COMMON PLEAS COURT

CUYAHOGA COUNTY

STATE OF OHIO

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Doe, 292

Diane M. Carrick,
Executrix, et cetera,

Plaintiff,

vs. : Case No. 185330

The Cleveland Clinic
Foundation, et al.,

Defendants.

- - -

DEPOSITION OF

MAURICE C. MAST, M.D.

A WITNESS herein, called by the plaintiff for cross-examination under the applicable Rules of Ohio Civil Court Procedure, taken before me, Beth A. Higgins, a Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel, at the offices of the witness, 497 East Town Street, Columbus, Ohio 43215, on Thursday, October 3, 1991, commencing at approximately 2:10 a.m.

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APPEARANCES:

BY: CHRISTOPHER M. MELLINO, Esquire
Charles I. Kampinski Company, L.P.A.
1530 Standard Building
Cleveland, Ohio 44113
(216) 781-4110,

On behalf of the Plaintiff.

BY: GEORGE F. GORE, Esquire
Arter & Hadden
1100 Huntington Building
Cleveland, Ohio 44115
(216) 696-1100,

On behalf of Defendant The Cleveland Clinic Foundation.

BY: LESLIE J. SPISAK, Esquire
The 113 Building, 7th Floor
Cleveland, Ohio 44114-1273
(216) 687-1311,

On behalf of Defendant Robert P. Riley, M.D.

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Thursday Afternoon Session
October 3, 1991
2:10 a.m.

- - -

STIPULATIONS

It is hereby stipulated by and between counsel for the respective parties herein that this deposition of MAURICE C. MAST, M.D. may be taken at this time by the Notary; that said deposition is being taken by agreement of counsel; that said deposition may be reduced to writing in stenotypy by the Notary, whose notes may thereafter be transcribed out of the presence of the witness: that proof of the official character and qualifications of the Notary, the time and place of the taking of said deposition, and the signature of the witness are hereby waived.

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PROCEEDINGS

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MAURICE C. MAST, M.D.,

being by me first duly sworn, as hereinafter certified, deposes and says as follows:

CROSS-EXAMINATION

BY MR. MELLINO:

Q. Would you state your full name, please?

A. Maurice C. Mast.

Q. And your address?

A. Home or office?

Q. Both.

A. Okay. Home address is 2733 Wickliffe Road, Columbus, Ohio 43221.

And office --

MR. SPISAK: Excuse me, Doc-or. You have a tendency to talk very fast, in anticipation that that may be --

THE WITNESS: All right.

MR. SPISAK: -- a little too fast.

A. Office address is 497 East Town Street, Columbus, Ohio 43215.

Q. Okay. Have you ever been deposed before?

A. No.

Q. I'm going to be asking you a number of questions today.

A. Uh-huh.

Q. If at any time you don't understand one of my questions, please feel free to ask me to repeat it or rephrase it, and I'll be happy to do so. And any question that you answer, you have to answer out loud so that the court reporter can take down your answer. Okay?

A. Okay.

Q. How old are you?

A. I am 36.

Q. Okay. Could you tell me what your educational training and background is?

A. Okay. College undergrad, I went to Ohio Northern University. Graduated with a dual degree in chemistry and pharmacy, 1979.

After that, I did not practice as a pharmacist, but I went directly into med school and graduated there in 1982 from Ohio State University.

After that, I stayed on at the university as an instructor for one year and was promoted to assistant professor in 1986 and stayed there for two years in that capacity.

At that point, I decided to go into the private practice of internal medicine; and after a search, ended up here at Central Ohio Medical Group,

Q. Okay. So you're no longer affiliated with the Ohio State University?

A. No.

Q. Okay. And why is it that you left Ohio State?

A. I was not satisfied with the academic medicine at that point, especially in internal medicine. It tended to be a specialty-based hospital and university, and a general internist didn't really have too much of a future there, so I decided to go into private practice.

Q. Was it your decision to leave Ohio State?

A. Yes.

Q. Are you board certified?

A. Yes. Internal medicine, 1985.

Q. Okay. Any others?

A. No.

Q. Have you taken any other board certification examinations?

A. No.

Q. And you have one publication listed on your

CV, --

A. Uh-huh.

Q. -- and I can't even pronounce half the words in the title of that publication. What does that publication have too deal with? What's it deal with?

A. That has to do with a drug interaction noted in a case that we had seen at University Hospital that we published.

Q. What drug was it?

A. The drug was Cimetidine, which is a drug for ulcers, and Metamucil, which is a drug for thyroid problems.

Q. And what currently does your practice involve? What do you do on a day-to-day basis?

A. My practice right now involves both inpatient and outpatient general internal medicine, adult medicine. All patients 18 years and older classically, general medical care of them. And also inpatients and lots of geriatrics. I also am a medical director of a nursing home.

Q. Okay. What nursing home?

A. That's Arbors at Hilliard.

Q. What percentage of your practice is geriatrics?

A. I would say approximately 30 percent.
Q. I take it since you only have one publication listed, that that's all you've published.
A. Right.
Q. Did you review any medical literature in preparation of giving opinions in this case?
A. Not medical literature as such. Some textbook review.
Q. What textbooks?
A. Cecil Textbook of Medicine, Harrison's Textbook of Internal Medicine, --
Q. Okay.
A. -- plus reviewed the PDR on Indocin basically.
Q. Did you review the PDR on any other drugs?
A. No.
Q. What training have you had in nephrology?
A. None.
Q. Okay. And I take it that you don't hold yourself out as a nephrologist --
A. No.
Q. -- or as having any special expertise in nephrology.
A. Right.

Q. Do you know a Dr. Riley?
A. No.
Q. Do you know any of the physicians that are involved in this case?
A. Not at all.
Q. Do you know how it was that you were asked to review this case?
A. A law firm contacted me.
Q. Who specifically?
THE WITNESS: A paralegal at your office?
MR. SPISAK: (Nodded affirmatively.)
Q. How many times previous to this have you been retained as an expert witness in a medical malpractice case?
A. As for a deposition or otherwise?
Q. No. Just retained to review material.
A. I think about two times.
Q. Two other times?
A. Correct.
Q. What were those -- What did those cases involve?
A. Most of them involved possible drug interactions: drugs causing some -- some kind of interaction causing harm to the patient as a

possibility.

