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IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO
FRANCES L. CHAPPELL, etc.,
et al.,
Plaintiffs,

JUDGE GRIFFIN
CASE NO. 324732

LLOYD COOK, M.D.,
et al.,

Defendants.

- - -

Deposition of DONALDW. JUNGLAS, M.D., taken as
if upon cross-examination before Laura L Ware, a
Notary Public within and for the State of Ohio, at
University Suburban Hospital, 1611 South Green Road,
Cleveland, Ohio, at 2:30 p.m. on Wednesday, February
9, 2000, pursuant to notice and/or stipulations of
counsel, on behalf of the Plaintiffs in this cause.

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(Thereupon, Plaintiffs' Junglas

Exhibits 1 through 6 were mark'd for purposes of
identification.)

- - -

DONALDW. JUNGLAS, M.D., of lawful age,

called by the Plaintiffs 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 DONALDW. JUNGLAS, M.D.

BY MR. GORDON:

Q. Could you please give us your full name and home
address, please.

A. Yeah, Donald W. Junglas, J-U-N-G-L-A-S, 2658
Kingston Road, Cleveland Heights, Ohio, 44118.

Q. Dr. Junglas, my name is Harley Gordon. This
afternoon I'll be asking you questions primarily
regarding your opinions and your bases for your
opinions in this case because you've been identified
by Mr. Betz as an expert on behalf of the late Dr.
Harold Klein.

Doctor, can we agree that if, for whatever
reason, you don't understand my question or
questions you'll not answer them and just tell me

5

1 that you don't understand the question?

2 A. Yes.

3 Q. If you want to take a break for whatever reason,

4 just stop me and we'll take a break. Okay?

5 A. Yes.

6 Q. You are an internist?

7 A. General internal medicine.

8 Q. And are you an oncologist?

9 A. No.

10 Q. Do you treat patients with cancer for the cancer?

11 A. No, not any longer. If they are in a position where

12 they are in a hospice situation then I may get

13 involved.

14 Q. But do you actually treat a patient for the

15 cancerous condition?

16 A. No.

17 Q. Do you stage cancer?

18 A. No. I don't know anything about staging.

19 Q. Okay. Do you do surgery?

20 A. No.

21 Q. Do you do endoscopies?

22 A. No.

23 Q. If you want an endoscopy, you order it?

24 A. Yeah. I have three gastroenterologist partners; I

25 have no trouble getting endoscopy

6

1 Q. Do you have any special interest in any area of

2 internal medicine?

3 A. No, just general internal medicine.

4 Q. Do you treat patients with peptic ulcer disease?

5 A. Yes.

6 Q. Do you also diagnose that condition?

7 A. Yes.

8 Q. What is peptic ulcer disease?

9 A. That's a disorder of the stomach and duodenum

10 whereby patients have an erosion in the mucosa or

11 the lining of the stomach which results in a defect

12 in that lining causing what's called an ulceration

13 or a scooped out area of the mucosa which is eroded

14 away.

15 Q. Have you ever diagnosed a patient with stomach

16 cancer?

17 A. Rarely.

18 Q. When was the last time you diagnosed a patient with

19 stomach cancer?

20 A. Twenty years.

21 Q. You are practicing presently with a group of other

22 physicians?

23 A. Yes.

24 Q. In terms of your knowledge of the patients of the

25 other physicians in your group, when was the last

7

1 time any member of your group --

2 A. I have no idea.

3 Q. -- diagnosed a patient with stomach cancer?

4 A. I have no idea.

5 Q. Okay. Please let me finish my question.

6 A. I'm sorry. I knew what it was going to be, so

7 that's why I answered it.

8 Q. I understand. Again, this is not a social

9 conversation.

10 A. I know, I know.

11 Q. When was the last time you treated a patient with

12 peptic ulcer disease?

13 A. Well, with a new ulcer probably six months. All of

14 my patients tend to be in the older age group with

15 their doctor and they tend to have been my patients

16 for a long time, and most of their illnesses we have

17 been through before and so I don't see very many new

18 patients, therefore I don't diagnose any new peptic

19 ulcer disease very often.

20 Q. When was the last time you had diagnosed a new case

21 of peptic ulcer disease?

22 A. Probably about six months.

23 Q. And how frequently in the last, let's say, five

24 years have you diagnosed a new case of peptic ulcer

25 disease?

8

1 A. I would say two a year maybe.

2 Q. Is there any difference in the workup of a duodenal

3 ulcer as compared to a stomach ulcer?

4 A. Not really.

5 Q. Have you authored any publications in the diagnosis

6 and treatment of peptic ulcer disease?

7 A. No.

8 Q. And am I correct you haven't authored any

9 publications in the area of stomach cancer?

10 A. No.

11 Q. Have you done any research in regard to any of the

12 issues in this case specifically for this case?

13 A. No.

14 Q. Do you rely upon any literature in conjunction with

15 your opinions in this case?

16 A. No. Most of what I'm going to give you today is

17 just my experience and practice.

18 Q. And --

19 A. In fact, I would say all of it.

20 Q. And in terms of that, when did you begin practicing

21 internal medicine after your education and

22 training?

23 A. 1964, December.

24 Q. And you've been continuously practicing internal

25 medicine since 1964 to the present?

9

1 A. Uh-huh. I started out part time in '64 and full
 2 time in July of '65.
 3 Q. Can you break down the nature of your practice into
 4 the type of diseases that you treat?
 5 A. Well, I usually tell people I take care of headaches
 6 to hemorrhoids, so that pretty much encompasses it.
 7 Q. How much is your practice in the area of treating
 8 patients with peptic ulcer disease?
 9 A. A quarter of one percent, very small.
 10 Q. And in terms of that percentage, how long has that
 11 been in place, going back for let's say the last ten
 12 years?
 13 A. I suppose when I was younger maybe it was half of
 14 one percent. I mean, as the patients have gotten
 15 older it's been less.
 16 Q. In 1991 when you were suspecting that a patient had
 17 peptic ulcer disease, did you on occasion order an
 18 upper GI series?
 19 A. I did occasionally do that, yes.
 20 Q. And why?
 21 A. If the patient's symptoms didn't respond to
 22 appropriate therapy I would further investigate
 23 their symptoms.
 24 Q. And why would you further investigate?
 25 A. Because I was looking to find out what was causing

10

1 their symptoms. The symptoms of peptic ulcer
 2 disease can also be symptoms of gastritis and other
 3 conditions of the stomach or small intestine.
 4 Q. And also --
 5 A. It could also be symptoms of cancer, although
 6 usually cancer is accompanied by weight loss, loss
 7 of appetite, nausea, a general lack of stamina.
 8 Q. Those--
 9 A. That's just a general, you know, a general
 10 overview.
 11 Q. Right, but --
 12 A. It's so rare that I see them.
 13 Q. Okay.
 14 A. And most of the time that practicing physicians see
 15 stomach cancer it is advanced. Unfortunately, it's
 16 picked up late.
 17 Q. And the symptoms that you described, including loss
 18 of weight, et cetera, including stamina, those are
 19 the symptoms of advanced stomach cancer?
 20 A. Well, advancing we'll say, yeah.
 21 Q. Well, with respect to --
 22 A. Early on stomach cancer probably has no symptoms at
 23 all and many patients they don't know they have it
 24 and that's why they don't seek medical attention.
 25 Q. You indicated that when a patient doesn't respond to

11

1 therapy you would order an upper GI series for a
 2 patient --
 3 A. Right.
 4 Q. -- you would suspect peptic ulcer disease. When you
 5 say would not respond to therapy, what are you
 6 referring to?
 7 A. Oh, I would say three to four months of usually the
 8 H2 blockers, Tagamet, Zantac, Pepcid, Axid, one of
 9 those. Nowadays we have things like Prevacid or
 10 Prilosec which are even more potent but usually use
 11 those as second line therapies.
 12 Q. In 1992, '93 and '94 --
 13 A. Those were not available.
 14 Q. -- you would order Zantac for peptic ulcer disease?
 15 A. Yeah.
 16 Q. Did you on occasion in 1991, '92 and '93 order an
 17 endoscopy for a patient who has peptic ulcer
 18 disease?
 19 A. My modus of practice is I interview the patient, I
 20 treat them as their symptoms indicate. If it
 21 doesn't respond, I order a GI series. I then rely
 22 upon the radiologist to tell me if the stomach
 23 lining is normal, does it move well, is there an
 24 ulcer, are there other findings that are indicative
 25 of possible further disease, and then they usually

12

1 are the ones that say, you know, I think this
 2 patient ought to have an endoscopy. So that's
 3 usually the way the patient gets an endoscopy from
 4 my end of the spectrum.
 5 Q. For instance, 1991, '92 or '93 if a radiologist
 6 identifies an abnormality --
 7 A. Right.
 8 Q. -- and you're suspecting peptic ulcer disease, would
 9 **you go ahead and do an endoscopy?**
 10 **MR. MEADOWS:** Objection.
 11 A. Not necessarily. If there's a small ulcer, I have
 12 frequently treated the patient for four to six
 13 weeks, had them have another x-ray, and if the x-ray
 14 is clear, the patient is asymptomatic, I conclude
 15 that they have been treated well and send them on
 16 their way with instructions to return if their
 17 symptoms reoccur.
 18 Q. Have you ever had an instance in which a radiologist
 19 did identify an abnormality and did not recommend an
 20 endoscopy but nonetheless you ordered an endoscopy?
 21 A. I can't recall any.
 22 Q. The ultimate determination as to whether to order an
 23 endoscopy is the internal medicine physician
 24 treating the patient?
 25 A. Yeah, the family practitioner or the internal

13

1 medicine person, unless, you know, some of my fellow
2 practitioners, the gastroenterologists, do general
3 internal medicine too, **so** they may select not --
4 they would naturally go toward doing something
5 that's in their line of work and therefore they
6 might not ever order a GI series, they may **just**
7 endoscope all of their patients.

8 I don't really know how they handle it, to be
9 honest with you. I'm not speaking for them, but I
10 mean I have never interviewed them as to find out
11 whether they ever order upper GIs. I don't know
12 whether they do or not.

13 Q. Did you finish your answer?

14 A. Yes. I say, I don't know whether they order them or
15 not. I can't tell you.

16 Q. Okay.

17 A. I suspect they don't order many.

18 Q. How do you know that if you don't know what they're
19 doing?

20 A. Just because I just know gastroenterologists like to
21 use endoscopes, that's all.

22 Q. Do you know or did you know Harold Klein, M.D.?

23 A. No.

24 Q. Do you know Dr. Gill?

25 A. No.

14

1 Q. Do you know Dr. Lloyd Cook?

2 A. No.

3 Q. Dr. Porter?

4 A. No.

5 Q. Now, prior to this case have you ever consulted with
6 the Gallagher, Sharp law firm before in a medical
7 malpractice case?

