COURT OF COMMON PLEAS
CUYAHOGA COUNTY
- - -

NANCY FARKAS,

Plaintiff,

vs.

CLEVELAND CLINIC FOUNDATION et al.,

Defendants.

Case No. 393101
Judge McCafferty

- - -

Transcript of videotaped deposition of MARK NOBLE, M.D., one of the Defendants herein, called by the Plaintiff as upon cross-examination, pursuant to Notice and Agreement of Counsel, pursuant to the Ohio Rules of Civil Procedure, before Denise C. Winter, a Registered Merit Reporter and Notary Public within and for the State of Ohio on Wednesday, April 5, 2000, at the offices of Mark Noble, M.D., Gates Medical Center, 125 East Broad Street, Suite 208B, Elyria, Ohio, commencing at 4:45 p.m. and concluding at 8:25 p.m.

- - -

MERIT REPORTING SERVICES
2000 East Ninth Street, Suite 310
Cleveland, Ohio 44115
216-781-7120

APPEARANCES:

Debra J. Dixon, Esq.
700 West St. Clair Avenue, Suite 216
Cleveland, Ohio
(216) 621-9100

on behalf of the Plaintiff;

Reminger & Reminger
James M. Kelley, III
113 St. Clair Avenue, NE
Cleveland, Ohio
(216) 687-1311

on behalf of the Defendant,
Cleveland Clinic Foundation;

Mazanec, Raskin & Ryder
John L. Cullen
100 Franklin's Row, 34305 Solon Road
Cleveland, Ohio
(440) 248-7906

on behalf of the Defendant,
Alan Starr, M.D.;

Bonezzi, Switzer, Murphy & Polito
Patrick J. Murphy
1400 Leader Building
Cleveland, Ohio
(216) 875-2767

on behalf of the Defendant,
Elyria Memorial Hospital;

Hanna, Campbell & Powell
Jeffrey E. Schobert
3737 Embassy Parkway
Akron, OH
(330) 670-7300

on behalf of the Defendants,
Teresita O'Campo, M.D. and Frederick H. Dengel, M.D.

- - -

Also present: Randall Buckosh, Litigaide
Joanne Sysack

- - -

I N D E X

- - -

- - -

(See Signature Page)

PROCEEDINGS

MARK NOBLE, M.D.

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

CROSS-EXAMINATION OF MARK NOBLE, M.D.

BY MS. DIXON:

Q. Dr. Noble, you and I met off the record. My name is Debra Dixon. I'm one of the attorneys representing the Plaintiff in this action.

Let me ask you to first state your full name and spell your last name for the record.

A. My full name is Mark Jeffrey Noble, and my last name is spelled N-O-B-L-E.

Q. And, Dr. Noble, have you ever previously had your deposition taken?

A. Yes.

Q. And on how many separate occasions?

A. Where I was the Defendant?

Q. In total, how many different occasions have you had your deposition taken?

A. I don't know the exact number. I have acted as an expert witness a number of times. Perhaps eight or ten times.

16:25 Q. And out of those eight or ten times, how many times have you been a party in the action that your deposition was being taken in?

MR. KELLEY: Objection, but you can

16:25 answer.

A. Can I clarify? You mean where I was the individual being named as the Defendant?

Q. Yes.

A. One time.

16:25 Q. And approximately how long ago was that?

A. I believe it was about seven years ago, but I would have to look up the exact date.

Q. That's fine. Dr. Noble, before we get started, since it has been at least ostensibly some period of time since

16:26 your last deposition, let me lay out a few ground rules that will facilitate this process and, most importantly, make it easier for Denise, our court reporter, who is taking down everything that you say, I say or any of the other lawyers say that are in the room.

16:26 First and foremost, you need to make all of your answers verbal. Although we're all inclined to use hand gestures, nods of the head, things of that nature, that's difficult for her to interpret correctly.

Second of all, if at any point in time you don't

16:26 understand a question that I have asked, please ask me to

rephrase it or clarify it. If you answer the question, I'll assume that you understood it and that your answer is truthful and accurate.

Thirdly, I'm not looking for you to guess on any answers. If you don't know, let me know. And if you answer, I will assume that you, again, that you understood the question and that your answer is accurate. Agreed?

A. Okay.

Q. Finally, if at any point in time you need to take a break, you get paged, you need something to drink, something of that nature, let me know and I will be happy to accommodate you.

A. Thank you.

Q. Certainly. Doctor, this morning I received a facsimile of what I understand to be your most recent curriculum vitae and I have premarked this Exhibit 1. Can you take a look at that document, please?

Does that appear to be a true and accurate copy of your most recent curriculum vitae?

A. It does.

Q. Do you recall the last time that CV was updated?

A. I believe it was last summer or last fall.

Q. Since either last summer or last fall, that general time frame, are there any appointments or addenda to the CV?

A. There is a paper that's going to be submitted in early

16:29 June.

Q. And what's the topic of that paper?

A. The prognostic significance of renal vein invasion by renal cell carcinoma.

16:29 Q. In what publication do you expect that paper to be submitted to?

A. It's being submitted for a special edition of the "Indian Journal of Urology".

Q. Other than that, there are no glaring omissions or additions to your curriculum vitae; correct?

16:29

A. Correct.

Q. Dr. Noble, you indicated that you have had your deposition taken approximately seven or eight times in the past; correct?

16:30 A. Approximately, yes.

Q. And on one of those occasions, that was as a party to a lawsuit; correct?

A. That is correct.

Q. And that instance was approximately seven years ago?

16:30 A. I don't remember the exact number of years without going back and looking it up.

Q. Are you comfortable with that in terms of an estimate?

A. It was either seven years ago that it was filed or that I did a deposition or something. It may have been six or five and a half years but some years ago.

16:30

16:30 Q. Fair enough. Where was that lawsuit pending?
A. It was in the state of Kansas.
Q. And do you recall what the claim that was being made against you was?
16:30 MR. KELLEY: Objection. You can answer if you know.
A. Yes; I recall.
Q. And can you tell me what that nature of that claim was?
16:30 MR. KELLEY: Objection. You can answer.
A. That I caused a patient to have damage to his rectum during an electrical ejaculation procedure to obtain sperm.
Q. Was that claim settled -- excuse me. Was that claim
16:31 resolved via settlement or dismissal?
MR. KELLEY: Objection. You can answer.
A. The patient dropped the claim.
Q. You indicated in one of your previous answers that on
16:31 several occasions, you have provided expert testimony in the context of litigation; correct?
A. That's correct.
Q. And that would be -- would half a dozen times be a fair estimate as to the number of occasions that you have
16:31 done that?

16:31 A. Approximately.

Q. Can you tell me the types of cases that you have provided expert testimony in?

A. I can try to remember some of them.

16:31 Q. As best you can recall.

A. One had to do with a neurogenic bladder problem in a patient who was claiming that an injury caused her to be unable to empty her bladder. I can't tell you the approximate date. I don't remember.

16:32 Another had to do with a wound infection that occurred in a patient and the surgery related to the bladder or the lower urinary tract, and I was asked about what I thought because I was a treating physician, but, also, I was retained as an expert after that complication had occurred.

16:32 I have given depositions relating to some Workmen's Compensation cases. I really don't remember the specifics of any others. I have also -- it's been a number of years.

Q. Have you ever provided expert testimony in a case which claimed a failure to diagnose cancer of a urological

16:32 nature?

A. I don't recall any such cases.

Q. Whether or not you had been retained to provide expert testimony in such a case, meaning a failure to diagnose cancer in a urological matter, have you ever simply provided

16:33 expert consultation in a case such as that?

16:33 MR. KELLEY: Objection. I think that would be work product.

MS. DIXON: The substance of it would but whether or not he did participate I don't believe 16:33 is work product.

A. I believe I have reviewed some charts in the past, but the specifics I really don't remember.

Q. Doctor, what's your current professional address?

A. There are two professional addresses. One would be 16:33 125 East Broad Street in Elyria. It's suite 208B here in Gates Medical Center, and the ZIP I think is 44035. The other would be the main campus of the Cleveland Clinic at 9500 Euclid Avenue, Cleveland, 44195, I believe.

Q. And what is your current residential address?

16:34 A. 31141 Huntington Woods Parkway, Bay Village, 44140.

Q. And, doctor, what is your date of birth?

A. 9/19/49.

Q. And your Social Security number?

A. 086-38-4487.

16:34 Q. Doctor, am I correct in understanding that your current employer is the Cleveland Clinic Foundation?

A. That is correct.

Q. And was the Cleveland Clinic Foundation your employer in October of 1998?

16:34 A. Yes.

16:34 Q. You are currently, as I understand it, associated with a urological practice here in Elyria, Ohio; correct?
A. That is correct. It's part of the Cleveland Clinic.
Q. And in this particular, in this particular location,
16:35 and I'm referring to 125 Gates Medical Center, are there other physicians with whom you associate in this office?
A. Yes.
Q. And all of those physicians are urologists?
A. Yes.
16:35 Q. How many physicians are you associated with at the Gates Medical facility?
A. Currently?
Q. Currently.
A. There are three others.
16:3 Q. And who are those physicians?
A. Louis D'Amico, M.D., William Larchain, M.D., and Yih-Wen Lai, M.D.
Q. In October of 1998, were you likewise associated in a group practice at the Gates Medical building?
16:: A. I was working with other doctors.
Q. Was Dr. D'Amico associated with you in a professional sense in October of 1998?
A. Yes.
Q. And how would you describe the nature of your
16:: professional relationship with Dr. D'Amico in October of

16:36 1998?
A. I'm not sure I understand the question.
Q. Fair enough. Were both you and Dr. D'Amico employees, if you know, were both you and Dr. D'Amico employees of the
16:36 Cleveland Clinic Foundation in October of 1998?
A. Yes.
Q. You were not involved in any separate partnership at that time; correct?
A. Correct.
16:36 Q. As co-members, if you will, of the group that was located at the Gates Medical building in October of 1998, did you share office responsibilities, and what I mean by that is basically patient responsibilities, in each other's stead?
16:36 A. May I clarify?
Q. Certainly.
A. If he went out of town, he might ask me to cover or see some of his patients or take care of emergencies that would crop up, and if I went out of town, he might do it for
16:36 me.
Q. Based on the best of your understanding, in October of 1998, did the group that you were associated with provide on-call urological services for the Elyria Memorial Hospital emergency department?
16:37 A. The group did based on the schedule.

16:37 Q. And as part of that schedule, did you personally, in October of 1998, provide on-call, excuse me, on-call services for the emergency department of Elyria Memorial Hospital?

16:37 A. May I clarify?

Q. Certainly.

A. Each of us is on call for generally a week at a time for emergency services. There are also other urologists in other groups that rotate that call, and so I presume that

16:37 one or both of us, Dr. D'Amico and myself, were on during October, but I don't know for sure and I don't have that schedule in my head.

Q. If I were to give you the general time frame of the fall of 1998, would it be fair to say at some point in time,

16:38 you would have served as an on-call urologist for the emergency department at EMH?

A. I believe so.

Q. Doctor, has your license to practice medicine ever been suspended or revoked?

16:38 MR. KELLEY: Objection.

A. No.

Q. Have you ever been subject to disciplinary proceedings associated with the medical facility with which -- with whom you had privileges?

16:38 MR. KELLEY: Objection in regards to

16:38 a medical facility. That might not be a public document. That would be peer review, so I'm going to instruct him not to answer.

BY MS. DIXON:

16:38 Q. Doctor, within the context of your employment as a medical doctor, have you ever been subject to disciplinary action?

MR. KELLEY: Objection. I think that within your employment is a quality assurance measure.

16:38 You're not taking a state medical action, so it's not public record. I think it's QA. I don't think it's Discovery. I'm instructing him not to answer.

BY MS. DIXON:

Q. Doctor, have you ever applied for privileges at a

16:38 medical facility which have been denied?

MR. KELLEY: Objection. You can answer.

A. No. I have never been denied.

Q. Doctor, can you tell me where you currently have

16:39 admitting privileges?

A. I have admitting privileges at the main campus of the Cleveland Clinic, at Elyria Memorial Hospital, and I have courtesy privileges, I think it's called, at Community Health Partners where I'm not supposed to have more than one

16:39 per month because I don't take ER call there.

16:39 Q. In your current employment situation, as I understand it, you have two offices in which you are able to see patients; correct?

A. Actually, there are three.

16:39 Q. Okay. You have told me about the Cleveland Clinic Foundation main campus; correct?

A. That's correct.

Q. You have told me the facility here at the Gates Medical building in Elyria. Is there a third location?

16:39 A. Yes. I see patients one half day a week at the satellite facility in Lorain off Oak Point off Route 2. Cleveland Clinic Lorain Family Health Center.

Q. As it relates to your office here at the Gates Medical facility, do you have a personal office contained at this

16:40 site?

A. Yes.

Q. And, in addition, is there a library available for your use at the Gates Medical facility office?

A. I don't believe there's a library in this building.

16:40 Q. Is there a library available to the urological -- medical urological staff at the Cleveland Clinic Foundation?

A. Yes.

Q. Can you tell me whether it's, and your answer, I would ask you not to confine it to just individually but also

16:40 through the urological staff's medical library at the

16:40 Cleveland Clinic Foundation. What urological journals are available to you?

A. We're including the entire Cleveland Clinic library?

Q. Yes.

16:40 A. The "Journal of Urology," "Urology," the "British Journal of Urology," "Clinical Urology," and probably some others. I don't know a complete list in my head.

Q. Fair enough. As it relates to this office, and "this office'' being the Gates Medical Center location, are there any textbooks or treatises that are housed here at this facility?

16:41

A. Not to my knowledge. May I ask for clarification?

Q. Certainly.

A. I sometimes keep some of my textbooks in my own office, but they're not library material.

16:41

Q. Let me clarify the question, then. What urological texts do you own?

A. I own Campbell's Urology, Gillenwater's Urology. I own a uroradiology text. I own a copy of Glenn's and Boyce's Urologic Surgery. I own a copy of the Novick and Streem edition of Stewart's Atlas of Urology and Urologic Surgery. I own a copy of Kelalis and King's Pediatric Urology, and I'm sure there are some other texts which I own. I can't give you a complete list off the top of my head.

16:42

16:42

16:42 Q. Dr. Noble, would it be fair to say that your purpose in owning the texts that you have just identified along with any others that may not be coming to the forefront of your mind is to provide you a source for guidance and advice in
16:43 diagnosing and treating your patients?

MR. KELLEY: Objection. You can answer.

A. That's not why I purchased those textbooks. I do try to stay current in my field, but textbooks, by the time book
16:43 chapters are written, are typically five to eight years out of date and one must integrate the knowledge contained in the textbooks with current practices which do change as technology changes and knowledge changes.

Q. Would it be fair to say that the textbooks that you
16:43 have just identified at a minimum provide you a baseline of information in assisting you to care for your patients?

MR. KELLEY: Objection. You can answer.

A. They provide a baseline for the original learning
6:43 process in learning urology. And I used to teach urology at the University of Kansas for 18 years, and so they were helpful in teaching my residents, but it was rare that I needed to look something up in an old textbook because of the things that I already mentioned.

16:44 Q. Doctor, you indicated that you taught urology at the

University of Kansas for approximately 18 years; correct?

A. That's correct.

Q. And is my understanding of the contents of your CV correct that simultaneously with your teaching responsibilities --

MS. DIXON: Off the record.

(Interruption in proceedings.)

BY MS. DIXON:

Q. Let me begin the question over again just to get us both back on track.

Upon review of your CV, it appears that during the 18 years you taught urology to residents at the University of Kansas, you likewise saw patients in a clinical setting; correct?

A. That's correct.

Q. And in toto, over what period of time have you seen urological patients in a clinical setting?

A. May I clarify that question?

Q. Certainly.

A. Are we including my residency training years?

Q. Yes.

A. I started seeing urology residents or urology patients during my residency in 1977, so it would be roughly 23 years from now backwards.

Q. Before I move on to the more substantive issues that I

16:48 have to discuss with you, let me ask you, what did you do to prepare for your deposition today absent conversations you may have had with Counsel?

A. I reviewed the patient's chart.

16:48 Q. Did you speak to Dr. D'Amico about the case?

A. I have discussed briefly the fact that there was this case; yes.

Q. And tell me what specifically you discussed with Dr. D'Amico.

16:48 A. Basically discussed the patient's course as noted in the chart.

Q. At the time you discussed that with Dr. D'Amico, did you have a specific or an independent recollection of Nancy Farkas?

