

COURT OF COMMON PLEAS
CUYAHOGA COUNTY

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NANCY FARKAS,)
)
)
 Plaintiff,)
)
 vs.) Case No. 393101
) Judge McCafferty
 CLEVELAND CLINIC FOUNDATION)
 et al.,)
)
 Defendants.)

- - -

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.

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13 Also present: Randall Buckosh, Litigaide
14 Joanne Sysack
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I N D E X

Examination of Mark Noble, M.D. Page

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EXHIBITSPAGE

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(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.

1 16:25 Q. And out of those eight or ten times, how many times
2 have you been a party in the action that your deposition was
3 being taken in?

4 MR. KELLEY: Objection, but you can
5 16:25 answer.

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

8 Q. Yes.

9 A. One time.

10 16:25 Q. And approximately how long ago was that?

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

13 Q. That's fine. Dr. Noble, before we get started, since
14 it has been at least ostensibly some period of time since
15 16:25 your last deposition, let me lay out a few ground rules that
16 will facilitate this process and, most importantly, make it
17 easier for Denise, our court reporter, who is taking down
18 — everything that you say, I say or any of the other lawyers
19 say that are in the room.

20 16:25 First and foremost, you need to make all of your
21 answers verbal. Although we're all inclined to use hand
22 gestures, nods of the head, things of that nature, that's
23 difficult for her to interpret correctly.

24 Second of all, if at any point in time you don't
25 16:25 understand a question that I have asked, please ask me to

1 16:26 rephrase it or clarify it. If you answer the question, I'll
2 assume that you understood it and that your answer is
3 truthful and accurate.

4 Thirdly, I'm not looking for you to guess on any
5 16:26 answers. If you don't know, let me know. And if you
6 answer, I will assume that you, again, that you understood
7 the question and that your answer is accurate. Agreed?

8 A. Okay.

9 Q. Finally, if at any point in time you need to take a
10 16:26 break, you get paged, you need something to drink, something
11 of that nature, let me know and I will be happy to
12 accommodate you.

13 A. Thank you.

14 Q. Certainly. Doctor, this morning I received a
15 16:2 facsimile of what I understand to be your most recent
16 curriculum vitae and I have premarked this Exhibit 1. Can
17 you take a look at that document, please?

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

20 16:2 A. It does.

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

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

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

25 16:2 A. There is a paper that's going to be submitted in early

1 16:29 June.

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

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

5 16:29 Q. In what publication do you expect that paper to be
6 submitted to?

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

9 Q. Other than that, there are no glaring omissions or
10 16:29 additions to your curriculum vitae; correct?

11 A. Correct.

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

15 16:30 A. Approximately, yes.

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

18 - A. That is correct.

19 Q. And that instance was approximately seven years ago?

20 16:30 A. I don't remember the exact number of years without
21 going back and looking it up.

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

23 A. It was either seven years ago that it was filed or
24 that I did a deposition or something. It may have been six
25 16:30 or five and a half years but some years ago.

1 16:30 Q. Fair enough. Where was that lawsuit pending?

2 A. It was in the state of Kansas.

3 Q. And do you recall what the claim that was being made
4 against you was?

5 16:30 MR. KELLEY: Objection. You can
6 answer if you know.

7 A. Yes; I recall.

8 Q. And can you tell me what that nature of that claim
9 was?

10 16:30 MR. KELLEY: Objection. You can
11 answer.

12 A. That I caused a patient to have damage to his rectum
13 during an electrical ejaculation procedure to obtain sperm.

14 Q. Was that claim settled -- excuse me. Was that claim
15 16:31 resolved via settlement or dismissal?

16 MR. KELLEY: Objection. You can
17 answer.

18 A. The patient dropped the claim.

19 Q. You indicated in one of your previous answers that on
20 16:31 several occasions, you have provided expert testimony in the
21 context of litigation; correct?

22 A. That's correct.

23 Q. And that would be -- would half a dozen times be a
24 fair estimate as to the number of occasions that you have
25 16:31 done that?

1 16:31 A. Approximately.

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

4 A. I can try to remember some of them.

5 16:31 Q. As best you can recall.

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

10 16:32 Another had to do with a wound infection that occurred
11 in a patient and the surgery related to the bladder or the
12 lower urinary tract, and I was asked about what I thought
13 because I was a treating physician, but, also, I was
14 retained as an expert after that complication had occurred.

15 16:32 I have given depositions relating to some Workmen's
16 Compensation cases. I really don't remember the specifics
17 of any others. I have also -- it's been a number of years.

18 — Q. Have you ever provided expert testimony in a case
19 which claimed a failure to diagnose cancer of a urological
20 16:32 nature?

21 A. I don't recall any such cases.

22 Q. Whether or not you had been retained to provide expert
23 testimony in such a case, meaning a failure to diagnose
24 cancer in a urological matter, have you ever simply provided
25 16:33 expert consultation in a case such as that?

1 16:33 MR. KELLEY: Objection. I think that
2 would be work product.

3 MS. DIXON: The substance of it
4 would but whether or not he did participate I don't believe
5 16:33 is work product.

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

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

9 A. There are two professional addresses. One would be
10 16:33 125 East Broad Street in Elyria. It's suite 208B here in
11 Gates Medical Center, and the ZIP I think is 44035. The
12 other would be the main campus of the Cleveland Clinic at
13 9500 Euclid Avenue, Cleveland, 44195, I believe.

14 Q. And what is your current residential address?

15 16:34 A. 31141 Huntington Woods Parkway, Bay Village, 44140.

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

17 A. 9/19/49.

18 Q. And your Social Security number?

19 A. 086-38-4487.

20 16:34 Q. Doctor, am I correct in understanding that your
21 current employer is the Cleveland Clinic Foundation?

22 A. That is correct.

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

25 16:34 A. Yes.

1 16:34 Q. You are currently, as I understand it, associated with
2 a urological practice here in Elyria, Ohio; correct?

3 A. That is correct. It's part of the Cleveland Clinic.

4 Q. And in this particular, in this particular location,
5 16:35 and I'm referring to 125 Gates Medical Center, are there
6 other physicians with whom you associate in this office?

7 A. Yes.

8 Q. And all of those physicians are urologists?

9 A. Yes.

10 16:35 Q. How many physicians are you associated with at the
11 Gates Medical facility?

12 A. Currently?

13 Q. Currently.

14 A. There are three others.

15 16:3 Q. And who are those physicians?

16 A. Louis D'Amico, M.D., William Larchain, M.D., and
17 Yih-Wen Lai, M.D.

18 — Q. In October of 1998, were you likewise associated in a
19 group practice at the Gates Medical building?

20 16:: A. I was working with other doctors.

21 Q. Was Dr. D'Amico associated with you in a professional
22 sense in October of 1998?

23 A. Yes.

24 Q. And how would you describe the nature of your
25 16:: professional relationship with Dr. D'Amico in October of

1 16:36 1998?

2 A. I'm not sure I understand the question.

3 Q. Fair enough. Were both you and Dr. D'Amico employees,
4 if you know, were both you and Dr. D'Amico employees of the
5 16:36 Cleveland Clinic Foundation in October of 1998?

6 A. Yes.

7 Q. You were not involved in any separate partnership at
8 that time; correct?

9 A. Correct.

10 16:36 Q. As co-members, if you will, of the group that was
11 located at the Gates Medical building in October of 1998,
12 did you share office responsibilities, and what I mean by
13 that is basically patient responsibilities, in each other's
14 stead?

15 16:36 A. May I clarify?

16 Q. Certainly.

17 A. If he went out of town, he might ask me to cover or
18 see some of his patients or take care of emergencies that
19 would crop up, and if I went out of town, he might do it for
20 16:36 me.

21 Q. Based on the best of your understanding, in October of
22 1998, did the group that you were associated with provide
23 on-call urological services for the Elyria Memorial Hospital
24 emergency department?

25 16:37 A. The group did based on the schedule.

1 16:37 Q. And as part of that schedule, did you personally, in
2 October of 1998, provide on-call, excuse me, on-call
3 services for the emergency department of Elyria Memorial
4 Hospital?

5 16:37 A. May I clarify?

6 Q. Certainly.

7 A. Each of us is on call for generally a week at a time
8 for emergency services. There are also other urologists in
9 other groups that rotate that call, and so I presume that
10 16:37 one or both of us, Dr. D'Amico and myself, were on during
11 October, but I don't know for sure and I don't have that
12 schedule in my head.

13 Q. If I were to give you the general time frame of the
14 fall of 1998, would it be fair to say at some point in time,
15 16:38 you would have served as an on-call urologist for the
16 emergency department at EMH?

17 A. I believe so.

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

20 16:38 MR. KELLEY: Objection.

21 A. No.

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

25 16:38 MR. KELLEY: Objection in regards to

1 16:38 a medical facility. That might not be a public document.
2 That would be peer review, so I'm going to instruct him not
3 to answer.

4 BY MS. DIXON:

5 16:38 Q. Doctor, within the context of your employment as a
6 medical doctor, have you ever been subject to disciplinary
7 action?

8 MR. KELLEY: Objection. I think that
9 within your employment is a quality assurance measure.
10 16:38 You're not taking a state medical action, so it's not public
11 record. I think it's QA. I don't think it's Discovery.
12 I'm instructing him not to answer.

13 BY MS. DIXON:

14 Q. Doctor, have you ever applied for privileges at a
15 16:38 medical facility which have been denied?

16 MR. KELLEY: Objection. You can
17 answer.

18 A. No. I have never been denied.

19 Q. Doctor, can you tell me where you currently have
20 16:39 admitting privileges?

21 A. I have admitting privileges at the main campus of the
22 Cleveland Clinic, at Elyria Memorial Hospital, and I have
23 courtesy privileges, I think it's called, at Community
24 Health Partners where I'm not supposed to have more than one
25 16:39 per month because I don't take ER call there.

1 16:39 Q. In your current employment situation, as I understand
2 it, you have two offices in which you are able to see
3 patients; correct?

4 A. Actually, there are three.

5 16:39 Q. Okay. You have told me about the Cleveland Clinic
6 Foundation main campus; correct?

7 A. That's correct.

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

10 16:39 A. Yes. I see patients one half day a week at the
11 satellite facility in Lorain off Oak Point off Route 2.
12 Cleveland Clinic Lorain Family Health Center.

13 Q. As it relates to your office here at the Gates Medical
14 facility, do you have a personal office contained at this
15 16:40 site?

16 A. Yes.

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

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

20 16:40 Q. Is there a library available to the urological --
21 medical urological staff at the Cleveland Clinic Foundation?

22 A. Yes.

23 Q. Can you tell me whether it's, and your answer, I would
24 ask you not to confine it to just individually but also
25 16:40 through the urological staff's medical library at the

1 16:40 Cleveland Clinic Foundation. What urological journals are
2 available to you?

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

4 Q. Yes.

5 16:40 A. The "Journal of Urology," "Urology," the "British
6 Journal of Urology," "Clinical Urology," and probably some
7 others. I don't know a complete list in my head.

8 Q. Fair enough. As it relates to this office, and "this
9 office" being the Gates Medical Center location, are there
10 16:41 any textbooks or treatises that are housed here at this
11 facility?

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

13 Q. Certainly.

14 A. I sometimes keep some of my textbooks in my own
15 16:42 office, but they're not library material.

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

18 A. I own Campbell's Urology, Gillenwater's Urology. I
19 own a uroradiology text. I own a copy of Glenn's and
20 16:42 Boyce's Urologic Surgery. I own a copy of the Novick and
21 Streem edition of Stewart's Atlas of Urology and Urologic
22 Surgery. I own a copy of Kelalis and King's Pediatric
23 Urology, and I'm sure there are some other texts which I
24 own. I can't give you a complete list off the top of my
25 16:42 head.

1 16:42 Q. Dr. Noble, would it be fair to say that your purpose
2 in owning the texts that you have just identified along with
3 any others that may not be coming to the forefront of your
4 mind is to provide you a source for guidance and advice in
5 16:43 diagnosing and treating your patients?

6 MR. KELLEY: Objection. You can
7 answer.

8 A. That's not why I purchased those textbooks. I do try
9 to stay current in my field, but textbooks, by the time book
10 16:43 chapters are written, are typically five to eight years out
11 of date and one must integrate the knowledge contained in
12 the textbooks with current practices which do change as
13 technology changes and knowledge changes.

14 Q. Would it be fair to say that the textbooks that you
15 16:43 have just identified at a minimum provide you a baseline of
16 information in assisting you to care for your patients?

17 MR. KELLEY: Objection. You can
18 answer.

19 A. They provide a baseline for the original learning
20 6:43 process in learning urology. And I used to teach urology at
21 the University of Kansas for 18 years, and so they were
22 helpful in teaching my residents, but it was rare that I
23 needed to look something up in an old textbook because of
24 the things that I already mentioned.

25 16:44 Q. Doctor, you indicated that you taught urology at the

1 16:4 University of Kansas for approximately 18 years; correct?

2 A. That's correct. '

3 Q. And is my understanding of the contents of your CV
4 correct that simultaneously with your teaching
5 16:4 responsibilities --

6 MS. DIXON: Off the record.

7 (Interruption in proceedings.)

8 BY MS. DIXON:

9 Q. Let me begin the question over again just to get us
10 16:4 both back on track.

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

15 16:4 A. That's correct.

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

18 A. May I clarify that question?

19 Q. Certainly.

20 16:4 A. Are we including my residency training years?

21 Q. Yes.

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

25 16:4 Q. Before I move on to the more substantive issues that I

1 16:48 have to discuss with you, let me ask you, what did you do to
2 prepare for your deposition today absent conversations you
3 may have had with Counsel?

