IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

DIANE M. CARRICK, Executrix, et al., Plaintiffs,

vs.

THE CLEVELAND CLINIC FOUNDATION, et al., Defendants.

No. 185 330

DEPOSITION OF ISAAC GORBATY, M.D., taken on behalf of the Defendants, commencing at 11:30 A.M., at 4835 Van Nuys Boulevard, Suite 212, Sherman Oaks, California, on Thursday, the 28th day of August, 1991, before BETSY A. HELD, C.S.R. No, 4940, pursuant to Notice.

Reported by: BETSY A. HELD, CSR No. 4940

APPEARANCES

For Plaintiffs:

BY: CHRISTOPHER M. MELLINO, ESQ.
1530 Standard Boulevard
Cleveland, Ohio 44113

For Defendant, CLEVELAND CLINIC FOUNDATION:

ARTER & HADDEN
BY: GEORGE GORE, ESQ,
1100 Huntington Drive
Cleveland, Ohio 44115

For Defendant, ROBERT RILEY, M.D. :

REMINGER & REMINGER CO, , L.P.A.
BY: LESLIE J. SPISAK, ESQ,
The 113 Building
Cleveland, Ohio 44114-1273

I N D E X

(No **Exhibits** Offered)

SHERMAN OAKS, CALIFORNIA, WEDNESDAY, **AUGUST** 28, 1991

11:30 A.M.

ISAAC GORBATY, M.D.,

called as a witness on behalf of Defendants, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. GORE:

Q Let the record show that this is a discovery deposition taken of Dr. Gorbaty, but I will ask him for the correct pronunciation in a moment,

A That is fine.

Q Initially, on behalf of Cleveland Clinic let me start by asking, how do you prefer to have your name pronounced?

A Gorbaty.

Q Fine.

Q Doctor, we have been provided with a copy of your report dated January 9, 1990 regarding this case.

Do you have a copy of that with you, sir?

A Yes,

Q Have you written or prepared any other reports regarding this case, sir?

A I have not, I have not written any reports

after this.

Q Did you write reports before that regarding this case?

A No.

Q So that is the only one you have written regarding this case?

A No. This is the only report I have written. I was sent Dr. Riley's office chart.

Q I will get into that in a moment.

But as far as you writing a report, that is the only one you have prepared in this case?

A This is the only report I have prepared, at the request of Mr. Rampinski.

Q When were you first retained in this case, Doctor?

A I don't recall the exact date.

Q Was it just shortly before the date of the report?

A Yes.

Q Within a couple of months before that?

A I received a telephone call, "Would you be willing to review a case," and I said, "Yes," and he sent me the records and I prepared this report.

Q And was it Mr. Rampinski who called you, sir?

A Yes.

Q Do you know how he came to get in contact with you?

A Yes. About a year prior there was a mailer that I received asking if doctors wished to be on a national register of people who were willing to review cases and I put my name down and I didn't expect to get any calls. And to date, this is the only call I have gotten.

Q Are you still listed with that service?

A Yes. I don't know if the service still exists.

Q Can you tell me the name of the service?

A I don't recall.

Q Have you at any time listed yourself with any other witness services, Doctor?

A No.

Q I think you have already answered this to some extent, Dr. Gorbaty, but let me ask you. What was it you were requested initially to do in this case?

A I was requested to look at the records that would be sent and to let Mr. Hampinski know my thoughts about the records.

Q What records or materials were provided to you initially regarding this case?

A The reports that were submitted included copies of Dr. Riley's office records, copies of the chart from Mr. Carrick's hospitalization at Lakewood Hospital in March of

1990.

Was it March?

MR. MELLINO: Yes,

THE WITNESS: And a report of Dr. Heyka from Cleveland Clinic. I believe there was a report, And then there was the hospitalization records of Mr. Carrick at Cleveland Clinic and then there was a letter from Dr. Heyka to Dr, Riley.

BY MR, GORE:

Q After receiving those records and before preparing your report, did you request any additional documents or records?

A No,

Q Did you receive any additional documents or records before preparing your report?

A No,

Q Did you review all of the materials that you received regarding the case?

A Yes,

Q Before preparing your report, Doctor, did you review any medical literature specifically with reference to this case?

A Yes.

Q Could you tell us what that was.

A I looked through two textbooks of internal

medicine. I believe Harrison and Sanford's Textbook of Internal Medicine.

I looked through the most recent edition of the -- of Brenner and Rector's Kidney, the Textbook of Nephrology. I looked through a textbook from the late '70s on the kidney and systemic disease, I have forgotten the author. I looked through one of the standard rheumatology textbooks.

Q Do you recall which one that was, sir?

A I think McCarty.

Q Other than the textbooks that you have just delineated for us, did you review any articles in the journals specifically with reference to this case?

A I regularly read probably ten to 15 different journals and I didn't feel I needed to do a literature search to know what was in both the kidney and the internal medicine literature.

Q Your report was prepared in January of 1990, according to the date?

A Yes.

Q What, if any, additional documents or materials have you received regarding this case subsequent to writing that report?

A Mr. Kampenski's office has sent me for review depositions, I believe a deposition of Dr. Heyka, a deposition of the anesthesiologist at Cleveland Clinic who

was in charge of his care, a deposition of Mrs. Carrick. I have been sent a medical report of Dr. Wish. What was his name?

Q There is a Dr, wish from the University Hospitals of Cleveland. Is that the one you have reference to?

A Yes,

MR. MELLINO: Just so you know, we sent him all of the depositions and both experts' reports.

MR, GORE: I know, I will go through the list.

Q You have already testified that before writing your report you were provided the records of Dr, Riley, the records of Lakewood Hospital, and the records of the Cleveland Clinic,

A Yes,

Q Were you subsequently provided, after writing the report, were you provided the deposition of Dr. Riley?

A Yes,

Q The deposition of Dr. Zein?

A Yes,

Q The deposition of Dr, Heyka, I think you already said.

A Yes,

Q The deposition of Dr. Broughan, who is the surgeon that did the parathyroidectomy.

A I don't think you sent me that one.

I don't think so.

Q The deposition of Dr. Bralliar, the anesthesiologist, I think you said you saw.

A That I have seen,

Q What about the deposition of Dr, Nakamoto?

A Yes, That one I have seen.

He was the nephrologist taking care on the clinic service.

Q That's correct.

A Yes, and he stated that it was unnecessary to obtain former records or talk to the former doctors taking care of the patient.

Q I don't recall, but --

A Okay.

Q And I think you said you did receive the deposition of Mrs. Carrick?

A Yes.

Q And the report of Dr. Wish?

A Yes.

Q Have you received the report of Dr. Mast?

A Yes.

Q Have you received the report of Dr. Burke?

A No. I don't recall Dr. Burke.

Q He is an economist.

A No. I have not received that report.

Q Is there anything else that we haven't touched upon, Doctor, that you have received and been requested to review regarding this case?

A No.

Q Have you reviewed all of the documents that you have been provided?

A Yes, I have read them,

Q Has your review of the depositions and other documents that you have been provided subsequent to your writing of your report changed or modified any of the opinions set forth in your report?

A The subsequent review of all records of reinforced my original report.

Q Now, Dr. Gorbaty, as of March of 1989, which was when Mr. Carrick was admitted to Lakewood Hospital, is it fair to say that his condition, his overall condition had been deteriorating for about a decade?

A His overall condition had been deteriorating most markedly since December of the year before. The nursing notes at Lakewood Hospital on the admission date say that he told the nurses that he had been feeling very poorly since Christmas of the prior calendar year, His laboratory work had been deteriorating over the course of a decade, but he himself had only been doing very poorly since the

prior Christmas.

Q On page three of your report, Doctor, near the bottom of the page, I believe you state that the review of the nursing notes from Lakewood Hospital and the Cleveland Clinic reveal that Mr. Carrick was sick for approximately one year, feeling especially weak and tired since Christmas of 1988; correct?

A Yes,

Q But, as you indicated just a moment ago, his laboratory values had been deteriorating for a number of years?

A Yes.

Q As of March of 1989 when he was admitted to Lakewood Hospital, would you agree that he had end-stage renal failure?

