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IN THE COURT OF COMMON PLEAS

SUMMIT COUNTY, OHIO

VICKIE MIGLORE, et al., Plaintiffs,	CASE NO. CV 99 03 0973
versus	**DEPOSITION OF**
DR. DAVID COLA, et al., Defendants.	**H. MORGENSTERN-CLARREN, MD**

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Deposition of **H. MORGENSTERN-CLARREN, M.D.**, a Witness herein, called by the Defendants for Cross-Examination pursuant to the Ohio Rules of Civil Procedure, taken before the undersigned, Christine Leisure, a Registered Professional Reporter and Notary Public in and for the State of Ohio, at the offices of 1611 South Green Road, South Euclid, Ohio, on Tuesday, October 3, 2000, at 3:20 p.m.

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APPEARANCES:

On Behalf of the Plaintiffs:

Howard D. Mishkind, Attorney at Law
Becker & Mishkind
Skylight Office Tower, Suite 660
1660 West Second Street
Cleveland, Ohio 44113

On Behalf of the Defendants:

Mark D. Frasure, Attorney at Law
Buckingham, Doolittle & Burroughs
4518 Fulton Drive, N.W.
Canton, Ohio 44718

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I N D E X

PLAINTIFF'S EXHIBITS MARKED

None

DEFENDANT'S EXHIBITS MARKED

None

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WHEREUPON,

H. MORGENSTERN-CLARREN, M.D.

after being first duly sworn, as hereinafter certified, testified as follows:

CROSS-EXAMINATION

BY MR. FRASURE:

Q. Let the Record show that the defense, Dr. Cola, is taking the discovery deposition of Dr. Hadley Morgenstern-Clarren. And we're at your office, Doctor, correct?

A. That is correct.

Q. On October 3 of this year of 2000, right?

A. Yes.

Q. Doctor, we have your C.V. here. You're board certified in internal medicine, right?

A. Yes, I am.

Q. Any other specialty you're board certified in?

A. No.

Q. All right. And you have hospital privileges at which hospitals?

A. My privileges are at the University Hospitals of Cleveland.

Q. And I take it they've never been suspended or revoked at any hospital?

A. That's correct.

Q. And you haven't had any licensure problems with the state?
A. True.
Q. Are you licensed in any other states besides Ohio?
A. No, only in Ohio.
Q. Do you have any subspecialty in nephrology or kidney?
A. I do not.
Q. Tell me about your medical-legal review, if you would, Dr. Morgenstern --

MR. MISHKIND: I'm sorry. I was going to ask you what you meant by that, but you were about to --

MR. FRASURE: That's just a preface. That's an introductory.

Q. How long have you been reviewing medical-legal cases?
A. I have reviewed medical-legal matters since 1983.
Q. Pretty much continuously since then?
A. Yes.
Q. And currently how often do you get a case in to look at approximately?
A. In the last few years I've been reviewing approximately thirty-five cases per year.

Q. Cases sent to you? That doesn't mean you give that many depositions, right?
A. Exactly.
Q. And that's been that way for the past few years?
A. That's right.
Q. What is the breakdown, if you can estimate, for plaintiff and defense?
A. Prior to the last few years it used to be pretty even, about fifty percent for each side. But in the last few years at the same time that the number of cases has increased, it also has gone more toward plaintiff. And I would say probably about seventy percent of the cases that I'm reviewing now are on the plaintiff's side.
Q. That is for the past two years?
A. Past three.
Q. Approximately how many cases have you reviewed from Mr. Mishkind or his law firm, Mr. Becker, any other members of that firm?
MR. MISHKIND: Before you answer, let me just -- I think you've asked three different questions, two lawyers in the firm.
MR. FRASURE: The whole firm.
MR. MISHKIND: As opposed to for me?
MR. FRASURE: We'll get to you.

MR. MISHKIND: That's fine.

A. I probably have reviewed about six cases for the Becker & Mishkind law firm over the last ten years.

Q. And for Mr. Mishkind; do you know?

A. This is, as far as we recall, the first time that we've worked on a case here together.

Q. All right. Doctor, what have you reviewed so far in this case?

A. The initial records which I was asked to review are here and then there are multiple additional records which keep coming in. The original records were the office records of Dr. Cola and of Dr. Spoljaric, S-p-o-l-j-a-r-i-c, which not only includes their office notes themselves, but Dr. Cola's also includes some discharge summaries and some additional hospital records interspersed.

In addition, I have read the two depositions that were taken of Vickie Miglore and the deposition of Dr. Cola and of Dr. Spoljaric. So I've had a chance to review them. Subsequent I have also received the report of Dr. Culley, C-u-l-l-e-y, the report of Dr. Zarconi, Z-a-r-c-o-n-i, some additional records from Dr.

Zarconi, a report from Dr. Hebert, H-e-b-e-r-t, a report from Dr. Perlman, P-e-r-l-m-a-n, and the report from Dr. Zizic, Z-i-z-i-c.

And just today Mr. Mishkind brought me a report from Dr. Schwarze, S-c-h-w-a-r-z-e, which quite frankly I've just received and I haven't had a chance to absorb it.

