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COURT OF COMMON PLEAS
CUYAHOGA COUNTY

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NANCY FARKAS,)
)
)
Plaintiff,)
)
vs.) Case No. 393101
) Judge McCafferty
CLEVELAND CLINIC FOUNDATION,)
et al.,)
)
Defendants.)

- - -

Transcript of videotaped continued deposition of LOUIS
D'AMICO, M.D., Witness herein, called by the Plaintiff as
upon cross-examination, pursuant to Notice and Agreement of
Counsel, pursuant to the Ohio Rules of Civil Procedure,
before Denise C. Winter, a Registered Merit Reporter and
Notary Public within and for the State of Ohio on Tuesday,
July 11, 2000, at Reminger & Reminger, 113 St. Clair
Building, Suite 700, Cleveland, Ohio, commencing at
3:15 p.m. and concluding at 5:00 p.m.

- - -

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APPEARANCES:

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on behalf of the Defendant,
Cleveland Clinic Foundation.

- - -

Also present: Randall Buckosh, Litigaide, Inc.
Joanne Sysack

- - -

I N D E X

Examination of Louis D'Amico, M.D. Page

BY MS. DIXON: 04

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Exhibits Page

Plaintiff's Exhibit 1 19

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PROCEEDINGS

LOUIS D'AMICO, M.D.

Witness herein, called by the Plaintiff as
upon cross-examination, having been first duly
sworn, as hereinafter certified, was examined and
testified as follows:

- - -

MS. DIXON: Good afternoon,
Dr. D'Amico. We're here to resume your deposition which was
began on May 9th of this year, and I'm prepared to ask you a
series of questions that I did not have the opportunity to
ask you when we met the last time. I'll remind you, as the
court reporter indicated, you are under oath, and if at any
point in time you feel the need to refer to the medical
records which I see you have a copy of in front of you,
please feel free to do so.

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CONTINUED CROSS-EXAMINATION OF LOUIS D'AMICO, M.D.

BY MS. DIXON:

Q. Let me first ask you, since we last met, have you
undertaken any additional review of medical records,
deposition transcripts or expert reports?

A. No; I have not.

Q. Would it be fair to say that other than meeting with
Counsel in preparation for today, you have not undertaken

1 any other efforts to prepare for today's deposition?

2 A. That's correct.

3 Q. Have you spoken to any of the Defendants in this case
4 or individuals or entities that may have been Defendants in
5 the past since we last met?

6 A. No; I have not.

7 Q. And just so that the record is clear, I'm not
8 referring to day-to-day conversations that you may have with
9 Dr. Noble. I'm inquiring regarding conversations specific
10 to this litigation.

11 A. That's correct. I have not.

12 Q. In October of 1998, were you the director of the EMH
13 urology group?

14 A. Yes.

15 Q. And you are currently the director of that group;
16 correct?

17 A. Yes.

18 Q. Can you describe for me what your duties are as the
19 director of the EMH urology group?

20 A. It's essentially a title. There are no specific
21 duties since the administrative duties are essentially
22 organized under the overall control of the main Department
23 of Urology at the downtown Cleveland Clinic, so essentially
24 the director is let's call it a figurehead or a contact
25 person for any questions or problems that might arise in the

1 group's relationship with Elyria Memorial Hospital and the
2 local hospital. It is not meant to imply I was an active
3 administrator, meaning in control of hiring, firing, the
4 actual day-to-day duties of the personnel within the office
5 itself.

6 Q. Let me make sure I understand the chronology of events
7 as it relates to the EMH urology group and its relationship
8 with the Cleveland Clinic Foundation. As I understand it, I
9 believe sometime in 1997 EMH established a relationship with
10 the Cleveland Clinic Foundation; correct?

11 A. Yes. Except there's a similar contract that predated
12 that with respect to cardiovascular surgery by about four
13 years.

14 Q. At some point in 1997, you, as an individual
15 physician, became an employee of the Cleveland Clinic;
16 correct?

17 A. That's correct.

18 Q. And I'm assuming as part of establishing that
19 relationship, there was some effort to coordinate efforts
20 between the suburban outlets or suburban campus of the
21 Cleveland Clinic such as Elyria Memorial Hospital and main
22 campus, downtown Cleveland?

23 A. Yes.

24 Q. My question becomes, what steps have been put in
25 place, to the best of your knowledge, to coordinate efforts

or ensure consistent care between the main campus Department of Urology of the Cleveland Clinic and the Elyria campus?

3 A. I'm not sure I understand your question. In reference
4 to what, to specific care delivered by a physician? The
5 physician care is the same both at the downtown campus and
6 at the suburban affiliates.

7 Q. Let me go back. It wasn't a very well-worded
8 question. I apologize.

9 Despite the fact your offices are physically located
10 in Elyria, you are considered part of the Cleveland Clinic
11 Foundation system; correct?

12 A. That's correct.

13 Q. And as part of that system, you are a member of the
14 Department of Urology of the Cleveland Clinic Foundation?

15 A. That's correct.

16 Q. And when we met the last time, you indicated that your
17 group, being the EMH urology group, is a true group?

18 A. Right.

19 Q. Meaning that you are physicians that function in the
20 same office and may share charts, share responsibility in
21 terms of call, but not withstanding that, you all are
22 employees of the Cleveland Clinic and members of the
23 Cleveland Clinic Department of Urology; correct?

24 A. That's correct.

25 Q. My question is, in terms of consistency of delivery of

1 patient care within the Department of Urology at the
2 Cleveland Clinic Foundation, what steps, procedures or
3 protocols are in place, to the best of your knowledge, to
4 ensure that consistency or continuity?

5 A. I'm still not sure what you are referring to,
6 seriously.

7 Q. In terms of delivery of patient care.

8 A. Patient care is delivered by each physician based on
9 his training and our training is similar. Even though we
10 are a group, each of us have private patients. We care for
11 them as private patients.

12 The group structure is essentially an administrative,
13 an administrative group that basically is there for sharing
14 of overhead, employees, you know, billing and the business
15 aspects of the practice, but the care that's delivered by
16 each physician is the same as would be by a private
17 urologist or a group urologist or an employee of an
18 institution.

19 Q. As a urologist employed by the Cleveland Clinic
20 Foundation, is there another physician within the Department
21 of Urology that you would consider your direct supervisor?

22 A. We have a chairman of the department, you know, who
23 essentially is not my direct supervisor, meaning directly
24 overseeing my care to patient A or B, but is in control and
25 in charge of the functioning of the department as a whole.

1 Q. Is that Dr. Novick?

2 A. That's correct.

3 Q. Have you been provided, since you became an employee
4 of the Cleveland Clinic Foundation, any global practice or
5 procedure guidelines as it relates to specific urological
6 problems or dysfunction?

7 A. No.

8 Q. Have you ever received a copy of the 1997 "Clinical
9 ~~Practice Guidelines for Renal Cell Carcinoma~~" that were
10 authored by Dr. Novick and Dr. Bukowski?

11 A. Not specifically, but I'm aware they were published,
12 and they may have been. I may have received them through
13 the American Urologic Association as a separate mailing.

14 Q. You're not aware of any efforts independent of the
15 American Urologic Society whereby you were provided those
16 practice guidelines by the Cleveland Clinic Foundation?

17 A. In what way? In a direct mailing or --

18 Q. Whether it be by interoffice mail, United States mail,
19 was there some effort to distribute that publication by
20 virtue of your employment with the Cleveland Clinic
21 Foundation?

22 A. I don't recall anything directly.

23 Q. Do you recall reviewing those guidelines?

24 A. I remember receiving them and scanning them a few
25 years ago. There were similar guidelines for a number of

1 other disease entities.

2 Q. Do you know, generally speaking, what the purpose of
3 the "Clinical Practice Guidelines for Renal Cell Carcinoma"
4 published in 1979 by Dr. Bukowski and Dr. Novick were?

5 A. No, I don't right now.

6 Q. As just a generic, for generic purposes, would you
7 agree that clinical practice guidelines are to define
8 practice guidelines for the diagnosis and treatment of renal
9 cell carcinoma?

10 MR. CONWAY: Objection.

11 A. I believe that's what their intent is.

12 Q. Would you agree that as it relates to renal cell
13 carcinoma, confirmatory studies are always necessary
14 whenever a renal mass is suspected, regardless of the
15 presence or absence of symptoms suggestive of renal cell
16 carcinoma?

17 A. Additional studies would certainly be indicated based
18 on the clinical course of the presenting signs and symptoms,
19 but whether all tests are done early or later would depend
20 on the presenting signs and symptoms.

21 Q. So as it relates to the statement "confirmatory
22 studies are always necessary whenever a renal mass is
23 suspected regardless of the presence or absence of symptoms
24 suggestive of renal cell carcinoma," do you agree or
25 disagree with that statement?

1 MR. CONWAY: Objection. He answered
2 it.

3 A. I need to know the presence of symptoms or signs,
4 because if there are signs or symptoms present, that would
5 clearly define the timetable or time frame with which to
6 conduct the appropriate testing.

7 Q. So you believe without that additional information,
8 you're unable to agree or disagree with that statement?

9 A. That's correct.

10 Q. So do you believe that Dr. Novick and Dr. Bukowski are
11 in error making a statement such as that?

12 A. No. I believe their intent was to write a guideline
13 which should be interpreted clinically with respect to each
14 individual patient and situation.

15 Q. Would you agree with the statement, "because of the
16 high mortality associated with renal cell carcinoma,
17 screening for the disease is worthy of consideration"?

