THE COURT OF COMMON PLEAS

STARK COUNTY, OHIO

MICHELLE OWENS,

Plaintiff,

-vs-

JUDGE REINBOLD
CASE NO. 2003CV00635

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

Defendants.

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

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W I T N E S S I N D E X

E X H I B I T I N D E X

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

CROSS-EXAMINATION OF GERARDO CISNEROS, M.D.

BY MS. KOLIS:

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

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

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

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

A. No.
Q. Ground rules are pretty simple. I'm sure your attorney has given you some advice in that regard but I will state for the record what my deposition rules are.

Are you aware, doctor, that you are required to answer each and every question orally?
A. Yes.
Q. And the reason I ask that, I think I tend to get very conversational in depositions and then that sort of makes the witness nod their head. She can't take down nods, shakes or anything else. She needs words, so we'll try to stay that way so that Pam can get your testimony.

I have your agreement on that?
A. Yes, you do.
Q. I assume that you, that you understand that you are under oath today just as if you were in a court of law?
A. I do.
Q. I don't know, but I'm soon going to find out what your current professional responsibilities are; but if you receive a page or something where you actually have a medical situation that you need to attend to, you just need to tell us that

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

A. Yes, certainly.

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

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

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

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

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

A. Yes, I do.

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

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

Can I secure that agreement from you?

A. Yes.

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

A. Yes.

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

A. Yes, that is correct.

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

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

A. July 12th, 1968.
Q. Your Social Security number?
A. 624-66-7220.
Q. Do you know your Ohio State medical license number, and if you have something in your pocket that can refresh your memory, that's fine to use.
A. You're asking the State Medical Board of Ohio?
Q. Yes.
A. 35-07-6345 letter C as in cat.
Q. I assume that that medical license is current?
A. Yes.
Q. Do you have a license to practice medicine in any other state other than Ohio?
A. No.
Q. You received your medical license in what year?
A. In, I'm not certain about this.
Q. If I guess somewhere around 1997 or '98, does that sound -- it doesn't matter if you don't specifically remember.
A. Well, the thing is that you have a license, multiple licenses as a resident and then you have the current one which happened before I graduated or finished the residency in my chief residency year, so I believe it was '99 but I'm not --
Q. Based upon the limited ability that I have to

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

A. It is correct.

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

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

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

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

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

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

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

correct?

A. Yes.

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

A. No.

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

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

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

A. Yes.

Q. And that was at Aultman Hospital?

A. Yes.

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

A. Yes.

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

Explain to me what that program is.

A. That's a residency program that is affiliated with NEOUCOM and it is based out of Canton. There are two hospitals, Aultman Hospital and Mercy Medical Center, and you are trained during a period of three years in internal medicine.

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

Do you recall those contracts?

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

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

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

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

A. Yes.

Q. Did you then immediately begin --

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. Yes.

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

A. That's right.

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

A. I don't remember.

Q. Would you have received an evaluation from each

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

A. Yes.

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

A. Yes.

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

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

A. I don't remember.

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

A. I don't remember.

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

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

publication now?
A. Yes.
Q. It has been accepted?
A. It has been accepted and I'm not the first author; but, yes, it has been accepted.
Q. Who accepted it for publication?
A. Annals of Internal Medicine.
Q. Who's the primary author?
A. Dr. Luis Lara.
Q. Can you spell that last name for me?
A. L-A-R-A.
Q. Do you have any other papers which you have worked on since the presentation of this curriculum vitae to me that may be in press at some point?
A. No.
Q. Are you doing any independent research in your current practice?
A. No.
Q. What is your current practice of medicine? Tell me what you're doing.
A. General internal medicine.
Q. Where are you doing that?
A. In Canton.
Q. Are you by yourself or are you in a group?

A. A group.
Q. What is your group name?
A. Mercy Professional Care Corporation.
Q. How many people are members of that group, estimate?
A. Five primary care physicians.
Q. Are you a shareholder or a partner in that organization or just an employee?
A. An employee.
Q. When did you become employed with that group?
A. December 1st, 2001.
Q. Hospital privileges at which hospitals?
A. Mercy Medical Center only.
Q. Generally speaking, people hate when I ask this, what is the nature of your practice?
A. I see, I'm a primary care physician for people of ages 12 or older.
Q. So you don't take care of the younger pediatric population. You take them 12 and up?
A. Yes.
Q. That's sort of your niche in the practice?
A. I do have to add, though, that I also do work at the StatCare that Mercy has in different locations in Stark and Carroll and Tuscarawas County on occasion as they need me and I do see

children there.

