical answer. And it's probably true on both accounts.

MR. VOLSKY: Thank you very much. That's all I have.

THE COURT: I think it's time for the morning recess. I gather you've concluded your questions of the witness at this time.

MR. VOLSKY: I have, Your Honor.

THE COURT: We'll call you back in approximately 15 minutes. While you're out of the room keep in mind the instructions.

Rise for the jury, please.

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(Thereupon, a recess was had.)

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(Thereupon, a discussion was had between Court and Counsel outside the presence of the jury as follows:)

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THE COURT: Counsel for Dr. Chisar has supplied the Court with the deposition of a prospective witness, Henry Smoak, S-m-o-a-k, for review and consideration for possible objections. More specifically, counsel for Defendant Chisar

suggests there are questions in the deposition that relate to or rely upon information supplied by another prospective expert witness named Glauser, G-l-a-u-s-e-r. At least according to counsel for Dr. Chisar, who is the person who arranged for the opinions of Dr. Glauser, she will not be calling Dr. Glauser as a witness. As far as I know, no one else will be calling Dr. Glauser as a witness.

So the question is whether or not the portions of the deposition which refer to or rely upon any information from Dr. Glauser should be redacted from the deposition at this time. Do you want to express your opinion on that first, Ms. Harris?

MS. HARRIS: Yes, Your Honor. First and foremost, yesterday Kerry indicated to me and to the Court that he was concerned about the duplication of experts, and I told him I was withdrawing Glauser. When we took Dr. Smoak's deposition, Dr. Glauser's testimony was cited by Kerry. As far as I'm concerned; one, it was hearsay. It has to do with what Dr. Glauser said. There was no question as to whether Dr. Smoak had even relied on this testimony at any time in

formulating his opinions. So it is my opinion that it's not only hearsay but it's not in evidence and should be redacted from the deposition.

THE COURT: All right.

Mr. Volsky, you had some contrary position?

MR. VOLSKY: Thank you, Your Honor. Yes, I do. The record should reflect that plaintiff's counsels these days face the additional challenge of having multiple experts identified and giving expert reports and deposition testimony allowing the defendants to pick and choose duplicative experts in the same field. Another practice which follows from that is that the defense counsel provides all the depositions to prepare the witness, subsequent witness, from the same specialty with the questions asked by plaintiff's counsel in the first deposition to the second. Part of that, however, the peril in doing that is the second doctor then considers the information and report and deposition testimony of the prior expert witness in the same specialty and therefore uses it in coming to their opinions and considers the information of the additional expert by the

same defendant in coming to their opinions, and when they do that, they open the door to allow questioning as to whether or not the opinions of the other expert in the same specialty for the same defendant had any bearing on their opinions.

And I therefore think it is appropriate Cross Examination to delve into the trial testimony of one of the two experts that ultimately the defendant picks to bring to trial.

THE COURT: I have reviewed the deposition, and in my review I did not find any statement by this witness, Dr. Smoak, that he relied upon any information that was obtained from Dr. Glauser or Dr. Glauser's report or any other source identified with Dr. Glauser. If in fact Dr. Smoak relied upon any such information, I perceive that it should be available for inquiry under Evidence Rule 703. Absent that, it would be simply the introduction of hearsay information where Dr. Glauser does not testify and we have no other source for that reported information.

Does either counsel represent to the court that there is something in the deposition which shows that Dr. Smoak relied upon any information from Dr. Glauser or attributable to Dr. Glauser

for his opinions?

MR. VOLSKY: It is my opinion that in reading Dr. Glauser's deposition testimony and considering all the information in evidence provided to the expert by counsel for the defendant hiring that expert, that it is fair Cross Examination inquiry to ask him about that information. Whether he admits that it had any direct bearing on his opinions, he certainly reviewed and considered it in coming to his opinions; and therefore, I think it's proper Cross Examination in trial.

THE COURT: Is there any testimony in the deposition of Dr. Smoak that he relied upon any information from Dr. Glauser or attributable to Dr. Glauser?

MR. VOLSKY: No, sir.

THE COURT: On that basis the Court will exclude references to Dr. Glauser or Dr. Glauser's information and will direct the proponent of the deposition, Ms. Harris, to cause that to be redacted from the deposition before it is played.

MS. HARRIS: Thank you.

THE COURT: The Court will deal with other objections to the deposition of Dr. Smoak, both

those asserted by Plaintiff's counsel and by various Defendants' counsel, at a later time.

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(Thereupon, proceedings were resumed within the presence of the jury as follows:)

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THE COURT: Ms. Harris, do you have any questions of this witness?

MS. HARRIS: Just a couple, Your Honor.

THE COURT: All right.

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CROSS-EXAMINATION OF ROBERT CIRINO

BY MS. HARRIS:

Q. Dr. Cirino, Mr. Volsky asked you some questions that were a hypothetical -- do you recall that -- just before you finished?

A. Yes.

Q. First off, Doctor, am I correct that when an emergency department physician contacts you, particularly when you're at home in the evening, that you would rely upon the recommendation of the emergency physician as to whether or not a patient needs to be admitted?

