State of Ohio, )
)
County of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

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THE ESTATE OF JOHN TUBER-SMITH,

Plaintiff,

vs. Case No. 439531

METROHEALTH MEDICAL CENTER,

Defendant.

- - -

DEPOSITION OF RITA K. CYDULKA, M.D.
Wednesday, November 28, 2001

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The deposition of RITA K. CYDULKA, M.D., an employee of the Defendant MetroHealth Medical Center, called for examination by the Plaintiff under the Ohio Rules of Civil Procedure, taken before me, Diane M. Stevenson, a Registered Merit Reporter, Certified Realtime Reporter, and Notary Public in and for the state of Ohio, by agreement of counsel, at MetroHealth Medical Center, Cleveland, Ohio, commencing at 11:40 a.m., the day and date above set forth.

APPEARANCES:

On behalf of the Plaintiff:

Francis E. Sweeney, Jr., Esq.
323 Lakeside Avenue, Suite 450
Cleveland, Ohio 44113

On behalf of the Defendant:

James L. Malone, Esq.
Reminger & Reminger Co., LPA
113 St. Clair Avenue, NE, 7th Floor
Cleveland, Ohio 44114-1273

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MR. SWEENEY: Excuse me, I have a cold today, so if I sniffle, I apologize.

MR. MALONE: We would like to find a doctor for you, but I don't know if we will.

MR. SWEENEY: That is understandable considering my capacity here today.

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RITA K. CYDULKA, M.D.

An employee of the Defendant MetroHealth Medical Center, called for examination by the Plaintiff under the Rules, having been first duly sworn, as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION

BY MR. SWEENEY:

Q. Hello. We just met. My name is Francis Sweeney. I represent the estate of John Tuber-Smith in regards to a medical malpractice action against MetroHealth Hospital.

I am here today to ask you some questions

about your interaction in this case and the treatment that you have of my client on a specific date. There are a lot of medical records, but, from my information, you only saw Mr. Smith on one

presenting date. I believe it was April 16, 1997. I am going to ask you questions about that.

A. Okay.

Q. Before we get into that, just could you please state your full name.

A. Rita K. Cydulka.

Q. Are you currently employed by MetroHealth Hospital?

A. Yes.

Q. And have been since this presenting date of 4/16/97. Have you ever given a deposition before?

A. Yes.

Q. You are familiar with the interaction of the questions and answers that go on?

A. Yes.

Q. I will dispense with the rest of the questions regarding depositions because you have done this before. So if there is anything that you have a problem with, any questions that arise during the deposition, either stop me and ask me or talk to your attorney. Fair enough?

A. Yes.

Q. Otherwise, we will just head right into it.

A. Yes.

Q. What is your current occupation with MetroHealth

Hospital System?

A. I am an emergency physician.

Q. How long have you been employed by them?

A. Since 1989.

Q. Are you employed by MetroHealth Hospital?

A. Yes.

Q. Are you involved with any sort of ER staffing group?

A. No.

Q. When was your first date of employment with MetroHealth Hospital?

A. July, 1989.

Q. And you have been here ever since?

A. Yes.

Q. Uninterrupted?

A. Yes.

Q. In the ER?

A. Yes.

Q. And that is your specialty?

A. Yes.

Q. Can you give me a brief educational background?

A. Went to Northwestern University Medical School. I completed internship and residency in emergency medicine/internal medicine. And I have a Master's degree in epidemiology and biostatistics from

Case.

Q. Now, you mentioned you had given a deposition before or given depositions before?

A. Yes.

Q. In what capacity have you done that?

A. In several capacities. One as a treating physician years ago for someone who had burned down a house and had sprained her ankle. And I saw her on route to jail. Once as a treating physician of a fellow who jumped off of a ramp at a Bears game and broke his neck and was suing the City of Chicago for inadequate design of the stadium.

Once here for somebody who was suing the hospital for I don't remember what, but I think had a GI bleed, and several times as an expert.

Q. Now, as a treating physician, do you mean in your capacity as an emergency room physician seeing these patients come into that department?

A. Yes, correct.

Q. At this facility?

A. No, that was before I came here.

Q. Where were you before that?

A. Northwestern University.

Q. You have also acted as an expert witness?

A. Yes.
Q. In what capacity?
A. What do you mean?
Q. Well --
MR. MALONE: You mean plaintiff versus defense? I mean, she is an ER doc.
Q. Okay, we will just start from the beginning. When was the first time you acted as an expert witness?
A. I don't know.
Q. Would it have been five years ago or ten years ago?
A. Maybe ten years ago.
Q. Did somebody hire you to do that?
A. Yes.
Q. Who?
A. I don't remember.
Q. Was it an attorney?
A. Yes.
Q. Do you remember the case, the facts involved, or what opinion you gave?
A. Very, very vaguely.

Q. Do you remember who you gave an opinion for? Was it the defense or the plaintiff?

A. I have given opinions for both.

Q. But in that case, who was it for?

A. I don't remember.

Q. So you have given expert opinions for plaintiffs and for defense attorneys --

A. Yes.

Q. -- in cases, correct?

A. Yes.

Q. How many times have you been an expert witness?

A. Over the decade?

Q. Yes.

A. Maybe a handful.

Q. Okay. Would that be a dozen a half a dozen?

A. I am going to say a half a dozen.

Q. So you were hired to give expert opinions in the areas of emergency medicine, correct?

A. Yes.

Q. Do any of those expert opinions have to do with presentation of gross hematuria?

A. No.

Q. Have you ever been a defendant, a named defendant, in a medical malpractice case?

A. I was named in the case that we are talking about

here with the fellow with the GI bleed.

Q. I don't know if I specifically named you.

A. No, no. You asked me --

Q. Oh, another unrelated case at the hospital?

A. Right. And I think my understanding is that I was dropped out from it.

Q. You have not been named in this case, do you understand that?

A. No, I didn't understand that, but okay.

Q. You are not a defendant in this case.

A. Okay.

Q. I brought you here as a factual witness.

A. Okay.

Q. Because I want to know what happened. That is it.

A. Okay.

Q. What did you do to prepare for this today, if anything?

A. I met briefly earlier with Mr. Malone.

Q. Did you review any text materials?

A. No.

Q. Did you review any depositions that you may have given in the past, or depositions of other emergency room physicians?