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

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

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

A. Yes.

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

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

Q. How frequently do you do that?

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

Q. Do you and your coworkers share that responsibility?

A. No.

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

A. Yes.

Q. How did you come to take on that responsibility?
A. Because I have been doing that kind of work since I was a resident that I was given, that I actually obtained my license to practice in the State of Ohio as what they call moonlighting and since then, I started my practice, I really, I'm concentrating more on my own office, which is my important, my most important interest I have; but because of occasional shortage of personnel, they know that I've done this work before and that I'm willing to do it.

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

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

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

A. Yes.
Q. When did you pass your internal medicine boards?
A. In 2001.
Q. Was that your first attempt to pass the board?
A. Yes.
Q. Are you at present preparing for or anticipating any subspecialty of internal medicine?
A. No.
Q. Going back to, I guess this is the easy place to do it, my reading of medical records indicates to me that Michelle Owens came under your care in the summer of 1999. Is that your recollection?
A. That's my recollection.
Q. That would have been your PGY year 2, correct?
A. Correct.
Q. And at that point you were seeing her in a clinic at Aultman Hospital; is that right?
A. Correct.
Q. Explain to me the nature of the services that you were providing in the clinic at Aultman Hospital during, beginning with June of 1999?
MR. MILLIGAN: For this patient or generally?
Q. No, just in general what services were you providing as a resident?

A. Okay. You are the patient's primary care physician.
Q. Explain that to me. When you say you are the patient's primary care physician, what do you mean when you tell me that?
A. Well, you are treating them as an internist under the supervision of an attending physician and that clinic is intended to give you the experience in treating patients on the outpatient basis that otherwise you wouldn't get because you're seeing patients, most inpatients at the hospitals.
Q. So as opposed to, let's say treating a person as an internal medicine physician because they've come to the hospital for a catastrophic accident, this clinic is actually a family care clinic where they receive office visits from the same primary care physician. Am I explaining it correctly?
A. Yes. Yes. The difference is internal medicine you see children as opposed to a family practitioner, so we are family physicians for adults or for older, you know, teenagers.
Q. We're going to go probably, unfortunately have to go through visit by visit, but I usually get to

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

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

A. Yes.

Q. Who did you receive your paychecks from?

A. Canton Medical Foundation.

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

A. Physically?

Q. Yes.

A. Correct.

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

When you write those in your medical notes,

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

A. Yes.

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

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

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

A. No, I'm not certain.

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

A. Correct.

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

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

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

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

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

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

A. I don't remember the exact date.

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

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

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

A. Yes.

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

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

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

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

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

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

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

Medicine Clinic?

A. Yes.

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

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

Q. It was later?

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

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

A. No.

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

A. The charts and some medical literature.

Q. Let's talk first about the charts.

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

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

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

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

A. No.
Q. So you've only read the Aultman Hospital chart?
A. To my knowledge, yes, because sometimes when you review other physician's records, they might be something from other hospital and I'm not aware of having seen anything like that.
Q. And then you said you reviewed other physicians' records. Can you with specificity tell me what physicians' records you've read?
A. I remember reviewing Dr. Weeman's.
Q. Do you know Dr. Weeman?
A. Yes, I do.
Q. Are you working, I don't want to say working with her. Do you have professional interaction with Dr. Weeman at this point?
A. No.
Q. And that's because she's with Aultman, correct?
A. As far as I know, yes.
Q. Who else did you look at? I mean what other physicians' records did you review?
A. I don't remember the names of the physicians but I remember seeing another hematologist and I don't remember the names of the other physicians that I reviewed.
Q. Doctor, when you sat for your internal medicine

