IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

SHERLEEN WYNN,
Plaintiff,
-vs-
CARL A. ROBSON, M.D., et al.,
Defendants.

JUDGE McMANAMON
CASE NO. 187066

DOC. 322

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Deposition of HADLEY MORGENSTERN-CLARREN, M.D., taken as if upon cross-examination before Susan M. Cebron, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the University Suburban Health Center, 1611 S. Green Road, South Euclid, Ohio, at 3:30 p.m. on Monday, April 15, 1991, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

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

APPEARANCES:

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

On behalf of the Plaintiff;

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

On behalf of the Defendants
Carl A. Robson, M.D.
And L & D Family Practice;

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

On behalf of the Defendant
Mt. Sinai Pathologists;

Charles W. Kitchen, Esq.
Kitchen, Messner & Deery
1100 Illuminating Building
Cleveland, Ohio 44113
(216) 241-5614,

On behalf of the Defendant
Mt. Sinai Medical Center.

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HADLEY MORGENSTERN-CLARREN, M.D., of lawful age, called by the Plaintiff for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF

HADLEY MORGENSTERN-CLARREN, M.D.

BY MR. MELLTNO:

Q. Would you state your full name, please?

A. My name is Dr. Hadley Morgenstern-Clarren, first name H-A-D-L-E-Y, last name, M-O-R-G-E-N-S-T-E-R-N hyphen capital C-L-A-R-R-E-N, M.D.

Q. And where do you live, doctor?

A. My office address or my home address?

Q. Your home address.

A. My home address is 3009 Claremont, C-L-A-R-E-M-0-N-T, Road, in Shaker Heights, Ohio.

Q. Okay. Before we started you handed me a copy of your CV. I haven't had a chance to look at it. Why don't you just tell me what education and training you've undergone?

A. I received my undergraduate degree, a

bachelor's, at Yale College of Yale University in 1971, my BA.

I then went to medical school at the University of Minnesota in Minneapolis, Minnesota. Graduated and received my M.D. degree in 1975.

I trained from 1975 until 1978 at the University Hospitals of Cleveland where I did my internship and residency in internal medicine.

From 1978 through 1979 I then served as an additional year as registrar, a position comparable to being a chief resident, at King Edward VII Hospital in Windsor, England.

Upon completing that, I returned to Cleveland and opened my practice here at the University Suburban Health Center, and on the faculty of Case Western Reserve University School of Medicine, where I have been practicing ever since 1979.

Q. Okay. The additional year of training you underwent in England, was that in any particular specialty?

A. That was in general internal medicine, although it was also the original diabetic center. It took care of the community of Windsor.

Q. Okay. And your practice now is basically a -- well, tell me what your practice now consists of.

A. I have a practice in adult internal medicine, general medicine, patients from their teens up until their 90s. A considerable portion of it is primary care and preventive care.

I also have a number of patients with multisystem disease that are managed with subspecialists and surgeons at University Hospitals.

Q. Okay. What gynecological services do you perform in your practice?

A. We do office gynecology in the sense that I will do Pap smears and treat simple infections. We do not do obstetrics, and complicated problems are referred to gynecologists.

Q. what about colposcopy or biopsies or anything like that?

A. I would not do procedures of that nature. Those would be referred to gynecologists.

Q. So am I correct then that the only gynecological services that you perform in your practice would be Pap smears and the treatment of simple gynecological infections?

A. That's exactly correct.
Q. Anything more complicated than that you would refer to the gynecologist?
A. Yes. That's right.
Q. What did you review before you prepared your report in this case?
A. The records which I reviewed included the office records of Dr. Carl Robson, the office records of Dr. Pamela Murphy, the office records of the Euclid Clinic, the office records of Dr. Michael MacFee, hospital records from University Hospitals of Cleveland for outpatient visits, and several admissions beginning in December of 1989 and going through approximately June of 1990.

The report which I prepared on January 29th, 1991 was based on these materials, but since that time I have also had a chance to review the deposition of Dr. Charles Engelberg.
Q. Okay. So the only thing you looked at since your report is Dr. Engelberg's deposition?
A. Correct.
Q. And everything else you looked at you have outlined that out in your January 29th report?
A. Yes.

Q. Is your January 29th report the only report that you authored in this case?
A. Yes.
Q. Did you have any verbal communications with Mr. Dapore prior to writing this report?
A. He gave me a telephone call in January of this year to ask me if I would be willing to review these materials and I said yes. So that kind of a quick phone call, yes.
Q. Okay. Do you recall the date of that conversation?
A. No. But it was sometime in January of this year.
Q. In January of '91?
A. Correct.
Q. Okay. Have you been retained by Mr. Dapore previously as an expert witness?
A. Not by Mr. Dapore, no.
Q. How about by any member of his firm?
A. Yes, I have reviewed a few other cases for the firm.
Q. How many other cases?
A. I think three or four.
Q. And who did you -- who were you retained by?
A. Mr. Bonezzi on I think two or three, and I can't

remember off the top of my head, but I believe another attorney in their group has also asked me to review a case. I'm sorry, I don't remember that person's name right now.

Q. Okay. For how long have you been consulting in medical/legal cases?

A. I have consulted since I believe 1984.

Q. And do you have any idea how many cases you've acted as an expert witness in?

A. I probably review about six to eight cases a year.

Q. And do you have any idea of what the breakdown is between plaintiffs and defendants?

A. About two-thirds of the cases that I have reviewed have been for plaintiff, and about one-third have been for the defendant.

Q. How many times have you been deposed?

A. I have probably had my deposition taken about 15 times.

Q. Okay. Have these all been as an expert witness?

A. Yes.

Q. Okay.

A. Well, not all. A few of the cases I reviewed, and in addition to these have been when my own patients have been injured and I have been asked

to have my deposition taken, you know, as the primary treating doctor.

Q. Uh-huh.

A. And there was one case against another doctor at University Hospital where my patient sued a surgeon at the hospital and, again, I was not a direct party in the suit, but I was the treating physician and was subpoenaed to be involved, and my deposition was taken for that, too.

So there have been a few additional cases involving the care of my patients directly where I was not an expert, but simply giving information about the care of the patient.