18 A. Yes. I agree it's worthy of consideration.

19 Q. Would you agree that a CT scan may be the single best
20 study to clinically stage the primary tumor site and to
21 exclude the possibility of intra-abdominal metastases as it
22 relates to renal cell carcinoma?

23 A. Would you repeat that?

24 Q. Absolutely. As it relates to renal cell carcinoma,
25 would you agree a CT scan may be the single best study to

1 clinically stage the primary tumor site and to exclude the
2 possibility of intra-abdominal metastases?

3 A. I could conditionally agree, but I would just
4 conditionally agree. I don't believe -- I believe the best
5 staging procedure is a surgical removal with a pathologic
6 study of the tumor itself.

7 Q. In terms of the conditional agreement you gave, was
8 that based on clinical presentation?

9 A. Partly.

10 Q. And what's the other part of your reservation?

11 A. The fact that we do see intra-abdominal metastases
12 from renal cell carcinoma is not a consistent first sign.
13 The cancer may often skip the abdomen and spread elsewhere
14 because of its nature by way of both lymphatic and vascular
15 spread, so, you know, it's possible to have a patient with
16 distant metastases and, frankly, a negative metastatic scan
17 intra-abdominally but yet have disease in the chest, the
18 lungs and so on.

19 Q. But you would agree that the CT scan would be the
20 single best study to clinically stage both the primary tumor
21 and to exclude the possibility of intra-abdominal --

22 A. No. The statement you read to me is maybe not -- it's
23 not a definitive course. In other words, the implication of
24 that statement is that you're defining a patient who you
25 essentially know what the disease is and the extent of the

1 disease is and you're saying, in this particular patient, we
2 picked up a renal mass and CT scan was consistent with a
3 renal mass with no other CT findings of metastatic disease
4 within the abdomen, and that statement basically doesn't say
5 too much other than the fact that you have identified the
6 presence or absence of a solid renal tumor and you have
7 identified the absence of any significantly-sized tumor
8 within the abdomen. It does not mean that that patient does
9 not have metastatic disease is what I'm trying to say.

10 Q. But it would say whether or not the patient has
11 metastatic disease in their intra-abdominal cavity; correct?

12 A. But that may not be clinically significant.

13 Q. Regardless of its clinical significance, a CT scan
14 would tell you whether you had intra-abdominal metastases;
15 correct?

16 A. Within the limit of the CT scan.

17 Q. Do you agree surgical excision is only effective
18 therapy with patients with stage 1 or stage 2 renal cell
19 carcinoma?

20 A. Yes, probably. There have been isolated instances of
21 spontaneous remission in the past, but generally surgical
22 removal is the best attempt at cure.

23 Q. Can you describe for me what nephron-sparing surgery
24 is?

25 A. Nephron sparing simply is something that is actually

1 Dr. Noble's particular interest along with some other
2 urologists around the country. It alludes to the fact that
3 in some situations in which a very small tumor is
4 identified, one may remove either the tumor itself or the
5 tumor and only part of a kidney and allow the patient to
6 spare a certain amount of kidney function which the patient
7 may need later.

8 It is most critical in patients that have some degree
9 of renal insufficiency or renal disease or perhaps who
10 present with a solitary kidney -- with a tumor present
11 within one kidney where obviously one would, if possible,
12 want to preserve part of the kidney so that they can avoid
13 dialysis. But that decision is always based on a discussion
14 with the patient and a judgment of whether the benefit/risk
15 ratio is present, namely, cure of the patient versus the
16 potential for dialysis and serious complications from kidney
17 failure.

18 Q. Would you agree with the Cleveland Clinic's own study
19 that related to nephron-sparing surgery in its, specifically
20 in its conclusions that for patients with a single,
21 unilateral small, and small being defined as less than 4
22 centimeters, localized renal cell carcinoma, nephron-sparing
23 surgery can have a 5-year survival rate of close to 80
24 percent?

25 A. That's correct. That's correct.

1 Q. Do you have any dispute with the Cleveland Clinic --
2 excuse me, with the Cleveland Clinic's practice guidelines
3 if it quoted a 5-year survival rate of 57 and 60 percent for
4 localized renal cell carcinoma even with inferior vena cava
5 tumor thrombosis?

6 MR. CONWAY: Objection.

7 A. I would have to see the study to be able to agree.
8 Generally, that's true. I can agree in a general sense.

9 Q. Do you use immunotherapy in the course of your
10 practice?

11 A. I have, but I have referred those patients usually to
12 the Clinic or a tertiary care center. Those are treatments
13 that are not easily available in community hospitals.

14 Q. Those patients that you refer either to the main
15 campus or another oncology department, do you continue to
16 follow those patients, their course of care?

17 A. At appropriate times, I have, in the immediate --
18 during the treatment phase and in the immediate treatment
19 phase. Afterwards, they're usually followed by the
20 oncologist or the institution I referred them to. But if
21 the patient survives for any length of time, they often
22 refer to me for local care problems and some testing
23 locally, and it's frequently a combined follow-up both
24 locally as well as with the tertiary care institution.

25 Q. Would you agree that certain patient profiles appear

1 to predict -- excuse me, to better predict the likelihood of
2 successful responses to immunotherapy?

3 A. I would have to have that clarified a little better.

4 Q. Would you agree that patients are likely to exhibit a
5 more favorable clinical response if they have had a
6 nephrectomy, exhibit non-bulky pulmonary and/or soft tissue
7 metastases and are asymptomatic or minimal symptoms?

8 A. That's generally true; yes.

9 Q. And, again, doctor, feel free to review the medical
10 record in front of you.

11 We talked the last time we were together regarding the
12 final report of the IVP performed on Nancy Farkas on
13 10/20/98, and I believe at that time we agreed there were
14 two separate findings on the IVP. One was an obstructive
15 uropathy and the other was persistent filling defect
16 suggestive of a cyst or mass.

17 Is that consistent with your recollection?

18 A. Yes. Yes; it is.

19 Q. Do you agree that by way of the 10/20/98 IVP, that
20 second finding was suggestive of a sign of renal cell
21 carcinoma?

22 A. No. I can't agree with that until I would have
23 additional information. You mean the IVP report alone?

24 Q. Let me rephrase the question. The second finding on
25 the IVP, the possible or probable cyst or mass.

1 A. That's correct.

2 Q. Would you agree that that is a sign or symptom
3 suggestive of or suspicious of renal cell carcinoma?

4 A. No.

5 Q. Would you agree with the statement that was published
6 by Dr. Bukowski and Novick that "it is of paramount
7 importance that a patient with laboratory abnormalities,
8 signs or symptoms suggesting renal cell carcinoma be
9 promptly evaluated for the possible presence of this
10 disease"?

11 A. Generally that's -- I would agree with that.

12 Q. Would you also agree with the statement published by
13 Drs. Bukowski and Novick "diligence and prompt attention
14 must be paid to individuals who present with the incidental
15 findings of a solid renal mass without accompanying clinical
16 signs or symptoms"?

17 A. Yeah; I would agree.

18 Q. Are you familiar with the clinical pathway or the
19 decision pathway that related to the diagnosis of renal cell
20 carcinoma that was published by Drs. Bukowski and Novick in
21 1997?

22 A. I don't recall the details right now, but I'm sure I
23 reviewed it at the time.

24 Q. So that we're both using the same lexicon, if you
25 will, is a decision pathway synonymous with a plan of care

1 as far as you're concerned?

2 A. No.

3 Q. How do you define a clinical pathway or decision
4 pathway?

5 A. A decision and clinical pathway would essentially be
6 generally helpful studies that would be ordered in a
7 step-wise fashion to allow you to rule in or rule out more
8 likely or less likely possibilities whereas a clinical care
9 path, you already have established a diagnosis or a disease
10 and you're establishing a specific detailed care plan with
11 respect to that disease entity.

12 Q. Would you agree that a decision pathway provides a
13 structured and reasonable general approach to patients
14 presenting -- excuse me.

15 You indicated earlier that you believe you reviewed
16 the decision pathway outlined in the 1997 Bukowski/Novick
17 report; correct?

18 A. Uh-huh. Yes.

19 Q. Does your personal practice follow the decision
20 pathway outlined in the Cleveland Clinic's "Journal of
21 Medicine Guidelines" that we have been discussing?

22 A. I'm not aware which pathway you are referring to now.

23 Q. I'm going to hand you what's marked, and I will mark
24 it when we have an opportunity, page SI-34 of the "Renal
25 Cell Carcinoma Report" authored by Drs. Bukowski and Novick

1 in 1997, specifically directing your attention to Figure 1.

2 A. Okay. Right. Okay.

3 Q. That pathway that is identified in Figure 1, is that a
4 flow chart, if you will, that is familiar to you?

5 A. Yes. This is simply a compilation of currently
6 accepted guidelines for the workup of a mass or cyst that's
7 identified. However, I would note that the top of the chart
8 indicates presenting signs and symptoms, namely, hematuria,
9 abdominal mass and some laboratory studies and, therefore,
10 this flow chart is based specifically on a presenting sign
11 or symptom. It is not based strictly on the presence of,
12 say, an abnormal IVP without a defined diagnosis with
13 respect to the abnormal finding as in the case of this
14 particular patient.

15 Q. My question, doctor, the pathway that's identified on
16 Figure 1, is that consistent with a plan of care or a
17 decision pathway, excuse me, that you utilize as part of
18 your own personal practice?

19 A. Yes.

20 Q. And would you agree with me that that is a fairly
21 mainstream decision pathway that's utilized by reasonably
22 prudent urologists?