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

A. Yes.

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

A. For the boards, no.

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

A. The med study and the MKSAP.

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

A. For the boards, yes.

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

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

A. Yes.

Q. Doctor, tell me what thrombocytosis is.

A. Elevation of number of platelets in blood.

Q. Platelets being one of the three components of

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

A. Yes.

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

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

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

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

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

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

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

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

saying are different?
A. That some labs report norms to be a certain range and some other labs report the norms to be another range.
Q. Doctor, wouldn't you agree with me that as part and parcel of your educational process in internal medicine that there are clearly defined parameters for the normal range for platelet counts?
A. I don't agree.
Q. You don't? Go ahead.
A. I don't agree with that statement.
Q. Are you going to disagree with the statement that a normal platelet range can be between 140 and 450, that that's generally accepted as the range for platelets?
A. Yes. You know, the reason why I'm saying that I don't want to mention a number is because it may vary; but, yes, although I don't want to mention a specific number because I don't want to say something that is incorrect, but I would agree that 140 to 450 sounds like the range that, with certain limits across the board, could be used as normal, yes.
Q. Just so we establish a baseline, a platelet count

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

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

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

A. For a certain individual, for example.

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

A. Of 20,000?

Q. Yes.

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

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

A. Of 20,000, certainly, yes.

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

A. In what setting?
Q. In the setting of an incidental finding that came back from a blood result. If you saw a platelet count of 725, what would you do?
A. I would probably, like I said before, take into consideration the patient's physical findings and medical history to see if that number is a number that is going to help me come up or look, find a diagnosis or establish a diagnosis or that is, there's an explanation for that number, or if it is or if it's not, 700,000 platelets is not by itself -- they'll mean one thing or another -- it doesn't tell me, doesn't mean a lot by itself or it doesn't mean, it doesn't mean a diagnosis other than thrombocytosis.
Q. So if you saw someone today, we're just going to use the number 725, 725,000 as a platelet count, you wouldn't call a hematologist?
A. No. I wouldn't do it the first thing.
Q. In terms of your knowledge as an internal medicine physician in the summer of 1999, what would you have believed to be the main danger in a person having too many platelets?
A. At that point I would see that as a sign of, there is, there's an acute phase reactant.

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

Q. So you're talking about reactive thrombocytosis?

A. Yes.

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

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

A. Yes, I am aware of the risks.

Q. Can you tell me what those risks are?

A. Bleeding or thrombosis.

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

A. An elevation above a million, yes.

Q. Is it your testimony that only when the elevation is above a million that those three consequences are possible?
A. No, but more commonly.
Q. Well, when you say more commonly, that doesn't mean that a person who has an elevated platelet count of 725 cannot experience stroke, blood clots or myocardial infarction because of that elevation, does it?
A. Correct. But a person with 300,000 platelets can also have a clot or a myocardial infarction so the number itself doesn't necessarily mean or is not a predictive factor.
Q. I appreciate your statements on that but, once again, that wasn't responsive to what I was asking you so let me ask you some different questions.

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

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

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

have to investigate the cause of the thrombocytosis?

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

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

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

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

A. I don't understand the question.

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

A. Yes, I was aware.

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

A. I'd have to see the record.

Q. Take a look at your record.

A. What date is that?

MR. MILLIGAN: Do you have a page number?

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

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

MR. MILLIGAN: July 21.

Q. July 21st, 1999.

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

A. Let me just read it.

Can you repeat the question?

Q. Sure, doctor.

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

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

A. Yes, I do.

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

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

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

A. What was that?

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

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

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

A. Yes.

Q. Wasn't your ESR negative?

A. It was 1.

Q. Meaning what to you?

A. That it was not elevated.

Q. Correct. So that excluded an inflammatory cause

for an increase in the platelets, didn't it?
A. No.
Q. Why didn't it?
A. Because an ESR of 1 does not exclude anything.
Q. Well, it didn't help you to confirm that she might have been experiencing a reactive thrombocytosis, did it?
A. No, it didn't. It didn't help me.
Q. As a matter of fact, doctor, there's absolutely no mention in your assessment of this patient on your first visit of July 21st, 1999 of any potential hematological problem. Is that a fair statement?
A. Yes.
Q. You didn't at any point between July of 1999 and August of 2002 consider referring Michelle to a hematologist. Is that also a fair statement?
A. Yes.
Q. Do you know, doctor, what some of the physical signs of essential thrombocytosis are in a patient?
A. Yes, I do.
Q. Would you like to tell me what those are?
A. People can have hemorrhagic or thrombotic events.
Q. Well, tell me what you mean by hemorrhagic or

thrombotic events.