4 A. I reviewed the patient's chart.

5 16:48 Q. Did you speak to Dr. D'Amico about the case?

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

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

10 16:48 A. Basically discussed the patient's course as noted in
11 the chart.

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

15 16:48 A. Yes. I remember the patient.

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

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

19 Q. During the course of your conversation or
20 16:49 conversations with Dr. D'Amico, did you discuss any matters
21 that went beyond the scope of the chart? For example, the
22 patient's ultimate outcome.

23 A. Yes. There was some discussion that Dr. D'Amico had
24 learned some of the subsequent outcome and, of course, it
25 16:49 was in the filing and so he conveyed what he knew to me.

1 16:49 Q. When you say the patient's outcome, are you referring
2 to the fact that she died?

3 A. That's correct.

4 Q. Did you have an understanding at the time of your
5 16:49 conversation with Dr. D'Amico as to what Nancy Farkas' cause
6 of death was?

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

10 16:49 A. No; I don't.

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

14 A. That's correct.

15 16:50 Q. Have you seen an autopsy report?

16 A. No.

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

19 A. No.

20 16:50 Q. Have you spoken to any other physicians regarding
21 either the care and treatment you provided Nancy or the
22 subject matter of this lawsuit?

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

24 Q. Have you read any of the depositions that have been
25 16:50 taken in this case?

1 16:50 A. No.

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

4 A. No.

5 16:50 Q. Doctor, you indicated that including your residency,
6 you have seen urological patients in a clinical setting for
7 approximately 23 years; correct?

8 A. That's correct.

9 Q. Would it be fair for me to assume that over those 23
10 16:50 years, you have had multiple opportunities to diagnose and
11 treat patients with renal cell carcinoma?

12 A. That's a fair statement.

13 Q. And would you agree with me that in a classic
14 presentation of renal cell carcinoma, one could find
15 16:51 hematuria? A patient could present with hematuria?

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

18 A. A classic presentation? In my experience, there
19 isn't necessarily a classic presentation. Hematuria occurs
20 16:51 a percentage of the time, but many times patients never have
21 hematuria.

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

25 16:51 A. There is historically a classic triad, but it's

1 16:5 extremely rare to encounter it except with very, very large
2 tumors.

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

4 A. A palpable mass, gross hematuria and flank pain,
5 16:5 persistent flank pain.

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

9 A. Renal cell carcinoma?

10 16:5 Q. Yes. I'm sorry.

11 A. Can I clarify that question?

12 Q. Sure.

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

15 16:5 Q. As the only treating physician.

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

19 BY MS. DIXON:

20 16:52 Q. Dr. Noble, would you agree that there are numerous
21 times in which you, as the urological consultant, provide
22 the primary diagnosis of renal cell carcinoma?

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

25 16:5 Q. It is. And are you able to estimate for me, and I

1 16:5 understand it would be an estimate, how many times you have
2 been the physician who has made the initial diagnosis of
3 renal cell carcinoma?

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

5 16:5 Q. Right.

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

9 Q. And within the context of that estimated 50 cases
10 16:5 where you have made the initial diagnosis of renal cell
11 carcinoma, can you think if there were any of those patients
12 that presented with the classic triad of symptoms of renal
13 cell?

14 MR. KELLEY: Objection. You can
15 16:5 answer. I don't want you to give any patient names, if you
16 happen to remember them.

17 BY MS. DIXON:

18 Q. I'm not interested in any patient names, doctor. I'm
19 asking for you to pull up the mental impression, if you can,
20 16:5 to respond to the question.

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

23 Q. Aside from the fact that it's rare, can you think of
24 an occasion in which a patient presented with the classic
25 16:5 triad of renal cell carcinoma symptoms?

1 16:5 A. I can think of one.

2 Q. And in that case, can you tell me, when that patient
3 presented to your office, what diagnostic tools you employed
4 to either rule in or rule out the diagnosis of renal cell
5 16:5 carcinoma?

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

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

10 16:5 Q. In general terms, and you did indicate that you had
11 taught urology for some 18 years at the University of
12 Kansas; correct?

13 A. That's correct.

14 Q. Would it be too far of a leap for me to make that
15 16:5 during the course of teaching residents the specialty of
16 urology, that you taught them what were appropriate
17 diagnostic tools in the face of certain symptoms a patient
18 was presenting with?

19 A. I taught them things like that; yes.

20 16:5 Q. And in a classic scenario of a patient presenting with
21 the triad of symptoms, the hematuria, palpable mass and
22 flank pain, what tests would you expect your residents to
23 employ to rule in or rule out renal cell carcinoma?

24 MR. KELLEY: Objection. You can
25 16:5 answer.

1 16:55 A. This is a hypothetical question now?

2 Q. Hypothetical question.

3 A. And it also depends upon whether there were comorbid
4 factors or other things going on with the patient. But if
5 16:55 we're just looking at that presentation, typically one would
6 get an IVP initially and because of the gross hematuria,
7 we're talking gross hematuria, the patient would need a
8 cystoscopic examination at some point along the line and
9 then one would proceed after that depending upon the
10 16:55 findings of those tests.

11 Q. In the event that IVP did, in fact, show a mass, would
12 you agree the next course of action in terms of diagnostic
13 tests would either be a renal ultrasound or a CT scan?

14 MR. KELLEY: Objection. You can
15 16:56 answer.

16 A. I would normally get a CT scan as the next test.

17 Q. You mentioned earlier that oftentimes the diagnosis of
18 - renal cell carcinoma is an incidental finding?

19 A. That's correct.

20 16:56 Q. And when you refer to that as being an incidental
21 finding, are you indicating the discovery of a mass as an
22 incidental finding?

23 A. That's correct.

24 Q. So you would agree that it's not unusual for the
25 16:57 diagnosis of renal cell carcinoma to stem from an incidental

1 16:57 finding; correct?

2 A. That's correct.

3 Q. And what types of diagnostic tools, based on your
4 experience, would provide the incidental finding of renal
5 16:57 cell carcinoma?

6 MR. KELLEY: Objection. You can
7 answer.

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

10 16:57 Q. Actually, let me clarify it for you because I think
11 that will further our efforts.

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

14 A. Or mass effect.

15 16:57 Q. Which would then need to have additional diagnostic
16 tests used to determine whether or not it was renal cell
17 carcinoma or a cyst of some type or other benign finding;
18 — correct?

19 A. One would want to characterize the mass with further
20 16:57 testing; that's correct.

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

25 16:58 A. Yes.

1 16:5 Q. Your earlier testimony indicated that there are and
2 there were in October of 1998 situations where you provided
3 on-call service for the emergency department at Elyria
4 Memorial Hospital; correct?

5 16:5 A. That's correct.

6 MR. KELLEY: Objection. Asked and
7 answered.

8 BY MS. DIXON:

9 Q. Can you explain to me the procedure in place in your
10 16:5 office regarding referrals from the emergency room here at
11 the Elyria office?

12 A. The procedure is that if a patient is referred from
13 the emergency room and the emergency room physician calls
14 the physician on call for that specialty, then depending
15 16:5 upon the clinical circumstances, that physician might take
16 additional action such as see the patient in the office in a
17 reasonably expeditious manner or might have to come into the
18 — emergency room or possibly admit the patient.

19 If the emergency room physician doesn't call the
20 16:5 physician but thinks that the problem can be managed on a
21 semi-elective basis, then the emergency room physician might
22 simply tell the patient to arrange an appointment in the
23 office for follow-up in a short period of time.

24 Q. For the next question, let me direct your attention to
25 16:5 the situations where you are actually contacted as the

1 16:59 on-call urologist by the emergency room physician. In that
2 scenario, first of all, do you keep any logs or records of
3 the calls that you receive from the emergency room
4 physician?

5 16:59 A. No.

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

10 17:00 A. I believe that the only tracking that occurs is if the
11 emergency room physician calls the office or if the patient,
12 on instruction of the emergency room physician, calls the
13 office and makes an appointment and records are forwarded
14 from the emergency room.

15 17:00 Q. In the event that you are the on-call urologist and
16 you receive a call from the emergency department and there's
17 a decision made that patient will subsequently be seen in
18 your office based on their presentation in the emergency
19 department, how is it that the records from the emergency
20 17:00 department are transmitted to your office?

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

23 Q. First of all, in patients who you consult, provide a
24 telephone consult from the emergency department, are you
25 17:01 then the physician that will see the patient once they come

1 17:01 to the office, or can that be any one of the physicians as
2 part of the group?

3 A. I think it depends on the situation and the scheduling
4 availability in the office and how urgently the patient
5 17:01 needs to be seen and so forth.

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

9 A. We try to get them.

10 17:01 Q. And what steps or how is that -- how does that occur?
11 For example, are there procedures or protocols in place in
12 your office as to how and when to acquire emergency
13 department records?

14 A. I don't believe we have any written-out procedures,
15 17:02 but it's customary to ask the secretary to call and see if
16 the records can be found or the patient's chart located and
17 those items relating to that emergency room visit copied or
18 sent or faxed here.

19 Q. Would that be based on information you had provided as
20 17:02 a physician who had taken a consult call, or is that
21 reactionary to the patient calling to schedule an
22 appointment?

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

25 17:02 Q. Sure.

1 17: A. What often happens is that the emergency will make an
2 appointment or fax records up here, assuming that the
3 patient will follow the recommendation and make an
4 appointment. But if the patient shows up in the office and
5 17: says I was seen in the emergency room two days ago and we
6 don't have any records, then it's reactionary that we
7 obviously then try to go get those records.

8 Q. Based on information that you would be provided as the
9 on-call urologist and provided by the emergency department,
10 17: are there ever situations where you alert your office staff
11 that a particular patient may be calling to schedule an
12 appointment?

13 A. I would think that if the patient or the emergency
14 room physician contacted me, I might try to alert the office
15 17: just to give them a heads up that there was a patient trying
16 to schedule and we should try to fit them in.

17 Q. I understand that you have provided on-call services
18 for EMH's emergency department in the past. In conjunction
19 with the same, have you ever been contacted by a Dr. Allan
20 17: Starr?

21 A. Yes; I have.

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

23 A. Yes.

24 Q. And those contacts that you have had as the urology
25 17: consultant, did those relate to a patient he was seeing in

1 17:04 the emergency department?

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

4 Q. And I'm assuming some of those times have commanded
5 17:04 that the patient come to your office for follow-up care;
6 correct?

7 A. Correct.

8 Q. And can you recall any circumstances where you may
9 have taken the on-call telephone inquiry and it was another
10 17:04 physician within your practice who actually saw that
11 patient?

12 MR. KELLEY: If you know.

13 A. If that occurred, I wouldn't know unless that other
14 physician told me, and I don't remember any such
15 17:04 circumstances.

16 Q. What I'm trying to understand, Dr. Noble, is in the
17 event you took a call from the emergency department and it
18 — was a case of at least a relatively serious nature and you
19 were not able to be the physician who saw the patient in an
20 17:05 office setting, how is it within your office you would
21 provide information to the then treating physician for the
22 office visit with that patient?

23 MR. KELLEY: Objection.

24 BY MS. DIXON:

25 17:05 Q. First of all, do you understand the question?

1 17:c A. I'm not sure. Could you please --

2 Q. Can you at least envision a situation where you may
3 have taken a telephone consult from the emergency department
4 and you determined that that patient needed to be seen in
5 17:c your office?

6 A. Yes.

7 Q. Once that decision was made, it turned out, for
8 whatever reason, vacation or scheduling or other
9 obligations, you personally were not able to see that
10 17:0 patient within the prescribed period of time and the office
11 staff then scheduled the patient with someone else
12 associated with your group.

13 Are you with me up until that point?

14 A. I'm understanding you.

15 17:0 Q. Okay. In that event, can you tell me whether or not
16 there are any procedures or protocols in place within this
17 office for you to communicate the information you had
18 gleaned from the emergency department to the physician who
19 ultimately examines the patient in the office visit?

20 17:0 MR. KELLEY: Objection.

21 A. I don't know of any specific written protocols to that
22 effect. I believe that as a matter of trying to arrange
23 follow-up and care, and, again, it depends upon the
24 situation and the circumstance, my practice is that if I'm
25 17:0 very concerned and feel a patient needs attention and I

1 17: cannot then see that patient, I would try to ensure that
2 that patient has an appointment with my colleague who is
3 covering.

4 Q. And would you take it upon yourself to communicate at
5 17: least whatever knowledge you would have been provided from
6 the emergency department regarding that patient prior to the
7 office visit?

8 MR. KELLEY: Objection. You can
9 answer.

10 17: A. If I think that that information is different from
11 what's contained in the record or would materially
contribute to the patient's care.

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

15 17: A. I was told when she came into the office that she had
16 been seen in the emergency room in the recent past and that
17 she was advised to make an appointment with my associate but
18 his schedule was full. That's what she said. And so I had
19 an opening and she was put into my schedule.

20 17: Q. And for the next series of questions, feel free to
21 refer to your chart if you feel more comfortable doing so.

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

25 17: A. That's correct.

1 17:08 Q. And at the time of that visit, were you aware that
2 Dr. D'Amico had consulted with Dr. Starr while Nancy was in
3 the emergency room on 10/20/98?

4 MR. KELLEY: Objection.

5 17:08 A. I was not aware specifically of what manner the
6 consultation took, whether it was phone or whatever.

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

8 MR. KELLEY: Objection.

9 A. I don't have anything specific in this chart that I
10 17:09 recall, but I believe the patient said that there was
11 something communicated, but I don't know the details.

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

15 17:09 A. On that visit -- please give me a second to review my
16 chart -- I don't believe that I had the emergency room
17 records on that visit, to the best of my recollection.