16:48 A. Yes. I remember the patient.

Q. Do you know whether or not, based on your conversation with Dr. D'Amico, he had a recollection of the patient?

A. I don't believe he knew the patient.

Q. During the course of your conversation or

16:49 conversations with Dr, D'Amico, did you discuss any matters that went beyond the scope of the chart? For example, the patient's ultimate outcome.

A. Yes. There was some discussion that Dr. D'Amico had learned some of the subsequent outcome and, of course, it

16:49 was in the filing and so he conveyed what he knew to me.

16:49 Q. When you say the patient's outcome, are you referring to the fact that she died?

A. That's correct.

Q. Did you have an understanding at the time of your 16:49 conversation with Dr. D'Amico as to what Nancy Farkas' cause of death was?

MR. KELLEY: Objection. Separate from anything you would have known from me for all of these questions.

16:49 A. No; I don't.

Q. Other than Nancy's chart. And I'm assuming you are referring to the chart that I have had an opportunity to review today; correct?

A. That's correct.

16:50 Q. Have you seen an autopsy report?

A. No.

Q. Have you reviewed any, prior to your deposition today and separate from your treatment of Nancy, any x-ray films?

A. No.

16:50 Q. Have you spoken to any other physicians regarding either the care and treatment you provided Nancy or the subject matter of this lawsuit?

A. I don't recall any specific questions or discussions.

Q. Have you read any of the depositions that have been 16:50 taken in this case?

A. No.

Q. Have you reviewed any of the Plaintiff's expert reports that have been prepared and propounded in this case?

A. No.

Q. Doctor, you indicated that including your residency, you have seen urological patients in a clinical setting for approximately 23 years; correct?

A. That's correct.

Q. Would it be fair for me to assume that over those 23 years, you have had multiple opportunities to diagnose and treat patients with renal cell carcinoma?

A. That's a fair statement.

Q. And would you agree with me that in a classic presentation of renal cell carcinoma, one could find hematuria? A patient could present with hematuria?

MR. KELLEY: Objection to the question. You can answer.

A. A classic presentation? In my experience, there isn't necessarily a classic presentation. Hematuria occurs a percentage of the time, but many times patients never have hematuria.

Q. Are there any symptoms that you would consider to be, atypical issues aside, a classic presentation of a patient with renal cell carcinoma?

A. There is historically a classic triad, but it's

extremely rare to encounter it except with very, very large tumors.

Q. Can you tell me what that classic triad consists of?

A. A palpable mass, gross hematuria and flank pain, persistent flank pain.

Q. Are you able to estimate for me over those 23 years approximately how many times you have diagnosed and treated patients with renal cell?

A. Renal cell carcinoma?

Q. Yes. I'm sorry.

A. Can I clarify that question?

Q. Sure.

A. As the only treating physician or as part of a team treating the patient?

Q. As the only treating physician.

MR. KELLEY: I object to the question because I don't know what you mean by treatment. Obviously there's an oncologic issue.

BY MS. DIXON:

Q. Dr. Noble, would you agree that there are numerous times in which you, as the urological consultant, provide the primary diagnosis of renal cell carcinoma?

A. There have been times where I found the problem first, if that's what you're asking.

Q. It is. And are you able to estimate for me, and I

understand it would be an estimate, how many times you have been the physician who has made the initial diagnosis of renal cell carcinoma?

A. Where I was the first one to find it?

Q. Right.

A. And the case wasn't referred to me initially, perhaps, over the course of my career, 50 times or more, but I don't know an exact number.

Q. And within the context of that estimated 50 cases where you have made the initial diagnosis of renal cell carcinoma, can you think if there were any of those patients that presented with the classic triad of symptoms of renal cell?

MR. KELLEY: Objection. You can answer. I don't want you to give any patient names, if you happen to remember them.

BY MS. DIXON:

Q. I'm not interested in any patient names, doctor. I'm asking for you to pull up the mental impression, if you can, to respond to the question.

A. It was extremely rare. These were almost always found incidentally.

Q. Aside from the fact that it's rare, can you think of an occasion in which a patient presented with the classic triad of renal cell carcinoma symptoms?

16:5 A. I can think of one.

Q. And in that case, can you tell me, when that patient presented to your office, what diagnostic tools you employed to either rule in or rule out the diagnosis of renal cell

16:5 carcinoma?

MR. KELLEY: Objection. You can answer if you recall.

A. I don't remember specifically what the first test was on that patient.

16:5 Q. In general terms, and you did indicate that you had taught urology for some 18 years at the University of Kansas; correct?

A. That's correct.

Q. Would it be too far of a leap for me to make that

16:5 during the course of teaching residents the specialty of urology, that you taught them what were appropriate diagnostic tools in the face of certain symptoms a patient was presenting with?

A. I taught them things like that; yes.

16:5 Q. And in a classic scenario of a patient presenting with the triad of symptoms, the hematuria, palpable mass and flank pain, what tests would you expect your residents to employ to rule in or rule out renal cell carcinoma?

MR. KELLEY: Objection. You can

16:5 answer.

16:55 A. This is a hypothetical question now?
Q. Hypothetical question.
A. And it also depends upon whether there were comorbid factors or other things going on with the patient. But if
16:55 we're just looking at that presentation, typically one would get an IVP initially and because of the gross hematuria, we're talking gross hematuria, the patient would need a cystoscopic examination at some point along the line and then one would proceed after that depending upon the
16:55 findings of those tests.
Q. In the event that IVP did, in fact, show a mass, would you agree the next course of action in terms of diagnostic tests would either be a renal ultrasound or a CT scan?
MR. KELLEY: Objection. You can
16:56 answer.
A. I would normally get a CT scan as the next test.
Q. You mentioned earlier that oftentimes the diagnosis of renal cell carcinoma is an incidental finding?
A. That's correct.
16:56 Q. And when you refer to that as being an incidental finding, are you indicating the discovery of a mass as an incidental finding?
A. That's correct.
Q. So you would agree that it's not unusual for the
16:57 diagnosis of renal cell carcinoma to stem from an incidental

finding; correct?

A. That's correct.

Q. And what types of diagnostic tools, based on your experience, would provide the incidental finding of renal cell carcinoma?

MR. KELLEY: Objection. You can answer.

A. That's a very general question. Do you want me to try to answer that?

Q. Actually, let me clarify it for you because I think that will further our efforts.

Would you agree, first of all, that the incidental finding you're referring to would be some sort of a mass?

A. Or mass effect.

Q. Which would then need to have additional diagnostic tests used to determine whether or not it was renal cell carcinoma or a cyst of some type or other benign finding; correct?

A. One would want to characterize the mass with further testing; that's correct.

Q. In the course of your practice, have you ever had a situation where a patient had undergone an IVP and you were able to discover as an incidental finding a mass in that patient's kidney?

A. Yes.

Q. Your earlier testimony indicated that there are and there were in October of 1998 situations where you provided on-call service for the emergency department at Elyria Memorial Hospital; correct?

A. That's correct.

MR. KELLEY: Objection. Asked and answered.

BY MS. DIXON:

Q. Can you explain to me the procedure in place in your office regarding referrals from the emergency room here at the Elyria office?

A. The procedure is that if a patient is referred from the emergency room and the emergency room physician calls the physician on call for that specialty, then depending upon the clinical circumstances, that physician might take additional action such as see the patient in the office in a reasonably expeditious manner or might have to come into the emergency room or possibly admit the patient.

If the emergency room physician doesn't call the physician but thinks that the problem can be managed on a semi-elective basis, then the emergency room physician might simply tell the patient to arrange an appointment in the office for follow-up in a short period of time.

Q. For the next question, let me direct your attention to the situations where you are actually contacted as the

16:59 on-call urologist by the emergency room physician. In that scenario, first of all, do you keep any logs or records of the calls that you receive from the emergency room physician?

16:59 A. No.

Q. Is there any tracking done in your office, and, again, I'm referring to the Elyria office, of referrals that are made to you as an on-call physician regarding patients that you have consulted on?

17:00 A. I believe that the only tracking that occurs is if the emergency room physician calls the office or if the patient, on instruction of the emergency room physician, calls the office and makes an appointment and records are forwarded from the emergency room.

17:00 Q. In the event that you are the on-call urologist and you receive a call from the emergency department and there's a decision made that patient will subsequently be seen in your office based on their presentation in the emergency department, how is it that the records from the emergency

17:00 department are transmitted to your office?

A. I believe that usually they are faxed up to the office.

Q. First of all, in patients who you consult, provide a telephone consult from the emergency department, are you

17:01 then the physician that will see the patient once they come

17:01 to the office, or can that be any one of the physicians as part of the group?

A. I think it depends on the situation and the scheduling availability in the office and how urgently the patient 17:01 needs to be seen and so forth.

Q. Is it your practice to have the records from the emergency department provided to you by whatever means in conjunction with an office visit for that patient?

A. We try to get them.

17:01 Q. And what steps or how is that -- how does that occur? For example, are there procedures or protocols in place in your office as to how and when to acquire emergency department records?

A. I don't believe we have any written-out procedures, 17:02 but it's customary to ask the secretary to call and see if the records can be found or the patient's chart located and those items relating to that emergency room visit copied or sent or faxed here.

Q. Would that be based on information you had provided as 17:02 a physician who had taken a consult call, or is that reactionary to the patient calling to schedule an appointment?

A. That's difficult to answer exactly. Can I ask a couple questions about that?

17:02 Q. Sure.

A. What often happens is that the emergency will make an appointment or fax records up here, assuming that the patient will follow the recommendation and make an appointment. But if the patient shows up in the office and says I was seen in the emergency room two days ago and we don't have any records, then it's reactionary that we obviously then try to go get those records.

Q. Based on information that you would be provided as the on-call urologist and provided by the emergency department, are there ever situations where you alert your office staff that a particular patient may be calling to schedule an appointment?

A. I would think that if the patient or the emergency room physician contacted me, I might try to alert the office just to give them a heads up that there was a patient trying to schedule and we should try to fit them in.

Q. I understand that you have provided on-call services for EMH's emergency department in the past. In conjunction with the same, have you ever been contacted by a Dr. Allan Starr?

A. Yes; I have.

Q. And is Dr. Starr somebody that you were familiar with?

A. Yes.

Q. And those contacts that you have had as the urology consultant, did those relate to a patient he was seeing in

17:04 the emergency department?

A. Yes. When he's called me, he's seen a patient and then consulted me and called me.

Q. And I'm assuming some of those times have commanded 17:04 that the patient come to your office for follow-up care; correct?

A. Correct.

Q. And can you recall any circumstances where you may have taken the on-call telephone inquiry and it was another 17:04 physician within your practice who actually saw that patient?

MR. KELLEY: If you know.

A. If that occurred, I wouldn't know unless that other physician told me, and I don't remember any such 17:04 circumstances.

Q. What I'm trying to understand, Dr. 'Noble, is in the event you took a call from the emergency department and it was a case of at least a relatively serious nature and you were not able to be the physician who saw the patient in an 17:05 office setting, how is it within your office you would provide information to the then treating physician for the office visit with that patient?

MR. KELLEY: Objection.

BY MS. DIXON:

17:05 Q. First of all, do you understand the question?

17:C A. I'm not sure. Could you please --
Q. Can you at least envision a situation where you may have taken a telephone consult from the emergency department and you determined that that patient needed to be seen in
17:C your office?
A. Yes.
Q. Once that decision was made, it turned out, for whatever reason, vacation or scheduling or other obligations, you personally were not able to see that
17:0 patient within the prescribed period of time and the office staff then scheduled the patient with someone else associated with your group.
Are you with me up until that point?
A. I'm understanding you.
17:0 Q. Okay. In that event, can you tell me whether or not there are any procedures or protocols in place within this office for you to communicate the information you had gleaned from the emergency department to the physician who ultimately examines the patient in the office visit?
17:0 MR. KELLEY: Objection.
A. I don't know of any specific written protocols to that effect. I believe that as a matter of trying to arrange follow-up and care, and, again, it depends upon the situation and the circumstance, my practice is that if I'm
17:0 very concerned and feel a patient needs attention and I

17: cannot then see that patient, I would try to ensure that that patient has an appointment with my colleague who is covering.

Q. And would you take it upon yourself to communicate at least whatever knowledge you would have been provided from the emergency department regarding that patient prior to the office visit?

MR. KELLEY: Objection. You can answer.

17: A. If I think that that information is different from what's contained in the record or would materially contribute to the patient's care.

Q. Dr. Noble, do you know how it is that Nancy Farkas came under your care?

17: A. I was told when she came into the office that she had been seen in the emergency room in the recent past and that she was advised to make an appointment with my associate but his schedule was full. That's what she said. And so I had an opening and she was put into my schedule.

17: Q. And for the next series of questions, feel free to refer to your chart if you feel more comfortable doing so.

Dr. Noble, I'll represent to you, based on review of the chart, that your first visit with Nancy Farkas was on October 26th of 1998.

17: A. That's correct.

17:08 Q. And at the time of that visit, were you aware that Dr. D'Amico had consulted with Dr. Starr while Nancy was in the emergency room on 10/20/98?

MR. KELLEY: Objection.

17:08 A. I was not aware specifically of what manner the consultation took, whether it was phone or whatever.

Q. Were you aware of the fact there was a consultation?

MR. KELLEY: Objection.

A. I don't have anything specific in this chart that I

17:09 recall, but I believe the patient said that there was something communicated, but I don't know the details.

Q. At the time of the 10/26/98 office visit, what records from the emergency room visit at EMH of 10/20/98 did you have available to you?

17:09 A. On that visit -- please give me a second to review my chart -- I don't believe that I had the emergency room records on that visit, to the best of my recollection.

Q. Do you know whether or not there was any attempt to retrieve Nancy Farkas' 10/20/98 emergency room records prior

17:10 to the time of her visit in this office on 10/26?

A. Can I ask for clarification? You said retrieve records from the emergency room from 10/29, but that was after she saw me. I didn't think she went back to the emergency room after she saw me.

17:10 Q. I may have misspoken. If I did, I apologize.

17:10 My question is, at the time of your visit with Nancy on 10/26/1998, do you know what efforts had been undertaken to retrieve her emergency room records from the 10/20/98 ER visit?

17:10 A. I don't have anything in writing, but I recall that, as is my custom, I ask the secretary at the desk to see if it was possible to call for those records that pertained to that visit. I don't believe she was able to get the records at that point.

17:11 Q. I'd like you to move to the portion of your chart that relates to the 10/26/1998 office visit.

A. Okay.

Q. At the top of that document there's a CCF number. I'm assuming that is a Cleveland Clinic Foundation number?

17:11 A. Yes.

Q. And does your copy of the record indicate that number is 87532895?

A. Yes.

Q. At the time of your first visit with Nancy on 10/26 of

17:11 1998, was she alone?

A. No.

Q. Who was present with her at the time of that --

A. I believe her sister was with her.

Q. And would you agree at the time of that visit, you

19:44 understood that she did not have a primary care physician?

19:44 A. That was my understanding,

Q. In light of -- based on your review of the October 26, 1998 note, can you tell me what that first visit consisted of?

19:44 A. The patient presented with a problem and that was that she had been having a lot of pain in her side, a lot of flank pain on the right side. The day that she actually came in, her pain had eased up. She had briefly seen some traces of blood in her urine one time. At the time, she thought she was passing a stone. She denied any prior history of urologic problems, and the visit was basically to coordinate further care for her stone which was the diagnosis that she was given when she was in the emergency room.

17:13 Q. Would you agree that at the time of the October 26th, 1998 visit, because you did not have the'emergency department records available to you, you were relying exclusively on Nancy's oral history of what had taken place on 10/20/98?

17:13 A. That's correct.

Q. As part of your 10/26/98 note, you say, "Seen in the ER last week for an attack of right ureteral colic"; correct?

A. That's what I wrote.

17:13 Q. And my question to you is, do you recall what Nancy

specifically told you? Because those are not her words; correct?

A. I paraphrased what she told me.

Q. Do you recall what it is that Nancy told you during that 10/26/98 visit?

A. She told me that she came to the emergency room, that she had a lot of pain and some nausea, that she had a kidney x-ray. The working diagnosis -- she didn't use those words -- was that she had a kidney stone with a lot of blockage of her kidney and that she needed to see a neurologist.

Q. You understood that at the time of the 10/26/98 visit she did not have pain; correct?

A. It had eased up as often happens when people are passing stones.

Q. When you said that Nancy informed you she had a kidney x-ray, what did you understand that to be?

A. I understood that she was saying an IVP.

Q. In light of the fact you did not have the ER records available to you, did you ask Nancy her understanding of what the results of the IVP were?