Q. And you counted those in the 15 depositions?

A. No, I think those would be extra.

Q. Those are in addition to the 15?

A. Certainly.

Q. How many cases do you think that would be?

A. Probably half a dozen through the years.

Q. Do any of these other cases involve gynecological care?

A. No. Not that I can remember immediately offhand.

Q. Do any of them involve facts similar to this case?

A. Involving Pap smears, no.
Q. Well, I mean, I didn't mean to limit my question the way you did.
Can you think of any similarities between any of these other cases and this case?
MR. DAPORE: Well, since this case involves Pap smears and follow-up, I think that pretty well covers the basic facts of this case.
A. I certainly have not reviewed any other cases that immediately seemed like this to me.
Q. Okay. Did you review any literature to prepare your report or give opinions in this case?
A. I looked at my Harrison's, my Textbook of Internal Medicine, but most of the information was really based on my own understanding of how we practice and the standard of care in the community as I've known it for myself and for the physicians that I have trained with and worked with.
Q. Okay. When you do Pap smears, where do you send your samples?
A. They are transported to the histopathology laboratory at the University Hospitals of Cleveland.

Q. When you do Pap smears, what's your practice when you get an abnormal reading?
A. There are, of course, many different kinds of gradations of abnormality.
Q. Yes.
A. So what we do depends on what the Pap smear says specifically what the abnormality is.

For example, if it shows that there are trichomonads, which is a very common thing to find, the follow-up would need to be we treat the patient's infection.

If it shows some kind of cancer, the immediate follow-up would be to send the patient on to see their gynecologist.

If we get a lower grade abnormality, the general practice would be to repeat the test after a specified period of time.

Q. What if the Pap -- what if the report you get back on the Pap says abnormal cells, what would you do in that instance?
A. Well, again, we would hopefully get better information than that, because that's a whole gamut of trivia to low grade inflammation and infection all the way up to precancer and cancer.

So, again, if those abnormal cells are already cancerous or precancerous, at that point the patient should go to the gynecologist forthwith.

If it's a lower grade abnormality, again, an infection should be treated or, again, if there's some question of whether or not there's a dysplasia, you would expect the Pap smear to need to be repeated at a future date.

Q. Well, what if that's all the information you have is abnormal cells, what would you do?

A. I have never received a Pap smear that said that. That's not what I would expect from a histopathology Laboratory.

Q. Well, I am asking you to assume that you did a Pap smear and that was the report you got back. What would you do?

A. I wouldn't know what to do because I wouldn't know what that report would mean. I probably would have to call the lab and say what is this.

Q. Okay.

A. It's not enough information to work from.

Q. Okay. When you do Pap smears, is it important to correlate the pathology report with any clinical findings you make?

A. Of course.
Q. Okay. What would be the significance of a clinical finding that the cervix is slightly eroded and bleeding?
A. It would indicate some inflammation, possibly some cervicitis, but, again, that could be for a gamut of reasons, including irritation, infection, and then on to the more serious possibilities of those changes that lead into precancer.

So, again, it's simply an abnormality with several different possibilities as to its meaning.
Q. All right.
A. The Pap smear would be one of the ways to help sort out what it means.
Q. All right. So if you have those clinical findings it would require some follow-up on your part?
A. Yes.
Q. And what if you did a Pap smear and that wasn't helpful in determining the cause of the problem? Would that then require further follow-up?
A. Well, certainly you would take another check at

a future time, but the Pap would be helpful, if it doesn't show evidence of cancer, that's helpful, and then you would check again later.

Q. Well, what if the Pap says abnormal cells? I think you said before that it could mean cancer, it could just mean infection.

A. Well, again, I'm also stating that that's not what I expect from a histopathology lab, I have never gotten that has a report, and I don't think I would stop at that point until I got additional information from the pathologist.

I don't think you would stop at that point if that's all they tell you.

Q. Okay. At what point would you refer a patient to a gynecologist?

A. There would be many ways in which I would refer the patient on to a gynecologist. I would refer the patient on if there were still some abnormalities that I was worried about, if the patient was having prolonged pain or changes in the menstrual periods or persistent bleeding.

If I had two Pap smears in a row that showed dysplasia or a Pap smear that showed something in the way of carcinoma in situ or frank cancer I would refer the patient on

immediately without a follow-up.

So I can think of several situations where I might refer the patient on.

Q. If you had a Pap smear that showed dysplasia, how soon would you repeat it?

A. The usual standard of care would be in about three months,

Q. If you had clinical findings of an abnormal cervix and a Pap smear that read as dysplasia, what would you do?

MR. DAPORE: What do you mean by an abnormal cervix?

Q. Findings of slightly eroded cervix that was bleeding.

A. In addition to the Pap smear I probably would have also taken cultures, and if I found an infection I would treat it.

when I did the follow-up Pap smear I would also be doing another visual inspection of the cervix to see if it had healed, which it most often will do.

Q. Okay. In Dr. Robson's records there's a note of a visit in July, July 18th of 1985 I think the date is.

A. Yes, I have that.

Q. Okay. And on that visit Dr. Robson noted that there was an abnormal cervix; is that true?
A. Yes. He stated that there was slight erosion, which bled apparently upon examination of the cervix, and he put down in his assessment that he thought it was a mild vaginitis.
Q. Did he do a Pap smear?
A. My records do not show a formal Pap smear report for that date, but on a flow sheet, which is included in Dr. Robson's chart, it is dated for July 18th, 1985 that he did a Pap smear and he describes his findings.
Q. Based on his findings, I'm talking about clinical findings on that day, does the standard of care require that he do a Pap smear?
A. Yes.
Q. Okay. And why don't you read what his findings were?

MR. DAPORE: What the Pap smear results were?

MR. MELLINO: Yes. Yes.

A. It is essentially read as neg, which I assume means negative for cancerous cells.
Q. Well, it just says N-E-G there, right?
A. That's what that would imply. It then says

profuse bacteria, inflammation and inflammatory cell changes.

Q. Okay. And what does inflammatory cell changes mean?

A. Exactly that. Inflammation is simply an irritation, a cell response which can be to an infective agent or to some kind of irritation.