18 Q. Do you know whether or not there was any attempt to
19 retrieve Nancy Farkas' 10/20/98 emergency room records prior
20 17:10 to the time of her visit in this office on 10/26?

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

25 17:10 Q. I may have misspoken. If I did, I apologize.

1 17:10 My question is, at the time of your visit with Nancy
2 on 10/26/1998, do you ¹know what efforts had been undertaken
3 to retrieve her emergency room records from the 10/20/98 ER
4 visit?

5 17:10 A. I don't have anything in writing, but I recall that,
6 as is my custom, I ask the secretary at the desk to see if
7 it was possible to call for those records that pertained to
8 that visit. I don't believe she was able to get the records
9 at that point.

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

12 A. Okay.

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

15 17:11 A. Yes.

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

18 - A. Yes.

19 Q. At the time of your first visit with Nancy on 10/26 of
20 17:11 1998, was she alone?

21 A. No.

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

23 A. I believe her sister was with her.

24 Q. And would you agree at the time of that visit, you
25 19:44 understood that she did not have a primary care physician?

1 19:44 A. That was my understanding,

2 Q. In light of -- based on your review of the October 26,
3 1998 note, can you tell me what that first visit consisted
4 of?

5 19:44 A. The patient presented with a problem and that was that
6 she had been having a lot of pain in her side, a lot of
7 flank pain on the right side. The day that she actually
8 came in, her pain had eased up. She had briefly seen some
9 traces of blood in her urine one time. At the time, she
10 19:44 thought she was passing a stone. She denied any prior
11 history of urologic problems, and the visit was basically to
12 coordinate further care for her stone which was the
13 diagnosis that she was given when she was in the emergency
14 room.

15 17:13 Q. Would you agree that at the time of the October 26th,
16 1998 visit, because you did not have the emergency
17 department records available to you, you were relying
18 -- exclusively on Nancy's oral history of what had taken place
19 on 10/20/98?

20 17:13 A. That's correct.

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

24 A. That's what I wrote.

25 17:13 Q. And my question to you is, do you recall what Nancy

1 17:13 specifically told you? Because those are not her words;
2 correct?

3 A. I paraphrased what she told me.

4 Q. Do you recall what it is that Nancy told you during
5 17:14 that 10/26/98 visit?

6 A. She told me that she came to the emergency room, that
7 she had a lot of pain and some nausea, that she had a kidney
8 x-ray. The working diagnosis -- she didn't use those
9 words -- was that she had a kidney stone with a lot of
10 17:14 blockage of her kidney and that she needed to see a
11 neurologist.

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

14 A. It had eased up as often happens when people are
15 17:14 passing stones.

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

18 A. I understood that she was saying an IVP.

19 Q. In light of the fact you did not have the ER records
20 17:14 available to you, did you ask Nancy her understanding of
21 what the results of the IVP were?

22 A. Yes.

23 Q. And I apologize, but I don't recall what your answer
24 to this was. in the past, did you know that Dr. D'Amico had
25 17:15 consulted with Dr. Starr at the time you examined or treated

1 17:15 Nancy on 10/26/98?

2 MR. KELLEY: Objection.

3 A. No; I did not know that.

4 Q. Did there come a point in time during your treatment
5 17:15 of Nancy where you learned that Dr. D'Amico had consulted
6 with Dr. Starr?

7 MR. KELLEY: Objection.

8 A. I believe that at some point, and I'm not sure exactly
9 when it was, whether it was during my treatment or sometime
10 17:15 later or if possibly he told me during the discussion, which
11 I mentioned earlier, when we discussed this case briefly
12 that I understood that he had had some phone contact with
13 Dr. Starr about this patient because of being on ER call
14 that week.

15 17:15 Q. Whenever that conversation did happen with Dr. D'Amico
16 regarding his contact with the emergency department,
17 specifically Dr. Starr, on 10/20/98, what did he tell you,
18 if anything, the sum and substance of that conversation was?

19 MR. KELLEY: Objection. You can
20 17:16 answer.

21 A. I don't believe that he went into any great detail,
22 My recollection again is that he mentioned he received a
23 call that the patient was managed in the emergency room and
24 was not too ill to be discharged and so he told Dr. Starr to
25 17:16 arrange for follow-up in our office.

1 17:16 Q. During that conversation, did Dr. D'Amico tell you
2 about any of the specific findings that were communicated to
3 him on Nancy's diagnostic tests?

4 A. No.

5 17:16 Q. Would you agree that one of the reasons that you
6 attempt to acquire a patient's emergency room records in a
7 situation such as this prior to the time of an office visit
8 is to give you a more complete picture as to what transpired
9 in the emergency department?

10 17:17 A. I think it's always helpful to have information when
11 you can get it, of course.

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

15 17:1 A. That's correct.

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

19 A. That's reasonable.

20 17:1 Q. In October of 1998, was there any ability of this
21 office, and again I'm referring to your office here in
22 Elyria, to simply go across the street and procure films or
23 procure copies of patients' records while they are actually
24 here in the office?

25 17:1 A. It's difficult to send a secretary out when you have a

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

5 17:1 Sometimes they do it and sometimes they can't find
6 those records right away and it takes a day or two.

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

10 17:1 A. I think that the medical records might have some
11 things in there that the patient might not recall. I think
12 the patient's own recollections, though, are very important,
13 too.

14 Q. And based on your experience, are the patients own
15 17:1 recollections generally accurate?

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

20 17:1 Q. Would you agree with me that Nancy's description, and
21 I'm referring back to your previous testimony of the
22 something was blocking her kidney, that you took that to
23 refer to a stone; correct?

24 A. Well, she said she had a stone.

25 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

1 17:2 room.

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

5 17:2 MR. CULLEN: Objection.

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

8 BY MS. DIXON:

9 Q. Well, doctor, you would agree with me that in the
10 17:2 course of emergency room care, oftentimes there are a
11 multitude of diagnostic tests performed on a patient;
12 correct?

13 MR. CULLEN: Objection.

14 A. That is correct.

15 17:2 Q. There may be situations that the results of those
16 diagnostic tests may lead to one or more ultimate diagnoses;
17 correct?

18 MR. CULLEN: Objection.

19 MR. KELLEY: You can answer. I'll
20 17:2 tell you if you can't.

21 A. Yes, of course that's true.

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

25 17:2 A. That's a reasonable statement.

1 17:2 Q. And my question is, in the face of abnormal -- more
2 than one abnormal or suspicious finding based on diagnostic
3 tests that are run in an emergency department, would you
4 expect each of those findings to be communicated to the
5 17:2 patient?

6 MR. CULLEN: Objection.

7 BY MS. DIXON:

8 Q. Prior to discharge.

9 MR. CULLEN: Objection.

10 17:2 MR. KELLEY: Objection. You can
11 answer if you know.

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

15 17:2 And I can give you an example. A patient might have a
16 slight abnormality on a chemistry test, but if it doesn't
17 bear any direct relevance to flank pain or a blockage of a
18 kidney, I don't think that that's something that necessarily
19 would be gone into by an emergency room.

20 17:2 Q. Would you expect that an abnormal or a suspicious
21 finding on a -- stemming from a diagnostic test performed in
22 an emergency room that could potentially or could suggest a
23 life-threatening condition would be explained to that
24 patient prior to discharge?

25 17:2 MR. CULLEN: Objection.

1 17:13 MR. KELLEY: Objection. We don't
2 know what the potential life-threatening condition is or the
3 time frame that you're talking about in an emergency room.
4 Second of all, he's not an emergency physician. You're not
5 17:23 limiting it to urologic issues.

6 BY MS. DIXON:

7 Q. Okay. Let's deal with it in terms of urology. We
8 established the fact that oftentimes patients have abnormal
9 or suspicious findings as a result of diagnostic tests that
10 17:23 they undergo in the emergency department; correct?

11 A. That's correct-

12 Q. And oftentimes in those situations, those patients are
13 referred to a specialist, and in the case of a urological
14 problem, to someone such as yourself for additional care,
15 17:23 diagnosis and treatment; correct?

16 A. Yes.

17 Q. My question is, and I believe you also established,
18 -- excuse me, that oftentimes a patient may have more than one
19 suspicious or abnormal result from diagnostic testing;
20 17:23 correct?

21 A. Yes.

22 Q. My question is, if one -- if a patient has abnormal or
23 suspicious findings which are suggestive of a
24 potentially-fatal condition, and you can limit your answer
25 17:24 to within the realm of urological care, would you expect

1 17:24 that emergency room physician to communicate that to the
2 patient prior to discharge?

3 MR. CULLEN: Objection.

4 MR. KELLEY: Objection.

5 BY MS. DIXON:

6 Q. Yes or no?

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

9 A. I can't answer it just yes or no because it's not a
10 17:24 simple question.

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

12 A. I think it really depends upon the circumstances. If,
13 for example, an x-ray, which is a type of test, shows
14 several findings but the radiologist produces what's called
15 17:14 a wet reading, the initial report is not necessarily going
16 to be inclusive of every finding that may come to light a
17 little later with more study, and so if one has a primary
18 explanation such as, in this case, a blocked kidney for the
19 patient's colicky pain, that is certainly the main thing
20 17:25 that one would convey.

21 But other findings, I really don't know if they were
22 present at the time that the patient was there in the
23 emergency room and I don't know, in other words, if the wet
24 reading had everything in it. I don't know if those were,
25 17:25 you know, pertinent or thought to be significant, and it's

1 17:25 difficult to tell if something else is also a
2 life-threatening condition or not or what probability. So
3 it's a tough -- you know, it's not an exact answer.

4 Q. In the realm of urological care, would you agree with
5 17:25 me that the presence of a cyst or mass is always a
6 suspicious finding?

7 A. I think that's an absolute question and one would
8 ultimately want to investigate and clarify what that is, but
9 it's a matter of judgment in terms of the timing of that, if
10 17:27 I'm understanding your question properly. Yes, you want to
11 clarify what that is, if that's a finding.

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

15 17:27 A. In my experience, a cyst or a mass is almost never an
16 immediate life-threatening condition. I think ultimately
17 and with reasonable timeliness, it needs to be investigated,
18 but I don't think that it's an emergency.

19 (Thereupon, a brief recess was taken.)

20 BY MS. DIXON:

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

24 A. That's correct.

25 17:41 Q. And can you amplify for me what you meant by that?

1 17:41 A. What I meant is that her colicky pain that she
2 described had eased up and wasn't bothering her right at
3 that moment when I saw her and examined her.

4 Q. And did you perform a physical exam on Nancy on
5 17:41 10/26/98?

6 A. I did a brief exam, tapped on her costovertebral
7 angles and I didn't -- give me one second -- and I did --
8 well, I didn't say in this note to refer to the primary note
9 which is a history and physical form that was also obtained
10 17:49 on that date, but I'm fairly certain that I did do a brief
11 exam, at least the pertinent urologic area.

12 Q. And for clarification, can you tell me what would be
13 involved in the urological physical exam in a patient
14 presenting with the symptoms that you understand Nancy
15 17:49 Farkas is to be presenting with on 10/26?

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

20 17:49 Q. Would you agree with me that as it relates to the
21 10/26/1998 visit, there's no notation of such a physical
22 exam in the record?

23 A. I think my statement "she's asymptomatic with no pain"
24 might also be inclusive and indicate that I did that basic
25 17:50 exam, but it doesn't say specifically.

1 17:50 Q. And the statement "she is asymptomatic with no pain"
2 may also stem from Nancy's self report on that day; correct?

3 A. It's possible, but it's my custom to do the brief exam
4 that I indicated.

5 17:50 Q. Given the fact that Nancy was asymptomatic with no
6 pain on 10/26/98, six days after her emergency department
7 visit, did you consider that perhaps the stone that she had
8 described to you had passed?

9 MR. CULLEN: I'm going to object to
10 17:50 that question.

11 A. I considered lots of possibilities.

12 Q. I'm sorry?

13 A. I considered a lot of possibilities.

14 Q. My question specifically is, given the fact that when
15 17:50 she presented to you on 10/26/98 asymptomatic and with no
16 pain, did you consider whether or not the stone had passed?

17 MR. CULLEN: Objection.

18 A. I thought that it was unlikely.

19 Q. And upon what did you base your conclusion that it was
20 17:51 unlikely that Nancy's stone had passed?

21 A. She had been having pains off and on. She asked for
22 more pain medication expecting that she would get more pain,
23 and I did give her a prescription for more pain medicine,
24 and she still had some microscopic blood in the urine
25 17:51 suggesting that the stone was not passed.

1 17:51 Q. Do you have any specific recollection of palpating
2 Nancy's kidneys on 10/26/98?

3 A. I think I already said earlier my best recollection is
4 that I did press or tap on her flanks and costovertebral
5 17:51 areas.

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

9 A. I don't believe that there were any symptoms right at
10 17:52 that particular moment in time when she was in the office.

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

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

15 17:52 Q. Again directing your attention to the 10/26/98 note
16 where you indicated she was asymptomatic\$, when you wrote
17 that Nancy was asymptomatic, what was she, based on your
18 understanding, asymptomatic of?

19 A. Basically asymptomatic of the nausea and the right
20 17:53 flank pain.

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

24 A. It's very common for patients who are passing stones
25 17:53 to have the pain ease up and even stop and then start again.

1 17:5 In my experience, when the stone stops moving, many times
2 the pain stops and then the stone will start to move some
3 more and then the pain re-occurs.

4 So the fact that she was not having pain during that
5 17:5 office visit doesn't really tell me anything further about
6 whether she still has a stone or not or has passed it or
7 anything more that's going on.