A. Yes.

Q. And I apologize, but I don't recall what your answer to this was. in the past, did you know that Dr. D'Amico had consulted with Dr. Starr at the time you examined or treated

Nancy on 10/26/98?

MR. KELLEY: Objection.

A. No; I did not know that.

Q. Did there come a point in time during your treatment of Nancy where you learned that Dr. D'Amico had consulted with Dr. Starr?

MR. KELLEY: Objection.

A. I believe that at some point, and I'm not sure exactly when it was, whether it was during my treatment or sometime later or if possibly he told me during the discussion, which I mentioned earlier, when we discussed this case briefly that I understood that he had had some phone contact with Dr. Starr about this patient because of being on ER call that week.

Q. Whenever that conversation did happen with Dr. D'Amico regarding his contact with the emergenay'department, specifically Dr. Starr, on 10/20/98, what did he tell you, if anything, the sum and substance of that conversation was?

MR. KELLEY: Objection. You can answer.

A. I don't believe that he went into any great detail, My recollection again is that he mentioned he received a call that the patient was managed in the emergency room and was not too ill to be discharged and so he told Dr. Starr to arrange for follow-up in our office.

17:16 Q. During that conversation, did Dr. D'Amico tell you about any of the specific findings that were communicated to him on Nancy's diagnostic tests?

A. No.

17:16 Q. Would you agree that one of the reasons that you attempt to acquire a patient's emergency room records in a situation such as this prior to the time of an office visit is to give you a more complete picture as to what transpired in the emergency department?

17:17 A. I think it's always helpful to have information when you can get it, of course.

Q. And that additional information would relate to diagnostic tests as were performed during the course of the emergency room visit; correct?

17:1 A. That's correct.

Q. Now, would you likewise agree that more complete picture that you have at the time of initial evaluation of that patient may shape the course of your treatment?

A. That's reasonable.

17:1 Q. In October of 1998, was there any ability of this office, and again I'm referring to your office here in Elyria, to simply go across the street and procure films or procure copies of patients' records while they are actually here in the office?

17:1 A. It's difficult to send a secretary out when you have a

17:1 busy office and patients are registering in order to go try to track down films and records on the spot like that. What we usually can do is get records faxed up to us and we hope that they will be faxed while the patient is still here.

17:1 Sometimes they do it and sometimes they can't find those records right away and it takes a day or two.

Q. Would you agree that the actual medical records would be a better source of information regarding Nancy's ER treatment of 10/20/98 as opposed to merely her oral report?

17:1 A. I think that the medical records might have some things in there that the patient might not recall. I think the patient's own recollections, though, are very important, too.

Q. And based on your experience, are the patients own

17:1 recollections generally accurate?

A. In my experience, most times a patient who's functionally healthy otherwise and has good mental faculties would give you an accurate depiction of what the recent events were.

17:1 Q. Would you agree with me that Nancy's description, and I'm referring back to your previous testimony of the something was blocking her kidney, that you took that to refer to a stone; correct?

A. Well, she said she had a stone.

17:1 Q. Did Nancy tell you about any other findings on her

diagnostic tests that were disclosed to her during the course of her 10/20/98 'emergency room visit?

A. She told me that she had had some blood in the urine when they examined her urine in the emergency room. She told me that she had a stone in her other kidney, also, but she didn't have pain in that other kidney.

Q. At any point in time did Nancy disclose to you any other diagnoses that she was provided during the course of her emergency room visit of 10/20/98?

A. No.

MR. KELLEY: You mean on October 20? From the ER visit you mean?

MS. DIXON: Yes, at that visit.

BY MS. DIXON:

Q. My question is, during your conversation with Nancy on 10/26/98, did she disclose to you any other diagnoses other than this kidney stone situation that you have just described that she received from the emergency room personnel on 10/20/98?

A. No.

Q. And do you know how it was that Nancy acquired the information regarding the stone first in her right kidney and then in her left kidney?

A. My best recollection is that she was told that that's what the x-ray showed at the time she was in the emergency

room.

Q. Would you expect that all abnormal findings are explained to a patient while they are in the emergency department?

MR. CULLEN: Objection.

MR. KELLEY: Objection. In regard to what type of test?

BY MS. DIXON:

Q. Well, doctor, you would agree with me that in the course of emergency room care, oftentimes there are a multitude of diagnostic tests performed on a patient; correct?

MR. CULLEN: Objection.

A. That is correct.

Q. There may be situations that the results of those diagnostic tests may lead to one or more ultimate diagnoses; correct?

MR. CULLEN: Objection.

MR. KELLEY: You can answer. I'll tell you if you can't.

A. Yes, of course that's true.

Q. And, in fact, oftentimes that's why you, as a urologist, i.e. a specialist, are contacted for additional consultation and treatment; correct?

A. That's a reasonable statement.

17:2 Q. And my question is, in the face of abnormal -- more than one abnormal or suspicious finding based on diagnostic tests that are run in an emergency department, would you expect each of those findings to be communicated to the 17:2 patient?

MR. CULLEN: Objection.

BY MS. DIXON:

Q. Prior to discharge.

MR. CULLEN: Objection.

17:2 MR. KELLEY: Objection. You can answer if you know.

A. My expectation is that tests that directly impact on the immediate problem would be discussed, if those results are back and, you know, are available.

17:2 And I can give you an example. A patient might have a slight abnormality on a chemistry test, but if it doesn't bear any direct relevance to flank pain or a blockage of a kidney, I don't think that that's something that necessarily would be gone into by an emergency room.

17:2 Q. Would you expect that an abnormal or a suspicious finding on a -- stemming from a diagnostic test performed in an emergency room that could potentially or could suggest a life-threatening condition would be explained to that patient prior to discharge?

17:2 MR. CULLEN: Objection.

MR. KELLEY: Objection. We don't know what the potential life-threatening condition is or the time frame that you're talking about in an emergency room. Second of all, he's not an emergency physician. You're not limiting it to urologic issues.

BY MS. DIXON:

Q. Okay. Let's deal with it in terms of urology. We established the fact that oftentimes patients have abnormal or suspicious findings as a result of diagnostic tests that they undergo in the emergency department; correct?

A. That's correct.

Q. And oftentimes in those situations, those patients are referred to a specialist, and in the case of a urological problem, to someone such as yourself for additional care, diagnosis and treatment; correct?

A. Yes.

Q. My question is, and I believe you also established, excuse me, that oftentimes a patient may have more than one suspicious or abnormal result from diagnostic testing; correct?

A. Yes.

Q. My question is, if one -- if a patient has abnormal or suspicious findings which are suggestive of a potentially-fatal condition, and you can limit your answer to within the realm of urological care, would you expect

that emergency room physician to communicate that to the patient prior to discharge?

MR. CULLEN: Objection.

MR. KELLEY: Objection.

BY MS. DIXON:

Q. Yes or no?

MR. KELLEY: Overly broad. He doesn't have to limit his answer to yes or no.

A. I can't answer it just yes or no because it's not a simple question.

Q. Then answer it the best you can in narrative.

A. I think it really depends upon the circumstances. If, for example, an x-ray, which is a type of test, shows several findings but the radiologist produces what's called a wet reading, the initial report is not necessarily going to be inclusive of every finding that may come to light a little later with more study, and so if one has a primary explanation such as, in this case, a blocked kidney for the patient's colicky pain, that is certainly the main thing that one would convey.

But other findings, I really don't know if they were present at the time that the patient was there in the emergency room and I don't know, in other words, if the wet reading had everything in it. I don't know if those were, you know, pertinent or thought to be significant, and it's

17:25 difficult to tell if something else is also a life-threatening condition or not or what probability. So it's a tough -- you know, it's not an exact answer.

Q. In the realm of urological care, would you agree with me that the presence of a cyst or mass is always a suspicious finding?

A. I think that's an absolute question and one would ultimately want to investigate and clarify what that is, but it's a matter of judgment in terms of the timing of that, if I'm understanding your question properly. Yes, you want to clarify what that is, if that's a finding.

Q. And would you agree the reason you would seek clarification is because it may be indicative of a life-threatening condition? "It" being a cyst or mass.

A. In my experience, a cyst or a mass is almost never an immediate life-threatening condition. I think ultimately and with reasonable timeliness, it needs to be investigated, but I don't think that it's an emergency.

(Thereupon, a brief recess was taken.)

BY MS. DIXON:

Q. Dr. Noble, your note indicates that when you saw Miss Farkas on 10/26 of 1998, that she was asymptomatic with no pain; correct?

A. That's correct.

17:41 Q. And can you amplify for me what you meant by that?

17:41 A. What I meant is that her colicky pain that she described had eased up and wasn't bothering her right at that moment when I saw her and examined her.

Q. And did you perform a physical exam on Nancy on 17:41 10/26/98?

A. I did a brief exam, tapped on her costovertebral angles and I didn't -- give me one second -- and I did -- well, I didn't say in this note to refer to the primary note which is a history and physical form that was also obtained on that date, but 17:49 I'm fairly certain that I did do a brief exam, at least the pertinent urologic area.

Q. And for clarification, can you tell me what would be involved in the urological physical exam in a patient presenting with the symptoms that you understand Nancy 17:49 Farkas is to be presenting with on 10/26?

A. Normally I would just press or tap on a person's costovertebral angle areas, over the kidneys and the flanks and palpate the abdomen just to get more information about that and see if there was pain elicited at that moment.

Q. 17:49 Would you agree with me that as it relates to the 10/26/1998 visit, there's no notation of such a physical exam in the record?

A. I think my statement "she's asymptomatic with no pain" might also be inclusive and indicate that I did that basic exam, but 17:50 it doesn't say specifically.

17:50 Q. And the statement "she is asymptomatic with no pain" may also stem from Nancy's self report on that day; correct?
A. It's possible, but it's my custom to do the brief exam that I indicated.
17:50 Q. Given the fact that Nancy was asymptomatic with no pain on 10/26/98, six days after her emergency department visit, did you consider that perhaps the stone that she had described to you had passed?
MR. CULLEN: I'm going to object to
17:50 that question.
A. I considered lots of possibilities.
Q. I'm sorry?
A. I considered a lot of possibilities.
Q. My question specifically is, given the fact that when
17:50 she presented to you on 10/26/98 asymptomatic and with no pain, did you consider whether or not the stone had passed?
MR. CULLEN: Objection.
A. I thought that it was unlikely.
Q. And upon what did you base your conclusion that it was
17:51 unlikely that Nancy's stone had passed?
A. She had been having pains off and on. She asked for more pain medication expecting that she would get more pain, and I did give her a prescription for more pain medicine, and she still had some microscopic blood in the urine
17:51 suggesting that the stone was not passed.

17:51 Q. Do you have any specific recollection of palpating Nancy's kidneys on 10/26/98?

A. I think I already said earlier my best recollection is that I did press or tap on her flanks and costovertebral

17:51 areas.

Q. On 10/26/98, other than the microscopic blood in Nancy's urine that you previously alluded to, did she have any symptoms on that day?

A. I don't believe that there were any symptoms right at

17:52 that particular moment in time when she was in the office.

Q. And, doctor, whether it be by review of your chart or your recollection, do you recali whether or not on palpation of Nancy's flank, she had any pain?

A. I think that she didn't at that particular time.

17:52 Q. Again directing your attention to the 10/26/98 note where you indicated she was asymptomatic$,when you wrote that Nancy was asymptomatic, what was she, based on your understanding, asymptomatic of?

A. Basically asymptomatic of the nausea and the right

17:53 flank pain.

Q. At the time of your 10/26 visit, did Nancy have any symptoms based on your eliciting her history and physical exam which suggested the presence of a kidney stone?

A. It's very common for patients who are passing stones

17:53 to have the pain ease up and even stop and then start again.

In my experience, when the stone stops moving, many times the pain stops and then the stone will start to move some more and then the pain re-occurs.

So the fact that she was not having pain during that office visit doesn't really tell me anything further about whether she still has a stone or not or has passed it or anything more that's going on.

Q. At the time of the 10/26 visit, did Nancy tell you when the last time she did have pain was?

A. I don't recall how the time intervals were, specifically whether it was two hours before coming in the office or twelve hours before, but I know she had been having intermittent pain.

Q. Would it be fair to say that based on your review, there's no notation in the record which indicates the last time Nancy experienced pain?

A. That's correct. I didn't specifically state that.

Q. Doctor, can you define for me the term "ureteral co1ic"?

A. The term "ureteral colic" commonly refers to a type of pain that is seen when a person is passing something down the ureter and it's a pain characterized by a particular location or several locations along the flank or loin or sometimes towards the groin. It can vary in exact location, but it's a kind of pain that you can't get away from. Lying

17:55 still doesn't make the pain better as opposed to pain from peritonitis, for example, or appendicitis, something inflamed with the peritoneal cavity where less movement generally eases the pain up.

17:55 Q. Would you agree that ureteral colic is not really --

MR. KELLEY: Were you done?

BY MS. DIXON:

Q. Did I interrupt you?

A. I think that's a reasonable explanation of what

17:55 ureteral colic means.

Q. I apologize. I didn't mean to interrupt.

A. That's all right.

Q. Would you agree that ureteral colic is not really a diagnosis but more akin to a symptom of something?

17:55 A. Ureteral colic is a symptom and it can be an observation or a clinical finding when you are examining a patient that they appear to be in pain typical for ureteral colic.

Q. Would you agree that other than the passage of a

17:56 kidney stone, there are other causes for ureteral colic?

A. There are other causes or pain that appears the same as ureteral colic.

Q. Are there other causes of ureteral colic?

A. Besides a stone?

17:56 Q. Yes.

17:56 A. Yes.

Q. And would you agree that one of those other causes may be an obstruction in the urinary tract?

A. No; I wouldn't.

17:56 Q. What about a blood clot in the ureter?

A. If a patient is passing a sizable blood clot, and usually it's more than one blood clot, that patient may have colicky pain.

Q. Can an infection also cause ureteral colic?

17:56 A. Not typically the exact same kind of pain, but I never say never in medicine. It's not an exact science.

Q. Again directing your attention to the 10/26/98 note, you indicate within the confines of that note that Nancy had one episode of hematuria with the stone.

17:57 Do you see the portion of the record I'm referring to, doctor?

A. Yes.

Q. In writing that statement, are you referring to the stone that Nancy told you about from the emergency

17:57 department?

A. Yes.

Q. And would you agree at the time that you saw Nancy on 10/26/98, you were relying exclusively on self report?

A. That's correct.

17:57 Q. Doctor, explain to me what an IVP is.

17:57 A. It stands for intravenous pyelogram. It's a type of x-ray where a material filtered out of the bloodstream by the kidneys is injected into the vein of the patient, hence the word "intravenous." That substance is radiopaque or
17:58 blocks so much of the x-rays going through it and appears white on a standard x-ray, and when the kidneys filter that substance out, it will light up the course of the urinary tract, kidneys and ureters and bladder.

Q. Would you explain for me -- you have explained the
17:58 illumination of different anatomical parts. Would you agree that it outlines the size, shape and position of the kidneys?

A. It does to a reasonable degree depending upon the patient's body habitus and bowel preparation or lack of
17:58 bowel preparation and other factors.

Q. As well as the size, shape and position of the renal pelvis?

A. It can if it's illuminated well, again, depending upon whether the patient has a bowel prep or not and whether
17:58 there are other things that affect the quality of the x-rays.

Q. Would you likewise agree that it outlines the size, shape and position of the ureters and bladder?

A. It does in a general way.

17:59 Q. And, also, would you agree it also reveals the

17:59 excretory function of the kidney?
A. Can I clarify that question?
Q. Certainly.
A. Are you asking if it is a measure of the kidney
17:59 function?
Q. No; I'm not. Just the manner in which urine is excreted from the kidney and travels hence to the bladder.
A. It will tell if a kidney is functioning or not, but it won't say if it's functioning normally or not, necessarily.
17:59 Q. Would you agree that a radiologist is able to determine at some level the time in which it takes for the contrast dye to travel from the kidney to the bladder by virtue of an IVP?
A. Can I ask for clarification again?
17:59 Q. Sure.
A. Are you asking can a radiologist tell something about function based upon delay in excretion of the contrast from the kidneys?
Q. My question is a little more simple than that. Over a
18:00 delayed period of time, would you agree the radiologist can appreciate or quantify the amount of time it takes for urine to travel from the kidney to the bladder via the ureter?
A. I don't think you can do that exactly. I think you can see how fast the contrast comes down and in terms of
18:00 what the contrast will light up and show on the x-ray, but

it takes a fair amount of contrast before you see.