There are other mechanical irritations that could also cause this, but in this instance he is at least suggesting since there's profuse bacteria that he thought there might be some kind of superficial infection.

He did take a culture under GC of that same date, the end would imply that he did a culture for gonococcus, that was negative, which would have been the organism he was most worried about, and he appropriately tested for it and found that there were none.

Q. Okay. So what would be, the cause of the inflammation to be then?

A. In this instance, in view of the fact that he saw a lot of bacteria, he probably would assume that it was another low grade infection, and there are many that could do it, but fortunately not gonococcus, which is the most dangerous

since it causes the most long-term complications and can lead to infertility as well as spread to other people.

In this instance I suppose anaerobic bacteria or Chlamydia would have been possibilities.

Q. And did Dr. Robson treat that?

A. He gave the patient Bacitracin ointment, which would be a surface acting antibiotic, and also had the patient use hydrogen peroxide to clean the area, and then the important point in this would be follow-up to just make sure it all went away, and he put down follow-up p.r.n.

So there would be some need for the patient to report symptoms back or for him to reexamine her in the future.

Q. Well, when is the next time he did an examination of her?

A. By the way, I'm not sure that that was Dr. Robson. The signature on that note is in my chart someone named Reynolds, but it isn't in the same chart as Dr. Robson's notes. 15

Q. Yes.

A. So I'm not sure that that's Dr. Robson who did that, but someone else at Hough Norwood.

Q. Well, is that significant to you?
A. No. It's a group practice.
Q. Pardon?
A. It's a group practice.
Q. Right. I mean, there is no doubt in your mind that Sherleen Wynn was Dr. Robson's patient?
A. We're simply talking about the correct treatment by Dr. Robson, If Dr. Robson wasn't the treating doctor, I just want to make that clear that we are probably talking about someone else on that date.
Q. Well, do you feel that she was given appropriate treatment on that date?
A. There are any number of treatments that probably would have been appropriate. That would be okay.
Q. Well, is there some treatment that would have been better?
A. No. I think almost anything would have worked. It was at this point very mild and, you know, any kind of just keeping the area clean and giving it time probably was going to work.
Q. Given those findings on that day then, wouldn't Dr. Robson be required to follow the patient until her cervix was normal?

A. When the patient would then come back for routine follow-up, which you would hope would be annual, that would be the important follow-up for this kind of a problem which is considered minor.

Other than that, it would be the patient's own return if she had symptoms or problems that persisted. This is not a dangerous change, and it would be something analogous to a rash on your arm. If it doesn't go away and the patient is still bothered by it they come back, but the doctor doesn't have to make a special point to say come back and let me see your rash again in two weeks. It's considered in the minor category.

Q. But he still would be required to follow it until the cervix was normal?

A. I don't know what you mean by "required". He would be available to continue to treat if it didn't go away or came back.

To a certain extent the patient also does assume some obligation to come back if they still have a problem. We don't police our patients.

Q. Well, when the patient came back did she have a

normal cervix?

MR. DAPORE: When are you talking about? She came back many times. Do you have a specific date?

A. I can't read the date of the next time the patient came back. Can you help me on that? Mine is sort of crossed off. It says 7th of some month in 1985.

Q. Mine is cut off, too.

A. So I don't know exactly when, something 17, and according to my chart there is not a description of the cervix on that date. The patient was coming mainly with the complaint of lumps on her thighs, and then again there is other things that came up, and the patient was late for her physical and canceled or didn't show up for some other appointments.

So I assume the next time that the patient for sure would have had a proper pelvic and Pap exam would have been on the visit when she had been scheduled for her physical examination in 1986.

She had been scheduled for November 15, 1986, and she came in late, and Dr. Robson apparently did a cursory exam rather than a full

physical examination, and I don't have any evidence of the cervix was examined or that a Pap was done.

Q. Okay. Between July of '85 and November of '86 how many times was she seen by Dr. Robson?

A. Between the visit we already described when she was found to have vaginitis and the date of the cursory physical at the end or the middle of November of '86, there are indications of two office visits in between, as far as I can tell.

Q. Two?

A. As far as I can tell, there is the one visit that we just discussed on the 17th of some unspecified month in 1985, and an additional visit on July 26th, 1986.

Q. What about April 19th of 1986?

A. Well, actually, I didn't know that that was an office visit. It looks like -- let's see. There is an urinalysis result, and then -- I have trouble reading it. Certainly she was treated for something, but I don't really see evidence of examination other than that her weight was taken. I don't know.

We have patients, for example, who come to my office just to drop off their urine and see

if it is clear or to see if the urine needs to be sent for culture, and they will do that without it being a full office visit or without me examining them, which we do as a service like a throat culture.

So I really don't know how much of a visit she had on that date and how much just wasn't documented in the note.

Q. All right. Well, we know she was seen in the office, though.

A. Correct.

Q. And wouldn't the standard of care require that Dr. Robson follow up on the findings of the abnormal cervix on July 18th, 1985, to follow-up on that to make sure that the cervix had returned to normal?

A. As I mentioned, and my answer is the same as what I have already said, the follow-up would be in terms of routine continuous annual Pap smears. I don't think a special visit needed to be performed to look at her cervix again, but the patient could have come back if her symptoms required her to schedule it, and that was open to her.

Q. Well, I'm not talking about a special visit.

I'm talking about the other times when she was in the office.

A. Well, when people are giving an office visit to a patient, a certain amount of time is scheduled, and at times when people are coming in for full physical or specifically for preventive care, that's when time enough when procedures like Pap smears are scheduled in.

When the patient is coming in for a specific acute problem, and a short visit of usually 15 minutes has been scheduled, there is not time to do a Pap smear and it would not be considered the usual standard of care to do one, you know, in 30 seconds while you are doing something else.

Pap smears are usually done at times of visits that are specifically set up for preventive care.

Q. How long does it take to do a Pap smear?

A. Well, to do a full pelvic exam and a Pap smear and get the patient ready, you usually should schedule about 10 minutes.