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

Q. A GI bleed?

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

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

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

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

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

A. Yes.

Q. Pulmonary embolus?

A. Yes.

Q. Myocardial infarction?

A. Yes.

Q. Cerebrovascular accidents?

A. Yes.

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

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

A. Yes.

Q. Headaches?

A. It has been described, yes.

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

A. Yes.

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

A. Yes.

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

A. I don't remember.

MR. MILLIGAN: Seeing?

Q. Prior to the time you were seeing Michelle?

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

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

this is clearly written about in the internal medicine literature.

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

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

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

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

A. Yes, I'm aware.

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

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

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

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

I remember reviewing.
Q. The Internet's a big vast place. What search engine did you use when you went to input your information?
A. PopMed.
Q. Do you know what search words you used?
A. Thrombocytosis.
Q. Do you know what the names of the articles were that you reviewed?
A. No.
Q. Did you print what you reviewed?
A. No.
Q. During the time that Michelle was under your care and treatment, did she not complain to you about headaches?
A. She did.
Q. Those headaches at different points were listed as etiology unknown, would you agree with that?
A. Yes.
Q. At one point you listed that they were believed to be migraines; is that correct?
A. Yes.
Q. You based that belief on what?
A. Previous history.
Q. Define for me, if you will, what constitutes a

migraine headache?

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

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

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

A. I agree.

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

A. I don't remember those details.

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

A. I need to go back.

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

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

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

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

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

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

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

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

A. Yes.

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

A. No.

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

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.)

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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?

A. Usually I don't, but I have done it before.
Q. But generally speaking, that's your custom is to, as you're with the patient, hand write the notes, correct?
A. No, I don't write as -- as soon as I finish the patient, I write, I walk out of the room and I write some things and then I dictate.
Q. It appears to me, doctor, and you tell me, in your handwritten portion for that first visit with her, your number one plan was get the ESR, right, and you drew, had a blood draw for that, right? Then you had the second thing you wanted her to have an ophthalmologist consult, correct?
A. Yes.
Q. Because you were concerned about visual disturbances, correct?
A. Okay.
Q. And then is that occupational therapy consult? I'm sorry. It probably is?
A. Yes, it is.
Q. And you wanted her to have an OT consult because she was exhibiting bilateral leg pain; is that right?
A. No. I was doing that because she was asking for disability medical coverage and I didn't know the

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

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

A. Yes.

Q. And that's your dictated note?

A. Yes.

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

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

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

discussing with you?
A. No, I don't.
Q. Doctor, number four of your assessment and plan in your typewritten session indicates that you are going to prescribe Flexeril as well as Tylenol for pain.

Which pain were you trying to address with Flexeril and Tylenol?
A. The leg pain.
Q. So you didn't disbelieve that Michelle Owens was experiencing bilateral leg pain, correct?
A. Oh, no, definitely.
Q. And in fact, you were going to medicate her for the same?
A. Yes.
Q. Would the administration of Flexeril or Tylenol have any effect on a person's headaches?
A. Yes.
Q. So taking new medications might relieve a headache that a person had already established; is that right?
A. Yes.
Q. Number five, what you were doing, and you correct me if I'm wrong, it says increased cholesterol and LDL of 143. You were referring back, were

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

A. Well, let me see.

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

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

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

A. I believe so.

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

Were you concerned with that number at all?

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

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

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

A. Uh-huh.
Q. And in that sentence you also indicate the patient has no other risk factors for coronary artery disease?
A. Yes, I do.
Q. As of July 21st, 1999 based upon the history that you had taken from this patient and the physical exam you performed, you believed that she had no other factors for coronary artery disease; is that right?
A. That's what I wrote, yes.
Q. Was Michelle Owens a smoker?
A. Yes.
Q. And that wasn't a risk factor for coronary artery disease in your opinion?
A. Yes, it is.
Q. You didn't include that in your --
A. You're right.
Q. I'm just asking. That's what I do is I ask questions.

Would you at this point say that that was an incorrect statement --
A. Yes.
Q. -- at the time that you put it into your medical note?

A. Yes.
Q. Would you say that a person who has an elevated platelet count of unknown etiology might also be at risk for coronary artery disease?
A. Yes, but it's not a major risk factor for coronary artery disease.
Q. It is, however, an increased risk factor for coronary artery disease; is it not?
A. About -- yes. The answer is yes.
Q. Thank you. And the last concern that you had that you discussed was premenstrual syndrome, correct?
A. Uh-huh.
Q. Now, at the end of that note, and I --
A. I want to say something, 645,000 is not, to my knowledge, an increased risk factor for myocardial infarction.
Q. The question I asked you was --
A. Coronary artery disease.
Q. -- high platelets of unknown etiology, 645,000 is an increased risk factor for coronary artery disease. Do you agree with that?
A. For coronary artery disease?
Q. Yes.
A. No.