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

10 17:5 A. I don't recall how the time intervals were,
11 specifically whether it was two hours before coming in the
12 office or twelve hours before, but I know she had been
13 having intermittent pain.

14 Q. Would it be fair to say that based on your review,
15 17:5 there's no notation in the record which indicates the last
16 time Nancy experienced pain?

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

18 Q. Doctor, can you define for me the term "ureteral
19 colic"?

20 17:5 A. The term "ureteral colic" commonly refers to a type of
21 pain that is seen when a person is passing something down
22 the ureter and it's a pain characterized by a particular
23 location or several locations along the flank or loin or
24 sometimes towards the groin. It can vary in exact location,
25 17:5 but it's a kind of pain that you can't get away from. Lying

1 17:55 still doesn't make the pain better as opposed to pain from
2 peritonitis, for example, or appendicitis, something
3 inflamed with the peritoneal cavity where less movement
4 generally eases the pain up.

5 17:55 Q. Would you agree that ureteral colic is not really --

6 MR. KELLEY: Were you done?

7 BY MS. DIXON:

8 Q. Did I interrupt you?

9 A. I think that's a reasonable explanation of what
10 17:55 ureteral colic means.

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

12 A. That's all right.

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

15 17:55 A. Ureteral colic is a symptom and it can be an
16 observation or a clinical finding when you are examining a
17 patient that they appear to be in pain typical for ureteral
18 colic.

19 Q. Would you agree that other than the passage of a
20 17:56 kidney stone, there are other causes for ureteral colic?

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

23 Q. Are there other causes of ureteral colic?

24 A. Besides a stone?

25 17:56 Q. Yes. .

1 17:56 A. Yes.

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

4 A. No; I wouldn't.

5 17:56 Q. What about a blood clot in the ureter?

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

9 Q. Can an infection also cause ureteral colic?

10 17:56 A. Not typically the exact same kind of pain, but I never
11 say never in medicine. It's not an exact science.

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

15 17:57 Do you see the portion of the record I'm referring to,
16 doctor?

17 A. Yes.

18 Q. In writing that statement, are you referring to the
19 stone that Nancy told you about from the emergency
20 17:57 department?

21 A. Yes.

22 Q. And would you agree at the time that you saw Nancy on
23 10/26/98, you were relying exclusively on self report?

24 A. That's correct.

25 17:57 Q. Doctor, explain to me what an IVP is.

1 17:57 A. It stands for intravenous pyelogram. It's a type of
2 x-ray where a material filtered out of the bloodstream by
3 the kidneys is injected into the vein of the patient, hence
4 the word "intravenous." That substance is radiopaque or
5 17:58 blocks so much of the x-rays going through it and appears
6 white on a standard x-ray, and when the kidneys filter that
7 substance out, it will light up the course of the urinary
8 tract, kidneys and ureters and bladder.

9 Q. Would you explain for me -- you have explained the
10 17:58 illumination of different anatomical parts. Would you agree
11 that it outlines the size, shape and position of the
12 kidneys?

13 A. It does to a reasonable degree depending upon the
14 patient's body habitus and bowel preparation or lack of
15 17:58 bowel preparation and other factors.

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

18 -- A. It can if it's illuminated well, again, depending upon
19 whether the patient has a bowel prep or not and whether
20 17:58 there are other things that affect the quality of the
21 x-rays.

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

24 A. It does in a general way.

25 17:59 Q. And, also, would you agree it also reveals the

1 17:59 excretory function of the kidney?

2 A. Can I clarify that question?

3 Q. Certainly.

4 A. Are you asking if it is a measure of the kidney
5 17:59 function?

6 Q. No; I'm not. Just the manner in which urine is
7 excreted from the kidney and travels hence to the bladder.

8 A. It will tell if a kidney is functioning or not, but it
9 won't say if it's functioning normally or not, necessarily.

10 17:59 Q. Would you agree that a radiologist is able to
11 determine at some level the time in which it takes for the
12 contrast dye to travel from the kidney to the bladder by
13 virtue of an IVP?

14 A. Can I ask for clarification again?

15 17:59 Q. Sure.

16 A. Are you asking can a radiologist tell something about
17 function based upon delay in excretion of the contrast from
18 the kidneys?

19 Q. My question is a little more simple than that. Over a
20 18:00 delayed period of time, would you agree the radiologist can
21 appreciate or quantify the amount of time it takes for urine
22 to travel from the kidney to the bladder via the ureter?

23 A. I don't think you can do that exactly. I think you
24 can see how fast the contrast comes down and in terms of
25 18:00 what the contrast will light up and show on the x-ray, but

1 18 it takes a fair amount of contrast before you see.

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

5 18 A. Sometimes.

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

9 A. It can sometimes.

10 18 Q. Would you agree that an IVP is not an appropriate test
11 to differentiate between a tumor or cyst?

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

14 Q. And in the event there's a tumor or cyst appreciated
15 18 by IVP, that patient would need further follow-up testing to
16 conclusively determine what the nature of that mass is?

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

19 Q. Would a renal sonogram be an appropriate test to
20 18 perform on a person whose IVP shows a cyst or mass?

21 MR. KELLEY: Objection. You can
22 answer.

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

25 18 Q. What information would a renal sonogram provide you as

1 18:C)1 to a cyst or mass in a patient's kidney?

2 A. Just as with the IVP, a renal sonogram is, many times,
3 not a precise test. There are artifacts that enter in just.
4 as with regular x-rays and shadows, and a sonogram can show
5 18:02 a clearcut cyst where the radiologist doesn't see anything
6 else, or there may be a tumor within the cyst that the
7 sonogram will not resolve, or it could show what appears to
8 be a solid mass or it could be a pus-filled cavity which
9 will appear different from a cyst but may re-assemble a
10 18:02 solid mass, and there are other possibilities, so it's not a
11 totally precise test.

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

15 18 02 A. A CT scan is what I normally would get to
16 differentiate those.

17 Q. Doctor, assume that it's true that -- assume the
18 following to be true, that on October 20th of 1998, while
19 Nancy Farkas was in the emergency department, the IVP test
20 18:03 that was performed on her showed a cyst or mass. Do you
21 have an opinion as to whether or not a CT scan should have
22 been performed on her while she was still within the
23 emergency department?

24 MR. CULLEN: Objection.

25 18:03 MR. KELLEY: Objection. We're

1 18:03 talking about Nancy Farkas now?

2 MS. DIXON: Exactly.

3 MR. KELLEY: You can answer.

4 A. I don't think that it necessarily should be done in
5 18:03 the emergency room setting because it's almost -- I don't
6 think that's an emergency type of finding based on what you
7 have told me.

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

10 18:05 A. Yes.

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

12 A. Yes.

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

15 18:05 A. You wish me to read them?

16 Q. Just review them to yourself. ```

17 A. Okay.

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

20 18:05 A. Yes.

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

25 18:05 A. Usually those would be separate conditions unless they

1 18:06 are related.

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

5 18:06 MR. CULLEN: Objection.

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

10 18:06 Q. My question was, you have agreed that those are two
11 separate conditions; correct?

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

14 Q. And my question is, assuming that they are two
15 18:06 separate findings, would you agree that each of those
16 findings, based on what you have reviewed, require a
17 separate course of follow-up care and treatment?

18 MR. KELLEY: Objection.

19 A. I wouldn't agree with that statement because sometimes
20 18:06 the follow-up care will encompass both of those conditions.

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

23 A. Yes; it does.

24 Q. And based on your review of that, would you have any
25 18:07 quibble that it was received in your office on October 28th

1 18:07 of 1998?

2 A. I would not disagree with that.

3 Q. And how is it when a fax like this comes into your
4 office on a patient that you have previously seen, is it
5 18:07 brought to your attention or simply put in their chart?

6 A. It's brought to my attention.

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

10 18:07 A. I'm sorry, can you clarify that?

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

14 A. Correct.

15 18:07 Q. And you said that it's customary in your office for
16 these types of facsimiles to be brought to your attention
17 immediately as opposed to simply being placed in the
18 patient's chart; correct?

19 A. That's correct.

20 18:08 Q. My question is, do you have a recollection of
21 reviewing these IVP findings when they arrived in your
22 office in October of 1998?

23 A. Yes. I remember reviewing these findings.

24 Q. And do you remember reviewing those findings upon
25 18:08 receipt in the office or in conjunction with an office visit

1 18:08 with Nancy Farkas?

2 A. Both.

3 Q. When you -- I'm assuming that your, based on review of
4 the chart, review upon receipt of the fax would have
5 18:08 happened prior to your second visit with Nancy; correct?

6 A. That's correct.

7 Q. When you reviewed the IVP results after they were
8 faxed to your office in October of 1998 and you reviewed the
9 two conclusions contained in there, did one of those
10 18:08 conclusions or findings cause you more concern than the
11 other?

12 A. The finding that the kidney was almost completely
13 obstructed made me concerned that that needed to be relieved
14 as soon as possible, that that was more of an immediate
15 18:09 concern.

16 Q. Let me back up for just a minute, doctor. On
17 10/26/1998, what was your differential diagnosis as it
18 relates to Nancy Farkas?

19 A. I didn't list a specific differential diagnosis. My
20 18:09 primary and most likely diagnosis was that she was passing a
21 stone, because that's far and away the most common thing to
22 explain the symptoms that she was having.

23 Q. Is it fair to say that on October 26th of 1998, and
24 directing your attention to that visit and that visit only,
25 18:10 that renal cell carcinoma was not part of your differential

1 18:10 diagnosis?

2 A. I didn't write that down, but there are always many
3 explanations for pain and bleeding, as we have discussed
4 earlier, but that's a very much less common cause of this
5 18:10 type of presentation.

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

9 A. As I said, I didn't write it down, but mentally I
10 18:10 always consider as many possibilities as I can think of.

11 Q. Whenever it was that you actually reviewed this fax
12 for the first time, and let's assume it was at least within
13 a day or two of receipt in your office, coupled with the
14 information you gleaned based on the 10/26/98 visit with
15 18:10 Nancy, did you amend or otherwise change your differential
16 diagnosis?

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

18 Q. And let's, for clarification purposes, identify in
19 your own words what the two problems or findings that you
20 18:11 were dealing with were.

21 A. I felt that the primary problem was that she had a
22 nearly totally obstructed kidney most likely from a stone.
23 There was a stone in the other kidney, so it was -- that
24 part was visualized as a stone, and so it seemed reasonable
25 18:11 that she was, in fact, passing a stone on the right side and

1 18:1 that it had caused some blockage, and so I felt that was the
2 primary problem that wa's causing her periodic pain and
3 illness.

4 And then there was a questionable area in the kidney
5 18:1 that was thought to be either a cyst or a mass based on the
6 IVP, and the great majority of the time these are cysts at
7 age 50 or older, but that needed to be addressed at some
8 point during the follow-up.

9 Q. Did you want to add something to that?

10 18:1 A. I recall that, not during my initial review of this
11 faxed x-ray report but during the next visit with the
12 patient and her sister --

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

15 18:1 THE WITNESS: Okay.

16 BY MS. DIXON:

17 Q. Based on the information you received either based on
18 the 10/26 visit independently or in conjunction with
19 receiving this final IVP report, did you have an
20 18:1 understanding as to what Nancy's family history was with
21 respect to cancer?

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

24 Q. And let me just make sure. Are you referring to the
25 18:1 form in your chart that says "history and physical"?

1 18:13 A. I am.

2 Q. And how is it -- is it your office procedure -- that
3 this information is elicited on the history and physical?

4 A. Okay. The nurse takes the initial interview
5 18:13 information, and you can see the date, 10/26/98, at the top
6 of the part which says "chief complaint," and the nurse goes
7 through a series of questions and takes vital signs, and
8 then I review that information when I see the patient to
9 make sure that there aren't any additions or corrections or
10 18:14 modifications.

11 Q. So would it be fair to say that form that's identified
12 as history and physical, the patient does not physically
13 complete this form? It's done by either you or one of your
14 staff?

15 18:14 A. That's correct.

16 Q. And where on the form is it that you can direct my
17 attention to which inquires as to what the patient's family
18 history is with respect to cancer?

19 A. There is not a specific question, but in medical
20 18:14 history, it's customary for our nurses and for me to ask
21 about that.

22 Q. And isn't it true that medical history under "history
23 and physical" relates to Nancy's medical history, not
24 necessarily that of her family?

25 18:14 A. That's correct.

1 18:1 Q. Since the time that you treated Nancy, have you become
2 aware of what her family history was with respect to cancer?

3 A. No.

4 Q. Based on a review of the final IVP test, you told me
5 18:1 there were basically two findings. One was a stone which
6 you considered a primary finding. The second was a
7 questionable area of a cyst or mass; correct?

8 A. That's correct.

9 Q. And would you agree that the questionable area
10 18:1 represented on Dr. O'Campo's note as a probable cyst or
11 mass, would you agree that that second finding is
12 potentially indicative of a life-threatening condition?

13 A. Potentially. And during what time course, may I ask?

14 Q. Let me ask you a predicate question. Doctor, is renal
15 18:1 cell carcinoma always a potentially life-threatening
16 condition?

17 A. That's really, again, an absolute type of question.
18 — Potentially, theoretically, cancer can certainly be life
19 threatening over a period of time ultimately.

20 18:1 Q. But you saw the questionable area of cyst or mass as a
21 secondary concern as opposed to the stone; correct?

22 A. I didn't think that it was an emergency at that point.

23 Q. Notwithstanding your analysis of that not being an
24 emergency at that time, did you believe that the area
25 18:1 identified as a probable cyst or mass needed further

1 18:16 investigation?