A. No.

Q. Did you review the chart?

A. Very quickly.

Q. Did you speak to any colleagues at the hospital?

A. No.

Q. Did you speak to anybody in urology?

A. No.

Q. Anybody in the family practice department?

A. No.

Q. Any other emergency room physicians?

A. No.

Q. Are you acquainted with Dr. Tom Noeller?

A. Yes.

Q. Are you acquainted with Dr. Mary Stewart?

A. Yes.

Q. Dr. Lynn Dezelon?

A. Yes.

Q. Dr. Jeffery Pennington?

A. No.

Q. Dr. Thomas Collins?

A. Yes.

Q. They are all emergency physicians here at this hospital?

A. Yes.

Q. I take it you know them fairly well. Did you speak with any of them prior to this?

A. No.

Q. Have any of them approached you, talked to you about anything regarding this case?

A. No, or this patient.

Q. Are you Board certified in emergency room

medicine?

A. Yes.

Q. When was that Board certification?

A. The original one was in 1985, and I recertified in 1995.

Q. And that is the two-part exam?

A. Right.

Q. Oral and a written?

A. Right.

Q. Do you occupy any teaching positions?

A. I teach here.

Q. Okay, tell me a little bit about that.

A. I used to be the residency director until I took a sabbatical and went back for my Master's degree. Now I do clinical teaching and I lecture.

Q. You said you had a Master's degree in epidemiology?

A. Yes.

Q. Tell me a little bit about that field.

A. Epidemiology is the study of disease and disease patterns. So we look at big pictures rather than

little pictures.

Q. Give me an example that I can sink my teeth into.

What would be an example of that, like maybe

something you are working on now?

A. For example, not something I am working on now, but an epidemiologist would be the one who realized that taking aspirin helps prevent heart disease. For example, looking at the Harvard Nurses and Physicians Study, they noticed that people who were taking aspirin tended to have less heart attacks than people who weren't taking aspirin. So they look at those big patterns and then they study them.

Q. So you are not related, then, to any specific disease process, it is just the overall picture of medicine and the interaction of random research facts, such as aspirin and the effect on whatever?

A. Well, it can be related to a disease process, too.

Q. But it is more from an overall perspective, then, isn't it?

A. Well, it depends what you are looking at.

Q. I guess we should probably just get right into this.

MR. MALONE: The first very pages ought to be this visit.

MR. SWEENEY: Yes, this is the first visit.

MR. MALONE: Now, Skip, if anything in front of you doesn't appear to be

copied, we can do that for you now. If your copies are not legible, we will have it.

MR. SWEENEY: Yes. I just wanted to see the bottom of one of the originals. This is fine. Everything else I believe I have.

Q. (Continuing.) I am really not going to go over anything past the 4/16 date. There is pretty much all there is. I could give you a copy, as well.

A. That would be great.

Q. Might as well go from the chart, that would probably be the best way.

MR. MALONE: Sure.

Q. You have never reviewed this chart, correct?

A. This particular?

Q. Have you seen this before today?

A. This actual physical --

Q. Have you seen copies of it?

A. I have seen copies of my visit.

MR. MALONE: Of her visit.

Q. That is the only --

MR. MALONE: That is all she

has looked at. When you asked her: "Have you seen this chart," She thinks you are talking the whole volume.

Q. No, just your visit, April 16 of '97.

A. Yes.
Q. So you have gone through it. I don't know how many pages there are, maybe six or seven pages. I think we might be a little bit out of order.
The first page that you have in front of you -- well, the initial page is an intake sheet?
A. This, yes.
MR. SWEENEY: You know what, Jim, I don't believe I have that. Let me take a quick look at it. I don't believe there is much on it.
MR. MALONE: You should have it, Skip. If you don't, I will make a copy right now.
MR. SWEENEY: You know what, I do have it. I can't read it very well, though.
Q. (Continuing.) Okay, Doctor, this is the intake sheet, emergency department MetroHealth Medical Center, April 16 of 1997, correct?
A. Yes.
Q. And you were the attending emergency room

physician that date?

A. Yes.

Q. Do you recall what your shift was or what it would have been on that date?

A. No.

Q. What is a typical shift?

A. They have changed over the years. There is 7:00 to 3:00. There used to be a 10:00 to 6:00. Now there is a 9:00 to 4:30. There is a 3:00 to 11:00, 4:00 to midnight, 6:00 to 1:00, 11:00 p.m. to 7:00 a.m.

Q. Wow. On this sheet we have an admitting time. It looked to be 10:29. That would be a.m.?

A. Yes.

Q. That would be within what shift?

A. Either the 7:00 to 3:00 shift or the 10:00 to 6:00 shift, or one of the day shifts.

Q. But can we tell from this record what shift it was?

A. No.

Q. And you don't recall?

A. No, I don't.

Q. We have a chief complaint up top?

A. Yes.

Q. That would be gross hematuria, correct?

A. Yes.

Q. The informant apparently was John Tuber-Smith, and that was his chief complaint. He came in on his own?

A. I don't know.
Q. Meaning ambulatory, he walked in?
A. I don't know that, either.
MR. MALONE: Right there.
A. Walking.
Q. Does it reflect anywhere in the records, was anyone else with him at the time?
A. I don't see anything about whether anyone was with him or not.
Q. Independently, do you remember anyone coming in with him?
A. No.
Q. Do you remember this guy?
A. No.
Q. Let's go down the list here. "Chief complaint, gross hematuria." Below that we have it looks like an acronym, I really can't read that. Is that APR by?
MR. MALONE: Where are you?
MR. SWEENEY: I am back on the original, the first page.

A. Oh, here. "Arrived by."

Q. "Arrived by," that is blank, correct?

A. Yes.

Q. And below that we have --

A. "PCP contract."

Q. Which is primary care physician contract?

A. Yes.

Q. What does that sa?

A. It says FA.

Q. What does that mean?

A. I don't know.

Q. You have no idea?

A. None.

Q. And then the rest of the columns are blank that I have.

Below that it says "MetroHealth Medical Center provider." Below that it says "none."

A. Yes.

Q. Do you know what that means?

A. It means that he likely didn't have a provider here at MetroHealth.

Q. You mean he didn't have a primary care physician?

A. Any provider.

Q. He didn't have insurance, or what?

MR. MALONE: That would refer

to doctor, not insurance. Provider is the guy that provides health care services.