Q. Do you want to take a chance to observe it?

A. Sure.

MR. MISHKIND: Just let me indicate that the notebook that he has in front of him, when he said various portions of the record, they're discharge summaries from Akron City.

MR. FRASURE: Sure. We'll get into that.

Q. Can I look at these while you're looking at that?

A. By all means.

MR. FRASURE: Sort of the core of all the records, right?

MR. MISHKIND: Right. And in that package also is a copy of the letter, the complaint letter. It's in the back.

A. Okay.

Q. So you've read Schwarze's two-page letter?

A. Correct.

Q. And you've reviewed portions of the patient's records, but not the complete set of later records, right, after the diagnosis was made?

A. That's right. Some additional treating records we looked at together prior to the deposition, but those were not originally given to me as part of my review. I also just today was given a copy of what is essentially a typed record of Dr. Cola's notes from August, September, October of 1997, which is good, because it's --

Q. It's hard to read?

A. It's easier to read typed. And a copy of the record requisition to the patient from Dr. Cola dated August 13th, 1997.

Q. Right. So am I correct that for your opinions you don't need the whole set of subsequent records once the diagnosis of this disease was made, correct?

A. I do not need those additional records to talk about the care issues for Dr. Cola.

Q. All right. Do you plan to -- I can narrow this down and maybe we can be out of here by 4:00.

Do you plan to get into at trial any of her present conditions today and her prognosis and her future condition?

MR. MISHKIND: You're looking to me?

MR. FRASURE: Either of you.

MR. MISHKIND: Let me just qualify that I do plan on asking him in general based upon the information that he has, but I'll let Dr. Morgenstern-Clarren answer it since I'm not sworn.

Q. Let me ask you, you have not examined the patient, of course, have you?

A. That's true.

Q. You have not planned to?

A. I am not planning to.

Q. What opinions do you feel you can render in light of that about her current condition and her future condition?

A. Mr. Mishkind asked me specifically before we started today, in view of the fact that her current kidney function has at least stabilized for now at the level of about one-third normal and that she has developed renal hypertension, although treated, what my opinion would be based on those facts about her life expectancy. And the opinion that I gave him is the same that I will give to you, and that is these would cause an expected reduction in life expectancy of ten

years less than it would have been if she did not have these problems.

Q. Ten years what it would have been without this disease?

A. Correct.

Q. Why is that?

A. Because the reduction in kidney function which is still present with reasonable medical certainty will deteriorate when she is older and does make her vulnerable to additional issues.

Q. Kidney issues?

A. With her kidneys as well as systemic issues. In addition, the hypertension accelerates atherosclerosis leading to increased risks of strokes and heart problems.

Q. And is this true even if she doesn't need a kidney transplant?

A. Yes, it is.

Q. Are you going to opine on what the odds are she would need a kidney transplant?

A. I will not give any opinion about that.

Q. Fair enough. Do you intend to offer any opinions, Doctor, on what her kidney and overall condition would have been had the diagnosis been made by someone, let's say, in the fall of 1997,

the September, October range?

A. I can answer as a general medical doctor when doctors have patients with Wegener's. I can't answer of course as a nephrologist. But we know that when her blood function of her kidney, the blood tests of her kidney function were obtained in August of 1997, they were normal. With reasonable medical certainty, if the diagnosis had been made and treatment offered while the kidney function was normal, it would have remained normal.

Q. So there would have been no kidney damage; is that what you're saying?

A. Correct.

Q. Can you have the disease present in your body and have normal kidney function by blood tests?

MR. MISHKIND: The disease meaning Wegener's granulomatosis?

MR. FRASURE: Yes.

A. Yes, you can.

Q. Is it your opinion here that as of August of '97 she had that disease present in her body but yet her kidney studies were normal, the creatinine and the BUN?

A. No, that's not my opinion.

Q. Go ahead. Explain.

A. My opinion is that at that point the blood in the urine was, as far as I can tell, the first evidence with reasonable medical certainty to state that there was Wegener's in her body. She had multiple other symptoms, as we know, which as you look back, you can say possibly they were related to Wegener's or not. But I'm not stating opinions about that because I don't think one can do it with reasonable medical certainty as of the fall of 1997.

But we do know that she developed Wegener's involving her kidney leading to renal failure requiring dialysis. The blood is the classical finding in Wegener's of the kidney. It's a continuum to me. It's not like blood was present from one thing in August of 1997, and then Wegener's was found sometime in 1998. To me that is the objective first finding even at that time, though kidney function as a global unit was still normal.

Q. Are you familiar with what percentage of Wegener's patients have a positive protein early on?

A. I'm not familiar with that percentage.

Q. Can we agree that most Wegener's patients have positive protein in their urine?

MR. MISHKIND: Objection. If you know.

A. I do not have an opinion about that.

Q. Is that outside of your area? Is that the reason?

A. With reasonable medical certainty, I can't give you any specific answer about what percentage of protein, either a majority or minority.

Q. That's all I'm asking. Do a majority of patients with that disease have protein in their urine?

MR. MISHKIND: Let me just object. I'm not sure you're stating at what stage in the disease and I'm not sure that -- I think the doctor has already answered the question.

