1

Doc. 164

IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

BERNITA M. QUINN, ADMRX., etc.,

Plaintiff,

-vs-

JUDGE GRIFFIN
CASE NO. 175672

HILLCREST HOSPITAL, et al.,

Defendants.

- - - -

Deposition of MICHAEL FRANK, M.D., taken as if upon cross-examination before Kenneth F. Barberic, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Charles Kampinski Co., L.P.A., 1530 Standard Building, Cleveland, Ohio, at 4:00 p.m., on Wednesday, November 27, 1991, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

- - - -

MEHLER & HAGESTROM
Court Reporters
1750 Midland Building
Cleveland, Ohio 44115
216.621.4984
FAX 621.0050
800.822.0650

APPEARANCES:

Charles I. Kampinski, Esq.
Charles Kampinski Co. L.P.A.
1530 Standard Building
Cleveland, Ohio 44113
(216) 781-4110,

On behalf of the Plaintiff;

David Best, Esq.
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue
Suite 1600
Cleveland, Ohio 44114-1192
(216) 736-8600,

On behalf of the Defendants
Walter Maciejewski, M.D. &
Lakeland Emergency Associates;

Stephen Walters, Esq.
Kitchen, Deery & Barnhouse
1100 Illuminating Building
Cleveland, Ohio 44114
(216) 241-5614,

On behalf of the Defendant
Hillcrest Hospital.

MICHAEL FRANK, 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 MICHAEL FRANK, M.D.

BY MR. KAMPINSKI:

Q. would you state your full name, please?

A. Michael Frank, F-R-A-N-K.

Q. And where do you work, doctor? Is this the address, Old Tannery Acres?

A. That's my professional address.

Q. Is that your home?

A. That's my home and my professional address.

Q. Okay. Do you have a CV, sir?

A. I don't have it with me. I have one. I can get it for you.

Q. Why don't you run me through your educational background starting with high school?

A. High school, I went to Wheatley School in Long Island, I left after I was a junior and entered Yale College in the mid '60's. I received my high school diploma after my first year at Yale.

Q. Was this some type of early admission program?

A. It wasn't really a program. I quit high school and convinced the college to accept me.
Q. How did you do that?
A. They liked me.
Q. Well --
A. I went there and said I was ready for college. I had taken some advanced placement already and even though I didn't have a high school diploma I met most of their admission requirements and I think they were making a trial to take some people like me.
Q. When did you start Yale?
A. The mid '60's. It would have been, I think, '66 when I entered.. I graduated after four years, in 1970, with a BA degree and I had an interdepartmental major in psychology and philosophy.

I took some studies in the summer of '70 at Dartmouth in organic chemistry and in the fall of '70 I entered Case Western School of Medicine, I graduated with an M.D. degree in 1974 and I took a one year surgical internship at North Shore University Hospital in Manhasset, New York, from July of '74 through June '75.

Then I returned to Cleveland and did a one

year surgical residency in the University Hospitals program. That would bring us to, through June of 1976.

And then I took one year of pathology residency at St. Luke's Hospital. That would bring us through June of '77.

Then I took six months off to recuperate from back surgery which took me through that entire year and while I had been doing the two years of residency here in Cleveland I had been moonlighting in emergency departments in town and while I was convalescing I was offered a full-time job and began the full-time practice of emergency medicine in January of 1978 at Huron Road Hospital where I was there for a year.

Then I spent four months working at the emergency department of St. Alexis and quit there and moved to, or changed my position to Akron, at Akron City Hospital, where I was with the emergency department there for five years,

And then I went to Barberton Hospital where I started in 1984 and I have been at Barberton since then. And during that time I, I entered Case Western's Law School and received my JD

degree in May of 1990.
Q. Okay. Do you practice law?
A. Yes, I do.
Q. And where do you practice law?
A. Out of that address there,
Q. What kind of law do you practice?
A. Mostly business law. Some, some plaintiff's work. It's not a large practice.
Q. Do you have any affiliation with Jacobson, Maynard, Tuschman & Kalur?
A. No, I do not.
Q. Are you insured by PIE?
MR. BEST: Objection. But go ahead.
A. I believe that the group I work for has a policy with PIE, although I'm not sure.
Q. What group?
A. I practice with Acute Care Specialists.
Q. And that's your work out of Barberton?
a. That's correct.
Q. Is that a corporation?
A. Yes, it is,
Q. So Acute Care Specialists, Inc,, right?
A. I believe *so.*
Q. All right. And they are insured with PIE?

MR. BEST: Objection.

A. I think so.

Q. Have you, yourself, ever been sued and defended by PIE?

MR. BEST: Objection,

A. I don't think so.

Q. Has your group been sued and defended by PIE?

A. I think they have.

Q. And who at PIE has defended your group?

A. I don't know. I'm not familiar with any of the particular cases. I think there have been because it's been mentioned to me before. Some of the other physicians asked my advice about what do I think of the case and I believe from hearing them that it's been PIE, but I have no, no other way of knowing that.

Q. You have never testified in any such case?

A. Involving Acute Care Specialists?

Q. Yes.

A. No.

Q. And you never met with any physicians who have been sued and any members of PIE with respect to those cases?

A, No.

To your knowledge, has Mr. Best?

