

1                    THE COURT OF COMMON PLEAS

2                    STARK COUNTY, OHIO

3           MICHELLE OWENS,

4           Plaintiff,

5           -vs-

JUDGE REINBOLD

CASE NO. 2003CV00635

6           GERARDO CISNEROS, M.D.,  
7           et al.,

8           Defendants.

9                    - - - - -  
10           Deposition of GERARDO CISNEROS, M.D., taken  
11           as if upon cross-examination before Pamela S.  
12           Greenfield, a Certified Realtime Reporter,  
13           Registered Diplomate Reporter and Notary Public  
14           within and for the State of Ohio, at the offices  
15           of Buckingham, Doolittle & Burroughs, 4518 Fulton  
16           Drive NW, Canton, Ohio, at 5:30 p.m. on Tuesday,  
17           August 12, 2003, pursuant to notice and/or  
18           stipulations of counsel, on behalf of the  
19           Plaintiff in this cause.

20                    - - - - -  
21                    MEHLER & HAGESTROM  
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On behalf of the Plaintiff;

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On behalf of the Defendants.

W I T N E S S I N D E XPAGE

CROSS-EXAMINATION  
GERARDO CISNEROS, M.D.  
BY MS. KOLIS

4

E X H I B I T I N D E XEXHIBIT:PAGE

Plaintiff's Exhibit 1, one-page  
Cisneros CV

7

Plaintiff's Exhibit B, 034-037,  
four-page 7/21/99 visit record

47

Plaintiff's Exhibit C, 062-64,  
three-page 9/8/99 visit records

56

Plaintiff's Exhibit D, 085, one-page  
1/19/00 outpatient report

61

1           GERARDO CISNEROS, M.D., of lawful age, called  
2       by the Plaintiff for the purpose of  
3       cross-examination, as provided by the Rules of  
4       Civil Procedure, being by me first duly sworn, as  
5       hereinafter certified, deposed and said as  
6       follows:

7           CROSS-EXAMINATION OF GERARDO CISNEROS, M.D.

8       BY MS. KOLIS:

9       Q.   Doctor, strictly for identification purposes on  
10      the record, could you please state your name,  
11      complete name and your business address.

12      A.   Gerardo Luis Cisneros. 1226 Market Avenue North,  
13      Canton, Ohio, 44714.

14      Q.   Doctor, we've been introduced, but for the  
15      record, I'll introduce myself. My name is Donna  
16      Kolís. I am the attorney who is representing  
17      Michelle Owens in the instant lawsuit that has  
18      been filed. My purpose this early evening is to  
19      take your deposition and find out a little bit  
20      about the care and treatment which you rendered  
21      to Michelle and some of the thinking that might  
22      have gone into the diagnoses that you made.

23           Doctor, before today's deposition, have you  
24      ever had the opportunity in any other  
25      circumstance to give a deposition?

1 A. No.

2 Q. Ground rules are pretty simple. I'm sure your  
3 attorney has given you some advice in that regard  
4 but I will state for the record what my  
5 deposition rules are.

6 Are you aware, doctor, that you are required  
7 to answer each and every question orally?

8 A. Yes.

9 Q. And the reason I ask that, I think I tend to get  
10 very conversational in depositions and then that  
11 sort of makes the witness nod their head. She  
12 can't take down nods, shakes or anything else.  
13 She needs words, so we'll try to stay that way so  
14 that Pam can get your testimony.

15 I have your agreement on that?

16 A. Yes, you do.

17 Q. I assume that you, that you understand that you  
18 are under oath today just as if you were in a  
19 court of law?

20 A. I do.

21 Q. I don't know, but I'm soon going to find out what  
22 your current professional responsibilities are;  
23 but if you receive a page or something where you  
24 actually have a medical situation that you need  
25 to attend to, you just need to tell us that

1           that's the situation. Can I get your agreement  
2           on that?

3   A. Yes, certainly.

4   Q. Because while this deposition is important to  
5       myself and my client, your current patients who  
6       are actually treating are a little more important  
7       than that.

8           Let me advise you of something else. Many  
9       attorneys, if you go through these more than one  
10      time, object to certain things.

11           If you come to a point in this deposition I  
12      ask you a question and you believe you need to  
13      confer with your counsel, all you need to do is  
14      indicate for the record that you would like a  
15      moment to speak with your attorney.

16           If you do that, then Pam and I can leave the  
17      room, or the two of you can.

18           So do you feel comfortable with that if  
19      there's something you feel you need to talk with  
20      him about, you can voice that for the record?

21   A. Yes, I do.

22   Q. Moreover, if I ask you a question that you don't  
23      understand, and that happens because I'm an  
24      attorney and you're a physician, more than I'd  
25      like it to happen but it does, I need for you to

1 tell me that you do not know what information I  
2 am seeking.

3 Can I secure that agreement from you?

4 A. Yes.

5 Q. If you don't tell me that you don't understand a  
6 question, I'm going to assume you understood the  
7 question and that the answer you gave me was  
8 responsive to it, and that's why it's important  
9 to keep that in mind also. Okay?

10 A. Yes.

11 Q. First, we're going to mark a copy of what I  
12 believe to be your current curriculum vitae.  
13 Could you just quickly take a look at that. This  
14 is what was submitted to me in discovery.

15 A. Yes, that is correct.

16 - - - - -

17 (Thereupon, Plaintiff's Exhibit 1, one-page  
18 Cisneros CV was marked for purposes of  
19 identification.)

20 - - - - -

21 Q. Doctor, your vitae I think is fairly  
22 self-explanatory, but I would like to spend just  
23 a couple of minutes going through your  
24 background; but before we do that, can you please  
25 tell me your date of birth?

1 A. July 12th, 1968.

2 Q. Your Social Security number?

3 A. 624-66-7220.

4 Q. Do you know your Ohio State medical license  
5 number, and if you have something in your pocket  
6 that can refresh your memory, that's fine to use.

7 A. You're asking the State Medical Board of Ohio?

8 Q. Yes.

9 A. 35-07-6345 letter C as in cat.

10 Q. I assume that that medical license is current?

11 A. Yes.

12 Q. Do you have a license to practice medicine in any  
13 other state other than Ohio?

14 A. No.

15 Q. You received your medical license in what year?

16 A. In, I'm not certain about this.

17 Q. If I guess somewhere around 1997 or '98, does  
18 that sound -- it doesn't matter if you don't  
19 specifically remember.

20 A. Well, the thing is that you have a license,  
21 multiple licenses as a resident and then you have  
22 the current one which happened before I graduated  
23 or finished the residency in my chief residency  
24 year, so I believe it was '99 but I'm not --

25 Q. Based upon the limited ability that I have to



1 research medical licenses on the Internet, can I  
2 assume that it's an accurate statement that no  
3 action has been taken against your license?

4 A. It is correct.

5 Q. Doctor, tell me briefly what made you decide to  
6 go into internal medicine.

7 A. I think that is an area of medicine that is more  
8 intellectually challenging than others to me and  
9 that I am exposed to a wide variety of patients  
10 agewise, diseasewise. It keeps me motivated.

11 Q. It's my understanding based upon your curriculum  
12 vitae that after you completed medical school,  
13 that you did a residency program in obstetrics  
14 and gynecology first and that was in Mexico City,  
15 Mexico, correct?

16 A. For nine months I did OB/GYN in Oaxaca.

17 Q. Between 1995 and 1997 when you began your  
18 transitional year residency program through  
19 NEOUCOM and Aultman, what did you do in that  
20 two-year period of time?

21 A. I went to my hometown and mostly prepared myself  
22 to take the U.S. boards and practiced medicine,  
23 general medicine there, and did some  
24 assistantships with a plastic surgeon.

25 Q. So then you took the boards to come here; is that

1 correct?

2 A. Yes.

3 Q. Passed them on your first try I'm going to guess?

4 A. No.

5 Q. Okay. I'm a bad guesser today.

6 A. There are three steps. Step number one, I took  
7 three times not during that year. I had taken  
8 that before. Step number two and three, I did  
9 take once.

10 Q. And then you were admitted into the transitional  
11 year residency program?

12 A. Yes.

13 Q. And that was at Aultman Hospital?

14 A. Yes.

15 Q. And you did that from July of 1997 through June  
16 of 1998, correct?

17 A. Yes.

18 Q. Then you entered the internal medicine residency  
19 program with NEOUCOM Canton affiliated hospitals.

20 Explain to me what that program is.

21 A. That's a residency program that is affiliated  
22 with NEOUCOM and it is based out of Canton.

23 There are two hospitals, Aultman Hospital and  
24 Mercy Medical Center, and you are trained during  
25 a period of three years in internal medicine.

1 Q. The contracts which I was provided with, and it  
2 could be the way that I asked the question, for  
3 you relative to care which you provided I believe  
4 at Aultman Hospital were signed for one-year  
5 periods from April 4th, 1999 through April 4th  
6 2000 and then again April 4th, 2000 to April 4th,  
7 2001.

8 Do you recall those contracts?

9 A. I recall the contracts but I don't recall the  
10 dates.

11 Q. Okay. Did you work exclusively at Aultman  
12 Hospital for two years?

13 A. No. Because, like I said, the residency program  
14 is combined training in both hospitals, both  
15 Aultman Hospital and Mercy Medical Center, so you  
16 do some of your training at one hospital and some  
17 of it at the other.

18 Q. Since I wasn't in your program, you're going to  
19 have to help me. You finished your transitional  
20 year program in June of 1998?

21 A. Yes.

22 Q. Did you then immediately begin --

23 A. Yes.

24 Q. -- the residency program with Canton affiliated  
25 hospitals?

1 MR. MILLIGAN: You need to wait  
2 until she's done with the question to help  
3 the court reporter. Okay?

4 Q. That was the last rule I should have told you.  
5 It's pretty easy to do that, also.

6 So when you started that program in the  
7 summer of 1998, was there a percentage split of  
8 your time between Aultman and Mercy or how did  
9 they manage to figure out where you should be on  
10 what day?

11 A. Okay. The answer is yes and I finished the year  
12 of transitional residency program and I was  
13 offered to enter the internal medicine program  
14 immediately after I finished the transitional.

15 In fact, they credited me with six months of  
16 internal medicine because I had done already at  
17 least six months of training in internal medicine  
18 during the transitional year so I entered, I  
19 officially became an internal medicine resident  
20 on July 1st of '98; and what happens is that  
21 every month you are assigned to a different  
22 rotation.

23 For example, you do the floors or the ICU or  
24 the CCU and you have a team of one or two or  
25 three seniors and one or two or three more

1       interns or -- and medical students and there's  
2       always an attending physician, and if you're  
3       doing the CCU, for example, at Aultman Hospital,  
4       then you spend four weeks at Aultman Hospital  
5       seeing patients, diagnosing and treating patients  
6       as a team and at the end of the four weeks you  
7       move on to another rotation which may be the  
8       medical floor, the regular floors at Mercy  
9       Medical Center, for example, and then you go to  
10      Mercy and they are different, not exactly the  
11      same residents or interns. It's a different  
12      attending and you see patients throughout the  
13      day. You take calls at Mercy and so every four  
14      weeks you are changing rotations.

15             Sometimes you do it in the hospital all the  
16      time. Sometimes you're assigned to a specialty  
17      physician, an internal medicine specialty  
18      physician, for example, a cardiologist so you  
19      spend four weeks with a cardiologist and you  
20      pretty much tag along, you know, and you see his  
21      or her patients and as you see how the  
22      cardiologist treats, you learn, you are studying  
23      constantly cardiology during those four weeks.  
24      You go to the office of the cardiologist and you  
25      see a patient, management of cardiac, you know,

1 diseases, inpatient and there are several  
2 specialties of internal medicine like cardiology,  
3 pulmonary medicine, et cetera, so every four  
4 weeks you are to a different rotation in  
5 different areas of internal medicine.

6 Q. Okay. I never interrupt somebody when they're  
7 answering a question. I got a general sense and  
8 I just want to reiterate it to some degree.

9 When you began in the summer of 1998 you were  
10 a PGY-1, right, that was your first year, you are  
11 telling me you got six months' credit --

12 A. Yes.

13 Q. -- for the kind of program that you were  
14 previously in?

15 A. Yes.

16 Q. So when you start this program, you're not always  
17 hospital based within that first PGY year, you  
18 could go into an office setting with a specific  
19 subspecialty of internal medicine?

20 A. That's right.

21 Q. Could you list for me the subspecialties of  
22 internal medicine that you studied under between  
23 June of 1998 and say April of 1999?

24 A. I don't remember.

25 Q. Would you have received an evaluation from each

1           physician for whom you studied under during that  
2           period of time?

3       A.   Yes.

4       Q.   And I gather that would be part of your personnel  
5           file with Canton affiliated hospitals?

6       A.   Yes.

7       Q.   I'll make a request through your attorney  
8           separately to obtain those.

9           Do you recall if during that time you did any  
10          rotation where you specifically studied  
11          hematology?

12      A.   I don't remember.

13      Q.   Do you believe that you had a rotation in  
14          hematology?

15      A.   I don't remember.

16      Q.   Leaving that aside, we're going to come back to  
17          that, what you were doing at a certain period of  
18          time, but I want to just move on to something  
19          else.

20           As I looked at research presentations and  
21          publications, one of the articles which you list,  
22          your most recent one, the comparison of one  
23          versus seven day treatment for, and I'm never  
24          going to get this right, what's called H. Pylori  
25          infection, so I can get away from it. Is that in

1 publication now?

2 A. Yes.

3 Q. It has been accepted?

4 A. It has been accepted and I'm not the first  
5 author; but, yes, it has been accepted.

6 Q. Who accepted it for publication?

7 A. Annals of Internal Medicine.

8 Q. Who's the primary author?

9 A. Dr. Luis Lara.

10 Q. Can you spell that last name for me?

11 A. L-A-R-A.

12 Q. Do you have any other papers which you have  
13 worked on since the presentation of this  
14 curriculum vitae to me that may be in press at  
15 some point?

16 A. No.

17 Q. Are you doing any independent research in your  
18 current practice?

19 A. No.

20 Q. What is your current practice of medicine? Tell  
21 me what you're doing.

22 A. General internal medicine.

23 Q. Where are you doing that?

24 A. In Canton.

25 Q. Are you by yourself or are you in a group?



1 A. A group.

2 Q. What is your group name?

3 A. Mercy Professional Care Corporation.

4 Q. How many people are members of that group,  
5 estimate?

6 A. Five primary care physicians.

7 Q. Are you a shareholder or a partner in that  
8 organization or just an employee?

9 A. An employee.

10 Q. When did you become employed with that group?

11 A. December 1st, 2001.

12 Q. Hospital privileges at which hospitals?

13 A. Mercy Medical Center only.

14 Q. Generally speaking, people hate when I ask this,  
15 what is the nature of your practice?

16 A. I see, I'm a primary care physician for people of  
17 ages 12 or older.

18 Q. So you don't take care of the younger pediatric  
19 population. You take them 12 and up?

20 A. Yes.

21 Q. That's sort of your niche in the practice?

22 A. I do have to add, though, that I also do work at  
23 the StatCare that Mercy has in different  
24 locations in Stark and Carroll and Tuscarawas  
25 County on occasion as they need me and I do see

1 children there.

2 Q. You'll have to forgive my ignorance, I do not  
3 know what StatCare is.

4 A. It's an immediate care center where people come  
5 to see a physician without a previous appointment  
6 for all kinds of medical conditions.

7 Q. So it's like what I would call instead of being  
8 in a hospital emergency room, it's like an urgent  
9 care center?

10 A. Yes.

11 Q. Where if you have a new illness but you don't  
12 have an established primary care doctor, you can  
13 come and be seen right away?

14 A. Yes, but not necessarily a new illness but just  
15 you have a medical need, old or new and you  
16 request to be seen by a physician, yes.

17 Q. How frequently do you do that?

18 A. It varies, but this month I've been there once a  
19 week.

20 Q. Do you and your coworkers share that  
21 responsibility?

22 A. No.

23 Q. That is something that you've taken on on your  
24 own?

25 A. Yes.

1 Q. How did you come to take on that responsibility?

2 A. Because I have been doing that kind of work since  
3 I was a resident that I was given, that I  
4 actually obtained my license to practice in the  
5 State of Ohio as what they call moonlighting and  
6 since then, I started my practice, I really, I'm  
7 concentrating more on my own office, which is my  
8 important, my most important interest I have; but  
9 because of occasional shortage of personnel, they  
10 know that I've done this work before and that I'm  
11 willing to do it.

12 I do it mostly to help out a little bit, they  
13 need someone, they're desperate to have a  
14 physician to work over there and I go and work.  
15 I do like the kind of work, seeing those patients  
16 like a different variation of my job but the  
17 more, the busier I'm getting in my own practice,  
18 you know, seeing more patients, then I'm going to  
19 have a good follow-up and I get to know them,  
20 then the less I'm doing that at the Stat.

21 Sometimes it will be two or three months  
22 without going to these urgent care or immediate  
23 care centers at all.

24 Q. Doctor, I see that you are in fact boarded in  
25 internal medicine?

1 A. Yes.

2 Q. When did you pass your internal medicine boards?

3 A. In 2001.

4 Q. Was that your first attempt to pass the board?

5 A. Yes.

6 Q. Are you at present preparing for or anticipating  
7 any subspecialty of internal medicine?

8 A. No.

9 Q. Going back to, I guess this is the easy place to  
10 do it, my reading of medical records indicates to  
11 me that Michelle Owens came under your care in  
12 the summer of 1999. Is that your recollection?

13 A. That's my recollection.

14 Q. That would have been your PGY year 2, correct?

15 A. Correct.

16 Q. And at that point you were seeing her in a clinic  
17 at Aultman Hospital; is that right?

18 A. Correct.

19 Q. Explain to me the nature of the services that you  
20 were providing in the clinic at Aultman Hospital  
21 during, beginning with June of 1999?

22 MR. MILLIGAN: For this patient or  
23 generally?

24 Q. No, just in general what services were you  
25 providing as a resident?

1 A. Okay. You are the patient's primary care  
2 physician.

3 Q. Explain that to me. When you say you are the  
4 patient's primary care physician, what do you  
5 mean when you tell me that?

6 A. Well, you are treating them as an internist under  
7 the supervision of an attending physician and  
8 that clinic is intended to give you the  
9 experience in treating patients on the outpatient  
10 basis that otherwise you wouldn't get because  
11 you're seeing patients, most inpatients at the  
12 hospitals.

13 Q. So as opposed to, let's say treating a person as  
14 an internal medicine physician because they've  
15 come to the hospital for a catastrophic accident,  
16 this clinic is actually a family care clinic  
17 where they receive office visits from the same  
18 primary care physician. Am I explaining it  
19 correctly?

20 A. Yes. Yes. The difference is internal medicine  
21 you see children as opposed to a family  
22 practitioner, so we are family physicians for  
23 adults or for older, you know, teenagers.

24 Q. We're going to go probably, unfortunately have to  
25 go through visit by visit, but I usually get to



1       treating the patient. The attending is there to  
2       provide you with some input or some additional,  
3       you know, information or insight into what the  
4       patient's problem is and you're responsible for  
5       seeing the patient that you're seeing and making  
6       your own decisions.

7       Q. Again, I gather, which I know I'm right but I  
8       always like to get it on the record so I don't  
9       forget later, I'm assuming that while you had  
10      this contract with, I keep forgetting what your  
11      group is called, Canton affiliated hospitals,  
12      that you received paychecks?

13     A. Yes.

14     Q. Who did you receive your paychecks from?

15     A. Canton Medical Foundation.

16     Q. If I understood your answer, the one you just  
17      gave me, am I to infer that at each and every  
18      visit with a patient, you didn't necessarily have  
19      an attending present?

20     A. Physically?

21     Q. Yes.

22     A. Correct.

23     Q. Some of your notes say discussed patient with  
24      Dr. So and so.

25               When you write those in your medical notes,

1 does that mean that after the fact you sat down  
2 with the attending physician on service and  
3 discussed your findings and your diagnoses of the  
4 day?

5 A. Yes.

6 Q. Was that a requirement that you review all of  
7 your physical examinations, assessments and plans  
8 with an attending physician?

9 A. I don't know if it is a requirement.

10 Q. Are you certain that it wasn't a requirement?

11 A. No, I'm not certain.

12 Q. When you worked in, so that we're calling it the  
13 right name for identification purposes in the  
14 record, the clinic which Michelle was seeing you  
15 in, was that called the Aultman Internal Medicine  
16 Clinic?

17 A. Correct.

18 Q. Because it doesn't say that on the documents, but  
19 that's all right.

20 How many residents were serving as primary  
21 care physicians in the Aultman Internal Medicine  
22 Clinic during the time you were there?

23 A. During the time that I was physically present,  
24 like that afternoon or in general?

25 Q. I'm sorry. Once again we're back to I don't know



1       where you are at all times because of your  
2       splitting between hospitals, so I guess we should  
3       just establish that.

4             Beginning in the spring of 1999, that's when  
5       you started working in the Aultman Internal  
6       Medicine Clinic?

7       A.    I don't remember the exact date. .

8       Q.    Well, at a minimum we know that you must have  
9       started working there as of the first time you  
10      saw Michelle; is that right?

11      A.    Okay. As a transitional residency, resident I  
12      was working already at the clinic at Aultman  
13      Hospital, so it was since 1997.

14      Q.    So you had actually, prior to becoming officially  
15      a member of the internal medicine residency  
16      program, had time in this internal medicine  
17      clinic?

18      A.    Yes.

19      Q.    During that transitional year residency program  
20      did you have the same sort of privileges that  
21      we're discussing today, that being that you got  
22      to serve as a primary care physician without the  
23      necessity of an attending being present for  
24      physical examinations?

25      A.    I couldn't say that because I, like I said, I

1 don't know what the requirements are about  
2 whether or not the necessity of having an  
3 attending.

4 Q. Anyway, my question was approximately how many  
5 residents were serving as primary care  
6 physicians, and let's begin with that PGY-2 year.