Q. Actually, if you look over the next column, we have registration date, arrival time. It looks to

be 10:00.

MR. MALONE: Yes.

Q. Registration time, 10:05. Date of birth -- or I am sorry, below that I can't read that.

MR. MALONE: Which line? Under --

Q. Right, illness, there is a date there.

MR. MALONE: Accident/illness date 8/16/96.

Q. Do you know what that reflects? Do you have any idea?

A. No.

Q. Below that we have personal information, his address, phone number, contact phone number. Age, 50 years old. Race, black. Sex, male. Correct?

A. Yes.

Q. Primary nurse, that is blank, correct?

A. Correct.

Q. Exam room number 3. What is area time as opposed to arrival time?

A. What time he was taken back into the emergency

department itself.

Q. And below that we have one note, apparently a nursing note, and I can't read that at all.

Apparently we have a time here of 11:20. And

then --

MR. MALONE: It should say "UA sent." Urinalysis sent at that time.

Q. So a urinalysis was taken upon presentation; is that correct?

A. Well, it was taken -- sent at 11:20.

Q. So a urine sample was taken from the patient at 11:20 and sent. Where was it sent to? The lab, I take it?

A. That is usually where it is sent.

MR. MALONE: Yes.

Q. I have collection date 11:10?

MR. MALONE: No, that is the time that the specimen was taken from the patient at 11:10. And this would tell you at 11 minutes later it was sent on down to the lab for study.

MR. SWEENEY: Okay.

Q. (Continuing.) Can you read -- apparently that is not your writing?

A. No.

Q. Can you read any of that?

A. No. I mean, I can read this, it is a signature.

But I don't know whose it is.

Q. Then on down the only other entries we have is

discharge time of 12:30, and disposition of

valuables, under that, what does that mean?

A. I don't know.

MR. MALONE: It looks like "With patient."

A. Oh, maybe --

MR. MALONE: I read more of these than you do.

MR. SWEENEY: Yes, that is very good.

MR. MALONE: Valuables went with the patient.

Q. And then we have "discharge to," and something is circled. I can't read that.

A. "Home."

Q. Right next to the "2" there is a circle. What is that?

MR. MALONE: The "H" is circled. That is the letter "H" for home.

Q. And then it says home?

A. Yes. The options would be admit, "AD," or transfer to another facility. And then if he is

admitted or transferred, then you fill in what floor, what section of the hospital. Or if he is transferred they would put transferred to elsewhere.

But in this case he was sent home and just says home.

Q. And then status at discharge, can you read that?

A. "A & O times three."

Q. What does that mean?

A. Alert and oriented times three.

Q. And then the signature. I don't know who that is. Do you recognize that signature?

A. Yes.

Q. Whose is that?

A. Ann Dombeck.

Q. Who is that?

A. A nurse. I think that is whose signature it is.

Q. Is she still employed here?

A. I am not sure.

Q. When is the last time you saw her?

A. Sometime in the last three years.

Q. What is your current shift?

A. All around the clock. I work whatever shift I am assigned.

Q. Is there any rhyme or reason to it?

A. None.

Q. I am trying to nail you down. Apparently I can't.

A. I have been trying to figure that out for 20 years.

Q. So you get a call and you have to work a shift?

A. Correct.

Q. Who calls you?

A. We submit schedule requests and then we get assigned a schedule.

Q. But they are rarely honored, I take it?

A. No, they are usually honored. It is request not to work a shift, not request to work a shift.

Q. And everything else is open?

MR. MALONE: It is not like she is home and somebody says, "You have to come in and work 12 hours."

Q. There is a monthly, or some leeway where you can schedule?

A. Right.

Q. Let's go to the next page.

MR. MALONE: Which page do you have next, triage form?

MR. SWEENEY: Yes.

A. Oh, no, you have a different one.

Q. All right. We can go to that, because that is the

order that you have it in. We have a triage form, and that would be the information taken down by, apparently, the nurse that was --

A. Kathy.

Q. Dombeck?
A. No, there is a triage nurse. See the signature in the middle of the right page?
Q. Who would that be?
A. Kathy Klamet.
Q. So none of this is your writing, and obviously you didn't take this information down?
A. That's right.
Q. But do you rely on this information --
A. I look at it.
Q. -- when you examine the patient?
A. I look at the information.
Q. Typically, people come in the emergency room for all number of reasons, correct?
A. Yes.
Q. You are the attending physician, which means you are in charge?
A. Yes.
Q. Typically, what is your first contact with the patient? Is it in the examining room?
A. Yes.

Q. After all this information is taken down?

A. Yes.

Q. Do you typically review this information before you see the patient?

A. Yes.

Q. Or do you, as some ER docs I know, sometimes like to go in blind? Not many, but some do. Are you one of those?

A. I am not one of them.

MR. MALONE: I don't think we have any of those at this institution.

MR. SWEENEY: That is good, because unless they are very good, they are dangerous.

Q. (Continuing.) Now, you would review this information, typically, before you go in and see a patient?

A. Yes.

Q. And I assume that is what you did in this case --

A. Yes.

Q. -- on April 16 of 1997? Again, I will just go through it and if you could follow-up with me. Triage time, 10:00 a.m. Walked in. The date. We have a stamp with his name and information already on it in the upper right-hand corner.

We have date of birth. Primary care physician, which means none. And then below that we have prehospital care. And it looks like "See note attached."

Can you see that there?

A. Yes.

Q. Do you know where that would refer to?

A. Right offhand, I don't.

Q. If a note is attached, where would it be?

A. Usually attached.

Q. Ask a stupid question. Is it in the chart or is a note in the chart?

A. Do you mean this note that they are referring to?

Q. Referring to.

A. I don't see it as far as my encounter goes.

Q. So I would have to ask Miss --

A. Klamet.

Q. Do you know her first name?

A. Kathy.

Q. Kathy Klamet. We have under the chief complaint we have gross hematuria, correct?

A. Yes.

Q. What does that indicate to you?

A. Bloody urine.

Q. What disease process does that indicate to you?

A. It could indicate lots of disease processes.

Q. For example?

A. Kidney stones, infections, tumors, sickle cell disease.

MR. MALONE: Trauma.