A. I'm not going to have an opinion about the protein in the urine.

Q. And even at the stage when blood, let's say, is present in the urine as a result of the disease, do you have any opinion on what percentage of those patients would you expect to have protein at the same time in the urine?

A. No, I would not have an opinion.

Q. Let me ask you your experience then with this

disease, Doctor, and let me step back even further. Glomerulonephritis, is that more general? Is that a broader term than Wegener's or is Wegener's broader?

A. Wegener's is broader.

Q. To have Wegener's, you have to have glomerulonephritis at some point?

A. No.

Q. You don't?

A. Wegener's is a necrotizing vasculitis that can involve multiple different organs, either singly or in some combination, within your body.

Q. Not necessarily kidneys?

A. Most but not all patients have involvement of the kidney. And there's variable amounts of involvement of the kidney and different ways that that can present.

Q. If it involves the kidneys, that is Wegener's, will the patient have glomerulonephritis?

A. Not always.

Q. How many patients would you estimate over the years that you've treated before the diagnosis of Wegener's was made, and then the diagnosis was made either by you or some specialist that you've sent the patient to? Can you estimate for me?

A. Can you repeat the question, please?
Q. Yes. Over your practice -- and that goes back how long?
A. Twenty-one years.
Q. In twenty-one years, can you estimate how many patients that you've had who, when they were with you initially didn't have Wegener's as far as you know, but at some point developed it, and you either picked it up yourself or it was picked up because the patient went on to another specialist and they were still your patient at the time and it was discovered?
A. I've had one of my own patients in the time I've been in practice. The other patient I had on my service. It was on the staff service. They were already admitted to my service at University Hospital, were already systemically ill and we made the diagnosis. But it had not been one of my own patients that I had followed when they were well and subsequently into their becoming ill.
Q. So by one, can we include even those that have come to you as a doctor already diagnosed with Wegener's? Would that include that one, too, or would that be more?

A. There may have been somebody else who has had Wegener's, but I don't recall them. I think those are the only two that are coming to mind at all.
Q. So we can agree it's a pretty rare condition in internal medicine and family practice?
A. I agree.
Q. We have your report, of course, in two parts.
A. Yes.
Q. February 1 concerns mostly I think Dr. Cola?
A. Yes.
Q. Would I be correct to say then that from reading this, that chronologically now your first standard of care criticism of Dr. Cola concerns the August 13th visit and the blood in the urine?
A. I agree.
Q. Knowing that family practitioners and general practitioners have different ways of doing the same thing, I want to ask you if something is still within the standard of care even though you may not do it that precise way. Do you follow me?

MR. MISHKIND: Let me object to the form of the question.

MR. FRASURE: Come on. He can handle

himself.

MR. MISHKIND: You've made a statement about doctors having different ways of doing it, and legally I'm not sure that you've made an accurate statement. My objection is noted but the doctor can go ahead and answer.

A. Can I answer?

Q. Well, we're not to the question yet. But do you know what I mean?

A. Actually I was going to say I have to disagree with you, because at least for medical problems for adult patients, the standard of care for a general internist, a family practitioner and a general practitioner is the same.

Q. I understand that, but my point is -- and I'm not to the given question yet. But on a given question there might be, depending on the issue, more than one way of handling something and still be within the standard of care, right?

A. There can be, but it would not be a difference between our specialty training.

Q. That wasn't what I was getting to. I understand what you're saying. Where I want to go is the urine dipstick. Did the standard of care require Dr. Cola on the 13th to get a urine on the

patient or not based upon the symptoms?
A. The standard of care did not require it on August 13th, although it did require that it be done.
Q. It did require that it be done --
A. That it be followed and repeated.
Q. Now, if he's going to get a urine initially on the 13th, does it have to be within the standard of care sent to the lab, or can you do urine dipstick on the initial urine? That's what I want to start with.
A. You can do it on the initial urine.
Q. In the office?
A. You could.
Q. Does your office ever do that?
A. Yes.
Q. Now, then we know that it was plus 3 on the blood, right?
A. We do.
Q. Not a 4; am I correct?
A. Yes.
Q. Do you accept that there was no protein by dipstick?
A. I certainly accept that there was no protein by dipstick.
Q. Right. Is dipstick sensitive for protein? Has

that been your experience?

A. There are more accurate tests that could be done and you can also do a quantitative measurement of the total amount of protein in a 24-hour urine collection. But in general, yes, it's generally sensitive.

Q. When you do dipsticks here in your office and you're looking for protein and you don't find it, do you sometimes stop at that point?

A. Yes.

Q. So he does the dipstick, plus for blood. In a woman am I correct that most of the time -- not all the time, but most of the time that will be a benign and/or urinary tract condition?

A. Again, I have to disagree with you because that depends a little bit on the context. The reason it is frequently common in women as a benign finding is because they're having a menstrual period -- we know this patient didn't -- or because they're having a bladder infection. But we know this woman didn't because the leukocyte test was negative. So if you're saying it's not a period and it's not an infection, then blood in the urine is not benign and is not common and demands an explanation.