8 A. Not that I recall. If it were, it was only once or
9 twice. I don't do a lot of these, and I don't keep
10 a list.

11 Q. You've consulted with the Reminger & Reminger law
12 firm before in a medical malpractice case?

13 A. Yes.

14 Q. On how many occasions?

15 A. Two dozen maybe.

16 Q. Have you ever consulted with Mr. Bill Meadows
17 before?

18 A. On occasion.

19 Q. How many cases?

20 A. Maybe three or four.

21 Q. Have you ever consulted with **Ms.** Beth Sebaugh before
22 today?

23 A. I believe once.

24 Q. Have you ever consulted with Mr. Mark O'Neill before
25 today?

15

1 A. In regards to his mother.

2 Q. Have you consulted with any other member of the
3 Weston, Hurd law firm?

4 A. No.

5 Q. Have you consulted with any other member of the
6 Quandt, Giffels & Buck law firm?

7 A. Yes, I think Mr. Buck many years ago.

8 THE WITNESS: Is he still practicing?

9 MS. SEBAUGH: No.

10 - - - -

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

13 - - - -

14 Q. In any of the cases in which you have acted as an
15 expert on a medical malpractice case, did any of
16 them involve the diagnosis and treatment of a peptic
17 ulcer disease **and/or** stomach cancer?

18 A. No.

19 Q. Do you consult with plaintiffs' attorneys on medical
20 malpractice cases?

21 A. On occasion.

22 Q. Have you ever testified on behalf of a patient or
23 injured party in the greater Cleveland area in a
24 medical malpractice case?

25 A. Once in Medina, I believe.

16

1 Q. Could you give me a percentage how many times you've
2 acted as a consultant for a plaintiff versus a
3 medical care provider or a defendant?

4 A. One out of ten.

5 Q. 90 percent for the medical care provider, 10
6 percent--

7 A. Yes.

8 Q. --for the patient?

9 A. Yes.

10 Q. What do you charge, for instance, for your review
11 of--

12 A. 250 an hour.

13 Q. What are you charging me for the deposition?

14 A. 350 an hour.

15 Q. And what do you charge for your trial testimony?

16 A. \$500 an hour.

17 Q. Have you ever testified in either trial or in a
18 deposition involving a case involving peptic ulcer
19 disease or stomach cancer?

20 A. No.

21 Q. **So** is this the first case you ever acted as a
22 consultant on involving those issues?

23 A. Uh-huh, that's correct.

24 Q. Have you ever been sued in malpractice?

25 A. Yes.

17

- 1 Q. How many times?
 2 A. Once.
 3 Q. And what was that case about?
 4 A. An infected post fractured patella where the patient
 5 ended up with a difficult leg.
 6 Q. And how was that case resolved?
 7 A. I won.
 8 Q. Who represented you on that?
 9 A. Bob Maynard.
 10 Q. Speaking of that, were you insured by PIE at any
 11 time?
 12 A. Yes.
 13 Q. When were you insured by PIE?
 14 A. Before they went out of business, but before that
 15 when I was sued I was, I'm trying to think of the
 16 firm in Illinois, Medical Protective. I was sorry
 17 to leave them. The price was right, but it was
 18 wrong.
 19 Q. Then in the '90s you were insured by PIE?
 20 A. Uh-huh, that's correct. Luckily we didn't have any
 21 cases at the time they went down.
 22 Q. Other than with Mr. Betz or any member of his law
 23 firm, have you had any discussions with any other
 24 individuals regarding this case?
 25 A. No.

18

- 1 Q. In conjunction with this deposition we issued a
 2 notice of deposition for you to bring certain
 3 materials. Did you ever see that notice?
 4 A. I guess I have.
 5 Q. Is today the first time then that you've seen the
 6 notice of deposition that was issued on December
 7 10th, 1999?
 8 A. As far as I know that is.
 9 Q. Okay. Request one asks for your current curriculum
 10 vitae.
 11 A. That's correct.
 12 Q. And is this your current curriculum vitae?
 13 A. That's correct.
 14 MR. GORDON: Is that the same one we've
 15 been forwarded?
 16 MR. BETZ: Yes.
 17 Q. Okay. And you brought your complete file?
 18 A. On this case?
 19 Q. Yes.
 20 A. Yes, you have seen it.
 21 Q. Okay. Did you prepare any notes while you reviewed
 22 any of the materials in conjunction with this case?
 23 A. No.
 24 Q. Do you intend to use any demonstrative exhibits in
 25 conjunction with your testimony?

19

- 1 A. No.
 2 Q. Exhibit 1 is your report dated September 14th,
 3 1999?
 4 A. Yes.
 5 Q. And then earlier you wrote a report August 16th,
 6 1999, Exhibit 2?
 7 A. Yes.
 8 Q. And why did you write two reports?
 9 A. It was felt that a little more explanation should be
 10 given in my second report vis-a-vis endoscopy.
 11 Q. And are Exhibits 3, 4, 5 and 6 correspondence that
 12 you've received from the Gallagher, Sharp law firm?
 13 A. Yes.
 14 MR. MEADOWS: While you're going
 15 through that, can we look at what you've marked
 16 as an exhibit?
 17 MR. GORDON: Yeah.
 18 Q. And you've also, just for purposes of
 19 identification, reviewed Dr. Porter's deposition?
 20 A. Yes.
 21 Q. Dr. Coppa's report?
 22 A. Yes.
 23 Q. The deposition of Dr. Levitan?
 24 A. Yes.
 25 Q. Do you know Dr. Levitan?

20

- 1 A. Yes.
 2 Q. And how do you know Dr. Levitan?
 3 A. He practices at University Hospitals.
 4 Q. And is that where you practice too?
 5 A. Yes. Everybody in this building practices at
 6 University Hospitals.
 7 Q. Have you had any of your patients treated by Dr.
 8 Levitan?
 9 A. Yes.
 10 Q. How many patients, approximately?
 11 A. Four or five.
 12 Q. And are any of your patients presently under the
 13 care of Dr. Levitan?
 14 A. There may be. Many times when you have patients
 15 treating with an oncologist you don't necessarily
 16 see them, and unless you're getting regular
 17 information you don't necessarily keep up with them,
 18 so I can't really say for sure. I think not, but
 19 I'm not sure.
 20 Q. You read the deposition of Dr. Barry Singer?
 21 A. Yes.
 22 Q. You've read the deposition of Dr. Gene Coppa?
 23 A. Yes.
 24 Q. The report that you authored September 14th, 1999
 25 also indicates that you read the deposition

21

1 transcripts of Dr. Gill and Dr. Cook. Do you have
 2 those depositions with you?
 3 A. No. Maybe they're upstairs in my office, however.
 4 I thought I had everything together. I'm sorry, I
 5 don't.
 6 Q. You also indicated in your report of September 14th,
 7 1999 you reviewed Dr. Cook's records. Did you bring
 8 those with you?
 9 A. Well, they're probably with the other and I don't
 10 know where they are. They must be upstairs. I
 11 happen to have a number of files and I may not have
 12 had them all together.
 13 Q. When you say a number of files, files involving your
 14 consultation in medical malpractice cases?
 15 A. Yes.
 16 Q. How many cases presently are you participating in as
 17 a consultant?
 18 A. Maybe four or five.
 19 Q. Are there any other materials that you reviewed,
 20 including we have Dr. Klein's records here, that we
 21 have not identified?
 22 A. No. Would you like me to go up and hunt for those
 23 others?
 24 Q. Only unless you put some notes --
 25 A. No, I didn't make any notes anywhere.

22

1 Q. There's nothing? As long as you didn't put any
 2 notes or anything.
 3 A. No.
 4 Q. Unless you feel you need them for your opinions
 5 today.
 6 A. No, my opinions today should be confined to Dr.
 7 Klein.
 8 Q. And why is that?
 9 A. Because that's what I was asked to do.
 10 Q. Could you briefly tell me what you understand the
 11 facts are in this case.
 12 A. Mr. Chappell had symptoms of abdominal distress,
 13 presumably in July of '91, for which he was given
 14 Maalox or took Maalox and was seen a month later by
 15 Dr. Klein and was better.
 16 And then a year later was seen with complaints
 17 of a pain in his belly relieved by food where an
 18 examination was performed and was negative. He was
 19 given Zantac which he took, I believe, one at
 20 bedtime.
 21 He was seen a month later and his belly pain
 22 was better. Evidently, he stopped the Zantac
 23 sometime in that month and his symptoms had
 24 recurred. He was given another prescription for
 25 Zantac at that time, 100 tablets, was seen a week

23

1 later for symptoms seemingly not related to those
 2 which he had the previous week, presumably was on
 3 Maalox at the time.
 4 Blood tests done in August of '92 were normal,
 5 stool guaiac done at the same time a week later was
 6 negative, his weight was stable. And that was the
 7 extent of Dr. Klein's dealings with Mr. Chappell.
 8 Q. Do you understand further that Mr. Chappell died of
 9 stomach cancer on December 28th, 1995?
 10 A. Yes.
 11 Q. And you also understand that after treating with Dr.
 12 Klein he sought treatment and was treated by Dr.
 13 Cook?
 14 A. Yes.
 15 Q. And to clarify some dates, in 1992 Dr. Klein first
 16 saw the patient July 10th, 1992?
 17 A. That's correct.
 18 Q. Where he prescribed Zantac; is that correct?
 19 A. That's correct.
 20 Q. And August 10th, 1992 you indicated that after
 21 stopping Zantac the belly pain returned?
 22 A. That's correct.
 23 Q. Now, you have Dr. Klein's records in front of you.
 24 Could you read for me -- first of all, Dr. Klein
 25 took care of Mr. Chappell before 1991; is that

24

1 correct?
 2 A. Yes.
 3 Q. Actually, Dr. Klein was taking care of Mr. Chappell
 4 at least from 1977?
 5 A. December 28th.
 6 Q. Okay. Now, in your review of Dr. Klein's records,
 7 did you find any complaints of belly pain, abdominal
 8 pain, before July 10th, 1992?
 9 A. Well, presumably in July of '91 he had, I think it
 10 says, broiling roiling guts, I don't know, under
 11 much tension, sister died. I presume that's a -- in
 12 reference to his abdominal symptoms. Prior to that
 13 it's very difficult for me to make out his
 14 handwriting. He had a rectal polyp.
 15 MR. BETZ: Is there a particular
 16 notation you have in mind that you'd like him
 17 to look at?
 18 A. I don't see anything that strikes me.
 19 Q. Okay. Could you look at the entry of August 13th,
 20 '91 and could you help us -- well, could you help
 21 us by reading that?
 22 MR. ONEILL: August 13?
 23 MR. GORDON: 1991.
 24 A. Age 63. Feels much better on Maalox. Moving his
 25 bowels well and abdominal roiling broiling is

25

1 improved. Blood pressure 100 over 60. Tenderness
 2 over --
 3 Q. Does that have abdomen tenderness?
 4 A. I'm not able to make that out, maybe it is abdomen
 5 tenderness, I can't make out that word, sigmoid, and
 6 E-X-T, I guess extremities, negative, no polyps.
 7 Sigmoidoscopy, no polyps seen, stool negative.
 8 Maalox PRN.
 9 Q. Can you read what's above that Maalox?
 10 A. No.
 11 Q. Then to the right?
 12 A. Rectal polyp history. Not sure. Something colon
 13 syndrome, maybe spastic, I'm not sure. Spastic
 14 colon syndrome, rectal **polyps** history. I don't know
 15 what the other word is.
 16 Q. When **you** mentioned abdominal railing, what does that
 17 mean?
 18 A. Roiling.
 19 Q. Roiling.
 20 A. That's not a medical term, **so** you'd have to ask Dr.
 21 Klein.
 22 Q. What do you understand it to mean?
 23 A. I would think there's a lot of intestinal
 24 borborygmi, which means noise caused by the
 25 peristaltic action and the fluid in the bowel.