Q. Were you retained on behalf of a defendant or a plaintiff?

A. A defendant, I believe, --

Q. Okay.

A. -- both cases.

Q. So all three cases have been on behalf of the defendant?

A. Yes.

Q. Do you remember the names of the other two cases?

A. No, I don't. Those were several years ago at OSU. I haven't done anything since.

Q. Okay. When were they?

A. Approximately 1987, I believe.

Q. Both of them?

A. Yes.

Q. Okay. Were they -- Do you know where the cases were pending? Were they in Franklin County or --

A. I don't recall. I believe one of them was, at least.

Q. Okay. Were any of the drugs --

Well, what were the drugs involved?

A. I can't recall right offhand.

Q. Did you say they were both drug interaction cases?

A. *Yes.*

Q. Okay. Did either of them involve Indocin?

A. No.

Q. Any of the drugs that were involved in this case?

A. No.

Q. Did either of those cases deal with any nephrology issues?

A. No.

Q. Do you know how it is that the law firm got your name?

A. No, I don't. Apparently, somebody gave them my name 'cause I had training in pharmacy and knew I was an internist, apparently. That's the word I got. I have no idea who gave it to them.

Q. Do you remember who retained you on the other two cases?

A. No, I don't.

Q. You don't remember the name of the firms?

A. No, not right offhand. It was just real brief run-it-by-you type things.

Q. Okay. You were never deposed --

A No.
Q -- or testified in those cases?
A No.
Q And Reminger & Reminger wasn't the firm?
A No.
(Discussion held off the record.)
Q Have you ever been sued?
A No.
Q Where is your file?
A File?
Q For this case.
A It's in the office.
Q What did you look at --
What?
A It's in the office down here.
Q Could I see it?
A All it is is the depositions basically and -- and the records. You can see it if you want. I can go get it.
Q Okay.
A You want me to go get it?
Q Yes. I'd like to see it.
A Okay.
(Thereupon, a brief recess was had.)

MR. MELLINO: Let's go back on the record.

Q. Okay, Doctor. You have just brought in here your file, and Mr. Spisak's taken out his correspondence to you.

A. Uh-huh.

Q. With the exception of that, is everything that you have brought in here everything that you reviewed, let's say -- well, everything you reviewed in this case?

A. Yes.

Q. And I'd like to go through this and just identify what's in your file. And on top is the complaint.

A. Okay.

Q. Next is the original and a copy of your report.

A. Uh-huh.

Q. Is that correct?

A. Uh-huh.

Q. Next is Dr. Riley's office chart?

A. Correct.

Q. Okay. Next is the deposition of Dr. Heyka, Dr. Nakamoto, Dr. Riley, Dr. Brallier, Dr. Broughan; and then the rest of these are medical

records.

A. Yes.

Q. These are what? the clinic chart -- clinic records?

A. The clinic -- Lakewood, I believe.

Q. Lakewood Hospital?

A. Lakewood Hospital.

Q. And that's everything you reviewed in this case?

A. Yes.

Q. Did you make notes on any of the depositions or the medical records?

A. No.

Q. Did you make --

A. Well, I might have --

No, I don't think I did.

Q. Okay. Did you make separate notes --

A. No.

Q. -- while you were going through this?

A. No. I just -- No, I don't believe I did.

Q. I take it since you don't -- you haven't had any training in nephrology, that when you have a patient that has a nephrology problem, you refer those patients to a nephrologist. Would that be true?

A. Yes, depending on what the specific nephrology problem is.

Q. Okay. Well, under what circumstances would you refer a patient to a nephrologist?

A. Many different circumstances. I mean, for instance, declining renal function, uncontrolled hypertension possibly; hematuria; but mostly, you know, problems that I don't understand or don't have a handle on and see declining renal function, I would certainly get a nephrologist.

Q. What is nephrology?

A. Nephrology is the study of the diseases of the kidney.

Q. During the period that Mr. Carrick was treating with Dr. Riley, didn't he have declining renal function and uncontrolled hypertension?

A. Yes.

Q. And wouldn't the standard of care have required that Dr. Riley refer Mr. Carrick to a nephrologist?

A. Not necessarily, I don't believe.

Q. Why not?

A. Dr. Riley was head of nephrology and hypertension at Lakewood Hospital. Apparently, he had

had some training in nephrology, and I'm sure he felt comfortable with his thinking of what was going on with his renal function. That is most likely why he did not.

Q. Well, what's your understanding of what Dr. Riley's belief was as to the renal fun- -- Mr. Carrick's renal function?

A. My belief from reading the record is that he felt that his declining renal function was most likely secondary to his uncontrolled hypertension. Facts to back that up would include an IVP that was done early on that showed small, shrunken kidneys. And therefore, I believe that he thought Mr. Carrick's kidney, decreasing kidney function was due to nephrosclerosis, which is the specific entity that uncontrolled hypertension causes.

Q. I'm sorry. When you -- You said the IVP's showed shrunken kidneys or --

A. Yeah, one shrunken kidney, I believe.

Q. Okay. Just one shrunken kidney?

A. Right. Which is what you see with a hypertensive kidney disease.

Q. Do you agree with that?

A. That is one explanation.

Q. Well, do you agree with that explanation?

A. In retrospect, there are -- were many factors that could have caused this man's renal failure.

Q. Well, do you have an opinion to a reasonable degree of medical probability as to what caused his renal failure?

A. I could not say what caused his renal failure. I did not see any tissue diagnosis of what the exact cause of renal failure was. I would believe you would need to know that to be a hundred percent certain that you knew what caused the renal failure.