Q. Let me follow up on that, if I may. There were negative leukocytes in the white blood count, right?
A. Yes, in the dipstick.
Q. Does that rule out urinary tract infection?
A. It makes it unlikely but it does not absolutely rule it out.
Q. Of course at the time Dr. Cola gets the dipstick with the blood, microscopic blood, he doesn't know yet that the leukocytes will be negative, right?
A. It's the same dipstick according to the --
Q. Oh, I see. I thought you meant based on the later blood work.
A. No, I'm talking about right on the same urine test.
Q. I follow you.
A. So it should be the same information at the same time.
Q. So that should tell him that a urinary tract infection is unlikely --
A. Exactly.
Q. -- and that it's something else? And that something else may be benign or not benign, right?

A. Well, actually most of the things that cause blood when they're not a simple bladder infection or a menstrual period are -- it's blood, so that's not benign. That could be cancer, that could be a polyp, it could be some other inflammatory condition within the urinary tract, it could be a kidney stone. It could still be an infection even with the negative leukocytes, either bacterial or tuberculosis, and it could be vasculitis. So it's actually a nasty list. It's not a benign list.

Q. There's some benign conditions on there?

A. That is actually a serious list, you know. And if you find -- if you're lucky enough to find a benign explanation, that's terrific. But this is a serious list.

Q. And the other laboratory work that Dr. Cola ordered on the 13th, the chem panel, the chemistry panel, was that appropriate to order what he did order?

A. Yes.

Q. The ultrasound of the abdomen that he ordered, was that appropriate?

A. Yes, it was.

Q. Would you agree then that the tests that he

ordered that day or did that day were appropriate?

A. Yes, and I said as much in my report.

Q. And that no further tests, except the follow-up on the urine, needed to be done at that point or needed to be ordered at that point on the 13th, correct?

A. Right. He did some things that were necessary and I agree that those were totally appropriate. But the repeat of that urine was critical and was not done.

Q. We'll get to that. Now, the blood work came back and the kidneys were okay, right, per the blood work?

A. Yes.

Q. We had two elevations on the liver functions?

A. Correct.

Q. And she had elevations a couple years before that in the same area, hadn't she?

A. I agree.

Q. Her sedimentation rate was normal, I believe.

MR. MISHKIND: Are you talking on the 13th?

MR. FRASURE: 13th of August or whenever the blood work was.

MR. MISHKIND: Here's a copy, Doctor.

THE WITNESS: Thank you.

A. Yes. Thank you for showing this to me, because I did not recall him doing the sedimentation rate and I don't see one on this sheet.

Q. I thought he had.

MR. MISHKIND: Those are the Barberton Citizens Hospital records and they do not reflect a sed rate having been done.

MR. FRASURE: I know Dr. Spoljaric did one.

MR. MISHKIND: Right. His was elevated.

A. It was elevated.

Q. Yes, I know. Well, let's assume there isn't one. Does the standard of care require him to have ordered one on the 13th?

A. No.

Q. All right. When Dr. Cola gets back the blood work showing two positives there for liver, he needs to repeat those, doesn't he, or not?

A. There are many ways that could be handled.

Q. What is the standard of care?

A. Since there was some abnormality in the past -- well, one way was the abdominal CT, which was

already ordered. One of the things that would include would be an image of the liver and the biliary tract draining from the liver. So that would be an important test right there.

And then having ruled out anything really frightening in the visual appearance of the liver in that scan, then you could follow up on those liver tests in many ways, follow them over time, send the patient to a liver specialist. There would be options.

Q. But sending the patient to a liver specialist wouldn't be required? In other words, the general practitioner could follow it for a while, at least?

A. I agree.

Q. Do serial tests?

A. Yes.

Q. Four to six to eight weeks apart, something like that?

A. That would be fine.

Q. When you do urine dipstick in the office, do you sometimes not have the results until after the patient has left?

A. Well, usually the reason I do a quick dipstick is because I've got the patient sitting there. So

in my own practice that situation wouldn't arise, because specifically I want something that they can do literally immediately and get a quick direction for me as to what way to go. It's frequent that a full urine analysis which includes microscopic examination will come to me after the patient has left.

Q. Come to you from the office?

A. From the lab up here or from the lab downstairs. That's common. But a dipstick, commonly I ask for that as a quick test while the patient is sitting there.

Q. So that you have the results?

A. Yes.

Q. Okay. Is it below the standard of care for Dr. Cola to have had the results after the patient had left but still the same day?

MR. MISHKIND: Let me object because you're asking him a hypothetical that I don't believe is consistent with Dr. Cola's testimony. You can go ahead and answer the question.

A. I also admit I don't know exactly when that day he became aware of this.

Q. Did you --

MR. MISHKIND: He's in the middle of

answering the question.

THE WITNESS: No, I'm finished.

MR. MISHKIND: It looked like your lips were about to move.

Q. Let's assume that he did not know the results until sometime after the patient has left but it's still the same day. Is that in and of itself below the standard of care that he doesn't know the results until the patient is gone that day?