23 A. Yes.

24 MS. DIXON: And just for the record,
25 we'll mark that as Exhibit 1, and when we have an

1 opportunity, I'll make a copy and provide it to the court
2 reporter.

3 BY MS. DIXON:

4 Q. Doctor, would you agree that based on the Cleveland
5 Clinic Foundation's own literature as well as generally
6 known statistics, that only 30 percent of the patients who
7 present with renal cell carcinoma have metastatic disease?

8 A. I believe that that statistic includes all patients,
9 all presentations and all diseases and it's a retrospective
10 analysis. In general, it will be true, but it would be
11 difficult -- each individual patient, though, would be an
12 isolated case, but, in general, it's true.

13 Q. You do not dispute that statistic on its face;
14 correct?

15 A. Not when you are doing a statistical study looking at
16 large numbers of patients. But it would be incorrect, for
17 example, to take patient A and say patient A has a 30
18 percent chance of metastatic disease without a considerable
19 amount of additional information.

20 Q. I assume that as part of your regular practice of
21 urology, because you told me earlier you do both diagnose
22 and treat patients with renal cell carcinoma; correct?

23 A. Yes.

24 Q. You are in the position oftentimes of quoting survival
25 statistics; correct?

1 A. Yes.

2 Q. And do you personally undertake quoting survival
3 statistics to patients, or do you refer them to an
4 oncologist?

5 A. No. I frequently do myself.

6 Q. Do you likewise engage in the process of staging
7 tumors?

8 A. Yes.

9 Q. Do you stage them both clinically and pathologically?

10 A. Yes.

11 Q. What classification of staging do you utilize in your
12 own personal practice?

13 A. Well, generally we use both -- we use the clinical
14 staging A, B, C for a more simpler discussion with the
15 patient to help them understand as opposed to the TNM system
16 which is a classification that is better for scientific
17 study.

18 Q. As it relates to your conversation with patients, the
19 more simplistic system, are you referring to the Robson
20 System?

21 A. That's correct.

22 Q. Do you rely on statistics that have been gathered in
23 conjunction with your utilization of the Robson System?

24 A. Yes.

25 Q. And would you agree with Dr. Bukowski and Dr. Novick

1 that, at least as of 1997, Robson's was the most widely
2 utilized staging system?

3 A. That's correct.

4 Q. And, in fact, the TNM system is a fairly recent
5 advent; correct?

6 A. That's correct.

7 Q. And would you likewise agree that even as we sit here
8 today, the TNM system has undergone and continues to undergo
9 modifications and modifications and changes to ensure the
10 accuracy of that system?

11 A. Yes; it does.

12 Q. And that's particularly true as it relates to the TNM
13 classification and/or staging of renal cell carcinoma;
14 correct?

15 A. Many tumors are -- I'm not sure if that's the one that
16 is the main focus of the changes in the TNM system, but they
17 are all under review.

18 Q. You would agree with me as it relates to TNM
19 classification of renal cell carcinoma, that the actual
20 classifications of renal cell tumors has changed as recently
21 as this year; correct?

22 A. I'm not sure what you are referring to.

23 Q. Would you agree with me as recently as this calendar
24 year, on the tumor size alone, the size of a tumor has
25 changed defining delineating between T1 and T2?

1 MR. CONWAY: Objection.

2 A. I would have to see the specific detail. I know there
3 has been changes, yes, with respect to tumor size.

4 Q. And that as we sit here today, a T2 -- excuse me, a T2
5 tumor can be as large as 7 centimeters?

6 A. I would have to see the reference first.

7 Q. When you are quoting survival statistics to your
8 patients, do you utilize a five-year survival rate?

9 A. Generally, yes. That's a rule of thumb that's used by
10 many, if not most, physicians in a discussion on cure rates.

11 Q. A discussion of cure as it relates to renal cell
12 carcinoma, you wouldn't dispute that five years equating a
13 cure is mainstream thinking; correct?

14 A. With the caveat that there are many, many exceptions
15 to that, though.

16 Q. But if we're having strictly a statistical
17 conversation, would you agree with me that mainstream
18 urologists would utilize a five-year survival rate equating
19 a cure?

20 A. Generally, yes.

21 Q. Doctor, are you familiar with Dr. Robert Motzer from
22 the Memorial Sloan Kettering and his writings?

23 A. I have heard the name. I'm not familiar with all of
24 his writings.

25 Q. You are familiar with Memorial Sloan Kettering;

1 correct?

2 A. Yes; I am.

3 Q. And in publications authored by Dr. Motzer, who,
4 again, I'll indicate is associated with that facility, he
5 considered patients with survival times greater than five
6 years as long-term survivors. You would agree with that;
7 correct?

8 A. Yes.

9 Q. And would you likewise agree that if a patient with
10 renal cell carcinoma is treated with a nephrectomy in
11 stage 1 or stage 2, they have a more likely than not
12 five-year survival rate?

13 MR. CONWAY: Objection.

14 A. That would strictly depend on the presentation of the
15 tumor, the extent of metastatic disease and last but not
16 least, the most important, the pathologic grading stage of
17 the disease.

18 Q. Let's take a moment, doctor. If a patient has
19 metastatic disease, they wouldn't be stage 1 or stage 2;
20 correct?

21 A. You may not always know that ahead of time because
22 there may be metastatic spread that is undiscoverable by
23 routine CT scan in the chest, abdomen and so on.

24 Q. But in the statistics that we were speaking about
25 earlier, those consider all patients; correct?

1 A. Those are all patients, and, again, just to remind you
2 that those statistics are all retrospective studies, you
3 know, that analyze, say, 100 cases of renal cell carcinoma
4 at the end when one knows the course already, and the
5 statistics usually are a way of identifying certain
6 subgroups or subsets of patients that can be classified A, B
7 and C. The purpose of that is essentially educative. It is
8 not really to establish a, quote, 30 percent chance of
9 metastatic disease with patient A with a tumor of 4
10 centimeters. That you cannot apply in the individual
11 patient.

12 You can apply that later after the patient is part of
13 a large group and you know the course of that patient's
14 outcome, let's say. Then you can fit that patient into that
15 subgroup, but you can't use that statistic to walk up to the
16 patient and their family and say you only have a 30 percent
17 chance of metastatic disease, 70 percent chance of a cure,
18 therefore, you must do this.

19 Q. In the course of your practice, if you had a patient
20 which you diagnosed with renal cell and were able to both
21 clinically and pathologically stage as stage 1 --

22 A. That's correct.

23 Q. -- would you agree with me that that patient would
24 more likely than not survive five years?

25 A. As a rule, as a general rule, I would say yes, but I

1 would with a number of reservations. First of all, I never
2 discuss prognosis or cure rates until the treatment has
3 already been established, meaning we have already done a
4 nephrectomy and we have a pathology and the patient has had
5 all the appropriate CT scanning and all that. Then and only
6 then can you give a reasonable estimate of a prognosis and
7 cure rate.

8 Q. Understood. My question is, once you had satisfied
9 all those inquiries that you just identified for the record
10 and you ultimately concluded both clinically and
11 pathologically that patient was stage 1 and underwent a
12 nephrectomy, more likely than not, that being defined as 51
13 percent, that patient would survive 5 years; correct?

14 A. Yes; I would agree.

15 **8.** My question then becomes, as it relates to stage 2,
16 clinically and pathologically diagnosed and treated with a
17 nephrectomy, would you agree with me that a patient would
18 more likely than not survive 5 years?

19 A. Probably; yes.

20 Q. Would you agree with the statement that CT scanning
21 has a 90 percent accuracy rate in defining the extent of a
22 renal tumor pre-nephrectomy?

23 MR. CONWAY: Objection.

24 A. I would have to see the study. I would balk at the 90
25 percent. I think it's a good study, but I would hesitate to

1 say 90 percent. That's a very, very high accuracy. I'm not
2 quite sure it's quite that high.

3 Q. Doctor, are you familiar with Dr. Nicholas Vogelzang?

4 A. No.

5 Q. I'll represent to you that Dr. Vogelzang is a
6 hematologist/oncologist associated with the University of
7 Chicago and that in 1998, he published an article in the
8 Lancet regarding kidney cancer.

9 Do you disagree with the statement that is identified
10 as part of that article that "long-term outcomes are
11 reasonably good with 56 percent 5-year survival at 5 years
12 for stage 3 tumors"?

13 A. What is the definition of a stage 3 tumor there?

14 Q. Stage 3 tumor being defined as a tumor extension to
15 the renal -- perirenal tissue but confined to Gerota's
16 fascia.

17 A. No. I would take issue with that, because that would
18 depend on the age of the presentation of the patient as well
19 as the exact pathologic and histological description of the
20 cancer. That would be the main determinate.

21 Q. Doctor, let me ask you to turn to the IVP final report
22 that is contained in Nancy's record.

23 A. Yes; I have it.

24 Q. Doctor, for the next series of questions, I would like
25 you to assume hypothetically that you, not Dr. Noble, were

i the one who saw Nancy Farkas for her follow-up visit after
2 the October 20th emergency, excuse me, emergency room
3 treatment she received.

4 Directing your attention to the second finding on the
5 IVP which we discussed earlier, you would agree with me that
6 that second finding is suspicious of a renal cancer;
7 correct?

8 MR. CONWAY: Objection.

9 A. No. I couldn't say it with quite that degree of
10 determination. It simply indicates an abnormality on the
11 IVP that requires further evaluation. In fact, an IVP mass,
12 based on the commonality of cysts versus tumors, you know,
13 the incidence of renal cell carcinoma is actually very small
14 whereas the incidence of finding cysts, even in the normal
15 population, is at least 10 to 15 percent and in some studies
16 approaches 20 plus percent.