7 A. Okay. Each class has 10 residents and they are  
8 three years, so approximately 30 residents at any  
9 given time. Approximately half of those  
10 residents have their clinic at Aultman Hospital  
11 and half of them are at Mercy. It may be a  
12 little more one way or the other.

13 I don't know what exact, exactly it is, but  
14 at any given time that I was at the clinic seeing  
15 patients, there were about two or three other  
16 residents the same afternoon that I was seeing  
17 patients there, a couple of them were from  
18 different years, you know, like first, second or  
19 third-year residents and I only worked there one  
20 afternoon every week, I believe it was Wednesday  
21 afternoon that I was seeing patients at the  
22 clinic.

23 Q. Did that remain true through the entire residency  
24 program for you? You were just there your PGY-2  
25 and 3 on Wednesday afternoons at Aultman Internal

1 Medicine Clinic?

2 A. Yes.

3 Q. Did you work at the Mercy Internal Medicine  
4 Clinic?

5 A. Not as a PGY-1, 2 or 3.

6 Q. It was later?

7 A. As a PGY-4 chief resident, I did see what they  
8 call priority clinics.

9 Q. Doctor, other than the instant case that we're  
10 here to discuss today, have you been sued for any  
11 other claims of medical negligence?

12 A. No.

13 Q. In anticipation of today's deposition, can you  
14 tell me what materials you reviewed?

15 A. The charts and some medical literature.

16 Q. Let's talk first about the charts.

17 When you say the charts, what records did you  
18 actually look at?

19 A. I looked at my clinic records and I looked at the  
20 hospital records and I looked at other treating  
21 physicians' records.

22 Q. I have a copy of your clinic records which were  
23 supplied to me so I know what those are.

24 When you say hospital records, are you  
25 referring to any hospital other than Aultman?

1 A. No.

2 Q. So you've only read the Aultman Hospital chart?

3 A. To my knowledge, yes, because sometimes when you  
4 review other physician's records, they might be  
5 something from other hospital and I'm not aware  
6 of having seen anything like that.

7 Q. And then you said you reviewed other physicians'  
8 records. Can you with specificity tell me what  
9 physicians' records you've read?

10 A. I remember reviewing Dr. Weeman's.

11 Q. Do you know Dr. Weeman?

12 A. Yes, I do.

13 Q. Are you working, I don't want to say working with  
14 her. Do you have professional interaction with  
15 Dr. Weeman at this point?

16 A. No.

17 Q. And that's because she's with Aultman, correct?

18 A. As far as I know, yes.

19 Q. Who else did you look at? I mean what other  
20 physicians' records did you review?

21 A. I don't remember the names of the physicians but  
22 I remember seeing another hematologist and I  
23 don't remember the names of the other physicians  
24 that I reviewed.

25 Q. Doctor, when you sat for your internal medicine

1 board, can I gather that you used a textbook to  
2 help you prepare for those boards?

3 A. Yes.

4 Q. Would you have used Harrison's on internal  
5 medicine?

6 A. For the boards, no.

7 Q. What textbook did you elect to use to help you  
8 prepare for the boards?

9 A. The med study and the MKSAP.

10 Q. Did you use those sources because you considered  
11 the medical information contained in them  
12 reliable?

13 A. For the boards, yes.

14 Q. Before we get into going through Michelle's  
15 records, I'd like to talk to you, doctor, about  
16 what you know about thrombocytosis.

17 When you first saw Michelle, and I'm going to  
18 call it July 21st, 1999 unless we decide you saw  
19 her earlier, but I think that's the first date,  
20 were you aware of the hematological disorder  
21 known as thrombocytosis?

22 A. Yes.

23 Q. Doctor, tell me what thrombocytosis is.

24 A. Elevation of number of platelets in blood.

25 Q. Platelets being one of the three components of

1 blood, red cells, white cells and platelets,  
2 right?

3 A. Yes.

4 Q. When you were in medical school or when you were  
5 participating in your transitional year of  
6 residency, what did you learn to be the  
7 significance of elevated platelets?

8 A. I don't think I understand the question.

9 Q. Well, that's good because I should ask you a  
10 different question first.

11 Doctor, in terms of a reference range that  
12 internal medicine physicians would use, what do  
13 you understand to be the normal reference range  
14 for platelet counts?

15 A. It varies between labs, so I cannot answer the  
16 questions with a number.

17 Q. Sorting out the variability between laboratories,  
18 doctor, were you meaning laboratory errors or how  
19 they code it? Which were you referring to?

20 A. Repeat that. I don't understand the question.

21 Q. You said it varies between laboratories,  
22 therefore you can't answer it; so I'm asking you,  
23 first of all, when you say it varies, are you  
24 talking about reference ranges in terms of  
25 milliliters? What reference ranges are you

1           saying are different?

2       A.   That some labs report norms to be a certain range  
3           and some other labs report the norms to be  
4           another range.

5       Q.   Doctor, wouldn't you agree with me that as part  
6           and parcel of your educational process in  
7           internal medicine that there are clearly defined  
8           parameters for the normal range for platelet  
9           counts?

10      A.   I don't agree.

11      Q.   You don't? Go ahead.

12      A.   I don't agree with that statement.

13      Q.   Are you going to disagree with the statement that  
14           a normal platelet range can be between 140 and  
15           450, that that's generally accepted as the range  
16           for platelets?

17      A.   Yes. You know, the reason why I'm saying that I  
18           don't want to mention a number is because it may  
19           vary; but, yes, although I don't want to mention  
20           a specific number because I don't want to say  
21           something that is incorrect, but I would agree  
22           that 140 to 450 sounds like the range that, with  
23           certain limits across the board, could be used as  
24           normal, yes.

25      Q.   Just so we establish a baseline, a platelet count

1           can be as low as 140 but go up to 450 and still  
2           be considered normal in terms of an individual,  
3           correct?

4   A.   The problem is that the word normal is a very  
5           ambiguous word and is very seldom used, you know,  
6           in, or not seldom but I would say that you have  
7           to be careful when you use it.

8   Q.   In what context would you like to use the word  
9           normal?

10   A.   For a certain individual, for example.

11   Q.   If you went to your Stat clinic tonight and you  
12           did a CBC with differential and a Chem 7 and an  
13           SMA because you were looking for something and  
14           got reported back a platelet of 20, what would  
15           you do?

16   A.   Of 20,000?

17   Q.   Yes.

18   A.   Well, I would take into consideration the  
19           physical examination, the past medical history to  
20           make a decision about what to do with that.

21   Q.   Would you be concerned if you saw a platelet  
22           count of 20?

23   A.   Of 20,000, certainly, yes.

24   Q.   Would you be concerned today if you saw a  
25           platelet count of 725?



1 A. In what setting?

2 Q. In the setting of an incidental finding that came  
3 back from a blood result. If you saw a platelet  
4 count of 725, what would you do?

5 A. I would probably, like I said before, take into  
6 consideration the patient's physical findings and  
7 medical history to see if that number is a number  
8 that is going to help me come up or look, find a  
9 diagnosis or establish a diagnosis or that is,  
10 there's an explanation for that number, or if it  
11 is or if it's not, 700,000 platelets is not by  
12 itself -- they'll mean one thing or another -- it  
13 doesn't tell me, doesn't mean a lot by itself or  
14 it doesn't mean, it doesn't mean a diagnosis  
15 other than thrombocytosis.

16 Q. So if you saw someone today, we're just going to  
17 use the number 725, 725,000 as a platelet count,  
18 you wouldn't call a hematologist?

19 A. No. I wouldn't do it the first thing.

20 Q. In terms of your knowledge as an internal  
21 medicine physician in the summer of 1999, what  
22 would you have believed to be the main danger in  
23 a person having too many platelets?

24 A. At that point I would see that as a sign of,  
25 there is, there's an acute phase reactant.

1 Platelets are good to determine if there's any  
2 kind of inflammatory process. In some kinds of  
3 infection the platelets can be raised, so an  
4 elevation of platelets sometimes can be taken as  
5 a sign of an inflammatory process and you call  
6 that as an acute phase reactant.

7 Q. So you're talking about reactive thrombocytosis?

8 A. Yes.

9 Q. But in a person who doesn't have anything  
10 suggestive of inflammatory process, which wasn't  
11 the question I was asking -- let me withdraw  
12 that.

13 The question that I wanted you to answer for  
14 me, not what was causing the thrombocytosis, what  
15 is the main danger in a person having too many  
16 platelets? Were you aware of what risks there  
17 were?

18 A. Yes, I am aware of the risks.

19 Q. Can you tell me what those risks are?

20 A. Bleeding or thrombosis.

21 Q. Would you have known in the summer of 1999 that  
22 increased platelet counts can lead to strokes,  
23 blood clots in arteries or a myocardial  
24 infarction?

25 A. An elevation above a million, yes.

1 Q. Is it your testimony that only when the elevation  
2 is above a million that those three consequences  
3 are possible?

4 A. No, but more commonly.

5 Q. Well, when you say more commonly, that doesn't  
6 mean that a person who has an elevated platelet  
7 count of 725 cannot experience stroke, blood  
8 clots or myocardial infarction because of that  
9 elevation, does it?

10 A. Correct. But a person with 300,000 platelets can  
11 also have a clot or a myocardial infarction so  
12 the number itself doesn't necessarily mean or is  
13 not a predictive factor.

14 Q. I appreciate your statements on that but, once  
15 again, that wasn't responsive to what I was  
16 asking you so let me ask you some different  
17 questions.

18 MR. MILLIGAN: Let me just object  
19 because I think he responded exactly to the  
20 question you asked. So go ahead, ask it  
21 again.

22 Q. Well, the record is going to speak for itself on  
23 that issue.

24 Dr. Cisneros, are you saying that when a  
25 person has a high platelet count that you don't

1           have to investigate the cause of the  
2           thrombocytosis?

3   A.   When you see an elevation of platelet count, you  
4           think is this a primary problem or a secondary  
5           problem.   You see the overall picture and say  
6           this patient has, does this patient have any  
7           signs or symptoms that would lead me to believe  
8           that it's suffering from a condition that I need  
9           to treat and then you investigate and treat  
10          whatever you find in the patient.

11   Q.   But needless to say if you do see a high platelet  
12          count, you do have to have a differential and  
13          investigate what is causing it.   Is that a fair  
14          statement?

15   A.   If you see an elevated platelet count, you have  
16          to have a differential, yes.

17   Q.   Doctor, in your care and treatment of Michelle  
18          Owens, you became aware that she had elevated  
19          platelet counts, didn't you?

20   A.   I don't understand the question.

21   Q.   During the time that Michelle Owens was your  
22          patient, you were her primary care physician at  
23          Aultman Internal Medicine Clinic, you were aware  
24          of two elevated platelet counts; were you not?

25   A.   Yes, I was aware.

1 Q. You were aware of one in April that, the platelet  
2 count actually, the blood was drawn in April of  
3 1999 and you commented on the platelet number in  
4 July of 1999. Does that comport with your  
5 recollection?

6 A. I'd have to see the record.

7 Q. Take a look at your record.

8 A. What date is that?

9 MR. MILLIGAN: Do you have a page  
10 number?

11 Q. Yes. Well, I don't know if you and I have the  
12 same Bates numbers.

13 In your narrative note of 7/21/99, it's Bates  
14 stamped, if you have the Records Deposition set,  
15 36 and 37, and those came out of Dr. Cisneros'  
16 clinical records.

17 MR. MILLIGAN: July 21.

18 Q. July 21st, 1999.

19 MR. MILLIGAN: Do you need to have  
20 the question repeated?

21 A. Let me just read it.

22 Can you repeat the question?

23 Q. Sure, doctor.

24 The first time that you document in the chart  
25 that you're aware of a platelet count is in your

1 July 21st, 1999 dictated report, referring you to  
2 Page 2, last paragraph where you indicate CBC  
3 with differential done 4/27/99 showed white blood  
4 cells 9930 with normal differential. Hemoglobin  
5 14.9. Hematocrit 43.0. RDW 12.8. Platelet  
6 645000. Do you see that?

7 A. Yes, I do.

8 Q. Doctor, anywhere in your notes on 7/21, 1999 do  
9 you discuss evaluating that platelet count?

10 A. Well, I do indirectly when I'm explaining of the  
11 leg pain of uncertain etiology and then I'm  
12 asking for an ESR screen for inflammatory  
13 process.

14 Q. Doctor, you had an ESR done, didn't you?

15 A. What was that?

16 Q. You had the ESR done, didn't you?

17 A. I don't remember, but I --

18 Q. Take a look in the records. That's what they're  
19 there for.

20 A. Yes.

21 Q. Wasn't your ESR negative?

22 A. It was 1.

23 Q. Meaning what to you?

24 A. That it was not elevated.

25 Q. Correct. So that excluded an inflammatory cause

1           for an increase in the platelets, didn't it?

2       A.   No.

3       Q.   Why didn't it?

4       A.   Because an ESR of 1 does not exclude anything.

5       Q.   Well, it didn't help you to confirm that she  
6           might have been experiencing a reactive  
7           thrombocytosis, did it?

8       A.   No, it didn't. It didn't help me.

9       Q.   As a matter of fact, doctor, there's absolutely  
10          no mention in your assessment of this patient on  
11          your first visit of July 21st, 1999 of any  
12          potential hematological problem. Is that a fair  
13          statement?

14      A.   Yes.

15      Q.   You didn't at any point between July of 1999 and  
16          August of 2002 consider referring Michelle to a  
17          hematologist. Is that also a fair statement?

18      A.   Yes.

19      Q.   Do you know, doctor, what some of the physical  
20          signs of essential thrombocytosis are in a  
21          patient?

22      A.   Yes, I do.

23      Q.   Would you like to tell me what those are?

24      A.   People can have hemorrhagic or thrombotic events.

25      Q.   Well, tell me what you mean by hemorrhagic or

1 thrombotic events.

2 A. Hemorrhagic, people can have bleeding gums or can  
3 have blood in their stools or their urine.

4 Q. A GI bleed?

5 A. Yes. And thrombotic, people can have stroke or  
6 they can have ischemic bowel.

7 Q. Those are some examples. I'm assuming that your  
8 answer is not exclusive of everything that you'd  
9 be aware of that represented physical signs of  
10 thrombocytosis, is it?

11 A. I don't think I understand the question.

12 Q. Okay. Well, we'll go through and we'll do what I  
13 call the Donna Kolis agreement list.

14 In terms of thrombotic events, would you  
15 agree with me that the following major events may  
16 be some evidence or lead to a diagnosis of  
17 thrombocytosis. DVTs, possible from  
18 thrombocytosis?

19 A. Yes.

20 Q. Pulmonary embolus?

21 A. Yes.

22 Q. Myocardial infarction?

23 A. Yes.

24 Q. Cerebrovascular accidents?

25 A. Yes.



1 Q. Let's talk about what I categorize as a more  
2 minor form of thrombotic events.

3 Transitory ischemic attacks could be caused  
4 by thrombocytosis. Would you agree with that?

5 A. Yes.

6 Q. Headaches?

7 A. It has been described, yes.

8 Q. And that is described pretty well in the  
9 literature, isn't it?

10 A. Yes.

11 Q. Painful discoloration of digits, meaning fingers  
12 and toes?

13 A. Yes.

14 Q. And prior to the time that you treated Michelle,  
15 had you not seen that in the medical literature  
16 as you were studying internal medicine?

17 A. I don't remember.

18 MR. MILLIGAN: Seeing?

19 Q. Prior to the time you were seeing Michelle?

20 MR. MILLIGAN: But seeing the  
21 what, discoloration of digits?

22 MS. KOLIS: No. Prior to the time  
23 Michelle became his patient, I'm asking him  
24 if, based upon his studying and preparation  
25 in internal medicine, if he can recall that

1                   this is clearly written about in the  
2                   internal medicine literature.

3                   MR. MILLIGAN: But I guess what  
4                   I'm going to ask is what is clearly written  
5                   about, that whole list?

6                   MS. KOLIS: No. The last thing he  
7                   and I just discussed.

8                   A. I don't remember reading about that prior to  
9                   seeing Michelle.

10                  Q. Today as you sit here, however, you are aware  
11                  that this is reported in the medical literature?

12                  A. Yes, I'm aware.

13                  Q. And is that because you reviewed medical  
14                  literature for this deposition?

15                  A. I had not read about essential thrombocytosis  
16                  since I took my boards for internal medicine in  
17                  2001 so it was not the first time that I read it,  
18                  read about it.

19                  Q. You clearly and quite candidly disclosed to me  
20                  that in preparation for today's deposition you  
21                  did review medical literature. Can you tell us  
22                  what you reviewed?

23                  A. I reviewed some articles about, on the Internet  
24                  and I reviewed Harrison's and I reviewed current  
25                  diagnosis and treatment. Those are the ones that

1 I remember reviewing.

2 Q. The Internet's a big vast place. What search  
3 engine did you use when you went to input your  
4 information?

5 A. PopMed.

6 Q. Do you know what search words you used?

7 A. Thrombocytosis.

8 Q. Do you know what the names of the articles were  
9 that you reviewed?

10 A. No.

11 Q. Did you print what you reviewed?

12 A. No.

13 Q. During the time that Michelle was under your care  
14 and treatment, did she not complain to you about  
15 headaches?

16 A. She did.

17 Q. Those headaches at different points were listed  
18 as etiology unknown, would you agree with that?

19 A. Yes.

20 Q. At one point you listed that they were believed  
21 to be migraines; is that correct?

22 A. Yes.

23 Q. You based that belief on what?

24 A. Previous history.

25 Q. Define for me, if you will, what constitutes a

1           migraine headache?

2       A.   A migraine headache is a headache that, the  
3           typical migraine headache is one-sided headache  
4           that is exacerbated with light and noise and it  
5           is not relieved with usual medications like  
6           over-the-counter medications; but there are  
7           atypical migraine headaches that don't follow  
8           those rules. They can be generalized headache.  
9           They can be associated with even some other  
10          associated, they can be certain symptoms like  
11          nausea and like numbness sensation of their, you  
12          know, face and so that's it.

13       Q.   Would you agree with me, and once again, we can  
14           go through these notes note by note, which we may  
15           go through some of them.

16               Can you and I at least agree even when you  
17           called it a migraine headache, Michelle Owens  
18           certainly did not have a classic migraine  
19           headache presentation?

20       A.   I agree.

21       Q.   No photophobia, the headache wasn't limited to  
22           one side?

23       A.   I don't remember those details.

24       Q.   If you want to look at your chart, you can.

25       A.   I need to go back.

1 MR. MILLIGAN: I just want to make  
2 sure you look at everything.

3 A. Okay. I'm ready. Mentioned about the headaches  
4 in two notes. The first one I saw her September  
5 21st, '99, that at that point she was having some  
6 blurred vision at that point and along with the  
7 headaches. That was the first time I ever saw  
8 her. And the following, or another time when I  
9 saw her again, okay, these are going backwards.  
10 I saw her on July 21 of '99 she was complaining  
11 of headaches and blurred vision.

12 The visit at the time that she had been at  
13 the clinic before that had been June 14th of '99  
14 and the physician who had seen her at that point  
15 had mentioned the patient's headache, as well,  
16 and tried a medication that is usually used for  
17 migraine headaches and I had read, so, but I  
18 don't see any follow-up on those headaches  
19 because the patient was not complaining of those  
20 headaches anymore after work.

21 When she came again to see me, the headaches  
22 were not an issue at that point. There were  
23 other issues that she was complaining of and I  
24 didn't address the headache anymore. So she had  
25 headaches, she had blurred vision. She had been

1           given a medication called Zomig that is used for  
2           migraine headaches by another physician. Then I  
3           saw her. She was having headaches at that point  
4           but she was having other concerns and complaints  
5           that I was concentrating more about.

6           The first time that I saw her on July 21st of  
7           '99 the most important problem or the number one  
8           problem that I addressed was the vision  
9           abnormalities and I sent her to an  
10          ophthalmologist for that.

11       Q. I guess we'll go through the notes anyway.

12           The physician, by the way, that saw her in  
13          June, I think it was June 14th, 1999, was that  
14          also a resident?

15       A. Yes.

16       Q. Do you know what the Joint Commission on Hospital  
17          Accreditation has to say about residents in  
18          internal medicine treating patients? Do you have  
19          any idea?

20       A. No.

21       Q. All right. So you see her July 21st. That's your  
22          first visit. By the way, doctor, it seems to me,  
23          I just want to establish this for myself when I  
24          go back to look at my notes.

25           Do you take -- I'm going to label this B.

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- - - -  
(Thereupon, Plaintiff's Exhibit B, 034-037,  
four-page 7/21/99 visit record, was marked  
for purposes of identification.)  
- - - -

Q. The first portion of the records, I tried to put  
these together by dates. Up here, it says  
Dr. Cisneros 7/21/99. Is this writing in this  
box your handwriting?

A. Yes.

Q. And then you dictate a note subsequent to that?  
Is that how you --

A. Yes.

Q. I just like to figure out people's custom and  
habit. So she comes in, you have a clinical  
sheet and then you write your assessment and your  
plan and whatever other pertinent information you  
need?

A. Yes.

Q. And then you sit down, do you sit down right  
after you write that note and dictate?

A. I do.

Q. So you don't wait until the end of your clinical  
afternoon and then dictate like ten charts at one  
time?

1 A. Usually I don't, but I have done it before.

2 Q. But generally speaking, that's your custom is to,  
3 as you're with the patient, hand write the notes,  
4 correct?

5 A. No, I don't write as -- as soon as I finish the  
6 patient, I write, I walk out of the room and I  
7 write some things and then I dictate.

8 Q. It appears to me, doctor, and you tell me, in  
9 your handwritten portion for that first visit  
10 with her, your number one plan was get the ESR,  
11 right, and you drew, had a blood draw for that,  
12 right? Then you had the second thing you wanted  
13 her to have an ophthalmologist consult, correct?