26

1 Q. Okay.
 2 A. The medical term is borborygmi.
 3 Q. Could you spell that?
 4 A. B-O-R-B-O-R-Y-G-M-I, I think it is.
 5 Q. Then could you turn to the entry of July 10th,
 6 1992. Could you read that for **us**?
 7 A. Belly pain relieved by food. PE negative. Blood
 8 pressure 110 over 60, weight 136 and
 9 three-quarters. Zantac 300 milligrams one at HS,
 10 and I don't know what that **IO** is or what that stands
 11 for. To come in next month.
 12 Q. Then could you read what is above that?
 13 A. **No**, I don't know what that is.
 14 Q. And then turning to August **10th**, 1992, could you
 15 read that note?
 16 A. Age **64**, I can't make out the first part, belly pain
 17 better since on Zantac, coming back since he quit,
 18 133 and a quarter.
 19 Q. That's the weight?
 20 A. Yeah.
 21 Q. Okay.
 22 A. PE, complete --abdomen tender right upper
 23 quadrant. I can't read the other part. Rectal --
 24 sigmoidoscopy deferred. I'm not sure what that
 25 rectal thing says there. Zantac 300 milligrams at

27

1 bedtime, number 100. Duodenal ulcer, and I don't
 2 know what the next word is, rectal polyp. And then
 3 on 8-17 he comes --
 4 Q. Wait. Can we stop there, August 10th, 1992.
 5 First of all, above renew Zantac there's a
 6 word. Can you identify that?
 7 A. No.
 8 Q. When it has D, period, ulcer, okay. Could that be
 9 diagnosis ulcer?
 10 MS. SEBAUGH: Objection.
 11 A. I don't know. It could be duodenal ulcer.
 12 Q. Go ahead.
 13 A. On August **17th**, '92 lower abdominal cramps, PE
 14 negative, I believe that's what it says,
 15 sigmoidoscopy normal, hemorrhoids, **stool** negative,
 16 which I presume means guaiac negative, and then
 17 there's a word I can't make out. It says rectal
 18 polyp and then parentheses, another word, his weight
 19 was 135 and a quarter.
 20 Q. Now, in your report you indicate that after
 21 reviewing the combined records and depositions that
 22 Dr. Harold Klein's care of Mr. Frances Chappell was
 23 exemplary. I assume that's an error. It's Isaac
 24 Chappell.
 25 A. Oh, okay.

28

1 Q. Okay. Why do you state that Dr. Klein's care was
 2 exemplary?
 3 A. Because that's what I would do.
 4 Q. Then it states his diagnosis and treatment program
 5 were appropriate and within the standard of care for
 6 a medical practitioner.
 7 A. Right.
 8 Q. What diagnosis are you referring to?
 9 A. Duodenal ulcer.
 10 Q. And how did Dr. Klein reach the diagnosis of a
 11 duodenal ulcer?
 12 A. Only by his conclusion. He didn't have any
 13 pathologic or x-ray evidence of it, he just treated
 14 him on the basis of what he thought the symptoms
 15 represented.
 16 Q. Would you say it was a guess on the part of Dr.
 17 Klein whether it was a duodenal ulcer?
 18 MR. BETZ: Objection.
 19 A. It's his diagnosis.
 20 Q. How then did Dr. Klein reach the diagnosis of a
 21 duodenal ulcer?
 22 A. The symptoms were consistent with **it** and the
 23 treatment relieved the symptoms, which is consistent
 24 with that diagnosis.
 25 Q. Were the symptoms also consistent with a stomach

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- 1 ulcer?
- 2 A. They could have been.
- 3 Q. Would you agree that before a physician can reach
- 4 the diagnosis of a duodenal ulcer that you need a
- 5 study, be it an upper GI series or endoscopy, to
- 6 demonstrate a duodenal ulcer?
- 7 A. No. I don't think you have to have something to
- 8 make it a diagnosis, other than the patient's
- 9 history and the treatment and the results of the
- 10 treatment. I'm not saying that it's going to be
- 11 right, I'm **just** saying that I don't think you need
- 12 that to make the diagnosis. You can make a
- 13 diagnosis which is appropriate based upon the
- 14 treatment and response.
- 15 Q. Isn't there a difference between the propensity of a
- 16 duodenal ulcer to be cancerous as compared to a
- 17 stomach ulcer to be cancerous?
- 18 A. Yes.
- 19 Q. And what is the difference?
- 20 A. Duodenal ulcers, I wouldn't say never, but are very,
- 21 very rarely associated with cancer. Stomach ulcers
- 22 more commonly are associated with cancer.
- 23 Q. And why are they more commonly associated with
- 24 cancer?
- 25 A. I don't know, they **just** are.

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- 1 Q. One statistic I saw is that five percent of all
- 2 stomach ulcers are malignant.
- 3 A. That may well be true.
- 4 Q. So for the benefit of the patient, this patient,
- 5 Isaac Chappell, wouldn't it be worthwhile to find
- 6 out whether he had a duodenal ulcer or a stomach
- 7 ulcer in terms of the potentiality of being a
- 8 stomach cancer?
- 9 **MR. BETZ:** Objection as to what's
- 10 worthwhile.
- 11 A. My own personal treatment plan for patients like
- 12 this is I treat them and withdraw the treatment
- 13 after a period of two to three months. If the
- 14 patient's symptoms recur, I then order appropriate
- 15 studies, GI series or endoscopy. If the GI series
- 16 is abnormal or if the patient doesn't respond to the
- 17 therapy I will order studies.
- 18 Q. But you're saying --
- 19 A. I don't initiate studies on the basis of a single
- 20 visit with a single complaint unless there's
- 21 evidence of lack of response.
- 22 Q. And it's also in your practice that you do not order
- 23 any study to differentiate between a duodenal ulcer
- 24 and a stomach ulcer?
- 25 A. Not necessarily, unless they don't respond. If the

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- 1 patients have a malignant ulcer their symptoms will
- 2 reoccur.
- 3 Q. And symptoms reoccurring would be a reoccurrence of
- 4 abdominal pain or belly pain?
- 5 A. Abdominal pain usually, belly pain, weight **loss**,
- 6 nausea, **loss** of appetite.
- 7 Q. And then why, under those circumstances, do you
- 8 order an upper GI series?
- 9 A. Well, because then you suspect there may be
- 0 something else.
- 1 Q. Something else, including cancer?
- 2 A. It could be including cancer. Rarely it could
- 3 include people that have a rare disorder called
- 4 Zollinger-Ellison which doesn't respond well to
- 5 ulcer treatment because they have an abnormality of
- 6 acid -- hyperacidity, and therefore they require
- 7 high doses of Prilosec or Prevacid and an
- 8 investigation of that condition.
- 9 Q. All right. Going on, you're talking about his
- 0 treatment program was appropriate. Why was the
- 1 treatment appropriate?
- 2 A. Well, the usual treatment that's given for duodenal
- 3 ulcer is one of the **H2** blockers, Zantac.
- 4 Q. Then you go on, no gastrointestinal endoscopy was
- 5 indicated because after treatment his symptoms

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- 1 disappeared. **Is** that your statement?
- 2 A. Yes.
- 3 Q. Where is evidence that his symptoms disappeared?
- 4 A. It says in his August 10th note that when he was
- 5 under treatment his symptoms were better, and when
- 6 he stopped the treatment his symptoms got worse. So
- 7 his symptoms did get better with treatment.
- 8 Q. But they came back when he was --
- 9 A. Treatment was stopped.
- 0 Q. Right. So how --
- 1 A. The treatment didn't go on long enough at the time.
- 2 Q. **So** --
- 3 A. Peptic ulcer disease with treatment with **H2** blockers
- 4 is not unusual for there to be a six to eight-week
- 5 period where treatment is required before the ulcer
- 6 heals.
- 7 Q. So with respect to your statement that the symptoms
- 8 disappeared, there's **no** evidence that they
- 9 disappeared?
- 0 A. When he was -- **well**, when he was on his treatment
- 1 his belly pain was better.
- 2 Q. But it came back, **so** you're saying that means the
- 3 symptoms disappeared?
- 4 A. When he stopped the treatment, the symptoms
- 5 reoccurred over this short period of time. This is

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- 1 a four-week period.
 2 Q. So is that, in your mind, the symptoms disappeared?
 3 A. While on treatment.
 4 Q. And while off of treatment they reappeared?
 5 A. Yes.
 6 Q. And you're saying that's irrelevant?
 7 A. Well, it's relevant only to the fact that he needed
 8 a more treatment at that time.
 9 Q. What type of treatment?
 10 A. H2 blockers.
 11 Q. And for how long?
 12 A. Well, he was given somewhat less than a month on the
 13 first occasion and on the second occasion was given
 14 enough to last three months, but the patient never
 15 came back.
 16 Q. If the symptoms did not disappear, then it's your
 17 opinion the standard of care would be that a
 18 gastrointestinal endoscopy be done?
 19 A. At the end of the period of time when the second
 20 prescription was finished, at that point if his
 21 symptoms reoccurred then I would have done further
 22 studies.
 23 Q. And that would be what further studies?
 24 A. Probably an upper GI series and then, depending upon
 25 what was found, an endoscopy.

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- 1 Q. If the upper GI series indicated a deformity of the
 2 antrum or stomach would you have ordered an
 3 endoscopy?
 4 MR. MEADOWS: Objection.
 5 MS. SEBAUGH: Show an objection.
 6 MR. BETZ: Me too.
 7 A. One of the difficulties of that statement is that
 8 you don't have the -- or I don't have a talk with
 9 the radiologist. Ordinarily when I order these, I
 10 talk with the radiologist. I'm just telling you
 11 what my experience is, to find out what their
 12 opinion is of this antral deformity, and usually
 13 they will tell me whether or not the stomach moves
 14 or whether they feel that there's some difficulty
 15 with the lining that doesn't allow it to move and
 16 they would suggest that maybe further studies be
 17 done at that time.
 18 Deformities of the antrum are classically
 19 associated with long-term chronic ulcer disease. In
 20 the medical field that's what they're usually
 21 associated with.
 22 Q. And why?
 23 A. Because there seems to be some abnormality that
 24 occurs in the stomach that allows the antrum to
 25 become deformed, and I'm not a pathologist so I

35

- 1 don't know what that is.
 2 Q. So if--
 3 A. Results of healing is possibly some scarring.
 4 Q. You're saying then if a radiologist just indicated
 5 to you that there was an antrum deformity you would
 6 talk to the radiologist to determine whether further
 7 studies would be done?
 8 A. Yes.
 9 Q. And why do you do that?
 10 A. Well, to get as much information as I can before I
 11 subject the patient to further studies.
 12 Q. Do you consider that the accepted standard of care?
 13 A. It is for me.
 14 Q. How do you then define accepted standard of care?
 15 A. When I do these cases the accepted standard of care
 16 is the care that I use.
 17 Q. You judge it from what you do?
 18 A. That's correct.
 19 Q. In terms of your opinions relative to Dr. Klein, can
 20 you refer me to any literature specifically that
 21 supports your opinions?
 22 A. No.
 23 Q. With respect to Harrison's on Internal Medicine, do
 24 you consider that a reliable authority?
 25 A. Yes.