A. I'm sorry?
Q. Has Mr. Best represented your group?
A. I don't know. If he has I don't know about it,
Q. And you've been with the group since '84?
A. Correct.
Q. How are you compensated for your work? I mean you contract with Acute Care Specialists. Are you an employee of theirs?
A. No.
Q. How do you get paid?
A. I'm an independent contractor and my professional corporation has an agreement with Acute Care Specialists.
Q. What's your professional corporation?
A. EMS M.D., Incorporated.
Q. And what's the nature of the contract? Do you get paid hourly, daily, monthly, yearly?
A. We just changed this year and it's, there is a fairly complex formula. It involves a fee for service formula. We get paid a certain amount hourly, but the amount of fees generated are calculated for the entire group and there's a complex formula which I can't relate to you because I don't understand it myself.
Q. How many employees does EMS M.D., Inc. have?

A. One.
Q. Yourself?
A. Correct.
Q. Does anybody else work out of this, out of your home?
A. No.
Q. What is F.A.C.E.P.?
A. Fellow of American College of Emergency Physicians. I'm going to ask you to bear with me, I've got a cold and if, I won't be able to talk louder.
Q. As long as you keep it to yourself.
A. Okay.
Q. Is there a board certification for emergency room physicians?
A. Yes.
Q. And are you board certified?
A. Yes, I am,
Q. And when did you become board certified?
A. 1984.
Q. And that's when you started with Barberton?
A. I had actually passed the exam, taken the exam just before I started with Barberton.
Q. Okay. Why did you leave Huron Road?
A. God, that's been so long ago. I think it was

because I wasn't happy there, I had some disagreement with the management, the people that hired me there.

Q. What were the nature of the disagreements?

A. They wanted me to be able to work at different hospitals and they had contracts with other hospitals and they had placed some requirements on certification at Hillcrest which I disagreed with and we had a falling out over that,

Q. I don't understand the certification.

A. They were trying out a new program out there at Hillcrest for physicians to become credentialed for the emergency department. Where there was some political moves by the anesthesiology department to have any physician who was working in the emergency department *go* through a certification in airway management, endotracheal intubation by the anesthesiologists, and I was the first and only person to go through that and I had a disagreement with the anesthesiologist about the appropriate way to do emergency intubations and even though I had demonstrated the proficiency in intubation he said that I needed more training and I said that it was nonsense. And that was our disagreement.

Q. Okay. How about St. Alexis, why did you leave there?
A. I left there because the person who had that contract turned out to be a somewhat unscrupulous gentleman and it became apparent that he was not long for that contract and in any case --
(Thereupon, Mr. Walters entered the deposition room.)
A. -- and I decided that I didn't want to work for him.
Q. Who was that?
A. His last name was Notash. Dr. Notash, N-O-T-A-S-H. I don't remember his first name.
Q. How about Akron City, why did you leave there?
A. The, there were a couple of reasons. One of which, the main one was that I had been appointed the associate director of EMS activities that works with the rescue squads, that was about in 1982, and that was a half time position. I was working half of my time in clinical hours and half in that position. We were getting busier in the emergency department and we needed more clinical coverage and they elected to assign increased clinical coverage to

me and not the other person who was in the EMS office with me rather than spreading it out and I told them I wouldn't do it. And we had a parting of the ways.

Q. Did they terminate you?

A. It was mutual.

Q. How --

A. It was not my original choice, though.

Q. How much time do you currently spend in the emergency room at Barberton?

A. It probably works out to between 40 to 50 hours a week. It will be about 2,000 hours for calendar year 1991.

Q. And what's your schedule?

A. I don't understand.

Q. Do you go in there daily 8:00 to 5:00?

A. It's erratic. There are two shifts that the attending physicians work. The day shift runs from 8:00 a.m. to 7:00 p.m. The night shift runs from 7:00 p.m. to 8:00 a.m. the next morning. Those are the only two shifts, There are occasional fill-in shifts that are shorter when we make special arrangements. Those are the most common shifts that I work and it's irregular.

Q. Who sets your schedule?
A. There is an assistant director who makes up the schedule monthly.
Q. Of Acute Care Specialists?
A. He's the assistant director at Barberton Hospital.
Q. 1 see,
A. In the emergency department.
Q. Okay. And your billing then would be done through Acute Care Specialists?
A. Billing?
Q. Yes.
A. You mean my billing of them?
Q. Billing of patients.
A. Patient billing is all done by Acute Care Specialists.
Q. Okay. How many times have you testified as an expert witness, doctor?
A. In malpractice cases?
Q. Okay. Sure.
A. We're restricting it to depositions?
Q. Any testimony.
A. Probably more than, more than ten, less than twenty-five. Something in that range.
Q. And how many times for Jacobson, Maynard,

Tuschman & Kalur?

A. That I'm not certain of. Probably about ten times.

Q. How many times for Mr. Best?

A. Once or twice? Something like that. No more than two or three times. I can recall one. I'm not sure if there were others.

Q. How about for Mr. Charms?

A. I never testified for Mr. Charms.

Q. When were you first --

A. This is Mr. Charms?

MR. WALTERS: No. I'm Steve Walters, by the way. I'm sorry.

A. I talked to Mr. Charms on the telephone. I never met him.

Q. When did you first write a report in this case?

A. I didn't write a report in this case.

Q. When were you first contacted?

A. Excuse me. I'm sorry. I stand corrected. The report was January 26th.

Q. Well, wait a minute. Did you or didn't you write a report?

A. I did write a report.

Q. Just so, just so we understand each other, I mean Mr. Best just handed you what I have been

provided with as apparently a report of yours to Mr. Charms. Did you write this, doctor?