A He had end-stage renal failure Christmas of 1988.

Q What does that mean, Doctor, end-stage renal failure?

A End-stage renal failure is a syndrome, and it has many components. And it essentially means that the patient will not be functional, functionally capable of having a meaningful existence without the addition of dialysis,

Usually people are asymptomatic from kidney

Renal osteodystrophy starts when creatinine clearance goes below 50. Without doing a bone biopsy, which was done neither at Lakewood Hospital nor at Cleveland Clinic, it is impossible to tell the exact nature of the demineralization. In fact, here at Wadsworth Hospital, there were some of the studies have been done until recently, all patients prior to parathyroidectomy were asked to have Tetracycline labeled bone biopsies because there can be aluminum toxicity and a combination of osteomalacia, aluminum toxicity and renal osteodystrophy.

Q My question is, Mr. Carrick in March --

A Mr. Carrick had renal osteodystrophy.

Q Now my question is, did the severe renal osteodystrophy involve extensive demineralization of his bones?

A Yes, it did.

Q And did the severe renal osteodystrophy involve metastatic calcifications of his soft tissues?

A On X-ray reports, that was reported.

Q In March of 1989, did he also have a renal vascular hypertension?

A That is unclear from the records, as this was not investigated. My conjecture is that he probably did, but that is a conjecture on the basis of his having had an IVP in the early '80s showing one small kidney, one normal

kidney and uncontrolled blood pressure.

Q He did have uncontrolled hypertension for a number of years?

A The record from Dr. Riley's office is that, despite medication, and despite institution of medicines such as Loniten, the diastolic was never in the appropriate range, and the blood pressure was poorly or suboptimally controlled over a period of years.

It is reasonable to conjecture that he may have had renal vascular hypertension, but I don't know for sure because no investigation was done of this.

Q In March of 1989 did he have gout?

A The doctor seeing him admitted him to the hospital as having gout.

Q But is it your opinion that he had gout?

A When he was seen at Cleveland Clinic, they felt that he had calcium phosphate deposition disease.

The rheumatologist who saw him at Lakewood Hospital wrote in his evaluation that Mr. Carrick had gout. I don't believe he aspirated any fluid to look at. I think --

Q Do you believe he had gout?

A I believe that he had chronic gouty arthritis and, in addition, had a superimposed steroid myopathy and a myopathy of uremia.

Q So he had chronic gouty arthritis and uremia?

A Uremic arthritis.

Q And steroid myopathy?

A Yes.

Q Did he also have gouty nephropathy?

A Without doing a kidney biopsy or without doing further studies, it is conjecture the nature of his kidney disease. I believe that he had a combination of pathologies in his kidneys. Gouty kidney disease includes both kidney stone disease, which he clearly had not had an episode of kidney stones, as well as deposition of uric crystals in the parenchyma of the kidney. This diagnosis can only be made at postmortem or after nephrectomy.

I believe it is reasonable to conjecture that he had gouty nephropathy. He ran uric acids in excess of ten or as high as 12 or 13 over a period of almost a decade with the picture of progressive renal insufficiency.

Q As of March of 1989, when he was admitted to Lakewood Hospital, he had hyperparathyroidism; did he not?

A Yes. All patients who have progressive renal insufficiency with creatinine clearances of less than 50 cc's per minute have the syndrome of hyperparathyroidism on a secondary basis,

Q Dr, Gorbaty, considering the medical facts that by March of 1989 when he was admitted to Lakewood Hospital, he had end-stage renal failure, a small right kidney,

profound renal acidemia, severe renal osteodystrophy, with extensive demineralization of his bones and metastatic calcifications of his soft tissues, probable renal vascular hypertension, chronic gouty arthritis, probable gouty nephropathy, uremia, steroid myopathy and hyperparathyroidism, do you have an opinion as to what his life expectancy was then?

MR. MELLINO: Objection.

THE WITNESS: I can tell you about the life expectancy of people on dialysis. Peter -- one of the professors --

BY MR. GORE:

Q No, Dr. Gorbaty. My question is this man with these conditions. Do you have an opinion as of that time as to what this man's life expectancy is?

MR. MELLINO: Objection.

You can answer.

THE WITNESS: At his age with control of blood pressure and proper dialytic intervention or subsequent kidney transplant in the absence of coronary disease or cancer, gives him a life expectancy of 20 to 30 years.

BY MR. GORE:

Q If he had a kidney transplant?

A If he were dialyzed, blood pressure controlled and in the absence of coronary disease or cancer, he has a

life expectancy in the United States of 20 to 30 years,

Q Did you take into consideration calcification of heart valves?

A In the United States, a man of his age who comes to end-stage renal failure who does not have coronary disease and does not have cancer has a 20- to 30-year life expectancy, taking all comers.

Q Do you believe this patient did have calcification of his heart valves?

A I don't recall X-ray reports or coronary angiograms being done on him regarding that,

There is literature of dialysis patients undergoing both coronary bypass and valve replacement, and these patients do not have increased mortality or morbidity from these conditions and the cardiac surgeons consider that they have their same outlook as if they were chronic dialysis patients.

Q Just so I am clear, with all of the conditions this man had in March of '89, assuming he was dialyzed, had blood pressure control and had a kidney transplant, you believe that he had a life expectancy of 20 to 30 years; is that your testimony?

A I believe so, with proper medical care, with aggressive medical care,

Q Doctor, as I understand your report, you have a

number of criticisms, first of all, of Dr, Riley. Is that correct?

A Well, I have observations regarding the care that Mr. Carrick received.

Q Well, one of the things I believe you indicated in your report was that Mr, Carrick's blood pressures throughout the 1980s were poorly controlled; is that correct?

A Yes.

Q And that was while he was under the care of Dr. Riley?

A Yes.

Q I think you also indicated his uric acid, it was routinely 12 from '82 to '88, and that was not reduced or controlled?

A Yes. The record bears that out.

Q You also indicated I believe that the BUN and creatinine rose steadily throughout the 1980s and were not reduced or controlled,

A Yes,

Q You also indicated that allopurinol was not prescribed or administered and that is indicated for gouty nephropathy?

A Yes.

MR. SPISAR: I think what you did say was it was discontinued; did you not?

THE WITNESS: In fact, may I go into that.

Looking at Dr, Riley's records, I could not reason out why it was discontinued,

BY MR. GORE:

Q When was it discontinued?

A I believe in '82 it was discontinued. '82 or '83. And subsequently when I read one of the depositions, I realized that he wrote down, rash. I wasn't able to read this, and that he had discontinued the allopurinol because of a rash,

What I was able to read in Dr. Riley's notes was that he had -- what I thought he had done was discontinued the allopurinol because the acidemia had progressed because the BUN and creatinine had gone up and that allopurinol may have been the cause of this,

Q Did you also indicate in your report that --

A May I just finish up. It is of interest that when Dr. Riley -- excuse me -- when Mr. Carrick was seen at I believe Lakewood or Cleveland Clinic by the rheumatologist, he did not tell them he was allergic to allopurinol and they gave it to him without any difficulty and, in fact, that was the first thing they did was that they instituted allopurinol.

9 I think you also indicated in your report, Doctor, that while Dr, Riley was taking care of Mr. Carrick

the patient was not referred to a nephrologist.

A Yes. I have subsequently from the depositions found out that Dr, Riley, though he was not specifically trained in nephrology, was one of our, quote, .grandfather nephrologists who practice nephrology in the community, but had not been specifically trained in this or boarded in this because he had not -- he had been trained prior to specific training programs or boards,

Q When in the course of Mr, Carrick's health care development do you believe that he needed a nephrologist for the first time?

A As a practicing nephrologist, internists refer me patients when they have a patient whose blood pressure is not controlled after several trials of blood pressure medicine, and/or when they have progressive renal insufficiency; that is, a serum creatinine of rising greater than 1.8.

Q With specific reference to Mr, Carrick when -- 1980, 1982, 1987, 1989 -- when do you believe that he needed a nephrologist?

A In 1982 I believe that Mr, Carrick's creatinine had risen even over two, his blood pressure was poorly controlled. He had problems because of the discontinuation of allopurinol. At that point, I believe he needed a nephrology evaluation.