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- 1 Q. Do you consider Cecil and Lowe a reliable authority?
 2 A. Yes.
 3 Q. Do you ever look at the Washington Manual?
 4 A. No.
 5 Q. You would agree that the patient did have belly or
 6 abdominal pain when he saw Dr. Klein?
 7 A. Yes,
 8 Q. Would you agree that the abdominal or belly pain was
 9 going on from 1991?
 10 A. It doesn't say that.
 11 Q. Are you saying the pain identified in August of '91
 12 is different than the pain that's identified in July
 13 of '92?
 14 A. It's described differently.
 15 Q. But does that mean it's in the same area or a
 16 different area?
 17 A. It's in the same area, it's just described
 18 differently.
 19 Q. And how would you characterize that?
 20 A. Well, what he describes in '91 appears to be more
 21 associated with his increased intestinal transit,
 22 possibly a nervous kind of disorder as opposed to a
 23 belly pain relieved by food, which appears more to
 24 be a physical condition, a pathological condition.
 25 What he describes above is not associated usually

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1 with a pathological condition, like an ulcer.
 2 Q. Is the pain though described in 1991 related to the
 3 pain described in '92?
 4 MR. BETZ: Objection. I don't know how
 5 the witness --
 6 A. I don't think that I can say that. If you have
 7 rapid intestinal transit, you frequently have cramps
 8 and distress, you feel that your abdomen is under
 9 stress, whereas when you have a belly ache from an
 10 ulcer you eat something, it gets better. You
 11 recognize there's something a little different about
 12 that.
 13 Q. Assume hypothetically that Isaac Chappell did have
 14 abdominal pain continuously from August of '91 until
 15 July of 1992. Did the standard of care require Dr.
 16 Klein to order an upper GI series?
 17 MS. SEBAUGH: Objection.
 18 MR. BETZ: Objection.
 19 A. No.
 20 Q. And why?
 21 A. I don't think that -- as I told you, I think the
 22 symptoms are different. It just appears from what
 23 he writes there the symptoms are different to me --
 24 Q. Okay, assume --
 25 A. -- so --

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1 Q. Go ahead.
 2 A. -- it doesn't appear that what he had in August of
 3 '91 would have warranted any particular study of
 4 any kind at any time. He got better with Maalox
 5 treatment, and ulcers do occasionally, but usually
 6 they require more than that.
 7 Q. Assuming, hypothetically, that the pain described in
 8 '91 is the same pain he's describing in July of
 9 '92. I want you to assume that hypothetically.
 10 Did the standard of care require Dr. Klein to order
 11 an upper GI series?
 12 A. Not at that time. He gave an entirely different
 13 treatment. He gave him Tagamet, which is much more
 14 potent and much more directed towards duodenal ulcer
 15 disease.
 16 Q. Assume hypothetically a patient does have chronic
 17 abdominal pain. Does the standard of care require a
 18 physician to do a workup to determine the cause of
 19 the abdominal pain?
 20 MR. BETZ: I'm going to object to the
 21 hypothetical because I don't think it provides
 22 enough facts for this witness to respond to it.
 23 MR. MEADOWS: Same objection.
 24 A. I can't say that there's anything here that tells me
 25 he's had chronic abdominal pain. He had pain a year

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1 before and he had pain again in July, so I'd say
 2 they're two separate episodes.
 3 Q. Mrs. Chappell, I don't think you read her
 4 deposition, indicated that he did have abdominal
 5 pain since 1991. Okay?
 6 A. All right.
 7 Q. I want you to assume that, that Mr. Chappell had
 8 abdominal pain since 1991.
 9 A. Yes.
 10 Q. And then he sees Dr. Klein in July of 1992. At that
 11 time, or in August of '92, did the standard of care
 12 require Dr. Klein to order further studies, such as
 13 an upper GI series or an endoscopy?
 14 MS. SEBAUGH: Objection.
 15 A. No. I think he can give him a therapeutic trial
 16 when he has symptoms that are so classic for ulcer
 17 disease, there being no other associated symptoms,
 18 weight loss, nausea, vomiting, loss of appetite.
 19 Q. And the trial of therapy would be for how long?
 20 A. I would say three to four months, if it were
 21 required that long. I don't know how long, you
 22 know, one never -- one doesn't know from looking at
 23 this record how long it was required. All we know
 24 is he got better with a period of less than a month
 25 of Tagamet and had another prescription given and we

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1 don't have any follow-up further from that, so I
 2 have no knowledge about whether he got better the
 3 second time around and for how long and whether or
 4 not he sought care from somebody else later or not.
 5 I don't know, other than the fact that he went to
 6 Dr. Cook some time later in March, I believe, of the
 7 next year.
 8 Q. Is it your opinion that the patient did have an
 9 ulcer in 1992?
 10 A. He could well have had, yes. I don't absolutely
 11 know what he had, but his symptoms and his results
 12 of treatment were consistent with an ulcer, a peptic
 13 ulcer.
 14 Q. What, in your opinion, was the type of ulcer that
 15 the patient had --
 16 A. I don't know.
 17 Q. -- in 1992?
 18 A. I don't know.
 19 Q. Now, retrospectively, do you have an opinion as to
 20 whether the patient had a stomach ulcer in 1992?
 21 A. I don't know.
 22 Q. And why don't you know that?
 23 A. Because I don't have any studies to prove or
 24 disprove anything I would say.
 25 Q. You're aware of the upper GI series that was done in

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1 March --
 2 A. Yes.
 3 Q. -- of '93 --
 4 A. Yes.
 5 Q. --which identified a chronic antrum deformity?
 6 A. Yes.
 7 Q. That indicates some deformity in the stomach?
 8 A. That's correct.
 9 Q. Is that suggestive that the patient had stomach
 10 cancer?
 11 MR. BETZ Stomach cancer or stomach
 12 ulcer?
 13 MR. GORDON: Stomach cancer.
 14 A. I don't know that.
 15 Q. Does that antral deformity indicate that the patient
 16 had a stomach ulcer?
 17 A. It indicates he had some stomach condition. I'm
 18 not -- I am not able to tell you what that is.
 19 Q. What condition --
 20 A. Radiologically, it is a diagnosis made on a series
 21 of shadows cast by barium against the film and does
 22 not give you a pathologic diagnosis.
 23 Q. What are the potential diagnoses?
 24 MR. MEADOWS: Objection.
 25 MS. SEBAUGH: Join in the objection.

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1 MR. BETZ Me too.
 2 A. Ulcer disease, gastritis, cancer, possibly other
 3 conditions which could be in existence and wouldn't
 4 be found unless something was biopsied.
 5 Q. And you can do a biopsy by endoscopy?
 6 A. That's correct.
 7 Q. So do you have an opinion to a reasonable degree of
 8 medical certainty or probability what condition or
 9 disease process Mr. Chappell had in 1992 relative to
 10 his belly or abdominal pain?
 11 A. My conjectural feeling is that he had an ulcer at
 12 that time, a peptic ulcer.
 13 Q. Okay. Do you hold that opinion to a reasonable
 14 degree of medical probability?
 15 A. Yes.
 16 MS. SEBAUGH: Objection.
 17 MR. MEADOWS: Objection.
 18 MS. SEBAUGH: Was there an answer to
 19 that?
 20 - - - -
 21 (Thereupon, the requested portion of
 22 the record was read by the Notary.)
 23 - - - -
 24 Q. Do you have any opinion as to whether the patient
 25 had stomach cancer in 1991 and/or 1992?

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1 A. No.
 2 Q. Do you have any opinion as to whether the cancer
 3 metastasized?
 4 A. No.
 5 Q. Do you have any opinion as to the prognosis of this
 6 patient if the cancer was diagnosed in '91, '92 or
 7 '93?
 8 A. No.
 9 MR. ONEILL: What is your question,
 10 sir? I didn't hear that.
 11 THE WITNESS: No.
 12 MR. GORDON: Why don't you repeat the
 13 question.
 14 - - - -
 15 (Thereupon, the requested portion of
 16 the record was read by the Notary.)
 17 - - - -
 18 MR. BETZ I'm going to object to the
 19 form of the question.
 20 Q. Do you have an opinion as to if an endoscopy was
 22 done in 1991 or 1992 what the endoscopy would have
 2 shown?
 23 A. No.
 24 Q. Do you have an opinion as to if an upper GI series
 2 would have been done in 1991 or 1992 what it would

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1 have shown?
 2 A. No.
 3 Q. Do you have an opinion as to, in the event the
 4 cancer was diagnosed and treated and the patient had
 5 survived, what his life expectancy would have been?
 6 A. No.
 7 Q. Do you have an opinion as to the cause of death of
 8 this patient?
 9 A. I believe the cause of death was cancer of the
 10 stomach. That's what you told me, I believe.
 11 Q. Are you familiar with the fact that patients with
 12 early stomach cancer have the same symptoms as
 13 gastric ulcers that are benign?
 14 MR. BETZ Objection.
 15 A. I am familiar with the fact that they may have those
 16 symptoms.
 17 Q. Are you also familiar with an early stage stomach
 18 cancer that patients sometimes have their symptoms
 19 relieved by food?
 20 MR. MEADOWS: Objection.
 21 MR. BETZ: Objection.
 22 A. They may have symptoms relieved by food.
 23 Q. Also, patients with early stomach cancer may have
 24 their symptoms relieved by Zantac or H2 blockers?
 25 MR. BETZ objection.

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- 1 A. They may have symptoms relieved by those.
 2 Q. Does Zantac normally make an ulcer go away within a
 3 few days?
 4 A. No.
 5 Q. How long does it take?
 6 A. Usually six to eight weeks.
 7 Q. And what do you base that on?
 8 A. That's what I have read over the years, and my
 9 experience would indicate that.
 10 Q. Would you agree that early gastric cancer may only
 11 show signs of an ulcer or no symptoms at all?
 12 A. That's correct, no symptoms at all would be more
 13 likely than anything, that's why they're not
 14 detected until very late.
 15 Q. Well, similarly, many patients with gastric cancer
 16 which is in an early stage may somatically improve
 17 with a period of H2 blockers or Zantac; is that
 18 correct?
 19 MR. BETZ: Objection. That's been
 20 asked and answered.
 21 MR. MEADOWS: Objection.
 22 They might.
 23 Q. Have we covered all your opinions?
 24 A. Yes.
 25 Q. Do you have --well, let me rephrase that.