Q. You don't believe that increased platelets that go unaddressed cause or contribute to coronary artery disease?
A. 645,000?
Q. Yes.
A. No.
Q. Your own reference laboratory at Aultman Hospital listed 645 as high; did they not?
A. Yes.
Q. At the end of your note, you indicate patient was seen and discussed with Dr. Johnson?
A. Yes.
Q. This is a situation once again, so that the record is perfectly clear, Dr. Johnson didn't come in and consult with the patient?
A. I don't remember that because at the beginning of your residency, they do more than they do after.
Q. But I thought you told me that you already had a lot of experience because you were in the transitional program?
A. I wouldn't say a lot of experience but I had been doing the clinic for six months before July 1st, 1999 and the attendings at the beginning during the first year of residency are more actively involved in seeing the patients than,

particularly Dr. Johnson, as well.
Q. So that I'm clear, based upon the way you wrote this, you don't know if Dr. Johnson saw Michelle that day or not?
A. Correct.
Q. Is it the habit and custom or the practice of the Internal Medicine Clinic to always have the attending sign off under the resident?
A. Yes.
Q. Whether they see them or not, they review your note and they sign off?
A. Yes.
Q. If I am reading my charts correctly, the next visit that you --
A. I do want to add something that if I write seen and discussed with so and so, that it means that I saw the patient with the attending.
Q. I'll just ask, you may or may not know the answer to it but I can ask it this way: If Michelle Owens says that the first time that she saw you, you were the only physician she met with, is she wrong or do you not know whether she's wrong?
A. I don't know.
Q. There. That's good enough. If you can mark this one Plaintiff's Exhibit C, we're going to go on

to the office visit of September 8th, 1999.

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

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

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

A. Yes.

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

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

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

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

Q. So that's what your assessment was.

Your plan was what?

A. Can you repeat the question?

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

A. Oh.

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

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

A. To read the dictated note?

Q. No, read what your handwritten plan was.

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

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

A. Yes.

Q. Go ahead.

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

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

A. Yes.

Q. I mean dictate your office note?

A. Yes.

Q. At this particular visit, it looks like she's had increased complaints of bilateral hip pain; is that right?
A. Yes.
Q. What else was I going to ask you about. It says the patient is also, also was seen by ophthalmologist who told her her blurred vision was related to migraine episodes and you concurred with that fact that those were migraines?
A. Yes.
Q. But no treatment was indicated for that --
A. Before that she had been treated with Zomig.
Q. I just wanted to finish the sentence.
Did you think she needed treatment for her headaches?
A. No. Number four says migraine headaches currently improved. Will not treat with any medication at the present time.
Q. Fair enough. At this point your assessment/plan, and I'm looking at your type, it says bilateral hip pain, uncertain etiology, and I then skip to where it says also the ESR was ordered and reported as one ml per hour.
Now, going back to when I said to you

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

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

A. Yes.

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

A. Nothing.

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

A. Yes.

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

A. I don't remember.

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

September visit?

MR. MILLIGAN: Give him the Bates number.

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

A. Yes.

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

A. Yes.

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

A. 725,000.

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

A. Yes.

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

A. Yes. My initials, yes.

Q. That is your initials at the bottom?

A. Yes.

Q. That this is a high platelet count?
A. Yes.
Q. Do you agree with that?
A. Yes.

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

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

- - - -

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

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

A. Yes.
Q. Let's go down the side.

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

A. Yes.
Q. Am I correct?
A. Yes.
Q. Doctor, please tell me why you had a concern that Michelle Owens had endocarditis?

A. Let me read my note.
Q. Well, I was going to ask you about that next.

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

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

Have you seen that note?

A. I don't remember seeing it.
Q. So that the record is clear, if you want to take five minutes -- I can walk down the hall -- look through what you have.

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

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

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

records.

MS. KOLIS: That's all I have.

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

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

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

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

A. Yes.

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

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

those things, so I probably did.

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

You have rule out endocarditis and underneath that is depression.