14 A. Yes.

15 Q. Because you were concerned about visual  
16 disturbances, correct?

17 A. Okay.

18 Q. And then is that occupational therapy consult?  
19 I'm sorry. It probably is?

20 A. Yes, it is.

21 Q. And you wanted her to have an OT consult because  
22 she was exhibiting bilateral leg pain; is that  
23 right?

24 A. No. I was doing that because she was asking for  
25 disability medical coverage and I didn't know the



1 patient at all. That was the first time that I  
2 was seeing her and I was recommended that by,  
3 actually I don't know by whom but when I was  
4 doing my residency that she could have permission  
5 to have occupational therapy to see how much she  
6 could do in terms of lifting, walking and to use  
7 that information to provide the information to  
8 the disability bureau.

9 Q. I guess I asked the question in a poor way. In  
10 her history she reported to you at that time that  
11 she was experiencing bilateral leg pain on  
12 exertion; is that correct?

13 A. Yes.

14 Q. And that's your dictated note?

15 A. Yes.

16 Q. And so you thought she needed an assessment by  
17 occupational therapy relative to that complaint  
18 which was causing her to say that she was having  
19 disability problems?

20 A. I don't remember the reason why she was applying  
21 for disability benefits.

22 Q. Do you have any idea what kind of disability she  
23 was discussing, whether it was to be off work  
24 until she felt better? Do you have a  
25 recollection today at all of what she was

1           discussing with you?

2       A.   No, I don't.

3       Q.   Doctor, number four of your assessment and plan  
4           in your typewritten session indicates that you  
5           are going to prescribe Flexeril as well as  
6           Tylenol for pain.

7           Which pain were you trying to address with  
8           Flexeril and Tylenol?

9       A.   The leg pain.

10      Q.   So you didn't disbelieve that Michelle Owens was  
11          experiencing bilateral leg pain, correct?

12      A.   Oh, no, definitely.

13      Q.   And in fact, you were going to medicate her for  
14          the same?

15      A.   Yes.

16      Q.   Would the administration of Flexeril or Tylenol  
17          have any effect on a person's headaches?

18      A.   Yes.

19      Q.   So taking new medications might relieve a  
20          headache that a person had already established;  
21          is that right?

22      A.   Yes.

23      Q.   Number five, what you were doing, and you correct  
24          me if I'm wrong, it says increased cholesterol  
25          and LDL of 143. You were referring back, were

1           you not, doctor, to the lab results that were  
2           drawn in April, sorry, June?

3       A.   Well, let me see.

4                       MR. MILLIGAN:   Do you have a page  
5                       number there, Donna?

6       Q.   Yes.   I'm trying to figure out where he got his  
7           LDL from.

8                       On June 15th, 1999 laboratories were done and  
9           that's where her LDL came from, correct?

10      A.   I believe so.

11      Q.   So you wrote in your assessment plan, you made  
12           note of her LDL of 143.

13                       Were you concerned with that number at all?

14      A.   I wouldn't say that I was concerned but I would  
15           say that I, it was increased, that I addressed  
16           that with the patient and let her know that her  
17           cholesterol was elevated.   To me concern is  
18           really like preoccupied, which I wasn't.

19      Q.   That's a layperson's word.   That's not a doctor's  
20           word.   I should choose a better word to use.

21                       In response to noting that she had an LDL of  
22           143, you did give her some medical advice and  
23           that was to decrease the fat content of her diet,  
24           correct, and you told her you do that and we'll  
25           recheck your cholesterol at a later point?

1 A. Uh-huh.

2 Q. And in that sentence you also indicate the  
3 patient has no other risk factors for coronary  
4 artery disease?

5 A. Yes, I do.

6 Q. As of July 21st, 1999 based upon the history that  
7 you had taken from this patient and the physical  
8 exam you performed, you believed that she had no  
9 other factors for coronary artery disease; is  
10 that right?

11 A. That's what I wrote, yes.

12 Q. Was Michelle Owens a smoker?

13 A. Yes.

14 Q. And that wasn't a risk factor for coronary artery  
15 disease in your opinion?

16 A. Yes, it is.

17 Q. You didn't include that in your --

18 A. You're right.

19 Q. I'm just asking. That's what I do is I ask  
20 questions.

21 Would you at this point say that that was an  
22 incorrect statement --

23 A. Yes.

24 Q. -- at the time that you put it into your medical  
25 note?

1 A. Yes.

2 Q. Would you say that a person who has an elevated  
3 platelet count of unknown etiology might also be  
4 at risk for coronary artery disease?

5 A. Yes, but it's not a major risk factor for  
6 coronary artery disease.

7 Q. It is, however, an increased risk factor for  
8 coronary artery disease; is it not?

9 A. About -- yes. The answer is yes.

10 Q. Thank you. And the last concern that you had  
11 that you discussed was premenstrual syndrome,  
12 correct?

13 A. Uh-huh.

14 Q. Now, at the end of that note, and I --

15 A. I want to say something, 645,000 is not, to my  
16 knowledge, an increased risk factor for  
17 myocardial infarction.

18 Q. The question I asked you was --

19 A. Coronary artery disease.

20 Q. -- high platelets of unknown etiology, 645,000 is  
21 an increased risk factor for coronary artery  
22 disease. Do you agree with that?

23 A. For coronary artery disease?

24 Q. Yes.

25 A. No.

1 Q. You don't believe that increased platelets that  
2 go unaddressed cause or contribute to coronary  
3 artery disease?

4 A. 645,000?

5 Q. Yes.

6 A. No.

7 Q. Your own reference laboratory at Aultman Hospital  
8 listed 645 as high; did they not?

9 A. Yes.

10 Q. At the end of your note, you indicate patient was  
11 seen and discussed with Dr. Johnson?

12 A. Yes.

13 Q. This is a situation once again, so that the  
14 record is perfectly clear, Dr. Johnson didn't  
15 come in and consult with the patient?

16 A. I don't remember that because at the beginning of  
17 your residency, they do more than they do after.

18 Q. But I thought you told me that you already had a  
19 lot of experience because you were in the  
20 transitional program?

21 A. I wouldn't say a lot of experience but I had been  
22 doing the clinic for six months before July 1st,  
23 1999 and the attendings at the beginning during  
24 the first year of residency are more actively  
25 involved in seeing the patients than,

1           particularly Dr. Johnson, as well.

2       Q.   So that I'm clear, based upon the way you wrote  
3           this, you don't know if Dr. Johnson saw Michelle  
4           that day or not?

5       A.   Correct.

6       Q.   Is it the habit and custom or the practice of the  
7           Internal Medicine Clinic to always have the  
8           attending sign off under the resident?

9       A.   Yes.

10      Q.   Whether they see them or not, they review your  
11           note and they sign off?

12      A.   Yes.

13      Q.   If I am reading my charts correctly, the next  
14           visit that you --

15      A.   I do want to add something that if I write seen  
16           and discussed with so and so, that it means that  
17           I saw the patient with the attending.

18      Q.   I'll just ask, you may or may not know the answer  
19           to it but I can ask it this way:  If Michelle  
20           Owens says that the first time that she saw you,  
21           you were the only physician she met with, is she  
22           wrong or do you not know whether she's wrong?

23      A.   I don't know.

24      Q.   There.  That's good enough.  If you can mark this  
25           one Plaintiff's Exhibit C, we're going to go on

1 to the office visit of September 8th, 1999.

2

3 (Thereupon, Plaintiff's Exhibit C, 062-64,  
4 three-page 9/8/99 visit records was marked  
5 for purposes of identification.)

6

7 Q. This is Bates number 62, 63 and 64.

8 Once again, doctor, on Page, this will be  
9 Plaintiff's Exhibit C and the Bates stamp is 62,  
10 that front note of 9/8 it's kind of blurred but I  
11 think it's 9/8/99, that's your handwriting on the  
12 bottom, correct?

13 A. Yes.

14 Q. Your assessment is what in handwriting? Tell me  
15 what your assessment was.

16 A. Number one, bilateral hip pain of uncertain  
17 etiology.

18 Q. And then under it, is that your handwriting where  
19 it says schedule x-rays of lumbar spine, PA and  
20 lateral?

21 A. PA and lateral lumbar spine x-rays, bilateral hip  
22 x-rays.

23 Q. So that's what your assessment was.

24 Your plan was what?

25 A. Can you repeat the question?



1 Q. Sure. I'm sorry. I didn't mean to make that so  
2 complicated. First I had you read your  
3 handwritten assessment. Then I was going to have  
4 you read your handwritten plan but you switched  
5 to your dictated notes, so --

6 A. Oh.

7 MR. MILLIGAN: Do you want him to  
8 just read it?

9 Q. Yes, that's fine. That would be great.

10 A. To read the dictated note?

11 Q. No, read what your handwritten plan was.

12 A. It says number one, consult Dr. Coggins regarding  
13 bilateral back and hip pain. Send copy of  
14 today's dictation as letter referral.

15 Q. Dr. Coggins, I take it, is an orthopedist?

16 A. Yes.

17 Q. Go ahead.

18 A. Number two is PA/lateral lumbar spine x-rays and  
19 bilateral hip x-rays and return to clinic in one  
20 or two months.

21 Q. And then you went on to, as your usual custom is,  
22 dictate a letter?

23 A. Yes.

24 Q. I mean dictate your office note?

25 A. Yes.

1 Q. At this particular visit, it looks like she's had  
2 increased complaints of bilateral hip pain; is  
3 that right?

4 A. Yes.

5 Q. What else was I going to ask you about. It says  
6 the patient is also, also was seen by  
7 ophthalmologist who told her her blurred vision  
8 was related to migraine episodes and you  
9 concurred with that fact that those were  
10 migraines?

11 A. Yes.

12 Q. But no treatment was indicated for that --

13 A. Before that she had been treated with Zomig.

14 Q. I just wanted to finish the sentence.

15 Did you think she needed treatment for her  
16 headaches?

17 A. No. Number four says migraine headaches  
18 currently improved. Will not treat with any  
19 medication at the present time.

20 Q. Fair enough. At this point your assessment/plan,  
21 and I'm looking at your type, it says bilateral  
22 hip pain, uncertain etiology, and I then skip to  
23 where it says also the ESR was ordered and  
24 reported as one ml per hour.

25 Now, going back to when I said to you

1           regarding your first visit that you didn't  
2           address the high platelet count, you told me you  
3           did indirectly and how you were doing it was you  
4           were doing an ESR.

5           The information that you then had in  
6           September, that ESR does not account for the  
7           increased platelets. Is that a fair medical  
8           statement?

9       A.   Yes.

10      Q.   What did you do on September 8th, 1999 to address  
11           the issue of what had caused Michelle's increase  
12           in platelets, increased platelets?

13      A.   Nothing.

14      Q.   Did you continue to do nothing between September  
15           of 1999 and the date when Michelle had a heart  
16           attack relative to her elevated platelets?

17      A.   Yes.

18      Q.   Doctor, sort of to cut to the chase to make it  
19           easy for all of us, there came a point while she  
20           was under your care where you had another blood  
21           draw done, another blood draw was performed at  
22           your direction; is that correct?

23      A.   I don't remember.

24      Q.   Let me refer you to January 19th, 2000, some  
25           about three-and-a-half months after your

1 September visit?

2 MR. MILLIGAN: Give him the Bates  
3 number.

4 Q. Sure. Let's take a look at, first let's look at  
5 Bates stamp 85 should be in your chart. Are you  
6 there?

7 A. Yes.

8 Q. You were the requesting physician, correct, for  
9 this hematology work to be done?

10 A. Yes.

11 Q. On January 19th, 2000, doctor, can you please  
12 tell me what the platelet count was?

13 A. 725,000.

14 Q. Doctor, you would agree with me that that is a  
15 higher number than even existed in the summer of  
16 1999?

17 A. Yes.

18 Q. And you would agree with me that the laboratory  
19 which performs this work for the hospital  
20 indicated to you in a written laboratory report,  
21 which by the way has your signature on it, am I  
22 correct?

23 A. Yes. My initials, yes.

24 Q. That is your initials at the bottom?

25 A. Yes.

1 Q. That this is a high platelet count?

2 A. Yes.

3 Q. Do you agree with that?

4 A. Yes.

5 MS. KOLIS: Go ahead and mark that  
6 for me D.

7 - - - - -

8 (Thereupon, Plaintiff's Exhibit D, 085,  
9 one-page 1/19/00 outpatient report, was  
10 marked for purposes of identification.)

11 - - - - -

12 Q. We'll take these out of sequence because it's  
13 just easier to do that.

14 You, doctor, have a handwritten note for  
15 January 19th that I was able to locate Bates  
16 stamped Page 58. Are you with me?

17 A. Yes.

18 Q. Let's go down the side.

19 Assessment. If I'm reading your handwriting  
20 correctly, this says rule out endocarditis?

21 A. Yes.

22 Q. Am I correct?

23 A. Yes.

24 Q. Doctor, please tell me why you had a concern that  
25 Michelle Owens had endocarditis?

1 A. Let me read my note.

2 Q. Well, I was going to ask you about that next.

3 Before we go, sort of like I'm directing  
4 traffic instead of asking questions. This is not  
5 very polite of me, but let me ask it this way.

6 Doctor, I've been through this chart three  
7 times. I went through all of my Aultman charts.  
8 I have never found a corresponding typed note to  
9 your January 19, 2000 visit.

10 Have you seen that note?

11 A. I don't remember seeing it.

12 Q. So that the record is clear, if you want to take  
13 five minutes -- I can walk down the hall -- look  
14 through what you have.

15 I will represent on the record that based  
16 upon documentation provided to me, I have never  
17 seen a narrative note that corresponds to your  
18 short note.

19 A. I see.

20 Q. But if you want to look and see if you can find  
21 it, you might have more records. I don't know  
22 what you have, but I just know I haven't seen it.

23 MR. MILLIGAN: He's looking at  
24 what you have which is the Records  
25 Deposition Service copy of the clinic

1 records.

2 MS. KOLIS: That's all I have.

3 MR. MILLIGAN: You don't recall  
4 seeing such a note?

5 A. Yes, I don't recall seeing that, and it also is  
6 not very unusual or it happens that sometimes the  
7 dictation, for whatever reason, are not  
8 transcribed.

9 Q. Would you make -- if you would dictate something,  
10 because that seems to be your custom and habit,  
11 it seems to me, every time you saw Michelle. I  
12 don't know what you did with everybody else in  
13 the universe but more -- every written  
14 Dr. Cisneros note that I have, I have a  
15 transcription.

16 If you saw a patient, you handwrote your  
17 note, you did your dictation and the next time  
18 the patient came back, you looked in your chart  
19 and you didn't have a dictation, would you bring  
20 it to someone's attention?

21 A. Yes.

22 Q. Do you know if in this case, you went back for  
23 some reason, said, oh, my gosh, my dictation is  
24 not there?

25 A. I don't remember, but I'm very careful about

1           those things, so I probably did.

2   Q.   Well, let's see what we can make out of this note  
3       alone.   Okay?

4           You have rule out endocarditis and underneath  
5       that is depression.

6           Doctor, as you sit here today based upon this  
7       handwritten note or any of your subsequent notes,  
8       and there's one about a week later, can you tell  
9       me why you thought she might have endocarditis.

10                               -   -   -   -

11                               (Off the record.)

12                               -   -   -   -

13   Q.   Were you able to find anything?

14   A.   No.

15   Q.   I can tell you I've been through them quite a few  
16       times.

17   A.   Yes.   I don't remember seeing that.

18                               MS. KOLIS:   Off the record.

19                               -   -   -   -

20           (Thereupon, a discussion was had off the  
21       record.)

22                               -   -   -   -

23   Q.   All right.   Doctor, we've established that, at  
24       least for purposes of today's testimony, that  
25       none of us can locate a narrative note, so we



1           want to look at this a little bit.

2           Once again, is there anything on this piece  
3           of paper that we do have which is your customary  
4           handwritten note that gives you a good indication  
5           as to why you thought endocarditis might be an  
6           issue?

7   A.   No, there is nothing there that helps me  
8           remember.

9   Q.   Okay. As a general matter, what would cause you  
10          to suspect that someone had endocarditis?

11   A.   Fever of uncertain etiology, and murmur and a  
12          drug addict. From a previous history of  
13          endocarditis.

14   Q.   Well, Michelle Owens was not a drug addict,  
15          correct?

16   A.   To my knowledge, she wasn't.

17   Q.   I mean, you saw her over a year's period, there  
18          was no indication to you that she was a drug  
19          addict?

20   A.   Yeah.

21   Q.   She didn't have a previous history of  
22          endocarditis; is that correct? Does any of that  
23          help you to --

24   A.   Uh-huh.

25   Q.   -- to a reason why you may have thought on a

1 particular day that she might be suffering from  
2 endocarditis?

3 A. You know, I gave this a thought before and I just  
4 don't remember, but obviously it was a very  
5 significant thought.

6 Q. Do you have a recollection that Michelle Owens in  
7 early January of 2000 told you that she was  
8 feeling tightness in her chest?

9 A. No.

10 Q. You don't remember that at all?

11 A. No.

12 Q. Do you recall having another physician coming in  
13 to listen to her chest at that visit?

14 A. No, I don't remember.

15 Q. Well, I shouldn't say that. Listen to her heart,  
16 I guess is more appropriate?

17 A. I don't recall.

18 Q. You don't recall that?

19 A. I don't recall that.

20 Q. So in response to these two assessments, rule out  
21 endocarditis and depression, you wanted blood,  
22 correct?

23 A. Uh-huh.

24 Q. You wanted what else?

25 A. A CMP, CBC with differential, a PTT, PT, ESR.

1           Triponin I, CK/MB.

2       Q.   And all of those tests were completed, correct?

3       A.   Yes.

4       Q.   If you could, they're a little bit out of range.

5           If you go to Bates stamp 84, this is part of the  
6       chemistry profile that you ordered, correct?

7       A.   Yes.

8       Q.   What information did you, if any, did you gain  
9       from these results?

10      A.   That there was no cardiac involvement.   There was  
11      no clotting disorder.   That her kidneys were  
12      working fine.   That there was no electrolyte  
13      imbalance.   There was no liver involvement.

14      Q.   Did that mitigate against you thinking that she  
15      had endocarditis of some sort?

16      A.   I'm trying to think what I was thinking then.

17      Q.   Well, that's why I'm asking you.

18           In other words, you thought she had  
19      endocarditis but you ordered a lot of tests?

20      A.   Yes.

21      Q.   You ordered a chem profile?

22      A.   Yes.

23      Q.   Did the chem profile suggest to you that she had  
24      endocarditis?

25      A.   No, it didn't.

1 Q. She had high glucose. And it wasn't that high  
2 but it was a little out of the reference range.  
3 What if anything did you make of that?

4 A. Nothing because it was at 5:45 p.m. and it was  
5 not fasting.

6 Q. And her BUN was slightly elevated, her  
7 BUN/creatinine ratio at that time?

8 A. The BUN/creatinine ratio, yes, was, according to  
9 that range back to me. That means nothing. BUN  
10 was normal. Creatinine was normal.

11 Q. Just asking. They reference it as high and I was  
12 wondering how that played into what your  
13 diagnosis was. They also did the CK/MB, correct?

14 MR. MILLIGAN: What number is  
15 that?

16 Q. I'm sorry, that's, believe it or not, all the way  
17 over at Page 100 of a Bates stamp.

18 A. Yes.

19 Q. Now, why would you have ordered a CK/MB?

20 A. When there is breakage of muscle of the heart by  
21 endocarditis, sometimes you can see an elevation  
22 of CK/MB.

23 Q. Where else can you see a CK/MB?

24 A. In a myocardial infarction.

25 Q. Does that help to refresh your recollection at

1 all as to whether or not Michelle complained to  
2 you at all about chest pain at all that day?

3 A. No, it does not.

4 Q. You had a blood culture done. No growth,  
5 correct?

6 A. Uh-huh.

7 Q. All right. So every test that you ordered came  
8 back not diagnostic for endocarditis. Is that a  
9 fair statement?

10 A. Yes, it is.

11 Q. You also at that point, and I'm skipping down,  
12 you ordered a lower extremity duplex of the  
13 arterial system. Do you remember why you did  
14 that?

15 MR. MILLIGAN: Do you remember?

16 Q. If you don't, it's okay. Let me suggest, if we  
17 go to your 1/25/2000 note, it said, this gives us  
18 some information which I'm going to assume is  
19 true, Page 56 of your set in your narrative  
20 portion, it says patient was seen on 1/19/2000  
21 complaining of right toe swelling and the pain?

22 A. Yes, that's what it was. That's what it was.

23 Q. And that was a new complaint, wasn't it?

24 A. I don't know if it was a new complaint, but it  
25 was, okay, yeah, I think I remember some of that.

1 She had some swelling of that toe and I saw her  
2 and I didn't know what to make of it and I  
3 gathered, you know, my -- yes, I did ask my  
4 attending to come and see her and it was a  
5 discoloration of the toe and we were thinking  
6 about different possibilities of that to be a  
7 foreign object or was that an -- yes, bacterial  
8 endocarditis, you can have thromboembolic events  
9 where you see that the toe, you have that toe  
10 kind of findings. And the arterial, the  
11 ultrasound was to rule out a thrombotic event.

12 Q. I didn't mean to trick you. I was just trying to  
13 see what you remembered.

14 A. That's something I remember.

15 Q. Going forward to January 25th helps because it  
16 relates back?

17 A. Yes.

18 Q. In fact, doctor, let's just read, and this --  
19 let's work through this together to see what you  
20 might have been thinking that day.

21 As you write your subjective portion of your  
22 1/25 note, it says Michelle Owens is a 35-year  
23 old female?

24 MR. MILLIGAN: 34.

25 Q. 34-year old female. I can't read at this point

1 of the day.

2 That is known to have anxiety/depression  
3 disorder as well as chronic back pain, who comes  
4 here today on a follow-up visit. She was seen on  
5 1/19/2000 complaining of right toe swelling and  
6 pain.

