University Suburban Health Center

1611 South Green Road
South Euclid, Ohio 44121

USHC Physicans, Inc.

Philip A. Anderson, M.D.
Internal Medicine

Richard H. Bailey, M.D.
Internal Medicine

Kara H. Browning, M.D.
Internal Medicine
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Robert B. Cameron, M.D.
Internal Medicine
Gastroenterology

Robert A. Cirino, M.D.
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Lawrence T. Kent, M.D.
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Rheumatology

Thomas J. King, M.D.
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Stephen A. Rudolph, M.D., Ph.D.
Internal Medicine
Clinical Pharmacology

William W. Steiner, M.D., Ph.D.
Internal Medicine

June 22, 2004

C/o Erin Siebenhar Hess, Esq.
Reminger & Reminger
1400 Midland Bldg.
101 Prospect Ave. West
Cleveland, OH
44115-1093

RE: Michael Paolella, E/O Beverly Paoella v. Sonia Kirk MD, et al.

Your File No. 4100-02-53291-03

Dear Ms. Hess,

I have received and reviewed the pertinent information on the above named case. Specifically, noted are the medical records of Bruce Long MD and Arun Gupta MD; the Lake Hospital System records concerning the admission of Beverly Paolella; and the deposition transcripts of Sandeep Kotak MD, Sonia Kirk MD, and that of John Novak PA. Finally, the autopsy report was reviewed.

Mrs. Beverly Paolella was a 59-year-old woman with a noted medical history of psoriasis, psoriatic arthritis, hypertension, hyperlipidemia, s/p hysterectomy and oopherectomy, diabetes mellitus, obesity, heartburn, and anxiety.

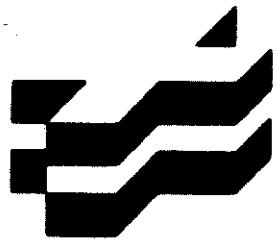
Her medications, over the years, had included longstanding Methotrexate and folic acid for her psoriatic issues; Xanax for anxiety; the blood pressure medications Calan and Vasotec; Glucotrol and Amaryl for diabetes; various anti-inflammatory tablets including Daypro, Indocin, and Voltaren; Zocor (briefly); Zantac; and finally nitroglycerin.

She had no known allergies.

She did not use tobacco products.

Her diabetes proved difficult to control, as she had refused further insulin therapy on multiple occasions after a brief trial. Likewise, she was unable to take the Zocor medication, and did not want further cholesterol therapy. There were multiple missed or cancelled visits. When she had atypical chest pain in the early 1990's, she did not want to have a stress test done in a timely manner. An echocardiogram in 1992 revealed normal left ventricular function. There was a treadmill exercise test done in 1993, but it was terminated due to shortness of breath.

It was apparent that Dr. Sandeep Kotak had none of this detailed information directly available to him. He had met Mrs. Paolella late on a weekday night when her regular physician or records were not available.



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Mrs. Paolella presented to the Lake Hospital System Emergency Room on August 22, 2002 and was seen by Mr. Novak and Dr. Kirk. Her complaint was shortness of breath and sputum production, nausea, vomiting, and diarrhea; these had been going on in some capacity for several days. She had in the past week been treated with amoxicillin. More recently, though, the nausea had subsided, and her main complaint was nasal congestion and coughing. She was afebrile and had a pulse oximetry of 97%. Her blood glucose was elevated, and there were mild signs of dehydration. Her white blood count was normal.

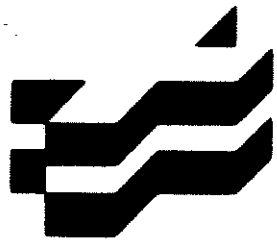
The initial read of the chest x-ray, apparently by a radiologist, suggested 'CHF with edema and/or unusual pneumonia.' This was available at the time the patient was present in the emergency room. The body of the chest x-ray report later stated '...pulmonary vascular congestion with mild diffuse interstitial and bibasilar alveolar edema. Small pleural effusion'. The summary stated 'Congestive heart failure. An unusual pneumonia could present this way as well. Appropriate clinical correlation is required.', although this was not available by the time the patient had been discharged. She had been given albuterol therapy and Levaquin prior to leaving with improvement.

She later called back after speaking with the covering physician from her regular internist's office, and returned to the Lake Hospital System Emergency Room for further evaluation that led to her admission.

After coming to her hospital bed, she complained of nausea. Several hours later, she experienced a syncopal episode, became diaphoretic, and had a loss of blood pressure. The house officer alerted Dr. Kotak to these changes, and she was transferred back to the Emergency Department due to the availability of a monitored bed there. She became asystolic, and despite cardiopulmonary resuscitation efforts, died. The autopsy had revealed extensive coronary disease, with an acute plaque rupture (without organized thrombus) in the left circumflex artery.

Dr. Kotak had not ever seen Mrs. Paolella prior to this admission. Based on a reasonable and thorough evaluation of her complaints, he treated her respiratory symptoms and nausea. When her condition changed, he took the most appropriate steps possible in the difficult circumstances of there not being any telemetry or intensive care beds immediately available. Tests and medications were ordered, numerous transfer arrangements were being made (including Life Flight and getting a physician from another hospital to accept her), and he even returned to the hospital in the middle of the night. Dr. Kotak met the highest standard of patient care in this respect.

The initial chest x-ray report and transcript from the emergency room could certainly have been interpreted a number of different ways. One way would unlikely have been 'coronary vascular disease'. The report is not inconsistent with an atypical pneumonia, which could present without fever or elevated white blood count in a patient taking immunosuppressive medication. A physician must take into account the entire evidence of the patient's subjective historical account, their own physical examination, and objective findings to make diagnostic and therapeutic decisions.



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In this respect, the decision to admit and care for Mrs. Paolella was based on the pertinent issues in her particular case, and her limited response to outpatient therapy. Because there was no historic or clinical evidence of cardiovascular complaints, and because her cardiac rhythm was normal, and because she did not have peripheral edema on examination, and because she was showing evidence of fluid loss (high BUN/creatinine ratio), it is unlikely a reasonable physician would have treated her with diuretics as may be seen generally in someone with acute congestive heart failure. In fact, she needed IV fluids administered secondary to the above findings.

I find that as a practicing internist who admits and cares for patients in the hospital, and gets multiple calls from emergency departments about issues with the same, it is not always entirely within a physician's ability alone to have a desirable outcome. The basis of disease can often precede the diagnosis for months or years without any clinically apparent symptoms.

When Mrs. Paolella's heart problems became evident, it was the middle of the night. Even had she been in a cardiac intensive care unit- to mobilize an interventional cardiology team, get her to a catheterization laboratory, and perform angiography and angioplasty would have taken longer than the actual events that transpired. These later symptoms were that of an acute coronary process, not congestive heart failure. Additionally, this is not something that Dr. Kotak, in his limited interactions with Mrs. Paolella, could have either foreseen, prevented, or treated differently to affect her outcome.

Therefore, with the highest degree of medical certainty, I find no basis for any issues with Dr. Kotak's care of Mrs. Paolella.

Of course, if there are any questions, please do not hesitate to give me a call at the office and I would be available to discuss this with you further.

Regards,

Robert A. Cirino MD

Asst. Clinical Professor of Medicine

CWRU