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

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(Off the record.)

- - - -

Q. Were you able to find anything?

A. No.

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

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

MS. KOLIS: Off the record.

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

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

want to look at this a little bit.

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

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

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

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

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

A. To my knowledge, she wasn't.

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

A. Yeah.

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

A. Uh-huh.

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

particular day that she might be suffering from endocarditis?

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

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

A. No.

Q. You don't remember that at all?

A. No.

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

A. No, I don't remember.

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

A. I don't recall.

Q. You don't recall that?

A. I don't recall that.

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

A. Uh-huh.

Q. You wanted what else?

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

Triponin I, CK/MB.

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

A. Yes.

Q. If you could, they're a little bit out of range. If you go to Bates stamp 84, this is part of the chemistry profile that you ordered, correct?

A. Yes.

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

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

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

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

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

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

A. Yes.

Q. You ordered a chem profile?

A. Yes.

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

A. No, it didn't.

Q. She had high glucose. And it wasn't that high but it was a little out of the reference range. What if anything did you make of that?
A. Nothing because it was at 5:45 p.m. and it was not fasting.
Q. And her BUN was slightly elevated, her BUN/creatinine ratio at that time?
A. The BUN/creatinine ratio, yes, was, according to that range back to me. That means nothing. BUN was normal. Creatinine was normal.
Q. Just asking. They reference it as high and I was wondering how that played into what your diagnosis was. They also did the CK/MB, correct?
MR. MILLIGAN: What number is that?
Q. I'm sorry, that's, believe it or not, all the way over at Page 100 of a Bates stamp.
A. Yes.
Q. Now, why would you have ordered a CK/MB?
A. When there is breakage of muscle of the heart by endocarditis, sometimes you can see an elevation of CK/MB.
Q. Where else can you see a CK/MB?
A. In a myocardial infarction.
Q. Does that help to refresh your recollection at

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

A. No, it does not.

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

A. Uh-huh.

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

A. Yes, it is.

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

MR. MILLIGAN: Do you remember?

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

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

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

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

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

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

A. That's something I remember.

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

A. Yes.

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

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

MR. MILLIGAN: 34.

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

of the day.

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

She was earlier that day, and I'm assuming you meant 1/19, 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 the clinic to be evaluated for this.

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

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

A. Erythematous.

Q. Sort of reddish; is that right?

A. Yes.

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

that, you started thinking endocarditis because you were concerned about a thrombolic event, correct?

A. Yes.

Q. High platelets can cause thrombolic and thrombolytic events, can they not?

A. Yes, they can.

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

A. Yes.

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

A. I'm sorry, repeat the question.

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

A. Yes.

Q. And you know that elevated platelets can cause thrombolic events?

A. Yes.

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

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

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

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

A. Yes.

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

A. No. You're correct about that.

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

A. I do.

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

A. No, they don't.

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

was noted in the previous evaluation.

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

A. No, it isn't.

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

A. Yes.

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

A. Yes.

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

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

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

A. Yes.

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

A. A foreign object was one. An injury.

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

they?
A. Yes.
Q. You had Michelle do a number of things, correct?
A. Yes.
Q. You had the venous duplex done, correct?
A. I believe so, but I don't remember exactly what the end result of that.
Q. Well, when they did the duplex study, do you recall that she did not have any circulatory difficulty?
A. I don't recall that.
Q. Doctor, did you ever get this patient an echocardiogram?
A. I mention on the 1/25 that I was going to obtain the echocardiogram. Hold on, I don't recall if it came back.
Q. Nor do I ever remember seeing a note, and you can correct me if I am wrong. I do not see a note that it was actually scheduled at any time or that Michelle cancelled one. Would you agree with that?
A. Yes.
Q. Michelle Owens, in fact, seemed to do exactly what you told her to do. Would you agree with that?

A. Say that again.
Q. Do you think Michelle Owens was a compliant patient while she was under your care?
A. Not 100 percent.
Q. What kinds of things didn't she comply with?
A. She didn't go and see Dr. Coggins.
Q. Who was a --
A. Orthopedic doctor that I advised her to see for excruciating hip pain.
Q. Ultimately, did her failure to see the orthopedist have anything to do with her myocardial infarction that she had in August of 2000?
A. I don't think so.
Q. Doctor, as you sit here today, obviously you've had an opportunity to review the records --
A. Yes.
Q. -- of July and August, and I think early September, 2000 from Aultman, correct?
A. Yes.
Q. Do you, doctor, have an opinion and will you be rendering an opinion at trial as to the cause of Michelle Owens' myocardial infarction?
A. I don't know if I understand. Are you saying that do I know what caused the myocardial

infarction?