17 Q. But for that very small percentage of the population
18 that it is renal cell carcinoma, that is a very deadly
19 finding; correct?

20 A. It can be.

21 Q. During the course of this litigation, I have had an
22 opportunity to take the deposition of Dr. Ocampo who was the
23 radiologist who signed the final report. During her
24 deposition, I'll represent to you Dr. Ocampo stated that the
25 finding of the mass on the lateral border of the right

1 kidney was the most serious finding on that report.

2 Would you agree with that statement?

3 A. No. I disagree.

4 Q. When we met the last time, you stated in your
5 testimony that the painful obstructive uropathy was the most
6 crucial finding on Nancy's October 20th IVP?

7 A. Absolutely. This was an emergency room visit, and
8 when the patient presented with flank pain, there was an
9 obstruction to the kidney. **An** obstruction potentially could
10 lead to loss of the kidney and that is clearly -- in the
11 immediate sense, and that is clearly the immediate finding
12 that needs attention at that point.

13 Q. If the patient's pain, "the patient" being Nancy,
14 resolved prior to the time she left the emergency department
15 on October 20th, '98 and the IVP shows no signs of
16 hydronephrosis, is your opinion the same?

17 A. You would have to define this a little better. By
18 "resolve," is the pain improved but the cause is still
19 undiscovered, or is the etiology uncovered and the problem
20 resolved?

21 Q. Let me put it to you this way: The information you
22 would have available to you, as the treating physician, is
23 the information contained in the four corners of the IVP
24 along with the patient's emergency room record and knowledge
25 that her pain had resolved prior to departing the emergency

1 department on 10/20/98 and that IVP shows no signs of
2 hydronephrosis.

3 A. Now, there is mild to moderate dilatation of the right
4 ureter, so there is mild to moderate hydronephrosis. So are
5 you discussing a different presentation or this
6 presentation?

7 Q. My question is, if that IVP showed no signs of
8 hydronephrosis, the patient was pain free at discharge,
9 would that change your conclusion that painful obstructive
10 uropathy was the most crucial finding?

11 MR. CONWAY: Objection as to form.

12 A. That presentation is inconsistent with -- if, if the
13 hydronephrosis has resolved, the patient would not have
14 pain, but you still haven't found the cause of the pain.
15 You need to know the cause of the pain and the swelling and
16 the bleeding and the presentation first.

17 Q. And that would mean that you would need to undergo
18 additional studies as they relate to the obstructive
19 uropathy; correct?

20 A. That's correct.

21 Q. And at the same time, at a minimum, you would also
22 need additional evaluation of the persistent filling defect
23 on the right, lower, lateral border of the kidney; correct?

24 A. At the appropriate point, yes.

25 Q. Would you agree with me that as to both of the

1 findings, the obstructive uropathy and the probable cyst or
2 mass, that a CT scan would give you good information in
3 further evaluating both of those conditions simultaneously?

4 A. It would be helpful, but it would not be necessary to
5 do at this point since you already have an IVP that gives
6 you enough initial information to proceed with your care
7 plan and workup.

8 Q. My question is, would you agree with me following the
9 findings obtained on the 10/20/98 IVP, that a CT scan would
10 give you further diagnostic information not just on one of
11 those findings but on both of those findings in order to
12 assist you in crafting your plan of care?

13 A. As a hypothetical situation?

14 Q. Yes.

15 A. As a hypothetical situation, I would submit that if I
16 could do all studies at one point, that would always be
17 better than trying to select one or two, but the practical
18 point is that people usually don't come in and get a shotgun
19 approach and have, you know, two to five x-rays done of all
20 different types.

21 You simply select the appropriate x-ray for the
22 presenting symptoms, which in this case, by the way, because
23 of the presence of hematuria, absolutely is the IVP.
24 Because of the presence of gross hematuria, the IVP is
25 clearly the traditionally indicated urologic study or

1 evaluation of this particular patient, meaning gross
2 hematuria.

3 If the patient did not have hematuria and had perhaps
4 vague or less defined pain, then one might shift to the CT
5 scan because it gives an additional view of the remainder of
6 the abdomen essentially to rule out other potential diseases
7 such as appendicitis or colon diseases or gallbladder
8 problems. Given the urologic presentation of the flank pain
9 and gross hematuria, clearly the IVP is absolutely the
10 single best study, not a CT scan, in the immediate sense.

11 Now, if your question is, you know, should I do both,
12 well, possibly that's a consideration, but the IVP is
13 absolutely the best step.

14 Q. Are you aware of whether or not the patient actually
15 had hematuria at the time she presented to the emergency
16 department?

17 A. I didn't examine the patient. It says, reason for
18 exam, hematuria, low back pain.

19 Q. You indicated in your previous answer that the
20 obstructive uropathy was the most crucial finding on the
21 10/20/98 IVP; correct?

22 A. That's correct.

23 Q. And would you agree with me that that finding of
24 obstructive uropathy required further evaluation and
25 diagnosis?

1 A. Yes.

2 Q. What test -- let me rephrase that.

3 I believe you told me the last time we met that the
4 most likely cause of that obstructive uropathy was a kidney
5 stone; correct?

6 A. Clinically and statistically, yes.

7 Q. And would you agree with me kidney stones present in
8 an opaque and non-opaque format?

9 A. Yes. And note that this particular patient does have
10 a stone in the other kidney, as well, which sort of
11 immediately alerts you to the likelihood of stone disease.

12 Q. But would you agree that stones can present in an
13 opaque and a non-opaque format?

14 A. Both; yes.

15 Q. Would you agree with me the best diagnostic tool
16 available to you as a urologist in diagnosing non-opaque
17 stones is a CT scan?

18 A. Not necessarily.

19 Q. What other test would you use?

20 A. I could use the IVP, retrograde pyelograms,
21 ultrasounds. These are in such a way as to better define
22 the presenting symptoms and, based on the patient's
23 presenting situation, whether one did or did not wish to use
24 radiographic studies involving radiation. But clearly you
25 need to define the situation better.

1 Q. Would you agree with me as part of the 10/20/98 IVP,
2 the radiologist was having difficulty determining whether or
3 not the cause could be a non-opaque calculus?

4 A. I'm not sure how much difficulty the person was
5 having, but the report simply states that there was not a
6 definitive diagnosis, and apparently it states that the
7 impression was that the obstruction at the level of the
8 distal right ureter, which is well away from the kidney, by
9 the way, was suspected as being due to either non-opaque or
10 faintly opaque stone.

11 That is fairly straightforward. It seems to me that
12 working diagnosis in the mind of the radiologist was a stone
13 in the distal ureter and, therefore, additional studies were
14 recommended.

15 Q. And if what is contained in the four corners of the
16 10/20/98 IVP final report as it relates to the obstructive
17 uropathy was the best information available at that time
18 regarding non-opaque calculus, would you agree that the next
19 most sophisticated or diagnostic tool with the higher level
20 of acuity would be the CT scan for better evaluating
21 non-opaque stones?

22 A. No. The next study would be -- the next study that I,
23 as a urologist, would need to carry out a care plan to treat
24 this particular problem would be a retrograde pyelogram.

25 Q. Which is an invasive procedure; correct?

1 A. That's correct.

2 Q. You would agree with me an abdominal CT scan is a
3 non-invasive procedure?

4 A. Yes.

5 Q. And based on the second finding, let me ask you this:
6 You don't disagree with the notion that a CT, abdominal CT,
7 scan would give you additional information as it relates to
8 the obstructive uropathy; correct?

9 A. I disagree to the point that it does not help me any
10 further. I have already discussed the fact that there is
11 obstruction there. I don't need another x-ray to tell me
12 there is obstruction there. You already have evidence of
13 obstructive uropathy on the IVP, so why do you need a CT
14 scan to tell me that, yes, I do have obstructive uropathy?
15 I already know that.

16 Q. Well, you don't know where you may have non-opaque
17 stones; correct?

18 A. I do. It says it's in the distal ureter at the
19 level -- that says obstructive uropathy at the level of the
20 distal right ureter which would mean the lower ureter near
21 the bladder. And a second study with a cystoscopic urogram
22 with retrograde is so you can outline the lower part of the
23 ureter with contrast, which was done.

24 Q. Are all non-opaque stones appreciable on an IVP?

25 A. Non-opaque, not necessarily. They are visible or,

1 rather, not visible but rather suspected of being there by
2 virtue of the fact they may be associated with obstruction.

3 Q. And are non-opaque stones able to be appreciated by
4 way of CT scan?

5 A. They can be.

6 Q. I believe you indicated earlier that the focus on the
7 kidney stone or the obstructive uropathy was for the purpose
8 of saving or preserving the kidney and kidney function;
9 correct?

10 A. The purpose of what now?

11 Q. The purpose of focusing initially on the kidney stone
12 or obstructive uropathy was to preserve the kidney and
13 kidney function?

14 A. That would be one consideration; yes.

15 Q. That would be the most serious consideration; correct?

16 A. If there was complete obstruction only, which this
17 does not imply.

18 Q. Based on your review of this IVP, is this patient at
19 risk for losing her kidney or kidney function based on that
20 obstructive uropathy?

21 A. The best practical statement that could be made is
22 that there is obstruction present to a mild to moderate
23 degree of dilatation which increases the risk of some damage
24 to the right kidney if attention is not directed to this in
25 a timely manner, "timely" meaning days to perhaps a few

1 weeks.