A. I did write it.

Q. When did you write it?

A. Shortly before January 26th, 1990.

Q. How do you know that?

A. It's dated that time. And I would write it before I sent it.

Q. And how is it that Mr. Charms contacted you? Do you recall?

A. I think he called me but I don't recall offhand.

Q. And did you review anything in addition to what's set forth in your report?

A. Prior to this report?

Q. Sure.

A. No.

Q. How about since then?

A. Yes.

Q. What have you reviewed since then?

A. I've reviewed the deposition of Walter Maciejewski, The deposition of --

Q. What's the date of that deposition?

A. That's from, I'm sorry, Friday, February 2nd, 1990.

I've reviewed the April 27th, 1990 deposition of Catherine Keating.

And I've reviewed the first 35 pages of the November 7th, 1991 deposition of Paul Kohn.

I've reviewed the emergency department record of October lst, 1988 of the Lakeland, or, excuse me, Houston Northwest Medical Center Emergency Department.

And I reviewed the reports of June 1st, 1989 and April 9th, 1990 of Dr. Paul Kohn.

Q. Okay. When did you review the '89 report of Dr. Kahn?

A. This morning,

Q. This morning?

A. Yes.

Q. All right. I take it then you reviewed both of those this morning?

A. Yes.

Q. When did you review the emergency room record from Houston?

A. This morning.

Q. How about the, how about Dr. Kohn's deposition?

A. The first 35 pages I read probably sometime this morning or this afternoon.

Q. How about Dr. Keating's and Dr. Maciejewski's?

A. Dr. Keating's deposition I read this morning.

Dr. Maciejewski's deposition I reviewed, I believe, a couple of weeks ago.

Q. When did you receive these documents?

A. I received Dr. Maciejewski's deposition on February 10th, 1990. The other ones I received last night.

Q. Is this your entire file, sir?

A. Yes, it is,

Q. Has anything been removed from it?

A. Just correspondence,

Q. What correspondence?

A. With Mr. Charms, Correspondence from Mr. Best.

Q. And where is that correspondence?

A. Probably at home,

Q. Why was it removed?

A. Because I didn't want it in my file,

Q. Why not?

A. It doesn't belong there for the deposition.

Q. Did you make that determination as an expert witness or as an attorney?

A. Probably both.

Q. Did somebody tell you to not bring it, though?

A. No.

And the reason you didn't bring it was what

again? I mean what is contained in there that you felt that I shouldn't see?

A. Correspondence between myself and the attorneys involved in the case.

Q. So there's letters from you to them?

A. I'm not sure. Probably.

Q. And how many letters are we talking about?

A. I don't know.

Q. And what are the dates of the letters?

A. I don't know that either.

MR. KAMPINSKI: Can I be provided with those, Mr. Best?

MR. BEST: I don't even know what he's talking about. But I will look into it.

MR. KAMPINSKI: In light of the fact that we have a trial shortly I don't want to run over to the court Monday morning with a motion.

MR. BEST: I haven't even looked at his file ever. I never looked at it. I'm seeing it with you. I don't know anything about it. I'll look into it. I assume they are just cover letters, but I don't know what they are.

Q. What are they?
A. The letters?
Q. Yes.
A* They are mostly cover letters, the introductory letter that was received with this. There's billing statements, things like that.
Q. Why don't you let me take a look at what you did bring.

Do you know Dr. Maciejewski?

A. No, I do not.
Q. Have you ever testified on behalf of the emergency room physicians at Hillcrest before?
A. Not on their behalf, no.
Q. Against them?
A. I believe *so.*
Q. When was that?
A. Sometime in the mid 1980's there was a case against, I believe, Dr. Gross. Nyerges versus Gross, N-Y-E-R-G-E-S, versus Gross. I'm sorry. I was on the defense on that, Paul Kaufman was the plaintiff's attorney and I was on the defense side. But I had some critical things to say about Dr. Gross.
Q. Well, had you been retained?
A. 1 had been retained by the defense.

Q. By a physician other than Dr. Gross?
A. No, I believe I was retained on behalf of Dr. Gross.
Q. Okay. And what did he do wrong?
A. To be honest with you, I don't even remember what that case was about.
Q. In becoming board certified -- and did you pass your board certification the first time?
A. Yes, I did.
Q. In becoming board certified do you have to be able to read and interpret **EKG's?**
A. Well, we would like to think so. But the two parts to the exam, the written part theoretically it's possible to pass that even if you miss all the EKG questions. And similarly the oral part, unless they give you a scenario which requires you to read and interpret an EKG, that plays a critical part, You might be able to pass through without doing it. Theoretically the answer is yes.
Q. All right. I want to make sure I understand. They do in fact test you on your ability to read EKG's in becoming board certified?
A. The answer to that is yes. Your question was do you have to read EKG's to pass and become board

certified. That was your first question.

Q. I understand. You can pass and not be able to read them, but nonetheless they try to test your ability to read them?

A. Yes.

Q. The training of someone who is an emergency room physician, he should be able to read EKG''s appropriately?

A. Correct.

Q. Because 1 take it it's not unusual to see people coming into the emergency room who have chest pain, who are given EKG's and it is then up to the emergency room physician to interpret those?