Q. Well, if a patient has declining renal function, isn't it incumbent upon the treating physician to determine what the cause of that decline is?

A. Yes.

Q And --

A And I believe in Dr. Riley's mind, he thought he knew that.

Q Well, what did Dr. Riley do to determine the cause of the declining renal function?

A He did an IVP.

Q And when did he do that?

A 1982, I -- as I recall. I may be wrong on the exact date.

Q. And are there other tests that could have been done to determine the cause of the declining renal function?

A. Yes.

Q. What are those?

A. He could have had various tests. Could have a renal ultrasound. Could have had a renal arteriogram.

Q. Anything else?

A. Kidney biopsy.

Q. Any others?

A. No. I think that covers it.

Q. Wouldn't those tests have been more definitive in determining the cause of the declining renal function?

A. Yes.

Q. And shouldn't they have been done, then?

A. Possibly.

Q. How about probably?

A. I do not -- I don't know what Dr. Riley was thinking at that time and his discussion with his patient, 'cause I believe the record is inadequate at that level.

Q. What record? His records?

A. His records.
Q. Okay. Would a reasonable, prudent treating physician with a patient such as Mr. Carrick who had declining renal function perform these definitive studies to determine the cause of his declining renal function?
A. In most cases.
Q. Well, how about in this specific case?
A. Well, I -- I think Dr. Riley assumed that the -- as I mentioned before, that the renal failure was from the nephrosclerosis from the uncontrolled hypertension, and he was trying to control that in hopes that that would stop the decreasing renal function.
Q. I guess that what I'm trying to get at is, is in your opinion, was that a reasonable assumption for him to proceed or should he have done these definitive tests so he would know what he was trying to treat?
A. I think it was a reasonable assumption with his background.
Q. With whose background?
A. Dr. Riley's.
Q. I guess you have to explain that to me.
A. Well, he -- I mean, he did have some expertise in nephrology other than internal medicine;

and I think in his mind, he felt he knew what the problem was.

Q. But you --

A. And he may well have been right, but there's no way to prove that at this point.

Q. Well, I thought you said earlier in retrospect that it appears that he was wrong.

A No, I didn't --

MR. SPISAK: I don't believe that was said.

A I don't believe that was said.

Q When you reviewed this case, did you review it from the standpoint of Dr. Riley being a nephrologist or being an internal -- an internist?

A I reviewed it from the standpoint of being a general internist with special interest in nephrology.

Q Okay.

A Which, at that time, when he came through, there was no, you know, boards in nephrology; and he was head of nephrology and hypertension at Lakewood, which is not uncommon with older physicians.

Q Well, the board certification examination certainly exists now, --

A Right. Uh-huh.

Q. -- and he could take that test.
A. No, he couldn't, because he would have to go back and get training, a residency in nephrology.
Q. Okay.
A. You have to have that to sit for the board exam.
Q. All right. But that's something he could do if he wanted to be a nephrologist, isn't it?
A. Yes.
Q. And that cause you any concern in reviewing this case, that you -- you were --
I mean, you're board certified in internal nedicine.
A. Uh-huh.
Q. You have no special training in nephrology.
A. Right.
Q. And you're rendering opinions on somebody you term as a general internist with special interest in nephrology.
A. Uh-huh.
Q. And apparently, you feel you're qualified to do that.
A. Yes. I do see patients in this situation and do have, you know, special interest in

pharmacology and deal with these types of drugs on a daily basis.

Q. Well, I take it from what you told me at the beginning of the deposition, if you saw a patient that's presented the same way that Mr. Carrick did to Dr. Riley, that you would refer that patient to a nephrologist. Would that be true?

A. Possibly, but not definitely.

Q. You would attempt to treat a patient such as Mr. Carrick in his condition during the eighties?

A. I'm not sure what the question is.

Q. Would you attempt to treat a patient who presented to you with Mr. Carrick's -- the same symptoms Mr. Carrick had during the eighties? Would you attempt to treat that patient or would you refer to a nephrologist -- refer him to a nephrologist?

MR. SPISAK: If you can answer that in a vacuum.

I'm going to note my objection.

A. I don't believe I can say what I would have done.

Q. Why not?

A. Because it's very case specific, I believe.

Q. Well, what I'm asking you is if

Mr. Carrick had presented to you instead of Dr. Riley, would you have treated him or would you have referred him to a nephrologist?

MR. SPISAK: Same objection.

A I -- I don't know if I can answer that.

Q And why is it that you can't answer it?

A Again, because that specific of a situation, I probably would have done some other testing first possibly, but before referring to a nephrologist.

Q Well, would you have done some of the other tests that we discussed: the renal arteriogram or renal ultrasound or kidney biopsy to determine the cause of his declining renal function?

A Possibly.

Q How about probably? Would you have probably done that?

A Probably.

Q All right.

And if it turned out that the declining renal function was caused by nephrosclerosis, would you have probably then referred him to a nephrologist?

A Possibly.

If it was definitely nephrosclerosis, there's not much a nephrologist can do at that point,

anyhow.

Q. That's not a treatable condition?

A. No. Nephrosclerosis is not in itself a treatable condition. Once the damage is done, it's done. You can arrest it by controlling the blood pressure.

Q. What is nephrosclerosis?

A. Nephrosclerosis is a scarring of the kidney caused by persistent elevated high blood pressure that is out of control.

Q. And what causes the uncontrolled high blood pressure?

A. Various causes. May well be essential hypertension. That is very difficult to control, which there is no cause. It's termed idiopathic, which is not uncommon.

Q. Do you have an opinion to a reasonable degree of medical certainty as to what caused Mr. Carrick's high blood pressure?

A. I would say the most likely cause is uncontrolled essential hypertension.

Q. Uncontrolled essential hypertension?

A. Right.

Q. What is that?

A. That is hypertension which is the most common form of hypertension in our population. We do not know the cause, however. It presents with elevated blood pressures. There is no known cause of essential hypertension.