At that point, I believe in the records there is a note that Mr. Carrick had an IVP that showed one small kidney, so that at that point there was a constellation of rising acidemia, problematic control of hyperuricemia, poorly controlled hypertension and an abnormal IVP.

Q From 1979 to 1989, Dr, Riley prescribed Indocin for Mr. Carrick; is that correct?

A Yes.

Q Is is Indocin a nephrotoxin?

A Indocin is a nephrotoxin,

Q In your opinion, should that Indocin have been prescribed for Mr, Carrick for those years in those quanitities?

A I was sent a record of several years of prescription renewals, In 1982, I believe Mr. Carrick received 22 prescription renewals for Indocin and I believe '83, '84, he received between 15 and 20 renewals.

On Dr. Riley's forms over the 1980s, he notes on each yearly history physical that Mr. Carrick was taking Indocin prn.

I don't know exactly how much he was taking over that entire period.

Indocin is an FDA-approved drug and is in a class of medications which are known to cause both acute and chronic kidney damage. This syndrome of nonsteroidal anti-

inflammatory, drug-induced nephropathy has been described since the mid 1970's. Indocin is a safe drug when given in people without renal impairment, and has been given under the care of rheumatologists on a chronic administration basis.

I believe that in the face of rising creatinine that it was imprudent to continue this medication, I believe that Mr. Carrick was taking as much as one hundred milligrams daily of this medication, which would be in the middle to high range of administration of this medication,

Q Doctor, in one or more respects do you believe, is it your opinion that Dr. Riley's care of Mr. Carrick fell below the requisite standard of care?

A I believe that Dr, Riley did not provide the care that a nephrologist would have provided to this patient and that several -- several findings in the record were not followed up, that the blood pressure was not aggressively controlled,

And I would say that this falls below the level of care expected of a specialist in this field. I have seen cases of similar problems in patients' care, so this occurs in the community, but I would say for a specialist, this would be considered below the standard that a specialist would be held to,

Q Are you going to express an opinion as to

whether Dr, Riley's care caused or contributed to cause Mr. Carrick's death?

MR, MELLINO: You can answer that.

MR. SPISAK: Leave this on the record. Go ahead.

THE WITNESS: Am I allowed --

Mr, Carrick had potentially treatable causes of renal insufficiency. He potentially had renal vascular disease, which in the early '80s might have been amenable to surgery or angioplasty. By the end of the 1980s, because of the chronicity of the problem, and because of the uncontrolled hypertension, surgical intervention at the end of the 1980s would not have saved his kidneys.

I believe that the blood pressure was not adequately controlled and that nephrosclerosis from hypertension was a clearly additive risk factor for Mr. Carrick. Nephrosclerosis on a hypertensive basis by itself can cause renal failure over a period of time.

I believe that an eight-year period of uric acids being in the 12's clearly has been shown in the literature to lead to parenchymal renal disease from uric acid deposition and was a potentially or a definite contributory factor.

MR. SPISAK: Thank you,

BY MR. GORE:

Q My question, Doctor, is are you going to

express an opinion at the trial of this case as to whether Dr, Riley's care and treatment caused or contributed to cause Mr, Carrick's death?

MR. MELLINO: Let me object because I think he just answered that, but go ahead.

MR. GORE: I don't believe he did,

THE WITNESS: I believe that the lack of follow-up on these three items led to progressive renal failure which might have been avoided had they been followed up and aggresively treated, I believe that the death of Mr. Carrick occurred under the care of Cleveland Clinic, and if he had not gone to Cleveland Clinic and had allowed Dr. Riley to place him on hemodialysis after he was noted to have a pericardial rub, he would almost certainly now be alive.

BY MR. GORE:

Q Is it your opinion that these problems that you have articulated with regard to Dr, Riley's care did not contribute to cause his death?

A These problems attributable to Dr. Riley's care led to renal failure, Dr, Riley, on the last day of hospitalization at Lakewood Hospital, asked Mr. Carrick to begin hemodialysis,

At that point the family requested transfer, I believe that Dr, Riley's actions contributed to his renal

failure, but that the proposed intervention by Dr. Riley would have allowed Mr. Carrick potentially to live another two decades.

Q Perhaps I am not making myself clear, Doctor. We are dealing here in a lawsuit with a death and what I have got to determine from you is what your testimony is going to be about what caused this man's death.

Now, in your report you said things about Dr. Riley's care, you said things about the Cleveland Clinic's care, and I am going to get to that.

My question to you is, are you going to testify that either Dr. Riley's care or lack of care caused or contributed to Mr. Carrick's death, that the Cleveland Clinic's care or lack of care caused or contributed to Mr. Carrick's death, or both?

MR. MELLINO: I object again, but go ahead and answer.

THE WITNESS: Mr. Carrick died during an intervention attempt to treat a secondary manisfestation of uremia. His uremia --

BY MR. GORE:

Q I understand that, Doctor. Can't you answer the question?

A I understand your question. You did not ask for yes or no.

Q I am not limiting it to yes or no, but I would like a yes or no, with whatever explanation you want to give.

A Yes, I believe that both the care given by Dr. Riley and the care extended by Cleveland Clinic were contributory to this man's death.

Q Fine. Are you going to testify as to the relative contribution of the two?

A I believe that that is for the jury to decide.

Q So you are not going to express an opinion in that regard?

MR. MELLINO: You are talking about specific allocation of negligence here?

MR. GORE: Yes.

MR. MELLINO: I object. Go ahead and answer.

THE WITNESS: I think that is for the jury to decide; isn't it?

BY MR. GORE:

Q Whether it is or not, I am getting the impression -- I don't want to put words in your mouth -- that you are going to testify that Dr. Riley's care contributed to cause Mr. Carrick's death, and that the Cleveland Clinic's care contributed to cause Mr. Carrick's death?

A Yes.

Q But you are not going to specify what percent and contribution each of them made; am I correct?

A You are correct.

Q Now, let's look at your criticism of the care rendered by the Cleveland Clinic doctors.

You have a number of statements in your report, Doctor, and I want to go over those with you.

A Yes.

Q But before doing so, is there any criticism that you have of the Cleveland Clinic doctors' care of Mr. Carrick that is not testified in your report?

A Well, I was -- should I include what I have learned from your depositions?

Q Sure.

A I was dismayed to find doctor after doctor at the Cleveland Clinic make the statement that it was unnecessary to review old records, talk to other doctors or review prior evaluations.

Q Do you know how --

A This is clearly outside of the pale of established practice.

Q In that regard, Doctor, let me ask you. Have you ever been to the Cleveland Clinic?

A Never.

Q Do you know how they function?

A I have been at several academic institutions.

Q I am not asking you about academic institutions. I am asking you if you know how Cleveland Clinic functions with regard to a unified chart.

A I have never been to Cleveland. I do not know their system.

Q Do you know, for example, if during the second confinement that Mr, Carrick had to Cleveland Clinic all of the records of his first confinement were available to the physicians taking care of him during the second confinement?

A I have read the depositions of Dr. Heyka, of of the anesthesiologist, and they all say that they did not consult with prior physicians, review old records, and the nephrologist taking care of Mr. Carrick said that it was unnecessary of him -- it was unnecessary for him to talk to Dr, Heyka, as this patient was there to have his procedure done,

Q Anything else, besides what is in your report?

A No.

Oh, there is one other thing. The anesthesiologist mentioned that he was not present during the intubation of Mr, Carrick, and that he routinely goes out to check his mail during anesthesia procedures and that he circulates and is available for problems. And he noted in his deposition that Mr, Carrick had a difficult

intubation, and that he was not personally present.

Q Did the difficulty in intubation cause anything in this case?

A Well, I think it bespeaks a general problem in care given at the Cleveland Clinic.

It is possible that there was a bit of aspiration that occurred during this difficult intubation.

Q Anything is possible. Is there evidence of aspiration, Doctor?

A There is no evidence. But as a general way of doing business, this is not the way business is done in the medical community outside of the Cleveland Clinic.

Q Everywhere else it is done differently; is that your testimony?