A. In and of itself that is not below the standard of care.

Q. Because it's not something that has to be addressed that very second, right?

MR. MISHKIND: Objection.

A. Well, that's not the reason. It actually is a very important finding, as I stated, and it does have to be addressed I think promptly. It simply isn't something that you have to address the minute that the patient is sitting there with you.

Q. That's what I was getting to. You've read Mrs. Miglore's deposition, right, both parts?

A. Yes.

Q. What is your understanding from her deposition of

what she learned from Dr. Cola's office at some time later in August, the last portion of August, about what they wanted her to do?

A. Actually I recall from her deposition that she was very frustrated and confused and she had tried several times to communicate with the office and she wasn't getting calls back. From what I recall, she was never told about the blood in the urine.

Q. All right. Are you assuming that she was told that the doctor wanted to see her again and come into the office?

A. I do not recall reading that in her deposition.

Q. Were you aware that she knew some tests were positive and the doctor wanted to do some more tests?

A. Let me go back and take a look as to her recollection. I'll be quick.

Q. It's the second part of the deposition. It's not the first part. I think it's the 65 to 75 range, somewhere in there.

MR. MISHKIND: Page 63, if you look at that, Doctor.

A. Well, perhaps you can help me, because this reflects my memory, which is she was having

trouble getting information and was trying to request his calling her back and he didn't. She was very confused as to what was found or what she was supposed to do.

Q. Top of 63, line 8, among some other things, she said that she knew that he wanted to see her again. Page 63, line 8.

A. It does say that.

Q. And that the doctor was a little concerned. She had mentioned hearing that from the staff person, line 5.

A. It does say that.

Q. And I agree, it goes on, she says that she wanted to talk to the doctor by phone.

A. But I don't see anything that states that she was told specifically what was wrong or given any information about it.

Q. No, she does not say that in her deposition, I don't think. I think she said he wanted some more blood work at page 70, line 12.

A. Yes, it does say that, too. I agree.

Q. All right. Now, you mentioned in your report the standard of care required repeat urinalysis within two weeks?

A. Yes.

Q. Two weeks of the 13th of August, correct?
A. Yes.
Q. If it had been done, let's say, at six weeks, do you have an opinion based upon reasonable medical probability what difference in the outcome would have been -- would have resulted, if any, as a result of four more weeks?
MR. MISHKIND: Let me just object to the question because it assumes that that would have been the specific test that we're talking about. I think we're confusing tests as to what he planned on doing in six weeks. But be that as it may, you can answer.
A. There should have been arrangements for her to come in for a complete urinalysis and additional tests actually as soon as Dr. Cola knew it was abnormal. And I've tried to be as fair to Dr. Cola as I possibly could be by giving him two weeks as an absolute limit.
Q. But if you add four more to the two to get six, can you say what difference --
A. I can. First it's a breach in the standard of care for a general medical doctor, you know, not to do it in a timely fashion. The blood can represent a serious condition as we've discussed.

We don't know what. In actual fact, I don't think I can state with reasonable medical certainty that a delay of four weeks beyond that would have actually resulted in Mrs. Miglore's case in any additional damage or problems because I don't know the exact time in which her kidney function would have started to become impaired.

Q. Fair enough. If hypothetically the BUN and/or creatinine had been significantly abnormal, which it wasn't --

A. Correct.

Q. -- but hypothetically and keeping everything else the same, what would that have added to the situation?

A. Two things. Number one, you would know there already is a kidney problem, so it would become, you know, obvious that you have to get investigations going as to what is going on in these kidneys. So that certainly would be an obvious situation.

Number two, viewed the other way, you would also know you already were too late to prevent kidney damage. This is a situation where you've got a kidney problem but you don't have damaged kidney function yet, which gives you the

opportunity to grab the situation, make the diagnosis, and start treatment before there's kidney damage. So the delay in getting started is the sacrifice of that opportunity.

Q. Now, we know that she went to two other physicians in the fall of '97. Dr. Torok, T-o-r-o-k, I think he's an orthopaedist.

A. Yes, that's my understanding.

Q. And Dr. Schirak, S-c-h-i-r-a-k, a gastroenterologist --

A. Yes.

Q. -- to whom she had been at different times in the past.

A. Yes.

Q. Is that your understanding?

A. Yes.

Q. And you've reviewed their notes, have you?

A. I reviewed whatever communication they've had with Dr. Cola.

Q. Do you see any communication that Dr. Cola got from either of those doctors in the fall of '97?

MR. MISHKIND: I think the communication is in Dr. Spoljaric's records.

(A discussion was had off the Record.)

A. I don't find a letter.

Q. Right. My question concerned in Dr. Cola's chart we see no letter or communication back from Dr. Schirak to Dr. Cola in the fall of '97, correct?
A. I agree with you.
Q. And the same with respect to Dr. Torok back to Dr. Cola?
A. Right. I've just reviewed Dr. Cola's records. I agree with you.
Q. Did you see that in one of those records, either Torok or Schirak or both, that in the early fall of '97 the patient was talking about going to Dr. Spoljaric as her new primary physician, that she wanted to go or was going to go to him?
A. I do not recall that.
Q. Do you find that unusual that Dr. Cola, if he's really still her primary care physician in September and October, did not get a report back from this referral by either of those doctors?
MR. MISHKIND: Let me just object. You're saying September and October and lumping them together. I think the reference is October 24th, Dr. Schirak.
MR. FRASURE: That's Schirak. Dr. Torok is September.
A. I don't have enough information to know if it's

unusual or not, because I don't know of the patterns of communication that these physicians had for communicating with each other.