A. Yes, well, trauma of course. Some of the glomerulonephritis.

Q. Kidney disease?

A. Yes.

Q. Anything else?

A. Well, there are lots.

Q. Keep going.

A. Many variations of kidney disease. Renal cancers. Cystitis.

Q. What importance does the chief complaint play when you examine a patient?

A. It usually helps us focus our line of questioning and exam.

Q. So go through with me, if you could, the differential diagnosis, then, for gross hematuria in this gentleman.

A. Okay. Infection, kidney stones.

Q. Is this in any order of priority or severity or importance?

A. Just in order of how I am thinking of them.

Q. Okay. What did we say so far?

MR. MALONE: You said sickle cell, trauma, nephritis, tumors, infections, kidney stones. That is what I have written down,

you may have some others that I didn't catch.

Q. Let's go on further here. We have gross hematuria, and it has times or by, or for the duration, I take it?

A. Okay.

Q. Of eight to nine months, correct?

A. Yes.

Q. With weight loss?

A. Yes.

Q. Correct?

A. Yes.

Q. It says "negative --" I can't read that.

MR. MALONE: "CP today."

Q. What does that stand for?

MR. MALONE: Chest pain, probably.

A. I know what it usually stands for.

Q. What does it usually stand for?

A. Chest pain.

Q. That is what it would stand for here?

A. I don't know.

Q. Would it stand for anything else?

A. Cerebral palsy.

Q. The gentleman doesn't have cerebral palsy, that is good. Okay. Anything else?

A. Nothing that I can think of offhand.
Q. Can we agree that is probably referring to chest pain?
A. Yes.
Q. As we go on it says "penile pain"?
A. Yes.
Q. By "penile pain," what does that tell you?
A. That he is either not complaining of penile pain or he is complaining of penile pain. I am not sure if it is referring to no chest pain and penile pain into flank, or if he is complaining of gross hematuria eight or nine months, weight loss, hematuria, penile pain into flank.
Q. You mentioned you review these before you talk to the patient.
A. Yes.
Q. If you are reviewing this, would you again go over this with the patient?
A. Yes.
Q. I assume that is what you did with this patient in this case?

A. I don't know.

Q. You don't remember this presentation because there have been tens of thousands of them since you have been here. But typically speaking, that is what

you would do?

A. Yes.

Q. So you would clarify the questions that you have now which you are not the quite sure what the penile pain is, whether it is negative or positive for it?

A. Oh, yes.

Q. And then going on it says apparently positive to flank, it looks like?

A. Yes.

Q. And then positive for abdominal pain?

A. Yes.

Q. What are all these things telling you, as an emergency room physician?

A. That he has had a problem with bloody urine for a while, he has lost some weight, he has pain in his penis and in his flank.

Q. Now, as part of a differential diagnosis, the complaints of the patient are important, as you stated?

A. Yes.

Q. And they allow you to focus your attention to a certain injury or disease, correct?

A. Yes.

Q. What is this focusing you towards?

A. This particular?
Q. Yes.
A. This particular thing would focus me towards either someone who has had an infection or stones intermittently, possibly looking for some type of -- possibly concerned about a malignancy.
Q. Why would you be concerned about a malignancy?
A. It is always in the back of my mind on everybody.
Q. Well, not if he comes in with a broken leg, is it?
A. Well, sometimes it is.
Q. Well, with gross hematuria, part of the differential diagnosis is malignancy, correct?
A. Yes.
Q. Part of your job as an emergency room physician is to deal with life-threatening situations?
A. Immediately life-threatening situations, yes.
Q. And if they are not immediately life-threatening, then to evaluate and provide proper instruction or follow-up or treatment, correct?
A. Yes.
Q. What is the difference between frank hematuria and

gross hematuria?

A. No difference.

Q. They can be used intermittently, correct?

A. Yes.

MR. MALONE: I think interchangeably is what you meant to say.

MR. SWEENEY: Thank you. I knew there was a reason you were here.

A. They could probably be used intermittently.

MR. MALONE: I are suppose they could be used intermittently, also. I didn't want to interrupt you.

Q. Going down here, we have vital signs here. We have temperature, and the "T" is circled?

A. Yes.

Q. That represents?

MR. MALONE: Tympanic.

A. Yes.

Q. Which means normal?

A. No, it means they took it in his ear.

MR. MALONE: As opposed to mouth, and "R," which would be rectal.

Q. Pulse?

A. Do you want me to read it?

Q. 80?

A. Yes.

Q. And that is regular?

A. Yes.

Q. Respirations 16?

A. Yes.
Q. Blood pressure looks to be normal, correct?
A. About, yes.
Q. Other than scoliosis, no chronic illnesses?
A. Correct.
Q. Allergies to codeine, question mark?
A. Yes.
Q. What does that mean?
A. It means he reported that he may have an allergy to codeine.
Q. Not sure, okay. Then we go down the next -- acuity, Level III, what does that mean?
A. Low acuity.
Q. Explain that to me in lay terms.
A. Something that is not life-threatening and not likely to need immediate attention within the emergency department in order to save his life.
Q. Now, is that your opinion or is that in the nurse's opinion?
A. Nurse's.
Q. Do you agree with that?

A. To be honest with you, we don't do triage ever.

Q. Disposition B, I believe?

A. Yes.

Q. What does that stand for?

A. We have an A side and a B side. A side sees patients with more acute illnesses, and the B side sees patients with less acute illnesses.

Q. So if somebody gets life-flighted, they go to the A side?

A. More often than not.

Q. Somebody walks in, they go to the B side or directed to the B side?

A. It depends what they walk in for.

Q. Generally speaking?

A. Not necessarily.

Q. There is an A and a B side. Are these separate parts of the emergency room?

A. They are separated by a supporting wall of the hospital.

Q. And as they come in, there is one emergency entrance, though, correct?

A. Correct.

Q. And as they come in, there is at least a preliminary triage like "Are you going to die soon," or "Can you walk over here and wait for a

few minutes?" Essentially, that is what it is?

A. Yes.

Q. I just want to put this in the simplest terms because I am not a doctor.

MR. MALONE: Well, I think in fairness, Skip, she is trying to help you as much as she can. But people can come in on stretchers and still be really nonacute. They may be on a stretcher because of a chronic problem with walking.

There are lots and lots of factors that go into this. Basically, it is a triage function to assess whether they are in imminent danger of demise or something real evil happening imminently, or can they wait a few minutes on a nonemergent basis to get care.