7 She was earlier that day, and I'm assuming  
8 you meant 1/19, at the pain management clinic  
9 where she was going to have an epidural block  
10 when she was found to have some lumbar back  
11 spinal stenosis and was also seen by a  
12 neurologist before who recommended the Pain  
13 Management Clinic. The spinal injection was  
14 cancelled due to the evidence of the swollen and  
15 erythematous toe and the patient was sent to the  
16 clinic to be evaluated for this.

17 Stopping right there because that's your  
18 relating your prior history.

19 You have a recollection, doctor, that in  
20 addition to being swollen, the toe had a hue or a  
21 color to it. It was discolored?

22 A. Erythematous.

23 Q. Sort of reddish; is that right?

24 A. Yes.

25 Q. And as you've already related to me, based upon

1           that, you started thinking endocarditis because  
2           you were concerned about a thrombotic event,  
3           correct?

4   A.   Yes.

5   Q.   High platelets can cause thrombotic and  
6           thrombolytic events, can they not?

7   A.   Yes, they can.

8   Q.   When you got back your lab work from 1/19, which  
9           we've already discussed earlier, that lab work  
10          didn't indicate to you endocarditis, correct?

11   A.   Yes.

12   Q.   But you did have an elevated platelet count  
13          elevated past what it was in July of 1999?

14   A.   I'm sorry, repeat the question.

15   Q.   An elevated platelet count above what it was in  
16          July of 1999, correct?

17   A.   Yes.

18   Q.   And you know that elevated platelets can cause  
19          thrombotic events?

20   A.   Yes.

21   Q.   So you already excluded infective or just  
22          endocarditis. Why didn't you consider that she  
23          was having thrombolytic events from her elevated  
24          platelets in January of 2000?

25   A.   Because I didn't think that that was causing the



1           problem, that one was connected to the other at  
2           that point.

3       Q.   But you would have medically been aware that  
4           there was a potential that those platelets could  
5           be the explanation for a discolored digit that  
6           was swollen and painful, correct?   I think you  
7           already testified to that earlier.

8       A.   Yes.

9       Q.   Nowhere in your assessment, doctor, is there a  
10          suggestion that the elevated platelets could be  
11          causing or contributing to the discoloration in  
12          the toe, is there?

13      A.   No.   You're correct about that.

14      Q.   When you relate your objective findings, you  
15          indicate under laboratory data, all blood work  
16          done including blood cultures, CBC, full chem,  
17          cardiac enzymes and coagulation studies are  
18          within normal limits.   Do you not say that?

19      A.   I do.

20      Q.   Your own hospital doesn't find that the platelets  
21          are within normal limits, do they?

22      A.   No, they don't.

23      Q.   When you go down to assessment/plan item number  
24          three, it says patient will have an  
25          echocardiogram done to assess the murmur which

1 was noted in the previous evaluation.

2 The murmur isn't listed on that front sheet  
3 for the 1/19 visit, correct?

4 A. No, it isn't.

5 Q. I'm assuming that that murmur was somewhere in  
6 your dictation of 1/19?

7 A. Yes.

8 Q. Once again, we have to assume because we don't  
9 have it?

10 A. Yes.

11 Q. And if Michelle Owens testifies that you told her  
12 that on the 1/19 visit that you heard something  
13 that sounded like a heart murmur, would that  
14 refresh your recollection?

15 A. Yeah, I would think that that's correct.

16 Q. Doctor, you continued to evaluate that toe over  
17 the next month-and-a-half or so, didn't you?

18 A. Yes.

19 Q. And what kinds of things were within your  
20 differential of what could be causing that  
21 painful discolored toe?

22 A. A foreign object was one. An injury.

23 Q. Doctor, as you went down the road, all of those  
24 potential causes for the discoloration and the  
25 painfulness in her toe were eliminated, weren't

1           they?

2   A.   Yes.

3   Q.   You had Michelle do a number of things, correct?

4   A.   Yes.

5   Q.   You had the venous duplex done, correct?

6   A.   I believe so, but I don't remember exactly what  
7       the end result of that.

8   Q.   Well, when they did the duplex study, do you  
9       recall that she did not have any circulatory  
10      difficulty?

11   A.   I don't recall that.

12   Q.   Doctor, did you ever get this patient an  
13      echocardiogram?

14   A.   I mention on the 1/25 that I was going to obtain  
15      the echocardiogram. Hold on, I don't recall if  
16      it came back.

17   Q.   Nor do I ever remember seeing a note, and you can  
18      correct me if I am wrong. I do not see a note  
19      that it was actually scheduled at any time or  
20      that Michelle cancelled one. Would you agree  
21      with that?

22   A.   Yes.

23   Q.   Michelle Owens, in fact, seemed to do exactly  
24      what you told her to do. Would you agree with  
25      that?

1 A. Say that again.

2 Q. Do you think Michelle Owens was a compliant  
3 patient while she was under your care?

4 A. Not 100 percent.

5 Q. What kinds of things didn't she comply with?

6 A. She didn't go and see Dr. Coggins.

7 Q. Who was a --

8 A. Orthopedic doctor that I advised her to see for  
9 excruciating hip pain.

10 Q. Ultimately, did her failure to see the  
11 orthopedist have anything to do with her  
12 myocardial infarction that she had in August of  
13 2000?

14 A. I don't think so.

15 Q. Doctor, as you sit here today, obviously you've  
16 had an opportunity to review the records --

17 A. Yes.

18 Q. -- of July and August, and I think early  
19 September, 2000 from Aultman, correct?

20 A. Yes.

21 Q. Do you, doctor, have an opinion and will you be  
22 rendering an opinion at trial as to the cause of  
23 Michelle Owens' myocardial infarction?

24 A. I don't know if I understand. Are you saying  
25 that do I know what caused the myocardial

1 infarction?

2 Q. Yes. I should never agree to do depositions this  
3 late in the day and that's my fault, not your  
4 fault. It's how I'm asking the question.

5 Do you have an opinion as a medical doctor as  
6 to what is more likely than not the cause of the  
7 heart attack --

8 A. Yes, I do.

9 Q. -- that Michelle had --

10 A. I do.

11 Q. -- in August of 2000?

12 A. I do.

13 Q. What is your opinion, doctor?

14 A. I think that it had to do with the coronary  
15 artery disease that she had shown on the heart  
16 catheterization she had after or during the time  
17 that she was admitted.

18 Q. And that's the basis of your opinion, the  
19 findings?

20 A. It was a very significant finding given the fact  
21 that she was so young and she indeed had an  
22 occlusion of the arteries.

23 Q. What do you recall being the degree of occlusion  
24 and where was it?

25 A. I would have to go back to see that.

1 Q. You can.

2 MR. MILLIGAN: Is it in there?

3 MS. KOLIS: I didn't bring his  
4 whole chart. He had a lot of stuff in his  
5 chart because he was still listed as the  
6 attending and they were sending him  
7 records.

8 A. I don't know it's in here, but I know that I've  
9 seen that.

10 MR. MILLIGAN: Don't talk until  
11 you're ready to answer the question.

12 Q. I'll give you a hint, doctor, make it a little  
13 bit easier. In your notes Bates stamped 68 you  
14 evidently had an opportunity to review the  
15 cardiac cath results on August 14th and it showed  
16 a 50 to 75 percent occlusion of the LAD; is that  
17 right?

18 A. Yes.

19 Q. And that was where the occlusion was, the LAD?

20 A. Yes.

21 Q. So she had, what, a stent, correct?

22 A. A PCA, yes.

23 Q. Do you understand, doctor -- I don't like to ask  
24 questions that way.

25 Do you have an understanding of how

1 thrombocytosis contributes to coronary artery  
2 disease?

3 A. Yes.

4 Q. Can you exclude the fact that this woman had  
5 essential thrombocytosis that we know of for now  
6 more than, the first result was in April of 1999  
7 and now we're in August of 2002. .

8 Can you exclude the fact that her essential  
9 thrombocytosis contributed to this myocardial  
10 infarction?

11 A. No, I can't.

12 MS. KOLIS: Doctor, you're going  
13 to be delighted. I don't have any further  
14 questions for you.

15 I will waive the seven day reading  
16 requirement because I will have him read,  
17 but can I have it within fourteen?

18 MR. MILLIGAN: Sure.

19 - - - -

20 (Thereupon, a discussion was had off the  
21 record.)

22 - - - -

23 MS. KOLIS: I don't care if he  
24 gives me his changes within fourteen  
25 instead of seven.

1 MR. MILLIGAN: That's fine. That  
2 means you've got to read it when you get it  
3 and make sure there aren't any mistakes.  
4 It's easy to have mistakes.

5 THE WITNESS: You mean things that  
6 weren't transcribed accurately?

7 MR. MILLIGAN: Yes.

8 We'll read.

9

10

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GERARDO CISNEROS, M.D.

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C E R T I F I C A T E

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

I, Pamela S. Greenfield, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named witness was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action; that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this \_\_\_\_ day of \_\_\_\_\_, A.D. 20\_\_\_\_.

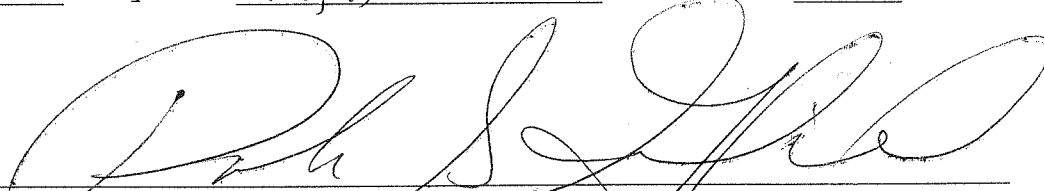
Pamela Greenfield, Notary Public, State of Ohio  
1750 Midland Building, Cleveland, Ohio 44115  
My commission expires July 3, 2008

1  
2  
3 C E R T I F I C A T E  
4

5 The State of Ohio, ) SS:  
6 County of Cuyahoga.)

7 I, Pamela S. Greenfield, a Notary Public  
8 within and for the State of Ohio, authorized to  
9 administer oaths and to take and certify  
10 depositions, do hereby certify that the  
11 above-named witness was by me, before the giving  
12 of their deposition, first duly sworn to testify  
13 the truth, the whole truth, and nothing but the  
14 truth; that the deposition as above-set forth was  
15 reduced to writing by me by means of stenotypy,  
16 and was later transcribed into typewriting under  
17 my direction; that this is a true record of the  
18 testimony given by the witness; that said  
19 deposition was taken at the aforementioned time,  
20 date and place, pursuant to notice or stipulation  
21 of counsel; and that I am not a relative or  
22 employee or attorney of any of the parties, or a  
23 relative or employee of such attorney, or  
24 financially interested in this action; that I am  
25 not, nor is the court reporting firm with which I  
am affiliated, under a contract as defined in  
Civil Rule 28(D).

17 IN WITNESS WHEREOF, I have hereunto set my  
18 hand and seal of office, at Cleveland, Ohio, this  
19 25<sup>th</sup> day of August A.D. 2003.  
20

21   
22 Pamela Greenfield, Notary Public, State of Ohio  
23 1750 Midland Building, Cleveland, Ohio 44115  
24 My commission expires July 3, 2008  
25

W  
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<p><b>0</b></p>	<p><b>3</b></p>	<p>98 8:17; 12:20 99 8:24; 45:5, 10, 13; 46:7 9930 38:4</p>	<p>along 13:20; 45:6 although 31:19 always 13:2; 14:16; 23:8; 55:7</p>	<p>11:4, 11, 15; 12:8; 13:3, 4; 20:17, 20; 24:15, 21; 25:5, 12; 26:10, 25; 27:25; 28:2, 17; 36:23; 54:7; 62:7; 76:19</p>
<p>034-037 47:2 062-64 56:3 085 61:8</p>	<p>3 26:25; 27:5 30 26:8 300,000 35:10 34 70:24 34-year 70:25 35-07-6345 8:9 35-year 70:22 36 37:15 37 37:15</p>	<p><b>A</b></p>	<p>ambiguous 32:5 Annals 16:7 anticipating 20:6 anticipation 27:13 anxiety/depression 71:2 anymore 45:20, 24 appears 48:8 applying 49:20 appointment 18:5 appreciate 35:14 appropriate 66:16 approximately 26:4, 8, 9 April 11:5, 5, 6, 6; 14:23; 37:1, 2; 51:2; 79:6 area 9:7 areas 14:5 around 8:17 arterial 69:13; 70:10 arteries 34:23; 77:22 artery 52:4, 9, 14; 53:4, 6, 8, 19, 21, 23; 54:3; 77:15; 79:1 articles 15:21; 42:23; 43:8 aside 15:16 assess 73:25 assessment 39:10; 47:16; 49:16; 50:3; 51:11; 56:14, 15, 23; 57:3; 61:19; 73:9 assessment/plan 58:20; 73:23 assessments 24:7; 66:20 assigned 12:21; 13:16 assistantships 9:24 associated 44:9, 10 assume 5:17; 7:6; 8:10; 9:2; 69:18; 74:8 assuming 23:9; 40:7; 71:7; 74:5 attack 59:16; 77:7 attacks 41:3 attempt 20:4 attend 5:25 attending 13:2, 12; 21:7; 22:11, 16; 23:1, 19; 24:2, 8; 25:23; 26:3; 55:8, 17; 70:4; 78:6 attendings 54:23 attention 63:20 attorney 4:16; 5:3; 6:15, 24; 15:7 attorneys 6:9 atypical 44:7 August 39:16; 76:12, 18; 77:11; 78:15; 79:7 Aultman 9:19; 10:13, 23;</p>	<p>author 16:5, 8 Available 22:17 Avenue 4:12 aware 5:6; 28:5; 29:20; 34:16, 18; 36:18, 23, 25; 37:1, 25; 40:9; 42:10, 12; 73:3 away 15:25; 18:13</p>
<p><b>1</b></p>	<p><b>4</b></p>	<p>ability 8:25 able 61:15; 64:13 abnormalities 46:9 above 34:25; 35:2; 72:15 absolutely 39:9 accepted 16:3, 4, 5, 6; 31:15 accident 21:15 accidents 40:24 according 68:8 account 59:6 Accreditation 46:17 accurate 9:2 accurately 80:6 across 31:23 action 9:3 actively 54:24 actually 5:24; 6:6; 19:4; 21:16; 25:14; 27:18; 37:2; 49:3; 75:19 acute 33:25; 34:6 add 17:22; 55:15 addict 65:12, 14, 19 addition 71:20 additional 23:2 address 4:11; 45:24; 50:7; 59:2, 10 addressed 46:8; 51:15 administration 50:16 admitted 10:10; 77:17 adults 21:23 advice 5:3; 51:22 advise 6:8 advised 76:8 affiliated 10:19, 21; 11:24; 15:5; 23:11 afternoon 24:24; 26:16, 20, 21; 47:24 afternoons 26:25 again 11:6; 23:7; 24:25; 35:15, 21; 44:13; 45:9, 21; 54:13; 56:8; 65:2; 74:8; 76:1 against 9:3; 67:14 age 4:1 ages 17:17 agewise 9:10 agree 31:5, 10, 12, 21; 40:15; 41:4; 43:18; 44:13, 16, 20; 53:22; 60:14, 18; 61:3; 75:20, 24; 77:2 agreement 5:15; 6:1; 7:3; 22:15; 40:13 ahead 31:11; 35:20; 57:17; 61:5 alone 64:3</p>	<p><b>B</b></p>	<p>B 46:25; 47:2 back 15:16; 20:9; 24:25; 32:14; 33:3; 44:25; 46:24; 50:25; 57:13; 58:25; 63:18, 22; 68:9; 69:8; 70:16; 71:3, 10; 72:8; 75:16; 77:25 background 7:24 backwards 45:9 bacterial 70:7 bad 10:5 Based 8:25; 9:11; 10:22; 14:17; 41:24; 43:23; 52:6; 55:2; 62:15; 64:6; 71:25 baseline 31:25 basis 21:10; 77:18 Bates 37:12, 13; 56:7, 9; 60:2, 5; 61:15; 67:5; 68:17; 78:13 became 12:19; 36:18; 41:23 become 17:10 becoming 25:14 began 9:17; 14:9 begin 11:22; 26:6 beginning 20:21; 25:4; 54:16, 23 belief 43:23 benefits 49:21 better 49:24; 51:20 big 43:2 bilateral 48:22; 49:11; 50:11; 56:16, 21; 57:13, 19; 58:2, 21 birth 7:25 bit 4:19; 19:12; 65:1; 67:4; 78:13 bleed 40:4 Bleeding 34:20; 40:2 block 71:9 blood 29:24; 30:1; 33:3; 34:23; 35:7; 37:2; 38:3; 40:3; 48:11; 59:20, 21; 66:21; 69:4; 73:15, 16 blurred 45:6, 11, 25; 56:10; 58:7 Board 8:7; 20:4; 29:1; 31:23</p>
<p>1 7:17; 38:22; 39:4 1/19 71:8; 72:8; 74:3, 6, 12 1/19/00 61:9 1/19/2000 69:20; 71:5 1/25 70:22; 75:14 1/25/2000 69:17 10 26:7 100 68:17; 76:4 10:00 22:2 12 17:17, 19 12.8 38:5 1226 4:12 12th 8:1 14.9 38:5 140 31:14, 22; 32:1 143 50:25; 51:12, 22 14th 45:13; 46:13; 78:15 15th 51:8 19 62:9 1968 8:1 1995 9:17 1997 8:17; 9:17; 10:15; 25:13 1998 10:16; 11:20; 12:7; 14:9, 23 1999 11:5; 14:23; 20:12, 21; 25:4; 29:18; 33:21; 34:21; 37:3, 4, 18; 38:1, 8; 39:11, 15; 46:13; 51:8; 52:6; 54:23; 56:1; 59:10, 15; 60:16; 72:13, 16; 79:6 19th 59:24; 60:11; 61:15 1st 12:20; 17:11; 54:22</p>	<p>4/27/99 38:3 43.0 38:5 44714 4:13 450 31:15, 22; 32:1 4th 11:5, 5, 6, 6</p>	<p><b>5</b></p>	<p><b>6</b></p>	<p><b>7</b></p>
<p><b>2</b></p>	<p>50 78:16 56 69:19 58 61:16 5:45 68:4</p>	<p>62 56:7, 9 624-66-7220 8:3 63 56:7 64 56:7 645 54:8 645,000 53:15, 20; 54:4 645000 38:6 68 78:13</p>	<p><b>8</b></p>	<p><b>9</b></p>
<p>2 20:14; 27:5; 38:2 20 32:14, 22 20,000 32:16, 23 2000 11:6, 6; 59:24; 60:11; 62:9; 66:7; 72:24; 76:13, 19; 77:11 2001 11:7; 17:11; 20:3; 42:17 2002 39:16; 79:7 21 37:17; 45:10 21st 29:18; 37:18; 38:1; 39:11; 45:5; 46:6, 21; 52:6 25th 70:15</p>	<p>7 32:12 7/21 38:8 7/21/99 37:13; 47:3, 8 700,000 33:11 725 32:25; 33:4, 17; 35:7 725,000 33:17; 60:13 75 78:16</p>	<p>84 67:5 85 60:5 8th 56:1; 59:10</p>	<p>9/8 56:10 9/8/99 56:4, 11</p>	<p>98 8:17; 12:20 99 8:24; 45:5, 10, 13; 46:7 9930 38:4</p>

boarded 19:24  
boards 9:22, 25; 20:2;  
29:2, 6, 8, 13; 42:16  
both 11:14, 14  
bottom 56:12; 60:24  
bowel 40:6  
box 47:9  
breakage 68:20  
briefly 9:5  
bring 63:19; 78:3  
BUN 68:6, 9  
BUN/creatinine 68:7, 8  
bureau 49:8  
busier 19:17  
business 4:11