Q. Doctor, would you agree that the defects in the dye filling that's filling the kidney during an IVP can indicate renal tumors or cysts?

A. Sometimes.

Q. And, also, that during an IVP, at least radiographically, deformation of the kidneys can also be appreciated?

A. It can sometimes.

Q. Would you agree that an IVP is not an appropriate test to differentiate between a tumor or cyst?

A. I would say that that's a reasonable statement by today's standards; that's right.

Q. And in the event there's a tumor or cyst appreciated by IVP, that patient would need further follow-up testing to conclusively determine what the nature of that mass is?

A. It's my opinion that ultimately one would want to do that.

Q. Would a renal sonogram be an appropriate test to perform on a person whose IVP shows a cyst or mass?

MR. KELLEY: Objection. You can answer.

A. That can give more information. I don't think that it's necessarily the only test.

Q. What information would a renal sonogram provide you as

to a cyst or mass in a patient's kidney?

A. Just as with the IVP, a renal sonogram is, many times, not a precise test. There are artifacts that enter in just. as with regular x-rays and shadows, and a sonogram can show a clearcut cyst where the radiologist doesn't see anything else, or there may be a tumor within the cyst that the sonogram will not resolve, or it could show what appears to be a solid mass or it could be a pus-filled cavity which will appear different from a cyst but may re-assemble a solid mass, and there are other possibilities, so it's not a totally precise test.

Q. In your experience, would a CT scan be a more appropriate test to perform on a person whose IVP showed either a cyst or mass?

A. A CT scan is what I normally would get to differentiate those.

Q. Doctor, assume that it's true that -- assume the following to be true, that on October 20th of 1998, while Nancy Farkas was in the emergency department, the IVP test that was performed on her showed a cyst or mass. Do you have an opinion as to whether or not a CT scan should have been performed on her while she was still within the emergency department?

MR. CULLEN: Objection.

MR. KELLEY: Objection. We're

talking about Nancy Farkas now?

MS. DIXON: Exactly.

MR. KELLEY: You can answer.

A. I don't think that it necessarily should be done in the emergency room setting because it's almost -- I don't think that's an emergency type of finding based on what you have told me.

Q. You have, in fact, seen the IVP results from 10/20/98 as they relate to Nancy Farkas; correct?

A. Yes.

Q. And do you have a copy of the same in your chart?

A. Yes.

Q. Directing your attention to the conclusions, can you take a moment and review those, please?

A. You wish me to read them?

Q. Just review them to yourself.

A. Okay.

Q. Would you agree with me that the conclusion showed two separate -- draws two separate conclusions based on the IVP?

A. Yes.

Q. And in the course of your practice, you would see an obstructive uropathy that's described under the conclusions as a different condition from a persistent filling defect; correct?

A. Usually those would be separate conditions unless they

18:06 are related.

Q. And being separate conditions, would you agree that each of those conditions needs its own course of follow-up care and treatment?

18:06 MR. CULLEN: Objection.

A. I think that one would normally integrate that information as part of one's patient care and make a judgment as to the appropriate timing for each of those problems.

18:06 Q. My question was, you have agreed that those are two separate conditions; correct?

A. I've agreed that they are stated as two separate findings.

Q. And my question is, assuming that they are two

18:06 separate findings, would you agree that each of those findings, based on what you have reviewed, require a separate course of follow-up care and treatment?

MR. KELLEY: Objection.

A. I wouldn't agree with that statement because sometimes

18:06 the follow-up care will encompass both of those conditions.

Q. Does the portion -- does your copy of the final IVP report have a fax header on the bottom?

A. Yes; it does.

Q. And based on your review of that, would you have any

18:07 quibble that it was received in your office on October 28th

of 1998?

A. I would not disagree with that.

Q. And how is it when a fax like this comes into your office on a patient that you have previously seen, is it brought to your attention or simply put in their chart?

A. It's brought to my attention.

Q. Do you have a recollection of reviewing Nancy Farkas' IVP results when they were faxed to your office on October 28th?

A. I'm sorry, can you clarify that?

Q. We established the fact that based on the review of the fax header, in all likelihood, this report arrived in your office on October 28th of 1998; correct?

A. Correct.

Q. And you said that it's customary in your office for these types of facsimiles to be brought to your attention immediately as opposed to simply being placed in the patient's chart; correct?

A. That's correct.

Q. My question is, do you have a recollection of reviewing these IVP findings when they arrived in your office in October of 1998?

A. Yes. I remember reviewing these findings.

Q. And do you remember reviewing those findings upon receipt in the office or in conjunction with an office visit

with Nancy Farkas?

A. Both.

Q. When you -- I'm assuming that your, based on review of the chart, review upon receipt of the fax would have happened prior to your second visit with Nancy; correct?

A. That's correct.

Q. When you reviewed the IVP results after they were faxed to your office in October of 1998 and you reviewed the two conclusions contained in there, did one of those conclusions or findings cause you more concern than the other?

A. The finding that the kidney was almost completely obstructed made me concerned that that needed to be relieved as soon as possible, that that was more of an immediate concern.

Q. Let me back up for just a minute, doctor. On 10/26/1998, what was your differential diagnosis as it relates to Nancy Farkas?

A. I didn't list a specific differential diagnosis. My primary and most likely diagnosis was that she was passing a stone, because that's far and away the most common thing to explain the symptoms that she was having.

Q. Is it fair to say that on October 26th of 1998, and directing your attention to that visit and that visit only, that renal cell carcinoma was not part of your differential

18:10 diagnosis?

A. I didn't write that down, but there are always many explanations for pain and bleeding, as we have discussed earlier, but that's a very much less common cause of this

18:10 type of presentation.

Q. So the answer is yes or no. You did or did not include renal cell carcinoma in your differential diagnosis on 10/26/98?

A. As I said, I didn't write it down, but mentally I

18:10 always consider as many possibilities as 1 can think of.

Q. Whenever it was that you actually reviewed this fax for the first time, and let's assume it was at least within a day or two of receipt in your office, coupled with the information you gleaned based on the 10/26/98 visit with

18:10 Nancy, did you amend or otherwise change your differential diagnosis?

A. Well, I knew that there were two problems there.

Q. And let's, for clarification purposes, identify in your own words what the two problems or findings that you

18:11 were dealing with were.

A. I felt that the primary problem was that she had a nearly totally obstructed kidney most likely from a stone. There was a stone in the other kidney, so it was -- that part was visualized as a stone, and so it seemed reasonable

18:11 that she was, in fact, passing a stone on the right side and

that it had caused some blockage, and so I felt that was the primary problem that was causing her periodic pain and illness.

And then there was a questionable area in the kidney that was thought to be either a cyst or a mass based on the IVP, and the great majority of the time these are cysts at age 50 or older, but that needed to be addressed at some point during the follow-up.

Q. Did you want to add something to that?

A. I recall that, not during my initial review of this faxed x-ray report but during the next visit with the patient and her sister --

MR. KELLEY: I think we'll get to that. She asked about the initial review.

THE WITNESS: Okay.

BY MS. DIXON:

Q. Based on the information you received either based on the 10/26 visit independently or in conjunction with receiving this final IVP report, did you have an understanding as to what Nancy's family history was with respect to cancer?

A. No. She did not give us a history of family problems with cancers. I think it would have been in my notes.

Q. And let me just make sure. Are you referring to the form in your chart that says "history and physical"?

18:13 A. I am.
Q. And how is it -- is it your office procedure -- that this information is elicited on the history and physical?
A. Okay. The nurse takes the initial interview
18:13 information, and you can see the date, 10/26/98, at the top of the part which says "chief complaint," and the nurse goes through a series of questions and takes vital signs, and then I review that information when I see the patient to make sure that there aren't any additions or corrections or
18:14 modifications.
Q. So would it be fair to say that form that's identified as history and physical, the patient does not physically complete this form? It's done by either you or one of your staff?
18:14 A. That's correct.
Q. And where on the form is it that you can direct my attention to which inquires as to what the patient's family history is with respect to cancer?
A. There is not a specific question, but in medical
18:14 history, it's customary for our nurses and for me to ask about that.
Q. And isn't it true that medical history under "history and physical" relates to Nancy's medical history, not necessarily that of her family?
18:14 A. That's correct.

Q. Since the time that you treated Nancy, have you become aware of what her family history was with respect to cancer?
A. No.
Q. Based on a review of the final IVP test, you told me there were basically two findings. One was a stone which you considered a primary finding. The second was a questionable area of a cyst or mass; correct?
A. That's correct.
Q. And would you agree that the questionable area represented on Dr. O'Campo's note as a probable cyst or mass, would you agree that that second finding is potentially indicative of a life-threatening condition?
A. Potentially. And during what time course, may I ask?
Q. Let me ask you a predicate question. Doctor, is renal cell carcinoma always a potentially life-threatening condition?
A. That's really, again, an absolute type of question. Potentially, theoretically, cancer can certainly be life threatening over a period of time ultimately.
Q. But you saw the questionable area of cyst or mass as a secondary concern as opposed to the stone; correct?
A. I didn't think that it was an emergency at that point.
Q. Notwithstanding your analysis of that not being an emergency at that time, did you believe that the area identified as a probable cyst or mass needed further

18:16 investigation?
A. Yes.
Q. And did you have a time frame in which you expected that further investigation to take place?
18:16 A. Yes.
Q. And what time frame would that be?
A. I told the patient's sister after the retrograde pyelogram, which we're going to get to, that I wanted to be sure that we got additional x-rays within or less than three
18:17 months. I didn't want too long a period of time to go by.
Q. And at the risk of going out of order, let me just follow up on that.
Was Nancy present for that conversation?
A. No.
18:17 Q. And this conversation that you had with the patient's sister indicating you wanted additionah x-rays within the next three months --
A. I said in three months or less; that's correct.
Q. What types of x-rays did you tell her you wanted Nancy
18:17 to have?
A. I don't remember if 1 said specifically CT scan versus ultrasound, but when I integrated the information and thought about the stone workup, I always get a CT scan at the end of my stone metabolic workup when the patient hasn't
18:17 yet had one because IVPs, especially with unprepped bowels,

18:18 are not precise enough, and I like to have a snapshot and know where all the stones are and how big, and I planned to do it at that time, during the outpatient follow-up phase.

Q. And that would relate back to your primary concern 18:18 which would be the stone?

A. It would, but it would also double check this questionable area in the kidney.

Q. During that conversation that you had with the patient's sister, did you tell her that you had any concerns 18:18 regarding the possibility of renal cell carcinoma?

A. I told her that a mass can be a cancer.

Q. Did you specifically tell her there was a mass?

A. Yes. Actually, she knew it before. She knew it from the November 12th visit where I went over the findings with 18:18 Nancy and her sister.

Q. And we'll get to that in just a moment. Let me follow up on this conversation after the retrograde pyelogram.

To confirm, Nancy wasn't present; correct?

A. She was still groggy in the recovery room.

18:19 Q. You don't recall if you specifically indicated what tests you would like to have performed; correct?

A. I'm quite certain I would have said CT scan. At least that's what I always get.

Q. And that CT scan, obtaining that CT scan is part of 18:19 your standard protocol as a stone workup; correct?

18:19 A. It's what I do at the end of a stone workup if a patient hasn't had one before to show where their stones are.

Q. Correct me if I'm wrong, but at the conclusion of the 18:19 10/26 visit, you gave Nancy instructions to strain her urine; correct?

A. That's correct.

Q. Do you know whether or not she had been provided a strainer upon departing the emergency department on 18:19 10/20/98?

A. I don't know, but the strainers in the emergency room are often paper and they disintegrate after a few times, so we give one here that's plastic and that holds up better.

Q. Do you know what -- so the answer to my question do you know whether or not she was given a strainer on 18:20 discharge is no?

A. I don't know for sure.

Q. Based on your review of the records, do you know whether or not Nancy was instructed to strain her urine while in the emergency department on 18:20 10/20/98?

A. I don't have a copy of the emergency room records to refer to and I can't recall.

Q. Notwithstanding the same, on 10/26/98, you gave her a strainer and instructions as to watch for the passage of a stone; correct?

18 20

18:20 A. That's correct.

Q. In addition, you instructed Nancy in the event that she passed a stone, she was to bring the specimen to your office for further analysis; correct?

18:20 A. That is correct.

Q. Moving from the time period of 10/26/98 through 11/12/98, and you would agree that 11/12/98 was the next time you saw Nancy in the office correct?

A. That's correct.

18:20 Q. And it was during that period of time that you expected Nancy to strain her urine at home; correct?

A. That's correct.

Q. And would you likewise agree that during that 17-day time period, she did not retrieve a stone and, in turn, 18:21 bring it back to your office for analysis?

A. That is correct.

Q. And separate and apart from that, she did not report to you that she had any passage of stone during those 17 days; correct?

18:21 A. She didn't report it; correct.

Q. So from the time of onset on 10/20/98 to the time of your 11/12 visit, there were 23 days that passed that Nancy, at least by self report, did not have a passage of a stone; correct?

18:21 A, That's correct.

Q. And, again, doctor, if you need to refer to your office note for 10/12/1998 --

MR. KELLEY: 11/12.

BY MS. DIXON:

Q. I'm sorry. 11/12/1998. Can you describe for me what Nancy's condition was when she presented on that date to your office?

A. My notes don't indicate what her condition was. By "condition," I assume you mean whether she was in pain at that moment.

Q. Well, let's take it one at a time. First of all, would you agree your note is silent as to whether or not Nancy was in pain on presentation on 11/12 of 1998?

A. I didn't specifically mention if she was in pain that day.

Q. Is there anything in your note which would illuminate whether or not she had been in pain between 10/26/98 and 11/12/98?

A. There's nothing specific that would say if she was in pain on particular days except that she wanted to still proceed with having the procedure. In our discussion, it was my understanding that she had had some intermittent pains along the course of her ureter.

MR. KELLEY: I'm showing him the record.

18:24 A. Let's just check all the records here. Okay. It is here in the notes. She had had some pain a few days before, a couple of times.

Q. Doctor, can I just ask you to identify for the record 18:24 what document you are referring to?

A. That's one of our office sheets dated 11/12/98. Not the typed note but the handwritten.

Q. Who would that have been completed by?

A. That was one of our nurses.

18:24 Q. And on the second handwritten line, it says, "episode of bleeding and"?

A. Slight pain.

Q. "On Sunday and Monday"; correct?

A. That's correct.

18:24 Q. And there's no indication as to which Sunday and Monday that was; correct?

A. It doesn't say specifically which Sunday and Monday, but when the nurse writes that, it's usually the most preceding date.

18:25 Q. When Nancy had been in your office on 10/26 of 1998, you gave her an additional prescription of Toradol, 30 tablets; correct?

A. That's what the record says.

Q. And that Toradol was for pain; correct?

18:25 A. Yes.

18:25 Q. And Nancy was to take the Toradol p.r.n.?
A. That's correct.
Q. When Nancy came back to your office on 10/12/98, did you refill the Toradol prescription?
18:25 MR. KELLEY: 11/12.
BY MS. DIXON:
Q. 11/12. I'm sorry.
A. You don't mind if I refer to my record?
Q. Absolutely not.
18:26 A. I don't have an indication that I wrote another refill for it on the 11/12/98 date.
Q. Was Nancy alone at the 11/12/98 visit?
A. No.
Q. Was she accompanied by her sister?
18:2 A. Yes.
Q. And is my understanding correct, that, at least as you understood, it was her sister who was a nurse?
A. That's correct, She had worked as a nurse in the past.
18:2 Q. Between the time of your 10/26 visit and your November 12th visit, you had received a faxed copy of the IVP final report; correct?
A. That is correct.
Q. Were you ever provided a copy of the provisiona IVP
18:2 report?

18:27 A. If I was, it would, I would think it would be in this chart and I don't spotlit, And I don't recall if I ever saw a provisional report on this patient.

Q. Dr. Noble, between the 10/26 visit and the

18:27 November 12th visit, did you request the totality of Nancy Farkas' emergency room records from October 20th of 1998?

A. It's our custom to try to get copies; yes.

Q. And is there a notation in the record that you can direct me to that suggests there was a request made of the

18:27 complete emergency department chart from 10/20/98?

A. I don't see anything in the record, but we don't usually write that request down.

Q. You're aware of the fact that while a patient in the emergency department on 10/20/98, Nancy not only had an IVP

18:2 but also a KUB; correct?