Obviously, the people that need it most get it first. I mean, I think that is the way we try to operate the emergency room.

THE WITNESS: Yes.

MR. MALONE: There is nothing conspiratorial about it. It is a judgment matter made by a triage nurse who is trained to make those judgments.

MR. SWEENEY: I don't think

there is any conspiracy going on, I am just trying to figure out what it is.

Q. (Continuing.) Do you agree with that?

A. Yes.

Q. "Assessment time, 10:30." It says "complete" or "focused." What does that mean?

A. Whether the assessment was a head to toe or whether they focused on the complaint that the patient had.

Q. "Medications, none." That means he is not taking any currently?

A. Yes.

Q. He is not on any?

A. He hadn't reported any, hasn't reported any.

Q. "Mental status: Awake. Breathe," no marks. "Neuro.," there was apparently not a neurological workup. "Normal skin condition, color, turgor," whatever. "Capillary refills are less than two seconds," which is --

A. Normal.

Q. -- normal. "Abdomen --" He complained of abdominal pain, it looks like, up top. And then "Abdomen" here we have "nontender and soft," which is normal.

And then we have "Pain right flank and --"

A. Dysuria.

Q. Which is pain when he urinates?

A. Yes.

Q. Now, relating that to the penile pain indication

under "Chief complaints," is that what that refers to?

A. I don't know. Dysuria usually is pain with urination. Penile pain is penile pain.

Q. Then "Assessment" is down below. What is an assessment?

A. It is the nurse writing what she thinks.

Q. So this is all in the nurse's input?

A. Yes.

Q. So whatever she tells you is what you get?

A. Yes.

Q. Whatever she gets is what the patient tells her?

A. Yes.

Q. So down below we have positive, which is a circle plus?

A. Yes.

Q. "Frank hematuria." Now we have "times seven months." Above we have eight and nine months. So what is it? Do we know? Somewhere between seven and nine months, it looks like?

A. Yes.

Q. "Positive for dysuria," which is painful urination, "times three months"?

A. Correct.

Q. "Increasing," what does that mean?

A. The dysuria is increasing.
Q. What does that tell you, increasing pain with urination?
A. It tells me that his symptoms are increasing.
Q. You have "Right flank pain," and I can't read that. By --
MR. MALONE: X years.
Q. By X years?
MR. MALONE: For years, F O R, not F O U R.
Q. "Seen at family practice," what is that? Do you know?
A. Some type of family practice clinic.
Q. That within this hospital?
A. I don't know.
Q. "And another hospital." So that statement, taken conjunctively, would say that -- imply to me that he was seen at the family practice department in this facility, because then he refers to another hospital?
A. To me, I don't know. It just implies that he has

been seen by a family practice and he has been seen in another hospital for the same complaint.

Q. And then it says here, "Given prescription --" I can't read the rest of that.

MR. MALONE: "Given prescription which patient never filled."

Q. Do we know what the prescription was for?

A. No.

Q. Would it be important to know what that was for?

A. It would be if the patient remembered.

Q. "Never filled. Also --" what does that mean, CD, CP?

A. I think it is "CP."

Q. So another chest pain reference, chest pain intermittently by nine months. I can't read the rest of it at the end of the question.

A. "Left-sided. Denies at present. Positive weight loss, 13 pounds in three months."

Q. It sounds like this guy has something going on in his urinary tract; is that right?

A. Yes.

Q. Let's refer to your discharge summary, if we could.

MR. MALONE: Her dictation?

Q. Yes. This is your dictation, correct?

A. Yes.

Q. Emergency department attending physician, Rita Cydulka?

A. Cydulka.

Q. Cydulka. Excuse me. We have "Chief complaint: Hematuria and flank pain"?

A. Yes.

Q. What is the differential diagnosis of hematuria and flank pain?

A. Kidney infection, kidney stone, tumor, papillary necrosis.

Q. What is that?

A. When the parts of the kidney sort of slough off. You usually see it in patients with sickle cell disease. And, you know, of course trauma.

Q. What is the most severe of those conditions or disease processes?

A. What do you mean by "severe"?

Q. What is the most life-threatening?

A. Well, it depends.

Q. On what?

A. On the condition.

Q. Well, you mentioned differential diagnosis consisted of urinary tract infection --

A. Yes.

Q. Is that a life-threatening disease process?

A. If the patient becomes septic from it, yes.

Q. What is the rest of the differential diagnosis?

A. Trauma. If the patient has disruption of their

renal system and loses kidney function, that can become life-threatening, or if they bleed to death, that can become life-threatening.

Q. Was that evident here?

A. No.

Q. There was no trauma?

A. Not that I got a history of.

Q. So we can rule that out?

A. Okay.

Q. Can we?

A. I suppose.

Q. Well, I am asking you. You are the emergency room physician that examined this patient. You need to rule things out.

A. Well, it doesn't look like I was worried about it, if that is what you are asking.

Q. Well, I am asking are you ruling it in or are you ruling it out?

A. I am ruling it out.

Q. Doctor, can we agree that 80 to 90 percent of bladder cancer diagnoses begin with gross

hematuria?

A. I don't know.

Q. You don't know?

A. No.

Q. Would that be important to know?
A. As an emergency physician?
Q. Yes.
A. Are you asking -- no, it would not.
Q. So a patient comes in with gross hematuria. Can that indicate that there is a neoplasm, that there is a malignancy going on, that there is some abnormal cell growth going on?
A. Can it indicate that?
Q. Yes.
A. Yes, it can indicate that.
Q. Would the standard of care be to assume that that does exist until proven otherwise?
A. No.
Q. What would the standard of care be in your position?
A. The standard of care would be to check a urinalysis and treat a cause that was apparently obvious in the emergency department and refer to urology.
Q. And that was done here?

A. Yes.

Q. So, basically, you did your job?

A. I think I did.

Q. I think you did, too. I don't mean to be

adversarial. I am just trying to figure out what is going on because I wasn't here.

It just seems to me that gross hematuria is -- one of the main causes of gross hematuria is bladder cancer, and I don't understand why that is not mentioned anywhere in this chart or your dictation, discharge summary, or follow-up.