Q. And is there a treatment for it?

A. Yes.

Q. What's the treatment?

A. Treatment is various antihypertensive medications.

Q. Such as?

A. Well, there's probably hundreds of different blood pressure medications.

Q. Did Dr. Riley give any of them to Mr. Carrick?

A. Yes.

Q. Which ones?

A. He gave him Apresoline, A-p-r-e-s-o-l-i-n-e, gave him Lasix, and he tried to give him Minoxidil once. Patient stated the reason for not taking that was it cost too much.

Q. Were you getting that from Dr. Riley's chart?

A. Yeah.

Q. Those are the only three?
A. I think there may have been a few more. I just can't recall at this -- at the moment.
Q. And those three all are blood pressure medications?
A. Yes.
Q. And you're saying there's hundreds of them?
A Probably at least a hundred.
Q. Okay. Are there any that are more effective with controlling blood pressure than these three?
A. They're all effective, depending on the individual patient. In other words, they have to be titrated with the individual patient. One responds maybe differently with each individual patient.
Q. Okay. Well, did any of these three work with Mr. Carrick?
A. Doesn't appear that they worked very well.
Q. And for what period of time did he give these medications?
A. He gave those medications over a period of 15 years? I would think.
There's one more there. Minipress. That was used prominently off and on by Dr. Riley.

Q. And that one didn't work very well, either, did it?
A. No.
Q. Well, if there's hundreds of medications and the ones that Dr. Riley's giving him over a 15-year period aren't working, wouldn't he be required to try different ones and see if he could control it better?
A. Possibly.
Q. How about probably?
A Okay. (Witness nodded affirmatively.)
Q What's renovascular hypertension?
A Renovascular hypertension is caused by narrowing of the renal arteries leading to the kidney.
Q Is that different than nephrosclerosis?
A Yes.
Q Okay. Did you consider that as a cause of his high blood pressure?
A That is a possibility.
Q Do you think it's a probability?
A I don't think it's any more probable than the other various possibilities.
Q Okay. Well, what are the other possibilities other than -- You told me uncontrolled essential hypertension, renovascular hypertension. What

are the other ones?

A. There is other various. It could have been interstitial nephritis.

Q. And what's that?

A. That's inflammation of the kidney tubules.

Q. Anything else?

A. Are we talking about causes of chronic renal failure, basically, I understand?

Q. Right.

Well, actually --

A. There's various other minor causes. I -- I don't know. Other causes, I'm not sure they apply to this case, though.

Q. Okay. So these are the three causes of the renal failure in this case, the three possible causes in this case?

A. Plus other drug effects.

Which drugs? Indocin?

That is a possibility.

Any other drugs?

Allopurinol.

I think that's about it.

Q. All right. And you think any of these are equally likely causes of the renal failure in this case

or is one more likely than the others?

A. I think they're both equal and possibly additive.

Q. Did you say "they're both equal"?

A. They're -- I mean, I -- I would say, yeah, I think they're all possibilities, equal possibilities.

Q. But they also may be cumulative of each other?

A. True.

Q. Okay. The interstitial nephritis, can that cause high blood pressure?

A Yes.

C Didn't the standard of care require that

r. Riley determine the cause of Mr. Carrick's high

lood pressure?

A I don' believe so. I think most general internists assume that it is essential hypertension

nless there's other factors that would lead him to

elieve otherwise.

Wasn't there a factor in this case, and

hat is the declining renal function?

Yes.

And shouldn't that have caused him to

o further investigation into the cause of the

hypertension?

A. Possibly.

Q. How about probably?

MR. SPISAK: I think he's answered the cpestion.

A. Yeah, I think I've already answered that.

Q. What's your answer?

MR. SPISAK: He said "possibly," didn't he?

A. Possibly.

Q. Yes. Well, this is a different question.

How about probably?

MR. SPISAK: And when you asked that a ninute ago, I said I think he's already answered the question.

But go ahead, Doctor. You can tell him again.

A. Possibly. As one of the options.

a. So it was just optional for him to determine what the cause of the high blood pressure was?

A. No. But I think each clinician has to make a clinical judgment. In his clinical judgment, apparently, he felt sure that he knew the cause.

a. Well, what did he think the cause of the high blood pressure was?

A As I have stated, nephrosclerosis secondary to high blood pressure.
Q That was the cause of the declining renal function, I thought,
A. State that question again.
Q. I asked you what did Dr. Riley think the cause of the high blood pressure was.
A. Oh, he thought it was essential hypertension out of control, which there is no cause, --
Q. Okay.
A. -- known cause.
Q. Where did you get that information from?
A. That essential hypertension?
Q. No. No. That Dr. Riley thought that was the cause.
A. From his deposition.
Q. Okay. When you have uncontrolled essential hypertension, is declining renal function associated with that always?
A. Not always.
Q. What percentage of cases is it?
A. I would estimate approximately 20 percent.
Q. So you would agree, then, that if he did have uncontrolled essential hypertension and the patient

started exhibiting decreased renal function, that would at least arouse the suspicion of the prudent internist to investigate the cause of the hypertension?

A. Yes. But I think Dr. Riley felt that he had already made the diagnosis of nephrosclerosis, which is irreversible, and the treatment is control of the blood pressure.

Q. Okay.

A. So apparently, he felt that there was no further testing indicated at that point.

Q. Well, I guess I'm Confused, because I thought the -- the nephrosclerosis was caused by the high blood pressure.

A. Yes.

Q. But the nephrosclerosis doesn't cause high blood pressure, does it?

A. No.

Q. Okay. So my question was: If you think a patient has uncontrolled essential hypertension and that patient starts exhibiting a decline in renal function, shouldn't you -- as a reasonable internist, shouldn't that at least arouse your suspicion that you need to investigate the cause of the hypertension?