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- 1 Do you believe that the earlier, generally
 2 speaking, you diagnose cancer the better the
 3 prognosis?
 4 A. Yes.
 5 Q. And why is that?
 6 A. Because cancer is a condition which is of a
 7 malignant type which means that it grows
 8 uncontrolled in the area where it starts and then
 9 frequently will spread into other areas, and in this
 10 case in the lymph nodes and then to other areas of
 11 the body and over a period of time consumes the
 12 patient because it deprives them of his vitality and
 13 eventually they die.
 14 Q. Is it correct that you'd like to diagnose the cancer
 15 before it metastasizes to the lymph nodes?
 16 A. Yes.
 17 Q. Because if you diagnose the cancer before it has
 18 nodal involvement it gives you a better prognosis?
 19 A. That's correct.
 20 Q. Is early stomach cancer a treatable and curable
 21 condition?
 22 MR. MEADOWS: Objection.
 23 A. Yes.
 24 Q. And why?
 25 A. Well, the usual treatment would be to remove the

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- 1 stomach where the cancer is, and if you remove the
 2 cancerous tumor and you do that, provided it hasn't
 3 spread into the lymph system or into the blood
 4 system, you have removed all the malignant cells
 5 from the body and therefore the patient should
 6 remain free of that cancer.
 7 Q. In terms of Mr. Chappell's presentation and
 8 complaints August 10th, '92, what is your opinion as
 9 to why when he did stop Zantac the pain came back?
 10 A. Because the ulcer wasn't completely treated.
 11 Q. And this is true even though he had been on Zantac
 12 for approximately a month?
 13 A. Well, somewhat less than a month. He stopped it at
 14 some point because he had -- because his pain
 15 recurred, so I would have to say somewhat less than
 16 a month of treatment, which is not enough.
 17 Q. You're saying that the accepted standard of care
 18 when you have a situation such as with Mr. Chappell,
 19 that he had pain while he was on -- am I reading --
 20 excuse me. Let me go back to the August 10th, 1992
 21 entry.
 22 It says belly pain better since on Zantac?
 23 A. That's correct.
 24 Q. Okay. Then coming back --
 25 A. Since he quit. So I would have to assume he quit

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- 1 some days before. So he really didn't have a full
 2 month of treatment.
 3 Q. Should Dr. Klein have investigated as to when he
 4 stopped the Zantac?
 5 A. No.
 6 Q. So you're saying that the standard of care was, with
 7 respect to Mr. Chappell as of August 10th, 1992,
 8 based upon his complaints and what's reported here
 9 is to continue the treatment of Zantac?
 10 A. Continue the treatment for a stipulated period of
 11 time, and in this case Dr. Klein chose 100 tablets,
 12 which was three months, and presumably be
 13 reevaluated or wait for the patient to come back if
 14 the symptoms reoccur after the treatment is
 15 discontinued. If he took it for 100 days and his
 16 symptoms reoccurred again, you would expect him to
 17 return.
 18 Q. And the Zantac that was prescribed August 10th was
 19 for what period of time?
 20 A. I presume a hundred days. It says a hundred. I'm
 21 making a presumption. I don't know whether that
 22 hundred refers to the number of tablets or the
 23 number of days or exactly what. That's just a
 24 presumption I'm making.
 25 Q. Should there have been, according to the standard of

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1 care, a specific time for the patient to come back?

2 In other words, return in a month, two months, three

3 months?

4 A. That varies with each physician. In general, I have

5 the patient come back. Dr. Klein seems to have

6 relied upon Mr. Chappell to make his appointments

7 when he needed to make them. I don't think that's a

8 deviation from the standard of care.

9 Q. So with the Zantac therapy from August 10th, 1992,

10 how long should Dr. Klein have had the therapy for

11 Mr. Chappell before he asked him to return?

12 A. Well, it's about a three-month --well, I don't know

13 whether he -- I didn't say he had to ask him to

14 return. I said that's an option. I don't think the

15 standard of care required him to return.

16 I think the patient would have returned if his

17 symptoms reoccurred. He came in July because he had

18 symptoms, so I would assume the patient would come

19 back if his symptoms recurred. It's another

20 assumption I'm making.

21 Q. So you're saying Dr. Klein didn't have to establish,

22 in terms of his treatment plan after he gave Zantac

23 on August 10th, any time to come back?

24 A. No. His diagnosis was duodenal ulcer, he gave him

25 an appropriate amount of time for treatment. His

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1 symptoms, I don't know what happened to the symptoms

2 after the 10th of August, so I have no more comment

3 because I don't know what happened to this patient's

4 symptoms.

5 Q. All right. Hypothetically if the symptoms

6 continued --

7 A. Hypothetically if the patient's symptoms continued

8 after the Tagamet or the Zantac ran out, Dr. Klein

9 was relying upon the patient to return.

10 Q. And if the patient returned with continued

11 complaints of abdominal pain --

12 MR. BETZ I think we've been through

13 this at least twice, Harley.

14 MR. MEADOWS: I object on the same

15 basis.

16 A. If he had come back three months later, then what

17 Dr. Klein would have done I don't know, but what I

18 would have done would be to investigate him.

19 Q. And that would be the standard of care?

20 A. Yes.

21 Q. Either do an upper GI series or --

22 A. I would have done an upper GI series.

23 Q. To determine what's causing the continued abdominal

24 pain?

25 A. Well, in an effort to identify some abnormality, and

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1 then depending upon what the study showed further

2 studies may have been indicated at that time.

3 MR. GORDON: Why don't you give me a

4 brief moment. I'm almost done.

5 MR. BETZ: Sure.

6 - - -

7 (Thereupon, a discussion was had off

8 the record.)

9 - - -

0 Q. Do you know Dr. Bukowski of The Cleveland Clinic

1 Foundation?

2 A. No.

3 Q. The only expert report that you've seen in this case

4 is that of Dr. Coppa's?

5 A. The expert reports that I've seen were the ones that

6 I gave you. I think there's Dr. Singer in there.

7 Is he an expert?

8 Q. Yes.

9 A. And Dr. Levitan, is he an expert?

0 Q. Yes.

1 A. Okay. I've seen those.

2 Q. You've seen their reports?

3 A. Yes.

4 Q. They're apparently upstairs too.

5 A. Maybe they are. Sorry.

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1 Q. You also read Dr. Singer's deposition?

2 A. Yes.

3 Q. Do you have any disagreement with what Dr. Singer

4 says--

5 MR. BETZ: Objection.

6 MR. MEADOWS: Objection.

7 Q. --with respect to Dr. Klein?

8 A. I think he makes some remarks that Dr. Klein was not

9 following the standard of care, and I would disagree

0 with that.

1 Q. What specifics does Dr. --

2 A. I believe he said something about doing an

3 endoscopy.

4 Q. And you disagree with that?

5 A. Yes. I don't think this patient needed an endoscopy

6 when Dr. Klein was taking care of him up to

7 8-17-92.

8 Q. And why wasn't an endoscopy indicated?

9 MR. BETZ: Wait a minute Harley. He's

0 answered this question about three times. I

1 think enough is enough.

2 MR. MEADOWS: No kidding.

3 A. His symptoms resolved with the appropriate

4 treatment.

5 Q. Do you have any other disagreement with Dr. Singer

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1 in terms of Dr. Klein's care?

2 MR. BETZ: Objection. I don't think

3 that's a fair question.

4 A. I didn't memorize the deposition.

5 Q. Okay. Because the questions are there, I might as

6 well pose them to you.

7 You read Dr. Coppa's deposition?

8 A. Yes.

9 Q. Do you have any disagreement with Dr. Coppa?

10 MR. BETZ: Objection.

11 A. I believe he made similar statements and I would

12 disagree with those.

13 MR. GORDON: All right. Let me just

14 take a brief break and I'll be right back.

15 - - -

16 (Thereupon, a recess was had.)

17 - - -

18 Q. What is the purpose of prescribing Zantac for peptic

19 ulcer disease?

20 A. It reduces the secretion of hydrochloric acid in the

21 stomach and therefore allows the ulcer to heal.

22 Usually the ulcers are assumed to be due to the

23 hydrochloric acid's action on the mucosa of the

24 lining of the stomach.

25 Q. Does a physician prescribe Zantac with just a

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1 history of peptic ulcer disease?

2 A. If there's a history of peptic ulcer disease it's

3 very frequently prescribed. It's also prescribed

4 for people that have nonspecific abdominal

5 complaints. And in fact, now it has been made over

6 the counter, so when patients have nonspecific

7 over-the-counter abdominal complaints, they go and

8 buy it and take it themselves. The physician isn't

9 even involved anymore.

10 Q. Do you, yourself, prescribe Zantac if a patient

11 doesn't have peptic ulcer disease?

12 A. Sure.

13 Q. For what purposes?

14 A. Nonspecific abdominal complaints.

15 Q. Is ulcer disease treated prophylactically with

16 Zantac?

17 A. Well, there are those people who in their -- who

18 have suffered the disorder who immediately, upon the

19 presentation of similar symptoms, begin it

20 themselves. And so, yes, the answer is prophylactic

21 treatment with Zantac sometimes prevents the

22 development of ulcers.

23 In other words, if you take it early on, the

24 symptoms which usually mean you're going to get an

25 ulcer are aborted. If you read the old textbooks,

55

1 the classical spring and fall recurrence of peptic

2 ulcers has been pretty much wiped out by the advent

3 of the treatment with H2 blockers.

4 Q. With respect to stomach cancer, does that occur, to

5 your knowledge, more often in black males?

6 A. I don't know.

7 Q. Do you know what age range stomach cancer occurs in

8 terms of males?

9 A. Older males. It's very rare. I've had two cases in

0 32 years, one a black, one a white.

1 Q. Even though stomach cancer is still diagnoseable?

2 A. Oh, yes. It's much more common in the orient.

3 Q. Would you agree that endoscopy is done for minimal

4 abdominal symptoms?

5 MR. MEADOWS: Objection.

6 Q. Let me rephrase the question. Endoscopy can be done

7 for minimal symptoms?

8 MR. MEADOWS: Objection.

9 MR. BETZ: Objection.

A. Endoscopy can be done for no symptoms.

11 MR. ONEILL: It can be done for a

12 fee.

A. That's the point, cha-ching, cha-ching, cha-ching.

13 At one point there was a physician in town that did

14 that and Medicare fired him.

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1 Q. In July or August of 1992 did the standard of care

2 require Dr. Klein to consider at all that the

3 patient may have cancer of the stomach or the

4 duodenum?

5 A. Only if he didn't respond to the therapy after a

6 period of some months. If I knew how to diagnose

7 cancer early I'd have a line from here down to

8 Public Square waiting to come in to see me. I don't

9 know how to do that.