A. Yes.

Q. And the life of the patient may depend upon his ability to do *so?*

A. Correct.

Q. Was that done correctly in this case?

A. Yes, it was.

Q. So you disagree with Dr. Nickel's interpretation of the EKG?

A. No, I don't disagree with his interpretation.

Q. Well, he indicated that he couldn't rule out an acute injury. Do you agree with that?

A. Yes, I do.

Q. Do you believe the ST waves were elevated in the EKG?
A. Which part of the EKG?
Q. Well, any part.
A. Well, there were portions that were elevated but those were not necessarily acute. The fact that you can't rule out something acute doesn't mean there is something acute going on.
Q. If you can't rule it out you don't send somebody home guessing that maybe it is acute, maybe it isn't?
A. You used the word guess. We always make an assessment. There's never a hundred percent certainty about anything. When you make an assessment if your findings are more consistent with a non-acute process or non-cardiac process you reach a certain point where you are confident enough to send somebody home.
Q. The ST waves in leads V2 and 3, those are the ones that you are referring to as not, not being able to rule out an acute injury?
A. No. I think he was referring to the whole constellation, What he's got there is complete left bundle branch block associated with tall peaked narrow T-waves in precordial leads V2 and

v3.

Q. Where do you see the abnormal ST waves?

A. If you take a look, for example, the ST looks like it's a little down in lead 1 and it looks like its up here.

Q. In lead 3?

A. Yes. Some of the precordial leads. What you see in the polygraph block, what we call the secondary ST. The ST segments will typically go the other way or the opposite direction from the main vector for the acute aspects.

Q. Dr. Maciejewski didn't read these as abnormal. Do you find any fault with his interpretation?

A. I think he did read this as a left bundle branch block. That is abnormal. He documented that in his record.

Q. I misspoke. He didn't read this as a potential reflection of an acute injury. Do you disagree with that?

A. He didn't count that these are potentially reflecting an acute injury. But he also testified --

Q. You read his testimony?

A. Yes, I did.

Q Q To the extent that he didn't believe there was

any evidence of an acute myocardial injury on the **EKG?**

A. I believe his testimony was that taking the clinical picture into consideration he was able to conclude that this did not reflect an acute process.

Q. Are you saying he didn't say that he felt that the **EKG** didn't no **show** any acute injury, is that your testimony?

A. I believe his testimony was that whatever changes he saw in here were not acute based on his, on his perception of the clinical picture. If you can find otherwise I will be glad to take a look at it.

Q. Well, the clinical picture, does that include the history?

A. Absolutely.

Q. And this man had a history of heart problems?

A. Yes, he did.

Q. And he was on heart medication?

A. Yes, he was.

Q. Does that lead one to conclude that a questionable **EKG** is more likely due to a heart problem as opposed to esophagitis?

A. It's one more piece of data that would be

balanced on the side that this is a cardiac problem.

Q. Do you believe that the EKG shows coronary ischemia?

A. Acute coronary ischemia?

Q. Yes.

A. Yes, I do.

Q. Well, Page 51 of Dr. Maciejewski's deposition, sir, do you recall reading that?

A. I read it. I don't recall specifically. Which lines are you pointing to?

Q. Well, where he indicates that he didn't think that there was acute coronary ischemia. I think that's line five.

A. And he said I don't think that this was coronary ischemia.

Q. Do you disagree with that?

A. No, I don't. I also don't see where this contradicted what I told you before.

Q. In other words, the word acute being the operative word?

A. The word acute is not used right in here.

Q. 1 understand. But you're distinguishing your belief that Dr. Nickel is correct in not being able to rule out acute coronary ischemia, you

agree with that, correct? I think that's what you just said?

a. On the EKG. The EKG being consistent with, you can't rule it out with just the EKG.

Q. And Dr. Maciejewski is indicating that he didn't believe the EKG is reflective of coronary ischemia. Now, are you telling me you are in agreement with him, in agreement with Dr. Nickel, in agreement with both of them and I'm confused?

A. I do agree with both of them and I'm not ready to say whether you are confused or not.

Q. Is the distinction then the word acute?

A. I don't think so. The distinction is based on the EKG only without the clinical presentation. There are many EKG findings which are abnormal which are consistent with or even typically acute or representing acute coronary ischemia but when placed in the clinical presentation aren't.

Q. I took out the clinical context and asked Dr. Maciejewski just to deal with the EKG, which is what I've asked you to do,

A. Yes.

Q. Okay. You say it is consistent with coronary

ischemia, he says it is not?

A, No. I think I said -- that's not what I said at all.

Q. Let's clear it up,

A. Dr. Nickel's interpretation that the constellation, the entire constellation, left bundle branch block, he's saying he can't rule out the possibility of an acute injury here.

Q. Okay. Well, but Dr. Maciejewski did?

A. Well, let me use another example to try to make it clear and if I'm getting off track please get me back on.

A typical finding in coronary ischemia or someone who is having acute coronary ischemia is premature ventricular contractions and in the setting of coronary ischemia these are considered when they are frequent to be very dangerous and they require treatment right away. If you see those on an EKG you have to say you can't rule out coronary ischemia and they can be very dangerous. However, we also know that there are hundreds of thousands of people who have these abnormal beats all the time without their having any clinical significance and if you point out on the EKG,

just on the **EKG**, that you can't rule out coronary ischemia, that would be correct. But the person examining the patient who realizes that this is a, an **EKG** done for other purposes and routine pre-op or that this person has had these for a long time, you can see those findings and agree with that interpretation but you have ruled that these are not acute. That's analogous, I think, to what's happened here.

Q. Do you agree or disagree with Dr. Maciejewski's conclusion that the EKG does not represent coronary ischemia?

A. I agree with that.

Q. Should an emergency room physician compare an **EKG** that he had done on a patient with a prior EKG if he can?

A. If he can and if the circumstances dictate. That's not a yes or no type of answer.

Q. Well, I mean if there is one there available, one of the things that I assume that you want to see is if there's been any changes since the last **EKG?**

A. It depends on what the findings are. For example, if you had a normal **EKG** you wouldn't bother with the previous one. So the answer to

your question is it would depend on the circumstances.