A Everywhere that I have been doctors talk to other doctors, consider it prudent to review old records and consider it appropriate to be present during the procedure that they are supervising.

Q Do anesthesiologists intubate patients?

A Yes.

Q You said a couple of times things about not reviewing records. Is it your understanding that in this case, the physicians taking care of Mr. Carrick didn't have his records available and didn't consult with the other physicians taking care of him?

A There is a poem about, for wont of the shoe, the kingdom was lost. In Mr. Carrick's case, because he was there for a procedure, volleys of doctors saw him and no one questioned any of the lab work that came back. No one questioned that this man was grossly uremic and was sent to general anesthesia. He was there for a procedure, and, come what may, he would get it,

Q That is your impression of reviewing the records and depositions in this case?

A Yes.

Q Did you ever talk to any of the Cleveland Clinic doctors about this case?

A I have never spoken to any doctor at the Cleveland Clinic,

Q Did you ever talk to Dr. Riley about this case?

A Never.

Q Did you ever talk to Mrs. Carrick about this case?

A I have never spoken to Mrs, Carrick. You are the first people from Cleveland I am talking to.

MR. SPISAK: Other than the other gentleman.

THE WITNESS: Okay.

BY MR. GORE:

Q In your report, you say that Nr. Carrick should have been placed on dialysis when he was first admitted to

the Cleveland Clinic and standard medical tre
including dialysis, probably would have rev'
in six to 12 months.

A Yes.

Q That is your opinion?

A That is the opinion of the literature, of t..
dialysis literature.

Q I am not asking about the literature. Is that your opinion?

A My opinion is that he deserved to have that trial and that he was grossly uremic and needed dialysis when he first saw Dr. Heyka.

Q And it is your opinion that medical treatment probably would have reversed this man's disease in six to 12 months; is that correct?

A I would say 50-50.

Q Did Mr. Carrick at the time he was admitted to the Cleveland Clinic require narcotic analgesics for pain control?

A I believe he did,

Q Was he debilitated?

A He was,

Q Was his parathyroid hormone level high?

A It was.

Q In fact, it was virtually unmeasurable; wasn't

it?

A I have patients who have higher levels than the level he had, And, with treatment, with intravenous calcijex, I and other nephrologists in the community have found, just as in the literature, that parathyroid hormones come from several thousand to several hundred in a period of three to six months,

Q Was his very high?

A His was very high, but not out of the range that I have seen in my own patients who start dialysis.

Q Was it contributing to the rapid destruction of his bones?

A Mr. Carrick definitely had renal osteodystrophy, It is not clear that Mr, Carrick could not walk because of it, I believe Mr, Carrick could not walk because he was uremic.

Q At the time he was admitted to the Cleveland Clinic, were his bones in extremis?

A Define extremis,

Q Well --

A No bone biopsy was done, and by extremis you mean that he was unable to walk, Be was clearly uremic and uremic people do not walk, They lie in bed and moan and just curl up in the corner, I believe that it is conjectural to ascribe Mr. Carrick's debilitated state

solely to a secondary manifestation of uremia when he was clearly uremic.

Q Whatever the cause was, his bones were in bad condition when he was admitted to Cleveland Clinic; is that correct?

A X-rays of bones are not a precise tool. It requires a loss of bone of 30 to 40 percent before there is any of change on X-rays,

Many patients on dialysis have severe changes on X-ray and are working and climbing stairs and riding bicycles.

Q Doctor, we are not communicating. When I ask you a question --

A I am answering your questions.

Q No. When I ask you a question, I am going to ask you, sir, to do one of three things, and then give whatever explanation you want to.

It isn't proper for me to limit you to yes or no, and I won't do that. What I am asking you to do is either answer the question yes or no, or tell me you can't answer it yes or no,

A Okay.

Q And then give whatever explanation you wish.

A Okay.

Q When Mr. Carrick was admitted to Cleveland

Clinic, were his bones in bad shape?

A He had renal osteodystrophy.

Q Is that a "yes"?

A Mr. Carrick had renal osteodystrophy.

Q Yes or no?

A I cannot tell from the studies that were sent to me how quote bad his bones were.

Q Can you answer this question yes or no? Were his bones in bad shape when he was admitted to the Cleveland Clinic?

A That is an imprecise statement.

Q So you can't answer it yes or no. Is that what you are telling me?

A I can tell you that he had renal osteodystrophy.

Q How bad were his shoulders?

A They were bad enough that he was not walking and he was not lifting things.

Q Are you aware of the fact that his shoulders were frozen and he couldn't lift his arms above the level of his shoulders?

A I did not read a physical therapy report. I know that he was unable to walk unassisted and he was unable to lift things.

Q Are you aware of the fact that his disease was

so bad at that time that he did have calcification of his heart valves?

A I am not aware of that.

Q You are aware of the fact that he subsequently had a spontaneous fracture of the hip?

A Yes.

Q Is that evidence of significant bone disease?

A At -- yes, But at the time that he had it, he had been immobilized, he had been on steroids and he had been receiving aluminum containing phosphate binders, all three of which are factors that may have been additive in causing a spontaneous fracture,

These three factors were unnecessary contributants.

Q Is it your opinion that when Mr. Carrick was admitted to the Cleveland Clinic his bone disease was reversible?

A His hyperparathyroidism was reversible and much of the bone disease was reversible with medical treatment or, failing that, parathyroidectomy.

Q You also say in your report that it is inexplicable that the anesthesiologist cleared this patient for anesthesia and a parathyroidectomy with a BUN in excess of 100. You state such patients are at risk for bleeding perioperatively and are routinely dialyzed to keep the BUN

at less than 100.

A Yes, I wrote that.

Q Did this patient bleed perioperatively?

A No, This patient's BUN was in excess of 224 pre-op.

Q Did he bleed perioperatively?

A No.

Q Did he?

A Those indications that I have mentioned are theoretical and are guidelines. We doctors prudently do things to avoid the five, ten, 15 or 20 percent of people who do get these complications,

Q Were the pro-time and PPT and blood counts done?

A Pro-times, PPT and platelet counts are not abnormal in renal failures. It is characterized by a platelet abnormality which is manifested by an abnormal bleeding time. I routinely order bleeding times on patients prior to procedures when they are in renal failure. A bleeding time was not done in this patient, which would be standard coagulopathy workup outside of the Cleveland Clinic for pre-op -- for pre-op evaluation of an end-stage renal failure patient,

Q What did the fact that a bleeding time --

A I am not finished.

We have specific treatment for abnormal bleeding times, which include increased dialysis and administration of intravenous DDAVP. This has been standard treatment since the mid 1980s.

Q What did the fact that a bleeding time was not clone cause?

A In the end, it did not cause a problem.

Q What did the fact that the patient was anesthetized and operated upon with a BUN over a hundred?

A Preoperative, Mr. Carrick was suffering from uremia. He had a diminished state of consciousness and a diminished state of coughing. When you receive general anesthesia, you routinely reduce renal profusion by 50 percent over a course of 24 to 72 hours, which makes your uremia much worse. You also have reduced clearance of anesthetic agents. This predisposes the patient to prolonged problem -- to prolonged intubation, to reduced gag reflex and cough. It is apparent that Mr. Carrick had a postoperative pneumonia probably from aspiration. This may have been contributed to from his grossly uremic state with the superimposed known cause of reduced renal blood flow for 72 hours, thus making his uremia even more profound and reducing his ability to clear postoperative pulmonary secretions.

Q Did you testify about ten minutes ago there is

no evidence of aspiration?

A On the chest X-ray that was taken pre-op there is no infiltrate, I believe three days later there is an infiltrate.

In the setting of a patient who is postoperative who then gets a pneumonia, the most likely cause is an aspiration in the setting of uremia.

Q That is your evidence of aspiration?

A It is a clinical impression.

The alternative is a bacturemia or a pneumonia that was hospital-acquired from improper handling of the intubation lines from contamination of solutions or contamination of the lines.

Q Is it your opinion that this patient needed or did not need a parathyroidectomy?

A It is my opinion that this patient had severe osteodystrophy. It is my opinion that he needed to be dialyzed and to be given aggressive medical treatment, lasting anywhere from four to eight weeks. If his functional state did not improve at that point, he was a candidate for parathyroidectomy.