2 Q. That finding in and of itself, the mild to moderate
3 obstruction, is not consistent with this patient being in
4 danger of losing the other kidney or kidney function;
5 correct?

6 A. It only, if ignored, it could lead to, but ignored in
7 the sense of long term, because we can actually leave a
8 kidney completely obstructed for several days, perhaps even
9 a week or two, and have complete recovery.

10 So I'm not sure what the point of your question is,
11 but if there's mild to moderate obstruction present, the
12 implication is that one would assume that that obstruction
13 would become more and more severe and eventually lead to
14 complete shutdown. And given the normal course of events,
15 that's something that could occur over days to weeks to
16 perhaps even months.

17 Q. So the risk of the first finding on the IVP is only in
18 relation as it relates to loss of kidney function, or loss
19 of the kidney relates to that condition being ignored in
20 toto; correct?

21 A. Ignored in total and also the possibility of having
22 sepsis in this case, because if the patient develops
23 infection behind this area which is obstructed due to, by
24 explaining it simply, due to increased back pressure,
25 bacteria can be forced into the kidney, into the bloodstream

1 and make the person very, very ill which would be, actually,
2 life threatening as opposed to simply threatening the renal
3 kidney itself.

4 Q. In the face of a diagnosis of renal cell carcinoma,
5 can we agree that focus is on removing that patient's kidney
6 in order to save that patient's life?

7 A. Based on the stage and presentation, assuming the
8 person does not have metastatic disease, and they should
9 know that with reasonable certainty, then removal of the
10 kidney, yes, can be and will be the main treatment plan for
11 that.

12 Q. When we were together the last time, you used the term
13 "renal colic CT scan." Can you tell me what that is or how
14 it differs between a standard abdominal CT scan?

15 A. A standard abdominal CT scan is one that is carried
16 out both with and without administration of intravenous
17 contrast medium. This is essentially a radiologic entity,
18 and I would defer to their expertise.

19 But in general, the addition of intravenous contrast
20 helps to outline certain conditions, conditions within the
21 abdominal cavity better because the iodine traveling within
22 the vein offers a contrast between tissues that do not take
23 up the dye and tissues that do. But renal colic CT is one
24 where the -- in fact, it was specifically performed
25 initially for kidney stones to help ease the diagnosis of

1 kidney stones, and the idea there was that you would not
2 give dye. The patient did not need to be prepped. The risk
3 of any contrast allergic reaction was lower, yet using fine
4 cuts, which means numerous small cuts, with a CT scan would
5 allow one to scan the urinary tract in a quick way to
6 identify obstruction stones and also rule out any other
7 confusing diseases that might affect your diagnosis like
8 appendicitis, gallbladder disease and other intra-abdominal
9 problems.

10 So the renal colic CT refers specifically to its use
11 without dye. In an immediate sense, it's an easier test to
12 do. It gives us a reasonable amount of information in a
13 quick way without IV injection, and, specifically, it can be
14 done without the presence of a radiologist, which was
15 probably the most crucial factor. As opposed to calling a
16 radiologist in in the middle of the night, a CT scan can be
17 done by a technician and read by an ER physician.

18 And that was actually the background of utilizing the
19 renal colic CT.

20 Q. And is the renal colic CT a diagnostic tool that is
21 still used today?

22 A. Yes.

23 Q. And that would be a scan that would be part of a
24 kidney stone evaluation?

25 A. Yes.

1 Q. Is that a diagnostic tool that is specifically
2 requested by you, as the urologist, as opposed to a standard
3 abdominal CT?

4 A. Yes.

5 Q. Can the renal colic CT scan appropriately -- be
6 appropriately performed when a patient is having
7 symptomatology such as renal colic associated with a stone?

8 A. Yes. The only limitation would be if the patient is
9 in such severe pain that they cannot hold still. But
10 assuming that they're medicated and are reasonably
11 cooperative to hold still for the scan, yes, it can be done
12 in just about any patient.

13 Q. Based on your review of the Nancy Farkas chart from
14 EMH Urology, would you agree that when she presented to
15 Dr. Noble on 10/26 of '98, she was not having flank pain?

16 A. I believe so. I believe that she was not having flank
17 pain.

18 Q. Based on the fact that Nancy was not having flank
19 pain, and do you know whether or not she also had -- if she
20 continued to have gross hematuria on 10/26?

21 A. That I'm not aware of.

22 Q. I'll represent to you that the chart does not indicate
23 gross hematuria on 10/26, and she is not experiencing flank
24 pain. Is there anything to be gained in terms of patient
25 management or care plan by not ordering a CT scan on 10/26?

1 A. Well, I would rather phrase that as saying what is
2 there to be gained by doing the CT scan, and at that point
3 there would be no additional information gained. The next
4 step would be what was appropriately done which would be the
5 retrograde and looking for a stone.

6 Q. Would you agree that performing the CT scan on
7 10/26/98 would have provided Dr. Noble with a variety of
8 pieces of information as it relates to the second finding on
9 the 10/20 IVP?

10 A. I think it would have provided additional information;
11 yes.

12 Q. In a patient such as Nancy, in the manner in which she
13 presented on 10/20/98, without flank pain and with no gross
14 hematuria, is that a patient who, in your opinion, continues
15 to be in urological distress?

16 A. If by distress you mean the absence of pain, yes, she
17 was not in acute distress, but she still had not found the
18 reason for her presenting symptoms.

19 Q. Is that a patient that you would still have concerns
20 about regarding the integrity of her kidney and kidney
21 function?

22 A. Yes, which is why I would do a retrograde pyelogram
23 and proceed with further evaluation.

24 Q. And in what time frame would you expect that
25 retrograde pyelogram to be performed?

1 A. Since her pain had improved and her hematuria is
2 absent, based on the information you provided, I would not
3 consider it an emergency, but I would plan to do it within
4 the space of perhaps a few weeks or less.

5 Q. Is there anything medically speaking that would
6 preclude you from simultaneously scheduling a CT scan to
7 evaluate the second finding on the 10/20/98 IVP?

8 A. I would plan to do one at some point in the future,
9 but my initial workup would be aimed at identifying the
10 reason for the obstruction, bearing in mind that my clinical
11 perception would be that there is a strong likelihood that a
12 stone was still present in the distal ureter since she
13 hadn't passed it and although the pain and bleeding had
14 subsided which would mean that the stone was acquiescing if
15 not moving.

16 Still, my main focus would be identifying and
17 eliminating the stone which we presume is there at that
18 point. Yes, I would certainly have some attention to
19 working up the cyst or mass on the second finding, but at
20 that point it would be a secondary factor which I would
21 attend to later as my workup and plan continued.

22 Q. Based on Nancy's presentation on 10/26/98, is there
23 any risk in not ordering the CT scan at that point?

24 A. Again, the question is not a risk but whether or not
25 it's indicated at that point. Again, the focus was the

1 presenting symptomatology and the suspicion of an
2 obstruction, a stone, a dilatation of the upper ureter, the
3 potential for infection and, therefore, that clearly needs
4 to be attended to first.

5 I understand what you're saying. Why didn't you order
6 20,000 other tests? I mean, to carry your point even
further, why did we not order a CT of the chest or CT of the
8 brain to look for metastatic disease just because there
9 might be a less than 1 percent chance of having a renal cell
10 carcinoma?

11 Q. Based on the findings on that IVP, there would be no
12 doubt in your mind as a practitioner that a CT scan was
13 indicated; correct?

14 A. Some form of additional test being the CT or
15 ultrasound, and per the flow chart you showed me, would be
16 appropriate in the workup indication.

17 Q. And my question is, is there any risk in not ordering
18 a CT scan or an ultrasound on 10/26/98?

19 MR. CONWAY: Objection. He has
20 answered that question.

21 MS. DIXON: Actually, he deferred
22 and said --

23 BY MS. DIXON:

24 Q. Doctor, you said you would not deem it in terms of
25 risk. You answered, actually, a different question. My

1 question this time is, specifically, is there any risk
2 associated with not ordering a CT scan on 10/26/98?

3 MR. CONWAY: I still object.

4 A. A CT scan is not risky to the patient.

5 Q. Is there any risk in delaying diagnosis and treatment
6 of renal cell carcinoma?

7 A. As a hypothetical question, yes, there would be.

8 Q. Had a renal colic CT scan been ordered on Nancy on or
9 about 10/26/98, would that have further defined the mass
10 which was identified in the October 20th IVP?

11 A. Probably; yes.

12 Q. When we met the last time, you indicated that you had
13 the sense from reviewing Nancy's chart that Nancy was called
14 by the staff of EMH Urology and asked to come back to the
15 office but declined?

16 MR. CONWAY: At what time?

17 MS. DIXON: He wasn't actually
18 clear.

19 BY MS. DIXON:

20 Q. I got the sense that you meant it towards the end of
21 her treatment.

22 A. I believe so; yes.

23 Q. Is there a place in the chart that you can point me
24 that fortifies or verifies your belief that Nancy was called
25 by the EMH staff and asked to come back in for treatment and

1 she declined?

2 A. I don't believe I saw that written as you phrased it,
3 but there clearly was contact with the patient and a request
4 for follow-up or return.

5 Q. My question is, can you take a few moments and flip
6 through the EMH urology group chart and show me where it was
7 that Nancy was requested to return for an additional
8 appointment or consultation?

9 A. Well, it's clearly implied in the discussions within
10 Dr. Noble's progress notes that he discussed the appropriate
11 workup.