A. Not --

A. Yes.
Q. Okay.
A. Unless you're sure that you know the cause.
Q. Well, what did Dr. Riley do to determine the cause of the hypertension?
A. The only tests that I saw that was done was an IVP back in 1982 or around that time. And it did show a small, shrunken kidney, which is consistent with nephrosclerosis.
Q. You're saying that that test helped him determine the cause of the hypertension?
A. Possibly. The record is unclear what he thought.
Q. Well, I mean, if it was consistent with nephrosclerosis, that would only assist him in determining the cause of the declining renal function, not the cause of the hypertension: right?
Let me rephrase the question, okay?
If he did the IVP and it's consistent with nephrosclerosis, --
A. Right.
Q. -- that wouldn't help him in determining the cause of hypertension or high blood pressure, would it?

A. No. It would confirm his thinking that the high blood pressure had already -- already damaged the kidney and had already caused the nephrosclerosis and therefore affirmed that this is what was going on with this man's renal function.

Q. So, but my -- Well, what did Dr. Riley do to determine the cause of Mr. Carrick's hypertension?

A. He did an IVP, which also helps.

Q. Well, what did the IVP tell him about the blood pressure?

A. Nothing. It told him that he had small, shrunken -- had a small, shrunken kidney, consistent with nephrosclerosis.

Q. Did he do anything else to determine the cause of the hypertension?

A. Not that I recall.

Q. If the declining renal function was caused by the other -- Well, let me strike that.

Is renovascular hypertension treatable?

A Sometimes.

Q And how is it treated?

A It's treated with -- Depending on what the anatomical lesion is, if it is amenable to surgery, then certainly surgery can be done to replace the renal

arteries.

Also, there's angioplasty of the renal arteries.

Q. Okay. And if he had interstitial nephritis, is that treatable?

A. Yes. It's not really treatable. Mainly, the thing to do is to stop the offending agent. It's usually medication related.

Q. It's usually medication related?

A. Right.

Q. So you would stop the medication.

A. Right.

Q. All right.

And I take it that if Indocin or Allopurinol was causing it, then you could also stop those medications.

A. Right. Right.

Q. Okay. So out of all the possibilities you have mentioned for the decline in renal function, the only one that's not treatable is the nephrosclerosis.

A. Correct.

Q. Okay. And isn't that also treatable in that the -- if the patient is a candidate for a

transplant, that could be done?

A. I'm sorry. Say that again.

Q. Can't a patient who has nephrosclerosis, can't they be treated with a kidney transplant?

A. Yes.

Q. And do you have an opinion to a -- Well, do you have an opinion if he was -- if Mr. Carrick was a candidate for a kidney transplant?

A. No, he wasn't at any time that I reviewed the records.

Q. Okay. Let's just talk about the time when he was seeing Dr. Riley for now. And why, in your opinion, wasn't he a candidate during that time?

A. He was not a candidate for transplant, you're talking?

Q. Yes.

A. Oh, okay. His renal function was never at the point where he would require a transplant.

Q. Okay.

A. He was still putting out urine. Creatinine basically was -- even when he was discharged from The Cleveland Clinic the first time, was only around seven, I believe. And he may have done well for years without a -- without any other intervention.

Usually, you do not do a transplant unless you're already on hemodialysis and your kidneys have completely failed.

Q. Uh-huh.

I take it your opinion that he was never a candidate is based on the fact that by the time he was on dialysis, that he was not medically stable to undergo a transplant operation.

A. Correct.

Q. Did you see anywhere in the record where Dr. Riley ever made a definitive diagnosis of gout?

A. Yes, I believe he did.

Q. Okay. When was that?

A. I believe early on.

Q. Well, how --

Do you treat gout?

A. Yes.

Q. How do you make a diagnosis of gout?

A. Well, there's several ways. The most definitive is getting -- aspirating a joint that is affected and checking uric acid crystals in the Laboratory.

Q. Is that how you make a diagnosis of gout?

A. Sometimes.

Q. Is that the most definitive way to diagnose gout?

A. It is the most definitive; --

Q. Okay.

A. -- however, there are other ways.

Q. How did Dr. Riley do it in this case?

A. He diagnosed it by an elevated uric acid level and response to a nonsteroidal anti-inflammatory medication.

Q. Is that how you make a diagnosis of gout?

A. Yes, one of the ways. Uh-huh.

Q. Is there any risk to aspirating the joint?

A. None other than just the pain of the actually inserting the needle.

Q. Would there be a reason for not making the definitive diagnosis of gout in this case?

A. Possibly. Perhaps he did not feel a joint effusion; and you wouldn't put a needle in it unless you thought there was an effusion that you could get some material to look at it.

Q. Uh-huh.

Would the fact that he didn't have a joint effusion mitigate against the diagnosis of gout?

A. I'm sorry. Say that again.

Q. The fact that he didn't have a joint effusion, would that mitigate against him having gout?

A. I'm not sure. What do you mean by "mitigate"?

Q. Well, maybe that's the wrong word.

Would that be something that would indicate that he might not have gout?

A. I think gout is a diagnosis of a clinical syndrome rather than a definite laboratory testing. It can be done if you have a joint effusion, but sometimes also you cannot get a definitive specimen. And if you have an elevated uric acid and there's arthralgias and you respond to nonsteroidal anti-inflammatory agents, then almost certainly it is gout. And I would believe that most general practitioners and general internists would take that as evidence and would treat accordingly.

Q. Okay. I understood your answer, but I'm not sure that it was the answer to my question.

A. Okay.

Q. And that is, if Dr. Riley didn't feel a joint effusion, would that be an indication that the patient didn't have gout?

A. He may or may not have gout just by the

joint effusion. In other words, you do not always have an effusion with gout.

(Discussion held off the record.)

Q. But the fact that there's not an effusion, would that make you suspicious that there wasn't gout?

A. It may or it may not be just from the effusion.

Q. Well, wasn't Dr. Riley treating Mr. Carrick for a 15-year period for gout?

A. Yes.

Q. Okay. And wouldn't a reasonable, prudent physician at some point during that 15 years make a definitive diagnosis of gout?