10 Q. Would you agree the identification of malignant

11 gastric ulcers prior to penetration in surrounding

12 tissues is crucial since the curability of such

13 early lesions, when limited to the mucosa or

14 submucosa, is greater than 80 percent?

15 MR. MEADOWS: Objection.

16 MR. BETZ: Objection.

17 MS. SEBAUGH: Join in the objection.

18 MR. BETZ: He's already indicated he's

19 not an expert in the treatment of cancer. You

20 can go ahead and answer if you can, Doctor.

21 THE WITNESS: What?

22 MR. BETZ: You're welcome to answer.

23 THE WITNESS: Oh.

24 A. The earlier the diagnosis is made, the more likely

25 the patient will be cured. If anybody has a cancer

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1 in their system, it is good luck if they do not have
2 invasion of the lymphatics or the blood system early
3 in the disorder, because even if it's found in a
4 very small area and it's invaded the lymphatics or
5 the blood system and you take out the original
6 lesion eventually the cancer will recur. So early
7 diagnosis is not always associated with cure.

8 MR. ONEILL: With good --

9 THE WITNESS: With cure.

10 MR. ONEILL: With good --with cure,
11 okay.

12 THE WITNESS: Yes.

13 Q. Have you ever read in the literature that
14 gastroscopic biopsy and breast cytology are required
15 with all patients with a gastric ulcer in order to
16 exclude a malignancy?

17 MS. SEBAUGH: Objection.

18 MR. MEADOWS: Objection.

19 MR. BETZ: Objection.

20 A. No.

21 Q. If you have any additional opinions could you --
22 that you formulate from now until the time of trial,
23 could you tell Mr. Betz so he'll advise us? Other
24 than that --

25 A. My opinions are that I don't like depositions and I

58

1 don't like trials.

2 Q. But could you tell Mr. Betz if you do arrive at any
3 further opinions?

4 A. Yes.

5 Q. Is there anything else that you find significant in
6 this case that we have not covered?

7 A. No.

8 MR. GORDON: That's all I have.

9 MR. BETZ: Okay.

10 MR. MEADOWS: Do you have anything?

11 MR. ONEILL: No.

12 MR. MEADOWS: Dr. Junglas --

13 THE WITNESS: Yes.

14 MR. MEADOWS: -- I have just a few
15 questions for you.

16 - - - -

17 CROSS-EXAMINATION OF DONALD W. JUNGAS, M.D.

18 BY MR. MEADOWS:

19 Q. As you know, my name is Bill Meadows. I represent
20 Dr. Cook in this case.

21 A. Yes.

22 Q. You have had a chance to look at Dr. Cook's
23 records?

24 A. Yes. I don't recall them very well, but I did look
25 at them at one time.

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1 Q. You may have answered this already. I apologize if
2 I'm repeating Mr. Gordon's questions. Have you
3 looked at Dr. Cook's depo transcript?

4 A. I looked at that too, but I don't recall what it
5 says.

6 Q. Is it fair to say that you have no opinions critical
7 of Dr. Cook's care?

8 A. Absolutely none.

9 Q. And when you reviewed the medical records, including
0 those of Dr. Cook, did you find from your experience
1 that it appeared he met the standard of care?

2 MR. GORDON: Objection.

3 MR. BETZ: Objection.

4 Q. As you recognize it.

5 A. It appeared from my memory, which is very vague,
6 that it was appropriate.

7 Q. In terms of your prior testimony regarding the
8 radiologist's role in doing upper GI studies, is it
9 your experience that a radiologist will call you as
0 the ordering physician if he or she finds or
1 interprets findings on upper GI that are concerning
2 to the radiologist?

3 MS. SEBAUGH: Objection.

4 A. Yes. I happen to be a bird dog, personally. I
5 usually go down and look at the pictures with him so

60

1 I know in my mind what we're looking at.

2 Q. Have you looked at the results of the upper GI --

3 A. I looked at the films --

4 Q. --that was done here?

5 A. -- but I don't know how to interpret them.

6 Q. With regard to the upper GI that was ordered by Dr.
7 Cook in March of 1993; have you looked at those
8 films?

9 A. That's the films, copies of those films, but I don't
0 know how to interpret them. See, a lot of the
1 interpretation of films depends upon not the static
2 picture but the way the barium traverses and the way
3 the stomach contracts, and of course if there is a
4 rigidity about the stomach lining or something the
5 nature that indicates that it's not functioning the
6 way it should like a muscular organ that contracts
7 and expands, then one has to be more suspicious of a
8 problem. That's why I go and talk to the
9 radiologist.

0 Q. I understand. What is the meaning of good
1 peristaltic activity?

2 A. Good peristaltic activity?

3 Q. Exactly.

4 A. Well, it seems to indicate that the stomach was
5 contracting properly.

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1 Q. Is that what you're referring to when you're talking
 2 about the --
 3 A. Yes.
 4 Q. -- movement --
 5 A. Uh-huh, that's correct.
 6 Q. -- that the radiologist would be able to report?
 7 A. Your intestines work in waves of contractions to
 8 push things from the mouth to the anus.
 9 Q. And that's the kind of activity that you want to
 10 know about when you rely upon a radiologist who does
 11 an upper GI study that you order?
 12 A. Yes.
 13 Q. And is it reasonable for you as a clinician, or any
 14 clinician who orders an upper GI study, to rely upon
 15 the radiologist to give them that sort of
 16 information?
 17 A. Yes. Radiologists are referred to as the doctors'
 18 consultant.
 19 Q. Was your CV marked as an exhibit?
 20 MR. GORDON: No.
 21 MR. BETZ: I thought it was.
 22 Q. You are licensed to practice medicine in the State
 23 of Ohio?
 24 A. Yes.
 25 Q. And I take it more than 50 percent of your

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1 professional time is spent in clinical practice?
 2 MR. GORDON: Objection.
 3 A. 98 percent.
 4 MR. MEADOWS: Thank you. That's all I
 5 have.
 6 - - - -
 7 CROSS-EXAMINATION OF DONALD W. JUNGLAS, M.D.
 8 BY MS. SEBAUGH:
 9 Q. Dr. Junglas, you're not critical of the radiologist
 10 who authored that upper GI --
 11 A. No.
 12 Q. -- study, are you?
 13 A. I have no opinions regarding specialties that I am
 14 not a part of.
 15 MR. ONEILL: I do have some
 16 questions. Oh, go ahead, Beth.
 17 MS. SEBAUGH: I have just one more.
 18 Q. You said that radiologists are often referred to as
 19 the doctors' consultant. If you had a question
 20 about a radiology report or a radiology film, in
 21 your practice you would contact the radiologist, is
 22 that correct --
 23 A. Yes.
 24 Q. -- if you didn't understand something or if you had
 25 further questions?

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1 A. Yes.
 2 MS. SEBAUGH: I don't have any further
 3 questions. Thanks for your time.
 4 - - - -
 5 CROSS-EXAMINATION OF DONALD W. JUNGLAS, M.D.
 6 BY MR. ONEILL:
 7 Q. Do you usually take the initiative in contacting the
 8 radiologist?
 9 A. I usually go down there at the time the patient is
 10 released when they're back in my office and look at
 11 the films, yes.
 12 Q. Would that include the movie films of the
 13 fluoroscope?
 14 A. In general if they do a movie film, yes.
 15 Q. The films that would normally be available for you
 16 would be the still pictures?
 17 A. Yes, but if you talk to the radiologist that does it
 18 he can sort of describe what he saw.
 19 Q. Do you expect a call from a radiologist every time
 20 they do an x-ray on one of your patients?
 21 A. I mark all my requisitions call.
 22 Q. Call, call me?
 23 A. Yes.
 24 Q. I see, okay, all right.
 25 A. That's been my habit.

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1 Q. You say that you are, by nature, a bird dog and
 2 therefore you assume the responsibility or the
 3 interest of following up with the radiologist --
 4 A. Yes.
 5 Q. -- to find out what his examination has disclosed?
 6 A. That's correct.
 7 MR. O'NEILL: Okay. Thanks. That's
 8 all.
 9 - - - -
 10 RECROSS-EXAMINATION OF DONALD W. JUNGLAS, M.D.
 11 BY MR. GORDON:
 12 Q. First of all, you rely upon the interpretations of a
 13 radiologist in the performance of an upper GI series
 14 in terms of the treatment and diagnosis that you
 15 render?
 16 A. Yes.
 17 Q. And why?
 18 A. Because I've had great success in following the
 19 disease processes that they define for me and
 20 therefore I have great confidence that their
 21 diagnoses are usually correct.
 22 Q. Did you bring with you today Dr. Cook's records?
 23 A. No.
 24 Q. And you're prepared today to discuss his care in
 25 terms of whether he complied with the accepted

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1 standard of care?

2 A. I said from my memory, that's all I said. It's very

3 foggy, but as far as I knew I had no criticisms of

4 it.

5 Q. But are you giving an opinion today that Dr. Cook

6 complied with the accepted standard of care or

7 you're saying I don't want to discuss that issue?

8 A. I don't want to discuss that issue because I don't

9 have the information in front of me, A. And B, if I

10 did I wouldn't want to discuss it because that's not

11 my role here.

12 Q. Did you testify in response to Mr. Meadows' question

13 that it was your opinion that Dr. Cook complied with

14 the accepted standard of care?

15 A. I said I think I had no criticism of it from my

16 memory, which was foggy. I believe I said that.

17 Q. Do you still want to state that, in light of the

18 fact you don't have his records here and your

19 assignment was not to evaluate the care of Dr. Cook?

20 MR. MEADOWS: Well, object. He's

21 answered my questions and I'm not sure what the

22 implication of your question is. I don't think

23 it's a proper question.

24 MR. BETZ: Well, let me weigh in too.

25 Q. I'm prepared to go ahead and discuss Dr. Cook with

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1 you.

2 MR. ONEILL: I think it's clear from

3 the record that Dr. Junglas is an expert not

4 for Dr. Cook but for Dr. Klein's estate and he

5 has not formed an opinion that he wishes to

6 testify to with respect to the compliance of

7 Dr. Cook with the standard of care, so let's

8 leave it go at that.

9 Q. Is that correct?

10 A. That's correct.

11 THE WITNESS: That's well said. Thank

12 you, Mark.

13 MR. BETZ: Yes, much better than I

14 could have done.

15 MR. GORDON: Okay. That's all I have.

16 MR. BETZ: Are we done? We'll read

17 it.

18

19 DONALD W. JUNGLAS, M.D.

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CERTIFICATE

1

2

3 The State of Ohio) SS:

4 County of Cuyahoga.)

5

6 I, Laura L. Ware, a Notary Public within and

7 for the State of Ohio, do hereby certify that the

8 within named witness, DONALD W. JUNGLAS, M.D., was

9 by me first duly sworn to testify truthfully the

10 whole truth, and nothing but the truth in the cause

11 aforesaid; that the testimony then given was reduced

12 by me to stenotypy in the presence of said witness,

13 subsequently transcribed into type by me under my

14 that the foregoing is a true and

15 correct transcript of the testimony so given as

16 aforesaid.