2 A. Yes.

3 Q. And did you have a time frame in which you expected
4 that further investigation to take place?

5 18:16 A. Yes.

6 Q. And what time frame would that be?

7 A. I told the patient's sister after the retrograde
8 pyelogram, which we're going to get to, that I wanted to be
9 sure that we got additional x-rays within or less than three
10 18:17 months. I didn't want too long a period of time to go by.

11 Q. And at the risk of going out of order, let me just
12 follow up on that.

13 Was Nancy present for that conversation?

14 A. No.

15 18:17 Q. And this conversation that you had with the patient's
16 sister indicating you wanted additional x-rays within the
17 next three months --

18 A. I said in three months or less; that's correct.

19 Q. What types of x-rays did you tell her you wanted Nancy
20 18:17 to have?

21 A. I don't remember if I said specifically CT scan versus
22 ultrasound, but when I integrated the information and
23 thought about the stone workup, I always get a CT scan at
24 the end of my stone metabolic workup when the patient hasn't
25 18:17 yet had one because IVPs, especially with unprepped bowels,

1 18:18 are not precise enough, and I like to have a snapshot and
2 know where all the stones are and how big, and I planned to
3 do it at that time, during the outpatient follow-up phase.

4 Q. And that would relate back to your primary concern
5 18:18 which would be the stone?

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

8 Q. During that conversation that you had with the
9 patient's sister, did you tell her that you had any concerns
10 18:18 regarding the possibility of renal cell carcinoma?

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

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

13 A. Yes. Actually, she knew it before. She knew it from
14 the November 12th visit where I went over the findings with
15 18:18 Nancy and her sister.

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

18 — To confirm, Nancy wasn't present; correct?

19 A. She was still groggy in the recovery room.

20 18:19 Q. You don't recall if you specifically indicated what
21 tests you would like to have performed; correct?

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

24 Q. And that CT scan, obtaining that CT scan is part of
25 18:19 your standard protocol as a stone workup; correct?

1 18:19 A. It's what I do at the end of a stone workup if a
2 patient hasn't had one¹ before to show where their stones
3 are.

4 Q. Correct me if I'm wrong, but at the conclusion of the
5 18:19 10/26 visit, you gave Nancy instructions to strain her
6 urine; correct?

7 A. That's correct.

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

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

14 Q. Do you know what -- so the answer to my question do
15 18:20 you know whether or not she was given a strainer on
16 discharge is no? \ \ '

17 A. I don't know for sure.

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

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

23 Q. Notwithstanding the same, on 10/26/98, you gave her a
24 strainer and instructions as to watch for the passage of a
25 18 20 stone; correct?

1 18:20 A. That's correct.

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

5 18:20 A. That is correct.

6 Q. Moving from the time period of 10/26/98 through
7 11/12/98, and you would agree that 11/12/98 was the next
8 time you saw Nancy in the office correct?

9 A. That's correct.

10 18:20 Q. And it was during that period of time that you
11 expected Nancy to strain her urine at home; correct?

12 A. That's correct.

13 Q. And would you likewise agree that during that 17-day
14 time period, she did not retrieve a stone and, in turn,
15 18:21 bring it back to your office for analysis?

16 A. That is correct.

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

20 18:21 A. She didn't report it; correct.

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

25 18:21 A, That's correct.

1 18:2 Q. And, again, doctor, if you need to refer to your
2 office note for 10/12/1998 --

3 MR. KELLEY: 11/12.

4 BY MS. DIXON:

5 18:2 Q. I'm sorry. 11/12/1998. Can you describe for me what
6 Nancy's condition was when she presented on that date to
7 your office?

8 A. My notes don't indicate what her condition was. By
9 "condition," I assume you mean whether she was in pain at
10 18:2 that moment.

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

14 A. I didn't specifically mention if she was in pain that
15 18:2 day.

16 Q. Is there anything in your note which would illuminate
17 whether or not she had been in pain between 10/26/98 and
18 -- 11/12/98?

19 A. There's nothing specific that would say if she was in
20 18:2 pain on particular days except that she wanted to still
21 proceed with having the procedure. In our discussion, it
22 was my understanding that she had had some intermittent
23 pains along the course of her ureter.

24 MR. KELLEY: I'm showing him the
25 18:2 record.

1 18:24 A. Let's just check all the records here. Okay. It is
2 here in the notes. She had had some pain a few days before,
3 a couple of times.

4 Q. Doctor, can I just ask you to identify for the record
5 18:24 what document you are referring to?

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

8 Q. Who would that have been completed by?

9 A. That was one of our nurses.

10 18:24 Q. And on the second handwritten line, it says, "episode
11 of bleeding and"?

12 A. Slight pain.

13 Q. "On Sunday and Monday"; correct?

14 A. That's correct.

15 18:24 Q. And there's no indication as to which Sunday and
16 Monday that was; correct?

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

20 18:25 Q. When Nancy had been in your office on 10/26 of 1998,
21 you gave her an additional prescription of Toradol, 30
22 tablets; correct?

23 A. That's what the record says.

24 Q. And that Toradol was for pain; correct?

25 18:25 A. Yes.

1 18:25 Q. And Nancy was to take the Toradol p.r.n.?

2 A. That's correct.

3 Q. When Nancy came back to your office on 10/12/98, did
4 you refill the Toradol prescription?

5 18:25 MR. KELLEY: 11/12.

6 BY MS. DIXON:

7 Q. 11/12. I'm sorry.

8 A. You don't mind if I refer to my record?

9 Q. Absolutely not.

10 18:26 A. I don't have an indication that I wrote another refill
11 for it on the 11/12/98 date.

12 Q. Was Nancy alone at the 11/12/98 visit?

13 A. No.

14 Q. Was she accompanied by her sister?

15 18:2 A. Yes.

16 Q. And is my understanding correct, that, at least as you
17 understood, it was her sister who was a nurse?

18 A. That's correct, She had worked as a nurse in the
19 past.

20 18:2 Q. Between the time of your 10/26 visit and your
21 November 12th visit, you had received a faxed copy of the
22 IVP final report; correct?

23 A. That is correct.

24 Q. Were you ever provided a copy of the provisiona IVP
25 18:2 report?

1 18:27 A. If I was, it would, I would think it would be in this
2 chart and I don't spotlight, And I don't recall if I ever saw
3 a provisional report on this patient.

4 Q. Dr. Noble, between the 10/26 visit and the
5 18:27 November 12th visit, did you request the totality of Nancy
6 Farkas' emergency room records from October 20th of 1998?

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

8 Q. And is there a notation in the record that you can
9 direct me to that suggests there was a request made of the
10 18:27 complete emergency department chart from 10/20/98?

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

13 Q. You're aware of the fact that while a patient in the
14 emergency department on 10/20/98, Nancy not only had an IVP
15 18:2 but also a KUB; correct?

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

19 Q. And after your 10/26 visit, you ordered a repeat KUB;
20 18:2 correct?

21 A. That is correct.

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

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

25 18:2 Q. At the time of your November 12th, 1998 visit with

1 18:2 Nancy Farkas, did you have available to you both the KUB
2 film from 10/20/98 as well as the KUB film from 10/27/98?

3 A. My notes don't indicate which KUB, but I'm pretty
4 certain that I would at least have had the most recent KUB
5 18:2 and I would have had her IVP, so I presume that included the
6 KUB done on the same 10/20/98 because an IVP, complete IVP,
7 includes a KUB.

8 Q. For clarification of the record, doctor, I'm just
9 going to show you that I have marked as Exhibit 2 the
10 18:2 requisition form for the KUB, 10/27/1998.

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

12 Q. Yes.

13 A. Okay.

14 Q. Is that the type of form you would prepare requesting
15 18:2 such a diagnostic film?

16 A. Yes.

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

19 A. Okay.

20 18:30 Q. And the originals of those documents are contained in
21 your chart that you have in front of you; correct?

22 A. That's correct.

23 Q. At the time of Nancy's November 12th visit, you would
24 have not only had the KUB film from 10/27 but also the final
25 18:30 narrative report for the KUB of 10/27/98?

1 18:30 A. On November 12th, would I have had the 10/27 reports?

2 Q. Yes.

3 A. If they came up with her films. My note says that I
4 reviewed the films. I know that I had the faxed IVP report,
5 18:30 but I would presume that I had all of those reports.

6 Q. On November 12th, did you also perform a physical exam
7 on Nancy?

8 A. Yes.

9 Q. And tell me what that examination consisted of.

10 18:31 A. I examined this patient's head, eyes, ears, nose and
11 throat, chest, heart and general appearance.

12 Q. Did you perform an additional urological examination
13 on Nancy on November 12th of 1998?

14 A. Only as far as the abdominal examination goes. I
15 18:31 didn't do a genital examination but planned to do that in
16 the operating room when the patient was prepped and
17 undressed.

18 Q. During the course -- actually, doctor, let me go back
19 to the last question.

20 8:31 When you were just identifying what your physical exam
21 from November 12th consisted of, I noted you were referring
22 to a page in your chart; correct?

23 A. That's correct.

24 Q. Can I just see what portion of your chart you are
25 18:32 referring to?

1 18:32 A. Okay. It's the part of this history form that is in
2 different ink. I think that I did that. Well, going back
3 on it now, the date on the bottom may be just when it was
4 faxed over to surgery, and I cannot tell for sure if this
5 18:32 exam was done on the initial visit on 10/26 or on the second
6 visit 11/12.

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

9 A. I said, "please see the written H and P," but that's a
10 18:32 typo there. History and physical, H and P. So that is what
11 led me to think that I went back and reviewed and did that
12 exam then.

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

15 12:48 A. My recollection is that that very day she did not.

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

19 A. That's correct.

20 12:48 Q. She had no physical pain on palpation in her flank
21 area on the right side; correct?

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

24 Q. There was no need to write her additional
25 12:48 prescriptions for pain medication; correct?

1 12:4 A. Either she hadn't used up her old pain medicine or she
2 found the pain was manageable without it.

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

5 18:3 A. That is correct.

6 Q. In the fourth sentence of your November 12th, 1998
7 progress note, you say, "I think they have a good
8 understanding of the situation and after a long discussion,
9 we elected to proceed with the ureteral stent placement,
10 18:3 possibly uteroscopy"?

11 A. That's correct.

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

14 A. That's correct.

15 18:3 Q. And would it simply be the three of you present in the
16 examining room at that time? \ \ '

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

19 Q. And this is a conversation that you would have had
20 18:3 after reviewing the films with Nancy and her sister;
21 correct?

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

24 Q. Were there any particular findings on either the IVP
25 18:3 or the KUB that you specifically pointed out to Nancy and

1 18:35 her sister?

2 A. Yes.

3 Q. And what were those findings?

4 A. I pointed out that there was an almost completely
5 18:35 blocked kidney and that there was an abnormal area in the
6 lower part of the right kidney that I thought was probably a
7 cyst but would need further evaluation.

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

10 18:35 A. I think a KUB doesn't show whether a kidney is blocked
11 or not.

12 Q. So had Nancy had an obstruction in her right side on
13 10/20 which had passed, there were no films that you had in
14 front of you on November 12th that would indicate that;
15 18:36 correct?

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

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

20 18:36 A. I was primarily relying on the symptoms plus my
21 clinical knowledge of how stones behave and the fact that
22 sometimes patients don't even have pain when a kidney
23 becomes blocked for awhile.

24 Q. Were there any other diagnostic tools available to you
25 18:36 on November 12th of 1998 to rule in or rule out whether or

1 18:36 not she, "she" being Nancy, continued to have a stone in her
2 right side absent surgery?

3 A. Well, the diagnostic tool that I normally proceed with
4 is a retrograde so that I can also treat and bypass the
5 18:37 stone and do it all in one setting and try to prevent
6 further pain or damage to the kidney. When a kidney is
7 blocked a long time, it can become damaged. I didn't order
8 a separate x-ray before doing the retrograde.

9 Q. And it's your testimony that during the course of the
10 18:37 November 12th, 1998 visit, you also pointed out to Nancy and
11 her sister an abnormality in her right kidney?

12 A. I did.

13 Q. And you identified that as a possible cyst?

14 A. I said that it was probably a cyst, but I told them
15 18:37 there was a slight chance, an outside chance, that it could
16 be a tumor that had bled and masqueraded as a stone, and
17 they had a look of shock, and I said, it's unlikely, but
18 it's possible and for that reason I felt we needed the
19 option to do other tests later.

20 18:37 Q. In the face of their look of shock, did they query
21 what other tests would be available to further rule out a
22 cyst or tumor?

23 A. We talked about those tests and the timing and we
24 agreed that the most important thing was to unblock the
25 17:43 blocked kidney and that's what I felt should be done first.

1 17:43 Q. So it's your testimony that during the November 12th,
2 1998 visit, confronted with a kidney stone that was not
3 currently -- a potential kidney stone which was not
4 currently causing her pain which she did not believe had
5 17:43 passed that she didn't need a refill of pain medication for,
6 she was fully ambulatory and reporting to work on a regular
7 basis, that she accepted your conclusion that the kidney
8 stone was a more -- demanded more immediate attention than a
9 potentially cancerous situation?

10 17:43 a. Based on the clinical presentation and the facts that
11 I had available to me at the time, it was my conclusion, my
12 feeling and my impression that this patient's primary
13 problem was an obstructed kidney, and in my experience,
14 sometimes an obstructed kidney stops hurting and patients
15 18:39 don't even know that a kidney has remained blocked. In
16 fact, many times a stone eases up and pain goes away and
17 it's dangerous to just leave it like that and not fully
18 -- investigate that and take care of it if there's a blockage
19 because the patient will lose their kidney.