Q. Okay. And in 10 minutes you can do a full pelvic exam, look at the cervix and do the Pap smear?

A. Sure.
Q. Okay. And Dr. Robson didn't do either one, either look at the cervix or a Pap smear on any of the visits, let's just take through November of '86, isn't that true?
A. That's correct, for reasons I have already stated.
Q. Well, the reason is what, he didn't have time?
MR. DAPORE: That's not what he said.
A. That's not what I said at all. What I said is she wasn't coming in for preventive physical, and when she was scheduled in for preventive physical she came late. So, again, the time that had been allotted for it was lost and it really wasn't his fault.
Q. I see. Well, how long was she there on the 15th?
A. I don't know, but they make a specific point of it being late, and I assume that he was nice enough not to just tell her to come back another day, but tried to do as much as he could in what time was left.
Q. How long was she there on September 26th?
A. September 26th of what year?

Q. I'm sorry. July 26th of 1986.
A. I don't know.
Q. I see. And you're not even sure if April 19th was an office visit?
A. Correct. That's exactly what I'm saying.
Q. Would you agree that she was in the office that day?
A. Yes.
Q. Okay. And you don't know how long she was in the office on that visit in '85 that we can't read the date on.
A. Correct.
Q. Did the standard of care require a follow-up in one year on the abnormal findings from July of '85?
A. The standard of care would not have been based on that episode of vaginitis, which again, as I stated, did not require specific follow-up. The specific standard of care for a woman of this age would be for a pelvic exam with a Pap smear once per year, just based on her being a woman and needing normal preventive care, but, again, having no bearing on what happened on that office visit in 1985.
Q. Okay. And Dr. Robson never did a Pap smear in

1986, did he?

A. One was not done.

Q. And it's your testimony that that's her fault because she was late for the physical exam in November of 1986?

A. I'm stating that when people cancel or don't show or come late --

Q. Well, she didn't cancel or no show on November 15, 1986, did she?

MR. DAPORE: Well, we haven't gone to those dates that she did cancel.

A. She did cancel on August 25th, she did cancel on September 13th, she did not show on November 29th.

Q. Yes.

A. And she did not show on an additional date, let me see if I can find the date on the next time, because, again, my chart seems to cut off the date.

On November 29th. So on a number of occasions, no, it's hard to blame the doctor when the patient isn't there and, in fact, the doctor is left just sitting there in the chair with time which has been scheduled for the patient and the patient is not there. It is

hardly the doctor's fault.

Q. What about when the patient was there?

A. I don't know exactly how much time was given, but it's clear that a point was made stating she was late and that a full physical was not given on November 15th, and it's also clear that a couple of additional times where opportunities were given for the patient to come back for that exam to be completed -- actually just once, November 29th, it is not two separate visits, just on the bottom of one page and the top of the next.

So he made an effort to get the patient back in a very short period of time to come back for the rest of the exam, which would have included the Pap, and, again, the patient didn't come.

Q. Well, where do you see in these notes that that would have included a Pap?

A. Well, that's the definition of a physical.

Q. Well, he did a physical on the 15th, didn't he?

A. We already discussed that. No, he did not.

Q. Well, what did he do?

A. It says patient came in late and it looks like he decided to see her briefly. It looks like

the patient's weight was taken, blood pressure was taken, there was a brief discussion about headaches and some skin lesions on her ankles, and he cleaned out her ear. I don't think that that would be anything close to a full physical.

And it's clear, again, by the juxtaposition with what is stated to be a physical two weeks later that he was trying to get her back so he could do it properly,

Q. All right. What's the next time she was seen in the office?

A. The next visit is then in 1987, and I believe the date is January 10th of 1987. This was an office visit for a respiratory infection.

Q. And so he wouldn't have time to do a Pap smear and pelvic exam then, would he?

A. No.

Q. And that's why it wasn't done then?

A. It would not even have been attempted. That would not have been a visit for preventive care. That would have been an acute care visit which was given.

Q. How about on April 4th of '87, could he have done a vaginal exam and a Pap smear on that visit?

A. I don't know if that's a visit. All I see is that a medicine was prescribed.
Q. Okay. What about on April 6th, is that a visit?
A. I'm not sure. She was weighed. But I'm not sure how much of a visit it was. Certainly he talked to the patient and thought that she had a gastroenteritis, a viral infection of the gastrointestinal track.
Q. Okay. She was seen again on April 18th of '87?
A. That's correct, and that is listed as a physical. So that again would be the opportunity to do preventive care such as a Pap, and a Pap was obtained.
Q. How long was she in the office on that date?
A. Not documented.
Q. Okay. And what were the pelvic findings?
A. You may be able to read this better than I can, but I don't see a specific description of the cervix. I see it says Pap done.
Q. So he didn't even look at the cervix that day?
A. I'm sure he did. I don't think he wrote down everything he saw. I think that's what we can tell so far by his notes.
Q. There's nothing noted about him examining the cervix, is there?

A. Well, he had to have at least examined the pelvis to have done the Pap smear, but he does not note what his visual findings were.
Q. And the Pap smear came back abnormal?
A. That's correct.
Q. Now, given the fact that this Pap showed dysplasia, does that give any importance to the findings on July 18th of '85?
A. Well, the important finding is that the Pap smear of 1985 did not show dysplasia. So you would consider this a new finding.
Q. So you would just ignore the findings of July 18th of '85?
A. I don't think you would ignore them. I think you would go back and look at them and say well, we didn't see dysplasia then, but we are seeing dysplasia now.
Q. He saw an abnormal cervix then.
A. Yes.
Q. Okay. And did he ever see a normal cervix between then and -- between July of '85 and April of '87?
A. I can't tell if he did from these notes, and I don't remember reading that in his deposition. I'm not sure,

Q. Well, wouldn't that be important to document if he did?

A. In terms of dysplasia, we're --

Q. well, I am not talking about dysplasia. I'm talking about his clinical findings now.

A. Excuse me. I am going to answer the question and I'll be happy to respond.

Q. Okay.

A. In terms of dysplasia, you wouldn't necessarily be able to make a diagnosis from the appearance. That's the whole idea of trying to do a cellular diagnosis, is to pick things up before there's necessarily any kind of deep lesions. What you see would really be really nonspecific and misleading in directions of being either more or less serious than what the cell findings truly would show.

The idea of the Pap smear is to truly see what's in the cells, what they really have inside of them. So that's the reason we do them.