A. I think you are confusing a presentation of bladder cancer with the epidemiology of gross hematuria.

Q. I am not saying that he had bladder cancer on this date. I am just saying that is part of your differential diagnosis, correct?

A. Yes.

Q. And in order to diagnose that, you cannot diagnose that in the emergency room, correct?

MR. MALONE: Diagnose what, cancer?

Q. Bladder cancer.

MR. MALONE: No.

Q. Or cell abnormalities, cell growth abnormalities.

Can you do that in the ER?

A. Usually not.

Q. Would hematuria require a thorough urological workup in a 50-year-old male who smokes and who

has had it for several months? It seems like that is what you did, that is what you ordered.

MR. MALONE: You are asking about what workup should be done in urology, or what workup should be done in the emergency setting with this patient with his problem?

MR. SWEENEY: Anywhere.

MR. MALONE: She can't comment beyond the emergency setting because that is what she is trained to do and what she does. She can tell you what is done in the ER, and she has already done that.

Q. Can you answer the question? Would gross hematuria in a 50-year-old gentleman who is a smoker, would that indicate to you that a urological workup would be necessary?

A. I think it depends on the circumstance.

Q. With these circumstances as presented to you, would a urological workup be appropriate, proper standard of care?

MR. MALONE: In the emergency

setting?

MR. SWEENEY: No.

MR. MALONE: Or on referral?

Q. No, just at some point after you have seen this

patient. I am not saying in the emergency room. That is not what I am asking you.

A. I still don't understand the question. Are you asking somebody who comes in with gross hematuria that was treated and responded to treatment, do they then require a full urologic workup, or are you asking somebody with gross hematuria that didn't respond to treatment?

Q. I didn't realize that treatment was part of my question. Was there a treatment here?

MR. MALONE: Well, you asked a general question, and she is telling you there are qualifications that go into it. There is no cookbook answer to questions of that type.

Q. Let me ask you: Was there treatment given to this gentleman in the emergency room?

A. No.

Q. What was recommended to the gentleman?

A. I recommended that he follow up with urology and follow up with the medicine clinic.

Q. Why did you do that?

A. Because I didn't know what was causing his hematuria or hem-positive stool, and I wanted someone to find out why.

Q. Okay, that is all I am trying to get at, and that

is what you did, and you did your job. I am just trying to figure out how we get there. Okay.

Do you know from your training or your experience what the presenting symptomology of bladder cancer is, typically? In other words, what does a patient come in complaining of first?

A. Well, I think it varies.

Q. What does it include?

A. It can include hematuria, dysuria.

Q. Age?

A. I am sorry?

Q. Age?

A. Well, they usually don't come complaining of their age.

Q. No, I mean, would age be a factor? "I am too old."

MR. MALONE: No, you are not.

A. Age, epidemiologically, it can be a factor.

Q. Is a history of smoking?

A. Smoking is associated with bladder cancer.

Q. We have a history of smoking here in this

gentleman.

A. Yes.

MR. MALONE: It was hard to tell that that was meant as a question. You sort

of said it. I didn't see the question mark at the end of it, and neither did she.

MR. SWEENEY: I am sorry.

Q. (Continuing.) It looks like a urinalysis was ordered.

A. Yes.

Q. If we could, if you want to go to the results of the urinalysis. The report date was the 25th. The collection date was the date of his presentation, which is the 16th, and it turns out that this report was generated on the 25th, I believe.

MR. MALONE: Can I help you with that? Only because that does not mean that no one knew the results of the urinalysis until April 25. That means that this particular piece of paper was generated by a computer and printed April 25, 1997 at 2:22 in the morning.

The results were out sooner. The results were probably on a computer screen and no one bothered to print it in hard copy because it wasn't necessary to have it in hard copy until

later. That is what that means, Skip.

Q. Doctor, the urinalysis we have here in front of us, did you take a look at this on the day that you examined Mr. Smith?

A. My practice is to look at all labs that I ordered.
Q. So, typically, if you order a lab, you take a look at it?
A. Yes.
Q. Now, would you take a look at it before you discharge the patient?
A. Yes.
Q. So I am going to assume that you took a look at this before you discharged the patient? Fair enough?
A. Yes.
Q. What does this urinalysis tell you? I am not going to go over each specific thing. We have a couple of abnormal findings, and it seems the rest are normal. I guess we could just go over the abnormals. Okay?
A. Do you want me to just comment on those?
Q. If you would.
A. The white cells indicate that he had five to ten white cells per high-powered field. White cells are inflammatory cells. It looked like five to

ten red cells per high-powered field. Those are

red cells. And zero to two renal cells.

Q. And blood, which is large, what does this mean?

A. That is on a dipstick. What happens, when someone

gives a urine sample, the first thing that is done, they have a dipstick with color markers. If it is absolutely normal, that is the end of the analysis, it doesn't go on. For example, if anything abnormal, for example, blood large, it is then sent to a lab where it is looked under a microscope.

Q. For the microscopic, and this is what they find?

A. Yes.

Q. What do those abnormalities mean in terms of a workup for a patient with these complaints and this history?

A. White blood cells in the urine can mean either there is some type of inflammatory process going on or white cells are being -- that is usually what it is, some type of inflammatory process.

Red cells, there is something irritating the lining of the vasculature, or something is being irritated, and so red cells are being sloughed.

And renal cells means that part of the kidney is showing up in the urine.

Q. Overall, what does that indicate, or what can it indicate?

A. Remember all those same things we talked about before?

Q. All those things?
A. The same, yes.
Q. And the bladder cancer would be involved in that?
A. Yes.
Q. So this does not rule out a neoplasm?
A. No.
Q. It doesn't rule it in, it just doesn't rule it out?
A. Correct.
Q. If those were normal, if those readings were normal, could you rule out a neoplasm, an abnormal growth of cells?
A. No.
Q. What would you need to do in order to rule it out?
MR. MALONE: Well, again, I am going to make an objection only because that is not her role. That is the specialty world of urology and cancer. She is an emergency room physician.
But I will let her answer it if she is comfortable with it. I don't really think that is

her --

Q. It needs a further workup?

A. Yes.

Q. And that is why you referred him to urology?

A. Yes.
Q. So I am sitting here, I am an emergency room physician, and I have a patient with these complaints, and part of the differential diagnosis is cancer, correct?
A. Yes.
Q. Did you sit down with him and say, "Listen, I don't want to scare you, but one of the things you might have is cancer?" Did you sit down and talk to him about that?
A. I sit down and talk to all my patients.
Q. And so would that typically be something that you would do with a patient who presents with these symptoms and this sort of urinalysis?
A. I would say that I probably mentioned it along with other things.
Q. Like what other things?
A. It didn't look like he had an infection. Could he possibly have a stone? Yes. The other thing that, quite frankly, I was very worried about with him was could he have some type of tuberculosis of

his kidney? Because he was a former drug abuser, and I don't remember if he had been in jail or not.