## C

C 8:9; 55:25; 56:3, 9  
call 18:7; 19:5; 27:8;  
29:18; 33:18; 34:5; 40:13  
called 4:1; 15:24; 23:11;  
24:15; 44:17; 46:1  
calling 24:12  
calls 13:13  
came 20:11; 33:2; 37:15;  
45:21; 51:9; 59:19; 63:18;  
69:7; 75:16  
can 5:14; 6:1, 16, 17, 20;  
7:3, 24; 8:6; 9:1; 15:25;  
16:10; 18:12; 27:13; 28:8;  
29:1; 31:14; 32:1; 34:3, 4,  
19, 22; 35:10; 37:22;  
39:24; 40:2, 2, 5, 6; 41:25;  
42:21; 44:8, 9, 10, 13, 16,  
24; 55:19, 24; 56:25;  
60:11; 62:13, 20; 64:2, 8,  
15, 25; 68:21, 23; 70:8;  
72:5, 6, 7, 18; 75:17; 78:1;  
79:4, 8, 17  
cancelled 71:14; 75:20  
candidly 42:19  
Canton 4:13; 10:19, 22;  
11:24; 15:5; 16:24; 23:11,  
15  
cardiac 13:25; 67:10;  
73:17; 78:15  
cardiologist 13:18, 19,  
22, 24  
cardiology 13:23; 14:2  
care 4:20; 11:3; 17:3, 6,  
16, 18; 18:4, 9, 12; 19:22,  
23; 20:11; 21:1, 4, 16, 18;  
22:10; 24:21; 25:22; 26:5;  
36:17, 22; 43:13; 59:20;  
76:3; 79:23  
careful 32:7; 63:25  
Carroll 17:24  
case 27:9; 63:22  
cat 8:9  
catastrophic 21:15  
categorize 41:1  
cath 78:15  
catheterization 77:16

cause 36:1; 38:25; 54:2;  
65:9; 72:5, 18; 76:22; 77:6  
caused 41:3; 59:11;  
76:25  
causes 74:24  
causing 34:14; 36:13;  
49:18; 72:25; 73:11; 74:20  
CBC 32:12; 38:2; 66:25;  
73:16  
CCU 12:24; 13:3  
cells 30:1, 1; 38:4  
Center 10:24; 11:15;  
13:9; 17:13; 18:4, 9  
centers 19:23  
Cerebrovascular 40:24  
certain 6:10; 8:16; 15:17;  
24:10, 11; 31:2, 23; 32:10;  
44:10  
certainly 6:3; 32:23;  
44:18  
certified 4:5  
cetera 14:3  
challenging 9:8  
changes 79:24  
changing 13:14  
chart 28:2; 37:24; 44:24;  
60:5; 62:6; 63:18; 78:4, 5  
charts 27:15, 16, 17;  
47:24; 55:13; 62:7  
chase 59:18  
Chem 32:12; 67:21, 23;  
73:16  
chemistry 67:6  
chest 66:8, 13; 69:2  
chief 8:23; 27:7  
children 18:1; 21:21  
cholesterol 50:24;  
51:17, 25  
choose 51:20  
chronic 71:3  
circulatory 75:9  
circumstance 4:25  
CISNEROS 4:1, 7, 12;  
7:18; 35:24; 37:15; 47:8;  
63:14; 80:10  
City 9:14  
Civil 4:4  
CK/MB 67:1; 68:13, 19,  
22, 23  
claims 27:11  
class 26:7  
classic 44:18  
clear 54:14; 55:2; 62:12  
clearly 31:7; 42:1, 4, 19  
client 6:5  
clinic 20:16, 20; 21:8, 16,  
16; 22:14; 24:14, 16, 22;  
25:6, 12, 17; 26:10, 14, 22;  
27:1, 4, 19, 22; 32:11;  
36:23; 45:13; 54:22; 55:7;  
57:19; 62:25; 71:8, 13, 16  
clinical 37:16; 47:15, 23  
clinics 27:8

clot 35:11  
clots 34:23; 35:8  
clotting 67:11  
CMP 66:25  
coagulation 73:17  
code 30:19  
Coggins 57:12, 15; 76:6  
collaborative 22:15  
color 71:21  
combined 11:14  
comfortable 6:18  
coming 66:12  
commented 37:3  
Commission 46:16  
commonly 35:4, 5  
comparison 15:22  
complain 43:14  
complained 69:1  
complaining 45:10, 19,  
23; 69:21; 71:5  
complaint 49:17; 69:23,  
24  
complaints 46:4; 58:2  
complete 4:11  
completed 9:12; 67:2  
compliant 76:2  
complicated 57:2  
comply 76:5  
components 29:25  
comport 37:4  
concentrating 19:7; 46:5  
concern 51:17; 53:10;  
61:24  
concerned 32:21, 24;  
48:15; 51:13, 14; 72:2  
concerns 46:4  
concurrent 58:9  
condition 36:8  
conditions 18:6  
confer 6:13  
confirm 39:5  
connected 73:1  
consequences 35:2  
consider 39:16; 72:22  
consideration 32:18;  
33:6  
considered 29:10; 32:2  
constantly 13:23  
constitutes 43:25  
consult 48:13, 18, 21;  
54:15; 57:12  
contained 29:11  
content 51:23  
context 32:8  
continue 59:14  
continued 74:16  
contract 22:20; 23:10  
contracts 11:1, 8, 9  
contribute 54:2  
contributed 79:9  
contributes 79:1

contributing 73:11  
conversational 5:10  
copy 7:11; 27:22; 57:13;  
62:25  
coronary 52:3, 9, 14;  
53:4, 6, 8, 19, 21, 23; 54:2;  
77:14; 79:1  
Corporation 17:3  
correctly 21:19; 22:11;  
55:13; 61:20  
corresponding 62:8  
corresponds 62:17  
counsel 6:13  
count 31:25; 32:22, 25;  
33:4, 17; 35:7, 25; 36:3,  
12, 15; 37:2, 25; 38:9;  
53:3; 59:2; 60:12; 61:1;  
72:12, 15  
counts 30:14; 31:9;  
34:22; 36:19, 24  
County 17:25  
couple 7:23; 26:17  
court 5:19; 12:3  
coverage 48:25  
coworkers 18:20  
Creatinine 68:10  
credit 14:11  
credited 12:15  
cross-examination 4:3,  
7  
culture 69:4  
cultures 73:16  
current 5:22; 6:5; 7:12;  
8:10, 22; 16:18, 20; 42:24  
currently 58:18  
curriculum 7:12; 9:11;  
16:14  
custom 47:14; 48:2; 55:6;  
57:21; 63:10  
customary 65:3  
cut 59:18  
CV 7:18

## D

D 61:6, 8  
danger 33:22; 34:15  
data 73:15  
date 7:25; 25:7; 29:19;  
37:8; 59:15  
dates 11:10; 47:7  
day 12:10; 13:13; 15:23;  
24:4; 55:4; 66:1; 69:2;  
70:20; 71:1, 7; 77:3; 79:15  
December 17:11  
decide 9:5; 29:18  
decision 32:20  
decisions 23:6  
decrease 51:23  
Define 43:25  
defined 31:7  
definitely 50:12  
degree 14:8; 77:23  
delighted 79:13  
deposed 4:5  
deposition 4:19, 23, 25;  
5:5; 6:4, 11; 27:13; 37:14;  
42:14, 20; 62:25  
depositions 5:10; 77:2  
depression 64:5; 66:21  
described 41:7, 8  
desperate 19:13  
details 44:23  
determine 34:1  
diagnoses 4:22; 24:3  
diagnosing 13:5  
diagnosis 33:9, 9, 14;  
40:16; 42:25; 68:13  
diagnostic 69:8  
dictate 47:11, 21, 24;  
48:7; 57:22, 24; 63:9  
dictated 38:1; 49:14;  
57:5, 10  
dictation 57:14; 63:7, 17,  
19, 23; 74:6  
diet 51:23  
difference 21:20  
different 12:21; 13:10,  
11; 14:4, 5; 17:23; 19:16;  
26:18; 30:10; 31:1; 35:16;  
43:17; 70:6  
differential 32:12; 36:12,  
16; 38:3, 4; 66:25; 74:20  
difficulty 75:10  
digit 73:5  
digits 41:11, 21  
directing 62:3  
direction 59:22  
disability 48:25; 49:8, 19,  
21, 22  
disagree 31:13  
disbelieve 50:10  
disclosed 42:19  
discoloration 41:11, 21;  
70:5; 73:11; 74:24  
discolored 71:21; 73:5;  
74:21  
discovery 7:14  
discuss 27:10; 38:9  
discussed 23:23; 24:3;  
42:7; 53:11; 54:11; 55:16;  
72:9  
discussing 25:21; 49:23;  
50:1  
discussion 22:5; 64:20;  
79:20  
disease 52:4, 9, 15; 53:4,  
6, 8, 19, 22, 23; 54:3;  
77:15; 79:2  
diseases 14:1  
diseasewise 9:10  
disorder 29:20; 67:11;  
71:3  
disturbances 48:16  
Doctor 4:9, 14, 23; 5:6;  
7:21; 9:5; 18:12; 19:24;  
22:13; 27:9; 28:25; 29:15,

23; 30:11, 18; 31:5; 36:17;  
37:23; 38:8, 14; 39:9, 19;  
46:22; 48:8; 50:3; 51:1;  
56:8; 59:18; 60:11, 14;  
61:14, 24; 62:6; 64:6, 23;  
70:18; 71:19; 73:9; 74:16,  
23; 75:12; 76:8, 15, 21;  
77:5, 13; 78:12, 23; 79:12  
**doctor's** 51:19  
**document** 37:24  
**documentation** 62:16  
**documents** 24:18  
**done** 12:2, 16; 19:10;  
38:3, 14, 16; 48:1; 51:8;  
59:21; 60:9; 69:4; 73:16,  
25; 75:5  
**Donna** 4:15; 40:13; 51:5  
**down** 5:12; 24:1; 47:20,  
20; 61:18; 62:13; 69:11;  
73:23; 74:23  
**Dr** 16:9; 23:24; 28:10, 11,  
15; 35:24; 37:15; 47:8;  
54:11, 14; 55:1, 3; 57:12,  
15; 63:14; 76:6  
**draw** 48:11; 59:21, 21  
**drawn** 37:2; 51:2  
**drew** 48:11  
**drug** 65:12, 14, 18  
**due** 71:14  
**duly** 4:4  
**duplex** 69:12; 75:5, 8  
**during** 10:7, 24; 12:18;  
13:23; 15:1, 9; 20:21;  
24:22, 23; 25:19; 36:21;  
43:13; 54:23; 77:16  
**DVTs** 40:17

## E

**earlier** 29:19; 71:7; 72:9;  
73:7  
**early** 4:18; 66:7; 76:18  
**easier** 61:13; 78:13  
**easy** 12:5; 20:9; 59:19;  
80:4  
**echocardiogram** 73:25;  
75:13, 15  
**educational** 31:6  
**effect** 50:17  
**elect** 29:7  
**electrolyte** 67:12  
**elevated** 30:7; 35:6;  
36:15, 18, 24; 38:24;  
51:17; 53:2; 59:16; 68:6;  
72:12, 13, 15, 18, 23;  
73:10  
**Elevation** 29:24; 34:4,  
25; 35:1, 9; 36:3; 68:21  
**eliminated** 74:25  
**else** 5:12; 6:8; 15:19;  
28:19; 58:5; 63:12; 66:24;  
68:23  
**embolus** 40:20  
**emergency** 18:8

**employed** 17:10  
**employee** 17:8, 9  
**employment** 22:21  
**end** 13:6; 47:23; 53:14;  
54:10; 75:7  
**endocarditis** 61:20, 25;  
64:4, 9; 65:5, 10, 13, 22;  
66:2, 21; 67:15, 19, 24;  
68:21; 69:8; 70:8; 72:1, 10,  
22  
**engine** 43:3  
**enough** 55:24; 58:20  
**enter** 12:13  
**entered** 10:18; 12:18  
**entire** 26:23  
**enzymes** 73:17  
**epidural** 71:9  
**episodes** 58:8  
**errors** 30:18  
**erythematous** 71:15, 22  
**ESR** 38:12, 14, 16, 21;  
39:4; 48:10; 58:23; 59:4, 6;  
66:25  
**essential** 39:20; 42:15;  
79:5, 8  
**establish** 25:3; 31:25;  
33:9; 46:23  
**established** 18:12;  
50:20; 64:23  
**estimate** 17:5  
**et** 14:3  
**etiology** 38:11; 43:18;  
53:3, 20; 56:17; 58:22;  
65:11  
**evaluate** 74:16  
**evaluated** 71:16  
**evaluating** 38:9  
**evaluation** 14:25; 74:1  
**even** 44:9, 16; 60:15  
**evening** 4:18  
**event** 70:11; 72:2  
**events** 39:24; 40:1, 14,  
15; 41:2; 70:8; 72:6, 19, 23  
**everybody** 63:12  
**evidence** 40:16; 71:14  
**evidently** 78:14  
**exacerbated** 44:4  
**exact** 25:7; 26:13  
**exactly** 13:10; 26:13;  
35:19; 75:6, 23  
**exam** 52:8  
**examination** 32:19  
**examinations** 24:7;  
25:24  
**example** 12:23; 13:3, 9,  
18; 32:10  
**examples** 40:7  
**exclude** 39:4; 79:4, 8  
**excluded** 38:25; 72:21  
**exclusive** 40:8  
**exclusively** 11:11  
**excruciating** 76:9  
**exertion** 49:12

**Exhibit** 7:17; 47:2; 55:25;  
56:3, 9; 61:8  
**exhibiting** 48:22  
**existed** 60:15  
**experience** 21:9; 35:7;  
54:19, 21  
**experiencing** 39:6;  
49:11; 50:11  
**Explain** 10:20; 20:19;  
21:3  
**explaining** 21:18; 38:10  
**explanation** 33:10; 73:5  
**exposed** 9:9  
**extremity** 69:12

## F

**face** 44:12  
**fact** 12:15; 19:24; 24:1;  
39:9; 50:13; 58:9; 70:18;  
75:23; 77:20; 79:4, 8  
**factor** 35:13; 52:14; 53:5,  
7, 16, 21  
**factors** 52:3, 9  
**failure** 76:10  
**fair** 36:13; 39:12, 17;  
58:20; 59:7; 69:9  
**fairly** 7:21  
**family** 21:16, 21, 22  
**far** 28:18  
**fasting** 68:5  
**fat** 51:23  
**fault** 77:3, 4  
**feel** 6:18, 19  
**feeling** 66:8  
**felt** 49:24  
**female** 70:23, 25  
**Fever** 65:11  
**few** 64:15  
**figure** 12:9; 47:14; 51:6  
**file** 15:5  
**filed** 4:18  
**find** 4:19; 5:21; 33:8;  
36:10; 62:20; 64:13; 73:20  
**finding** 33:2; 77:20  
**findings** 24:3; 33:6;  
70:10; 73:14; 77:19  
**fine** 8:6; 57:9; 67:12; 80:1  
**fingers** 41:11  
**finish** 48:5; 58:14  
**finished** 8:23; 11:19;  
12:11, 14  
**first** 4:4; 7:11; 9:14; 10:3;  
14:10, 17; 16:4; 20:4; 25:9;  
26:18; 27:16; 29:17, 19;  
30:10, 23; 33:19; 37:24;  
39:11; 42:17; 45:4, 7; 46:6,  
22; 47:6; 48:9; 49:1; 54:24;  
55:20; 57:2; 59:1; 60:4;  
79:6  
**Five** 17:6; 50:23; 62:13  
**Flexeril** 50:5, 8, 16  
**floor** 13:8

**floors** 12:23; 13:8  
**follow** 44:7  
**follow-up** 19:19; 45:18;  
71:4  
**following** 40:15; 45:8  
**follows** 4:6  
**foreign** 70:7; 74:22  
**forget** 23:9  
**forgetting** 23:10  
**forgive** 18:2  
**form** 41:2  
**forward** 70:15  
**found** 62:8; 71:10  
**Foundation** 23:15  
**four** 13:4, 6, 13, 19, 23;  
14:3; 50:3; 58:17  
**four-page** 47:3  
**fourteen** 79:17, 24  
**frequently** 18:17  
**front** 56:10; 74:2  
**full** 73:16  
**functioned** 22:9  
**further** 79:13

## G

**gain** 67:8  
**gather** 15:4; 23:7; 29:1  
**gathered** 70:3  
**gave** 7:7; 23:17; 66:3  
**general** 9:23; 14:7;  
16:22; 20:24; 24:24; 65:9  
**generalized** 44:8  
**Generally** 17:14; 20:23;  
31:15; 48:2  
**GERARDO** 4:1, 7, 12;  
80:10  
**GI** 40:4  
**given** 5:3; 19:3; 26:9, 14;  
46:1; 77:20  
**gives** 65:4; 69:17; 79:24  
**glucose** 68:1  
**good** 19:19; 30:9; 34:1;  
55:24; 65:4  
**gosh** 63:23  
**graduated** 8:22  
**great** 57:9  
**Ground** 5:2  
**group** 16:25; 17:1, 2, 4,  
10; 23:11  
**growth** 69:4  
**guess** 8:17; 10:3; 20:9;  
25:2; 42:3; 46:11; 49:9;  
66:16  
**guesser** 10:5  
**gums** 40:2  
**gynecology** 9:14

## H

H 15:24

**habit** 47:15; 55:6; 63:10  
**half** 26:9, 11  
**hall** 62:13  
**hand** 48:3  
**handwriting** 47:9; 56:11,  
14, 18; 61:19  
**handwritten** 48:9; 57:3,  
4, 11; 61:14; 64:7; 65:4  
**handwrote** 63:16  
**happen** 6:25  
**happened** 8:22  
**happens** 6:23; 12:20;  
63:6  
**Harrison's** 29:4; 42:24  
**hate** 17:14  
**head** 5:11  
**headache** 44:1, 2, 2, 3, 3,  
8, 17, 19, 21; 45:15, 24;  
50:20  
**Headaches** 41:6; 43:15,  
17; 44:7; 45:3, 7, 11, 17,  
18, 20, 21, 25; 46:2, 3;  
50:17; 58:16, 17  
**heard** 74:12  
**heart** 22:1; 59:15; 66:15;  
68:20; 74:13; 77:7, 15  
**help** 11:19; 12:2; 19:12;  
29:2, 7; 33:8; 39:5, 8;  
65:23; 68:25  
**helps** 65:7; 70:15  
**Hematocrit** 38:5  
**hematological** 29:20;  
39:12  
**hematologist** 28:22;  
33:18; 39:17  
**hematology** 15:11, 14;  
60:9  
**Hemoglobin** 38:4  
**hemorrhagic** 39:24, 25;  
40:2  
**hereinafter** 4:5  
**high** 35:25; 36:11; 53:20;  
54:8; 59:2; 61:1; 68:1, 1,  
11; 72:5  
**higher** 60:15  
**hint** 78:12  
**hip** 56:16, 21; 57:13, 19;  
58:2, 22; 76:9  
**history** 32:19; 33:7;  
43:24; 49:10; 52:6; 65:12,  
21; 71:18  
**Hold** 75:15  
**hometown** 9:21  
**Hospital** 10:13, 23; 11:4,  
12, 15, 16; 13:3, 4, 15;  
14:17; 17:12; 18:8; 20:17,  
20; 21:15; 25:13; 26:10;  
27:20, 24, 25; 28:2, 5;  
46:16; 54:7; 60:19; 73:20  
**hospitals** 10:19, 23;  
11:14, 25; 15:5; 17:12;  
21:12; 23:11; 25:2  
**hour** 58:24  
**hue** 71:20

# I

ICU 12:23  
idea 46:19; 49:22  
identification 4:9; 7:19;  
24:13; 47:4; 56:5; 61:10  
ignorance 18:2  
illness 18:11, 14  
imbalance 67:13  
immediate 18:4; 19:22  
immediately 11:22;  
12:14  
important 6:4, 6; 7:8;  
19:8, 8; 46:7  
improved 58:18  
incidental 33:2  
include 52:17  
including 73:16  
incorrect 31:21; 52:22  
increase 39:1; 59:11  
increased 34:22; 50:24;  
51:15; 53:7, 16, 21; 54:1;  
58:2; 59:7, 12  
indeed 77:21  
independent 16:17  
indicate 6:14; 38:2; 52:2;  
54:10; 72:10; 73:15  
indicated 22:8; 58:12;  
60:20  
indicates 20:10; 50:4  
indication 65:4, 18  
indirectly 38:10; 59:3  
individual 32:2, 10  
infarction 34:24; 35:8,  
11; 40:22; 53:17; 68:24;  
76:12, 23; 77:1; 79:10  
infection 15:25; 34:3  
infective 72:21  
infer 23:17  
inflammatory 34:2, 5,  
10; 38:12, 25  
information 7:1; 23:3;  
29:11; 43:4; 47:17; 49:7, 7;  
59:5; 67:8; 69:18  
initials 60:23, 24  
injection 71:13  
injury 74:22  
inpatient 14:1  
inpatients 21:11  
input 23:2; 43:3  
insight 23:3  
instant 4:17; 27:9  
instead 18:7; 62:4; 79:25  
intellectually 9:8  
intended 21:8  
interaction 28:14  
interest 19:8  
internal 9:6; 10:18, 25;  
12:13, 16, 17, 19; 13:17;  
14:2, 5, 19, 22; 16:7, 22;  
19:25; 20:2, 7; 21:14, 20;  
24:15, 21; 25:5, 15, 16;

26:25; 27:3; 28:25; 29:4;  
30:12; 31:7; 33:20; 36:23;  
41:16, 25; 42:2, 16; 46:18;  
55:7  
Internet 9:1; 42:23  
Internet's 43:2  
internist 21:6  
interns 13:1, 11  
interrupt 14:6  
into 4:22; 9:6; 10:10;  
14:18; 23:3; 29:14; 32:18;  
33:5; 52:24; 68:12  
introduce 4:15  
introduced 4:14  
investigate 36:1, 9, 13  
involved 54:25  
involvement 67:10, 13  
ischemic 40:6; 41:3  
issue 35:23; 45:22;  
59:11; 65:6  
issues 45:23  
item 73:23

# J

January 59:24; 60:11;  
61:15; 62:9; 66:7; 70:15;  
72:24  
job 19:16  
Johnson 54:11, 14; 55:1,  
3  
Joint 46:16  
July 8:1; 10:15; 12:20;  
29:18; 37:4, 17, 18; 38:1;  
39:11, 15; 45:10; 46:6, 21;  
52:6; 54:22; 72:13, 16;  
76:18  
June 10:15; 11:20; 14:23;  
20:21; 45:13; 46:13, 13;  
51:2, 8

# K

keep 7:9; 23:10  
keeps 9:10  
kidneys 67:11  
kind 14:13; 19:2, 15; 34:2;  
49:22; 56:10; 70:10  
kinds 18:6; 34:2; 74:19;  
76:5  
knowledge 28:3; 33:20;  
53:16; 65:16  
known 29:21; 34:21; 71:2  
KOLIS 4:8, 16; 40:13;  
41:22; 42:6; 61:5; 63:2;  
64:18; 78:3; 79:12, 23

# L

L-A-R-A 16:11  
lab 51:1; 72:8, 9  
label 46:25  
laboratories 30:17, 21;