A. A KUB is normally part of an IVP. It's done as the preliminary film before giving the contrast, so I would assume that's correct.

Q. And after your 10/26 visit, you ordered a repeat KUB;

18:2 correct?

A. That is correct.

Q. What was the purpose for ordering the repeat KUB?

A. It's customary to get that as a minimum when following a kidney stone just to see if the stone has moved.

18:2 Q. At the time of your November 12th, 1998 visit with

Nancy Farkas, did you have available to you both the KUB film from 10/20/98 as dell as the KUB film from 10/27/98?

A. My notes don't indicate which KUB, but I'm pretty certain that I would at least have had the most recent KUB and I would have had her IVP, so I presume that included the KUB done on the same 10/20/98 because an IVP, complete IVP, includes a KUB.

Q. For clarification of the record, doctor, I'm just going to show you that I have marked as Exhibit 2 the requisition form for the KUB, 10/27/1998.

A. Okay. The one which we ordered you mean?

Q. Yes.

A. Okay.

Q. Is that the type of form you would prepare requesting such a diagnostic film?

A. Yes.

Q. And I have also marked as Exhibit 3 what I understand to be the final report from the 10/27/98 KUB

A. Okay.

Q. And the originals of those documents are contained in your chart that you have in front of you; correct?

A. That's correct.

Q. At the time of Nancy's November 12th visit, you would have not only had the KUB film from 10/27 but also the final narrative report for the KUB of 10/27/98?

18:30 A. On November 12th, would I have had the 10/27 reports?
Q. Yes.
A. If they came up with her films. My note says that I reviewed the films. I know that I had the faxed IVP report,
18:30 but I would presume that I had all of those reports.
Q. On November 12th, did you also perform a physical exam on Nancy?
A. Yes.
Q. And tell me what that examination consisted of.
18:31 A. I examined this patient's head, eyes, ears, nose and throat, chest, heart and general appearance.
Q. Did you perform an additional urological examination on Nancy on November 12th of 1998?
A. Only as far as the abdominal examination goes. I
18:31 didn't do a genital examination but planned to do that in the operating room when the patient was prepped and undressed.
Q. During the course -- actually, doctor, let me go back to the last question.
8:31 When you were just identifying what your physical exam from November 12th consisted of, I noted you were referring to a page in your chart; correct?
A. That's correct.
Q. Can I just see what portion of your chart you are
18:32 referring to?

18:32 A. Okay. It's the part of this history form that is in different ink. I think that I did that. Well, going back on it now, the date on the bottom may be just when it was faxed over to surgery, and I cannot tell for sure if this 18:32 exam was done on the initial visit on 10/26 or on the second visit 11/12.

Q. On your note of November 12th, is there any indication that you performed a urological physical exam on Nancy?

A. I said, "please see the written H and P," but that's a 18:32 typo there. History and physical, H and P. So that is what led me to think that I went back and reviewed and did that exam then.

Q. Do you know whether or not on November 12th of 1998 Nancy had pain on palpation in her flank area, right side?

12:48 A. My recollection is that that very day she did not.

Q. So, as I understand it, when she presented to your office, "she" being Nancy, on November 12th of 1998, she did not present in pain; correct?

A. That's correct.

12:48 Q. She had no physical pain on palpation in her flank area on the right side; correct?

A. At that particular time of day on that day, that's correct.

Q. There was no need to write her additional 12:48 prescriptions for pain medication; correct?

A. Either she hadn't used up her old pain medicine or she found the pain was manageable without it.

Q. And she, at least by self report, had not passed any stones; correct?

A. That is correct.

Q. In the fourth sentence of your November 12th, 1998 progress note, you say, "I think they have a good understanding of the situation and after a long discussion, we elected to proceed with the ureteral stent placement, possibly uteroscopy"?

A. That's correct.

Q. The "they" you are referring to would be Nancy and her sister?

A. That's correct.

Q. And would it simply be the three of you present in the examining room at that time?

A. That's generally correct, unless the nurse was in there for part of it.

Q. And this is a conversation that you would have had after reviewing the films with Nancy and her sister; correct?

A. That's correct. After going over the films and the findings and the reports.

Q. Were there any particular findings on either the IVP or the KUB that you specifically pointed out to Nancy and

her sister?

A. Yes.

Q. And what were those findings?

A. I pointed out that there was an almost completely blocked kidney and that there was an abnormal area in the lower part of the right kidney that I thought was probably a cyst but would need further evaluation.

Q. This blockage in the right kidney, was that also able to be appreciated on the October 27th, 1998 KUB?

A. 1 think a KUB doesn't show whether a kidney is blocked or not.

Q. So had Nancy had an obstruction in her right side on 10/20 which had passed, there were no films that you had in front of you on November 12th that would indicate that; correct?

A. There were no films to indicate whether that was correct or not.

Q. You were relying exclusively on her symptoms via self report; correct?

A. I was primarily relying on the symptoms plus my clinical knowledge of how stones behave and the fact that sometimes patients don't even have pain when a kidney becomes blocked for awhile.

Q. Were there any other diagnostic tools available to you on November 12th of 1998 to rule in or rule out whether or

not she, "she" being Nancy, continued to have a stone in her right side absent surgery?

A. Well, the diagnostic tool that I normally proceed with is a retrograde so that I can also treat and bypass the stone and do it all in one setting and try to prevent further pain or damage to the kidney. When a kidney is blocked a long time, it can become damaged. I didn't order a separate x-ray before doing the retrograde.

Q. And it's your testimony that during the course of the November 12th, 1998 visit, you also pointed out to Nancy and her sister an abnormality in her right kidney?

A. I did.

Q. And you identified that as a possible cyst?

A. I said that it was probably a cyst, but I told them there was a slight chance, an outside chance, that it could be a tumor that had bled and masqueraded as a stone, and they had a look of shock, and I said, it's unlikely, but it's possible and for that reason I felt we needed the option to do other tests later.

Q. In the face of their look of shock, did they query what other tests would be available to further rule out a cyst or tumor?

A. We talked about those tests and the timing and we agreed that the most important thing was to unblock the blocked kidney and that's what I felt should be done first.

Q. So it's your testimony that during the November 12th, 1998 visit, confronted with a kidney stone that was not currently -- a potential kidney stone which was not currently causing her pain which she did not believe had passed that she didn't need a refill of pain medication for, she was fully ambulatory and reporting to work on a regular basis, that she accepted your conclusion that the kidney stone was a more -- demanded more immediate attention than a potentially cancerous situation?

A. Based on the clinical presentation and the facts that I had available to me at the time, it was my conclusion, my feeling and my impression that this patient's primary problem was an obstructed kidney, and in my experience, sometimes an obstructed kidney stops hurting and patients don't even know that a kidney has remained blocked. In fact, many times a stone eases up and pain goes away and it's dangerous *to* just leave it like that and not fully investigate that and take care of it if there's a blockage because the patient will lose their kidney.

Q. Would you also agree with me oftentimes renal cell carcinoma has an absolutely asymptomatic presentation?

A. Many times it does, but then it doesn't present. It's found in the course of accidentally by other tests.

Q. At the time of your November 12th, 1998 visit with Nancy Farkas, were there any -- are there any lab results or

18:39 diagnostic studies that you can direct me to which would suggest that Nancy was in danger of kidney damage or kidney failure?

A. There are none suggesting kidney failure because her 18:40 other kidney was not blocked and you can remove one kidney entirely and a patient would have normal kidney function on any kind of laboratory testing. But from experience, I know that if a kidney is completely blocked, there's damage that becomes irreversible.

18:40 Q. Now forgive me if I have asked this already, but in the face of your disclosure on November 12th of 1998 of an abnormal right kidney that was a probable cyst and may remotely be -- there may be a remote chance it was a tumor, did either Nancy Farkas or her sister inquire as to what 18:40 diagnostic tests would be employed to rule cancer in or out?

A. I believe I already said that I would need to do some additional tests later, but the first priority I felt was to get the kidney unblocked because I assumed there was a fairly significant possibility that it was still blocked.

18:41 Q. I appreciate that answer, doctor, but my question was, were there any specific diagnostic tools discussed with Nancy and/or her sister that would be utilized by you to rule in or rule out renal cell carcinoma?

MR. KELLEY: Objection. Asked and 18:41 answered. You can answer again.

18:41 a. I told them I would need to do additional imaging later to clarify that, and my best recollection is that I said a CT scan but I thought that could be done afterwards.

Q. Would it be fair to say that on November 12th of 1998, 18:41 renal cell carcinoma was part of your differential diagnosis?

A. I thought that it was a very low probability but certainly it was a possibility.

Q. Okay, doctor. And I would like to confine your answer 18:41 to the next question to your record as it relates to accepting this patient through your conclusion of the visit on November 12th of 1998.

Is there anywhere in your record that indicates a concern regarding renal cell carcinoma?

01:05 A. I didn't specifically say those words, but I know that I reviewed all of the findings of the x-rays with the patient and the sister including the findings as listed in the x-ray report and that there was some type of a possible mass there.

01:05 Q. An again confining your answer to your record up through the conclusion of the visit on November 12th of 1998, is there anywhere you can direct me to a plan of care as it relates to further evaluation of Nancy Farkas' abnormal right kidney which you found to be or believed was 01:05 a probable cyst and had a remote possibility of being a

tumor?

A. Well, in the x-ray it says that and I think you have seen it that a CT scan or renal sonogram would be helpful for further evaluation.

Q. I appreciate --

A. I didn't rewrite that; no. I didn't rewrite that.

MR. KELLEY: Is it in his chart? That was your question?

MS. DIXON: It was.

BY MS. DIXON:

Q. And is there anywhere in -- let me rephrase the question.

Would it be fair to say that November 12th, 1998 was the first time you had met with Nancy Farkas after receiving both the narrative report or the final narrative report of the IVP as well as having had an opportunity to review the actual films?

A. Yes.

Q. Is there anywhere contained in the November 12th, 1998 note which indicates a concern regarding the possibility of renal cell carcinoma?

MR. KELLEY: I'll object. 1 don't know what you mean by "indicates a concern." Do you mean the words "renal cell carcinoma"?

MS. DIXON: Yes.

18:44 THE WITNESS: Do you want me to answer that now?

MR. KELLEY: You can answer. I'm objecting.

18:44 A. I didn't specifically say renal cell carcinoma in my note.

Q. Is there anywhere in your November 12th, 1998 note which states that a CT scan would be ordered for this patient prospectively?

18:45 A. I didn't say that in the note because it was already in the x-ray report and recommended, and I went over that with the patient and her sister.

Q. At the time of your meeting with Nancy Farkas and her sister on November 12th, 1998, did they reveal to you any

18:4 relevant family history regarding cancer?

A. I don't recall that they did.

Q. Do you have any recollection of them informing you that their father was in the process of dying from stage four prostate cancer at the time of that visit?

18:4 A. I don't recall them saying that.

Q. Your note goes on to indicate that Nancy would also like a Pap test at that time; correct?

A. Well, actually, she didn't get routine tests for general health checkups and she agreed to have a Pap test at

18:4 my urging because I would be doing a pelvic examination at

the time of the cystoscopy anyway and I would be there and in case I found something during that examination, I wanted to be able to go ahead and get that test, so she agreed to it.

Q. And you are obviously alarmed by the fact that Nancy had not had a Pap test in 15 years as indicated by the exclamation point at the end of your sentence there; correct?

A. I was quite concerned that this patient didn't get routine care.

Q. And what was your primary concern as to Nancy not having regular Pap tests?

A. Cancer of the cervix is one of the most common cancers in women and routine Pap tests have been shown to be very helpful in enabling early diagnosis of that condition at a time when it might be more curable.

Q. And at least in the face of cervical cancer, early diagnosis and treatment enhances a patient's likelihood of a successful outcome; correct?

MR. KELLEY: Objection to generality. You can answer.

A. That's very general. One would obviously like to diagnose it earlier rather than years later when it's more advanced.

Q. Specific patient profiles aside, this is a generic

18:47 question. Would you agree with the fact that in most forms of cancer you deal with in the course of your practice, early treatment is an important factor in a successful outcome?

18:47 A. I think that's a very general and hypothetical question, but certainly one would ordinarily strive towards finding out things at an earlier stage. The exact timing is something that depends upon the clinical situation at hand.

Q. Your note from November 12th, '98 also indicates that

18:48 "risks and complications discussed at length"; correct?

A. That's correct.

Q. And what risks and complications were discussed with Nancy and her sister on November 12th of 1998?

A. Ordinarily I discuss the risks and complications of

18:48 the procedure that I am planning to do, and those complications are typically bleeding or infection, possible perforation of the ureter, if one puts a scope up, or perforation into the bladder, through the bladder, pardon me. Sometimes there are anesthetic complications including

18:48 death. Those are the main ones.

Q. Your note seems to indicate, as well, that you discussed alternatives with Nancy and her sister; correct?

A. Yes.

Q. What type of alternatives did you discuss with Nancy

18:49 and her sister?

18:49 A. Alternatives to the direct intervention which would include other types of imaging studies being done right then.

Q. Such as?

18:49 A. Such as the ones we have discussed. A CT scan to be done right then, a renal scan or another IVP to see if there's any further obstruction, but the CT would usually tell you that, and basically alternatives in terms of just putting a stent up, if there's a stone, or going after it with a scope and a basket. Different types of interventions to deal with the obstruction.

Q. At any point during that November 12th office conversation with Nancy and her sister when these alternatives were being discussed, did either Nancy or her sister query why it wouldn't be more prudent to begin with the CT scan since, as you indicated earlier, that would assist you in further diagnosing the cyst or mass that you had been appreciating on IVP?

A. We talked about the possibility, based on my best recollection, but it was my feeling and they agreed that the most urgent thing was to relieve the obstruction of the kidney, and we decided we would wait on further imaging studies of the kidneys.

Q. Dr. Noble, I understand that there was, in fact, a time it was determined that you would proceed with the

ureteral stent placement and uteroscopy; correct?

A. That's correct.

Q. Is there anything, and I mean medically, that would prohibit performing that procedure in conjunction with an, and I mean either before or after, a CT scan?

A. You mean medically would there be something wrong with getting a CT scan first?

Q. Correct.

A. There's nothing medically wrong except that it doesn't solve the immediate problem, which is relieving a blockage, which I thought was very likely to still be present. Also, a CT scan can take sometimes a couple of weeks to get scheduled, and so my first priority was to diagnose and relieve the stone problem that I thought was in effect with respect to the blocked right kidney.

And, also, I thought there was a possibility of a tumor within the lining of the urinary tract that had bled, and so the operative findings could dictate a different course and a different set of studies depending upon, you know, what one found. And in the course of our discussion, we, based on an integration of all of the clinical information available at that time and the way the patient and her sister felt, we agreed that we should proceed with the retrograde pyelogram, possible stent, possible stone intervention first.

18:52 Q. Based on your previous testimony, you indicated that you reviewed the final IVP report at least somewhat contemporaneously with it arriving in your office; correct?

A. That's correct.

18:52 Q. And that would have been either the 28th or 29th of October; correct?

A. I don't know exactly which day. It would have arrived in the office the 28th, but if I was in the operating room or out of the office for several days, it's possible that it

18:52 was on my desk and they found the chart and a few days more may have passed.

Q. I believe you indicated earlier based on your review of the IVP, final report of the IVP, you had intentions of following Dr. O'Campo's suggestion in getting a CT scan;

18:52 correct?

A. That's correct.

Q. From the time you reviewed Dr. O'Campo's final IVP report, did you take any steps between that time and seeing Nancy on November 12th to schedule a CT scan?

18:53 A. Not at that time.

(Thereupon, a .recesswas taken.)

BY MS. DIXON:

Q. Doctor, when we went off the record, we were discussing the November 12th, 1998 note and we discussed the

18:54 fact that at the conclusion of that meeting with Nancy,

18:54 there was a decision to place the ureteral stent; correct?
A. As the first thing.
Q. And undergoing, possibly undergoing, a ureteroscopy?
A. That's correct.
18:54 Q. At the end of your time with Nancy, was that procedure or procedures scheduled?
A. (No response).
Q. Maybe I can facilitate things for you, doctor. My review of the record seems to indicate there was an initial
18:59 procedure scheduled for November 16th of 1998.
A. That's correct.
Q. Would that procedure have been scheduled at the time of the November 12th office visit?
A. Yes; it would have.
18:59 Q. Now, let me jump back to the alternatives that you discussed with Nancy and her sister. At any point during that conversation, did you offer as an alternative simply waiting to see if her symptoms returned before undergoing any additional or more aggressive intervention?
18:59 A. I'm sure I would have mentioned that as an option, but I would not have recommended it, because if the kidney were obstructed and it said almost total and after quite a few hours, no contrast was seen in the lower ureter, I would be concerned about further damage and that's why we tried to
19:00 get radiograph -- this retrograde done within a few days.