20 18:39 Q. Would you also agree with me oftentimes renal cell
21 carcinoma has an absolutely asymptomatic presentation?

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

24 Q. At the time of your November 12th, 1998 visit with
25 18:39 Nancy Farkas, were there any -- are there any lab results or

1 18:39 diagnostic studies that you can direct me to which would
2 suggest that Nancy was in danger of kidney damage or kidney
3 failure?

4 A. There are none suggesting kidney failure because her
5 18:40 other kidney was not blocked and you can remove one kidney
6 entirely and a patient would have normal kidney function on
7 any kind of laboratory testing. But from experience, I know
8 that if a kidney is completely blocked, there's damage that
9 becomes irreversible.

10 18:40 Q. Now forgive me if I have asked this already, but in
11 the face of your disclosure on November 12th of 1998 of an
12 abnormal right kidney that was a probable cyst and may
13 remotely be -- there may be a remote chance it was a tumor,
14 did either Nancy Farkas or her sister inquire as to what
15 18:40 diagnostic tests would be employed to rule cancer in or out?

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

20 18:41 Q. I appreciate that answer, doctor, but my question was,
21 were there any specific diagnostic tools discussed with
22 Nancy and/or her sister that would be utilized by you to
23 rule in or rule out renal cell carcinoma?

24 MR. KELLEY: Objection. Asked and
25 18:41 answered. You can answer again.

1 18:41 a. I told them I would need to do additional imaging
2 later to clarify that,¹ and my best recollection is that I
3 said a CT scan but I thought that could be done afterwards.

4 Q. Would it be fair to say that on November 12th of 1998,
5 18:41 renal cell carcinoma was part of your differential
6 diagnosis?

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

9 Q. Okay, doctor. And I would like to confine your answer
10 18:41 to the next question to your record as it relates to
11 accepting this patient through your conclusion of the visit
12 on November 12th of 1998.

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

15 01:05 A. I didn't specifically say those words, but I know that
16 I reviewed all of the findings of the x-rays with the
17 patient and the sister including the findings as listed in
18 the x-ray report and that there was some type of a possible
19 mass there.

20 01:05 Q. **An** again confining your answer to your record up
21 through the conclusion of the visit on November 12th of
22 1998, is there anywhere you can direct me to a plan of care
23 as it relates to further evaluation of Nancy Farkas'
24 abnormal right kidney which you found to be or believed was
25 01:05 a probable cyst and had a remote possibility of being a

1 01:05 tumor?

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

5 18:44 Q. I appreciate --

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

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

9 MS. DIXON: It was.

10 BY MS. DIXON:

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

13 Would it be fair to say that November 12th, 1998 was
14 the first time you had met with Nancy Farkas after receiving
15 18:44 both the narrative report or the final narrative report of
16 the IVP as well as having had an opportunity to review the
17 actual films?

18 A. Yes.

19 Q. Is there anywhere contained in the November 12th, 1998
20 18:44 note which indicates a concern regarding the possibility of
21 renal cell carcinoma?

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

25 18:44 MS. DIXON: Yes.

1 18:44 THE WITNESS: Do you want me to answer
2 that now?

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

5 18:44 A. I didn't specifically say renal cell carcinoma in my
6 note.

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

10 18:45 A. I didn't say that in the note because it was already
11 in the x-ray report and recommended, and I went over that
12 with the patient and her sister.

13 Q. At the time of your meeting with Nancy Farkas and her
14 sister on November 12th, 1998, did they reveal to you any
15 18:4 relevant family history regarding cancer?

16 A. I don't recall that they did. \ \ '

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

20 18:4 A. I don't recall them saying that.

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

23 A. Well, actually, she didn't get routine tests for
24 general health checkups and she agreed to have a Pap test at
25 18:4 my urging because I would be doing a pelvic examination at

1 18:46 the time of the cystoscopy anyway and I would be there and
2 in case I found something during that examination, I wanted
3 to be able to go ahead and get that test, so she agreed to
4 it.

5 18:46 Q. And you are obviously alarmed by the fact that Nancy
6 had not had a Pap test in 15 years as indicated by the
7 exclamation point at the end of your sentence there;
8 correct?

9 A. I was quite concerned that this patient didn't get
10 18:46 routine care.

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

13 A. Cancer of the cervix is one of the most common cancers
14 in women and routine Pap tests have been shown to be very
15 18:47 helpful in enabling early diagnosis of that condition at a
16 time when it might be more curable. \ \ '

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

20 18:47 MR. KELLEY: Objection to generality.
21 You can answer.

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

25 18:47 Q. Specific patient profiles aside, this is a generic

1 18:47 question. Would you agree with the fact that in most forms
2 of cancer you deal with in the course of your practice,
3 early treatment is an important factor in a successful
4 outcome?

5 18:47 A. I think that's a very general and hypothetical
6 question, but certainly one would ordinarily strive towards
7 finding out things at an earlier stage. The exact timing is
8 something that depends upon the clinical situation at hand.

9 Q. Your note from November 12th, '98 also indicates that
10 18:48 "risks and complications discussed at length"; correct?

11 A. That's correct.

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

14 A. Ordinarily I discuss the risks and complications of
15 18:48 the procedure that I am planning to do, and those
16 complications are typically bleeding or infection, possible
17 perforation of the ureter, if one puts a scope up, or
18 perforation into the bladder, through the bladder, pardon
19 me. Sometimes there are anesthetic complications including
20 18:48 death. Those are the main ones.

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

23 A. Yes.

24 Q. What type of alternatives did you discuss with Nancy
25 18:49 and her sister?

1 18:49 A. Alternatives to the direct intervention which would
2 include other types of imaging studies being done right
3 then.

4 Q. Such as?

5 18:49 A. Such as the ones we have discussed. A CT scan to be
6 done right then, a renal scan or another IVP to see if
7 there's any further obstruction, but the CT would usually
8 tell you that, and basically alternatives in terms of just
9 putting a stent up, if there's a stone, or going after it
10 18:49 with a scope and a basket. Different types of interventions
11 to deal with the obstruction.

12 Q. At any point during that November 12th office
13 conversation with Nancy and her sister when these
14 alternatives were being discussed, did either Nancy or her
15 18:5 sister query why it wouldn't be more prudent to begin with
16 the CT scan since, as you indicated earlier, that would
17 assist you in further diagnosing the cyst or mass that you
18 had been appreciating on IVP?

19 A. We talked about the possibility, based on my best
20 18:5 recollection, but it was my feeling and they agreed that the
21 most urgent thing was to relieve the obstruction of the
22 kidney, and we decided we would wait on further imaging
23 studies of the kidneys.

24 Q. Dr. Noble, I understand that there was, in fact, a
25 18:5 time it was determined that you would proceed with the

1 18: 0 ureteral stent placement and uteroscopy; correct?

2 A. That's correct. ¹

3 Q. Is there anything, and I mean medically, that would
4 prohibit performing that procedure in conjunction with an,
5 18:. 0 and I mean either before or after, a CT scan?

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

8 Q. Correct.

9 A. There's nothing medically wrong except that it doesn't
10 18:5 1 solve the immediate problem, which is relieving a blockage,
11 which I thought was very likely to still be present. Also,
12 a CT scan can take sometimes a couple of weeks to get
13 scheduled, and so my first priority was to diagnose and
14 relieve the stone problem that I thought was in effect with
15 18:5 respect to the blocked right kidney.

16 And, also, I thought there was a possibility of a
17 tumor within the lining of the urinary tract that had bled,
18 — and so the operative findings could dictate a different
19 course and a different set of studies depending upon, you
20 18:5 know, what one found. And in the course of our discussion,
21 we, based on an integration of all of the clinical
22 information available at that time and the way the patient
23 and her sister felt, we agreed that we should proceed with
24 the retrograde pyelogram, possible stent, possible stone
25 18:5 intervention first.

1 18:52 Q. Based on your previous testimony, you indicated that
2 you reviewed the final IVP report at least somewhat
3 contemporaneously with it arriving in your office; correct?

4 A. That's correct.

5 18:52 Q. And that would have been either the 28th or 29th of
6 October; correct?

7 A. I don't know exactly which day. It would have arrived
8 in the office the 28th, but if I was in the operating room
9 or out of the office for several days, it's possible that it
10 18:52 was on my desk and they found the chart and a few days more
11 may have passed.

12 Q. I believe you indicated earlier based on your review
13 of the IVP, final report of the IVP, you had intentions of
14 following Dr. O'Campo's suggestion in getting a CT scan;
15 18:52 correct?

16 A. That's correct.

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

20 18:53 A. Not at that time.

21 (Thereupon, a recess was taken.)

22 BY MS. DIXON:

23 Q. Doctor, when we went off the record, we were
24 discussing the November 12th, 1998 note and we discussed the
25 18:54 fact that at the conclusion of that meeting with Nancy,

1 18:54 there was a decision to place the ureteral stent; correct?

2 A. As the first thing.

3 Q. And undergoing, possibly undergoing, a ureteroscopy?

4 A. That's correct.

5 18:54 Q. At the end of your time with Nancy, was that procedure
6 or procedures scheduled?

7 A. (No response).

8 Q. Maybe I can facilitate things for you, doctor. My
9 review of the record seems to indicate there was an initial
10 18:59 procedure scheduled for November 16th of 1998.

11 A. That's correct.

12 Q. Would that procedure have been scheduled at the time
13 of the November 12th office visit?

14 A. Yes; it would have.

15 18:59 Q. Now, let me jump back to the alternatives that you
16 discussed with Nancy and her sister. At any point during
17 that conversation, did you offer as an alternative simply
18 -- waiting to see if her symptoms returned before undergoing
19 any additional or more aggressive intervention?

20 18:59 A. I'm sure I would have mentioned that as an option, but
21 I would not have recommended it, because if the kidney were
22 obstructed and it said almost total and after quite a few
23 hours, no contrast was seen in the lower ureter, I would be
24 concerned about further damage and that's why we tried to
25 19:00 get radiograph -- this retrograde done within a few days.

1 19:0 We had already done a lot of waiting, basically.

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

5 19:0 A. And the fact that she had continued to have
6 intermittent pain, that she still had traces of blood in her
7 urine and that she told me she still felt like something was
8 passing along the tube.

9 Q. Any of the symptoms you have just described, blood in
10 19:0 her urine, intermittent pain and a sensation of something
11 foreign on her right side, would any of those three symptoms
12 be consistent with the presence of a cyst or mass?

13 A. Very unusual unless the mass or cyst were very large
14 and were pressing on the ureter causing obstruction, and the
15 19:0 course of the pain that she described was not typical for
16 that type of a presentation. \ , ,

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

20 19:0 A. That's correct.

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

22 A. That's correct.

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

25 19:0 A. That is correct.

1 19:01 Q And, likewise, she agreed, as a result of your
2 October 20th visit, to return to the hospital and have an
3 additional KUB film done; correct?

4 A. That's correct.

5 19:03 Q And, in fact, this surgical procedure was scheduled
6 for November 15th of 1998 and Nancy appeared at the hospital
7 as directed at the appointed time; correct?

8 A. That is correct.

9 Q. Confining your answer to just this time frame through
10 19:03 November 15th of 1998, did you find Nancy Farkas to be a
11 compliant patient?

12 A. Yes; I did.

13 Q. She arrived at all scheduled appointments; correct?

14 A. That is correct.

15 19:03 Q. Underwent all diagnostic tests that you requested she
16 or suggested she underwent; correct? \ \

17 A. That's correct.

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

20 19:04 A. That's correct.

21 Q. Now, directing your attention to November 16th of
22 1998, the date of the initial surgical procedure, as we
23 stated earlier, Nancy presented at EMH; correct?

24 A. That is correct.

25 19:05 Q She was prepared for surgery in the usual fashion?

1 19:03 A. She was pre-opped, but she did not get a surgical
2 prep. Well, I guess she may have. I would have to review
3 the in-hospital chart to see if she actually had a surgical
4 prep, but my recollection is that the x-ray machine was
5 19:04 broken that day and we had to reschedule, and I'm not
6 certain how complete a prep she had on the 16th.

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

10 19:04 A. When the machine would be working; that's correct.

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

13 A. That was November 23rd, 1998.

14 Q. And describe for me what procedure you undertook on
15 19:0 November 23rd of 1998.

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

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

20 19:0 A. She was under IV sedation, so she was not 100 percent
21 asleep, but she was groggy and relaxed.

22 Q. Would that be considered a twilight anesthesia?

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

25 19:0 Q. Is that an unusual circumstance under which to

1 19:05 perform, in your practice, to perform a bimanual exam and a
2 Pap?

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

5 19:05 Q. And both of those procedures were scheduled on 11/23;
6 correct?

7 A. That's correct.

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

10 19:06 A. On 11/23?

11 Q. Yes.

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

13 Q. Let me back up and ask a different question. In
14 classic situations, would you agree the placement of a
15 19:06 ureteral stent is to assist you in locating a stone or an
16 obstruction?

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

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

19 A. Well, maybe I can clarify and help a little bit.

20 19:06 There are different kinds of ureteral stents. One is an
21 indwelling or internal stent that you use as a bypass tube,
22 but in this particular case, I didn't place a ureteral
23 stent. I used a bulb tip uretero catheter which is inserted
24 just into the opening leading up to the ureter right where
25 19:07 it enters the bladder to introduce contrast or dye to light

1 19 up that tube to get a picture, to get an x-ray. So in this
2 case, that's what I was doing.

3 Q. Was the procedure that you ultimately performed on
4 Nancy on 11/23 the same procedure you had planned to perform
5 19 on 11/16 but were precluded from doing so because of the
6 equipment malfunction?