Q Have you ever -- excuse me -- have you ever done a parathyroidectomy?

A In the early 1980s, I had -- well, in the 1970s and early 1980s, I had between two and three patients a year

being sent for parathyroidectomy. And I have watched those surgeries. I have not performed parathyroidectomies because I am not a surgeon, but I am aware of the procedure itself, its pre- and post-op care, and the indications for it, and I have personally had an experience of patients having parathyroidectomies,

Q Have you ever administered anesthesia for a parathyroidectomy?

A I am not an anesthesiologist. It would be presumptuous of me to say that I know everything that there is to know about anesthesia,

Q Doctor, among the other things you say in your report are that the prolonged postoperative ileus and large bowel dilatation were caused by the large quantities of dialume that he was administered at the clinic right up until the time of surgery,

Dialume is a known aluminum hydroxide phosphate binder, and such medications are well known to cause constipation, Nephrologists routinely give such patients strong laxatives in the days prior to surgical procedures. And you said you were surprised that none of the doctors recognized that the rocks in Mr, Carrick's colon were phosphate binder,

Those are your opinions, Doctor?

A Yes. And they still stand,

Q In conjunction therewith, you also said you were critical of the fact that the patient's serum aluminum was not checked at any time, Is that correct?

A Yes.

Dr. Wish subsequently wrote a report reviewing my findings and stated that it was inexplicable to him that the bowel obstruction was from aluminum hydroxide and, in fact, I went back and looked at the records, and a GI, either fellow or trained doctor, did a colonoscopy twice and literally described the duodenum being full of rock.

Back in the 1970's when I was trained, it was routine when we were all using aluminum phosphate binders to give patients laxatives prior to surgery.

Q Was it in 1989?

A In 1989, the nephrology community for the most part is no longer using aluminum phosphate binders, because of our increased -- our increased awareness of aluminum toxicity, both of terms of encephalopathy, which was described in the early 1980s, and because of our increased awareness of both bone disease and most recently aluminum's incidious interferences with renal function.

We continue to take blood when patients have aluminum administration. So most nephrologists that I know are not using aluminum phosphate binders both because of bone disease and because of our use now of epogen, in both

cases of which aluminum administration is relatively contraindicated,

Q Did this patient have aluminum bone disease?

A No bone biopsy was done. No serum aluminum level was done, because the doctors decided that this patient's problem was primary -- was secondary hyperparathyroidism.

Q How long does it take to develop aluminum bone disease?

A Aluminum bone disease can be developed either primarily or in association with other forms of bone disease and it depends on the ingestion of aluminum.

Q Would you agree that it takes years to develop this?

A Aluminum bone disease develops over years and it is potentiated by renal insufficiency. Mr. Carrick had renal insufficiency extending at least five to six years of an extent that would lead to aluminum retention.

Q How long did he get aluminum administered?

A Mr. Carrick may have had both bone aluminum levels and serum aluminum level -- aluminum level elevations before he received any aluminum under the care of Dr. Heyka.

Q That wasn't my question. How long was he administered aluminum?

A He was begun on it when he first saw Dr. Heyka,

and then was referred for admission, I believe, two OK four weeks later.

Q He only received it for a couple weeks; isn't that right?

A For a couple of weeks, yes.

The vast majority of storage of aluminum is in the bone, and to assess aluminum levels in body burden, you have to do an aluminum level in the bone.

Q Did this patient need control of his phosphorus level?

A This patient needed control of his phosphorus level.

Q How do you do that?

A By dietary manipulation involving reduction in the ingestion of high phosphate foods, and through a combination of phosphate binders.

At the present time, we are using calcium carbonate and calcium acetate. Before we were using these medications we were routinely using aluminum phosphate binders.

Q If you use calcium binders, would you agree that extra calcification will continue to occur?

A That is variable.

Q Did this patient when he was admitted to the Cleveland Clinic need phosphate binders to control his

phosphorus level?

A Yes, he did.

Q You indicated that in -- let me be specific.

In 1989, is it your testimony that nephrologists were routinely giving patients strong laxatives prior to procedures such as this?

A In 1989, nephrologists were not using aluminum phosphate binders, and I suppose that some of the people who were trained in the late '80s might not have seen these complications. Having been trained in the mid '70s, we routinely saw these complications and we routinely did this. I do not know when Dr. Heyka was trained.

Q Can you give me a reference to any literature regarding routine use of laxatives before procedures such as this?

A Much of medical practice is lore. And people see complications and they do things to avoid them.

I don't recall seeing specific articles, but when I was an intern in 1974, several attendings quoted to me published reports of patients requiring surgery for bowel obstruction from aluminum hydroxide. The FDA circular which comes with aluminum hydroxide reports that patients can develop severe constipation. I have not personally read the case reports, but I believe the people who told me about them. My attendings, when I was an intern and subsequently,

my nephrology attendings, as I did not doubt their word and their veracity, I did not go to the medical literature and specifically look for it,

Q This aluminum situation you are talking about, with specific reference to Mr. Carrick, what did that cause in your opinion?

A I believe that the aluminum may have contributed to his bone disease when he was immobilized and continued on steroids, which may have been a contributory factor both to his almost bowel obstruction, and to his spontaneous fracture.

Q Two weeks of aluminum and two weeks of dialysis?

A He may have had aluminum burden in his bones, to begin with. And he may also have had quite a bit of aluminum absorption, considering that he had rocks of aluminum phosphate sitting in his bowel,

Q How long does it take dialysis to cause accumulation of aluminum?

A This is hard to say.

Q Would you agree that it takes years of dialysis to cause aluminum accumulation?

A It is not the dialysis that causes the aluminum toxicity. It is the renal failure and reduced clearance of aluminum and the fact that aluminum is primarily stored in

bone.

Q You mention that they didn't take an aluminum level; correct?

A That is right.

Q would you agree that aluminum levels are routinely notorious for reflecting recent intake and total body burden of aluminum?

A I agree. And, in fact, I also think that this man should have had a bone biopsy, which would have established whether he had pure renal osteodystrophy or, in fact, also had aluminum burden or, in fact, may have even had osteomalacia.

Q What did the fact that he didn't have a bone biopsy cause?

A It did not delay his surgery and it did not change his course.

Q You also indicated in your report that postoperative pneumonia may have been contributed to by his having uremia.

A Yes.

Q And not being properly dialyzed pre-operatively.

A Yes. For the reasons that I have mentioned before of reduced renal profusion and reduced cognitive function, reduced gag reflex in patients who are uremic and reduced clearance of anesthetic.

Q Can you direct me to any clinical study in patients with chronic renal failure that suggests that early or more aggressive dialysis reduces the incidence of infectious complications?

A Offhand, no. However, there are studies regarding dialysis in surgical patients, trauma patients. I am not -- I can't specifically cite you for this specific type,

Q Would you agree that Mr. Carrick had a number of medical conditions which may have predisposed him to developing pneumonia, aside from his renal failure?

A Mr. Carrick had a multiplicity of ills,

Q In your report, you also indicate that Mr, Carrick suffered a hearing loss which was not recognized as being almost certainly caused by the administration of several weeks of aminogfycosides, Would you agree that he needed the aminoglycosides?

A Yes. I did not mention that as that it would have made a difference in his care, but, in general, that troops of doctors were coming in, looking at problems, and disregarding obvious causes,

But his aminoglycoside administration, or not administration, would not have made a difference in his outcome,

Q Would the recognition of the cause of a hearing

loss have made a difference in his outcome?

A In the ENT literature, patients who receive chronic aminoglycosides are recommended to have hearing conduction tests done on weekly intervals to monitor for this side effect. We internists do not routinely do that.

Q My question is, let's assume you are correct that nobody recognized the cause of a hearing loss in this case.

A Yes.

Q What did that cause?

A It did not cause any difference. They may have made a decision anyway to continue the medications in spite of a hearing loss.

So it did not make a difference in the outcome. But it is inexplicalbe that an ENT doctor did not recognize aminoglycosides as the obvious cause of this man's hearing loss.