Q. How about under these circumstances where a man comes with chest pain having had prior cardiac problems?

A. Yes, it would be helpful to see the previous EKG.

Q. Would you consider it substandard then for a physician if he was handed a previous EKG to refuse to compare the two?

A. How old are we talking about?

Q. In this case. Let's assume that Dr. Maciejewski was handed an EKG that had been done, you know, a year, year and a half before and he refuses to compare the two. would that be a failure to adhere to the appropriate standard of care for an emergency room physician?

A. If that had been done in the early part of this evaluation a year before?

Q. A year, a year and a half.

A. A year might be helpful. After the evaluation and his response to the medication it probably wouldn't be very helpful from that long before,

Q. The response to that medication --

A. I have a problem with refusing to consider any

information.
Q. What do you mean you have a problem?
A. Well, you indicated a scenario where he's been offered an EKG and he is refusing it.
Q. Yes.
A. And that, my answer remains that under certain circumstances you would want to see the other EKG. The less likely a cardiac problem is the less important are previous EKG's. EKG's are, again, just one piece of information. The diagnosis of coronary ischemia is not an EKG diagnosis, it's a clinical diagnosis.
Q. I take it the problem you are having with the scenario I just laid out for you is that it would not be appropriate for an, for a physician to refuse to take a part of the information that is available to him so he could make an adequate assessment?
A. The problem I'm having with it is it depends on certain circumstances. I still think it's inappropriate. The circumstances may be such that it's not substandard.
Q. Well, under these circumstances where Mr. Quinn was at the hospital, you know, the evening that he was seen by Dr. Maciejewski and he did an

EKG, if he had been presented with another EKG that had been done within a year and a half, should he have looked at it in your opinion?

A. You mean after all this is done?

Q. All what, doctor? How long was he here?

A. He was only there a couple of hours.

Q. All what?

A. That's what I meant. All the things that were done, the testing, the medication,

Q. Sure.

A. The answer is I think it would be inappropriate not to look at it. If you are equating substandard and appropriate or inappropriate?

Q. Yes.

A. Then I disagree with it.

Q. So it was okay for him to throw it back in the wife's face and say this isn't helpful to me?

MR. BEST: Objection.

A. If you are saying to throw things back in the wife's face, obviously that is not standard or acceptable in anybody's practice.

Q. And if in fact the previous -- have you looked at the previous EKG?

A. No.

Q. So you don't even know what it shows?

A. That's correct. I don't think I have. I have some. I would like to take a look at the file.
Q. Sure.
A. I haven't seen it for a long time.
Q. Absolutely.
A. And I would like to check and see if the other EKG is there so I don't misspeak.

There's an **EKG** in here from April of 1988 which is in my records so 1 have must have seen it. If it is the one that you are talking about, That would be a year and a half prior to this.

Q. I don't think so.
A. Then I haven't seen the **EKG** you are talking about.
Q. Okay. Just for the sake of argument if it was in fact different, showing changes from the **EKG** that was done the night of the visitation, would that in any way change your opinion?
A. A year and a half, you are still saying a year and a half ago?
Q. Yes.
A. No, it would not.
Q. Why not?
A. Well, there's, a year and a half before that is,

it's too long to say when the changes occurred and again you're going to have to make a clinical and not an EKG diagnosis,

Q. Your testimony is that if there is a change in a prior EKG and an EKG done on an individual having chest pain that's not significant to you as an emergency room physician? Is that your testimony?

A. That's not what 1 said.

Q. Why don't you say it again.

A. I said that a year and a half prior, if you're dealing with an EKG which is different than the one you are looking at presently and if the interval is a year and a half that's too long to figure out when the changes occurred and you're going to be thrown back upon your clinical impression, your clinical assessment as to what's going on.

Q. So it is your testimony that if you are presented with an EKG from a year and a half prior that is substantially different than one that you are looking at for a person who comes in with chest pain that that's not significant to you?

MR. BEST: I object. He said what

his answer is twice. If you want him to give it to you a third time. But you're trying to re-characterize it and put a spin on it that he has twice rejected. So it might be simpler to go onto a new topic. If you want to answer it a third time, doctor, go ahead.

Q. Go ahead.

A. Well, the first question you asked was any change from a previous EKG. And if you're asking specifically about a year and a half, again, if it's going to depend on this case no, that would not be significant. It depends on what the changes were. I can certainly imagine that there are some changes where it might be significant from a year and a half previously to presently depending on what the changes are and the clinical circumstances.

Q. Were you aware of the emergency room physician being provided with an earlier EKG in your review of the records?

A. No, I was not,

Q. Would that have made any difference to you in your review, if you had been made aware of that?

A. In terms of that he had an EKG that was

different than the one presently?

Q. Yes.

A. I doubt it, I would have to see the EKG to make that final determination,

Q. Do you disagree -- I'm sorry. You said you saw Dr. Kohn's report for the first time today?

A. Well, I saw it for the first time last night, I read it the first time today.

Q. You are not a cardiologist?

A. No, I'm not.

Q. Do you disagree with Dr. Kohn's interpretation of the EKG taken in the emergency room as reflecting marked ST segment depression of four to five millivolts in leads 2 and precordial lead V6 the tracing was not considered to be significant and the patient was advised to use antacids for relief of his symptoms? Do you agree or disagree with that?