Q. What does that do to your kidney? What does

the --

A. TB.

Q. What does drug abuse do to your kidneys?

A. Well, my concern was more using dirty needles. He was a former IV drug abuser, and I was also very concerned about him having AIDS.

Q. And did he?

A. At this visit I don't know.

Q. Would it be important to know that in the setting of an ER?

A. Oh, yes. I mean, here in the social history I have HIV-negative. But I am sure that I discussed that with him.

Q. So then, typically, if you have -- I mean, how many patients that you see during a day have a differential diagnosis that includes cancer?

A. Oh, I don't know.

Q. Every single one?

A. Well, I don't know.

Q. But each one of those that does, do you sit them down and say, "Listen, you might have an

infection, you might have problems with your kidneys, and you might have cancer"? Can I assume that you did that as part of your care?

A. I think I usually use the word tumor. But yes.

Q. The patient needs to know what they are suffering from or could be suffering from, correct?
A. Yes.
Q. And is there any indication on here that he didn't understand any directions?
A. No.
Q. We have the emergency department course sheet here?
A. Yes.
Q. If we could just go through that. Is any of this your writing?
A. That is all my writing.

MR. MALONE: Off the record.

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

Q. Up top we have "UA" checked. What is that?
A. I ordered a urinalysis.
Q. Which we just discussed. And down below we have "Medical record ordered."
A. It means if he had a medical record at the hospital, I wanted to look at it.

Q. And did you?

A. If I ordered it and there was one, I looked at it.

Q. Can we tell if you looked at it from this record?

A. No.

Q. Do you remember if you looked at one?
A. I don't remember.
Q. Do they usually get it to you when you order it pretty quickly?
A. It depends.
Q. Well, we have here part of the entire chart, and this looks like the first presentation that this patient has to this hospital. Is there any indication on that chart that you know of that maybe he was here before?
MR. MALONE: There is a Volume I that was considered inactivated, which I think that means it is on microfilm. This is Volume II of two parts. There are old archival records.
MR. SWEENEY: Yes, I took a look at them.
Q. (Continuing.) But I am asking you, as part of your care, you don't specifically remember looking at a prior chart?
A. No, I don't remember.
Q. So these are your handwritten notes?

A. Yes.

Q. Why don't you just go through and tell me everything you wrote down here.

A. Okay. "Exam time 10:50. Dictated, yes." That is

the dictation number.

"Dysuria, four to five months. Hematuria, six to seven months. Lost 13 pounds since one year ago. Pain in back and right flank. Chronic active hepatitis --"

Q. Can I stop you? Let's back up. We have prior medical history question mark, or is that for below?

A. I am sorry?

MR. MALONE: What are you talking about?

Q. "PMH," prior medical history?

A. Yes. So past medical history. "Medicines, none. Past medical history: Chronic active hepatitis," and then in parenthesis, question mark, "(? Hepatitis C. ? Hepatitis B.)

Then "Social history: Former IV drug abuser, more than 20 years ago. Consumes about a pint and a half of alcohol every day. Smokes cigarettes."

And then it looks like here I marked down

significant findings on the exam. It was hemoccult positive.

Q. What does that tell you?

A. Meaning he had occult blood in the stool when I

did the exam and had huge hemorrhoids. And then this was the result of the urinalysis, specific graft 10-25, large blood. Negative leucs. or nitrates.

Q. What does that mean?

A. That means it is unlikely he had an infection.

Q. So it is unlikely he had a urinary tract infection?

A. Yes.

Q. Up top, discharge home?

A. "Discharge home. Follow-up urinalysis. Return to the emergency department for fever or chills. Follow-up medicine as soon as possible for hemoccult-positive schools. Sitz baths."

Q. What is that?

A. Like having someone sit in a warm tub trying to decrease the inflammation from the hemorrhoids. "Please make both urology and medicine appointments for the patient."

Q. What does that mean, have someone else make those appointments for him?

A. It is a note to the secretary that, if possible, if she has the ability to make an appointment in their clinics from the emergency department, to do so.

Q. Do you follow-up with that and make sure that is done?
A. They will tell us if they can or can't do it.
Q. But that is it? That is the only indication you have?
A. That is the only mechanism we have to do it.
Q. In other words, you don't --
A. We don't have the capability to get into the appointment system of the computer.
Q. So you don't come in the next day and say, "We have Mr. Smith set up for urology and family practice"?
A. No.
Q. You don't do that?
A. No. Our responsibility ends when we give instructions to the patients.
Q. And did you tell the patient that he has to make an appointment with urology?
A. Yes.
Q. And medicine?
A. Yes.

Q. And that is then indicated where?

MR. MALONE: This sheet right here, "Emergency Department Patient Instructions." It is signed by the patient down at the bottom.

Q. He was told, it says here, follow-up medical?
A. Yes.
Q. And it then it says an appointment has been made for you April 21, which is about a week later, in the medical clinic. Where is that?
A. Right now it is across the street. I am not sure where it was in 1997.
Q. And then it says "Other instructions: Call urology clinic today for appointment." Is that for him to do it or for the secretary to do it?
A. That is for him.
Q. Because it looked like you told the secretary to do it on the other page.
A. If they didn't do it, it means they didn't have the capability to access the appointment log in urology clinic.
Q. They are like, "Listen, we can't do this, you need to do this"?
A. Yes.
Q. But they did make the family practice follow-up appointment, correct?

A. Medical clinic.

Q. Is that the same thing?

A. No.

Q. What is the difference?

A. Medical clinic is internal medicine, and family practice is family practice clinic.

Q. What is -- I thought family practice was internal medicine.

A. No, family practice is family practice, and internal medicine is --

Q. Internal medicine?

A. -- internal medicine. Family practice takes care of people of all ages, babies, adults, they deliver babies. Internal medicine takes care of only adults with medical problems.