Q Which ENT doctor did not recognize that as the cause of his hearing loss, the aminoglycosides?

A I may be wrong. There may not have been an ENT doctor.

Q Which doctor?

A May have been the medical team.

Q Somebody wrote down they didn't recognize the cause of the hearing loss?

A It was noted that he had suffered a hearing impairment and a hearing loss. And I believe in the record it is noted that they were unsure as to why.

Q Now, we were handed before your deposition a copy of your CV. Is this up to date?

A I believe so, yes.

Q I note that you practice geriatrics; is that correct?

A Yes.

Q What percentage of your practice is geriatrics?

A Thirty percent.

Q What percentage of your practice is nephrology?

A Seventy percent.

Q Do you teach?

A Yes.

Q Where?

A I am a clinical instructor at UCLA multi-division campus of geriatrics.

Q Where do you specifically teach?

A I specifically teach at the Jewish Homes for the Aging in Reseda, California, and we have both geriatric fellows and students who come through the program.

Q So you teach geriatrics?

A I teach geriatrics, yes.

Q Do you teach nephrology?

A I do not teach nephrology.

Q Doctor, in your career have you had occasion to author or eo-author any publications, any articles in your field?

A I have never authored or co-authored any publications in my field.

Q You have already indicated in your testimony that you are not a surgeon or an anesthesiologist; correct?

A That's correct.

Q You are also not a specialist in infectious diseases; is that correct?

A That's correct,

Q How many medical lawsuits or claims have you reviewed?

A I believe three.

Q And besides this one, what were the other two?

A The other -- one was related to a dialysis graft malfunction, And the other one was related to a kidney transplant with ureteral implantation and the leaving behind of the stent for six years.

Q The other two instances, did you review those at the request of the attorney for the patient or for the doctors?

A The attorney for the patient.

Q Is this the first deposition --

A No. One for the hospital, for the doctor, and one for the patient.

Q Is this the first deposition you have ever given?

A No. I gave a deposition seven years ago on a patient -- a dialysis patient of mine who was suing Valley Hospital Medical Center because of aminoglycoside-related renal failure,

Q In that case, were you testifying as a treating physician as opposed to testifying as an independent --

A I was testifying as a treating physician.

Q That is the only other time you have given a deposition?

A Only other time.

Q Have you ever testified in court?

A No,

Q I think it is obvious from your earlier testimony that this is the first case in which you have worked with Mr. Kampinski and his office,

A That is correct,

Q Was either of the other two cases that you reviewed in any way connected to Ohio?

A No.

Q Are you coming to Cleveland to testify at the trial of this case?

A If you don't settle.

Q I think that is a yes.

A If you don't settle, yes.

Q On page one of your report you make reference to a 1988 textbook, and the fact that you sent some sections from that textbook to Mr. Kampinski.

What textbook was that?

A Do you have those extracts? It says on it. I think it is Brenner and Recter, The Kidney.

Q Which sections did you send to Mr. Rampinski?

A I believe I sent him a section on uric nephropathy, a section, I believe, on renal-vascular disease, and I believe I sent a copy of the section on nonsteroidal anti-inflammatory disease-related nephropathy and I sent from a general medical textbook a list of side effects and symptoms of uremia, and I think that was from Harrison's medical textbook, and the presentation of uremia.

Q Your report at the top of it says, "File #4-311." What does that mean?

A That is Nr. Kampinski's file number.

Q That is not your file number?

A No. I don't keep file numbers. I am a little guy.

Q Doctor, in your earlier testimony you agreed that as of March of 1989 when Mr. Carrick was admitted to

Lakewood Hospital he had end-stage renal failure, a small right kidney, profound renal acidemia, severe renal osteodystrophy, extensive demineralization of his bones, metastatic calcification of his soft tissues, probable renal hypertension, chronic gouty arthritis, probable gouty uremia, steroid myopathy and hyperparathyroidism.

Have you ever treated a patient with all of those conditions at the same time?

A Yes, Most patients who present in uremia have eight or nine superimposed problems at the same time.

Q Those specific ones?

A I have treated two or three patients with that constellation. Every patient is different. Some come with myelopathy. Some come with other problems, but they all come with eight or nine problems,

Q In the two or three instances that you have treated patients with all of these conditions that you just made reference to, how long had their problems been going on?

A Most of these patients had suffered progressive deteriorating renal disease over a period of two to five years prior to going on dialysis.

MR. GORE: Doctor, at this time I don't have any further questions. I will see you in court,

MR. SPISAK: I have some questions for you, Doctor.

THE WITNESS: Okay.

EXAMINATION

BY MR. SPISAK:

Q Doctor, you mentioned in your report that you saw some pharmacy records, Do you recall that?

A Yes,

Q Can you tell me what pharmacy records you saw?

A I believe they were -- well --

Q Can I see what you saw if you have those?

A It is in this morass.

MR. MELLINO: They were in the 1983 pharmacy records.

THE WITNESS: Here is 1987.

BY MR. SPISAK:

Q Reason I asked that is I had asked Mrs. Carrick for hers and I have not seen these. I asked her in her deposition.

A It is incomplete, Here is 1983.

Figuring out how much he took is problematic, because the record is incomplete.

MR. SPISAK: Can I get copies of these?

MR. MELLINO: Sure.

MR. SPISAK: I will renew my request again that you send those to me, Okay.

MR. MELLINO: Just for the record, I didn't see any

request for them in Mrs. Carrick's deposition, but I will send them to you.

MR. SPISAK: Fine, Thank you.

THE WITNESS: So you don't need me to go through this.

MR. SPISAK: I don't need to do that right now,

Q Doctor, in your practice you have indicated 70 percent is --

A Nephrology.

Q -- nephrology. Give me a flavor, if you will, as to what kind of nephrology patients you have, if there is some sort of a common theme?

A Well, I have ten patients on chronic ambulatory peritoneal dialysis. I follow at any time about ten patients who are on chronic hemodialysis. I am seeing in the office anywhere from 20 to 30 people who I follow at regular or irregular periods because their creatinines are above two and they have associated problems, and I see between five and eight new hospital patients a week because of kidney-related things, which include electrolyte disorders, hypertension, endocrinologic problems, renal failure, patients who need acute dialysis.

Q So it kind of runs the gamut of nephrology?

A Electrolyte hypertension, dialysis and pre-dialysis management.

Q You don't see one type of nephrology patient, say, as a more common thread than others?

A If I owned a dialysis unit or were a director, I would see only one type, say, dialysis patients. And there are nephrologists who see only dialysis patients.

Q Yours is more general practice of --

A My mine goes from beginning to end,

Q You mentioned earlier in response to when Mr. Gore asked you that you did note that Dr. Riley recommended prior to Mr. Carrick's leaving Lakewood Hospital that he go onto dialysis.

A Yes.

Q In your opinion, that was a proper recommendation at that time?

A Yes,

Q Correct?

A And it was based on clinical findings of very high BUN, friction rub that was heard, and on Mr. Carrick's debilitated state.

Q It is further your opinion, as I understand your testimony so far, that had Mr. Carrick and his family agreed to that treatment at that point in time, that you believe there was potential for an additional 20 or 30 years' life expectancy; is that a fair statement?

MR. MELLINO: Objection, I think he said if he had

done the dialysis. I don't think he said why it wasn't done.

THE WITNESS: What I said is if he had received aggressive medical treatment as I described before, that he --

BY MR. SPISAH:

Q Including dialysis?

A Dialysis and aggressive medical treatment for hyperparathyroidism, aggressive physical therapy and approximately one month of hospitalization.

With these things in mind, that he had the potential of substantial recovery, and down the line, ten, 20, 25 years of functional life.

Q I am not sure you answered this as such. What, Doctor, in your opinion, were the less-than-standard treatment or treatments rendered at the Cleveland Clinic that either caused or contributed to Mr. Carrick's death?

A Off the record, is it appropriate for for him to ask that?

Anyone can ask about anyone else's --

MR. SPISAK: Right.

MR. MELLINO: You want him to repeat the question.

THE WITNESS: Am I supposed to answer that?

MR. MELLINO: What specific doctors.