A. You're speaking of a joint as separate?

Q. Yes. Let's start with that.

A. If he had one, possibly.

I have seen no record, nothing on the record that would indicate that he did.

Q. If he had one what? If he had a joint --

A. An effusion that was able to be aspirated.

Q. I see. All right.

Q. Do you have an opinion as to whether or not Mr. Carrick had gout?

A. I think he did.

Q. Do you think it was primary or secondary gout?

A. Primary.

Q. Have you ever treated a patient that had progressive renal failure, gouty attacks, and uric acid levels of 12 to 14?

A. Yes.

Q. And is that a well-described entity in the literature?

A. Yes.

Q. And what's the treatment for that?

A. Treatment is to control the gout and uric acid levels.

Q. How?

A. Usually with Allopurinol.

Q. Is there any other treatment you give concurrently with that?

A. I assume you're talking a chronic gout rather than the acute situation.

Q. Well, how would you describe Mr. Carrick's gout?

A. Mr. Carrick had chronic gout with acute exacerbations.

Q. All right. Well, let's talk about the kind

of gout he had.

A. Well, he had both. You use different medications in both.

To prevent the recurrent exacerbations, you treat with Allopurinol to lower the uric acid level; however, in this situation, it is very tricky because Allopurinol itself can be a nephrotoxin.

Q. Uh-huh.

A. And apparently, Dr. Riley felt that Allopurinol, which he did try, was possibly a cause of -- would possibly hurt his kidneys more than they already were.

Q Okay. Do you feel that Mr. Carrick received an adequate trial of Allopurinol?

A I think so. I believe if you checked the record, he did bring down the uric acid early on and -- But then, as Dr. Riley believes in his deposition, the BUN went up rather dramatically, and therefore he stopped it,

Q Do you think that was appropriate, to stop the Allopurinol?

A Yes. Yes.

Q But during that time period, he was also receiving Indocin, wasn't he?

A. I believe so.
Q. And Dr. Riley continued to prescribe Indocin after he stopped the Allopurinol, didn't he?
A. Correct. But his BUN creatinine came down, too. So in view of that, I believe the Allopurinol was the culprit.
Q. And not the Indocin?
A. At that point, yes. This was way when he first started the Allopurinol.
Q. Did he ever go back to try the Allopurinol after that?
A. No. I don't believe anybody would after seeing a dramatic worsening of renal function.
Q. Well, do you believe that the Indocin at some point began damaging the kidneys?
A That's a tough question. It may have contributed a small amount, I would say.
Q. Well, is that an opinion based on reasonable medical certainty?
A Yes, I believe so. I believe of you read the literature on Indocin, most of the nephropathy associated with nonsteroidal anti-inflammatory agents is relatively -- a relatively low amount of cases that go on to complete chronic renal failure.

Q What's your understanding of how much Indocin Mr. Carrick was taking?

A That's very tough from the record, and I have no idea, From the record, I noted at Cleveland -- a note on The Cleveland Clinic, a record possibly that --

THE WITNESS: What was it?

MR. SPISAK: You want to check the record?

A I don't know where that was, but it was something like 200 -- two to 400 tablets in a year of a 25-milligram dosage.

Q That's based on the clinic record?

A Yes, which I don't know how they determined that, whether it was from the patient or discussions with Dr. Riley. It does not say. Certainly cannot be determined by the -- Dr. Riley's records.

Q You can't determine how much Indocin he was taking --

A No.

Q -- from Dr. Riley's records?

A. No.

Q. Is it appropriate for a physician to prescribe nephrotoxins such as Indocin over a 15-year

period in a patient that has declining renal function?

A. It may be in a special situation where other medications have been tried and nothing else works. And therefore, you would have to weigh the risk versus benefit of a particular medication.

Q. Do you feel it was appropriate in this setting?

A. Yes, I believe it was appropriate treatment of the -- his repeated, severe arthralgias.

Q. Without knowing how much Indocin he was prescribing?

A. Well, the record does not indicate that he -- that he -- how much he prescribed, so I'm not aware if Dr. Riley knew or not. Have no way of knowing.

Q. No. I mean, can you render this opinion without knowing how much Indocin Dr. Riley prescribed?

A. Well, it would be -- Well, I could render an opinion that there are other causes of his renal failure other than Indocin, certainly. And I don't -- I think that's an impossible question to answer if you don't know how much he took. And although --

Obviously, it would be -- it would -- you know, it would be more likely that it's the Indocin if he took a lot and less if he took less; although, again,

I state that Indocin in itself would probably not cause, is a sole cause of this, renal failure.

Q. As you sit here today without knowing how much Indocin Dr. Riley prescribed, do you have an opinion based on reasonable medical certainty whether it was appropriate for him to prescribe Indocin to Mr. Carrick over a 15-year period in light of the fact that he had declining renal function during that period of time? Do you have an opinion? Yes or no.

A. Yes.

Q. Okay. And what's your opinion?

A. My opinion is that it was appropriate that Dr. Riley prescribe Indocin for acute gouty attacks based on a risk/benefit ratio of the medication.

Q. Would there be any amount of Indocin prescribed that would be appropriate?

A. Certainly you want to limit it to the least amount that does the job. You would certainly not want to have him on it on a chronic basis. You would just use it for -- and just use it for severe exacerbations, which is -- as I read the records, the way that Dr. Riley had treated him.

Q. All right. If I asked you to assume that he was on Indocin on a chronic basis, would that change

your opinion?

MR. SPISAK: Note my objection. There's no indication of that anywhere.

A. There is no indication of that in the record, that he was on it on an everyday --

Q. Well, I'm just -- You said on a chronic basis, so I was using your terminology. Nobody said -- not even Mr. Spisak said "every day."

A. That's what we mean by "chronic," though.

Q. Okay. What I mean by "hypothetical" is, I want you to assume that he was on it on a chronic basis.

MR. SPISAK: Every day?

A. "Chronic" means every day to a physician. I mean, you take the medicine every day.

Q. Okay. Assume that --

MR. SPISAK: Assume that he took it every single day for 15 years? Is that what you're asking this doctor?