A. Yes.

Q. And Mr. Volsky gave you some I believe symptoms in

that hypothetical when you were talking to the emergency department physician you would like to know all of the symptoms such as food getting stuck in the throat, just had a heavy meal, had a history of esophageal cancer. Would you like to know those before you make a decision, those kinds of things?

A. Yes.

Q. So you want as much information from that emergency physician?

A. Yes.

Q. And I take it you would like to know the results of tests such as EKGs, enzymes, that kind of thing, before you make a decision along with the emergency room physician as to further handling of the patient?

A. Yes. That sounds reasonable, yes.

Q. By the way, you are aware from the testimony in this courtroom that Dr. Chisar got a history of Mr. Frankhauser eating a heavy meal and then having food stuck in his throat; is that correct?

A. Yes.

Q. And when you saw Mr. Frankhauser three days later, he indicated that he had had food stuck in his throat for three days; is that correct?

A. Yes, that's correct.

Q. From your point of view, that was a very important

finding from his cancer perspective, correct?
A. Yes.
Q. And would you agree then that it would be a very important finding for Dr. Chisar if she knew about his cancer problems?
A. Well, yes.
Q. That's critical to your thinking, correct?
A. Yes.

MS. HARRIS: Thank you, Doctor. I have no further questions.

THE COURT: Mr. Jones?

MR. JONES: I have no questions for Dr. Cirino, Your Honor.

THE COURT: Mr. Kilbane?

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DIRECT EXAMINATION OF ROBERT CIRINO

BY MR. KILBANE:

Q. It has been suggested, Dr. Cirino, you had already reached in your mind the decision you were going to do only a G.I. workup when you saw him on the 18th. Do you remember those questions and suggestions?
A. I remember those questions and suggestions.
Q. If in fact you had already reached the conclusion that this patient was absolutely going to have only a G.I. workup, would you have been able to refer him directly to

a gastroenterologist to do that G.I. workup?
A. I guess we could have missed the visit altogether and made a direct referral to his gastroenterologist, yes.
Q. Would there be any reason to see this patient in your office on the 18th if you had already reached the decision in your mind that a G.I. evaluation was going to be done?
A. No particular reason.
Q. Was the reason that you saw him in your office was -- Was the reason to re-evaluate his complaint and make a determination what type of workup to do?
A. Yes, of course.
Q. When you start asking a patient a history and you see them in your office for the first time, how do you begin that history?
A. Hello, how are you doing, and then start to ask like, What are you here for?
Q. When you ask them, What are you here for, do you say what has been going on, what brings you here today?
A. Well, something like that, but probably even more general than that.
Q. When you ask that question do you expect that patients will tell you what has been leading up to coming to your office?
A. Yes, I have that reasonable expectation.
Q. If that patient has been to multiple emergency room

visits, is that something you expect the patient would share with you when you ask them what brings you here today?

A. Yes.

Q. Unless the patient tells you that they've been to an emergency room, is there any way for you to know to even ask that they've been to an emergency room?

A. Well, no, not really.

Q. When you see patients do you routinely go through a list of all the emergency rooms in town to see if they have been to all of them?

A. I'm afraid I don't, no.

Q. Are there multiple things that could be an explanation for a feeling of food stuck in a patient's throat?

A. Are there multiple explanations for that? That's pretty specific for food being stuck in your throat.

Q. Would one of the potential problems be with stricture of the anastomosis at the area of the surgery?

A. That could certainly be one of them.

Q. Could one of those be esophageal spasm?

A. Yes. Yes, it could.

Q. Could one of them be return of cancer?

A. Yes.

Q. Could one of them be laceration or lesion from reflux

or acid?
A. Yes.
Q. Are some of those things immediately life-threatening?
A. Yes, they are.
Q. Do you feel very bad about Mr. Frankhauser dying?
MR. VOLSKY: Objection.
THE COURT: The form of the question. This is your client.
Q. (BY MR. KILBANE) How do you feel about Mr. Frankhauser dying?
A. I feel terrible.
THE COURT: The objection is overruled. The answer may stand.
Q. (BY MR. KILBANE) Despite the terrible feeling about his death, do you believe you gave him excellent care?
A. Yes.
Q. Do you believe you acted appropriately and your treatment met the standard of care?
A. Yes.
THE COURT: Any Redirect at this time?
MR. VOLSKY: No, Your Honor.
THE COURT: Thank you. You may step down. Plaintiff may call the next witness.
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C E R T I F I C A T E

I, Angela R. Cudo, Official Court Reporter for the Court of Common Pleas, Cuyahoga County, Ohio, do hereby certify that I am employed as an Official Court Reporter, and I took down in stenotypy all of the proceedings had in said Court of Common Pleas in the above-entitled cause; that I have transcribed my said stenotype notes into typewritten form, as appears in the foregoing Excerpt Transcript of Proceedings; that said transcript is an excerpt record of the proceedings had in the said cause, and constitutes a true and correct Excerpt Transcript of Proceedings had therein.

Angela R. Cudo, RPR
Official Court Reporter
Cuyahoga County, Ohio