THE WITNESS: I believe that Dr. Heyka was negligent in his initial evaluation in which he did not deem Mr.

Carrick to be uremic, in need of dialysis, and instead focused on a secondary manifestation,

I believe that the Cleveland Clinic as a group were negligent in that no one questioned this initial evaluation and an anesthesiologist, surgeon, clinical attending continued this care without questioning it, despite obviously grossly abnormal lab values.

BY MR. SPISAK:

Q Anything else?

A I believe Mr. Carrick did have severe uremic osteodystrophy, but that his initial care should have been medical management with intensive dialysis.

Q Anything else?

A No,

Q Is it further your opinion that those areas that you have just enumerated of less-than-standard care caused or contributed to Mr. Carrick's death?

A Those were contributory to his death.

Q All right.

Stated another way, would it be your opinion that if Mr. Carrick had received the kind of treatment that you have basically indicated upon his transfer to the Cleveland Clinic, that he had a potential life expectancy of 20 to 30 years?

A Yes. If he had done poorly on that treatment,

I couldn't fault it. If he had done well, we would take credit as nephrologists.

Q Doctor, before I go on, I just want to mention one thing that I like to mention in depositions such as this. If for any reason you have any either additional opinions or any additional insights into this matter after today and before the trial, will you make sure to communicate those to either Mr. Mellino or Mr. Rampinski and we would ask that we be provided that information as well. The point being, under our rules we are entitled to know all of your opinions prior to trial and that is why we have come all this way at this point in time. Sometimes because something additional is made available to you or you see mother note in a record or whatever, it may change things or alter opinions in some way and I want your assurance if that does happen you will let us know.

MR. MELLINO: He will let either Chuck or I know.

THE WITNESS: Are there any more people to be deposed?

MR. GORE: I would make the same request.

MR. SPISAK: Yes. As a matter of fact, there are some other people that will be deposed, I can almost guarantee you that.

THE WITNESS: Send the depositions and if I am asked to send opinions, then you are obligated to do the same

thing, I understand,, No?

MR. SPISAK: That is my understanding.

THE WITNESS: I am not a lawyer,

MR, MELLINO: If his opinion changes or something or he has a new opinion, then certainly we will provide it to you.

THE WITNESS: I think all of the principals have been deposed by now,

MR. SPISAK: There may be additional experts that are being deposed that I would anticipate.

THE WITNESS: Okay.

BY MR. SPISAH:

Q Let me ask it this way, Have you treated patients with Indocin?

A Yes, I have.

Q Have you treated patients with gouty-type symptomatology with Indocin?

A Yes, Yes,

Q And is that something I suppose much of medicine involves, a weighing and a balancing of risk/benefits type of thing; does it not?

A Yes,

Q Would that apply to the use of Indocin under those circumstances as well?

A Yes, it would.

Q All right. Often you need to prescribe something for a reason, but then there are potential ramifications to it as well?

A Yes.

Q Would you agree that a patient such as Mr. Carrick with the type of symptomatology that he had -- let's take the '80s, that the period leading up to the late '80s /when he had his problems that started at Lakewood Hospital. /Patients such as that sometimes do well and sometimes do not do well, even under the best of circumstances. Isn't that a fair statement?

A That is a fair statement.

Q So that even with all of the best of the appropriate standard of care provided by a nephrologist, for example, Mr. Carrick may or may not have done well; correct?

A He might have had the same course anyway.

Q Doctor, is there in your opinion a curative aspect to dialysis in a patient with end-stage renal disease?

A Dialysis is an iron lung technology. It replaces partial function. It is not a cure.

Q What does it do then?

I know you just said it replaces partial function. Can you elaborate on it.

A It replaces -- renal failure gives a

constellation of symptoms which include both laboratory parameters and physical findings.

Usually people do not feel sick until they have loss of 90 to 95 percent of kidney function. Way before that time, at 50 percent function loss, biochemical parameters start showing up. Usually hemodialysis or peritoneal dialysis at the amounts we give in the dialysis prescription gives people between eight to ten percent kidney function. We attempt to treat biochemical abnormalities. We attempt to treat the anemia of kidney disease. It is a poor treatment and it allows us to keep people less sick. It is not a cure.

We do have a cure and that is called kidney transplant. It reverses the biochemical parameters and the anemia, but it comes with its own problems.

Q Is a patient with chronic hypertension a candidate for kidney transplant?

A Yes. In fact, most -- many, many dialysis patients who go for kidney transplant, may number about seven to eight thousand a year in the United States -- have hypertension and are on medications when they go for kidney transplant.

Q Is it required that you get the hypertension within a certain range, though?

A It is prudent to control the blood pressure

down to an acceptable, normal range and, in fact, hypertension as a complication is frequently seen after transplantation.

Q What is the range you want to get it into?

A We arbitrarily pick 140 over 90 as a benchline, but I usually tell patients who are on home monitoring and usually dialysis patients are on blood pressure medications and are told to get a blood pressure cuff and keep a diary. They are told their pressures should never be below 120 systolic and never above 160 and that they self-titrate medications.

Q Are there situations where a patient who is considered as a candidate for transplant might be turned down because the hypertension would not be controllable?

A Yes. Uncontrolled hypertension.

Q Even with appropriate medications?

A Malignant hypertension or accelerated hypertension would be a contraindication.

Q Can you strike any kind of a percentage of patients who have end-stage renal failure who are transplant candidates?

A Potentially they are all transplant candidates potentially and, in fact, on the government forms, we are required -- we nephrologists are required to check off that we have considered them as a transplant candidate.

Most transplant programs do not transplant people over either 60 or 65, do not transplant people with malignant disease, do not transplant people who have had significant permanent neurologic deficit,

Q Let me ask it another way.

A People under the age of 60 or 65 as a population are transplant candidates.

Q In this country, present knowledge, let's say, 1989, 1990, 1991, what percentage of patients in end-stage renal failure get transplanted?

A It is said that there are 20 to 25,000 people on waiting lists and that we transplant seven to 8,000 kidneys per year. These include people who are getting their first, second and third kidneys.

Q So if we transplant seven to 8,000 --

A There are 120,000 people with end-stage renal failure in the registry.

MR. GORE: You can do the math,

BY MR. SPISAK:

Q We can do the math later. But whatever the percentage is, 120,000 would be the number of people on an annual basis who are in end-stage.

A It is said in the registry that, taking all comers who start hemodialysis in the United States, the average patient lives between seven and nine years on

hemodialysis and that includes my 92-year old man at the Jewish home, And it includes the six-year old who goes on hemodialysis,

Q And so 9 years is the average life on hemodialysis?

A All comers.

Q What is the average life expectancy after transplant? Do you know a figure on that?

A The stats that we have is the life of the transplant, rather than the life of the person. It depends whether it is a living, related donor or it is a cadaveric donor,

Cadaveric donors, depending on the program, have a life between five and ten years. For that kidney transplant, you can then get another one. Living, related donors, depending on the program, have eight to 12 years' expectancy, If it is an exact match, 20 years, 30 years,

Q That gives me a feel for that.

A Obviously these are statistics. Each patient has to be looked at in in their own subgroup,

8 Doctor, a couple questions about your report. Very last paragraph of your report, look at that.

That is where you mention the Cleveland Clinic. Read that for me, if you will.

A "I found, what may be a clue, to the perplexing

behavior of Mr. Carrick's physicians. Dr. Riley is listed in the AMA directory of Medical Specialists as having completed his medical training in Internal Medicine at Cleveland Clinic 1961-63 prior to Board certification in 1964."

Q What do you mean by that?

A I mean to say that the disregard of uremia is probably a function of the local teaching mores of that institution and the fact that neither Dr. Riley recognized the uremic patient that he was following for ten years who was uremic four months before hospitalization nor the physicians who were in the nephrology section at Cleveland Clinic, nor the entire house staff at Cleveland Clinic, nor the surgeon who did the parathyroidectomy probably reflects a different definition of uremia than the rest of the country.

Q All right.

You mention also in your report -- and I don't recall exactly; I don't have it in front of me at the moment -- but that the hospitalization at Lakewood Hospital was precipitated by an iatrogenic complication of steroid administration.