Q. Yes. I thought you told me before that it's important to correlate your clinical findings with the Pap smear findings?

A. Well, of course it is, in the same way that we

do physical examinations because we're looking for what we can see.

But in terms of your question about the meaning of the Pap going back to 1985, I would consider it only important as far as past records on the patient, but I would not consider the fact that there was some cervical irritation to necessarily imply that there was dysplasia at that time, and, in fact, having a Pap smear at that time that did not show any dysplasia, I would think that there was not dysplasia in 1985.

Q. Well, given the fact that you had those prior records, that prior history, and that you now have dysplasia, would that -- what would be your course of treatment then?

A. Well, the important thing would be to repeat the Pap smear after a period of about three months to find out if it was a dysplasia that was going to persist or progress or if, in fact, it was simply going to decrease or go away, which happens most of the time.

Q. Did Dr. Robson treat the problem of July 18th, 1985, whatever it was, treat it successfully?

A. He thought that he saw Monilia, according to a

wet prep, and I believe this is Monostat cream given, which would be a treatment for a superficial fungal infection.

Q. Where are you reading from?

A. It's in the note of April 18th, 1987.

Q. Okay.

A. Where it says vag inch, wet positive Monilia, RX, I believe that says Monostat cream, and then Pap done.

Q. Yes.

A. So if that's what he assumed would be the source of infection, that ought to be the correct treatment theoretically, and then he correctly stated he wanted to have the patient come back for repeat Pap, and he wrote here on the note to come back in three months.

And then when the three months came around on July 24th, the patient was supposed to come back but didn't come.

Q. I'm sorry, where did you see come back in three months?

A. It's the next note after the physical, it says 4/87, second line from the bottom, it says abnormal Pap, repeat three months.

Q. Yes.

A. So that's his plan.
Q. Right.
A. Okay.
Q. That doesn't; say he told the patient to come back in three months, does it?
A. It doesn't tell us if he told the patient. It certainly states that that was his intention, to have the patient come back. I am not sure what communication occurred with the patient.
Q. Okay.
A. Then on July 24, 1987 is when this visit was scheduled. So he must have told the patient to come back, but it says patient did not show for appointment for repeat Pap.

On July 25th, and it's not at all clear that the patient was seen, but some more Monostat cream was prescribed for the patient, and presumedly that meant the patient was still having I would assume some itching.

And then on August 8th the patient canceled and didn't come back, and then on August 22nd she came back, and the specific reason for the visit and it states in the beginning of this note, here for follow-up of cervical dysplasia.

So this was set up as a specific visit and

follow-up to that abnormal Pap smear.
Q. Okay. And I think you put in your report that it's not significant to you that the repeat Pap was done in August as opposed to July?
A. No, it isn't, but it would have been done in July if the patient had come. I don't think a difference of a few weeks would matter.
Q. Okay. Did the problem that Sherleen had on July 18th of 1985 that was causing the eroded cervix and the bleeding, was that treated? Treated to a resolution, I mean?
A. I am not sure I see anything on the April 18th visit that says eroded cervix with bleeding.
Q. Not April. July 18th of '85 I'm talking about.
A. Well, that would have been gone. That was over two years before. Specifically the implication of the April 18th visit is that I would think by deduction they didn't necessarily see that. There is no documentation that it had the same appearance that they saw in 1985, and normally a mild vaginitis in 1985 would have been gone way, way long ago.
Q. Well, there is no indication at all of what he saw on April 18th, is there?
A. He doesn't document it.

Q. In fact, between July 18th of 1985 and April 18th of 1987 there is no documentation in this chart that her cervix is normal, is there?

MR. DAPORE: There is no documentation that it is abnormal, either.

A. I was going to say that. It is simply not documented.

Q. Well, we know it was abnormal on July 18th. It is documented there.

A. July 18th --

Q. Of 1985.

A. Right, we know that much.

Q. And we know --

A. I don't think you can make a loop that it stayed persistently abnormal all the way through after that. I just don't think we can tell from those records.

Q. Well, don't we know that it was abnormal on April 18th, 1987? She had dysplasia on the Pap smear.

A. We know that she had dysplasia on the Pap smear, but we don't really have a description of the cervix.

Q. So it's okay for us to make the leap and assume that he didn't have enough time to do a Pap

smear on November of '86, but we can't make the leap that her cervix was never normal because he never documented it as normal?

A. I'm sorry, could you --

MR. DAPORE: That's argumentative. Don't answer the question.

Q. If you have two abnormal Pap smears, two consecutive abnormal Pap smears, would the standard of care require that a family practitioner refer the patient to a gynecologist?

MR. DAPORE: What degree of abnormality are you speaking of? There are multiple degrees.

A. Are you going to rephrase the question or do you want me to answer?

Q. Unless you want me to and then I will, but I am not going to respond to any of Mr. Dapore's questions.

MR. DAPORE: That wasn't a question.

A. I think I can answer.

Q. Okay.

A. I think that the original Pap you're referring to is as the original Pap is in this particular

case, which is different than just saying not specifically abnormal, if you are saying dysplasia was found once, the standard of care is to look for dysplasia on the second occasion, and if you do find dysplasia twice, yes, the patient should be referred to a gynecologist.

If there are minor inflammatory or infectious changes short of dysplasia, that doesn't necessarily require the same follow-up in three months that we've talked about for dysplasia, and the persistence of off again/on again nature for these changes, which are very common in young women, do not necessarily imply that the patient has to get referred on to a gynecologist.

And if the first Pap smear did show dysplasia, but the second one didn't, it doesn't have to read a perfect normal, I would think that there is a judgment area over which doctors have a real range of independent action over where they are comfortable in following and where they are comfortable in referring the patient on to a gynecologist in a shorter time.

If it clearly was dysplasia at the beginning and dysplasia three months later,

that's straightforward, the patient should be seen by an gynecologist.

If it is dysplasia and three months later it is perfectly normal, that is straightforward the patient is fine.

There's an area in between where there is a matter of judgment up to the individual physician, and it's left to them because what happens to the patient, there's a fail-safe built into the system, if you will continue to work with the patient and do surveillance and Pap smears over time, then if something is going on it will show up over time.