17 I do further certify that this deposition

18 was taken at the time and place as specified in the

19 foregoing caption, and that I am not a relative,

20 counsel or attorney of either party or otherwise

21 interested in the outcome of this action.

22 IN WITNESS WHEREOF, I have hereunto set my

23 hand and affixed my seal of office at Cleveland,

24 Ohio, this day of , 2000.

25

1 Laura L. Ware, Ware Reporting Service

2 21860 Crossbeam Lane, Rocky River, Ohio 44116

3 My commission expires May 17, 2003.

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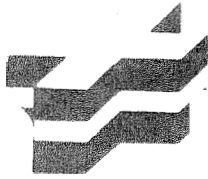
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<p>Tagamet 11:8; 38:13; 39:25; 50:8</p> <p>taken 1:11; 67:0</p> <p>taking 24:3; 52:16</p> <p>talk 34:8,10; 35:6; 60:18; 63:17</p> <p>talking 31:19; 61:1</p> <p>tell 4:25; 9:5; 11:22; 13:15; 22:10; 34:13; 41:18; 57:23; 58:2</p> <p>telling 34:10</p> <p>tells 38:24</p> <p>ten 9:11; 16:4</p> <p>tend 7:14,15</p> <p>tender 26:22</p> <p>Tenderness 25:1,3,5</p> <p>tension 24:11</p> <p>term 25:20; 26:2</p> <p>Terminal 2:0</p> <p>terms 6:24; 8:20; 9:10; 30:7; 35:19; 477; 49:22; 53:1; 55:8; 59:17; 64:14,25</p> <p>testified 15:22; 16:17</p> <p>testify 65:12; 66:6; 67:0</p> <p>testimony 16:15; 18:25; 59:17; 67:67</p> <p>tests 23:4</p> <p>textbooks 54:25</p> <p>Thank 62:4; 66:11</p> <p>Thanks 63:3; 64:7</p> <p>That's 6:9; 7:7; 10:9,24; 12:2; 13:5,21; 16:23; 17:20; 18:11,13; 22:9; 23:17,19,22; 24:11; 25:20; 26:19; 27:14,23; 28:3; 31:22; 33:6; 34:20; 35:18; 36:12; 41:8; 42:6; 44:10; 45:8,12,13,19; 46:19; 47:23; 48:23; 49:7,14; 53:3; 55:23; 58:8; 60:9,18; 61:5,9; 62:4; 63:25; 64:6,7; 65:2,10; 66:10,11,15</p> <p>themselves 54:8,20</p> <p>therapeutic 39:15</p> <p>therapies 11:11</p> <p>therapy 9:22; 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55:9</p> <p>type 9:4; 33:9; 40:14; 46:7</p> <p>typewriting 67:0</p>	<p>40:9,12,13,14,20; 41:12,16; 42:2,11,12; 45:2,11; 47:10; 49:24; 53:19,21; 54:1,2,11,15,25; 57:15</p> <p>ulceration 6:12</p> <p>ulcers 29:20,21; 30:2; 38:5; 44:13; 53:22; 54:22; 55:2; 56:11</p> <p>ultimate 12:22</p> <p>uncontrolled 46:8</p> <p>understand 4:24; 5:1; 7:8; 22:10; 23:8,11; 25:22; 60:20; 62:24</p> <p>Unfortunately 10:15</p> <p>University 1:14; 20:3,6</p> <p>unless 13:1; 20:16; 21:24; 22:4; 30:20,25; 42:4</p> <p>unusual 32:14</p> <p>upon 1:12; 8:14; 11:22; 29:13; 33:24; 48:8; 49:6; 50:9; 51:1; 54:18; 60:11; 61:10,14; 64:12</p> <p>upper 9:18; 11:1; 13:11; 26:22; 29:5; 31:8; 33:24; 34:1; 37:16; 38:11; 39:13; 40:25; 43:24; 50:21,22; 59:18,21; 60:2,6; 61:11,14; 62:10; 64:13</p> <p>upstairs 21:3,10; 51:24</p> <p>use 11:10; 13:21; 18:24; 35:16</p> <p>usual 31:22; 46:25</p> <p>usually 9:5; 10:6; 11:7,10,25; 12:3; 31:5; 34:12,20; 36:25; 38:5; 45:6; 53:22; 54:24; 59:25; 63:7,9; 64:21</p>	<p>Weston 2:7; 15:3</p> <p>whatever 4:23; 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	<p>U</p> <p>Uh-huh 9:1; 16:23; 17:20; 61:5</p> <p>ulcer 6:4,8; 7:12,13,19,21,24; 8:3,3,6; 9:8,17; 10:1; 11:4,14,17,24; 12:8,11; 15:17; 16:18; 27:1,8,9,11; 28:9,11,17,21; 29:1,4,6,16,17; 30:6,7,23,24; 31:1,15,23; 32:13,15; 34:19; 37:1,10; 38:14; 39:16;</p>		<p>Z</p>

Zantac 11:8,14;
22:19,22,25; 23:18,21;
26:9,17,25; 27:5; 31:23;
44:24; 45:2,17; 47:9,11,22;
48:4,9,18; 49:9,22; 50:8
53:18,25; 54:10,16,21



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University Suburban
Health Center**

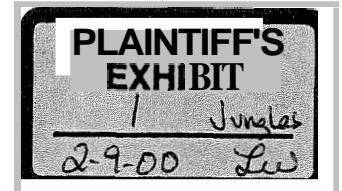
**1611 South Green Road
South Euclid, Ohio 44121**

Abby Goulder Abelson, M.D.
James M. Coviello, M.D.
Debra Anne DeJoseph, M.D.
Kevin T. Geraci, M.D.
Edgar B. Jackson, M.D.
Donald W. Junglas, M.D.
Philip D. Junglas, M.D.
Georgianna P. Kates, M.D.
Michael K. Koehler, M.D.
Todd W. Locke, M.D.

Hermann Menges, Jr., M.D.
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Michael G. Sheahan, M.D.
R.D. Thompson, Jr., M.D.
Richard Tonn, M.D.
Chester L. Plotkin, M.D., emeritus

September 14, 1999

Ms. Pamela S. Schremp
Gallagher, Sharp, Fulton & Norman
Seventh Floor, Bulkley Bldg.
1501 Euclid Avenue
Cleveland, Ohio 44115-2108



Dear Pam:

I have reviewed the chart of Dr. Harold Klein and his care of Frances Chappell. I have also reviewed Dr. Lloyd Cook's medical record as well as deposition transcripts of Dr. Wilfrid Gill, Dr. Lloyd Cook, and Dr. Robert J. Porter.

I have concluded after reviewing the combined records and depositions that Dr. Harold Klein's care of Mr. Frances Chappell was exemplary. His diagnosis and treatment program were appropriate and within the standard of care for a medical practitioner. No gastrointestinal endoscopy was indicated because after treatment his symptoms disappeared. I stand ready to defend this position in both deposition and at trial if this becomes necessary.

Sincerely yours,

Donald W. Junglas MD
Donald W. Junglas, M. D.
DWJ/nmi



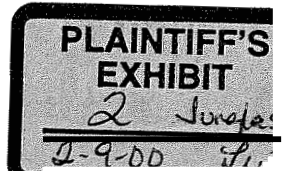
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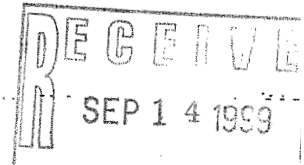
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Michael G. Sheahan, M.D.
R.D. Thompson, Jr., M.D.
Richard Tomlin, M.D.
Chester L. Plotkin, M.D., emeritus

August 16, 1999



Ms. Pamela S. Schremp
Gallagher, Sharp, Fulton & Norman
Seventh Floor, Bulkley Bldg.
1501 Euclid Avenue
Cleveland, Ohio 44115-2108



I have reviewed the chart of Dr. Harold Klein and his care of Frances Chappell. I have also reviewed Dr. Lloyd Cook's medical record as well as deposition transcripts of Dr. Wilfrid Gill, Dr. Lloyd Cook, and Dr. Robert J. Porter.

I have concluded after reviewing the combined records and depositions that Dr. Harold Klein's care of Mr. Frances Chappell was exemplary. His diagnosis and treatment program were appropriate and within the standard of care for a medical practitioner. I stand ready to defend this position in both deposition and at trial if this becomes necessary.

Sincerely yours,

Donald W. Junglas, M.D.

Donald W. Junglas, M.D.

DWJ/nmi

*No upper gastrointestinal
endoscopy was performed indicated
because his symptoms disappeared.
After treatment*

Law Offices of
GALLAGHER, SHARP, FULTON & NORMAN

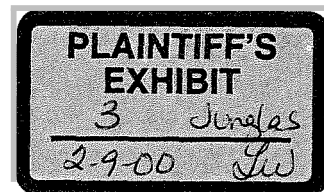
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E-Mail: pss@gsfn.com

September 15, 1999

VIA FAX TO (216) 691-3531

Donald Junglas, M.D.
Cleveland Physicians, Inc.
1611 South Green Road
South Euclid, OH 44121



Re: Frances L. Chappell, etc. vs. Lloyd Cook, M.D., et al
Case No. 324732
Our File No. 94418-102009

Dear Dr. Junglas:

Accompanying this transmission is the report of another expert retained by plaintiff in the above-captioned matter, Gene F. Coppa, M.D. Dr. Coppa opines that had Mr. Chappell been properly evaluated and diagnosed in March of 1993, the gastric cancer would have been treated a year earlier and would have been smaller, less evasive, and would not have metastasized to lymph nodes. According to Dr. Coppa, Mr. Chappell would, to a reasonable degree of medical certainty, more likely than not, have survived after proper surgical therapy in early 1993.

Once again, my sincere thanks for your assistance in the defense of Dr. Harold Klein.

Very truly yours,

A handwritten signature in cursive script, appearing to read "Pamela S. Schremp".

Pamela S. Schremp

PSS/lec
Enclosures
cc: Tom Betz
328693

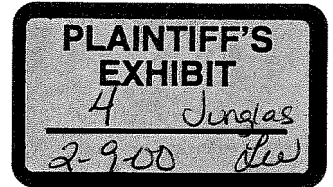
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Pamela S. Schremp
Direct Dial: (216) 522-1277
E-mail: pss@gsfn.com

May 12, 1999

Donald Junglas, M.D.
1611 S. Green Road
S. Euclid, OH 44121



RE: Frances Chappell, Extrx. etc., v. Lloyd Cook, M.D.
Cuyahoga County Common Pleas
Case No. 324732
File #94418-102009

Dear Dr. Junglas:

Thank you for agreeing to review this matter on behalf of our client, the estate of Harold Klein, M.D. Dr. Klein was Mr. Chappell's physician until August 17, 1992. According to information this firm received from previous counsel, Mr. Chappell began being followed by Dr. Cook when he began to complain of abdominal difficulties in late February of 1993. A laparoscopy and subtotal gastrectomy were performed on April 12, 1994. Pathology revealed invasive poorly differentiated adenocarcinoma.