12 Q. Would you agree with me that there's no place in the
13 chart where there was an affirmative call placed by the
14 staff of EMH urology group requesting Nancy to return for
15 further treatment?

16 A. I'm not aware -- I'm not quite sure what you mean by
17 that.

18 Q. Actually, I think when we spoke the last time, you
19 indicated that when you, in the course of your practice,
20 when you had a patient who, whether it be by way of
21 misunderstanding or noncompliance, does not show for what
22 you believe was an additional scheduled appointment, you
23 have either directed your staff or you have personally
24 called that patient to try and get them in; correct?

25 A. Yes.

1 Q. And I believe you indicated that it would be your
2 practice to note that in the chart; correct?

3 A. No, not always, because, you know, for example, in
4 this particular case, there is no documentation that anyone
5 called Miss Farkas to come back to see Dr. Noble for her
6 first appointment, and equally, when Dr. Noble first saw
7 her, there's no documentation in there regarding any
8 instructions on returning. After the surgery and the
9 retrograde was done, there's nothing written asking her to
10 come back for her post-op, which she did. There's an
11 implied sense here where the patient will come back for
12 follow-up. I don't have to actually write out a separate
13 sheet, have the patient sign it and keep a duplicate. That
14 is not standard of care.

15 Q. I'm not suggesting that, doctor. Maybe we're not
16 communicating appropriately. The question I'm asking you
17 relates to a patient who may have misunderstood instructions
18 given by you or your staff regarding the need to schedule an
19 additional follow-up appointment or has simply chosen to
20 discontinue treatment against medical advice.

21 A. Okay.

22 Q. In those situations, when we spoke the last time, you
23 indicated that you or your staff would make efforts to
24 contact that person either by telephone or by letter to
25 impress upon them the importance of an additional visit. Do

1 you remember that conversation?

2 A. Yes.

3 Q. And I believe when I asked you the last time, you said
4 that you would expect there to be some record of that, those
5 extra efforts.

6 A. Uh-huh.

7 Q. To impress upon the patient the importance of
8 follow-up treatment contained in that patient's chart;
9 correct?

10 A. Yes.

11 Q. My question becomes, is there anything contained in
12 Nancy Farkas' chart that indicates to you or memorializes
13 for you efforts undertaken by the staff of EMH Urology or
14 Dr. Noble to suggest to Miss Farkas that she had either
15 misunderstood instructions or she chose to discontinue
16 treatment against medical advice and needed to schedule an
17 additional appointment?

18 A. As I recall, there was, there was a call into the
19 office and Dr. Noble replied by stating he had not finished
20 his workup, specifically the metabolic stone profile, and
21 recommended she have this done either by returning to us or
22 there's some question about her moving out of the area and
23 have it done by another urologist elsewhere. It was clear
24 to me the communication to the patient was to encourage her
25 to follow up on more than one occasion, and there's, I

1 believe on that last, one of the last routing sheets,
2 there's the indication by the staff person or the secretary
3 that she did note or give Mrs. Farkas an appointment for
4 follow-up or noted the instruction to give her that,
5 instruct her on following up.

6 Q. Is there any indication contained in the chart of a no
show?

8 A. I don't know.

9 Q. And that's something you would want to be noted in the
10 chart; correct?

11 A. Not always; no.

12 Q. Is there any letter indicated in the file indicating
13 that Miss Farkas had not shown for an appointment which was
14 medically indicated?

15 MR. CONWAY: Objection.

16 A. A letter by whom?

17 Q. A letter from the staff of EMH Urology or Dr. Noble
18 indicating, Nancy Farkas, I instructed you, you need
19 additional care, you discontinued treatment against medical
20 advice, I suggest you contact the office and schedule an
21 appointment?

22 A. We don't normally do that. Basically, if the
23 condition is a benign problem, we don't normally write a
24 letter quite with that strongly an emphasis.

25 Q. Would you agree with me in December of 1998, Dr. Noble

1 had not performed the tests necessary to give him the
2 information as to whether or not the condition he was
3 dealing with was benign?

4 A. In December was the presenting date?

5 Q. No. The presenting date was October. The purported
6 telephone conversation with the staff was in December.

7 A. That's correct. Yeah. The workup was not finished at
8 that point.

9 Q. No CT scan had been done, no ultrasound had been done;
10 correct?

11 A. Well, secondarily. But, actually, the presenting
12 symptoms had not essentially been diagnosed clearly either,
13 meaning that the stone disease itself had not -- he had not
14 completed his workup for stone disease. If he had completed
15 his workup for stone disease, he would have proceeded to
16 perform an ultrasound or CT scan.

17 And, in fact, I know Dr. Noble's routine because it's
18 my routine, and any time there's an obstruction, we always
19 obtain some additional study to be sure the obstruction has
20 resolved. Even though we have done a retrograde pyelogram,
21 we always obtain an IVP, ultrasound or a CT, whichever is
22 appropriate, at a later point.

23 You know, usually it's within six to twelve weeks or
24 within roughly that range of time to be sure that
25 obstruction is clear, kidney is back to normal, functioning

1 normally and to evaluate for the presence or absence of
2 other stones. That's part of the workup. That's a standard
3 part of the workup.

4 Q. You would defer as part of good medical practice
5 evaluation of a potentially-cancerous mass to undertake a
6 stone risk profile?

7 A. 90 percent of renal cell cysts, 90 percent are benign,
8 so I would question your use of the question of malignant.
9 But in this patient's case, it was malignant. But at the
10 point of presentation to Dr. Noble, there were no
11 indications that this was a malignant cell carcinoma based
12 on the workup at that point.

13 Q. Do you honestly believe it's fair to gamble with the
14 patient's life that way?

15 MR. CONWAY: Objection. You don't
16 have to answer, doctor. Objection. You don't. That's
17 argumentative.

18 BY MS. DIXON:

19 Q. You told me earlier it can put the patient at risk
20 delaying a CT scan; correct?

21 MR. CONWAY: Objection. That's not
22 what he testified to, Debra.

23 A. I don't understand.

24 Q. Doctor, when we talked earlier regarding obtaining a
25 CT scan on or about October 26th of 1998 --

1 A. Okay.

2 Q. -- I asked you if there was any risk to the patient,
3 given the secondary finding on the IVP, in delaying that CT
4 scan.

5 A. My answer was that the CT scan itself posed no risk to
6 the patient, but the question was whether or not it was
7 appropriate to do. Frankly, in a patient that has gross
8 hematuria, your greater risks would be not doing an IVP and
9 perhaps missing a transitional cell carcinoma or a cancer of
10 the collecting system of the ureter which is at least
11 frequent or as frequent as renal cell carcinoma.

12 The only way to diagnose that is with an IVP, so
13 appropriately the IVP was done. So not doing the CT scan
14 would have not placed this patient at the risk of death, so
15 to speak, at that particular point.

16 Q. Doctor, let me ask you this: Is there any delay -- is
17 there any risk to a patient in delaying the diagnosis of
18 renal cell carcinoma?

19 A. In general, yes.

20 Q. Would you agree that the earlier a renal cell
21 carcinoma is diagnosed and treated, the more likely a
22 person's chances to avoid metastatic disease?

23 A. In general, yes.

24 Q. Are you aware of the fact that on November 23rd of
25 1998, when Nancy underwent a retrograde pyelogram, that that

1 pyelogram absolutely ruled out a kidney stone or obstruction
2 in her ureter?

3 A. I would have to refer to the report.

4 Q. Feel free to do so.

5 A. Okay. Now, would you rephrase your question again?

6 Q. For the record, you now have in front of you the
7 report relative to the November 23rd, 1998 retrograde
8 pyelogram; correct?

9 A. Yes.

10 Q. Would you agree that the result of that retrograde
11 pyelogram absolutely ruled out a kidney stone or obstruction
12 in Nancy's ureter?

13 A. Well, essentially the report states that there are no
14 stones or no visible stones or obstruction within the
15 collecting system of the kidney, meaning the ureter and the
16 inside part of the kidney. It does not essentially tell you
17 about the kidney proper, meaning stone within the parenchyma
18 or tissue of the kidney.

19 But the retrograde pyelogram indicates that the
20 obstructive element that had been present on the IVP is now
21 resolved and that they did not visibly see any signs of a
22 visible stone on the films.

23 Q. As you read the term "visible stone" on the retrograde
24 pyelogram, is that contrasting, if you will, an opaque
25 versus a non-opaque stone?

1 A. Yes. A radiographically-opaque stone. The
2 implication is that they did not see one that is calcified,
3 therefore, radiographic low visibility, therefore,
4 theoretically, there could be a non-opaque stone which was
5 small enough not to cause obstruction which does occur at
6 times. So the retrograde pyelogram theoretically still
7 would not rule out a loosened or non-opaque stone in the
8 absence of obstruction which would suggest perhaps a tiny
9 stone -

10 Q. And likewise --

A. -- still present.

Q. I'm sorry. Likewise, the retrograde pyelogram, based
on the findings you have in front of you, could not rule out
the possibility of a stone contained within the kidney
proper; correct?

16 A. No. Within the fleshy part or the parenchyma of the
17 kidney itself, that's correct.

18 Q. Would you agree with me that a CT scan would assist
19 Dr. Noble in ruling out a stone in the parenchyma of the
20 kidney?

21 A. Yes. A renal colic CT scan would be appropriately
22 performed at some point in the further workup of this
23 patient as well as in general; yes.

24 Q. And, likewise, a renal colic CT scan would assist
25 Dr. Noble in evaluating that right kidney and ureter for

1 non-opaque stones, as well; correct?