So it's a little bit up to the nature of the doctor, what they are comfortable with, whether the patient goes on now or you wait for subsequent abnormalities later.

But there's a range of judgment here, which is acceptable in clinical care, and you will find people who will disagree within that range, but as long as they are continuing to follow the patient they will all be right. As long as the patient is not lost in the system the abnormality will be found, if it's significant, because the definition of a cancerous change is

that it persists and progresses.

Q. Well, her Pap smears in this case showed progression, didn't they?

A. No, it did not. In fact, that's the point I have made in my report.

Q. Well, wait a minute. Between July of '85 and April of '87 did it show progression?

A. No, I don't think you can read that as showing progression. There is enough of a gap in-between that I think you have to take those at distant points in time.

I think the discussion has to begin with the Pap smear with dysplasia. I think that's really where you have to begin the discussion. It's the only place we have a firm abnormality, and I think you have to start there.

Q. Well, she had an abnormality in July of '85, she had an abnormal cervix and she had abnormal cells in the Pap result, didn't she?

A. As I mentioned to you, there was some dysplasia syndrome.

("NO" per change?)

Q. So if the next Pap smear shows dysplasia, isn't that a progression?

A. No. We are talking about the first Pap smear showing dysplasia and then the follow-up Pap

smear three months after that as being the critical sequence.

Q. Well, that's what you're talking about, but that's not what I'm talking about.

MR. DAPORE: Well, he's giving you his interpretation and his opinion on that, and that's what he is going to testify to. If you don't like it, that's tough.

MR. MELLINO: It's not a question of liking it or not, all right?

Are you done testifying or do you want him to answer?

MR. DAPORE: I am not testifying about anything. I am just telling you.

MR. MELLINO: Yes, you are.

A. I have tried to answer your question. I think I have.

Q. Well, see, I don't think you have. That's why I was going over it again.

I want you to focus on the two Pap smears between the July of '85 one and the April of '87 one.

A. I can't interpret that as a progression.

Q. Well, isn't abnormal or let me use the term that Dr. Robson did, inflammatory cell changes I

think it is, isn't going from there to dysplasia a progression?

A. No. As I have actually tried to explain, many of the inflammatory infectious changes are quite trivial, and they certainly are not on a continuum leading up to cancer.

Q. What if you have a patient that you -- that's come into your practice with a prior history of Pap smear that showed abnormal cells and that's all you knew, and you did a Pap smear and it read dysplasia, what would you do with that patient?

A. The first thing **I** would do is get ahold of the past records and then, again, if I wasn't sure what that meant by abnormal cells **I** would get in touch with the laboratory to find out if they meant dysplasia, and then if, again, I had two Pap smears showing dysplasia **I** would go back to the general rule, which we've already discussed, the patient then should be seen by a gynecologist.

Q. Okay. That's standard of care?

A. Yes.

Q. Okay. Did you get ahold **of** the Pap smear report from '85 in this case?

A. No.

Q. Do you think it would be important to know what that report said?

MR. DAPORE: Well, for the record, what is written in the chart on the lab flow sheet is what the report stated, that's been the testimony of Dr. Robson, and it is written down by his nurse word for word as it comes off the Pap smear report.

A, I would certainly think that if there is any other additional information that wasn't supplied to me I would be happy to see it and, of course, the more information you have on the Pap it would be useful.

The conclusions that I reached are based on the Pap report which is listed on the flow sheet.

Q. Would it make any difference to you if the time between the readings of inflammatory cell changes and dysplasia were three months apart as opposed to 23 months in this case?

A. Not necessarily, because, again, they are almost in two different spectra of abnormalities. One would be like an infection you didn't

eradicate. The other is where you're talking about cell changes that are going to lead possibly into cancer. They are really separate spectra.

So it wouldn't necessarily be more helpful to me than having them as far apart as we found in this case.

Q. Doesn't cancer start out as an inflammatory process, cervical cancer?

A. Not always. And certainly there's concern that some viruses eventually lead as a trigger into cancer.

Other things can also lead to triggers into cancer, but that's not a continuous persistent state of infection. That's an intracellular trigger that is working on the DNA within the cells over a period **of** many years, and you probably would not be able to see it from the outside.

Q. Well, what if you had a Pap that showed inflammatory cell changes?

A. We've talked about that several times. Those are, again, are considered "not" pre-cancer changes edysplasia, for example. Those are simply what they mean, they are inflammatory.

Q. Well, could they be predysplasia?
A. I would think the first changes of dysplasia are dysplasia.
Q. What's atypia?
A. That's a good question. Atypia is a term that simply, I would think, defines some nonspecific abnormality. It's hard to know exactly what that does mean.
Q. Okay. So it's your testimony, if I understand it, that in terms of diagnosing cervical cancer, the only Pap findings that are important are dysplasia or greater -- in other words -- well, dysplasia, carcinoma in situ and invasive cancer?
A. Yes,
Q. But any finding of cell changes less than dysplasia aren't important to you in terms of diagnosing cervical cancer or cervical cancer in its precancerous state?
A. I would say they could represent a problem in their own right, but that's right, they would not help me lead to a diagnosis of cancer of the cervix.
Q. And if you were treating a patient you wouldn't correlate those findings in order to or they

wouldn't affect your treatment of the patient if you had those findings in conjunction with the finding of dysplasia?

A. I want to make sure I understand your question.

Q. Okay.

A. You're asking if I found dysplasia and cervical erosions and bleeding?

Q. No. Let me rephrase the question.

A. Okay. Fine.

Q. It wasn't asked very well.

You would treat any findings less than dysplasia, such as inflammatory cell changes or atypia or something of that nature, as a separate entity from dysplasia and other findings that -- that's not a very good way to ask it either.

Let's just deal specifically with the finding of inflammatory cell changes. You treat that as a separate entity from dysplasia, would that be fair?

A. I believe that would be fair.

Q. Okay. Would the same be true of a finding of atypia?

A. Atypia is hard because it's not precise. The most important point in atypia to me would be

that it wouldn't seem to meet the criteria for dysplasia. I would think if a pathologist saw dysplasia they would call it and say dysplasia.