19:0 We had already done a lot of waiting, basically.

Q. And would it be fair to say that when you met with Nancy on November 12th of 1998, you based your evaluation of this blockage on the October 20th IVP?

19:0 A. And the fact that she had continued to have intermittent pain, that she still had traces of blood in her urine and that she told me she still felt like something was passing along the tube.

Q. Any of the symptoms you have just described, blood in 19:0 her urine, intermittent pain and a sensation of something foreign on her right side, would any of those three symptoms be consistent with the presence of a cyst or mass?

A. Very unusual unless the mass or cyst were very large and were pressing on the ureter causing obstruction, and the 19:0 course of the pain that she described was not typical for that type of a presentation.

Q. You made several suggestions to Nancy during the November 12th visit; correct? You suggest that she have surgical intervention for the stone; correct?

19:0 A. That's correct.

Q. You also suggest that she undergo a Pap test?

A. That's correct.

Q. And she consented to both of those procedures; correct?

19:0 A. That is correct.

19:01 Q And, likewise, she agreed, as a result of your October 20th visit, to return to the hospital and have an additional KUB film done; correct?

A. That's correct.

19:03 Q And, in fact, this surgical procedure was scheduled for November 16th of 1998 and Nancy appeared at the hospital as directed at the appointed time; correct?

A. That is correct.

Q. Confining your answer to just this time frame through November 16th of 1998, did you find Nancy Farkas to be a compliant patient?

A. Yes; I did.

Q. She arrived at all scheduled appointments; correct?

A. That is correct.

19:03 Q. Underwent all diagnostic tests that you requested she or suggested she underwent; correct?

A. That's correct

Q And underwent all procedures that you requested or suggested that she have done; correct?

19:0 A. That's correct.

Q. Now, directing your attention to November 16th of 1998, the date of the initial surgical procedure, as we stated earlier, Nancy presented at EMH; correct?

A. That is correct

19:03 Q She was prepared for surgery in the usual fashion?

19:03 A. She was pre-opped, but she did not get a surgical prep. Well, I guess she may have. I would have to review the in-hospital chart to see if she actually had a surgical prep, but my recollection is that the x-ray machine was
19:04 broken that day and we had to reschedule, and I'm not certain how complete a prep she had on the 16th.

Q. Ultimately, you gave Nancy instructions to -- you discharged her from the hospital and she was instructed to return on an alternative date; correct?

19:04 A. When the machine would be working; that's correct.

Q. What was that date that Nancy returned for surgical intervention?

A. That was November 23rd, 1998.

Q. And describe for me what procedure you undertook on
19:0 November 23rd of 1998.

A. I did a Pap test and a pelvic examination and then I performed a cystoscopy and right retrograde pyelogram.

Q. At the time that you did the Pap test and bimanual exam on Nancy, was she under anesthesia?

19:0 A. She was under IV sedation, so she was not 100 percent asleep, but she was groggy and relaxed.

Q. Would that be considered a twilight anesthesia?

A. Some people call it IV conscious sedation or light anesthesia.

19:0 Q. Is that an unusual circumstance under which to

perform, in your practice, to perform a bimanual exam and a Pap?

A. It's very usual if you're also doing a cystoscopy and a retrograde pyelogram.

Q. And both of those procedures were scheduled on 11/23; correct?

A. That's correct.

Q. Can you explain to me why it was you elected to proceed with the ureteral stent placement?

A. On 11/23?

Q. Yes.

A. I didn't proceed with placement of the ureteral stent.

Q. Let me back up and ask a different question. In classic situations, would you agree the placement of a ureteral stent is to assist you in locating a stone or an obstruction?

A. No; I wouldn't agree with that statement.

Q. What is the purpose for placing a ureteral stent?

A. Well, maybe 1 can clarify and help a little bit. There are different kinds of ureteral stents. One is an indwelling or internal stent that you use as a bypass tube, but in this particular case, I didn't place a ureteral stent. I used a bulb tip uretero catheter which is inserted just into the opening leading up to the ureter right where it enters the bladder to introduce contrast or dye to light

up that tube to get a picture, to get an x-ray. So in this case, that's what I was doing.

Q. Was the procedure that you ultimately performed on Nancy on 11/23 the same procedure you had planned to perform on 11/16 but were precluded from doing so because of the equipment malfunction?

A. Well, it was the initial part of the procedure planned for either day. May I clarify?

Q. Please do.

A. I didn't find an indication to go ahead with either leaving an internal stent or doing a ureteroscopic procedure because the retrograde pyelogram was normal on 11/23/98.

Q. And what is a retrograde pyelogram diagnostic of, diagnostic for?

A. It helps to light up the ureter and the renal collecting system to see if there's an obstruction or filling defect that might indicate tumor or blood clot within that part of the upper urinary tract.

Q. Did you re-review the IVP films prior to the procedure on November 23rd?

A. Yes; I did.

Q. And when you saw Nancy at the hospital on November 23rd, was she still complaining of persistent right flank pain?

A. She had indicated that it was coming and going. I

don't recall how severe the pain was at that particular moment, again, but I know that she had intermittent pain still.

Q. Dr. Noble, I apologize for any duplicity of this question, but on November 23rd, 1998, you performed a retrograde pyelogram; correct?

A. That's correct.

Q. Are there any other procedures that you performed on Nancy on 11/23?

A. I did a Pap test and I did a pelvic examination and I did a cystoscopy, which we mentioned, to look around the bladder and the urethra.

Q. And the retrograde did give you the ability to inspect both the urethra and the bladder; correct?

A. The cystoscopy allowed me to inspect the urethra and bladder and the retrograde delineated the ureter and the collecting system of the right kidney.

Q. And were both the urethra and the bladder normal?

A. Yes.

Q. Would you agree that your findings relative to the retrograde pyelogram were that there was no obstruction?

A. That's correct.

Q. There was no hydronephrosis?

A. That's correct.

Q. And that the right side had a normal collecting system

and a normal ureter?

A. That's correct.

Q. So there was, in fact no blockage to Nancy's kidney on November 23rd, 1998 when you performed this procedure; correct?

A. That's correct.

Q. Your concerns that were discussed with Nancy and her sister in terms of your primary diagnosis on November 12th, 1998 were, at least by the time the procedure was finally done, unwarranted; correct?

MR. KELLEY: Objection to the word "unwarranted."

A. I don't think they were unwarranted. I think I was relieved that she had passed whatever had been obstructing and that we didn't have to be worried about a continuing blockage of the kidney.

Q. And at that point in time, Nancy was -- am I correct that Nancy's kidney was not in danger any longer?

A. I didn't feel that it was in danger from a blockage at that point.

Q. Now, as it relates to the retrograde pyelogram, does that diagnostic tool provide you any additional information regarding the probable cyst or mass that you were able to appreciate on the IVP?

A. It doesn't in this case except to say that whatever

19:12 that is in the kidney is not big enough or in a location such as to impinge or press on the collecting system or the ureter.

Q. So the fact that the retrograde pyelogram was, for all 19:12 intents and purposes, normal, did not give you any additional diagnostic information relative to the cyst or mass?

A. That's correct.

Q. At the conclusion of the retrograde pyelogram, did you 19:12 speak to Nancy, Nancy's sister or both of them?

A. I spoke to Nancy, but she was groggy from the intravenous sedation, and I spoke to her sister in the waiting room to just go over the results.

Q. From the time that you first reviewed the final IVP 19:12 report to the date that you did this retrograde pyelogram, there was approximately between, dependihg on when you reviewed it, 21 and 23 days that had passed; correct?

A. From the time that I reviewed the report to the date of this procedure? It could have been two or two and a 19:13 half weeks. It depends whether I was out of the office for a few days or something or whether they had to find the chart, but something like two to three weeks.

Q. Between receipt of the final IVP report and the date you performed the retrograde pyelogram, had there been any 19:13 efforts undertaken either by you or on your behalf to

19:13 schedule Nancy Farkas for a CT scan?

A. Not at that time.

Q. At the conclusion of the retrograde pyelogram, did you discuss either with Nancy or her sister scheduling a CT

19:13 scan?

A. I talked to her sister because she asked me what about the mass that I had mentioned on November 12th and I said we would get to it during the course of the outpatient workup and follow-up for the stones.

19:13 Q. Did you describe for Nancy's sister a time horizon in which you expected to perform the CT scan?

MR. KELLEY: Objection. Asked and answered.

A. She asked when I was going to get it and I said, well,

19:14 we have to get it certainly within three months of the initial visit or sooner. I told her that.

Q. So at the hospital on November 23rd, it's your testimony that you echoed what you had explained to her on 11/12; correct?

19:14 A. That's correct.

Q. Why was it that you performed a bimanual exam in conjunction with the 11/23 procedure?

A. Well, first of all, that's part of the Pap test and pelvic examination. Second, it's part of every cystoscopy

19:14 on the female, and, third, the patient had indicated that

she had had some pain that had moved down into the right lower quadrant.

Q. Did you receive the results of Nancy's Pap test?

A. Yes.

Q. And was it normal?

A. It didn't show anything malignant or dangerous.

Q. Your bimanual exam did indicate a thick adnexa; correct?

A. That's correct.

Q. What is the significance of a thick adnexa?

A. Sometimes it may be non-specific. Sometimes it can indicate that there's an inflammation or sometimes it can indicate a tumor or some neoplastic process.

Q. It is my understanding that subsequent to the retrograde pyelogram you recommended a pelvic ultrasound for Nancy.

A. That's correct.

Q. And based on your review of the record, when was that pelvic ultrasound ultimately done?

A. That was done the day that she came back to see me, on 12/7/98.

Q. How is a pelvic ultrasound different from a renal ultrasound?

A. Pelvic ultrasound looks at the structures in the pelvic cavity and renal ultrasound looks at the kidneys.

19:16 Q. Would you agree with me that a pelvic ultrasound would not provide you with any additional information regarding that cyst or mass that was appreciated on the IVP?

A. I would agree, assuming that the mass wasn't big enough to extend down into the pelvis, which was the case.

Q. As a result of the bimanual exam, did you tell Nancy that her uterus was tipped and that was the reason why you wanted to perform a pelvic ultrasound?

A. I don't recall saying that. I just mentioned that there was some thickening and she had had some pain in that area and that's why I thought we should get that.

Q. Doctor, at the conclusion of the 11/23/98 procedure, you did assume that Nancy had passed the stone or whatever foreign body was creating blockage; correct?

19:1 A. That is correct.

Q. And not withstanding that conclusion, you sent her home with instructions to continue to strain her urine; correct?

A. That's correct.

19:1 Q. And can you describe for me or explain to me what your thinking was in instructing her to continue to strain her urine in the face of basically a negative retrograde pyelogram?

A. Sometimes a stone can be small or have fragments and

19:1 break into small pieces and there could be an additional

19:1 piece that you might not visualize on the retrograde pyelogram that the patient could pass. Furthermore, we knew she had a stone in her left kidney. Sometimes that will pass just as a result of time and going through a procedure.

19:1 I felt that as a matter of course, in case any fragments might be recovered, we would want to analyze them.

Q. Would you agree that there are patients who simply have one episode of a renal calculous as opposed to a protracted history of multiple, multiple episodes of renal calculous?

19:1 A. Yes.

Q. And is it part of your normal course to further or undertake a stone-risk profile on patients that have only had one episode of a renal calculous?

19:1 A. Actually, I do it because approximately 70 percent of patients will have one or more additional stones over a five to ten year follow-up period if you don't diagnose and find out the factors that predispose a stone formation.

But this patient had another stone sitting in her kidneys, so she was already a multiple stone former, in my impression.

Q. She may have had multiple stones, but they were during one episode; correct?

A. No. She didn't have any pain or symptoms relating to the left one. That was an incidental finding.

19:19 Q. Would it be fair, then, to say that your additional studies that related to Nancy's stone profile were prophylactic in nature?

A. The studies are prophylactic in terms of trying to 19:19 prevent more stones from forming in the future, but they're diagnostic because once in awhile a patient can have a life-threatening condition that's causing them to form stones.

Q. I'm sorry. I want to make sure I understood your last 19:19 answer. That is, a patient may have a life-threatening condition that causes them to form stones?

A. Occasionally.

Q. What types of conditions are there that cause, life-threatening conditions that cause, a patient to form 19:19 stones?

A. Well, I can name one that's not that common, but it can happen. That's hyperparathyroidism which is sometimes a serious metabolic disorder. There can be sarcoid or occasionally other conditions that cause stone formation. 19:20 Hyperoxaluria. But usually those patients will have had it for a preceding period of time.

Q. After receiving or determining your results of the retrograde pyelogram on November 23rd, did you draw the conclusion that Nancy's right kidney was normal?

19:20 A. No.

19:20 Q. Let me ask you to take a look at your progress note as it relates to the 11/23 visit -- I'm sorry, procedure.

A. You mean the operative report?

Q. No. Your progress note.

19:20 MR. KELLEY: Is this the 7th?

MS. DIXON: Yeah; I think it is.

MR. KELLEY: I don't know if that's the December 7th note.

MS. DIXON: It's from November 23rd.

BY MS. DIXON:

Q. Do you see the document I'm referring to, doctor?

A. That was from the inpatient chart. I don't have a copy of that. Do you want me to look at that?

Q. Sure. Doctor, I have handed you the inpatient

19:23 progress note from the 11 -- or following the 11/23/1998 procedure.

Would you agree with me that included in that progress note is your evaluation of a normal right kidney?

A. What I meant was that the inside portion of the right

19:23 kidney, the right kidney's collecting system was normal. You can't tell anything about the rest of the kidney on a retrograde pyelogram.

Q. Okay. Prior to the 11/23/1998 procedure, Nancy underwent standard pre-op testing; correct?

19:23 A. Yes.

19:2 Q. She had a chest x-ray?
A. Yes.
Q. You had an opportunity to review the final report on that chest film; correct?
A. Yes.
Q. Would you agree that Nancy's chest film was normal?
A. Yes.
Q. And all of her lab chemistries were within normal limits prior to the 11/23 procedure, as well; correct?
19:2 A. That's correct.
Q. Following up on one of your previous answers specifically as it related to the progress note that said normal right kidney, you indicated that was the internal structures of the kidney; correct?
19:2 A. I meant the inside of the kidney was normal, because that's the only part I examined with the retrograde.
Q. Would you agree that only a CT scan or a renal ultrasound would permit you to visualize the entire kidney?
A. No; I wouldn't say that. But I would say that they
19:2 can visualize the entire kidney.
Q. As a practitioner in the specialty of urology, would you say that a CT scan is the best tool available to you currently to visualize the entire kidney?
A. I think that it's the most complete way to examine a
19:2 kidney.

19:25 Q. Up through November 16th of 1998, you found Nancy to be a compliant patient; correct?

A. That's correct.

Q. And, in fact, she came to Elyria Memorial Hospital for a surgical procedure which had to be aborted because of mechanical difficulties; correct?

A. That is correct.

Q. And despite that unfortunate need to reschedule, she did, in fact, reschedule and again return to EMH; correct?

A. That is correct.

Q. And she underwent the procedure that you suggested; correct?

A. Yes; that's correct.

MR. KELLEY: Objection. Asked and answered

BY MS. DIXON:

Q. And, in addition, she followed back up with your office on December 7th; correct?

A. That is correct.

Q. And she also underwent a pelvic sonogram at your suggestion; correct?

A. That same day.

Q. And up until that point, were there any tests or procedures that you had suggested or requested that Nancy undergo that she refused or declined?

MR. KELLEY: You mean urological tests?

MS. DIXON: Diagnostic tests.

MR. KELLEY: I only say that because of the mammogram reference in the chart. Are you limiting it to urology or not?

BY MS. DIXON:

Q. With the exception of deferring on the mammogram.

A. Well, she refused it.

Q. You did ultimately refer her to Dr. Stamatis; correct?

A. That's correct.

Q. And she did have a mammogram there; correct?

A. I don't know.

Q. I'll represent to you that she did. With the exception of the mammogram, did Nancy Farkas refuse or decline any diagnostic test or procedure which you suggested or asked she undergo through December 7th of 1998?