Q. I'm asking you to assume that he was on it on a chronic basis, however you define that.

MR. SPISAK: And I want you to put in the record how you define that before you answer that.

THE WITNESS: Okay.

A. I define chronic as being prescribed on a daily basis. Usually, the usual dosage is three times a day.

And you're asking me again if he was on it chronically? I should assume that?

Q. Yes. Assume that he was prescribed on a chronic basis.

A. Okay.

Q. Would that change your opinion as to whether or not it was appropriate for Dr. Riley to prescribe Indocin over a 15-year period to Mr. Carrick, given the fact that he had declining renal function during that period?

A. I think so, yes.

Q. You think that would change your opinion?

Right.

Okay. And so it would be below the standard of care to do that. Would that be true?

MR. SPISAK: If he took it three times a day every day for 15 years.

Right. That would be right,

Now let's say that he was just -- let's say he just took it every day, not necessarily three times a day. Would that change your opinion?

MR. SPISAK: Note my objection to all the hypothesizing.

A. Yes, because as a -- Yes.

Q. That would change your opinion?

A. Right.

Q. Would it be below the standard of care?

A. If it was prescribed once a day, just one a day, I mean, you wouldn't do that.

Q. How often should he have been prescribing it?

MR. SPISAK: I think that's already been testified to, but go ahead, Doctor.

A. I think as often as he has an acute exacerbation.

Q. We're talking about -- When we say once or three times a day, are we talking about 25 milligrams? Is that what you said before was the tablet?

A. Right.

Q. So we're talking about 25 milligrams, one for three times a day.

A. Right.

Q. All right. So it would be appropriate in your opinion for Dr. Riley to prescribe it over this

period of time, even though the patient had declining renal function, if it was prescribed only when the patient had exacerbated gouty attacks?

A. Correct.

Q. Okay.

A. And it was assumed that the patient took it only when he had an acute attack. And usually, it responds within several days.

Q. And how often do you envision these attacks occurring? Once a month? Once every other month?

A That is highly variable. I have no idea.

Q You have no idea how often Mr. Carrick had attacks over the 15-year period of time?

A No, I don't.

Q Well, what if he had one once a month? would it have been appropriate for Dr. Riley to continue to prescribe the Indocin?

A Yes, assuming he only took it for several days, --

Q. Okay.

A -- which is the usual treatment for gout.

Q You said earlier that you gleaned from the records somewhere that Dr. Riley prescribed 200 to 400 tablets per year.

A That was in a reference from Cleveland Clinic.

MR. SPISAK: Reference from Cleveland Clinic. Excuse me. And that reference does not say that Dr. Riley prescribed that: that that, I believe, says that's what the patient took.

THE WITNESS: That's what -- Well, it at least says --

MR. SPISAK: At least there's a reference to that.

Q. I'll ask you to assume that Dr. Riley was the one that prescribed this 200 to 400 tablets per year. Would that have been an appropriate amount of Indocin for him to prescribe?

MR. SPISAK: Given what he's -- what Dr. Mast has already indicated, that it be taken for acute episodes only?

MR. MELLINO: Sure.

A I think that would fall within the range of possibility, depending on how many acute attacks he had, which nobody knows. Probably Dr. Riley didn't know, either.

I'm sure it's not -- It's not uncommon for a patient to have a supply of Indocin; and when he has a

chronic condition like this, just to take the medication for a few days and then stop without the doctor even knowing it.

Q. Well, is it your understanding that anybody other than Dr. Riley prescribed Indocin to Mr. Carrick?

A. No.

Q. Okay. So it was just Dr. Riley prescribing it?

A. As far as I know.

Q. And isn't that something that would have been important for Dr. Riley to know, how often he had had gouty attacks?

A Yes.

Q And, I mean, that's something that should be in Dr. Riley's records, isn't it?

A Not necessarily. Not if the patient didn't call in. And it's not noted anywhere. He may ask him on his annual physical.

Q But it's nowhere in his record?

A No.

Q And Dr. Riley couldn't remember when he was deposed how often they were, could he?

A Well, that may very well be.

I don't remember specifically on every patient, you know.

Q. Well, I mean, you agreed with me it's something that's important for Dr. Riley to know. And there's absolutely nothing in this record that demonstrates that he knew how often he was having gouty attacks, is there?

A. Yes. No, there is nothing on the record to indicate that.

Q. Do you agree with Dr. Riley that Mr. Carrick needed dialysis at the time that he was transferred to The Cleveland Clinic?

MR. GORE: I'm going to object. This witness has not been proposed to testify in this regard.

MR. SPISAK: You may answer, if you can.

A. That is not a judgment of a general internist.

Q. So would you be qualified to render any opinions about dialysis or its role in this case?

A. Are you talking specifically about the time that he was transferred from Lakewood to Cleveland Clinic?

Q. Well, I wasn't limiting to that at all.

A. That's up to a nephrologist, but I don't --

I don't see anything inappropriate about dialysizing a patient with a BUN of 150 and creatinine --

Q. Dialysizing this patient?

A. Right.

Q. Do you have an opinion as to whether or not it would have reversed his disease process?

MR. GORE: Objection. Lack of qualifications.

MR. SPISAK: Go ahead, Doctor.

A. No, it wouldn't. The dialysis does not reverse disease processes.

Q. Well, would I -- Is your opinion that he would have needed a kidney transplant?

A. That's impossible to ascertain, That's -- He may have down the line if he had complete chronic renal failure, but he never -- he never did till the very end; and obviously, he was in no medical condition to undergo a transplant at that point.