So I would think what they're saying is it is not completely normal, but it's not dysplasia, and so it's in some kind of nonspecific low grade area.

Q. So anything that doesn't meet the criteria of dysplasia you would treat as a separate disease entity?

A. I'm not a pathologist, but as a treating physician receiving reports, that's how I would have to use the information given. If I am told dysplasia I know what to do, and until that point I would believe that I am dealing with innocent phenomena.

Q. Even if you had a subsequent Pap that showed dysplasia?

A. The first Pap of concern would be the one with the dysplasia.

Q. And the fact that you had a previous Pap that showed some kind of abnormality less than dysplasia wouldn't raise any red flags to you?

A. None.

MR. DAPORE: How many more times

are you going to ask him that question, Chris?

A. It would not raise any red flags for me.

MR. MELLINO: Since he answered it that time that would be the last time I ask it.

Is there some limit on how many times I can ask a question?

MR. DAPORE: Well, he has given you that answer four times now.

MR. MELLINO: Well, I guess I am stupid. It took me that long to understand the answer.

MR. DAPORE: I would not have said that, but --

MR. MELLINO: Well, you probably would have,

How many more times are you going to interrupt my deposition?

MR. BONEZZI: Come on, let's continue. You were 35 minutes late.

MR. MELLINO: So?

MR. BONEZZI: I don't want to be here until 7:00.

MR. MELLINO: That is not my

purpose, but I don't appreciate being interrupted.

MR. BONEZZI: I am not finished, don't interrupt me. I would appreciate if we could continue on with the deposition without the interplay that is taking place. We don't need that. *Go* ahead and get the responses.

MR. MELLINO: You're right, I don't.

Q. And do abnormal clinical cervical findings have any significance if they are found in conjunction with a Pap smear that's less than dysplasia?

A. Not necessarily, because they could be associated with, again, nonprecancerous conditions. So their importance would only be insofar as their relationship to some other inflammatory infectious process that would need treatment, but again, it wouldn't necessarily mean that you are dealing with precancerous changes.

Q. Okay. Could it, though?

A. You couldn't rule it out bsolutely, but you would have no information to think that that's

where you were headed.

Q. What if you had abnormal -- a finding of an abnormal cervix, and then which never returned to normal, and then later on you take a Pap smear again and you have a finding of dysplasia?

A. That's an interesting question. If you did have multiple views of a physical appearance that didn't change and then a series of Pap smears, and I would think you would need more than a point 1985 and a point of 1987, you would need serial versions, sure, I would think that a continuous unchanging physical appearance that then takes on a Pap smear of precancer, then you would have to say the Pap smear may have given me false information and may have been what they call a false negative. It was read as not showing cancerous changes when, in fact, cancerous things were evolving, but that, of course, is the limit of this kind of a screening test. We do the best we can with it, but it's not perfect.

Q. Okay. So at that point let's assume that you did have this abnormal cervix that was unchanged, and then a Pap smear that read dysplasia. What would you do then? What would

be the standard of care as far as treating this patient?

A. If, in fact, you could document that, I think you would have that concern, again,, that the dysplasia may have been there longer than on that first day. But I think your management would still be the same of repeating the Pap smear after a short period of time and seeing if, in fact, you are seeing persistent dysplasia.

Again, one Pap smear showing dysplasia still doesn't prove any precancer, and much of the time the follow-up, in fact, will show that those changes disappeared.

Q. All right. So the standard of care would not require referral to a gynecologist then until a second Pap, even with an abnormal cervix?

A. Again, as I stated, at that point I would think the standard of care would be -- could be to just repeat the Pap smear a few months down the line to check again for the persistence of the abnormality.

The conclusion I reached here has been based not on looking at someone having unexplained cervicitis for two years

continuously, but on getting this Pap smear that showed dysplasia. Based on the dysplasia alone, the follow-up would be the repeat Pap smear to see if dysplasia persists.

For persisting cervicitis for any reason, even if you are not dealing with a cancerous change, that would be a perfectly appropriate referral to a gynecologist just for that problem in its own right, even if there never was a cancerous problem associated with the cervix and that, again, would be a matter of judgment for the treating physician as to what point you do that, and you may make that judgment based on how severe it looks in term of abnormality or how much symptomatology it is causing for the patient.

Q. And would it still be judgment given the abnormal Pap or the Pap showing dysplasia?

A. I still think there's judgment involved, yes.

Q. What is your understanding of what the next Pap showed, the one in August?

A, The next Pap smear says source Pap smear, this is dated August 24, 1987, and then it says neoplastic exam, cell study negative. Then it says see end of this report, and at the bottom

it says neoplastic exam, atypical cervical cells are present.

So this is a Pap that says on the one hand it's negative and on the other hand that there are some atypical cervical cells. So this is a report that I would look at and say there's no dysplasia, but there still are some cells here that don't look entirely normal, but the important point is that there's no dysplasia.

Q. Okay. And so that means he wouldn't be required to refer to a gynecologist?

A, He would not be required to refer to a gynecologist.

Q. If that Pap showed dysplasia and it was reported to him as dysplasia, then he would have been required to refer the patient to a gynecologist?

A. Yes.

Q. Okay. You read Dr. Siegler's deposition?

A. I did.

Q. Okay. And what's your understanding as to what he sees on that slide?

A. According to the deposition, as they look back on it in retrospect, apparently there were more fields in more detail than ever before, there were a few cells that he would have been more

concerned about is the impression that I got from the deposition.

Beyond that, not being a pathologist myself I really can't judge what he was finding.

Q. Okay. And you believe that since it was reported back as it was that Dr. Robson had no obligation to do any follow-up for a year?

A. First of all, I would not think that Dr. Robson would have had any way to know that there was anything that could turn into cancer going on here, and 1 think, yes, he would have referred it to the importance of ongoing surveillance as you would give any woman. In other words, not say you are fine for the rest of your life but say I will see you again next year and keep checking.

It's also, as I stated in my report, my belief that if the patient had come back the next year, the next Pap smear would have shown dysplasia, and intervention would have been appropriate and required at that time, the next time she came back.

Q. And what would have been her outcome then?

A. 1 would have to honestly leave the discussion for exactly what her prognosis would be at this

point to either an oncologist or gynecologist that practices in terms of oncology of the pelvis.