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

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

A. Yes, I do.

Q. -- that Michelle had --

A. I do.

Q. -- in August of 2000?

A. I do.

Q. What is your opinion, doctor?

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

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

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

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

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

Q. You can.

MR. MILLIGAN: Is it in there?

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

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

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

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

A. Yes.

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

A. Yes.

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

A. A PCA, yes.

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

Do you have an understanding of how

thrombocytosis contributes to coronary artery disease?

A. Yes.

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

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

A. No, I can't.

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

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

MR. MILLIGAN: Sure.

- - - -

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

- - - -

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

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

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

MR. MILLIGAN: Yes.

We'll read.

_____

GERARDO CISNEROS, M.D.

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

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 stipulation of counsel; and 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 25th day of August A.D. 2003.

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

WORD INDEX

C

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

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.
- Fourth Year Chief Resident, NEOUCOM/Canton Affiliated Hospitals, 01-11/01.
- 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

- 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 IM 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.
- General Secretary, medical school technical council, 1990-1991.

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.

0161

CL 000

INSTRUCTIONS TO PATIENT	AULTMAN HOSPITAL AMBULATORY CLINIC INTERNAL MEDICINE	CL 000241064-9992 WOO, MICHELE L DR.GYN, CLINIC 33 F 10/02/65
Bring all medicines every visit. Return to Ambulatory Care Clinic on ______ at ______ am/pm		

MEDICATION	No.	SIGNATURE	Ref.	Rx. Number
PREVACID 30mg	30	T PO QD	0	
FLEXERIL 10mg	30	T PO QHS		

DATE 7/21/99 SIGNATURE [signature] M.D.

D.A.W. ☐ D.E.A.

W.P. ... 7-21-99

DATE

VITAL SIGNS: T B/P 130/80 P 80 R WT 173

SUBJECTIVE

Dr Congeni July 29 12:50

OBJECTIVE

PLAINTIFF'S EXHIBIT 15 8/12/03

PENGAD-Bayonne, N. J.

ASSESSMENT	PLAN
(1) GASTRITIS	(1) ESR, NOW drawn CR
(2) PMS	(2) OPHTALMOLOGIST CONSULT: PLEASE SEND COPY OF TODAY'S DICTATION AS LETTER OF REFERRAL
(4) VISUAL DIST OF ? ETIOLOGY	(3) OT CONSULT: EVAL FUNCTIONAL CAPACITY (SEND COPY OF DICTATION AS LETTER OF REF TODAY)
(1) OPHTALMOLOGIST Consult	we will call
(2) OT Consult	
(3) RTC 1	RTC 1 MONTH

SIGNATURE [signature]

000034

Form 1362

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 a 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.

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

Plfs C
8/12/03

INSTRUCTIONS TO PATIENT	AULTMAN HOSPITAL AMBULATORY CLINIC INTERNAL MEDICINE	Owens, Michele 241064
Bring all medicines every visit. Return to Ambulatory Care Clinic		
on		
at am/pm		

	MEDICATION	No.	SIGNATURE	Ref.	Rx. Number
	Celebrex 200mg	30	i po QD	2	
RHG					

DATE 9/8/99 SIGNATURE M.D.

D.A.W. ☐ D.E.A.

DATE 9-8-99

VITAL SIGNS: T B/P 122/80 P 68 R WT 174

SUBJECTIVE

OBJECTIVE

ASSESSMENT

1. B/LAT HIP PAIN ? ETIOLOGY

PLAN

1. CONSULT DR. COGGINS RE: (B) HIP & BACK PAIN. SEND COPY OF TODAY'S DICTATION AS LETTER OF REFERRAL

Consult c Dr Coggins Re: Hip & back pain 10-4-99 1:30PM

2. (A) LAT LUMBAR SPINE X-RAYS (B) HIP X RAYS → (A) give pt mail

schedule x-ray of lumbar spine 9-15-99 10:15 AM
Both hips x ray
(1) (2) #454-2076 or 455-2004 (Coordinator) (call pt c appt for x-rays only mail others)

RTC 1-2 months c Cisneros

RTC 1-2 MONTHS 11-27-99

SIGNATURE 9-8-99

000062

Form 1382 D:3/94

OWENS, MICHELLE 241064 09/08/99

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.