2 A. Yes; it would.

3 MS. DIXON: Doctor, I don't think
4 I'm going to have too much more. I want to take a moment
5 and review my notes.

6 THE WITNESS: Sure.

7 (Thereupon, a recess was taken.)

8 THE VIDEOGRAPHER: We're back on.

9 BY MS. DIXON:

10 Q. Doctor, before we went off the record, we talked about
11 the findings on the November 23, 1998 retrograde pyelogram,
12 and at the conclusion of that study, based on the findings
13 you have in front of you, is it your opinion that it was not
14 below the standard of care to proceed to a CT scan at that
15 time?

16 MR. CONWAY: Objection. I don't
17 understand that question. I don't know if he does. Can you
18 repeat it?

19 MS. DIXON: Sure. I would be happy
20 to rephrase it.

21 BY MS. DIXON:

22 Q. Doctor, you have reviewed the 11/23/98 retrograde
23 pyelogram conclusions; correct?

24 A. Uh-huh. That's correct.

25 Q. You agree with the fact that there is no at least

1 overt obstruction at that point; correct?

2 A. That's correct.

3 Q. My question is once that information was available to
4 Dr. Noble that there was no overt obstruction as of
5 November 23rd, 1998, is it your opinion that it was not the
6 standard of care to proceed to a CT scan at that time to
7 further evaluate the second finding on the 10/20/98 IVP?

8 MR. CONWAY: Objection.

9 A. So the presumption is that you're saying it is the
10 standard of care to do the CT at this point?

11 Q. My question to you is, is it the standard of care to
12 proceed to a CT scan once you know there is no overt
13 obstruction?

14 MR. CONWAY: Immediately?

15 BY MS. DIXON:

16 Q. Doctor.

17 MR. CONWAY: I'm just trying to be
18 clear.

19 BY MS. DIXON:

20 Q. I'm not talking about later that afternoon, but is it
21 the standard of care for the next active medical
22 intervention, if you will, to be to proceed to a CT scan?

23 A. A CT scan would be appropriate and reasonable to
24 perform as part of a continued kidney stone workup protocol.
25 The only question is when to do it, and, as you said, it's

1 not necessary to do it on that particular day but within a
2 reasonable amount of time. And follow-up, we normally would
3 probably proceed with a CT renal colic at some point in the
4 patient's workup.

5 Q. In your own personal practice, what time frame would
6 you impose on yourself and your patient once you learned
7 there had been no overt obstruction?

8 A. After an acute presentation similar to this particular
9 patient's, a stone workup would reasonably carry from
10 between one to perhaps three months as a rule or guide, as a
11 rule of thumb, meaning within that time frame, one would
12 have seen the patient back perhaps two or three times, done
13 appropriate metabolic studies, have urine cultures, have
14 other lab work available and some additional follow-up
15 radiographic studies, one of which would be a CT renal
16 colic, which I personally like, but one could also argue for
17 an ultrasound, as well.

18 Q. And is there any medical text or treatise that you can
19 direct me to that defines the appropriate time frame for
20 obtaining that CT scan or ultrasound to further evaluate the
21 cyst or mass?

22 A. No. Any statements referable would be similar to what
23 you showed me as a flow chart, but that would always depend
24 on the patient's presenting signs and symptoms and clearing
25 up those signs and symptoms first and then proceeding to the

1 next level of the studies.

2 Q. Would you agree with me that as of the conclusion of
3 the retrograde pyelogram on 10/23/98, there is no medical
4 reason for not proceeding to a CT scan to evaluate the cyst
5 or mass?

6 A. Well, there was -- I'm not sure what you mean by
7 medical reason.

8 Q. Well, frankly, doctor, I got the impression based on
9 your testimony up until this point that because of the
10 concerns surrounding an obstructive uropathy and the
11 potential kidney damage and all the sequelae that may follow
12 that, it was critical to evaluate that obstruction; correct?

13 A. That's correct. In the immediate sense, that's true.
14 And then electively, after one is sure that the obstruction
15 is cleared up and you have all your other appropriate
16 laboratory studies finished, then a follow-up scan, as I
17 mentioned earlier, would be appropriate such as a CT renal
18 colic or ultrasound or even an IVP, if necessary, at some
19 point in the workup.

20 Q. My question, doctor, is once you had the information
21 available to you that Dr. Noble did in conjunction with the
22 November 23rd retrograde pyelogram, although you may have
23 some preferences regarding additional metabolic workup and
24 additional stone risk profiles, is there any reason, and
25 what I mean by "reason" is any medical concern or

1 prohibition, that would cause you or cause you not to be
2 able to order the CT scan at that time?

3 A. I'm sorry, I'm having trouble with your use of the
4 negatives. We don't order things because it's not harmful
5 not to order things. We order things for indications, so
6 the indication here is that the obstruction is cleared, the
7 obstruction is cleared and it is now appropriate to continue
8 with further workup.

9 One of the things which we would include in that
10 further workup would be a CT renal colic along with other
11 metabolic studies.

12 Q. Is there any benefit to a patient such as Nancy
13 Farkas, once the obstruction had been ruled out as of
14 November 23rd, 1998, to reserve -- for a physician to
15 reserve or hold off on obtaining a CT scan and obtain
16 additional metabolic workup?

17 A. No. But I don't see any indication that Dr. Noble
18 was -- did not plan to proceed with further workup either.
19 Is this a hypothetical question?

20 Q. Well, you're the one who keeps telling me that after
21 one completed the metabolic workup, they may then proceed to
22 a scan such as a renal colic CT scan or abdominal CT scan.

23 A. Right. As part of the continued workup; right.

24 Q. My question is, is there any risk to the patient as of
25 November 23rd, 1998 to defer on the further metabolic

1 testing and proceed directly to a CT scan?

2 A. Okay. I'm not sure what you mean by "risk." You mean
3 is it risky for the patient -- is it harmful for the patient
4 to have the CT? I don't understand your use of the word
5 "risk."

6 Q. My question doesn't relate to the risk associated with
7 undergoing a CT scan. As it relates to the two findings on
8 the October 20th IVP.

9 A. Well, that's what I thought you meant. At this point
10 you still do not know that the patient has renal cell
11 carcinoma, so you can't make a case or argument stating that
12 it's very risky not to do the CT scan because the patient is
13 going to die from a cancer which we don't know is really
14 there yet. Once you know the cancer is there, the answer to
15 your question would be yes.

16 Q. But you have to do the test to know she has --

17 A. No. You have to do a needle biopsy of the mass to
18 know whether or not it is there. The renal CT or the
19 ultrasound simply shows the presence of a solid mass. It
20 does not diagnose renal cell carcinoma. About 10 to 20
21 percent of solid renal masses are benign. There are renal
22 oncocytomas and a few other benign tumors that exist.

23 You only know a person has renal cell carcinoma if you
24 do an x-ray that gives you the suspicion of a solid renal
25 mass, and then you proceed with a needle biopsy or some form

1 of surgical biopsy. Then you know the patient has renal
2 cell carcinoma, then you can appropriately make statements
3 regarding the patient's prognosis.

4 Q. And you would agree that the x-ray you were referring
5 to is either a renal ultrasound or a CT scan?

6 A. Right. Which, again, is part of a normal kidney stone
7 workup.

8 Q. My question becomes, doctor, once you had removed
9 overt concern regarding obstruction, i.e. the findings on
10 the 11/23 retrograde pyelogram, would you agree with me that
11 at that point not turning to evaluation of the cyst or mass
12 can place a patient at risk?

13 MR. CONWAY: Objection.

14 A. I think I answered that.

15 Q. Well, you have told me that --

16 A. Is it a little bit of risk or a lot of risk?

17 Q. Just risk as a general principle.

18 MR. CONWAY: Objection. Let me put
19 on the record you have asked the same question about --

20 MS. DIXON: He hasn't answered it,
21 Tom, and speaking objections are totally inappropriate.

22 MR. CONWAY: I have to speak,
23 otherwise, I can't object. Objection. He's -- it's been
24 asked and answered. You're phrasing it four or five
25 different ways. He's given the same answer.

1 A. You're not establishing the risk. Are you speaking of
2 risk of death from metastatic disease from cancer, or are
3 you speaking of other forms of risk, the risk of the test
4 itself, meaning that test is a benign test and, therefore,
5 not risky for the patient to have done?

6 Q. Doctor, I appreciate that most medical procedures
7 carry some risk independent of the disease they seek to
8 diagnose. That being said, once an overt obstruction had
9 been ruled out on 11/23/98 --

10 A. That's correct.

11 Q. -- would you agree that by a physician choosing to
12 undergo additional metabolic testing and by virtue of doing
13 that deferring a CT scan or ultrasound places the patient at
14 greater risk for metastatic disease associated with renal
15 cell carcinoma by virtue of failing to diagnose it in the
16 timeliest or earliest, excuse me, at the earliest time
17 possible?

18 MR. CONWAY: Objection. That is an
19 impossible question. I know what you're trying to ask.
20 That's an impossible question to answer. It's got four
21 different parts in it, Debra. You want him to answer your
22 ultimate issue of the case.

23 A. Part -- again, back up. As I mentioned earlier, part
24 of a continued or proper kidney stone evaluation and workup
25 is to do both radiographic studies and metabolic stone risk

1 testing if they are ongoing. I see no sign that this
2 particular physician elected to simply stop at the metabolic
3 part, so to speak, or stop at the retrograde or stop at the
4 IVP. It was an ongoing relationship, and based on my own
5 knowledge of the field as well as my knowledge of the way we
6 were trained, there is no question that some form of the CT
7 scanning or ultrasound would have been carried out at some
8 point in the workup of this patient.