I'm certain that if it would have been detected at an earlier stage than it was in 1989 that her prognosis would have been better.

Q. This is if the Pap smear hypothetically would have been taken in August of '88 or thereabouts would have showed dysplasia?

A. Sure.

Q. Okay. And your belief is that it would?

A. Yes.

Q. Do you have a belief as to what the August of '87 Pap shows?

A. The only thing I can go by as a nonpathologist is to place myself in Dr. Robson's shoes and say what would I do if this is the report that I received.

Q. Well, the only reason I asked you is because you were speculating on what was going to be a year from now, I mean a year from that Pap. So I just wondered if you had any opinion on what it was in August of '87.

A. My only opinion in '87 is what it says here, as it was reported out.

Q. Okay. Are you familiar in your practice with the disease progressing from dysplasia to normal and back to dysplasia?

MR. DAPORE: Are you asking him in his own practice?

MR. MELLINO: Well, I guess I did ask him that, yes.

A. I have not seen that in my own practice.

Q. Are you familiar with that occurring?

A. That's a issue that I would honestly have to leave to a pathologist since, again, that's a pathological process of analysis. That wouldn't be within my area of specialty.

Q. I take it since you don't have any opinion on what her prognosis would have been had this been diagnosed in '88, you don't have any opinions on what her prognosis would have been had it been diagnosed in '87, or am I wrong about that?

A. I don't have any evidence that she had cancer in 1987. So presumedly what I'm stating is that if the cancer would have been diagnosed at a point earlier than the diagnosis in 1989, at an earlier period of time, presumedly she would have been followed at an earlier stage and in a general way would have had a better prognosis, a

better probability of doing well.

But for exactly what the numbers would be, the statistics, I would have to leave that to experts that do this as their specialty.

Q. Okay. So you don't -- your opinion is that she did not have cancer in 1987?

A. That's my opinion.

Q. Okay. So she would have been treatable and curable at that time?

A. Well, again, at that time I don't have any evidence that she had cancer. So there wouldn't have been anything yet to treat.

Q. Okay. Let's say if she had dysplasia in August of '87, what would -- what would the treatment be?

A. I don't have any primary evidence from what I received here that she did.

If dysplasia had been found in August of 1987, as a theoretical, yes, I believe that could have been very easily treated.

Q. Okay. Have we pretty much talked about all of your opinions in this case? Do you have any other opinions that I haven't covered?

A. No. I think I have had a chance here to share with you all the major conclusions that I have

reached.

Q. Okay. Do you have any criticisms of any of the other doctors that were involved in this case?

A. No.

Q. Do you know Dr. MacFee?

A. Yes.

Q. How do you know him?

A. We have worked together on several shared patients. He has been the regular office gynecologist for some of my patients, and he has also seen some of my patients ultimately in gynecologic/oncology consultation, and I respect him.

Q. Do you know Dr. Murphy?

A. I don't think so.

Q. Dr. Pamela Murphy.

How about Dr. Hines?

A. No.

Q. How about Dr. Siegler?

A. No.

Q. Do you know Dr. Robson?

A. No.

Q. How about Dr. Rabin, who is a pathologist?

A, No.

Q. Did you talk to Dr. MacFee about this case at

all?
A. No.
Q. On other cases that you've acted as an expert witness in, have you ever been retained by the firm of Reminger & Reminger?
A. No.
Q. How about Kitchen, Messner & Deery?
A. No.
Q. Have you been sued before?
A. No. Although I have testified before, as I said before.

MR. MELLINO: Okay. I don't think I have any other questions of the doctor.

THE WITNESS: Thank you.

MR. BONEZZI: I have no questions.

MR. KITCHEN: Just one or two.

- - - -

CROSS-EXAMINATION OF

HADLEY MORGENSTERN-CLARREN, M.D.

BY MR. KITCHEN:

Q. I represent Mount Sinai Medical Center, and part of the materials that you reviewed included the deposition of Virginia Fogaras?
A. Yes.

Q. Reading between the deposition of Virginia Fogaras and the path report of August of 1987, do you have any opinions regarding the standard of practice of Virginia Fogaras as a cytotechnologist in this case?

A. I have no opinions about this.

Q. And I assume you have no opinions as against Mount Sinai Medical Center either?

A. Correct.

MR. KITCHEN: Thank you. I have no further questions.

MR. DAPORE: You have the right to review the transcript and sign it or waive signature.

I will supply you a copy in either event.

THE WITNESS: I think I would prefer to read it.

MR. DAPORE: Okay.

_____

HADLEY MORGENSTERN-CLARREN, M.D.

C E R T I F I C A T E

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

I, Susan M. Cebron, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named HADLEY MORGENSTERN-CLARREN, M.D., was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this 29 day of April, A.D. 1991.

Susan M. Cebron

Susan M. Cebron, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires August 16, 1993

WITNESS INDEX

University Suburban Health Center

1611 South Green Road
Cleveland, Ohio 44121

USHC Physicians, Inc

Robert B. Cameron, M D
Internal Medicine
Gastroenterology

Lawrence T. Kenr, M D
Internal Medicine
Rheumatology

Thomas J King, M D
Internal Medicine

H. Morgenstern-Clarren, M D
Internal Medicine

J. Dennis Morton, M D
Internal Medicine
Nephrology

Stephen A Rudolph, M D
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Richard A. Wiant, M D
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Emeritus

Gerald T. Kent, M.D.

Douglas J. Moore, M.D

William E. Schlesinger, M.D.

April 7, 1991

re: DOC. 322

Susan M. Cebron
Mehler and Hagestrom
1750 Midland Building
Cleveland, Ohio 44115

RE: WYNN vs. ROBSON et. al.

Dear Ms. Cebron,

I have reviewed my deposition of April 15, 1991 and request the following corrections:

E) page 18, line 21, change "isn't" to "is"

2) page 41, line 20, change "some" to "no"

3) page 45, line 23, change "are considered" to "are not considered"

I appreciate your courtesy.

Yours sincerely,

Hadley S. Morgenstern-Clarren

Hadley S. Morgenstern-Clarren, M.D.