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

AHs D

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

Patient name: **OWENS, MICHELE**

Location: OUT PATIENT
Adm.date: 01/19/00

M.R.N.: 000777288 Room:
Billing no.: 0007772880019
Att.physician: CISNEROS, GERARDO
DOB: 10/02/1965 Age: 34 Sex: F

Order Id : 37191461
Date&Time Ordered: 01/19/00 18:08
Req. physician: **CISNEROS, GERARDO, MD**
Copy to: **CISNEROS, GERARDO, MD**

FINAL
ROUTINE 01/19/00

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

HEMATOLOGY

TEST-NAME	RESULT	AB	REF-RANGE	UNITS
HEMOGRAM				
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

INSTRUCTIONS TO PATIENT	AULTMAN HOSPITAL AMBULATORY CLINIC INTERNAL MEDICINE	241041-0602 Owens Michele
Bring all medicines every visit. Return to Ambulatory Care Clinic		
on		
at am/pm		

MEDICATION	No.	SIGNATURE	Ref.	Rx. Number
Zoloft 100mg	30	1 PO QD	1	
Axid ... 875 mg	28	1 PO BID	1	
[illegible]	30	1 PO Q 8h	1	

Rx GIVEN

DATE ____ SIGNATURE ____ M.D.

D.A.W. ☐ 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 — Hc INST
DEPRESSION	(2) CMP, CBC c DIFF, APTT/PT, ESR NOW — Hc INST; + TROPONIN I & CK/MB
RTC 1-25-00 10A c Cisneros	(3) LOWER EXT DUPLEX OF ARTERIAL CIRC
1-21 11:15AM M-MODE	(4) 2-D M-MODE ECHO c COLOR FLOW — INST GIVEN; CARDIOLOGY ASSOC TO READ ASAP Re: R/O VEGETATION
Sched 2-D c COLOR FLOW ECHO CARDIOLOGY	(5) ECG NOW DONE 1-24 7:30 AM ... OF ARTERIAL CIRC

RTC 1/25/00 @ 10:00 AM SIGNATURE

000058

Form 1262 R-3/94

012500

INSTRUCTIONS TO PATIENT	
Bring all medicines every visit. Return to Ambulatory Care Clinic	AULTMAN HOSPITAL AMBULATORY CLINIC INTERNAL MEDICINE
on	CL 000241064-9992 OWENS, MICHELE L DR. MEDICAL, CL 34 F 10/02/65
at am/pm	

MEDICATION	No.	SIGNATURE	Ref.	Rx. Number

DATE ______ SIGNATURE ______ M.D.

D.A.W. ☐ D.E.A. ______

Dr Cisneros

DATE 1-25-00

VITAL SIGNS: T B/P 130/80 P 72 R WT 173

SUBJECTIVE

OBJECTIVE

ASSESSMENT	PLAN
① DEPRESSION/ANX	① 2-D M MODE ECHOCARDIOGRAM c̄ COLOR FLOW Re: R/O VALVULAR DISEASE — was scheduled
② BACK PAIN 2-15 10:15 AM	② CANCEL DUPPLEX (ARTERIAL)
① Cancel Dupplex (arterial)	③ PREGNANCY TEST (SERUM) NOW sent
	④ UA / C&S (NOW) sent
② RTC 2-2 2PM next available Wed	NEXT AVAILABLE WED. (NOT PRE-ADDED ON)

RTC SIGNATURE

000055

OWENS, MICHELLE 241064 01/25/00

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

PAGE	LINE	

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

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.
- Fourth Year Chief Resident, NEOUCOM/Canton Affiliated Hospitals, 01-11/01.
- 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

- 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.
- 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.
- General Secretary, medical school technical council, 1990-1991.

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.

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;
   -
   -

- 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 — Date: 4/7/99

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: 4-6-99

Administrator for CMEF — Date: 4/12/99

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

Exhibit B

CORRECTIVE ACTION

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;
   -
   -

- 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.
5.) Counseling, medical, psychological and other support services - See Exhibit A.

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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, 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: 6/15/2000

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

Exhibit B

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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.