A. No.

Q. Let me ask you to take out your office note of December 7th, 1998.

A. Okay.

Q. Noting Nancy's CCF number, that's a different number than she had when she first saw you on October 26th of 1998. Is there a reason for the change in the patient number?

A. My best understanding, and I would have to research

this, would be that when the patient originally came in on October 26th, she was Given a temporary number of 87532895 and that the office, in going through the demographic information, found out that she, at some point in time, had been registered in the Cleveland Clinic system in the remote past, presumably, and they found an original Cleveland Clinic number which is a lower number and probably from some years ago, and I think that's the reason the number changed.

Q. Let's talk about the December 7th, '98 visit.

A. Yes.

Q. On that visit, did you perform a physical examination?

A. No.

Q. And why was that?

A. She was feeling well at that time.

Q. Did you discuss any of the diagnostic tests or procedures that you had performed on her'or had requested that she undergo during that visit?

A. Yes; I did.

Q. And which tests were those that you discussed?

A. Well, I discussed the results of all the tests up until then and I explained that we needed to find out why she was a stone former, and her sister said, what about checking on that abnormal area in the kidney, and I said we would get to that, and she said, when, and I said we would get that next visit because it would coincide with my

completion of the metabolic workup and I would have a snapshot of where all the stones were, whatever didn't show up on the IVP, and then I would know if she formed new stones while on a metabolic prevention program.

Q. Is a pelvic ultrasound performed in your office or in the hospital?

A. In the hospital radiology department.

Q. So as of December 7th of 1998, at your request, Nancy had been to EMH for diagnostic testing and/or procedures on four separate occasions; correct? 10/27/98 for the KUB; correct?

A. Okay.

MR. KELLEY: Asked and answered. Go ahead.

BY MS. DIXON:

Q. 11/16/98 for the first attempted retrograde pyelogram; correct?

MR. KELLEY: Objection. Asked and answered three times.

A. That's correct.

Q. 11/23/98 for the actual retrograde pyelogram?

MR. KELLEY: Objection. Asked and answered three times.

A. That's correct.

Q. And 12/7/98 for the pelvic sonogram; correct?

19:29 MR. KELLEY: Objection. Asked and answered three times.

A. That's correct.

Q. And none of those times, despite the fact that she was at the hospital, were any efforts undertaken by you or your staff to schedule a CT scan to further evaluate the cyst or mass appreciated on the October 20th IVP; correct?

MR. KELLEY: Objection.

A. I did not do it in that time frame of several weeks; that's correct.

MR. KELLEY: Deb, you are not going to ask those same six questions again.

BY MS. DIXON:

Q. Doctor, during the pelvic ultrasound that was performed on December 7th of 1998, what would be involved in conducting a renal ultrasound simultaneously?

A. You mean what mechanically is involved?

Q. Yes.

A. Basically one orders the test and the radiology department performs the test scanning higher up in the abdomen with their instruments.

Q. Would there be anything medically that would preclude the ability to perform the pelvic ultrasound and a renal ultrasound during the same visit?

A. There would be nothing to preclude it, but I felt I

was going to get a CT scan anyway in a short time, and in my experience, when I get renal ultrasounds, many times they are not completely diagnostic, as I would like, and I end up having to get a CT scan anyway, and I knew I was going to get a CT scan at the end of my stone metabolic workup and that's why I didn't also get a renal ultrasound at the time of the pelvic ultrasound.

Q. Did you have any plans to, in fact, obtain a renal ultrasound?

A. Not at that time.

Q. Based on review of your December 7th note, you indicated that you recommended Nancy undergo metabolic testing to evaluate stone risk parameters; correct?

A. That's correct.

Q. And Nancy agreed to that; correct?

A. She did.

Q. And what would have been involved in a metabolic workup to evaluate stone risk parameters?

A. We have a panel of tests that we get which we call a stone risk profile here, and the tests are basically written out on the copy of the return sheet that I think you have a copy of.

Q. And didn't Nancy previously have a metabolic panel done on 11/12/98 as part of her pre-op testing, as part of the cystoscopy?

19:32 A. She had a blood chemistry. She didn't have a urine chemistry and she didn't have a parathyroid hormone test.

Q. On 12/7 of '98, did you have any working differential diagnosis as to Nancy Farkas?

19:32 A. Yes.

Q. And what was that?

A. Well, I felt that she had a stone problem and I felt that she probably had a cyst in the right kidney, but we needed to be certain about it as far as urologic problems

19:32 went.

Q. Is there anywhere in the December 7th, 1998 note where you discuss the abnormal findings in Nancy's right kidney, specifically the cyst or mass?

A. I didn't rewrite it in the note; no.

19:33 Q. Is there anywhere in the December 7th, 1998 note where you memorialize any conversations you may have had with Nancy or her sister regarding a course of action to further evaluate the cyst or mass?

A. It's not rewritten in there, no, because it's already

19:33 been written in general in the chart.

Q. Actually, doctor, other than the final IVP report, there is nowhere else in your chart that indicates a course of action to further evaluate the cyst or mass in Nancy's right kidney; correct?

19:33 MR. KELLEY: Objection. You can

answer.

A. There's nothing specifically saying CT, repeating what's in the IVP report, recommendation, but I did refer to the fact that I went over the films and the findings with the patient and her sister during the November 12th visit, and that is in that note.

Q. And that's where you're referring to the "situation"?

A. That's where I'm referring to I went over these films with her and her sister. That's on 11/12/98.

Q. Doctor, is there anywhere in your record through December 7th of 1998 where you, and, again, with the exception of the IVP final report, where you outline a course of action to further investigate or evaluate the cyst or mass in Nancy Farkas' right kidney?

A. There is nothing where I specifically rewrote that.

Q. In fact, there's no place where you actually even wrote it. It was not a matter of rewriting it; correct? You're relying in your testimony exclusively on the findings in the IVP from 10/20/98?

A. And the fact that I remember specifically talking to the patient and her sister about it, because it came up several times during the course of the follow-up.

Q. When patients leave your office and are requested to return, is an appointment scheduled at that time prior to their departure?

19:35 A. Yes, if possible.
Q. And when was Nancy's follow-up appointment after 12/7/98 scheduled for?
A. We wanted to get it in four weeks, but she had some
19:35 things planned over the holidays, and with the office scheduling, it was scheduled for January 15th of 1999 at 1:30 p.m.
Q. And your office calendar would reflect that?
A. We have a computerized scheduling system that is
19:35 through the main campus of the Cleveland Clinic and we don't have a separate printout of all of those computerized schedules.
Q. The notation that you are relying upon that an appointment was made for Nancy on 12/7 of '98 is the entry
19:36 in red in your chart that indicates 1/15/99 at 1:30; correct?
A. That is correct.
Q. And do you know what shift Nancy worked in January of 1999?
19:36 A. No; I don't.
Q. Do you know what time of day her previous appointments were generally scheduled?
A. I would have to go back and look that up, if possible. I don't know what time of day exactly.
19:36 Q. Would you find it unusual that a patient in a

19:36 non-emergency situation would schedule an appointment at a time when they would have to take off of work?

MR. KELLEY: Objection. Don't guess.

A. I wouldn't find it unusual that a patient would take
19:36 off part of the day of work to come see me for continuing tests and evaluation.

Q. Doctor, you mentioned a 24-hour urine had been ordered for Nancy; correct?

A. That is correct.

19:36 Q. Can you tell me what role -- first of all, what's involved in that study?

A. That involves a patient putting all urine that they make into a collection container that would then be submitted to the laboratory for analysis over that 24-hour
19:37 time frame.

Q. That collection container, does that need to be refrigerated?

A. I think the lab instructions say to refrigerate it until it's brought in.

19:37 Q. Is the patient at any point NPO?

A. No.

Q. And would those instructions regarding the 24-hour urine come from your office or the lab?

A. Normally the lab provides the instructions.

19:37 Q. You had had a specific conversation with Nancy

19:37 regarding the need for a 24-hour urine; correct?
A. That is correct.
Q. And if I told you that Nancy Farkas did, in fact, report to the lab at your direction with an order for a
19:37 24-hour urine but was told that she had to save her urine for 24 hours time in order to complete the test and that armed with that information, she returned to your office and asked for clarification as to whether or not the test needed to be done in light of her previously normal findings, would
19:38 you have any reason to disagree with or dispute the fact that such a conversation took place?
MR. KELLEY: That she came back?
A. 1 don't know if she came back to the office or this was over the telephone. I know there was a notation that
19:38 she wanted to know if she really did need to do further tests and we emphasized that she did need further testing.
Q. And are you referring to the portion of your chart that at the top of it says "Noble" then "message/problem"?
A. Yes.
19:38 Q. And it indicates the patient is Nancy Farkas, of course; correct?
A. Yes.
Q. And I assume that is someone on your staff's handwriting, the first three sentences; is that accurate?
19:38 A. That's correct.

19:38 Q. And that note indicates that patient wants to note if 24-hour urine has to be done, if she has to have it, can she wait until around Christmas when she has some time off?
A. And I said it was okay to wait a couple of weeks.
19:39 Q. Do you know who would have been responsible for communicating a response back to Nancy Farkas regarding the parameters, if you will, for the 24-hour urine?
A. Well, of course it was already discussed in the office, but in terms of reinforcing the need to complete
19:39 testing, that would have been my secretary, Joan Holmes, I believe. I think that's her initials on the bottom.
Q. And this message, would this have been done -- I'm trying to understand how this document would have been created. Is this either the patient calls or stops and the
19:39 query is identified on the document, it's left for you in some sort of interoffice mail for you to respond to, or is it brought to your attention immediately?
A. It's put on my desk with any and all messages or concerns from patients and either I, or if I write a note,
19:39 one of my office personnel would call the patient back and tell them that.
Q. Ordinarily once you're confronted or your staff attempts to elicit a solution for a message or a problem for a patient, is there any documentation that there is a
19:41 call-back made or that that communication, that information,

19:41 has been communicated back to the patient?
A. The procedure is that if the patient can't be reached or if the communication is not relayed back to the patient, then I'm told about it so that I can then write a letter.
19:41 Q. My question is, is there any form within your office that confirms that the patient has been -- that that information has been transmitted to the patient?
A. No. There is not a separate form, but, as I say, we keep trying until we reach the patient to answer their
19:41 questions.
Q. It's your position, as I understand it, that Nancy Farkas discontinued treatment after her 12/7/98 visit with you; correct?
A. She never followed up after that.
19:42 Q. And it's your testimony as you sit here today that at the conclusion of the 12/7/98 visit, there was an additional appointment made for January 15th of '99?
A. That's correct.
Q. Is there anywhere in Nancy's chart with your office
19:42 that shows her either as a cancellation or a no show for January 15th of 1999?
A. When there's a no show, it's in the computer as a no show and then we think the patient just forgot. But if the patient cancels, it's my understanding that it gets
19:42 overwritten in the computer scheduling, then the patient may

have decided not to come back, they may have gone to another doctor or chosen not to follow up and finish their testing.

Q. Is it fair to say that in December of 1998, you at least had some degree of concern regarding further investigation and evaluation of the cyst or mass in Nancy's right kidney?

A. I had some concern that we complete the evaluation.

Q. In the face of that concern and an alleged, as you at least portrayed it to me, the patient discontinued treatment, do you have either any protocol or any personal practice as to treatment to follow up with that patient?

A. If the patient has had a long discussion with me and understands as a fully competent and functioning adult and a family member is there and I have emphasized the importance of completion of tests and then there's another conversation to that effect, then I don't know anyway beyond that to coerce a patient to come back in. That patient has to take an active role in helping me to complete the evaluation and testing to figure everything out.

Q. Do you know for a fact that there was an appointment scheduled for Nancy on January 15th of 1999?

A. When it's written out with a specific date and time, that's always been the case in my experience in this office, that that's, in fact, been made and occurred. And the patient knew that there was follow-up because when she made

another contact, she knew that she had to get the tests and come back, so I don't think there was any doubt of that.

Q. Dr. Noble, you're aware of the fact that in the fall of 1999, Nancy's sister came to this office and requested a copy of Nancy's medical records; correct?

A. That's correct.

Q. And that release of those records needed to be approved or authorized by you; correct?

A. Well, actually, I don't have to approve it, but they like me to be aware in case there are any other records that need to be included and so forth or, you know, just as a matter of course.

Q. And as it relates to Nancy Farkas, you were made aware of the request for her records; is that correct?

A. That's correct.

Q. And, in fact, you informed your staff to reiterate that she needed to see a urologist for further metabolic workup; correct?

A. That's correct.

Q. And that metabolic workup would relate to a stone situation as opposed to a cancerous scenario; correct?

A. Actually, I feel they're synonymous in this case because, as I said earlier, it's like having gasoline with a car. The car is not really useful without the gasoline, and when you have a patient and you're doing a stone evaluation

19:45 and you know there's also a questionable area in the kidney that you need to finish delineating, I think that it's important to have a complete picture of any and all stones in that patient, which is my customary practice at the end
19:46 of metabolic chemistry tests.

So in my mind, metabolic testing includes having an up-to-date radiographic imaging, as well, and, as I said, the CT is the most accurate way to do that, so I knew we were going to get those things and I was concerned that she
19:46 had never come back and completed any of her testing. Of course at that time, I didn't know any other things about the patient.

Q. When we were talking earlier about your decision regarding order of findings to deal with, you explained to
19:46 me the reason that you considered the stone or obstruction to be primary was your concern over damage to the kidney; correct?

A. And that patient had been having intermittent pain, that that was the symptomatic problem that needed immediate
19:47 addressing; that's correct.

Q. Once that immediate concern -- let me rephrase that.

At the conclusion of the 11/23/98 retrograde pyelogram, would you agree that that immediate concern had been quelled?

19:47 A. I would say that it was no longer a concern about an

19:47 obstructed kidney.

Q. At that point, is there a reason you can direct me to that your attention did not immediately focus onto further evaluation and investigation into the cyst or mass in Nancy Farkas' right kidney?

A. Immediate like the next day?

Q. The next day, the next week or even the next month.

A. I felt that it would be done sometime in the next few weeks as part of the outpatient follow-up and that's what I told her sister because she asked about it.

Q. Early on in your testimony you indicated that you have at least with some regularity treated patients with renal cell carcinoma; correct?

A. That's correct.

Q. And that includes both the initial diagnosis of those patients as well as the subsequent treatment; correct?

A. That is correct.

Q. Do you understand, based on your education, training and experience, renal cell carcinoma to be a relatively aggressive form of cancer?

MR. KELLEY: Objection.

A. That's a very generalized question. When renal cancers are small, they tend to be slow growing and usually they progress slowly, but everything is, you know, dependent upon the biology of the tumor, the specifics of the cancer.

19:48 It's hard to make an exact general statement.

Q. In the face of a diagnosis of, and, again, based on your education, training and experience, in the face of a diagnosis of renal cell carcinoma that is stage 1 or

19:48 stage 2, can you tell me, generally speaking, what the prognosis is for a person who at that point undergoes a nephrectomy?

MR. KELLEY: Objection.

A. First of all, this is stage 1 or stage 2 based on

19:48 clinical information, or this is after the kidney has been analyzed, you know, under the microscope and they have a pathologic stage?

Q. Let's take those one at a time. First of all, based on the clinical presentation.

19:49 A. Based on the clinical presentation, you really don't know exactly what stage you are talking about because you can't see with an x-ray what the microscopic extent of the tumor is and you don't know what the cell type is, where the -- or the nuclear grade or anything of that type, so

19:49 it's difficult to give an exact prognosis in that situation.

Q. Doctor, as I understood that last answer, based on clinical presentation alone, there are a number of uncertainties that prohibit you, as a treating physician, to understand how advanced renal cell carcinoma is in that

19:49 patient; correct?

19:49 A. That is correct.

Q. That being the case, doesn't that make it more incumbent upon you for a swift intervention and diagnosis in a patient such as Nancy with suspicious findings in her

19:50 kidney?

MR. KELLEY: Objection.

A. "Swift" is a very general term. Again, I feel that as long as the test is done in a timely manner, within three to six weeks or so, that that's certainly reasonable and

19:50 adequately rapid.

Also, based on the clinical experience and the setting, most of the -- the majority of presentations such as hers turn out to be simple cysts.

Q. In the course of your practice where you have

19:50 diagnosed an individual with renal cell carcinoma, is it your practice to recommend a nephrectomy as a course of treatment?