A. I don't disagree that there's that finding, Not a determination. That's not a determination. Description.

Q. Do you agree that the significance of the ST segment depression is that it is indicative of myocardial injury and is seen in the very early phases of an acute myocardia9 infarction or, at

the very least, is found as a feature of unstable angina or pre-infarction angina?

A. I agree that it's consistent with that or that one can't rule that out.

Q. And in view of the patient's past history and the EKG that Mr. Quinn should not have been allowed to leave the emergency room but rather should have been transferred to the coronary care unit?

A. I disagree with that.

Q. Why is that?

A. Because the overall assessment did not support a diagnosis of coronary ischemia,

Q. What assessment are you referring to specifically, doctor?

A. I'm referring to the overall assessment.

Q. Tell me specifically what findings it is that leads you to that conclusion?

A. The history indicated that this gentleman was suffering from a pain which was characteristic of a gastrointestinal type of pain. He had it typically after meals. It was a burning pain, It also seemed to improve with antacids. It also was not relieved with nitroglycerin. He did not have any of the other typical signs or

symptoms which we usually associate with coronary disease,

Q. Such as?

A. Such as a crushing pain, sweating, discomfort in the arms, neck or radiation of his discomfort into those areas, profound weakness and which would be especially important in this gentleman who had a documented history of coronary ischemic disease and who had obviously had symptoms of coronary problems in the past and who did not provide any symptoms like that. We have enzymes which although not definitive were clearly within the normal range at this point. And we had his response to the medication, too. And also we have the history that he provided that he had had problems with esophagitis in the past and they were similar to the problems that he was having now.

Q. Okay. Anything else?

A. There may be. That's just what I recall offhand.

Q. What was the interpretation in the chart by Dr. Maciejewski of the EKG?

A. Normal sinus rhythm. Left bundle branch block. Old anterior MI.

Q. Do you agree with that?
A. Yes, I do.
Q. There's no mention of the MI or ST segment depression, is there, doctor?
A. Well, there is some mention of left bundle branch block.
Q. Is that different than ST depression, doctor?
A. It's almost as if he put left bundle branch block and then you are saying he didn't mention an MI.
Q. I know. I just asked you a question is left bundle branch block ST depression?
A. ST depression is a component of left bundle branch block. If you are mentioning that you are going to assume that there is some secondary ST changes.
Q. Can't left bundle branch block mask marked ST segment depression which can be indicative of an impending MI?
A4 Actually that's an old belief that used to be taught and is still taught, unfortunately, to lots of people and if you take a look at the literature now it's pretty clear that, that that's not true. You expect to see ST changes and when they are beyond a certain amount then

you can say there is something acute there. If you don't have that above a certain, for example, if you don't have at least around eight millivolts of depression or elevation in left bundle branch block then you conclude that it's not acute.

Q. Well, what well known medical texts will I find that in?

A. I know it's referenced in a lot of texts. There was an article that was published in the Annals of Emergency Medicine.

Q. What was that article?

A. I would have to get you the reference. I don't have it off the top of my head. It was in the Annals of Emergency Medicine.

Q. When?

A. Within the last two or three years.

Q. And what was the name of the article?

A. I can't give you the title. I'm sure I have it in a file somewhere.

Q. And how long would it take you to find it?

A. Once I'm home probably about five minutes.

Q. How about these ten to twenty-five times that you testified, do you keep track of those cases? Do you have some record of those cases?

A. A record of the names of the cases?
Q. Yes.
A. I have a list of cases. I'm not sure all of them are broken down whether I testified in a case or not.
Q. Do you have a list of attorneys involved in those cases?
A. I think I do,
Q. All right. How long would it take you to get your hands on that? Do you have that at home as well?
A. Probably not too long.

MR. KAMPINSKI: Could I be provided with those, Mr. Best?

MR. BEST: I'll let you know.

MR. KAMPINSKI: When will you let me know?

MR. BEST: I don't know. I don't know that I've had anybody ask that before. So I'll reflect on it. But I don't know the answer to that question.

MR. KAMPINSKI: Would it be too much for me to ask you to let me know by Monday?

MR. BEST: Why don't you give me a

call and we'll talk about it. Believe it or not I'm going to take a couple of days off.

MR. KAMPINSKI: That's why I said Monday. I plan to myself.

Q. Well, that old time thinking might have saved Mr. **Quinn's** life here?

MR. BEST: Objection.

Q. Being as he had a heart attack and died?

A. That's not a question,

MR. BEST: Objection.

Q. Yes, it is.

MR. BEST: You don't have to answer.

Q. If somebody would have used old time antiquated thinking in this case in your opinion might Mr. Quinn's life have been saved?

A. Not in this case.

Q. Why not?

A. Because, again, the clinical, the clinical assessment was not consistent with coronary ischemia.

Q. Well, what does the old time antiquated thinking say with respect to the masking of ST segment depression by a left bundle branch block?

A. Everybody says that on the EMG because there are these secondary ST changes you can't tell if you have acute ST changes.
Q. And that's still being taught?
A. I believe so. I think it is taught and those who believe those are, true, are in good company. If you take a look at most cardiology texts or electrocardiology texts they make an attempt to go by that.
Q. Which texts are these, sir?
A. I'm not sure. I remember it saying that in most.
Q. You just said most. Give me one,
A. I wouldn't even try to tell you which ones.
Q. How long would it take to you come up with that?
A. That would take me quite a while.
Q. Who wrote this article?
A. I don't know the authors' names offhand.
Q. Is he a cardiologist?
A. I don't know.
Q. In light of the reading of this EKG by Dr. Maciejewski, do you find the reading of Dr. Nickel to be, the reading of the EKG by Dr. Nickel to be of any significance at all?
A. I'm not sure what you're asking me.