Do you recall that statement?

A Yes.

Q What do you mean by that?

A The sequence of events was that in March or the beginning of March Mr, Carrick called and -- called Dr. Riley stating that he was having a bad attack, And he was switched to naproxyn because the Indocin was not working. The naproxyn did not work. And Mr. Riley -- excuse me -- Dr. Riley then gave Mr. Carrick a dose or began a dose of oral prednisone.

Q Which is a steroid?

A Which is a steroid. And Mr. Carrick was then unable to walk after this was begun. Dr. Riley was called and he hospitalized him,

Q So what in your opinion did the prednisone do?

A In my opinion, Mr, Carrick had uremic myopathy, and then had superimposed administration of steroids which had a superimposed steroid myopathy and, between the two, was unable to walk.

Q Do you recall how long that prednisone was given?

A Not exactly. I think a few days. 'How long, I don't recall.

Q Just prior to the hospitalization, though?

A It was begun prior to hospitalization, in an attempt to ameliorate his symptoms, And they got worse on prednisone.

Q Was it your understanding that the prednisone

was then discontinued?

A The prednisone was continued and, in fact --

Q Continued or discontinued?

A It was continued.

Q In the hospital?

A In the hospital. And during his subsequent evaluation at Cleveland Clinic and, in fact, was on his medication sheet when he came to Cleveland Clinic.

Q And was continued at the clinic?

A It was continued.

I might add that cortisone and prednisone causes osteoporosis and bone breakdown.

Q When you mentioned earlier that this patient, Mr. Carrick's lab work was deteriorating for a period of time, tell me specifically what lab work are you talking about?

A Dr. Riley obtained yearly physicals on Mr. Carrick and with the physicals that I have in the records sent to me are appended SMA-12 panels, which include calcium phosphate, phosphorus, BUN, creatinine, liver function tests, uric acid.

Q And you are referring to all of those?

A Yes. I am referring to these yearly notes from Dr. Riley.

Q You mentioned, I believe, earlier that in your

opinion Mr. Carrick had end-stage renal failure in December of 1988.

A Yes,

Q On what do you base that?

A I base that on his lab work and the progression. The purpose of the modern nephrology treatment is to anticipate end-stage renal failure and to institute treatment of it and institute treatment of the secondary metabolic manifestations prior to the patient's collapsing or being nonfunctional.

Mr. Carrick was seen in Christmas of 1988 and I believe his BUN was 100 or 110 and there is a note in Dr, Riley's ledgers or notes that this needs to be repeated.

Now, Dr, Riley is enigmatic in the sense that his notes say very little. And many of his notes just have a blood pressure and a "renew" or something like that. His notes throughout this ten-year period allow me no way to guess what his thoughts were regarding these problems.

But I recall that in December of '88 when he was seen, lab work came back and Dr. Riley wrote on it that "This needs to be repeated."

Routinely when I have patients whose BUN has hit 100, I target them as, "It is about time to go on dialysis," I call them in, show them the lab work, and we plan for the orderly accession of some form of dialysis kidney transplant

or peritoneal dialysis. This was not done.

Q All right. Would it be fair to say that you base that judgment on the lab work primarily at that point in time, as opposed to anything else?

A I would have to go back and see if there was a complaint noted, but I also base that on the nursing notes, on the intake nursing notes at Lakewood Hospital in which the patient told the nurse that he had been feeling progressively worse over a year and much so since Christmas.

Q All right.

A Now, I don't know if he called Dr. Riley repeatedly. I know that Mr. Carrick was not seen formally in the office during April or February of that year. And I don't know if there was a conversation regarding the orderly transition to dialysis, because Dr. Riley's notes do not have such a discussion. I routinely write down in my notes that the patient was informed, that we are planning what to do about this problem.

So it is my clinical impression, based on the nursing notes at Lakewood Hospital, based on the ten-year progression, that this man was uremic in Christmas of 1988, and that his doctor noticed that his lab work was at a panic level, but did not follow that up specifically.

Q If renal disease is in any way contributed to by a nephrotoxin such as Indocin, does the discontinuation

of the Indocin then reverse the condition or stop the nephrotoxicity?

A Damaged kidneys deteriorate faster than normal kidneys. A normal kidney at birth with the normal deterioration lasts 180 years. Kidneys that are damaged both in animal models and human models have an accelerated deterioration and function, even if you take away active toxins and active insults.

Q So would you agree --

A So at the point of 1986, 1987, 1985, Mr. Carrick had severely damaged kidneys, and in the absence of Indocin administration, would have almost certainly had a deterioration in function, Maybe not as precipitous.

Q Would you disagree then that the removal of the nephrotoxins generally reverses the condition?

A In acute nephrotoxicity on the background of a normal kidney, removal of the nephrotoxin almost always results in a complete recovery.

On the background of a moderately to severely damaged kidney, the remaining kidney function, when the insult is removed, continues to deteriorate probably slower than it would have if it were still subject to the same insult.

MR. SPISAK: I have nothing further for you.

MR. GORE: Just a few, based upon his questioning.

FURTHER EXAMINATION

BY MR. GORE:

Q It is your opinion that when this patient was admitted to the Cleveland Clinic, he was uremic?

A Yes. The record shows that.

Q And is it your opinion that none of the Cleveland Clinic doctors recognized that?

A It was recognized that he had renal insufficiency. It was not recognized that it was of a sufficient nature to require intervention with dialysis.

Q Did they recognize that he was uremic?

A No. Uremia, per se, requires institution of dialysis because uremia is the name of the syndrome for which we institute dialysis.

Q Is it your testimony that the reason they didn't institute dialysis is because they didn't recognize that he was uremic?

A Yes. They did not recognize this as his primary problem. They focused on a secondary problem of uremic osteodystrophy.

Q I take it from your testimony and from the last paragraph from your report that you seem to think there is some sort of problem with the way doctors are trained at the Cleveland Clinic, that they don't recognize uremia.

A That was my black humor. That was a facetious

comment. I believe that this man's renal failure treatment was two to five standard deviations off the norm practice in the rest of the country.

Now, I have been trained in Los Angeles and in New York City and I have gone to conferences in Boston and Washington D.C., so I can not tell you how nephrologists practiced in Chicago or Cleveland myself. Sorry, I can only base it on the basis of reports that I receive that I can identify from there.

Q Do you know how many nephrologists there are at the Cleveland Clinic?

A Probably 40 or 50.

Q How about how many are there at the University of Cleveland?

A Probably 30. How many are there?

Q Have you ever been to the University Hospitals of Cleveland?

A I already said I have never been to Cleveland.

Q How many Board certified nephrofogists are there in the country?

A Nephrologists, I believe between five and 10,000. It is in the thousands.

MR. GORE: Nothing further at this time.

Cleveland Clinic does not waive any of the requirements, and it is a discovery deposition.

MR. MELLINO: He will read it and sign it under penalty of perjury.

Copy also.

MR. SPISAK: Send me a copy, also.

MR. GORE: I want the original.

STATE OF CALIFORNIA)
ss.
COUNTY OF LOS ANGELES)

I declare under penalty of perjury that I have read the foregoing transcript, I have made any corrections, additions, or deletions that I was desirous of making in order to render the within transcript true and correct, and IN WITNESS WHEREOF, I have hereunto subscribed my name on this _____ day of _____, 1991.

_____
WITNESS

STATE OF CALIFORNIA)
) ss
COUNTY OF LOS ANGELES)

I, BETSY A. HELD, C.S.R. 4940, do hereby certify:

That prior to being examined, the Witness named in the foregoing transcript, was duly sworn to testify the truth, the whole truth and nothing but the truth;

That said deposition was taken down by me at the time and place therein set forth and was taken down by me in shorthand and thereafter transcribed by computer under my direction and supervision, and I hereby certify the foregoing transcript is a true and correct transcript of my shorthand notes so taken;

I further certify that I am neither counsel for nor related to any party to said action nor in anywise interested in the outcome thereof.

IN WITNESS WHEREOF, I have hereunto subscribed my name this 3rd day of October, 1991.

Betsy A. Held

BETSY A. HELD, C.S.R. 4940