MR. KELLEY: Objection. You can answer.

19:50 A. Once I have diagnosed a renal cancer, I do a metastatic workup to see if there's been any spread of tumor.

Q. Once you have drawn your conclusions regarding the metastatic course that that cancer may have taken, let's

19:51 assume it's confined to stage 1 or stage 2 contained

somewhere in the kidney, do you recommend a nephrectomy?
A. Yes.
Q. And do you personally perform nephrectomies, or do you refer that to an alternative specialist?
A. I personally perform nephrectomies.
Q. And in evaluating that patient as a candidate for a nephrectomy, what does your metastatic workup consist of?
A. Now we're getting hypothetical and, of course, it depends on the person's other clinical parameters again.
Q. Let's just assume an otherwise healthy individual.
A. Okay. Because obviously if a person has neurologic signs or something, that would direct your focus towards that area of the body as part of it. But if you have a patient with a renal cancer and you're doing a metastatic workup, the most common tests would be, in my experience, a bone scan and CT scan of the chest.
Q. Over your 23 years as a urologist, you have treated patients that have been stage 1 or stage 2 that have undergone a nephrectomy; correct?
A. Yes.
Q. And I want to ask you two separate questions about that. The first is, based on your personal experience treating these patients having had a nephrectomy in stage 1 or stage 2, in your practice, what is the five-year survival percentage for those patients?

MR. KELLEY: Objection.

MR. SCHOBERT: Objection.

MR. KELLEY: What type of cancer?

MS. DIXON: Renal cell carcinoma.

MR. KELLEY: You say that like there's only one type.

A. That's a difficult question to answer generally because it really depends on the histology. Also, stage 1 or stage 2, are we talking again pathologic stage after you have analyzed the tissue that you removed, or are we talking clinical stage where that's all you see on the x-ray?

Q. Let's confine this question to a pathological stage 1 or stage 2. When the patient has undergone a nephrectomy, what is your experience, the experience you have had in your practice, with five-year survival in those patients?

MR. KELLEY: Objection. If you have data. I don't want you to guess.

A. I don't have exact data on my -- I haven't written up those patients in a series to be able to give you any kind of a close percentage from my experience.

Q. Doctor, stepping out of the confines of your office, you have told me early on that you have access to numerous journals in the area of urology; correct?

A. That's correct.

Q. And, in fact, based on review of your CV, you serve as

an expert reviewer on several journals, as well; correct?

A. That is correct.

Q. I'm assuming you keep up with the literature within your specialty; correct?

A. Generally I do.

Q. And as part of your review of the literature in a current fashion, that oftentimes includes review of statistics of different diseases, mortality and morbidity rates, et cetera; correct?

A. That's contained in various journal articles at times.

Q. The efficacy of various treatments for different diseases?

A. That's often included in the journals, too.

Q. Doctor, do you have an understanding based on statistics generally available to you as a practitioner with a patient who has been pathologically diagnosed as clear cell nuclear grade 3 renal cell carcinoma in stage 1 or stage 2 that undergoes a nephrectomy, what is that patient's likelihood of a five-year survival statistically?

MR. KELLEY: Objection.

A. This is grade 3 on a 4 scale?

Q. Yes.

A. I would have to look up that statistic because I don't know exactly.

Q. Is there a source that you would look to for that

statistic?

A. I would have to go through the urologic literature and get some articles out to give you that approximate five-year survival because I don't have that exact number in my head.

Q. In endeavoring --

MS. DIXON: Off the record.

(Thereupon, a recess was taken.)

BY MS. DIXON:

Q. Doctor, before we went off the record, we were talking about some five-year survival statistics. I believe you indicated that you would need to endeavor to review some additional materials before answering that question; correct?

A. I don't know the exact or even approximate statistics without a guess and I would rather not guess.

Q. Certainly. Would that exploration of information include reviewing statistics contained in various journals that you subscribe to?

A. It would involve reviewing journals and articles published in textbooks and various other sources to get essentially a median analysis to give me the best picture.

Q. Are there certain journals that you find more reliable or you're more comfortable relying upon?

MR. KELLEY: Objection.

A. There's a lot of variability to journals. I really

prefer to see what the exact study is and the individual group that's done the study, what the patient population is that they're reviewing and so forth. I can't say specifically that a journal is necessarily reliable by itself. It depends on the article.

Q. I see by virtue of your CV that you're an expert reviewer for both -- for "Urology," "Journal of Urology" and "Cancer"; correct?

A. I have done reviews for all three journals; that's correct.

Q. Do you find any and/or all of those journals reliable?

MR. KELLEY: Objection. He just answered.

A. That's --

MR. KELLEY: You can answer again.

A. It's a speculative question. I think sometimes they have reliable articles and sometimes they don't.

Q. In the course of your service as an expert reviewer for either "Urology," "Journal of Urology" or "Cancer," have you ever reviewed an article that included survival statistics related to renal cell carcinoma?

A. 1 have reviewed such an article.

Q. As an expert reviewer?

A. I can't recall. It's possible.

Q. Do you keep any notes or records that would reflect

20:02 the projects in which you have been -- you have served on as an expert reviewer for any of those three journals?

A. No. I don't keep any notes about that.

Q. And are those assignments given to you through the 20:02 general administrative offices of each of those journals or periodicals?

A. They are. They send an article to me and ask my opinion and I put comments, and I don't even know if my opinion is even registered or if they pick two out of the 20:02 three reviewers they send them to. I have no idea how they do it each time.

Q. I just have a few clean-up questions and then I will be through.

You indicated very early on you currently have one 20:03 unpublished article that you expect to go into publication the summer of 2000; correct?

A. We're submitting it in June of the year 2000.

Q. Are there co-authors on that article?

A. I haven't turned it in, so I can't say which people 20:03 will be co-authors. I expect there will probably be one or two co-authors.

Q. And is that article currently a format that is prepared to go to publish?

A. No. It's not quite ready.

Q. Was there research conducted in conjunction with 20:03

preparation of that article?

A. There was. We reviewed cases at the University of Kansas back when I was at that facility.

Q. Can you identify some of the doctors who worked in conjunction with you on that article, whether or not they will be ultimately named as a co-author?

MR. KELLEY: My only objection is are you allowed to disclose anything about the article before it's published?

THE WITNESS: I was going to ask that. I don't think that ethically I'm supposed to because it's not any kind of an authoritative record until it's accepted at least for publication.

A. It's basically an article that is still in preparation stage. It's not completed, and who will be the final authors included on the manuscript hasn't been finalized yet.

Q. Separate and apart from Nancy Farkas' chart which you currently have on your lap, have you made and/or kept any notes regarding her care and treatment --

A. No.

Q. -- that aren't contained in the chart?

A. No.

Q. You directed my attention to the red ink demarcation of 1/15/99, 1:30 p.m. appointment for Nancy.

20:04 A. That is correct.

Q. Is there anywhere else in that chart where an appointment for Miss Farkas is noted in that type of a fashion?

20:05 A. You mean in red ink?

Q. No. Actually, just in the margin indicating when the patient will return.

A. There's the one for the surgery scheduling where the date is fixed and it's in the morning. We never get the

20:05 exact time of that until the day before.

Q. Let me clarify my question. It related exclusively to office visits.

A. Okay. The form was a different kind of form when I saw her on October 26th, 1998. It was about that time that

20:06 the form was changed to the one that you see for November 16th and November 23rd, is it, or November -- or January 15th return and the November 16th surgery dated 11/12.

On the 26th, we were not using that type of form and

20:06 so it wasn't specifically noted as to time, for example, like the 11/12 visit because we didn't have that form back on 10/26. Pardon me.

Q. But, actually, it was not a blank on the form that the 1/15/99 date was entered. It was simply a marginal note;

20:07 correct?

MR. KELLEY: I object. It's right next to the note saying return to office.

A. The secretary put that there.

Q. And which secretary's handwriting is that?

A. That's -- I'm not positive, but I think it may have been -- I'm not for certain whose handwriting that is. Back then we had several secretaries back then. At least one or more aren't working in the office now.

Q. Doctor, you indicated in your previous answers that you have not only diagnosed renal cell carcinoma, you have personally performed nephrectomies on some of those patients; correct?

A. That is correct.

Q. What is your standard time frame from diagnosis of renal cell and performing a nephrectomy in the patients you deem it's appropriate for?

A. Well, because patients are worrying and because of a variety of clinical factors, you want to try to get the patient in within a reasonable time and that is usually three to six weeks you would like to get the nephrectomy done from the time you have found the problem.

But, of course, it depends upon the clinical status. If the patient has got chest pains that are non-specific, you may have to get a cardiac evaluation and they may need a heart cath. or other tests, so those things may delay it.

20:08 Q. Doctor, based on your experience in the area of urology and treating patients with renal cell carcinoma, can a nine to ten-month delay in diagnosis of renal cell impact that patient's chances of survival?

20:08 MR. KELLEY: Objection to the form of the question as being overbroad. You can answer if possible. Don't guess if it's not specific.

A. I don't know if there are published data in terms of any reported studies that could give an answer to what that

20:09 impact would be. On a theoretical note, if there's a delay of that period of time, you know, naturally one would expect that it might affect, but I don't have any specific data to answer that with statistics for you.

Q. And other than your own personal practice, are you

20: aware of any written protocol or standard in a urological text or journal that states that a CT scan is part of a metabolic workup?

A. Well, it's not in itself a metabolic test, but, again, I would have to look in the literature. I'm sure that in

20: some of the articles I have written about stones before we went to CT scans as a lot of the diagnostic testing for stones, I'm sure that there was some reference to up-to-date imaging being performed as part of the stone treatment and follow-up.

20: MS. DIXON: I don't have anything

20:: 0 further. Thank you for your time.

MR. MURPHY: I do have a few questions, doctor. I know it's getting late at night.

- - -

CROSS-EXAMINATION OF MARK NOBLE, M.D.

BY MR. MURPHY:

Q. You talked before about the inquiry Miss Farkas made concerning the necessity for this 24-hour urine test. Do you recall that discussion?

20:10 A. Yes.

Q. You were asked whether or not there was a form in your chart to check off, yes, she received the phone call. You said there's no form, per se; is that correct?

A. I don't believe we have a separate form. We just have

20:1 a practice if the patient isn't reached, the secretary tells me, could not convey this message, patient can't be reached. That way I can write a letter.

Q. And there is no such letter. So based on your normal routine, office practice, that would tell you, as you review

20:1 this chart, that Miss Farkas was reached with that information about the test?

A. That's the ordinary practice; yes.

Q. 1 know you said your plan was to finish the metabolic workup prior to doing the CT scan and I know you have tried

20:1 to explain. I have tried to listen. Can you give me

20:11 further explanation as to why that was the sequence you wanted to do it in?

A. 1 felt that IVP wasn't a very good test. It was with an unprepped bowel in an emergency room setting.

20:11 When you have a blocked kidney, there is often inflammation associated with and around the kidney and there was a small calcification you could barely see in the left kidney.

When I don't have complete information, I want to get 20:11 a complete picture *of* the stones in that patient when I'm going to try to prevent more, so I had intended to coordinate being meticulous about the findings on the IVP with that final determination at the completion of the metabolic testing phase and I thought it would be within a 20:12 few weeks.

Q. I saw a note some place in here, -- it was dated 11/16/98 -- from an EMH chart when she was first scheduled for the retrograde pyelogram. I couldn't tell if it was your handwriting or not, but it said the machinery or the 20:12 x-ray machinery had been working earlier during that day for other cases but was not working at the time of her scheduled case.

Do you recall that situation or not?

A. I would have to go back and look at that chart to see 20:12 that note, and I don't have it, but I seem to recall that I

may have written something to that effect.

Q. From the standpoint that that test was delayed for one week, from the 16th to the 23rd of November, in your opinion, did that have any impact on your workup of Nancy Farkas?

A. I don't think that one week would make a difference unless you had an out and out emergency, and, to my knowledge, she didn't.

Q. You were asked whether or not, I think, your office notes actually detailed your plan for, first, a retrograde pyelogram, then a metabolic workup and then a CT scan, and you testified that, per se, you don't have such terminology in your notes basically?

A. Well, I initialed the report that was in the chart and I went over that report and the findings as well as the x-rays themselves with the patient and her sister. No, I did not rewrite it again in a separate place in my notes.

Q. I was going to follow up with a question. As you do write your progress notes, do you try to summarize in a brief manner what you are doing with a patient, what you are talking to the patient about so that you will have a record of what was discussed later on when you look back?

A. It depends on what we're talking about. Generally the notes are to indicate what I have done so far.

Q. Looking at your November 12, 1998 note, you state in

09:52 part, "I think they have a good understanding of the situation and after a long discussion, we elected to proceed with those procedures."

When you talk about the "situation" and the "long
09:52 discussion," is that your notation manner of indicating you have gone over the findings of the IVP, you have talked to her about the cyst versus mass issue and what your plan is to work all of this up?

A. Yes.

09:52 Q. I believe your office chart contains the IVP report from the 10/20/98 ER visit but not any other ER records; is that correct?

A. That's correct. I didn't see any ER records contained in there.

20:15 Q. You said your custom would normally be to request the complete ER chart and try to get it?

A. It's possible when I was performing the patient's retrograde, it was in the main chart and I looked at it there, but I don't have a copy of that right now to
20:15 demonstrate it.

Q. Whether or not you had reviewed the complete ER chart completely, which is kind of redundant, do you believe there's anything contained in there which in any way would have changed or altered your workup and plan given the
20:15 results of the actual IVP films?

A. Based on my knowledge, no.

Q. Were the films themselves the key piece of information for you to try to assess her complaints and -- the up to determine the etiology of her complaints?

A. Well, the films plus her clinical history.

Q. Certainly. And when you looked at the films, did you actually go to the hospital and look at the original films?

A. I had the films picked up and brought to the office, and I took the original film and put them on the view box with the patient and her sister, because I always try to show the films to the patient if I think they can understand, you know, what the films show.

Q. Do you recall doing that in this case, showing them the films actually while you were talking to them about the situation?

A. Yes.

Q. You indicated that at all times you were managing Nancy Farkas who were an employee of the Cleveland Clinic Foundation?

A. That is correct.

Q. You were not employed at all by Elyria Memorial Hospital during that time frame?

A. No; I was not.

Q. You have never been employed by them, have you?

A. No.

Q. And serving periodically as an on-call urologist for the emergency room is part of your staff privilege relationship with Elyria Memorial to admit patients there?

A. That is correct.

MR. MURPHY: Thanks for your time.

- - -

CROSS-EXAMINATION OF MARK NOBLE, M.D.

BY MR. CULLEN:

Q. Doctor, from the time that you reviewed the IVP report of Dr. O'Campo, it was your plan to work this mass or cyst up within three months time; correct?

A. That is correct.

Q. You don't think that a CT was required at the emergency room or within 24 hours of her visit?

A. No; I don't think so.

MR. CULLEN: Thanks.

MR. SCHOBERT: No questions.

MS. DIXON: Nothing else.

MR. KELLEY: He will read it.

- - -

(Thereupon, the deposition was concluded at 8:25 p.m. and signature was not waived.)

SIGNATURE PAGE

_____
MARK NOBLE, M.D.

I certify that this deposition was signed in my presence by MARK NOBLE, M.D. on this_____day of _____., 2000.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office in this City of_____, County of_____, on this _____ day of_____, 2000.

_____
Notary Public

My commission expires:

NANCY FARKAS vs. CLEVELAND CLINIC FOUNDATION, et al.
Case Number, 393101 Judge McCafferty
Deposition Date Wednesday, April 5, 2000

I, MARK NOBLE, M.D., wish to make the following changes:

PAGE	LINE	
______	______	CHANGE :_
______	______	CHANGE :_
______	______	CHANGE :_
______	______	CHANGE :_
______	______	CHANGE :_
______	______	CHANGE :_
______	______	CHANGE :_
______	______	CHANGE :_
______	______	CHANGE :_
______	______	CHANGE :_
______	______	CHANGE :_
______	______	CHANGE :_
______	______	CHANGE :_
______	______	CHANGE :_
______	______	CHANGE :_
______	______	CHANGE :_
______	______	CHANGE :_
______	______	CHANGE :_
______	______	CHANGE :_

State of Ohio) SS.
County of Cuyahoga)

CERTIFICATE

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

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

IN WITNESS WHEREOF, I have hereunto set my hand this 27th day of April, 2000.

Denise C. Winter
Notary Public

My commission expires March 3, 2001.

N

O

V

W

X

Y

Z