51:8  
laboratory 30:18; 54:7;  
60:18, 20; 73:15  
labs 30:15; 31:2, 3  
LAD 78:16, 19  
Lara 16:9  
last 12:4; 16:10; 38:2;  
42:6; 53:10  
late 77:3  
later 23:9; 27:6; 51:25;  
64:8  
lateral 56:20, 21  
law 5:19  
lawful 4:1  
lawsuit 4:17  
layperson's 51:19  
LDL 50:25; 51:7, 9, 12, 21  
lead 34:22; 36:7; 40:16  
learn 13:22; 30:6  
least 12:17; 44:16; 64:24  
leave 6:16  
Leaving 15:16  
leg 38:11; 48:22; 49:11;  
50:9, 11  
less 19:20  
letter 8:9; 57:14, 22  
license 8:4, 10, 12, 15,  
20; 9:3; 19:4  
licensed 22:25  
licenses 8:21; 9:1  
lifting 49:6  
light 44:4  
likely 77:6  
limited 8:25; 44:21  
limits 31:23; 73:18, 21  
list 14:21; 15:21; 40:13;  
42:5  
listed 43:17, 20; 54:8;  
74:2; 78:5  
listen 66:13, 15  
literature 27:15; 41:9, 15;  
42:2, 11, 14, 21  
little 4:19; 6:6; 19:12;  
26:12; 65:1; 67:4; 68:2;  
78:12  
liver 67:13  
locate 61:15; 64:25  
locations 17:24  
look 7:13; 27:18; 28:19;  
33:8; 37:7; 38:18; 44:24;  
45:2; 46:24; 60:4, 4; 62:13,  
20; 65:1  
looked 15:20; 27:19, 19,  
20; 63:18  
looking 32:13; 58:21;  
62:23  
looks 58:1  
lot 33:13; 54:19, 21;  
67:19; 78:4  
low 32:1  
lower 69:12  
Luis 4:12; 16:9  
lumbar 56:19, 21; 57:18;

71:10

# M

M.D 4:1, 7; 22:24; 80:10  
main 33:22; 34:15  
major 40:15; 53:5  
makes 5:11  
making 23:5  
manage 12:9  
management 13:25;  
71:8, 13  
Many 6:8; 17:4; 24:20;  
26:4; 33:23; 34:15  
mark 7:11; 55:24; 61:5  
marked 7:18; 47:3; 56:4;  
61:10  
Market 4:12  
materials 27:14  
matter 8:18; 22:1; 39:9;  
65:9  
may 13:7; 16:14; 26:11;  
31:18; 40:15; 44:14;  
55:18, 18; 65:25  
mean 21:5; 24:1; 28:19;  
33:12, 13, 14, 14; 35:6, 12;  
39:25; 57:1, 24; 65:17;  
70:12; 80:5  
meaning 30:18; 38:23;  
41:11  
means 55:16; 68:9; 80:2  
meant 71:8  
med 29:9  
medical 5:24; 8:4, 7, 10,  
15; 9:1, 12; 10:24; 11:15;  
13:1, 8, 9; 17:13; 18:6, 15;  
20:10; 23:15, 25; 27:11,  
15; 29:11; 30:4; 32:19;  
33:7; 41:15; 42:11, 13, 21;  
48:25; 51:22; 52:24; 59:7;  
77:5  
medically 73:3  
medicate 50:13  
medication 45:16; 46:1;  
58:19  
medications 44:5, 6;  
50:19  
medicine 8:12; 9:6, 7, 22,  
23; 10:18, 25; 12:13, 16,  
17, 19; 13:17; 14:2, 3, 5,  
19, 22; 16:7, 20, 22; 19:25;  
20:2, 7; 21:14, 20; 22:25;  
24:15, 21; 25:6, 15, 16;  
27:1, 3; 28:25; 29:5; 30:12;  
31:7; 33:21; 36:23; 41:16,  
25; 42:2, 16; 46:18; 55:7  
member 25:15  
members 17:4  
memory 8:6  
mention 31:18, 19;  
39:10; 75:14  
Mentioned 45:3, 15  
Mercy 10:24; 11:15; 12:8;  
13:8, 10, 13; 17:3, 13, 23;  
26:11; 27:3

met 55:21  
Mexico 9:14, 15  
Michelle 4:17, 21; 20:11;  
24:14; 25:10; 29:17;  
36:17, 21; 39:16; 41:14;  
19, 23; 42:9; 43:13; 44:17;  
50:10; 52:12; 55:3, 19;  
59:15; 61:25; 63:11;  
65:14; 66:6; 69:1; 70:22;  
74:11; 75:3, 20, 23; 76:2,  
23; 77:9  
Michelle's 29:14; 59:11  
might 4:21; 28:4; 39:6;  
50:19; 53:3; 62:21; 64:9;  
65:5; 66:1; 70:20  
migraine 44:1, 2, 3, 7, 17,  
18; 45:17; 46:2; 58:8, 17  
migraines 43:21; 58:10  
MILLIGAN 12:1; 20:22;  
22:3; 35:18; 37:9, 17, 19;  
41:18, 20; 42:3; 45:1; 51:4;  
57:7; 60:2; 62:23; 63:3;  
68:14; 69:15; 70:24; 78:2,  
10; 79:18; 80:1, 7  
milliliters 30:25  
million 34:25; 35:2  
mind 7:9  
minimum 25:8  
minor 41:2  
minutes 7:23; 62:13  
mistakes 80:3, 4  
mitigate 67:14  
MKSAP 29:9  
ml 58:24  
moment 6:15  
month 12:21; 18:18  
month-and-a-half 74:17  
months 9:16; 12:15, 17;  
14:11; 19:21; 54:22;  
57:20; 59:25  
moonlighting 19:5  
more 6:6, 9, 24; 9:7;  
12:25; 19:7, 17, 18; 26:12;  
35:4, 5; 41:1; 46:5; 54:17,  
24; 62:21; 63:13; 66:16;  
77:6; 79:6  
Moreover 6:22  
most 15:22; 19:8; 21:11;  
46:7  
mostly 9:21; 19:12  
motivated 9:10  
move 13:7; 15:18  
much 13:20; 49:5  
multiple 8:21  
murmur 65:11; 73:25;  
74:2, 5, 13  
muscle 68:20  
must 25:8  
myocardial 34:23; 35:8,  
11; 40:22; 53:17; 68:24;  
76:12, 23, 25; 79:9  
myself 4:15; 6:5; 9:21;  
46:23

N	O			
<p>name 4:10, 11, 15; 16:10; 17:2; 24:13 names 28:21, 23; 43:8 narrative 37:13; 62:17; 64:25; 69:19 nature 17:15; 20:19 nausea 44:11 necessarily 18:14; 23:18; 35:12 necessity 25:23; 26:2 need 5:24, 25; 6:12, 13, 19, 25; 12:1; 17:25; 18:15; 19:13; 36:8; 37:19; 44:25; 47:18 needed 49:16; 58:15 needless 36:11 needs 5:13 negative 38:21 negligence 27:11 NEOUCOM 9:19; 10:19, 22 neurologist 71:12 new 18:11, 14, 15; 50:19; 69:23, 24 next 55:13; 62:2; 63:17; 74:17 niche 17:21 nine 9:16 nod 5:11 nods 5:12 noise 44:4 none 64:25 Nor 75:17 normal 30:13; 31:8, 14, 24; 32:2, 4, 9; 38:4; 68:10, 10; 73:18, 21 norms 31:2, 3 North 4:12 note 37:13; 44:14, 14; 47:11, 21; 49:14; 51:12; 52:25; 53:14; 54:10; 55:11; 56:10; 57:10, 24; 61:14; 62:1, 8, 10, 17, 18; 63:4, 14, 17; 64:2, 7, 25; 65:4; 69:17; 70:22; 75:17, 18 noted 74:1 notes 23:23, 25; 38:8; 44:14; 45:4; 46:11, 24; 48:3; 57:5; 64:7; 78:13 noting 51:21 Nowhere 73:9 number 8:2, 5; 10:6, 8; 29:24; 30:16; 31:18, 20; 33:7, 7, 10, 17; 35:12; 37:3, 10; 46:7; 48:10; 50:3, 23; 51:5, 13; 56:7, 16; 57:12, 18; 58:17; 60:3, 15; 68:14; 73:23; 75:3 numbers 37:12 numbness 44:11</p>	<p>oath 5:18 Oaxaca 9:16 OB/GYN 9:16 object 6:10; 35:18; 70:7; 74:22 objective 73:14 obstetrics 9:13 obtain 15:8; 75:14 obtained 19:4 obviously 66:4; 76:15 occasion 17:25 occasional 19:9 occlusion 77:22, 23; 78:16, 19 occupational 48:18; 49:5, 17 Off 22:3, 5; 49:23; 55:8, 11; 64:11, 18, 20; 79:20 offered 12:13 office 13:24; 14:18; 19:7; 21:17; 56:1; 57:24 officially 12:19; 25:14 Ohio 4:13; 8:4, 7, 13; 19:5 old 18:15; 70:23, 25 older 17:17; 21:23 once 10:9; 18:18; 24:25; 35:14; 44:13; 54:13; 56:8; 65:2; 74:8 one 6:9; 8:22; 10:6; 11:16; 12:24, 25; 15:21, 22, 22; 23:16; 26:12, 19; 29:25; 33:12; 37:1; 43:20; 44:22; 45:4; 46:7; 47:24; 48:10; 55:25; 56:16; 57:12, 19; 58:24; 64:8; 73:1; 74:22; 75:20 one-page 7:17; 61:9 one-sided 44:3 one-year 11:4 ones 42:25 only 17:13; 26:19; 28:2; 35:1; 55:21 ophthalmologist 46:10; 48:13; 58:7 opinion 52:15; 76:21, 22; 77:5, 13, 18 opportunity 4:24; 76:16; 78:14 opposed 21:13, 21 orally 5:7 ordered 58:23; 67:6, 19, 21; 68:19; 69:7, 12 organization 17:8 Orthopedic 76:8 orthopedist 57:15; 76:11 OT 48:21 others 9:8 otherwise 21:10 out 4:19; 5:21; 10:22; 12:9; 19:12; 30:17; 37:15; 47:14; 48:6; 51:6; 61:12,</p>	<p>20; 64:2, 4; 66:20; 67:4; 68:2; 70:11 outlines 22:22 outpatient 21:9; 61:9 over 19:14; 65:17; 68:17; 74:16 over-the-counter 44:6 overall 36:5 Owens 4:17; 20:11; 36:18, 21; 44:17; 50:10; 52:12; 55:20; 61:25; 65:14; 66:6; 70:22; 74:11; 75:23; 76:2, 23 own 18:24; 19:7, 17; 23:6; 54:7; 73:20</p> <p><b>P</b></p> <p>p.m 68:4 PA 56:19, 21 PA/lateral 57:18 page 5:23; 37:9; 38:2; 51:4; 56:8; 61:16; 68:17; 69:19 pain 38:11; 48:22; 49:11; 50:6, 7, 9, 11; 56:16; 57:13; 58:2, 22; 69:2, 21; 71:3, 6, 8, 12; 76:9 Painful 41:11; 73:6; 74:21 painfulness 74:25 Pam 5:14; 6:16 paper 65:3 papers 16:12 paragraph 38:2 parameters 31:8 parcel 31:6 part 15:4; 31:5; 67:5 participating 30:5 particular 58:1; 66:1 particularly 55:1 partner 17:7 pass 20:2, 4 Passed 10:3 past 32:19; 72:13 patient 13:25; 20:22; 23:1, 5, 18, 23; 36:6, 6, 10, 22; 39:10, 21; 41:23; 45:19; 48:3, 6; 49:1; 51:16; 52:3, 7; 54:10, 15; 55:17; 58:6; 63:16, 18; 69:20; 71:15; 73:24; 75:12; 76:3 patient's 21:1, 4; 23:4; 33:6; 45:15 patients 6:5; 9:9; 13:5, 5, 12, 21; 19:15, 18; 21:9, 11; 22:17; 26:15, 17, 21; 46:18; 54:25 paychecks 23:12, 14 PCA 78:22 pediatric 17:18 people 17:4, 14, 16; 18:4; 39:24; 40:2, 5 people's 47:14</p>	<p>per 58:24 percent 76:4; 78:16 percentage 12:7 perfectly 54:14 performed 52:8; 59:21 performs 60:19 period 9:20; 10:25; 15:2, 17; 65:17 periods 11:5 permission 49:4 person 21:13; 22:23; 33:23; 34:9, 15; 35:6, 10, 25; 50:20; 53:2 person's 22:9; 50:17 personnel 15:4; 19:9 pertinent 47:17 PGY 14:17; 20:14 PGY-1 14:10; 27:5 PGY-2 26:6, 24 PGY-4 27:7 phase 33:25; 34:6 photophobia 44:21 physical 24:7; 25:24; 32:19; 33:6; 39:19; 40:9; 52:7 Physically 23:20; 24:23 physician 6:24; 13:2, 17, 18; 15:1; 17:16; 18:5, 16; 19:14; 21:2, 4, 7, 14, 18; 22:10; 24:2, 8; 25:22; 33:21; 36:22; 45:14; 46:2, 12; 55:21; 60:8; 66:12 physician's 28:4 physicians 17:6; 21:22; 24:21; 26:6; 27:21; 28:7, 9, 20, 21, 23; 30:12 picture 36:5 piece 65:2 place 20:9; 43:2 Plaintiff 4:2 Plaintiff's 7:17; 47:2; 55:25; 56:3, 9; 61:8 plan 47:17; 48:10; 50:3; 51:11; 56:24; 57:4, 11 plans 24:7 plastic 9:24 platelet 30:14; 31:8, 14, 25; 32:14, 21, 25; 33:3, 17; 34:22; 35:6, 25; 36:3, 11, 15, 19, 24; 37:1, 3, 25; 38:5, 9; 53:3; 59:2; 60:12; 61:1; 72:12, 15 platelets 29:24, 25; 30:1, 7; 31:16; 33:11, 23; 34:1, 3, 4, 16; 35:10; 39:1; 53:20; 54:1; 59:7, 12, 12, 16; 72:5, 18, 24; 73:4, 10, 20 played 68:12 please 4:10; 7:24; 60:11; 61:24 pocket 8:5 point 6:11; 16:15; 20:16; 28:15; 33:24; 39:15; 43:20; 45:5, 6, 14, 22;</p>	<p>46:3; 51:25; 52:21; 58:20; 59:19; 69:11; 70:25; 73:2 points 43:17 polite 62:5 poor 49:9 PopMed 43:5 population 17:19 portion 47:6; 48:9; 69:20; 70:21 possibilities 70:6 possible 35:3; 40:17 potential 39:12; 73:4; 74:24 practice 8:12; 16:18, 20; 17:15, 21; 19:4, 6, 17; 22:25; 55:6 practiced 9:22 practitioner 21:22 predictive 35:13 premenstrual 53:11 preoccupied 51:18 preparation 41:24; 42:20 prepare 29:2, 8 prepared 9:21 preparing 20:6 prescribe 50:5 present 20:6; 23:19; 24:23; 25:23; 58:19 presentation 16:13; 44:19 presentations 15:20 press 16:14 pretty 5:2; 12:5; 13:20; 22:1; 41:8 previous 18:5; 22:8; 43:24; 65:12, 21; 74:1 previously 14:14 primary 16:8; 17:6, 16; 18:12; 21:1, 4, 18; 22:9; 24:20; 25:22; 26:5; 36:4, 22 print 43:11 prior 25:14; 41:14, 19, 22; 42:8; 71:18 priority 27:8 privileges 17:12; 25:20 probably 21:24; 33:5; 48:19; 64:1 problem 23:4; 32:4; 36:4, 5; 39:12; 46:7, 8; 73:1 problems 49:19 Procedure 4:4 process 31:6; 34:2, 5, 10; 38:13 professional 5:22; 17:3; 28:14 profile 67:6, 21, 23 program 9:13, 18; 10:11, 19, 20, 21; 11:13, 18, 20, 24; 12:6, 12, 13; 14:13, 16; 25:16, 19; 26:24; 54:20 provide 23:2; 49:7 provided 4:3; 11:1, 3; 62:16</p>



providing 20:20, 25  
PT 66:25  
PTT 66:25  
publication 16:1, 6  
publications 15:21  
pulmonary 14:3; 40:20  
purpose 4:2, 18  
purposes 4:9; 7:18;  
24:13; 47:4; 56:5; 61:10;  
64:24  
put 47:6; 52:24  
Pylori 15:24

## Q

quickly 7:13; 22:1  
quite 42:19; 64:15

## R

raised 34:3  
range 30:11, 13; 31:2, 4,  
8, 14, 15, 22; 67:4; 68:2, 9  
ranges 30:24, 25  
ratio 68:7, 8  
RDW 38:5  
reactant 33:25; 34:6  
reactive 34:7; 39:6  
read 28:2, 9; 37:21;  
42:15, 17, 18; 45:17; 57:2,  
4, 8, 10, 11; 62:1; 70:18,  
25; 79:16; 80:2, 8  
reading 20:10; 42:8;  
55:13; 61:19; 79:15  
ready 45:3; 78:11  
really 19:6; 51:18  
reason 5:9; 31:17; 49:20;  
63:7, 23; 65:25  
recall 11:8, 9, 9; 15:9;  
41:25; 63:3, 5; 66:12, 17,  
18, 19; 75:9, 11, 15; 77:23  
receive 5:23; 21:17;  
23:14  
received 8:15; 14:25;  
23:12  
recent 15:22  
recheck 51:25  
recollection 20:12, 13;  
37:5; 49:25; 66:6; 68:25;  
71:19; 74:14  
recommended 49:2;  
71:12  
record 4:10, 15; 5:4;  
6:14, 20; 22:3, 6; 23:8;  
24:14; 35:22; 37:6, 7; 47:3;  
54:14; 62:12, 15; 64:11,  
18, 21; 79:21  
records 20:10; 27:17, 19,  
20, 21, 22, 24; 28:4, 8, 9,  
20; 29:15; 37:14, 16;  
38:18; 47:6; 56:4; 62:21,  
24; 63:1; 76:16; 78:7  
red 30:1

reddish 71:23  
refer 59:24  
reference 30:11, 13, 24,  
25; 54:7; 68:2, 11  
referral 57:14  
referring 27:25; 30:19;  
38:1; 39:16; 50:25  
refresh 8:6; 68:25; 74:14  
regard 5:3  
regarding 57:12; 59:1  
regular 13:8  
reiterate 14:8  
relate 73:14  
related 58:8; 71:25  
relates 70:16  
relating 71:18  
relative 11:3; 49:17;  
59:16  
reliable 29:12  
relieve 50:19  
relieved 44:5  
remain 26:23  
remember 8:19; 14:24;  
15:12, 15; 25:7; 28:10, 21,  
22, 23; 38:17; 41:17; 42:8;  
43:1; 44:23; 49:20; 54:16;  
59:23; 62:11; 63:25;  
64:17; 65:8; 66:4, 10, 14;  
69:13, 15, 25; 70:14; 75:6,  
17  
remembered 70:13  
rendered 4:20  
rendering 76:22  
Repeat 30:20; 37:22;  
56:25; 72:14  
repeated 37:20  
report 31:2, 3; 38:1;  
60:20; 61:9  
reported 32:14; 42:11;  
49:10; 58:24  
reporter 12:3  
represent 62:15  
represented 40:9  
representing 4:16  
request 15:7; 18:16  
requesting 60:8  
required 5:6  
requirement 24:6, 9, 10;  
79:16  
requirements 26:1  
research 9:1; 15:20;  
16:17  
residency 8:23, 23; 9:13,  
18; 10:11, 18, 21; 11:13,  
24; 12:12; 25:11, 15, 19;  
26:23; 30:6; 49:4; 54:17,  
24  
resident 8:21; 12:19;  
19:3; 20:25; 22:16, 22;  
25:11; 27:7; 46:14; 55:8  
residents 13:11; 24:20;  
26:5, 7, 8, 10, 16, 19;  
46:17  
responded 35:19

response 51:21; 66:20  
responsibilities 5:22  
responsibility 18:21;  
19:1  
responsible 23:4  
responsive 7:8; 35:15  
result 33:3; 75:7; 79:6  
results 51:1; 67:9; 78:15  
return 57:19  
review 24:6; 28:4, 20;  
42:21; 55:10; 76:16; 78:14  
reviewed 27:14; 28:7, 24;  
42:13, 22, 23, 24, 24; 43:9,  
11  
reviewing 28:10; 43:1  
right 14:10, 20; 15:24;  
18:13; 20:17; 23:7; 24:13,  
19; 25:10; 30:2; 46:21;  
47:20; 48:11, 12, 23;  
50:21; 52:10, 18; 58:3;  
64:23; 69:7, 21; 71:5, 17,  
23; 78:17  
risk 52:3, 14; 53:4, 5, 7,  
16, 21  
risks 34:16, 18, 19  
road 74:23  
room 6:17; 18:8; 48:6  
rotation 12:22; 13:7;  
14:4; 15:10, 13  
rotations 13:14  
rule 12:4; 61:20; 64:4;  
66:20; 70:11  
Rules 4:3; 5:2, 5; 44:8