Q. Are you under any plan in which you have to refer the patient to a specialist in order for that to be covered by the patient's insurance?

A. Yes, frequently.

Q. If you approve a referral to another doctor, a specialist, do you typically get back some type of report from the specialist after he or she is done?

A. Typically, yes.

Q. Is it your understanding that neither Dr. Schirak or Dr. Torok are primary care physicians?

A. I'm agreeing.

Q. Now, we have a primary care physician, Dr. Cola, through his office -- am I correct, is your understanding from Ms. Miglore's deposition -- telling her that he wants to see her in about six weeks, and that he wants to run some more studies, run some more tests?

MR. MISHKIND: I'm sorry. You're basing that on what?

MR. FRASURE: Mrs. Miglore's testimony.

A. I did not see that in Mrs. Miglore's testimony. Mrs. Miglore's testimony in her deposition, which we just looked at together, said that Dr. Cola did not speak with her and that the office said they wanted her to come back at some point and to do blood tests.

Q. I said through his office, not directly. But through his office she knew as of August, late August, a couple of things. First, she knew that he was concerned about her condition, secondly, that she was to come back and see him in about six weeks and, thirdly, he wanted to run some more tests?

MR. MISHKIND: I'm going to object to that because you're giving him a hypothetical which is not supported by the facts. But you can go ahead and answer.

A. I have to hear that as a hypothetical because, again, I don't see in the deposition where it says come back in six weeks. And moreover, I have to tell you from my own experience that if a doctor is concerned about a patient, just passing on a message like that through your staff does not convey concern.

Q. That does not convey concern?

A. No, it does not.
Q. That he wants to see you in six weeks and he wants to repeat some studies?
A. If you're concerned about the patient, you contact the patient and you return their call.
Q. At page 63 at the top -- I thought we went over this -- she said the doctor was a little concerned, he wanted to see me again.
MR. MISHKIND: Let me and let him get to the depo just so we're not --
MR. FRASURE: Okay. In the first part of 63.
MR. MISHKIND: Hold on one second, please.
A. Yes, we're actually saying the same things again. Specifically he wouldn't talk to her, but someone in the staff said the doctor was a little concerned and did want her to come back. I mean there's nothing about that that sounds very dramatic.
Q. Well, on page 70, line 12, they said he wanted to get some more blood work and I said that I wanted to speak with Dr. Cola because the symptoms were worse.
A. Yes.

Q. And the next answer was I think they said that he wanted to have it within the next six weeks. Okay?
A. But she doesn't agree with that. She says she agreed that they did want to get some more blood work.
Q. Within the next six weeks?
A. I don't know if she agreed with that from the way it's answered here, Mr. Frasure.
Q. I'm just asking you whether it was your understanding she was told by the doctor's office what they wanted. I'm not asking you if she liked that or whether she agreed to it or whether she wanted to do it differently. Just that she was told at least those three things, maybe more or maybe less, that he's a little concerned --
A. Yes.
Q. -- he wants to see her again in about six weeks and he wants to repeat some blood work?
A. Now, it says that she agreed that she thought they said they wanted to have the blood work within six weeks. I'm not sure I see where it says they wanted her to have an office visit in six weeks. So if I'm missing that, if you can show that to me I'll be happy to agree with you.

But I just can't find that.
Q. Fair enough. Back to 63 then, if you would, line 8, he did want to see me again?
A. Yes, I agreed with that.
Q. So he wanted to see me again, he wanted to get some more blood work, and he was a little concerned, right?
A. With those three facts. And it's not clear exactly when he wanted to see her again, but I'm agreeing that at least she thought she recalled that someone in the staff said he wanted the blood work within six weeks.
Q. Okay. We're close enough.
A. Okay.
Q. She does not see a primary care doctor within six weeks. In fact, she doesn't see a primary care doctor for three more months, does she, late December of '97?
A. True.
Q. Now, you mentioned in your report -- I think I'm almost done here -- that he fell below the standard of care by failing to repeat the urine test for blood and by failing to provide the appropriate consultations, which would have resulted in diagnosis and treatment of the

disease.

If he had repeated the blood within the time frame you believe he should, is it your opinion that more than likely it would have been positive again for blood?

A. That is my opinion.

Q. And that would in appropriate care have led to what?

A. That would have led to referral to a urologist and nephrologist, a kidney specialist.

Q. To both or --

A. Well, you probably would start with one and, if necessary, go to the other. For example, normally you would start with the urologist. And if the urologist found it, you would be there. And if the urologist didn't, you wouldn't stop there, you would go to the nephrologist.