Q. Did Dr. Riley fall below the standard of care in not anticipating and preventing Mr. Carrick's tone disease?

A. No.

Q. What did he do to anticipate and prevent it?

A. I don't think he did anything.
Q. Well, did he have a duty to do something?
A. I'm not clear on the extent of the bone disease.
Q. You're not clear on the extent of Mr. Carrick's bone disease?
A. Yes.
Q. Okay. Well, does an internist have a duty to -- You know, given a patient with Mr. Carrick's presentation, does he have a duty to anticipate or prevent bone disease in that patient?
A. Yes.
Q. Okay. And Dr. Riley didn't do anything to anticipate it or prevent it, did he?
A. Not that -- not from the record that I could ascertain.
Q. Do you know what the treatment is for renal bone disease?
A. Yes.
Q. Okay. What is it?
A. It is trying to reverse the calcium resorption from the bone.
Q. How do you do that?
A. Includes lowering the phosphorus and giving

calcium supplementation. That's how it's treated medically.

Q. And Dr. Riley didn't do that, did he?

A. No, he didn't.

Q. Okay.

A But I'm a little bit unclear from reviewing the record about how extensive his bone disease was.

Q Well, if a patient has a decline in renal function, isn't that one of the possibilities, --

A Right.

Q -- that he'll develop renal bone disease?

A Right. But usually that occurs in people that are on long-term hemodialysis.

Q Are you just saying that you're unclear as to the extent of his bone disease or that he had bone disease -- renal bone disease at all?

A Well, yes, to the extent, I am unclear on that. And no -- I -- I think he had some, but I'm not clear to how extensive it was.

Q So it is clear that he had renal bone disease?

A Yes.

MR. SPISAK: He says he thinks he had some.

MR. MELLINO: Okay.

Q. Do you have any opinions about the care that Dr. -- that Mr. Carrick received at The Cleveland Clinic?

MR. GORE: Is that a yes-or-no question?

MR. MELLINO: Yes.

A. Any opinions?

Q. Right.

A. No.

Q. You have no opinions?

A. No.

Q. Do you have an opinion on whether or not at the time Mr. Carrick was transferred to The Cleveland Clinic whether or not his condition, his disease process was treatable and reversible?

MR. GORE: Objection for lack of qualifications and lack of foundation, particularly since he's already testified he didn't know the extent of the bone disease.

MR. SPISAK: You may answer if you can answer.

Q Yes. I mean, if you don't have an opinion you can just say that.

A What was the question again?

Q The question was: Do you have an opinion

based on reasonable medical certainty as to whether or not at the time Mr. Carrick was transferred to The Cleveland Clinic, whether his condition was -- his medical condition was treatable and reversible?

MR. GORE: Same objection.

A Some of his -- Obviously, there was more than one thing going on. Some of them were reversible and some of them weren't, probably.

Q Which ones were reversible?

MR. GORE: Same objection.

A His acute arthritis -- arthralgia and severe arthritis, which is -- that is the reason he was admitted to Lakewood, as I understand. Severe pain,

Q Okay. Anything else?

A Also, his renal function could have been improved with dialysis if that was thought to be necessary. But it was not a cure. Dialysis just is a method to remove toxins.

Q Okay.

A And this person may well have had acute renal failure on top of chronic renal failure, which would have been reversible to some degree.

Q And if his renal failure was caused by interstitial nephritis or from Indocin, --

A. His chronic renal failure?
Q. Yes.
-- then that could have also been treated?
A Yes, if -- if that was the case.
Q Have we talked about all the opinions that you are going to render at trial in this case?
A No.
Q Okay. What have I missed?
MR. SPISAK: Well, I don't -- I'm going to object.
THE WITNESS: What was the question here?
MR. SPISAK: "What have I missed?"
I don't know what you've missed.
THE WITNESS: Oh, okay.
A I'm sorry. I didn't understand your question.
Q I asked you if -- if we've talked about all the opinions that you have in this case that you're going to render at trial.
A I believe so.
MR. MELLINO: Okay. I don't have any other questions.
MR. GORE: I have one question, but I think it may be more a question for Mr. Spisak than for Dr.

Mast.

Am I correct in my understanding, based on Dr. Mast's report and the testimony he has just given, that he has not been asked to and will not be at trial presenting any opinions with regard to the liability issues vis-a-vis The Cleveland Clinic physicians?

MR. SPISAK: I believe that's an accurate representation at this point.

And if for any reason there should be anything different on that, you would certainly be entitled to know that and to discover it from this witness well in advance of trial.

MR. GORE: Then I don't have any questions for you, Dr. Mast.

THE WITNESS: Okay.

MR. GORE: Beth, I'd like a copy.

MR. SPISAK: Beth, what I'd like you to do is to send me my copy, and I will make it available to Dr. Mast for review, and then I'll send you a letter with copies to everybody else saying that we waive signature subject to those corrections. I don't want you to have to go through the process of sending him a letter and all that business for signature. And we do this all the time, so I think it's agreeable to all of

us.

MR. MELLINO: What? I missed that.

MR. SPISAK: I'll have Dr. Mast review my copy of it, and then we'll send you a letter waiving signature. I'll send it to Beth waiving signature to any corrections he makes, but he doesn't have to go through the rigamarole of actually signing it.

MR. MELLINO: Okay. That's agreeable.

(Signature waived.)

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Thereupon, the deposition concluded at approximately 3:30 p.m.

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C E R T I F I C A T E

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THE STATE OF OHIO:
SS:
COUNTY OF FRANKLIN:

I, Beth A. Higgins, a Registered Professional Reporter and Notary Public in and for the State of Ohio, do hereby certify that before the taking of his said deposition, the said MAURICE C. MAST, M.D. was first duly sworn by me to tell the truth, the whole truth, and nothing but the truth;

That said deposition was taken in all respects pursuant to the stipulations of counsel heretofore set forth; that the foregoing is the deposition given at the said time and place by the said MAURICE C. MAST, M.D.;

That I am not an attorney for or relative of either party and have no interest whatsoever in the event of this litigation.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal of office at Columbus, Ohio, this 10th day of October, 1991.

BETH A. HIGGINS, RPR
NOTARY PUBLIC, STATE OF OHIO

My commission expires
July 16, 1995.

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