Enclosed are the records from Dr. Klein's treatment of Mr. Chappell between the years 1977 and 1992. Due to the poor legibility of these records, I am enclosing a transcription of the records prepared by one of the nurse consultants from this office. I am in the process of obtaining the records of Mr. Chappell's subsequent treating physicians. As soon as I have those records, I will provide you with same. If there is any other information I can provide, please free to call.

I look forward to discussing this matter with you once you have had the opportunity to review these materials.

Very truly yours,

GALLAGHER, SHARP, FULTON & NORMAN

A handwritten signature in cursive script, reading "Pamela Schremp".

Pamela S. Schremp

PSS:plz

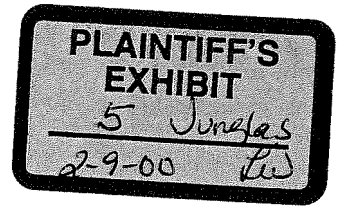
Enclosures

cc: Thomas E. Betz, Esq.

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Writer's Direct Dial 216 522-1277
May 17, 1999



Donald Junglas, M.D.
1611 S. Green Road
S. Euclid, OH 44121

RE: *Frances Chappell, Extrx. etc., v. Lloyd Cook, M.D.*
Cuyahoga County Common Pleas
Case No. 324732
File #94418-102009

Dear Dr. Junglas:

Thank you for reviewing this case on behalf of our client, the Estate of Harold Klein, M.D. Enclosed please find copies of the lab work you requested:

1. ~~SMA performed on 8/1/91~~ not needed A.
2. CBC performed on 7/31/91
3. SMA performed on 8/11/92

Thank you for your continued assistance in this matter. If there is further information I can provide, or if questions arise, please feel free to contact me at the telephone number noted above.

Very truly yours,

A handwritten signature in cursive script, appearing to read "Pamela Schremp".
Pamela Schremp

Enc.
PS/ebc
cc: Thomas Betz w/oc

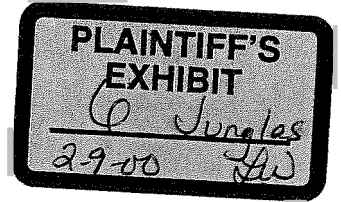
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Law Offices of
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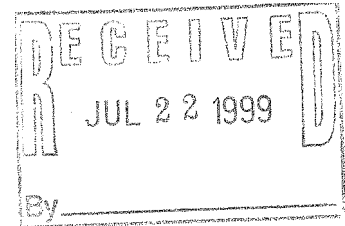
Pamela S. Schremp
Direct Dial: (216) 522-1277
E-mail: pss@gsfn.com

July 21, 1999



Donald Junglas, M.D.
1611 S. Green Road
S. Euclid, OH 44121

RE: Frances Chappell, Extrx. etc., v. Lloyd Cook, M.D.
Cuyahoga County Common Pleas
Case No. 324732
File #94418-102009



Dear Dr. Junglas:

Enclosed please find the deposition of Robert J. Porter, M.D. taken in the above-captioned matter. At the time in question, Dr. Porter was president of the Radiology Group that employed Dr. Gill as a locum tenens physician. Dr. Gill was the radiologist who performed the Upper GI series on Isaac Chappell. Please review the material at your convenience and let me know your thoughts.

Also enclosed are plaintiffs expert reports from the following experts: Gene F. Coppa, M.D., Myron Marx, M.D. and Barry L. Singer, M.D. Drs. Coppa and Marx focus on the interpretation of the radiology report for the Upper GI series and Dr. Cook's decision not to do any further testing at that time. Dr. Singer's supplemental report, dated May 28, 1999, does indicate that Dr. Klein deviated from the standard of care when he failed to order an endoscopy which, according to plaintiff's expert, would have revealed Mr. Chappell's carcinoma.

Please contact me after you have had the opportunity to review these expert reports.

Thank you for your assistance in this matter.

Very truly yours,

A handwritten signature in cursive script, appearing to read "P-S Schremp".

Pamela S. Schremp

PSS:lec

Enclosures

cc: Thomas Betz, Esq.
Stephanie Jursek (OIGA 104724)

12/13/99

IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

FRANCES CHAPPELL, et al.

Plaintiffs,

-v-

LLOYD COOK, M.D., et al.

Defendants.

CASE NO. 324732

JUDGE BURT GRIFFIN

NOTICE OF DEPOSITION
WITH DUCES TECUM TO
DONALD JUNGLAS, M.D.

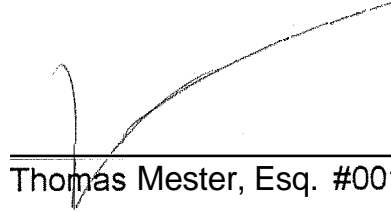
The Defendants will take notice that the Plaintiffs will take the deposition of Donald Junglas, M.D., pursuant to Ohio Rules of Civil Procedure 45 and 30, at the offices of:

Donald W. Junglas, Esq.
Cleveland Physicians, Inc.
1611 South Green Road
South Euclid, Ohio 44121

on the 9th day of February, 2000, commencing at 2:30 p.m. The deposition will be taken before a Notary Public and will continue from day to day until completed. No subpoena will be issued to the deponent inasmuch as she is a party to the within action.

At the time of the deposition, the deponent is requested to produce the following documents, records and things:

1. A current and up to date Curriculum Vitae and/or Resume.
2. Your complete file including any personal notes relative to this case.
3. Any and all medical research the deponent has done relative to the issues in this case.
4. Any demonstrative exhibits the deponent intends to use during his trial testimony.



Thomas Mester, Esq. #0019042

Attorney for Plaintiffs

SERVICE

A copy of the foregoing Notice of Deposition with Duces Tecum to Donald Junglas, M.D. has been mailed this 10 day of December, 1999, to the following:

William Meadows, Esq.
Reminger & Reminger
The 113 St. Clair Building
Cleveland, Ohio 44114

Attorney for Defendant
Lloyd Cook, M.D., & Greater Primary
Care

Beth A. Sebaugh, Esq.
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Cleveland, Ohio 44114

Attorney for Defendants
Robert J. Porter, M.D., & Central
Radiology
Consultants, Inc.

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Cleveland, Ohio 44113

Attorney for Defendants
Wilfrid M. Gill, Jr., M.D., and
Westlake Radiology, Inc.

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Cleveland, Ohio 44115

Attorney for Defendants
Miraim Klein, Exec., of Estate of Harold
C. Klein, M.D., and Internal Medicine,
Inc.

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Gravens & Franey
1240 Standard Building
1370 Ontario Street
Cleveland, Ohio 44113

Attorney for Defendant
St. Vincent Charity Hospital


Thomas Mester, Esq.

Attorney for Plaintiff

Donald W. Junglas, M. D

CURRICULUM VITAE

EDUCATION:

B.A. Adelbert College, Case Western Reserve University	1955
M.D. Case Western Reserve University, School of Medicine	1959

POST GRADUATE EDUCATION:

Internship, Internal Medicine - University Hospitals of Cleveland	1959-60
Residency, First Year - University Hospitals of Cleveland	1960-61
Medical Officer, Captain - U. S. Air Force	1961-63
Residency, Second Year - University Hospitals of Cleveland	1963-64
Residency, Third Year - University Hospitals of Cleveland	1964-65

BOARD CERTIFICATION:

American Board of Internal Medicine	1966
American Board of Internal Medicine - Recertification	1974

MEDICAL SCHOOL APPOINTMENTS

Demonstrator, Case Western Reserve University, School of Medicine	1965-66
Clinical Instructor, Case Western Reserve University, School of Medicine	1966-67
Senior Clinical instructor, Case Western Reserve University, School of Medicine	1967-68
Assistant Clinical Professor, Case Western Reserve University, School of Medicine	1968-82
Associate Clinical Professor, Case Western Reserve University, School of Medicine	1982-1995
Clinical Professor, Case Western Reserve University, School of Medicine	1995-present
Faculty Council, Case Western Reserve University School of Medicine	1988-present
Committee on Appointments, Promotions, and Tenure, Case Western Reserve University School of Medicine	1998-present

HOSPITAL APPOINTMENTS

University Hospitals of Cleveland, Assistant Physician	1965-present
Benjamin Rose Institute, Assistant Physician	1965-present
Veterans Administration Hospital, Attending Physician, Dialysis	1965-71
University Hospitals of Cleveland, Professional Advisory Committee	1987-1998
University Hospitals of Cleveland, Department of Medicine, Quality Assurance Committee	1990-present

DONALD W. JUNGLAS, M. D.

PRIVATE PRACTICE:

Internal Medicins	1966-present
Cleveland Physicians, Inc., University Suburban Health Center	1973-present

ORGANIZATIONS:

The Academy of Medicine of Cleveland	1965-present
Ohio State Medical Association	1965-present
American Medical Association	1965-present

COMMITTEES AND ORGANIZATIONS:

Case Western Reserve University, Medical Alumni	
Board of Directors	1972-75
President	1974-75
Greater Cleveland Health Quality Choice	
Trustee	1990-93
Laurel Lake Retirement Community	
Trustee	1985-1995
Vice President	1992-93
Margaret Wagner Mouse	
Medical Advisory Committee	1974-90
Chairman, Executive Committee	1974-75:1984-87
Cleveland Allen Medical Library	
Trustee	1990-2000
President-Elect	1992-93
President	1994-95
University Suburban Health Center	
Member, Board of Governors	1982-90
Chairman, Personnel Committee	1986-90
Quality Assurance Committee	1998-present
Cleveland Physicians, Inc.	
President	1984-88
Academy of Medicine of Cleveland	
Board Member	1980-1993
Member, Public Information Committee	1984-85
Medical-Surgical Peer Review Committee, Chairman	1985-91
Trauma Committee	1990-92
Public Relations Committee	1990-92
Community Advisory Committee	1990-present
Steering Committee, Greater Cleveland Health Quality	
Choice Program	1990-92
Chairman, Honors	1992
Chairman, Nominating	1992
Vice President	1988-90
President Elect	1990-91
President	1991-92
Past President	1992-93

DONALD W. JUNGLAS, M. D

TEACHING RESPONSIBILITIES:

University Hospitals, of Cleveland	
Ward Rounds	1966-82:1984-86
Renal Clinic Visitant	1966-75
Diabetes Clinic Visitant	1975-90
Medical Clinic Visitant, Wednesday afternoons, three months each year	1988-present
Resident "Teaching, University Suburban Health Canter	1997-present
Case Western Reserve University, School of Medicine	
Phase II - Clinical Teaching	1983-85
Medical Student Teaching-In-Office at USHC, Preceptorship 1/2 day per week, September through May	1977-present

PUBLICATIONS:

None

OTHER:

Blue Cross of Cleveland, Review Consultant	1983-88
Clinician of the Year, The Academy of Medicine of Cleveland	1996-97

9/9/99