## S

same 13:11; 21:17;  
25:20; 26:16; 37:12; 50:14  
sat 24:1; 28:25  
saw 25:10; 29:17, 18;  
32:21, 24; 33:3, 16; 45:4,  
7, 9, 10; 46:3, 6, 12; 55:3,  
17, 20; 63:11, 16; 65:17;  
70:1  
saying 31:1, 17; 35:24;  
76:24  
schedule 56:19  
scheduled 75:19  
school 9:12; 30:4  
screen 38:12  
search 43:2, 6  
second 26:18; 48:12  
secondary 36:4  
secure 7:3  
Security 8:2  
seeing 13:5; 19:15, 18;  
20:16; 21:11; 23:5, 5;  
24:14; 26:14, 16, 21;  
28:22; 41:18, 19, 20; 42:9;  
49:2; 54:25; 62:11; 63:4, 5;  
64:17; 75:17  
seeking 7:2  
seemed 75:23  
seems 46:22; 63:10, 11  
seldom 32:5, 6  
self-explanatory 7:22  
Send 57:13  
sending 78:6  
seniors 12:25  
sensation 44:11  
sense 14:7  
sent 46:9; 71:15  
sentence 52:2; 58:14  
separately 15:8  
September 45:4; 56:1;  
59:6, 10, 14; 60:1; 76:19  
sequence 61:12  
serve 25:22  
served 22:9  
service 24:2; 62:25  
services 20:19, 24  
serving 24:20; 26:5  
session 50:4  
set 37:14; 69:19  
setting 14:18; 33:1, 2  
seven 15:23; 79:15, 25  
several 14:1  
shakes 5:12  
share 18:20  
shareholder 17:7  
sheet 47:16; 74:2  
short 62:18  
shortage 19:9  
showed 38:3; 78:15  
shown 77:15  
side 44:22; 61:18  
sign 33:24; 34:5; 55:8, 11  
signature 60:21  
signed 11:4  
significance 30:7  
significant 66:5; 77:20  
signs 36:7; 39:20; 40:9  
simple 5:2  
sit 42:10; 47:20, 20; 64:6;  
76:15  
situation 5:24; 6:1; 54:13  
six 12:15, 17; 14:11;  
54:22  
skip 58:22  
skipping 69:11  
slightly 68:6  
SMA 32:13  
smoker 52:12  
Social 8:2  
somebody 14:6  
someone 19:13; 33:16;  
65:10  
someone's 63:20  
Sometimes 13:15, 16;  
19:21; 28:3; 34:4; 63:6;  
68:21  
somewhere 8:17; 74:5  
soon 5:21; 48:5  
sorry 24:25; 48:19; 51:2;  
57:1; 68:16; 72:14  
sort 5:11; 17:21; 25:20;  
59:18; 62:3; 67:15; 71:23  
Sorting 30:17  
sound 8:18  
sounded 74:13  
sounds 31:22  
sources 29:10  
speak 6:15; 35:22  
speaking 17:14; 48:2  
specialties 14:2  
specialty 13:16, 17  
specific 14:18; 31:20  
specifically 8:19; 15:10  
specificity 28:8  
spell 16:10  
spend 7:22; 13:4, 19  
spinal 71:11, 13  
spine 56:19, 21; 57:18  
split 12:7  
splitting 25:2  
spring 25:4  
stamp 56:9; 60:5; 67:5;  
68:17  
stamped 37:14; 61:16;  
78:13  
Stark 17:24  
start 14:16  
started 12:6; 19:6; 25:5,  
9; 72:1  
Stat 19:20; 32:11  
StatCare 17:23; 18:3  
state 4:10; 5:4; 8:4, 7, 13;  
19:5  
statement 9:2; 22:14, 21;  
31:12, 13; 36:14; 39:13,  
17; 52:22; 59:8; 69:9  
statements 35:14  
stay 5:13  
stenosis 71:11  
stent 78:21  
Step 10:6, 8  
steps 10:6  
still 32:1; 78:5  
stools 40:3  
Stopping 71:17  
strictly 4:9  
stroke 35:7; 40:5  
strokes 34:22  
students 13:1  
studied 14:22; 15:1, 10  
studies 73:17  
study 29:9; 75:8  
studying 13:22; 41:16,  
24  
stuff 78:4  
subjective 70:21  
submitted 7:14  
subsequent 47:11; 64:7  
subspecialties 14:21  
subspecialty 14:19; 20:7  
sued 27:10  
suffering 36:8; 66:1

suggest 67:23; 69:16  
suggestion 73:10  
suggestive 34:10  
summer 12:7; 14:9;  
20:12; 33:21; 34:21; 60:15  
supervision 21:7; 22:10,  
23  
supplied 27:23  
sure 5:2; 37:23; 45:2;  
57:1; 60:4; 79:18; 80:3  
surgeon 9:24  
suspect 65:10  
swelling 69:21; 70:1;  
71:5  
switched 57:4  
swollen 71:14, 20; 73:6  
sworn 4:4  
symptoms 36:7; 44:10  
syndrome 53:11  
system 69:13

## T

tag 13:20  
talk 6:19; 27:16; 29:15;  
41:1; 78:10  
talking 30:24; 34:7  
team 12:24; 13:6  
teenagers 21:23  
telling 14:11  
ten 47:24  
tend 5:9  
terms 30:11, 24; 32:2;  
33:20; 40:14; 49:6  
test 69:7  
testified 73:7  
testifies 74:11  
testimony 5:14; 35:1;  
64:24  
tests 67:2, 19  
textbook 29:1, 7  
therapy 48:18; 49:5, 17  
therefore 30:22  
Thereupon 7:17; 22:5;  
47:2; 56:3; 61:8; 64:20;  
79:20  
thinking 4:21; 67:14, 16;  
70:5, 20; 72:1  
third-year 26:19  
though 17:22  
thought 49:16; 54:18;  
64:9; 65:5, 25; 66:3, 5;  
67:18  
three 10:6, 7, 8, 25;  
12:25, 25; 19:21; 26:8, 15;  
29:25; 35:2; 62:6; 73:24  
three-and-a-half 59:25  
three-page 56:4  
thrombocytosis 29:16,  
21, 23; 33:15; 34:7, 14;  
36:2; 39:7, 20; 40:10, 17,  
18; 41:4; 42:15; 43:7; 79:1,  
5, 9

thromboembolic 70:8  
thrombolic 70:11; 72:2,  
5, 19  
thrombolytic 72:6  
thrombosis 34:20  
thrombotic 39:24; 40:1,  
5, 14; 41:2  
thrombolytic 72:23  
throughout 13:12  
tightness 66:8  
till 22:2  
times 10:7; 25:1; 62:7;  
64:16  
today 5:18; 10:5; 25:21;  
27:10; 32:24; 33:16;  
42:10; 49:25; 64:6; 71:4;  
76:15  
today's 4:23; 27:13;  
42:20; 57:14; 64:24  
toe 69:21; 70:1, 5, 9, 9;  
71:5, 15, 20; 73:12; 74:16,  
21, 25  
toes 41:12  
together 47:7; 70:19  
told 12:4; 51:24; 54:18;  
58:7; 59:2; 66:7; 74:11;  
75:24  
tonight 32:11  
took 9:25; 10:6; 42:16  
traffic 62:4  
trained 10:24  
training 11:14, 16; 12:17  
transcribed 63:8; 80:6  
transcription 63:15  
transitional 9:18; 10:10;  
11:19; 12:12, 14, 18;  
25:11, 19; 30:5; 54:20  
Transitory 41:3  
treat 36:9, 9; 58:18  
treated 41:14; 58:13  
treating 6:6; 13:5; 21:6, 9,  
13; 23:1; 27:20; 46:18  
treatment 4:20; 15:23;  
36:17; 42:25; 43:14;  
58:12, 15  
treats 13:22  
trial 76:22  
trick 70:12  
tried 45:16; 47:6  
Triponin 67:1  
true 26:23; 69:19  
try 5:13; 10:3  
trying 50:7; 51:6; 67:16;  
70:12  
Tuscarawas 17:24  
two 6:17; 10:8, 23; 11:12;  
12:24, 25; 19:21; 26:15;  
36:24; 45:4; 57:18, 20;  
66:20  
two-year 9:20  
Tylenol 50:6, 8, 16  
type 58:21  
typed 62:8

typewritten 50:4  
typical 44:3

## U

U.S 9:22  
Ultimately 76:10  
ultrasound 70:11  
unaddressed 54:2  
uncertain 38:11; 56:16;  
58:22; 65:11  
under 5:18; 14:22; 15:1;  
20:11; 21:6; 22:10; 43:13;  
55:8; 56:18; 59:20; 73:15;  
76:3  
underneath 64:4  
understood 7:6; 23:16  
unfortunately 21:24  
universe 63:13  
unknown 43:18; 53:3, 20  
unless 29:18  
unusual 63:6  
up 17:19; 32:1; 33:8; 47:7  
upon 8:25; 9:11; 41:24;  
52:6; 55:2; 62:16; 64:6;  
71:25  
urgent 18:8; 19:22  
urine 40:3  
use 8:6; 29:7, 10; 30:12;  
32:7, 8; 33:17; 43:3; 49:6;  
51:20  
used 29:1, 4; 31:23; 32:5;  
43:6; 45:16; 46:1  
usual 44:5; 57:21  
usually 21:25; 45:16;  
48:1

## V

variability 30:17  
variation 19:16  
varies 18:18; 30:15, 21,  
23  
variety 9:9  
vary 31:19  
vast 43:2  
venous 75:5  
versus 15:23  
vision 45:6, 11, 25; 46:8;  
58:7  
visit 21:25, 25; 23:18;  
39:11; 45:12; 46:22; 47:3;  
48:9; 55:14; 56:1, 4; 58:1;  
59:1; 60:1; 62:9; 66:13;  
71:4; 74:3, 12  
visits 21:17  
visual 48:15  
vitae 7:12, 21; 9:12; 16:14  
voice 6:20

## W

wait 12:1; 47:23  
waive 79:15  
walk 48:6; 62:13  
walking 49:6  
way 5:13; 11:2; 26:12;  
46:12, 22; 49:9; 55:2, 19;  
60:21; 62:5; 68:16; 78:24  
Wednesday 26:20, 25  
week 18:19; 26:20; 64:8  
weeks 13:4, 6, 14, 19, 23;  
14:4  
Weeman 28:11, 15  
Weeman's 28:10  
weren't 74:25; 80:6  
what's 15:24  
white 30:1; 38:3  
Who's 16:8  
whole 42:5; 78:4  
wide 9:9  
willing 19:11  
withdraw 34:11  
within 14:17; 73:18, 21;  
74:19; 79:17, 24  
without 18:5; 19:22;  
22:23; 25:22  
witness 5:11; 80:5  
woman 79:4  
wondering 68:12  
word 32:4, 5, 8; 51:19, 20,  
20  
words 5:13; 22:20; 43:6;  
67:18  
work 11:11; 17:22; 19:2,  
10, 14, 14, 15; 22:15; 27:3;  
45:20; 49:23; 60:9, 19;  
70:19; 72:8, 9; 73:15  
worked 16:13; 24:12;  
26:19  
working 22:14; 25:5, 9,  
12; 28:13, 13; 67:12  
write 23:25; 47:16, 21;  
48:3, 5, 6, 7; 55:15; 70:21  
writing 47:8  
written 22:14; 42:1, 4;  
60:20; 63:13  
wrong 50:24; 55:22, 22;  
75:18  
wrote 51:11; 52:11; 55:2

## X

x-rays 56:19, 21, 22;  
57:18, 19

## Y

year 8:15, 24; 9:18; 10:7,  
11; 11:20; 12:11, 18;  
14:10, 17; 20:14; 25:19;  
26:6; 30:5; 54:24

year's 65:17  
years 10:25; 11:12; 26:8,  
18  
young 77:21  
younger 17:18

## Z

Zomig 46:1; 58:13



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#### **EDUCATION/WORK EXPERIENCE**

- Clinical Instructor, Internal Medicine Residency Program NEOUCOM/Canton, 07/02-present.
- General Internal Medicine Practice, Mercy Professional Care Corporation, Canton, 12/01-present.
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- Internal Medicine Residency Program, NEOUCOM/Canton Affiliated Hospitals, graduated 12/31/00.
- Transitional Year Residency Program (Internship), NEOUCOM/Aultman Hospital, 7/97-6/98.
- Obstetrics and Gynecology Residency, National Institute of Perinatology/Mexico City, 1-9/95.
- M.D., Institute of Technology of Monterrey/Mexico, 08/87-10/94 (as part of exchange program, last year or medical school attended at Baylor College of Medicine/TMC, Houston, TX).
- Bachelor, International Baccalaureate, Tijuana, Mexico, 8/85-6/87.

#### **RESEARCH, PRESENTATIONS & PUBLICATIONS**

- nc
- A Comparison of One vs Seven-Day Treatment for *Helicobacter Pylori* Infection, NEOUCOM/Canton, 2/99-2/02. Presented at the ACP-Ohio/Cincinnati and National ACG in New York City, 10/00 & National ACP Meeting, Atlanta, GA 03/01. Publication in progress. /ANNALS of LM LARA
  - Humoral Hypercalcemia of Malignancy in Squamous Cell Carcinoma of the Skin: Parathyroid Hormone-Related Protein as a Cause. *Southern Medical Journal* 2001; 94:329-331.
  - Benzocaine-Induced Methemoglobinemia during Transesophageal Echocardiography. Presented at the National ACP Meeting, Philadelphia, 4/00, and presented at the ACP-Ohio/Columbus, 11/99.
  - Reconstruction of Fallopian tubes and Fertility Rates after Elective Ligation, INPer/Mexico, 1995.
  - Cardiovascular Effects of Endothelins, Tulane/New Orleans, 1991.

#### **AWARDS/ACTIVITIES**

- First Place, National ACP research abstract presentations, 03/01.
- First Place, NEOUCOM Research Day, Rootstown, OH, 5/00.
- Honorable Mention, ACP-Ohio, clinical vignette presentations, 11/99.
- Honorable Mention, ACP-Ohio, clinical vignette presentations, 11/98.
- Honorable Mention, graduating class of 1994.
- President, Organizing Committee of the First International Congress of Medicine/Institute of Technology of Monterrey, Mexico, 1991-1992.
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#### **LANGUAGES**

- Spanish, native language. English, certified by ECFMG, TSE and TOEFL.

#### **LICENSES AND CERTIFICATIONS**

- American Board of Internal Medicine, Ohio State Medical Board, Drug Enforcement Administration.
- ECFMG & MD with unrestricted license to practice medicine in Mexico.

#### **PROFESSIONAL ORGANIZATIONS**

- American College of Physicians, American Society of Internal Medicine, American Medical Association, Ohio State Medical Association and Stark County Medical Society.

#### **INTERESTS**

- Traveling, classical music, gourmet cuisine, water and snow skiing.

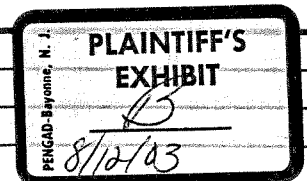
#### **REFERENCES**

- Excellent references furnished upon request.



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~~000034~~



HISTORY OF PRESENT ILLNESS:

Mrs. Woo is an established patient of our Clinic who comes here for the second time, and I have evaluated her for the first time since Dr. Bishara saw her during her previous visit. She is here with similar complaints that she had last time which includes headaches that are bifrontal occasionally, not associated with other symptoms. Also she has isolated episodes of blurred vision which are also not associated with any other symptoms and that last only a few seconds. They happened several times per week and she states that she loses her vision completely momentarily. She fully recovers her vision after each episode and the only associated symptom that she has noticed is her bilateral leg pain which happens especially when she is exerting. The patient also complains of abdominal pain in the epigastric area which happened twice since last time she was seen here. The night previous to being seen today, the patient was awakened by epigastric pain followed by an episode of vomiting of gastric contents. She also has had two episodes of watery diarrhea with no blood. Presently, the patient's most significant complaint is her leg pain. She states that due to this she is unable to continue with her normal daily activities. She states that walking a few feet triggers the pain which is bilateral, dull, especially in her thighs and knees. She has not noticed any skin changes or swelling of her legs, or swelling of her joints. She has been taking Ibuprofen 200 mg p.o. 4 times a day for the last month with some relief. She also was given by Dr. Bishara Zomig for two days for her headaches which were categorized as migraine headaches. This medication has improved the symptoms but has not completely resolved the headaches.

The patient also complains of premenstrual syndrome which is characterized by abdominal cramping and mood swings that last for up to one week before her menstrual period is started. She is very anxious and agitated during this time and those symptoms completely resolve once her menstrual period starts each month. This has been going on for several months but the last few times it has increased in severity.

She has no other symptoms or complaints.

PAST MEDICAL HISTORY:SURGERIES:

Previous surgeries include lipoma excision and tubal ligation at Aultman Hospital.

ALLERGIES:

Patient is allergic to Ampicillin and codeine.

SOCIAL HISTORY:

She smokes one pack of cigarettes per day. She denies any alcohol use or any illicit drug abuse.

000035

REVIEW OF SYSTEMS:

She otherwise has no other chronic medical conditions.

PHYSICAL EXAMINATION:

Vital signs: Blood pressure 130/80; pulse 80; respirations 16; temperature 98.7 degrees; weight 173 pounds.

General: Patient is alert and oriented x four, In no acute distress.

HEENT:

Head: Normocephalic and atraumatic.

Eyes: Pupils are equally round and reactive to light and accommodation. Funduscopic examination shows no abnormality, no evidence of papil edema, hemorrhages or exudates.

Ears: Tympanic membranes show no erythema or exudate.

Mouth: Oropharynx shows no erythema or exudate.

Neck: Supple. No increased JVD, no carotid bruits, no lymphadenopathy.

Lungs: Clear to auscultation bilaterally.

Heart: Regular rate and rhythm.

Abdomen: Slightly tender at the epigastric area with no positive rebound.

Rectal: Examination shows no abnormalities and guaiac stools are negative.

Extremities: Without clubbing, cyanosis or edema. All joints have full range of motion and no evidence of swollen joints.

Neurological: Cranial nerves II through XII grossly intact. Sensation and motor not affected.

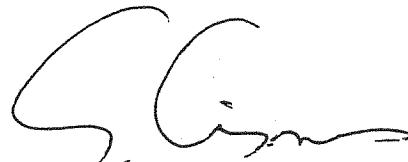
Laboratory data: Includes MRI of the brain done on 6/23/99 which shows mild inflammatory change of the right mastoid air cell, but otherwise no intracranial abnormality. Specifically no evidence of multiple sclerosis. Other laboratory data includes fasting lipid profile done 6/15/99 which shows total cholesterol 198, triglyceride 80, HDL 39, LDL 143. Fasting glucose was 83. Vitamin B-12 560, folate 442, VDRL nonreactive. CBC with differential done 4/27/99 showed WBC 9930 with normal differential. Hemoglobin 14.9, hematocrit 43.0, RDW 12.8, platelet 645000. Blood chemistry sodium 138, potassium 5.0, chloride 106, CO2 24, BUN 9, creatinine 0.7, total bilirubin 0.5, direct bilirubin 0.0. Alkaline phosphatase 60, AST 23, ALT 33. TSH 0.98, T4 6.5.


ASSESSMENT/PLAN:

1. Vision abnormality of uncertain etiology. There is no cause identified at the present time. Will ask ophthalmologist to evaluate patient to further assess this problem.
2. Acute gastritis. Patient has been taking large amount of nonsteroidal anti-inflammatory drugs and her physical findings are consistent with this diagnosis. Will discontinue Ibuprofen and begin Prevacid 30 mg p.o. q.d. for one month. Will reassess as needed. No evidence of active bleeding and we do not believe that the patient needs to be further evaluated for this.
3. Leg pain of uncertain etiology. Patient will have an ESR done as screening test for inflammatory process. Will be evaluated by occupational therapy to establish her functional capacity. She is claiming that she is unable to continue with any kind of physical activity and is unable to work anymore. She is asking for Disability approval. Unable to make this decision at the present time and we will evaluate as mentioned above. Will discuss during the next visit.
4. Will also prescribe Flexeril 10 mg p.o. q h.s., as well as Tylenol for pain p.r.n.
5. Increased cholesterol and LDL of 143. The patient has no other risk factors for coronary artery disease. Will encourage her to decrease the fat content of her diet and recheck her cholesterol level in six months. Patient agreed to that.
6. Premenstrual syndrome. Patient has been seen at the OB/GYN Clinic of this hospital. We discussed with the resident the further management of this problem.

Patient will be seen again in one month to reassess her condition.

Patient was seen and discussed with Dr. Johnson.

  
\_\_\_\_\_  
G. CISNEROS, M.D.

  
\_\_\_\_\_  
C. JOHNSON, M.D.

GC:mms

D: 07/21/99 1529

T: 07/21/99 1940

000037



[illegible]

S: Michelle Owens is a 33-year-old female established patient of our Clinic who is here for a follow up visit. Today the patient complains of excruciating bilateral hip pain that occur intermittently. It is not related to any kind of physical activity, can happen when she is standing up or sitting down, and lasts for several hours each episode. Worst episode she had was when she had to walk one mile because her car broke down and after that she had this pain continuously for four days, not relieved with any medications which she was taking over-the-counter, nor Flexeril which was prescribed to her. The patient also was seen by the ophthalmologist who told her that her blurred vision was related to migraine episodes but no specific treatment was indicated for that. She has not complained of abdominal pain which she was having at the previous visit. Otherwise, the patient has no other symptoms or complaints.

O: Vital signs: Blood pressure 122/80; respirations 18; pulse 68; weight 174 pounds.

General appearance: She is awake and oriented x four, anxious and tearful.

HEENT: Unremarkable.

Lungs: Clear to auscultation bilaterally.

Heart: Regular rate and rhythm.

Abdomen: Benign.

Extremities: Without clubbing, cyanosis or edema.

Neurological: Examination is intact. No focalization or areas of abnormal sensation. Motor strength is 5+/5+. No pain to full mobilization of both hips.

- A/P: 1. Bilateral hip pain of uncertain etiology. Patient was seen initially at this Clinic and MS was suspected. MRI of the brain was ordered which did not show any abnormality, except for some mild inflammatory changes in the right mastoid air cells. Also an ESR was ordered which was reported as 1 mL/hour. All the lab work done so far has been within normal limits except for LDL cholesterol of 143. Physical examination does not reveal any significant findings and for this reason we are going to obtain x-rays of lumbar spine as well as both hips and will obtain a consult with Dr. Coggins to provide some input in the assessment and management of this problem.
2. Gastritis, resolved. Due to abuse of nonsteroidal anti-inflammatory medications that she was taking round the clock before being seen at this Clinic a month ago.
3. Anxiety disorder appears to be a component of patient's complaints. Will wait for Dr. Coggins input to decide whether or not patient is to be confronted with this problem and treated for it.

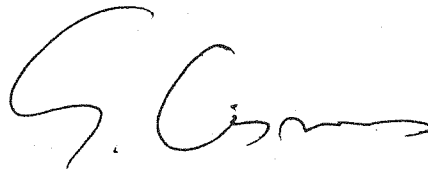
OWENS, MICHELLE  
Page 2

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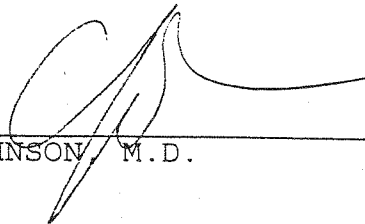
09/08/99

4. Migraine headaches, currently improved. Will not treat with any medications at the present time.

Patient was discussed with Dr. Johnson.