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

9 Q. Please do.

10 19 A. I didn't find an indication to go ahead with either
11 leaving an internal stent or doing a ureteroscopic procedure
12 because the retrograde pyelogram was normal on 11/23/98.

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

15 19 A. It helps to light up the ureter and the renal
16 collecting system to see if there's an obstruction or
17 filling defect that might indicate tumor or blood clot
18 within that part of the upper urinary tract.

19 Q. Did you re-review the IVP films prior to the procedure
20 19:09 on November 23rd?

21 A. Yes; I did.

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

25 19: A. She had indicated that it was coming and going. I

1 19:09 don't recall how severe the pain was at that particular
2 moment, again, but I know that she had intermittent pain
3 still.

4 Q. Dr. Noble, I apologize for any duplicity of this
5 19:09 question, but on November 23rd, 1998, you performed a
6 retrograde pyelogram; correct?

7 A. That's correct.

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

10 19:10 A. I did a Pap test and I did a pelvic examination and I
11 did a cystoscopy, which we mentioned, to look around the
12 bladder and the urethra.

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

15 19:10 A. The cystoscopy allowed me to inspect the urethra and
16 bladder and the retrograde delineated the ureter and the
17 collecting system of the right kidney.

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

19 A. Yes.

20 19:10 Q. Would you agree that your findings relative to the
21 retrograde pyelogram were that there was no obstruction?

22 A. That's correct.

23 Q. There was no hydronephrosis?

24 A. That's correct.

25 19:10 Q. And that the right side had a normal collecting system

1 19:1 and a normal ureter?

2 A. That's correct. ' ,

3 Q. So there was, in fact no blockage to Nancy's kidney
4 on November 23rd, 1998 when you performed this procedure;
5 19:1 correct?

6 A. That's correct.

7 Q. Your concerns that were discussed with Nancy and her
8 sister in terms of your primary diagnosis on November 12th,
9 1998 were, at least by the time the procedure was finally
10 19 1 done, unwarranted; correct?

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

13 A. I don't think they were unwarranted. I think I was
14 relieved that she had passed whatever had been obstructing
15 19:1 and that we didn't have to be worried about a continuing
16 blockage of the kidney. \ \ ,

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

19 A. I didn't feel that it was in danger from a blockage at
20 19:1 that point.

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

25 19:1 A. It doesn't in this case except to say that whatever

1 19:12 that is in the kidney is not big enough or in a location
2 such as to impinge or press on the collecting system or the
3 ureter.

4 Q. So the fact that the retrograde pyelogram was, for all
5 19:12 intents and purposes, normal, did not give you any
6 additional diagnostic information relative to the cyst or
7 mass?

8 A. That's correct.

9 Q. At the conclusion of the retrograde pyelogram, did you
10 19:12 speak to Nancy, Nancy's sister or both of them?

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

14 Q. From the time that you first reviewed the final IVP
15 19:12 report to the date that you did this retrograde pyelogram,
16 there was approximately between, depending on when you
17 reviewed it, 21 and 23 days that had passed; correct?

18 — A. From the time that I reviewed the report to the date
19 of this procedure? It could have been two or two and a
20 19:13 half weeks. It depends whether I was out of the office for
21 a few days or something or whether they had to find the
22 chart, but something like two to three weeks.

23 Q. Between receipt of the final IVP report and the date
24 you performed the retrograde pyelogram, had there been any
25 19:13 efforts undertaken either by you or on your behalf to

1 19:13 schedule Nancy Farkas for a CT scan?

2 A. Not at that time.

3 Q. At the conclusion of the retrograde pyelogram, did you
4 discuss either with Nancy or her sister scheduling a CT
5 19:13 scan?

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

10 19:13 Q. Did you describe for Nancy's sister a time horizon in
11 which you expected to perform the CT scan?

12 MR. KELLEY: Objection. Asked and
13 answered.

14 A. She asked when I was going to get it and I said, well,
15 19:14 we have to get it certainly within three months of the
16 initial visit or sooner. I told her that.

17 Q. So at the hospital on November 23rd, it's your
18 testimony that you echoed what you had explained to her on
19 11/12; correct?

20 19:14 A. That's correct.

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

23 A. Well, first of all, that's part of the Pap test and
24 pelvic examination. Second, it's part of every cystoscopy
25 19:14 on the female, and, third, the patient had indicated that

1 19::4 she had had some pain that had moved down into the right
2 lower quadrant.

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

4 A. Yes.

5 19::4 Q. And was it normal?

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

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

9 A. That's correct.

10 19:15 Q. What is the significance of a thick adnexa?

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

14 Q. It is my understanding that subsequent to the
15 19:15 retrograde pyelogram you recommended a pelvic ultrasound for
16 Nancy.

17 A. That's correct.

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

20 19:15 A. That was done the day that she came back to see me, on
21 12/7/98.

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

24 A. Pelvic ultrasound looks at the structures in the
25 19:16 pelvic cavity and renal ultrasound looks at the kidneys.

1 19:16 Q. Would you agree with me that a pelvic ultrasound would
2 not provide you with any additional information regarding
3 that cyst or mass that was appreciated on the IVP?

4 A. I would agree, assuming that the mass wasn't big
5 19:16 enough to extend down into the pelvis, which was the case.

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

9 A. I don't recall saying that. I just mentioned that
10 19:16 there was some thickening and she had had some pain in that
11 area and that's why I thought we should get that.

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

15 19:1 A. That is correct.

16 Q. And notwithstanding that conclusion, you sent her
17 home with instructions to continue to strain her urine;
18 correct?

19 A. That's correct.

20 19:1 Q. And can you describe for me or explain to me what your
21 thinking was in instructing her to continue to strain her
22 urine in the face of basically a negative retrograde
23 pyelogram?

24 A. Sometimes a stone can be small or have fragments and
25 19:1 break into small pieces and there could be an additional

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

5 19:1 I felt that as a matter of course, in case any
6 fragments might be recovered, we would want to analyze them.

7 Q. Would you agree that there are patients who simply
8 have one episode of a renal calculous as opposed to a
9 protracted history of multiple, multiple episodes of renal
10 19:1 calculous?

11 A. Yes.

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

15 19:1 *Pl.* Actually, I do it because approximately 70 percent of
16 patients will have one or more additional stones over a five
17 to ten year follow-up period if you don't diagnose and find
18 - out the factors that predispose a stone formation.

19 But this patient had another stone sitting in her
20 19:1 kidneys, so she was already a multiple stone former, in my
21 impression.

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

24 A. No. She didn't have any pain or symptoms relating to
25 19:1 the left one. That was an incidental finding.

1 19:09 Q. Would it be fair, then, to say that your additional
2 studies that related to Nancy's stone profile were
3 prophylactic in nature?

4 A. The studies are prophylactic in terms of trying to
5 19:19 prevent more stones from forming in the future, but they're
6 diagnostic because once in awhile a patient can have a
7 life-threatening condition that's causing them to form
8 stones.

9 Q. I'm sorry. I want to make sure I understood your last
10 19:19 answer. That is, a patient may have a life-threatening
11 condition that causes them to form stones?

12 A. Occasionally.

13 Q. What types of conditions are there that cause,
14 life-threatening conditions that cause, a patient to form
15 19:19 stones?

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

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

25 19:20 A. No.

1 19:20 Q. Let me ask you to take a look at your progress note as
2 it relates to the 11/23rd visit -- I'm sorry, procedure.

3 A. You mean the operative report?

4 Q. No. Your progress note.

5 19:20 MR. KELLEY: Is this the 7th?

6 MS. DIXON: Yeah; I think it is.

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

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

10 BY MS. DIXON:

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

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

14 Q. Sure. Doctor, I have handed you the inpatient
15 19:23 progress note from the 11 -- or following the 11/23/1998
16 procedure.

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

19 A. What I meant was that the inside portion of the right
20 19:23 kidney, the right kidney's collecting system was normal.
21 You can't tell anything about the rest of the kidney on a
22 retrograde pyelogram.

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

25 19:23 A. Yes.

1 19:2 Q. She had a chest x-ray?

2 A. Yes.

3 Q. You had an opportunity to review the final report on
4 that chest film; correct?

5 A. Yes.

6 Q. Would you agree that Nancy's chest film was normal?

7 A. Yes.

8 Q. And all of her lab chemistries were within normal
9 limits prior to the 11/23 procedure, as well; correct?

10 19:2 A. That's correct.

11 Q. Following up on one of your previous answers
12 specifically as it related to the progress note that said
13 normal right kidney, you indicated that was the internal
14 structures of the kidney; correct?

15 19:2 A. I meant the inside of the kidney was normal, because
16 that's the only part I examined with the retrograde.

17 Q. Would you agree that only a CT scan or a renal
18 ultrasound would permit you to visualize the entire kidney?

19 A. No; I wouldn't say that. But I would say that they
20 19:2 can visualize the entire kidney.

21 Q. As a practitioner in the specialty of urology, would
22 you say that a CT scan is the best tool available to you
23 currently to visualize the entire kidney?

24 A. I think that it's the most complete way to examine a
25 19:2 kidney.

1 19:25 Q. Up through November 16th of 1998, you found Nancy to
2 be a compliant patient;¹ correct?

3 A. That's correct.

4 Q. And, in fact, she came to Elyria Memorial Hospital for
5 19:25 a surgical procedure which had to be aborted because of
6 mechanical difficulties; correct?

7 A. That is correct.

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

10 19:25 A. That is correct.

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

13 A. Yes; that's correct.

14 MR. KELLEY: Objection. Asked and
15 19:25 answered

16 BY MS. DIXON:

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

19 A. That is correct.

20 19:25 Q. And she also underwent a pelvic sonogram at your
21 suggestion; correct?

22 A. That same day.

23 Q. And up until that point, were there any tests or
24 procedures that you had suggested or requested that Nancy
25 19:25 undergo that she refused or declined?

1 19:2 MR. KELLEY: You mean urological
2 tests?

3 MS. DIXON: Diagnostic tests.

4 MR. KELLEY: I only say that because
5 19:2 of the mammogram reference in the chart. Are you limiting
6 it to urology or not?

7 BY MS. DIXON:

8 Q. With the exception of deferring on the mammogram.

9 A. Well, she refused it.

10 19:2 Q. You did ultimately refer her to Dr. Stamatis; correct?

11 A. That's correct.

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

13 A. I don't know.

14 Q. I'll represent to you that she did. With the
15 19:2 exception of the mammogram, did Nancy Farkas refuse or
16 decline any diagnostic test or procedure which you suggested
17 or asked she undergo through December 7th of 1998?

18 - A. No.

19 Q. Let me ask you to take out your office note of
20 19:2 December 7th, 1998.

21 A. Okay.

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

25 19:2 A. My best understanding, and I would have to research

1 19:2 this, would be that when the patient originally came in on
2 October 26th, she was Given a temporary number of 87532895
3 and that the office, in going through the demographic
4 information, found out that she, at some point in time, had
5 19:2 been registered in the Cleveland Clinic system in the remote
6 past, presumably, and they found an original Cleveland
7 Clinic number which is a lower number and probably from some
8 years ago, and I think that's the reason the number changed.

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

10 19:2 A. Yes.

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

12 A. No.

13 Q. And why was that?

14 A. She was feeling well at that time.

15 19:2 Q. Did you discuss any of the diagnostic tests or
16 procedures that you had performed on her'or had requested
17 that she undergo during that visit?

18 — A. Yes; I did.

19 Q. And which tests were those that you discussed?

20 19:2 A. Well, I discussed the results of all the tests up
21 until then and I explained that we needed to find out why
22 she was a stone former, and her sister said, what about
23 checking on that abnormal area in the kidney, and I said we
24 would get to that, and she said, when, and I said we would
25 19:2 get that next visit because it would coincide with my

1 19:20 completion of the metabolic workup and I would have a
2 snapshot of where all the stones were, whatever didn't show
3 up on the IVP, and then I would know if she formed new
4 stones while on a metabolic prevention program.

5 19:20 Q. Is a pelvic ultrasound performed in your office or in
6 the hospital?

7 A. In the hospital radiology department.

8 Q. So as of December 7th of 1998, at your request, Nancy
9 had been to EMH for diagnostic testing and/or procedures on
10 19:20 four separate occasions; correct? 10/27/98 for the KUB;
11 correct?

12 A. Okay.

13 MR. KELLEY: Asked and answered. Go
14 ahead.

15 BY MS. DIXON:

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

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

20 19:20 A. That's correct.

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

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

24 A. That's correct.

25 19:20 Q. And 12/7/98 for the pelvic sonogram; correct?

1 19:29 MR. KELLEY: Objection. Asked and
2 answered three times.

3 A. That's correct.

4 Q. And none of those times, despite the fact that she was
5 19:29 at the hospital, were any efforts undertaken by you or your
6 staff to schedule a CT scan to further evaluate the cyst or
7 mass appreciated on the October 20th IVP; correct?

8 MR. KELLEY: Objection.

9 A. I did not do it in that time frame of several weeks;
10 19:29 that's correct.

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

13 BY MS. DIXON:

14 Q. Doctor, during the pelvic ultrasound that was
15 19:30 performed on December 7th of 1998, what would be involved in
16 conducting a renal ultrasound simultaneously?

17 A. You mean what mechanically is involved?

18 Q. Yes.

19 A. Basically one orders the test and the radiology
20 19:30 department performs the test scanning higher up in the
21 abdomen with their instruments.