Q. So we have as part of your differential diagnosis bladder cancer?

A. Yes.

Q. Which you explained. And according to the discharge instructions, an internal medicine clinic appointment was made for him, but a urology appointment was not made for him, he had to do that on his own, correct?

A. Yes.

Q. Did you sit down with him and say, "Listen, I

examined you today, part of what you might have is cancer, and you need to make this appointment immediately, and don't screw around and don't blow it off?" Did you sit down and tell him that?

MR. MALONE: She has already answered that question, I think. She can certainly answer it again.

A. I sat down and reviewed the instructions and what the problems could be.

Q. But I mean specifically we are talking about a really nasty disease process that is quite possibly what he had at that time.

A. My practice is to talk to the patients, tell them what I think the problem is and tell them how to follow up.

Q. You told me that you like to use the word "tumor."

A. Yes.

Q. Did you do any other follow-up after you saw this patient?

A. No.

Q. Did I ask you what is the most common presenting symptom or complaint of bladder cancer?

A. The most common?

Q. Yes.

A. You did not ask me.

Q. What is that?

A. I don't know.

Q. If you know.

A. I don't know.

Q. Do you have any idea?
A. No.
Q. So you wouldn't know what the gold standard for diagnosing bladder cancer would be?
A. No, I wouldn't.
Q. So according to the records and your testimony today, this was not a traumatic incident that brought him here?
A. It wasn't --
Q. He didn't suffer any trauma?
A. I didn't think he suffered any trauma.
MR. MALONE: Having blood in your urine might be traumatic for an individual. It would be traumatic for me, I can tell you.
Q. But it wasn't caused by a traumatic event is what I am asking.
A. No.
Q. And it is your opinion that he did not have a urinary tract infection?
A. Yes.
Q. Do you know if there was any indication that he

was exposed to any chemicals or was exercising vigorously, which would have caused these conditions?

A. I didn't record any.

Q. So we can rule that out? Can we or can't we?
A. He didn't tell me about any.
Q. So can we assume, at least for your purposes, that there weren't any?
A. For my purposes, yes.
Q. So we don't have a urinary tract infection. So then a gentleman with his history with this age factor, smoking factor, and history that we have here, he doesn't have an infection, he doesn't have any significant renal problems, does he?
I mean, you said your goal is to focus on something and figure out what we have here. I realize your job is not to definitively diagnose in the emergency room. I understand that. And I am not claiming you did anything wrong here. I am saying what is going through your mind? We are talking bladder cancer?
MR. MALONE: She has told you she made a referral to urology because she was concerned.
Q. You can have your own thoughts. You are a well-

educated doctor.

A. All I can tell you is what I told you. I don't remember what exact thoughts were running through my mind.

Q. This guy wasn't suffering from a heart attack. We could be here all day. The point I am trying to make is that there were a few things that he probably had, correct?

A. Yes.

Q. One of them was bladder cancer?

A. Yes.

Q. Or some form of malignancy or abnormal cell growth?

A. Yes.

Q. Another would have been what?

A. Kidney stones.

Q. Another would have been what?

A. Something related to tuberculosis.

Q. Anything else?

A. I think those were probably the main thoughts running through my mind at the time.

Q. So you are like you need to get to urology because these are all urologic problems?

A. Issues.

Q. GU problems?

A. Yes.

Q. So you made the proper referral?

A. Yes.

Q. Is there a hospital policy that you need to follow

up in any sort of way with patients that you refer to subspecialties or other departments?

A. No.

MR. MALONE: You mean from the emergency department?

MR. SWEENEY: Yes.

A. No.

Q. Is there?

A. No. We treat people and refer, and then we are done.

Q. Do you know if this gentleman had any insurance?

A. I don't know.

Q. And from your examination, could you tell whether this was a lower urinary tract problem as opposed to an upper?

A. No.

Q. You can't tell?

A. No.

Q. Did you have the ability to perform a complete urological workup in the emergency room on that day?

A. No.

Q. Do you ever do that?

A. No.

Q. Is there anything missing from the record?

A. Not that I know about, except for that --
Q. "See note attached"?
A. -- "See note attached," no.
Q. Is there anything that you specifically remember from that date that stuck out in your mind that you want to tell me about? I mean, do you remember what this guy looks like? Was there an earthquake that day?
A. Honestly, I don't have any.
MR. MALONE: She says, "Oh, please, Mr. Malone, let me tell you about everything --"
THE WITNESS: Well, it is four and a half years ago.
Q. I don't remember what I had for lunch yesterday.
A. I had red and green M & Ms.
Q. That is not good for you.
So the diagnosis that you make in the emergency room, which is on your dictated report, that is basically -- that is really not a diagnosis, then, that is just complaints, you are

just restating the complaints?

A. There is a diagnosis. There is an ICD 9 code for hematuria.

Q. There is a billing code. That is fine. But our

focus hasn't been narrowed enough, correct?

A. Yes.

Q. And it needs to be narrowed more fully?

A. Yes.

Q. Which means a referral to urology, correct?

A. Yes.

MR. SWEENEY: Thanks. That is it.

MR. MALONE: Diane, if you do a transcript, please mail a copy to Dr. Cydulka for reading. Where do you want it mailed, home or here?

She will mail you a copy with an instruction sheet. You can proofread to make sure she has taken down what you remember saying.

THE WITNESS: Mail it to my house, 2692 Landon, L A N D O N, Road, Shaker Heights, 44122.

(Deposition concluded at 12:55 p.m.)

22

23

24 _____

25 RITA CYDULKA, M.D.

CERTIFICATE

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

I, Diane M. Stevenson, a Registered Merit Reporter, Certified Realtime Reporter, and Notary Public in and for the state of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, RITA CYDULKA, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by her was by me reduced to stenotypy in the presence of said witness, afterwards transcribed by means of computer-aided transcription, and that the foregoing is a true and correct transcript of the testimony as given by her as aforesaid.

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

I do further certify that I am not a relative, employee or attorney of any party, I am not, nor is the court reporting firm with which I am affiliated, under contract as defined in Civil Rule 28(D), or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this _____ day of _____, 2001.

22

Diane M. Stevenson, RMR, CRR
23 Notary Public in and for
The State of Ohio.

24

25

My Commission expires November 8, 2005.