Q. So you've gone to urologists frequently, right, with unexplained hematuria?

A. That's the appropriate referral.

Q. Do you have any opinion more likely than not what the urologist would have done by way of testing? We've got two positive bloods now in the urine.

A. Not completely. Conventionally what urologists will do in the situation is do a direct look

inside the bladder, a cystoscopy, and they will do some imaging tests to the kidney. It could be an IVP, it could be a CAT scan or ultrasound. There are lots of different ways that they can do it. And beyond that, I would honestly have to defer to them as to what to do in this situation.

Q. Do you have an opinion on probability now whether the cystoscopy, if done, looking back in retrospect now, would have been positive to suggest this disease or to lead to this disease or not?

A. I honestly have no opinion.

Q. And same way on the imaging studies?

A. Similarly, I truly have no opinion about that.

Q. And are you saying that if hypothetically the urologist doesn't find the Wegener's or the kidney disease and tells you that, that he has no explanation, you would then as an internist have gone to a nephrologist?

A. Exactly.

Q. What time period are we talking about here? Within your standard of care, if Dr. Cola repeats this within two weeks, it's positive, how soon does he have to get her to a urologist approximately?

A. Working with just sort of normal speed, not any excessive speed, you're talking about the fall of 1997, we're talking about --

Q. A couple of more weeks?

A. August, September, into early October, probably over a period of within I would think about six, eight weeks at most, you would have had all of these tests and complete evaluations done by the specialists, and with reasonable medical certainty leading to a diagnosis of Wegener's involving the kidney.

Q. Six to eight weeks after the initial visit or the visit of August 13th; is that --

A. Exactly.

Q. I've got you.

A. And that's conservative. You could do it much faster, but I'm really trying to be as fair as I can be.

Q. If the nephrologist caught it, do you have an opinion on how he or she would have caught it, what tests, how the diagnosis would have been made within the standard of care?

A. Presumably it would have been a combination of the ANCA test and with or without biopsy of the kidney.

Q. Based on what you told me earlier, just to be sure I understand, have you had the one patient you recall that went through this type of route that led to an ANCA test or a biopsy being positive?

A. The patient that I had actually came in with a pulmonary presentation and it was a lung biopsy and the ANCA that led to the diagnosis. The patient that we had in the hospital actually had minimal kidney involvement. It was really heart and lung, as well as sinus involvement.

Q. I see.

A. And we had the ANCA and lung tissue again made the diagnosis.

Q. Done by which specialist?

A. Pulmonary.

Q. Okay. You referred the patient first to a pulmonary --

A. It was a patient who actually had unexplained infiltrates in her lungs and the Wegener's actually was a surprising finding.

Q. Fair enough. You mentioned the pulmonary manifestation or involvement of Wegener's. Are you saying here -- and I don't think you are, but just for clarification -- that as of August 13

there was a reason for Dr. Cola to think there was pulmonary involvement of her lungs?

A. At that time, no.

Q. Okay. Do you think we've covered your opinions regarding Dr. Cola's care?

MR. MISHKIND: Let me object because it's an awfully broad question. And I'm certainly not going to be -- if you're going to leave it at that, I'm not going to guarantee you that I'm not going to ask him specifics as it relates to the opinions that he has in this case or that he's authored or anything that is relevant to those opinions.

MR. FRASURE: I think the Rules of Civil Procedure -- and I think it's Rule 36 -- says the purpose of a discovery deposition is to find out the doctor's opinions and those that he will express at trial.

Q. So I'm not trying to trick you and I know one can't predict the future necessarily exactly what is going to be asked. But we've talked about the blood work, what he should have done, what that would have led to, your opinions on what difference, if any, it made. Anything else where you see Dr. Cola fell below the standard of care?

A. Yes.
Q. Okay.
A. And these are related to the opinion I've given here, but just to flush it out a little bit. In addition to Dr. Cola having the duty to repeat the urinalysis to confirm the presence of blood and then initiate these consultations as we've described, Dr. Cola also had the duty to inform Mrs. Miglore that there was blood in her urine. The patient has a right to know that they've got an abnormality.
Q. And this is separate from repeating it within two weeks?
A. Yes, she should have known that it was being tested for and what they found. And especially at the time that she left Dr. Cola's practice, she left without knowing that there was this important issue which had not been worked up and she didn't know that she needed to get someone else to do it.

In the same vein, when Dr. Spoljaric assumed her care from Dr. Cola, Dr. Cola had not reconfirmed the presence of the blood. He did send on the records as he was requested to do, but he should have specifically communicated

somehow to Dr. Spoljaric -- this could have been by a note, a circle, as well as by a phone call or some direct communication to Dr. Spoljaric -- by the way, you need to check this, this is the issue I intended to do but we didn't get it done, but there's blood in the urine when I saw her in August, so that needs to be re-checked.

What happened, because Dr. Cola didn't specifically flag this for the patient and for the new doctor, is that they both came into the situation almost guaranteed to fail because they didn't know that there was a specific issue from the previous treating physician that now they're left with the job of managing. So those are important criticisms.