9 Now, whether it was on this particular day or the
10 following week or the following month, I don't know, but it
11 would have been done because that's part of the workup for
12 the disease and, therefore, we would have uncovered the
13 presence of a solid renal mass and then we would have
14 followed the flow chart that you indicated and proceeded
15 with a biopsy and appropriate therapy.

16 Q. You agree with me, based on review of that record,
17 Dr. Noble, once he was armed with the findings of the
18 November 23rd retrograde pyelogram, chose to defer the CT
19 scan and --

20 A. I see no evidence --

21 Q. Excuse me. -- and undertake further metabolic
22 studies?

23 A. I see no statements in the chart that says that I
24 defer a CT scan and proceed with a metabolic stone profile.

25 Q. But he did, in fact, undertake additional metabolic

1 studies; correct? He ordered a pelvic sonogram and he
2 requested a patient undergo a 24-hour urine test; correct?

3 A. Yes. I'm not sure of the date, but I do remember the
4 urine collections; yes.

5 Q. So by virtue of ordering those, he made certain care
6 decisions; correct? He ordered one test over another in
7 terms of order?

8 A. Yes.

9 Q. My question is, once Dr. Noble had the findings of the
10 November 23rd retrograde pyelogram and ruled out the kidney
11 obstruction, is it your testimony that it was within the
12 standard of care for Dr. Noble to further delay a CT scan in
13 favor of further metabolic testing?

14 MR. CONWAY: Objection to the term
15 "further delay."

16 A. We don't know that he delayed it. That's the issue
17 here. You're using loaded terminology. Because when I or
18 any physician approaches the workup of a patient, I do not
19 always write down the next 100 things I'm going to do on a
20 particular date. I may order a test number 1 and then order
21 test number 2, but I may not write down that there is test
22 number 10 which is to follow at a later date and that is
23 what you are implying.

24 You are stating to me that, you know, a doctor
25 intentionally delays treatment if he did not mention test

1 number 10 to do when he was doing test number 1 and 2 and
2 that is not part of the standard of care. There is no
3 standard of care that says that I, or any physician, have to
4 write down 100 tests in order to be done for the coming year
5 or ten years on a patient. You know, we order one test at a
6 time in order based on the patient's clinical progress and
7 presenting signs or symptoms and the timing of their
8 follow-ups and so on.

9 Q. The pelvic sonogram that Dr. Noble ordered for Nancy
10 Farkas, is that a test that would be utilized in furthering
11 a metabolic workup?

12 A. Not normally. My understanding there, and it's
13 somewhat limited, is that the patient apparently had not
14 been or had not followed or been to medical physicians. I'm
15 not clear why but had not had either a Pap smear or
16 something, and he elected to proceed to do that as part of
17 his continuing care of the patient. To me that means he was
18 attending the patient and planned for continued follow-up
19 not only of stone disease but also in general.

20 Certainly it's not an indication of a physician that
21 intentionally would delay either diagnostic studies or
22 treatment. But the selection of the pelvic sonogram itself
23 was, I believe, to evaluate some other gynecologic problem
24 which was extraneous to the stone workup itself, but it was
25 just part of his continued offering of care to the patient.

1 That's why I say it's ridiculous to even infer that, you
2 know, anyone elected to abandon this patient or not call the
3 patient back. There's a sign that there was an effort made
4 for continued care for follow-up of the patient not only for
5 stone disease but also for medical problems, as well.

6 Q. Are you able to identify for me any advantage to
7 purposefully or intentionally delaying the diagnosis of
8 renal cell carcinoma?

9 MR. CONWAY: Objection. You don't
10 have to answer that one either, doctor.

11 A. You answered it yourself.

12 Q. Is the answer no?

13 MR. CONWAY: Objection. Don't
14 answer. That is argumentation. You know that's an improper
15 question.

16 A. The answer is self-evident.

17 Q. Meaning no?

18 MR. CONWAY: Objection. Doctor, you
19 don't have to answer the question.

20 MS. DIXON: Tom, I'll go back to the
21 judge again. I'm sure she's still there.

22 MR. CONWAY: Read back that question.

23 MS. DIXON: I'll restate it.

24 BY MS. DIXON:

25 Q. Can you give me one advantage of intentionally

1 delaying the renal cell? It's a yes or no.

2 MR. CONWAY: Objection. That is an
3 improper question.

4 MS. DIXON: Based on what?

5 MR. CONWAY: It's argumentative.

6 MS. DIXON: Absolutely not. It's a
7 yes or no. He has given us a standard of care. It clearly
8 delayed the diagnosis. My question is --

9 MR. CONWAY: Then argue that to the
10 jury.

11 MS. DIXON: I'm entitled to an
12 answer today.

13 MR. CONWAY: Doctor, you know what
14 our position is.

15 MS. DIXON: Certify the question.

16 MR. CONWAY Go ahead. Let's call
17 the judge right now.

18 MS. DIXON: Go get her on the phone.

19 MR. CONWAY: You get her. You want
20 the question. The question insinuates that he did it
21 intentionally. There was no intentional delay in diagnosis.

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

23 BY MS. DIXON:

24 Q. Doctor, I have one final question for you.

25 Doctor, based on your review of the medical record of

1 Nancy Farkas and knowing what you know of the IVP from
2 10/20/98, is it within the standard of care for a physician
3 to pursue gynecological workup on a patient prior to ruling
4 in or ruling out renal cell carcinoma?

5 MR. CONWAY: Objection.

6 A. I don't think I could comment on standard of care, but
7 I was just happening to go through here. I note Dr. Noble
8 mentioned specifically that patient requested a Pap smear
9 and a gynecologic evaluation, so he was simply complying
10 with a request for a lab test. So the intent was not to
11 divert one's attention to working up a different problem but
12 rather to comply with a request, a reasonable request, by a
13 patient to have an additional study because she had not had
14 one for some period of time.

15 Q. Correct me if I'm wrong, but the Pap smear was done in
16 conjunction with the pelvic ultrasound which was done at
17 Dr. Noble's request; correct?

18 A. No. The Pap smear, as I saw here, was done at the
19 time of her retrograde which was in surgery supposedly -- I
20 just saw that in here -- not separately at the time of her
21 ultrasound.

22 Q. But there was a supplemental pelvic ultrasound done on
23 12/7?

24 A. There was a separate ultrasound done later, but in the
25 operative note of Dr. Noble on 11/23, he says specifically

1 it should be mentioned that prior to the actual prep, a Pap
2 test was taken at the request of the patient.

3 Q. Would you agree that a pelvic ultrasound is more
4 likely to have gynecologic information than it would
5 urologic information?

6 A. It's difficult to say because we frequently use pelvic
7 ultrasounds to evaluate the bladder, too, but in general,
8 one could make an argument that there may be more of a
9 likelihood of use of pelvic ultrasound in gynecologic
10 applications, but urologists frequently use it, as well.

11 Q. Was there any information gleaned by way of a pelvic
12 ultrasound that would provide Dr. Noble with additional
13 information as to the obstructive uropathy that was
14 identified in the October 20th IVP?

15 A. I don't believe the ultrasound showed anything
16 specifically related to her urologic status.

17 Q. As a general principle, would a pelvic ultrasound
18 provide a physician such as Dr. Noble information relative
19 to the obstructive uropathy identified?

20 A. Yes, it could, certainly, because a pelvic ultrasound
21 can show a dilated bladder, dilated ureter it can show. It
22 can also reflect by sound the presence of a stone, too, as
23 well.

24 Q. Would a pelvic ultrasound provide any information
25 relative to the cyst or mass?

1 A. Not in a kidney, unless an ultrasound was directed at
2 the kidney itself.

3 MS. DIXON: Okay. Pending the
4 Court's ruling, I don't have any further questions.

5 MR. CONWAY: You don't have any more?

6 MS. DIXON: I said pending the
 Court's ruling, I do not have any further questions.

8 MR. CONWAY: Let me, in the spirit of
9 being reasonable, reconsider.

10 MS. DIXON: You should have thought
11 about it before I called.

12 MR. CONWAY: What?

13 MS. DIXON: Nothing.

14 MR. CONWAY: If she rules in your
15 favor, I do not want to have my client come back down here.

16 MS. DIXON: Absolutely not.

17 MR. CONWAY: I still think it's an
18 improper question. I'm willing to be practical about
19 things, as well.

20 If you could read back the question that I
21 vociferously objected to.

22 MS. DIXON: I can give it back to
23 you. I can place it in a format that would be more
24 palatable to Mr. Conway.

25 BY MS. DIXON:

1 Q. Can you tell me one advantage to delaying the
2 diagnosis of renal cell carcinoma?

3 A. In general, there are no advantages to delaying
4 diagnosis of renal cell carcinoma.

5 MS. DIXON: I don't have anything
6 else. Thank you.

7 - - -

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11 (Thereupon the deposition was concluded at 5:00 p.m.)
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State of Ohio) SS.
County of Cuyahoga)

CERTIFICATE

I, Denise C. Winter, a Notary Public within and for the State aforesaid, duly commissioned and qualified, do hereby certify that the above-named witness, LOUIS D'AMICO, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed upon a computer; that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid, and that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, employee or attorney of any of the parties hereto, and further that I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my
hand this 31st day of July, 2000.


Denise C. Winter
Notary Public

My commission expires March 3, 2001.

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