Q. Yeah. I think I hear you saying, maybe I'm wrong, that Dr. Maciejewski read this the same as Dr. Nickel. Is that what you are saying?
A. I don't think he, he attached the same significance that Dr. Nickel is proposing.
Q. Well, did you read Dr. Nickel's statement? Was that provided to you?
A. No.
Q. All right. I'll ask you to assume that Dr. Nickel's opinion is that Mr. Quinn should have been admitted to the hospital because he had a potential impending MI and shouldn't have been discharged from the hospital. Do you agree with that?
A. No, he's wrong,
Q. Okay. Dr. Kohn is wrong also?
A. Oh, absolutely.
Q. But you're right?
A. Absolutely.
Q. What did Mr. Quinn die from?
A. It appears that he died of pulmonary edema which led to hypoxia and failed rhythm.
Q. How did all that come about? Was it as a result of a heart attack?
A. It was not due, as best I can piece it together,

the information is a little skimpy here, but based on the records from the emergency department and what there is in the autopsy report it looks like he had longstanding coronary disease and a weak heart muscle and developed an episode of acute pulmonary edema.

Q. Did you read the deposition of the coroner?

A. No.

Q. He said he had a heart attack. Are you aware of that?

A. That's not what was said in the autopsy report,

Q. He says that is what was said in the autopsy report. You don't agree with that either?

A. I don't find the information necessary to support that in his autopsy report.

Q. So he's wrong then, too?

A. It depends. Why didn't he say that in his autopsy report? That's not what he said.

Q. So then he's wrong as well?

MR. BEST: He didn't do the autopsy, that's why.

MR. KAMPINSKI: It was done under his direction,

A. I don't know if he is right or wrong. If he knows something else other than what's in the

autopsy report then tell me.

Q. Well, maybe he knows a little more medicine than you do. I mean as hard as that it is for anybody to believe,

A. I assume that that does not require a response?

MR. BEST: It does not.

Q. Well, does the EKG reflect any condition that caused Mr. Quinn's death, in your opinion?

A. Well, sure. He's got, he's a got a left bundle branch block and he's had damage to his heart muscle, he has enough damage to ruin it.

Q. Did he have fresh damage to his heart that caused his death?

A. Based on what, the EKG?

Q. No. Based on the autopsy on his death.

A. Well, the autopsy findings, again, are a little bit skimpy and what I can see on there is he had damage and there's nothing there on which I can say that there's been an acute MI and apparently whoever did the autopsy and made the report thought the same thing.

Q. Are you a pathologist?

A. No, I'm not.

Q. Oh, I thought maybe you were. Do you have the autopsy report?

A. Yes.
Q. The, you highlighted part of the autopsy, the hard findings. When did you do that?
A. Probably when I reviewed this shortly after I received it.
Q. All right. The area of gray-white fibrosis with red gelatinous mottling on the posterior surface and lateral wall, what was that due to?
A. The gray-white fibrosis usually means that there's been some damage to the heart muscle.
Q. How about the red gelatinous mottling?
A. That's I'm not sure about.
Q. Well, does that reflect an acute process?
A. An acute MI looks a little different than that. It's not on top of a gray-white fibrosis. Like you said, I'm not a pathologist.
Q. The fact that the mammary bypasses were identified and patent, you highlighted that, too, does that tell you that the bypasses done in 1971 on Mr. Quinn were still open?
A. That's another way of saying the same thing that's said there.
Q. All right. So whatever damage to his heart was not done as a result of any old problem he had, would that be a fair statement?

A. I'm not sure what that question is.
Q. Do you know what was bypassed in '71?
A. I'm not sure,
Q. You are weren't provided with those records?
A. His 1971 records?
Q. Yes.
A. No. If it's in his office records then I have to take a look again to see, look at it.
Q. Was the left anterior descending artery bypassed?
A. I'm not sure.
Q. Would the injury that you see reflected in the heart on the autopsy be consistent with a stenosis of the left anterior descending artery on the lateral and posterior walls? .
A. It might be more likely with certain things that might have caused that.
Q. Should Dr. Nickel's opinion have been passed on to either the family physician or the emergency room, in your opinion?

MR. BEST: I object. He's not being offered to render opinions about --

Q. Let me ask it differently. Should the emergency room department have been told of any difference in their interpretation with that of a

cardiologist who apparently is to read these later on?

MR. BEST: The same objection.

MR. WALTERS: I'll object, too.

MR. BEST: Go ahead.

A. If the question is should the cardiologist report to the emergency department any differences between his reading and that of the emergency department the answer is no.

Q. Why not?

A. Because there may be lots of differences that don't need to be passed on.

Q. How about the difference in this case, should that have been passed on?

A. If the difference is only that he could not rule out coronary ischemia in this case I would say no.

Q. Even though Dr. Nickel indicates that even he believes that it should have been reported?

A. The difference is that if Dr. Nickel believes that he has something that indicates proof positive an acute process that the patient should be admitted he should be reporting it,

Q. But that's what he testified to or, I'm sorry, you are not aware of that?

A. That's a different question than what you asked.

Q. I thought it was the same.

A, I'll be glad to have it read back.

MR. KAMPINSKI: Would you read it back?

- - - -

(Thereupon, the requested portion of the record was read by the Notary.)

- - - -

A. My answer was, and I will repeat it, if the difference was that he is, based on the EKG he could not rule out an acute coronary process or ischemia then no.