Also related -- and these go back just to the follow-up in August of 1997. We talked about the communication between Mrs. Miglore and Dr. Cola and Dr. Cola's office when there was the telephone communication on August 27, 1997. I mean this clearly wasn't just an issue of blood in the urine. She was sick and she was calling and wanting to talk to the doctor. She should have been given an appointment at that time to come back in for a re-evaluation.

As a general statement, when a patient calls the doctor and says I want to discuss this with the doctor, the doctor should have called her back. In this situation Dr. Cola should have called Mrs. Miglore back and returned her phone call. She was very concerned and he didn't call her back. He should have done that. Those are all of my opinions.

Q. Are you saying that based on the symptoms reported on the phone call to the staff of the 27th, that that should in and of itself have led to a re-appointment?

A. It is.

Q. What specifically can you point to there that you say that --

A. The entirety of it. It takes about a quarter of a page just to get out all of her complaints. And she thought that she was having multiple complaints that were -- some of which were new that needed to be evaluated.

Q. Now, you mentioned that it was almost destined to fail when the patient starts with Dr. Spoljaric and the patient hasn't been told of the blood, nor has Dr. Spoljaric had that flagged to him. Am I fairly paraphrasing your statement?

A. Yes.
Q. But you did go on and criticize in one of your reports Dr. Spoljaric for not picking up on this in the records, right?
A. Yes. It is my opinion, as I stated in my other report, that Dr. Spoljaric had an independent duty, --
Q. To pick that up?
A. -- regardless of what he had been given by Dr. Cola or the patient, to get the old records and really just to look at the last office visit to see what had been done before the patient came to him. Right on the side panel it's got the 3 plus blood. It just jumps right off the page at you.
Q. So it's not a matter of Dr. Spoljaric has to study the records going back years, but the last visit he would have seen it?
A. Exactly.
Q. And if he would have seen that and followed up, are you going to express an opinion either way based on probability what difference that would have made if the diagnosis had been made, for example, in January, mid to late January?
A. That would have been good because that would have again allowed involvement before she went into

ultimate kidney failure and before she went into respiratory failure and got so desperately ill. But I can't give an opinion exactly of what the delay of those three months would have made.

Q. All right. Let me check my notes here. I think we're probably done.

Have you spoken to any of the physicians involved in the patient's care or any of these experts whose reports you mentioned?

A. I have not.

Q. Do you know, for example, Dr. Zizic, of him?

A. No.

Q. Have you done any research specifically for this case, Doctor?

A. No, my opinions are based on my own training and experience. I did look in my old Harrison's textbook, as I always do.

Q. What did you find helpful there? Anything?

A. No, it's consistent with what I've always been trained in, particularly under the finding of isolated blood in the urine, the list of serious conditions that it can mean.

Q. I noticed Dr. Spoljaric got a chest x-ray. I can't remember if it was the first or second visit. Do you remember that?

A. Yes.
Q. And I think it was normal. Is that your understanding?
A. I agree.
Q. Does that give us any lead on whether she had Wegener's or not at that point?
A. Unfortunately it doesn't because, again, it can go from organ to organ. Certainly it would be suggestive that there was no involvement of the lung as of the time that that x-ray was taken, which was December 31st, 1997.
Q. And one other question of what Dr. Spoljaric found. He found the significantly increased sed rate, right? Do you agree? I think it was 51.
A. I agree with that.
Q. That's fairly high?
A. It is.
Q. And prospectively looking at it then, can you tell what that should have led Dr. Spoljaric just in that alone to have done or to not have done?
A. As an isolated finding, no.
Q. I just wanted to ask you your charges for review and then coming to trial and depositions.
A. It's all the same. I charge $275 per hour.
Q. Door-to-door pretty much?

A. Pretty much.
Q. For the time at trial?
A. Yes.
Q. Fair enough. I'm looking for one other thing here and I don't think I brought it.

MR. MISHKIND: Can I help you with anything?

MR. FRASURE: No, it's my notes. That's all.

THE WITNESS: Thank you very much.

(Whereupon, signature was not waived by the witness.)

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(Deposition concluded at 4:20 p.m.)

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WITNESS CERTIFICATE

I, H. Morgenstern-Clarren, M.D., do hereby certify that I have read the foregoing deposition taken on October 4, 2000, in the case of Vickie Miglore, et al. versus Dr. David Cola, et al., consisting of fifty-two pages, and that said deposition constitutes a true and correct transcription of my testimony given at the specified time.

_____
H. Morgenstern-Clarren, M.D.

Dated this _____ day of _____, 20___.

Sworn to and subscribed before me this _____ day of _____, 20___.

_____
Notary Public

My commission expires _____.

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C E R T I F I C A T E

STATE OF OHIO)
) SS
SUMMIT COUNTY)

I, Christine Leisure, a Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named Witness, **H. MORGENSTERN-CLARREN, M.D.**, was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony given was by me reduced to Stenotypy and afterwards transcribed upon a computer, and that the foregoing is a true and correct transcription of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, counsel or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Akron, Ohio, on this 7th day of October, 2000.

Christine Leisure, RPR (Rodriguez)
Christine Leisure, RPR & Notary Public
My commission expires April 1, 2002.