G. CISNEROS, M.D.



C. JOHNSON, M.D.

GC:mms  
D: 09/08/99 1703  
T: 09/08/99

cc: Dr. Coggins

000064

A45 D 10

AULTMAN HOSPITAL  
2600 Sixth Street S W Canton OH 44710  
OUTPATIENT REPORT

Patient name: OWENS, MICHELE

M.R.N.: 000777288 Room:

Billing no.: 0007772880019

Location: OUT PATIENT

Att.physician: CISNEROS, GERARDO

Adm.date: 01/19/00

DOB: 10/02/1965 Age: 34 Sex: F

Order Id : 37191461

FINAL

Date&Time Ordered: 01/19/00 18:08

ROUTINE 01/19/00

Req. physician: CISNEROS, GERARDO, MD

Copy to: CISNEROS, GERARDO, MD

CISNEROS, GERARDO, MD  
AULTMAN RESIDENCY-TY  
2600 SIXTH ST SW  
CANTON, OH 44710

HEMATOLOGY

TEST-NAME	RESULT	AB	REF-RANGE	UNITS
<u>HEMOGRAM</u>				
COLLECTED 01/19/00 17:45 RECEIVED 01/19/00 18:08				
WBC	9.52		4.80-10.80	k/mm3
RBC	4.26		4.20-5.40	m/mm3
Hemoglobin	13.5		12.0-16.0	G/dL
Hematocrit	39.4		37.0-47.0	%
MCV	92.5		81.0-99.0	uM3
MCH	31.8		27.0-32.0	pg
MCHC	34.4		32.0-36.0	G/dL
RDW	12.8		11.5-14.5	%
Platelet Count	725	H	150-450	k/mm3
Mean Platelet Volume	7.8		6.7-10.5	fL

WBC DIFFERENTIAL

COLLECTED 01/19/00 17:45 RECEIVED 01/19/00 18:08				
Lymphocyte %	38.4		20.0-40.0	%
Monocyte %	5.1		2.0-12.0	%
Neutrophil %	52.5		50.0-75.0	%
Eosinophil %	3.6		1.0-5.0	%
Basophil %	0.3		0.0-2.5	%
Neutrophil, Absolute	5.00		1.80-7.80	K/mcL

SPECIAL HEMATOLOGY

COLLECTED 01/19/00 17:45 RECEIVED 01/19/00 18:08				
Erythrocyte Sed Rate	7		0-20	mm/hr

Patient name: OWENS, MICHELE

MRN: 000777288 Room:

Location: OUT PATIENT

Att.physician: CISNEROS, GERARDO

INSTRUCTIONS TO PATIENT		AULTMAN HOSPITAL AMBULATORY CLINIC INTERNAL MEDICINE		241041-CR02 Owens, Michele	
Bring all medicines					
every visit. Return					
to Ambulatory Care Clinic					
on _____					
at _____	am/pm				
	MEDICATION	No.	SIGNATURE	Ref.	Rx. Number
	ZOLOF 100mg	33	T P D UP	1	
	ABUTMENT 875mg	38	T P D 3.0	1	
	PAROLINE 11-11	31	T P D 0 86	1	
RX GIVEN					
DATE 1/1/00		SIGNATURE S. C.		M.D.	
D.A.W. <input type="checkbox"/>		D.E.A.			

DATE 1-19-00 CISNEROS

VITAL SIGNS: T BP 124/72 P 78 R WT 172

SUBJECTIVE

OBJECTIVE

ASSESSMENT	PLAN
R/O ENDOCARDITIS	(1) BLOOD CULT X2 NOW
DEPRESSION	(2) TMP, CBC & DIFF, H <sup>2</sup> INST, APT/PT, ESR NOW
	+ TROPONIN I & CK/MB
	(3) LOWER EXT DUPLEX OF ARTERIAL CIRC
	(4) ECG 2-D M-MODE ECG & COLOR FLOW
	CARDIOLOGY APOC TO READ ASAP
	(5) BCG MW DONE
	1-24 7:24 AM
	1-25 10:00 AM
	SIGNATURE S. C.

000058

012500

## INSTRUCTIONS TO PATIENT

Bring all medicines  
every visit. Return  
to Ambulatory Care Clinic  
on \_\_\_\_\_  
at \_\_\_\_\_ am/pm

CL 000241064-9992  
AULTMAN HOSPITAL WENS, NICHELE L  
AMBULATORY CLINIC, MEDICAL, CL 34 F 10/02/65  
INTERNAL MEDICINE

MEDICATION

No.

SIGNATURE

Ref.

Rx. Number

M.D.

DATE

SIGNATURE

D.A.W. ☐

D.E.A.

DATE

VITAL SIGNS: T

B/P 130/80

P 72

R

WT

173

SUBJECTIVE

OBJECTIVE

ASSESSMENT

PLAN

2-D M MODE

ECHOCARDIOGRAM

E COWR FLOW

NO. ~~ARTERY~~ R/O VALVULAR DISEASE

CANCER DUPLEX (ARTERIAL)

PREGNANCY TEST (SERUM)

NOW SENT

VA/C&amp;S (NOW)

SENT

SIGNATURE

000055

S: Michelle Owens is a 34-year-old female that is known to have anxiety/depression disorder as well as chronic back pain, who comes here on a follow up visit. Patient was seen on 1/19/00 complaining of right toe swelling and pain. She was earlier that day at the Pain Management Clinic where she was going to have an epidural block, when she was found to have some lumbar back spinal stenosis and was also seen by a neurologist before who recommended the Pain Management Clinic. The spinal injection was cancelled due to the evidence of the swollen and erythematous toe and the patient was sent to this Clinic to be evaluated for this. Patient was complaining of the extreme pain of this toe which today has markedly improved. Patient has complained of some urinary frequency, and back pain as well as leg pain, but otherwise has no other complaints or symptoms.

O: Vital signs: Blood pressure 130/80; respirations 16; pulse 72; temperature 98.7 degrees; weight 133 pounds.

Patient is awake and oriented and in no acute distress.

HEENT: Unremarkable.

Lungs: Clear to auscultation bilaterally.

Heart: Regular rate and rhythm. There is a Grade II/VI systolic ejection murmur best heard at the left sternal border with no radiation.

Abdomen: Benign.

Extremities: There is evidence of erythema fifth toe of the right foot which appears to be improved from previous examination.

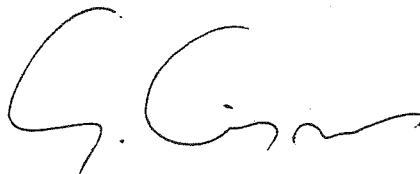
Laboratory data: All blood work done including blood cultures, CBC, full chemistry, cardiac enzymes and coagulation studies are within normal limits.

- A/P: 1. Anxiety/depression. Will continue with Zoloft which appears to be working. Patient has no suicidal or homicidal ideation.
2. Chronic back pain. Patient will be referred again to Pain Management Clinic for spinal block. It has been documented before that there is no evidence of arterial circulatory problems or embolic events. The condition that is affecting this right foot toe is resolving and is most likely related to an ingrown toenail. It does not appear to be infected and no other measures need to be done (a needle puncture was done to rule out any abscess formation, which was negative).
3. Patient will have an echocardiogram done to assess the murmur which was noted in previous evaluation, but bacterial endocarditis is less likely because she is not febrile, blood pressures are negative and there are no other diagnostic criteria for this diagnosis.

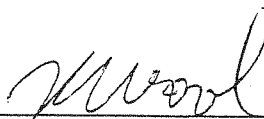
4. Patient has also mentioned that her menstrual period was different last time and for this reason we will go ahead and do a pregnancy test. She does have a history of bilateral tubal ligation.
5. Will also obtain a urinalysis for bladder symptoms.

Patient will be seen again within the next month.

Patient was discussed with Dr. Wood.



G. CISNEROS, M.D.



K. WOOD, M.D.

GC:mms

D: 01/25/00 1054

T: 01/25/00 1941



**LAWYER'S NOTES**

[illegible]

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1226 Market Avenue North, Canton, OH 44714  
Work: (330) 456-8592 Fax: (330) 456-9476  
E-mail: gerardocisneros@yahoo.com

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- Reconstruction of Fallopian tubes and Fertility Rates after Elective Ligation, INPer/Mexico, 1995.
- Cardiovascular Effects of Endothelins, Tulane/New Orleans, 1991.

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- Honorable Mention, ACP-Ohio, clinical vignette presentations, 11/99.
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- Honorable Mention, graduating class of 1994.
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- General Secretary, medical school technical council, 1990-1991.

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- ECFMG & MD with unrestricted license to practice medicine in Mexico.

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#### **INTERESTS**

- Traveling, classical music, gourmet cuisine, water and snow skiing.

#### **REFERENCES**

- Excellent references furnished upon request.

**CANTON MEDICAL EDUCATION FOUNDATION  
RESIDENT AGREEMENT**

CANTON MEDICAL EDUCATION FOUNDATION (CMEF) and Gerardo Cisneros, M.D., ("Resident") enter into this Residency Position Agreement ("Agreement") in Canton, Ohio, on April 4, 1999.

IN CONSIDERATION OF THE FOLLOWING PROMISES, THE PARTIES AGREE THAT:

1. POSITION: The Resident is accepted into the **Internal Medicine** Training Program as post-graduate year level **3**.
2. QUALIFICATIONS: The housestaff physicians must meet one of the following qualifications for the resident to be eligible for this training program.
  - A.) Graduate of medical school in the United States accredited by the Liaison Committee on Medical Education (LCME).
  - B.) Graduate of a college of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
  - C.) Graduate of medical school outside the United States and Canada who meet one of the following qualifications:
    - (1.) Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates or
    - (2.) Have full and unrestricted license to practice in a U.S. licensing jurisdiction.
  - D.) Graduate of medical school outside the United States and completed a Fifth Pathway program provided by an LCME-accredited medical school.
3. TERM: This Agreement begins on **January 1, 2000** and ends on **December 31, 2000**.
4. RESIDENT'S RESPONSIBILITIES: The Resident shall devote full-time effort in performing satisfactory in all areas of the residency program including, without limitation, demonstrating didactic and clinical competency and displaying appropriate, professional behavior. General responsibilities are outlined in the Resident Physician Manual, which is attached as Exhibit "A" and incorporated by reference. The position of housestaff physician entails provision of care commensurate with the housestaff physician's level of advancement and competence, under the general supervision of appropriately privileged attending teaching staff. This includes:
  - Participation in safe, effective and compassionate patient care;
  - Developing an understanding of ethical, socioeconomic and medical legal issues that affect graduate medical education and how to apply cost containment measures in the provision of patient care;
  - 
  -

000001

- Participation in the educational activities of the training program and, as appropriate, assumption of responsibility for teaching and supervising other residents and students, and participation in institutional orientation and education programs and other activities involving the clinical staff;
- Participation in institutional committees and councils to which the housestaff physician is appointed or invited; and
- Performance of these duties in accordance with the established practices, procedures and policies of the institution, and those of its programs, clinical departments and other institutions to which the housestaff physician is assigned, including, among others, state licensing requirements for physicians in training, where these exist.

The Resident may not assign or delegate any of these responsibilities.

#### 5. PROGRAM RESPONSIBILITIES:

**CMEF** shall offer the Resident a postgraduate training opportunity in a community hospital setting. **CMEF** agrees to provide the Resident the following support, benefits and conditions of employment.

##### A.) Financial Support

The Resident shall receive an annual stipend in the amount of **\$38,600.00**, payable biweekly.

##### B.) Benefits

- 1.) Vacation Policies - See Exhibit A.
- 2.) Professional liability insurance - See Exhibit A.
- 3.) Disability insurance and other hospital and health insurance - See Exhibit A.
- 4.) Professional, parental and sick-leave benefits - See Exhibit A.
- 5.) Counseling, medical, psychological and other support services - See Exhibit A.

##### C.) Other Responsibilities and Policies

- 1.) Conditions under which living quarters, meals and laundry are provided - See Exhibit A.
- 2.) Policy on Outside Employment (Moonlighting) - See Exhibit A.
- 3.) Harassment Policy - See Exhibit A.

##### D.) Resident Evaluations

As the position of housestaff physician involves a combination of supervised, progressively more complex and independent patient evaluation and management functions and formal educational activities, the competence of the housestaff physician is evaluated on a regular basis. The program maintains a confidential record of evaluations.

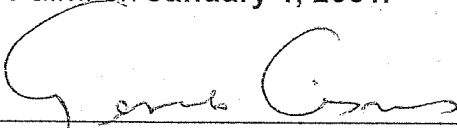
6. CANCELLATION: Continuation and/or renewal of this Agreement is expressly conditioned on satisfactory performance and behavior at all times. Failure by the resident to perform or behave satisfactorily at all times during the term of this Agreement shall be just cause for dismissal of the resident from Internal Medicine Resident Training Program as provided for in Exhibit "B," which is attached and incorporated by reference.

Employment is contingent upon an acceptable pre-employment physical examination including a test for substance abuse. Consistent with the provisions in Exhibit "B", a resident may be immediately suspended if he or she is adversely influenced or impaired by alcohol or substance abuse. By signing this Agreement, the resident agrees that he or she will not, at any time while expected to perform duties prescribed by this Agreement, be under the influence of or be impaired by alcohol and/or substances of abuse. The resident agrees to comply with the provisions of the Alcohol and Substance Abuse Policy found in Exhibit "A".

The resident, upon reasonable notice, may cancel this Agreement at anytime. There shall be no liability for either party in the event of cancellation.

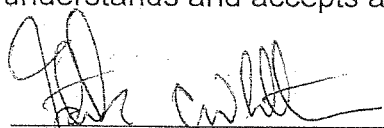
7. ENTIRE AGREEMENT: This Agreement, including Exhibits "A" and "B," represents the entire understanding of the parties and supersedes all other agreements or representations, oral or written. It may not be changed, except in writing and signed by both parties.

This contract is in effect beginning at 8:00 a.m. on **January 1, 2000** and ending at 8:00 a.m. on **January 1, 2001**.

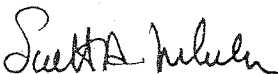
  
Resident

4/7/99  
Date

By signing this Agreement, the Resident acknowledges that he/she has received, read, understands and accepts all terms described in Exhibits "A" and "B."

  
Program Director

4-6-99  
Date

  
Administrator for CMEF

4/12/99  
Date

Attachments: Exhibit "A" - Resident Physician Manual  
Exhibit "B" - Corrective Action

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1. **Immediate Suspension.** Whenever a resident's professional conduct or behavior appears unsatisfactory, deficient, disruptive, not conducive to the Residency Program, or presents the potential of harm or serious disruption to patients or others or substance abuse is involved or any type of harassment, the Program Director, or the Administrator for CMEF or designee, may take immediate action. This action may include immediate suspension of the resident without pay pending further action as described below.
2. **Corrective Action.** If a resident's professional conduct or behavior appears unsatisfactory, deficient, disruptive or not conducive to the Residency Program, the Program Director or the Administrator for CMEF or designee shall request that corrective action be taken by the appropriate steering committee within the resident's individual program.

If the resident's conduct or behavior is illegal or requires reporting to a regulatory agency or licensing board or if the conduct or behavior creates a potential of harm or serious disruption to patients or others or substance abuse is involved or any type of harassment, corrective action shall be taken by a committee of three, two physicians outside of the resident's own training program and the CMEF administrator or designee. The physicians on this committee will be appointed by the Program Director of the Resident's Program and the CMEF Administrator and/or designee.

Formal corrective action may include, but is not limited to, immediate dismissal, suspension, non-renewal of contract, probation, counseling, rehabilitation or other appropriate action. Grounds for corrective action should be described with particularity and supported by evidence. The resident may meet with the Committee. No attorneys shall be present.

Any formal corrective action taken must be communicated in writing to the resident. It may either be hand-delivered to the resident, in which case the resident shall sign a receipt, or sent by certified mail, return receipt required. The notice shall inform the resident of the action and briefly describe the basis for it. It shall also inform the resident of the opportunity to be heard on appeal.

Ordinarily, the corrective action process should take less than thirty days.

3. **Right of Appeal.** The resident, following receipt of a notice of formal corrective action, shall have seven (7) days to request in writing an opportunity to be heard before an independent five member committee, comprised of four physicians and the CMEF administrator or designee, which will serve as an appellate body. The physicians will be appointed by the Chairman and Vice Chairman of the CMEF Board /or designee. The request shall be addressed to the Program Director of the resident's individual residency program. Failure to request an opportunity to be heard within seven days shall operate as a waiver of the right of appeal.

The resident's opportunity to be heard shall be conducted within a mutually convenient time set to give each side a reasonable opportunity to prepare. The Program Director or his designee shall present the position of the Program. The resident shall present himself. No attorneys shall be present. Both sides have the right to present evidence supporting their respective positions, and each side shall have an opportunity to question supporting and opposing witnesses, if any. The proceedings need not be conducted according to technical rules of evidence.

The appellate body may affirm, modify or overturn the corrective action taken, based on the evidence before it. Its decision shall be rendered as soon as practicable after the hearing. The appellate body shall notify the resident in writing of its decision, which decision shall be final.

**CANTON MEDICAL EDUCATION FOUNDATION  
RESIDENT AGREEMENT**

CANTON MEDICAL EDUCATION FOUNDATION (CMEF) and Gerardo Cisneros, M.D., ("Resident") enter into this Residency Position Agreement ("Agreement") in Canton, Ohio, on June 1, 2000.

IN CONSIDERATION OF THE FOLLOWING PROMISES, THE PARTIES AGREE THAT:

1. POSITION: The Resident is accepted into the **Internal Medicine** Training Program as post-graduate year level **4**.
2. QUALIFICATIONS: The housestaff physicians must meet one of the following qualifications for the resident to be eligible for this training program.
  - A.) Graduate of medical school in the United States accredited by the Liaison Committee on Medical Education (LCME).
  - B.) Graduate of a college of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
  - C.) Graduate of medical school outside the United States and Canada who meet one of the following qualifications:
    - (1.) Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates or
    - (2.) Have full and unrestricted license to practice in a U.S. licensing jurisdiction.
  - D.) Graduate of medical school outside the United States and completed a Fifth Pathway program provided by an LCME-accredited medical school.
3. TERM: This Agreement begins on **January 1, 2001** and ends on **December 31, 2001**.
4. RESIDENT'S RESPONSIBILITIES: The Resident shall devote full-time effort in performing satisfactory in all areas of the residency program including, without limitation, demonstrating didactic and clinical competency and displaying appropriate, professional behavior. General responsibilities are outlined in the Resident Physician Manual, which is attached as Exhibit "A" and incorporated by reference. The position of housestaff physician entails provision of care commensurate with the housestaff physician's level of advancement and competence, under the general supervision of appropriately privileged attending teaching staff. This includes:
  - Participation in safe, effective and compassionate patient care;
  - Developing an understanding of ethical, socioeconomic and medical legal issues that affect graduate medical education and how to apply cost containment measures in the provision of patient care;
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- Participation in the educational activities of the training program and, as appropriate, assumption of responsibility for teaching and supervising other residents and students, and participation in institutional orientation and education programs and other activities involving the clinical staff;
- Participation in institutional committees and councils to which the housestaff physician is appointed or invited; and
- Performance of these duties in accordance with the established practices, procedures and policies of the institution, and those of its programs, clinical departments and other institutions to which the housestaff physician is assigned, including, among others, state licensing requirements for physicians in training, where these exist.

The Resident may not assign or delegate any of these responsibilities.

#### 5. PROGRAM RESPONSIBILITIES:

**CMEF** shall offer the Resident a postgraduate training opportunity in a community hospital setting. **CMEF** agrees to provide the Resident the following support, benefits and conditions of employment.

##### A.) Financial Support

The Resident shall receive an annual stipend in the amount of \$40,900.00, payable biweekly.

##### B.) Benefits

- 1.) Vacation Policies - See Exhibit A.
- 2.) Professional liability insurance - See Exhibit A.
- 3.) Disability insurance and other hospital and health insurance - See Exhibit A.
- 4.) Professional, parental and sick-leave benefits - See Exhibit A.
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##### C.) Other Responsibilities and Policies

- 1.) Conditions under which living quarters, meals and laundry are provided - See Exhibit A.
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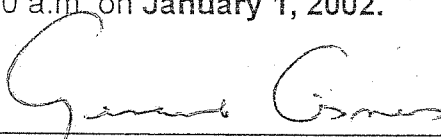
6. CANCELLATION: Continuation and/or renewal of this Agreement is expressly conditioned on satisfactory performance and behavior at all times. Failure by the resident to perform or behave satisfactorily at all times during the term of this Agreement shall be just cause for dismissal of the resident from Internal Medicine Resident Training Program as provided for in Exhibit "B," which is attached and incorporated by reference.

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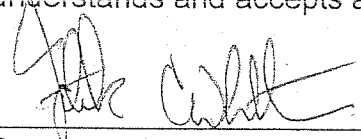
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This contract is in effect beginning at 8:00 a.m. on **January 1, 2001** and ending at 8:00 a.m. on **January 1, 2002**.

  
Resident \_\_\_\_\_ Date 6/15/00

By signing this Agreement, the Resident acknowledges that he/she has received, read, understands and accepts all terms described in Exhibits "A" and "B."

  
Program Director \_\_\_\_\_ Date 6-15-00

  
Administrator for CMEF \_\_\_\_\_ Date 6/5/2000

Attachments: Exhibit "A" - Resident Physician Manual  
Exhibit "B" - Corrective Action

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## Exhibit B

## CORRECTIVE ACTION

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