The next question was is the difference that he believes that this EKG definitely shows an acute process such that this patient needs to be admitted then he should pass that on.

Q. Assuming he did pass that on and that there was an acute process that needed the attention of somebody in the emergency room, should that have then been either told to the patient and/or his physician?

A. It needs to be told to someone. It could be the emergency physician to review the record. It's

not necessarily to the patient or the patient's private physician, if that's what you are asking.

Q. Well, what would he review if he got different information?

A. The emergency department record. If he's told by the cardiologist, though, that the EKG in his opinion is such that it requires the patient to be seen, I mean does he then say to the cardiologist well, the cardiologist didn't see the patient and evidently didn't know what happened in the emergency department. So the emergency physician would take a look. It's like when I mentioned before about the PVC's, if the report goes to the cardiologist without a notation the cardiologist, I think, is going to say hey, you guys missed this, these could be serious. If there is an acute process this guy needs to be admitted and the emergency room physician on duty would take a look at the chart and might be able to see it's just an incidental finding, it's not clinical at all.

Q. I guess your position then is whatever the emergency room physician does based upon his interpretation of the clinical findings

supercedes any findings made by scientific means such an EKG?

A. That's not what I said either. I will give you a situation where he would be wrong. If the emergency physician failed to recognize some clear sign of an MI, such an acute MI with classical ST segment elevation or ST depression and that shows up and the emergency room physician fails to recognize that. But when this comes back down to the history and it's atypical and it looks like a coronary ischemic process that doesn't matter at that point.

Q. Doctor, the cardiologist in this case believes that that's precisely what this EKG shows.

MR. BEST: I object.

A. That's not what I read. And that's not what he read. If you tell me that he has something else then I disagree,

Q. With Dr. Nickel?

A. Right.

Q. What is it that differentiates a cardiologist from an emergency doctor? Is it their training versus theirs? I mean do they go through additional training to learn cardiology that you don't?

A. I believe they do. But I've never investigated that. I believe they could have additional training.

Q. How much training did you receive in cardiology?

A. You mean the training that a cardiologist receives?

Q. No. No. How much did you receive, what independent cardiology training?

A. Just the standard clerkship in medical school and plus whatever there was in residency.

Q. What clerkship?

A. You do a rotation as a medical student for, I don't even remember if it was a month or two months, on a cardiology service.

Q. I thought your residency, I thought you said it was a surgical residency?

A. But you rotate on medical, You do some rotation.

Q. How long was your rotation?

A. I don't recall.

Q. A month? Two months?

A. It would have been the maximum of a month.

Q. The maximum of a month?

A. Yes.

Q. So you've had what, two months training then in cardiology?
A. Something like that.
Q. You mentioned that you read the Annals of Emergency Room Medicine or Emergency Medicine?
A. I refereed to an article which had been submitted for publication in the Annals of Emergency Medicine.
Q. Do you have any publications yourself, sir?
A. Yes.
Q. How many?
A, About 25.
Q. Would that be on your CV?
A. Yes.

MR. KAMPINSKI: All right. Can I have that?

MR. BEST: Yes. I didn't even have to think about it.

MR. KAMPINSKI: When might I have that?

MR. BEST: As soon as 1 get it. If I have a copy I'll have it sent over. I don't know. I didn't see one today when I was rummaging through this stuff,

Q. Are any of your articles on cardiology? Or let

me make it wider, or EKG interpretations?
A. I'm not sure. I don't recall any offhand.
Q. Are you an editor or have you been an editor of any publications?
A. Yes.
Q. Okay. What? What are those?
A. I'm a reviewer for the Annals of Emergency Medicine and have been through, since the early 1980's. I'm a contributing editor for the Journal of Emergency Medical Services, I was a contributing editor for a newsletter which is now out of business. I believe it was the Emergency Medical Services Management Bulletin. That's been out of publication for probably about five years. And I know I've edited some other publications but I can't recall exactly what offhand.
Q. Do you have any opinions about the care rendered by Dr. Keating in this case?
A. None.
Q. Do you know why it is you were provided with her testimony?
A. I am not sure why. It was sent to me,
Q. Were you asked to render any opinions with respect to her care?

A. No.
Q. Do you know any of the physicians involved in this case?
A. No.
Q. What group did you work for when you worked at Huron Road?
A. It was called Emergency Medical Associates. And I have no idea whether they are still operational or what.
Q. And who is the head of that group?
A. A fellow named Carl Meyer.
Q. How about at St. Alexis?
A. Dr. Notash was the head of that.
Q. And what was the name of the group?
A. I don't know. I don't even know that there was. I don't recall.
Q. The moonlighting you did in emergency rooms, did they include any moonlighting at Hillcrest?
A. No.
Q. Okay. So your only contact then with Hillcrest was as it related to this credentialing disagreement that occurred when you were at Huron Road?
A. That's correct.
MR. KAMPINSKI: Okay. That's all 1

have.

MR. WALTERS: I just missed one part in the beginning about the credentialing disagreement. Can you just explain it?

MR. BEST: He was going through why he left his various employments.

MR. WALTERS: Okay. That's all I need. Thanks. I don't have any-questions.

_____

MICHAEL FRANK, M.D.

C E R T I F I C A T E

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

I, Kenneth F. Barberic, 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 **MICHAEL** FRANK, M.D., was by me, before the giving of his 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, and was subscribed by said witness in my presence; 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.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of _____, A.D. 19 __.

_____
Kenneth Barberic, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires October 16, 1993