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

25 19:30 A. There would be nothing to preclude it, but I felt I

1 19:30 was going to get a CT scan anyway in a short time, and in my
2 experience, when I get renal ultrasounds, many times they
3 are not completely diagnostic, as I would like, and I end up
4 having to get a CT scan anyway, and I knew I was going to
5 19:30 get a CT scan at the end of my stone metabolic workup and
6 that's why I didn't also get a renal ultrasound at the time
7 of the pelvic ultrasound.

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

10 19:31 A. Not at that time.

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

14 A. That's correct.

15 19:31 Q. And Nancy agreed to that; correct?

16 A. She did.

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

19 A. We have a panel of tests that we get which we call a
20 19:31 stone risk profile here, and the tests are basically written
21 out on the copy of the return sheet that I think you have a
22 copy of.

23 Q. And didn't Nancy previously have a metabolic panel
24 done on 11/12/98 as part of her pre-op testing, as part of
25 19:32 the cystoscopy?

1 19:32 A. She had a blood chemistry. She didn't have a urine
2 chemistry and she didn't have a parathyroid hormone test.

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

5 19:32 A. Yes.

6 Q. And what was that?

7 A. Well, I felt that she had a stone problem and I felt
8 that she probably had a cyst in the right kidney, but we
9 needed to be certain about it as far as urologic problems
10 19:32 went.

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

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

15 19:33 Q. Is there anywhere in the December 7th, 1998 note where
16 you memorialize any conversations you may have had with
17 Nancy or her sister regarding a course of action to further
18 evaluate the cyst or mass?

19 A. It's not rewritten in there, no, because it's already
20 19:33 been written in general in the chart.

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

25 19:33 MR. KELLEY: Objection. You can

1 19:3 answer.

2 A. There's nothing specifically saying CT, repeating
3 what's in the IVP report, recommendation, but I did refer to
4 the fact that I went over the films and the findings with
5 19:3 the patient and her sister during the November 12th visit,
6 and that is in that note.

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

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

10 19:3 Q. Doctor, is there anywhere in your record through
11 December 7th of 1998 where you, and, again, with the
12 exception of the IVP final report, where you outline a
13 course of action to further investigate or evaluate the cyst
14 or mass in Nancy Farkas' right kidney?

15 19:3 A. There is nothing where I specifically rewrote that.

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

20 19:3 A. And the fact that I remember specifically talking to
21 the patient and her sister about it, because it came up
22 several times during the course of the follow-up.

23 Q. When patients leave your office and are requested to
24 return, is an appointment scheduled at that time prior to
25 19:3 their departure?

1 19:35 A. Yes, if possible.

2 Q. And when was Nancy's follow-up appointment after
3 12/7/98 scheduled for?

4 A. We wanted to get it in four weeks, but she had some
5 19:35 things planned over the holidays, and with the office
6 scheduling, it was scheduled for January 15th of 1999 at
7 1:30 p.m.

8 Q. And your office calendar would reflect that?

9 A. We have a computerized scheduling system that is
10 19:35 through the main campus of the Cleveland Clinic and we don't
11 have a separate printout of all of those computerized
12 schedules.

13 Q. The notation that you are relying upon that an
14 appointment was made for Nancy on 12/7 of '98 is the entry
15 19:36 in red in your chart that indicates 1/15/99 at 1:30;
16 correct?

17 A. That is correct.

18 Q. And do you know what shift Nancy worked in January of
19 1999?

20 19:36 A. No; I don't.

21 Q. Do you know what time of day her previous appointments
22 were generally scheduled?

23 A. I would have to go back and look that up, if possible.
24 I don't know what time of day exactly.

25 19:36 Q. Would you find it unusual that a patient in a

1 19:36 non-emergency situation would schedule an appointment at a
2 time when they would have to take off of work?

3 MR. KELLEY: Objection. Don't guess.

4 A. I wouldn't find it unusual that a patient would take
5 19:36 off part of the day of work to come see me for continuing
6 tests and evaluation.

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

9 A. That is correct.

10 19:36 Q. Can you tell me what role -- first of all, what's
11 involved in that study?

12 A. That involves a patient putting all urine that they
13 make into a collection container that would then be
14 submitted to the laboratory for analysis over that 24-hour
15 19:37 time frame.

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

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

20 19:37 Q. Is the patient at any point NPO?

21 A. No.

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

24 A. Normally the lab provides the instructions.

25 19:37 Q. You had had a specific conversation with Nancy

1 19:37 regarding the need for a 24-hour urine; correct?

2 A. That is correct.'

3 Q. And if I told you that Nancy Farkas did, in fact,

4 report to the lab at your direction with an order for a

5 19:37 24-hour urine but was told that she had to save her urine

6 for 24 hours time in order to complete the test and that

7 armed with that information, she returned to your office and

8 asked for clarification as to whether or not the test needed

9 to be done in light of her previously normal findings, would

10 19:38 you have any reason to disagree with or dispute the fact

11 that such a conversation took place?

12 MR. KELLEY: That she came back?

13 A. I don't know if she came back to the office or this

14 was over the telephone. I know there was a notation that

15 19:38 she wanted to know if she really did need to do further

16 tests and we emphasized that she did need further testing.

17 Q. And are you referring to the portion of your chart

18 that at the top of it says "Noble" then "message/problem"?

19 A. Yes.

20 19:38 Q. And it indicates the patient is Nancy Farkas, of

21 course; correct?

22 A. Yes.

23 Q. And I assume that is someone on your staff's

24 handwriting, the first three sentences; is that accurate?

25 19:38 A. That's correct.

1 19:38 Q. And that note indicates that patient wants to note if
2 24-hour urine has to be done, if she has to have it, can she
3 wait until around Christmas when she has some time off?

4 A. And I said it was okay to wait a couple of weeks.

5 19:39 Q. Do you know who would have been responsible for
6 communicating a response back to Nancy Farkas regarding the
7 parameters, if you will, for the 24-hour urine?

8 A. Well, of course it was already discussed in the
9 office, but in terms of reinforcing the need to complete
10 19:39 testing, that would have been my secretary, Joan Holmes, I
11 believe. I think that's her initials on the bottom.

12 Q. And this message, would this have been done -- I'm
13 trying to understand how this document would have been
14 created. Is this either the patient calls or stops and the
15 19:39 query is identified on the document, it's left for you in
16 some sort of interoffice mail for you to respond to, or is
17 it brought to your attention immediately?

18 -- A. It's put on my desk with any and all messages or
19 concerns from patients and either I, or if I write a note,
20 19:39 one of my office personnel would call the patient back and
21 tell them that.

22 Q. Ordinarily once you're confronted or your staff
23 attempts to elicit a solution for a message or a problem for
24 a patient, is there any documentation that there is a
25 19:41 call-back made or that that communication, that information,

1 19:41 has been communicated back to the patient?

2 A. The procedure is that if the patient can't be reached
3 or if the communication is not relayed back to the patient,
4 then I'm told about it so that I can then write a letter.

5 19:41 Q. My question is, is there any form within your office
6 that confirms that the patient has been -- that that
7 information has been transmitted to the patient?

8 A. No. There is not a separate form, but, as I say, we
9 keep trying until we reach the patient to answer their
10 19:41 questions.

11 Q. It's your position, as I understand it, that Nancy
12 Farkas discontinued treatment after her 12/7/98 visit with
13 you; correct?

14 A. She never followed up after that.

15 19:42 Q. And it's your testimony as you sit here today that at
16 the conclusion of the 12/7/98 visit, there was an additional
17 appointment made for January 15th of '99?

18 — A. That's correct.

19 Q. Is there anywhere in Nancy's chart with your office
20 19:42 that shows her either as a cancellation or a no show for
21 January 15th of 1999?

22 A. When there's a no show, it's in the computer as a no
23 show and then we think the patient just forgot. But if the
24 patient cancels, it's my understanding that it gets
25 19:42 overwritten in the computer scheduling, then the patient may

1 19:4 have decided not to come back, they may have gone to another
2 doctor or chosen not to¹ follow up and finish their testing.

3 Q. Is it fair to say that in December of 1998, you at
4 least had some degree of concern regarding further
5 19:4 investigation and evaluation of the cyst or mass in Nancy's
6 right kidney?

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

8 Q. In the face of that concern and an alleged, as you at
9 least portrayed it to me, the patient discontinued
10 19:4 treatment, do you have either any protocol or any personal
11 practice as to treatment to follow up with that patient?

12 A. If the patient has had a long discussion with me and
13 understands as a fully competent and functioning adult and a
14 family member is there and I have emphasized the importance
15 19:4 of completion of tests and then there's another conversation
16 to that effect, then I don't know any way beyond that to
17 coerce a patient to come back in. That patient has to take
18 an active role in helping me to complete the evaluation and
19 testing to figure everything out.

20 9:4 Q. Do you know for a fact that there was an appointment
21 scheduled for Nancy on January 15th of 1999?

22 A. When it's written out with a specific date and time,
23 that's always been the case in my experience in this office,
24 that that's, in fact, been made and occurred. And the
25 19:4 patient knew that there was follow-up because when she made

1 19:4 another contact, she knew that she had to get the tests and
2 come back, so I don't think there was any doubt of that.

3 Q. Dr. Noble, you're aware of the fact that in the fall
4 of 1999, Nancy's sister came to this office and requested a
5 19:4 copy of Nancy's medical records; correct?

6 A. That's correct.

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

9 A. Well, actually, I don't have to approve it, but they
10 19:4 like me to be aware in case there are any other records that
11 need to be included and so forth or, you know, just as a
12 matter of course.

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

15 19:4 A. That's correct.

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

19 A. That's correct.

20 19:4 Q. And that metabolic workup would relate to a stone
21 situation as opposed to a cancerous scenario; correct?

22 A. Actually, I feel they're synonymous in this case
23 because, as I said earlier, it's like having gasoline with a
24 car. The car is not really useful without the gasoline, and
25 19:4 when you have a patient and you're doing a stone evaluation

1 19:45 and you know there's also a questionable area in the kidney
2 that you need to finish¹ delineating, I think that it's
3 important to have a complete picture of any and all stones
4 in that patient, which is my customary practice at the end
5 19:46 of metabolic chemistry tests.

6 So in my mind, metabolic testing includes having an
up-to-date radiographic imaging, as well, and, as I said,
8 the CT is the most accurate way to do that, so I knew we
9 were going to get those things and I was concerned that she
10 19:46 had never come back and completed any of her testing. Of
11 course at that time, I didn't know any other things about
12 the patient.

13 Q. When we were talking earlier about your decision
14 regarding order of findings to deal with, you explained to
15 19:46 me the reason that you considered the stone or obstruction
16 to be primary was your concern over damage to the kidney;
17 correct?

18 A. And that patient had been having intermittent pain,
19 that that was the symptomatic problem that needed immediate
20 19:47 addressing; that's correct.

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

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

25 19:47 A. I would say that it was no longer a concern about an

1 19:47 obstructed kidney.

2 Q. At that point, is there a reason you can direct me to
3 that your attention did not immediately focus onto further
4 evaluation and investigation into the cyst or mass in Nancy
5 19:47 Farkas' right kidney?

6 A. Immediate like the next day?

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

8 A. I felt that it would be done sometime in the next few
9 weeks as part of the outpatient follow-up and that's what I
10 19:47 told her sister because she asked about it.

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

14 A. That's correct.

15 19:47 Q. And that includes both the initial diagnosis of those
16 patients as well as the subsequent treatment; correct?

17 A. That is correct.

18 - Q. Do you understand, based on your education, training
19 and experience, renal cell carcinoma to be a relatively
20 19:48 aggressive form of cancer?

21 MR. KELLEY: Objection.

22 A. That's a very generalized question. When renal
23 cancers are small, they tend to be slow growing and usually
24 they progress slowly, but everything is, you know, dependent
25 19:48 upon the biology of the tumor, the specifics of the cancer.

1 19:48 It's hard to make an exact general statement.

2 Q. In the face of a¹ diagnosis of, and, again, based on
3 your education, training and experience, in the face of a
4 diagnosis of renal cell carcinoma that is stage 1 or
5 19:48 stage 2, can you tell me, generally speaking, what the
6 prognosis is for a person who at that point undergoes a
7 nephrectomy?

8 MR. KELLEY: Objection.

9 A. First of all, this is stage 1 or stage 2 based on
10 19:48 clinical information, or this is after the kidney has been
11 analyzed, you know, under the microscope and they have a
12 pathologic stage?

13 Q. Let's take those one at a time. First of all, based
14 on the clinical presentation.

15 19:49 A. Based on the clinical presentation, you really don't
16 know exactly what stage you are talking about because you
17 can't see with an x-ray what the microscopic extent of the
18 — tumor is and you don't know what the cell type is, where
19 the -- or the nuclear grade or anything of that type, so
20 19:49 it's difficult to give an exact prognosis in that situation.

21 Q. Doctor, as I understood that last answer, based on
22 clinical presentation alone, there are a number of
23 uncertainties that prohibit you, as a treating physician, to
24 understand how advanced renal cell carcinoma is in that
25 19:49 patient; correct?

1 19:49 A. That is correct.

2 Q. That being the ¹case, doesn't that make it more
3 incumbent upon you for a swift intervention and diagnosis in
4 a patient such as Nancy with suspicious findings in her
5 19:50 kidney?

6 MR. KELLEY: Objection.

7 A. "Swift" is a very general term. Again, I feel that as
8 long as the test is done in a timely manner, within three to
9 six weeks or so, that that's certainly reasonable and
10 19:50 adequately rapid.

11 Also, based on the clinical experience and the
12 setting, most of the -- the majority of presentations such
13 as hers turn out to be simple cysts.

14 Q. In the course of your practice where you have
15 19:50 diagnosed an individual with renal cell carcinoma, is it
16 your practice to recommend a nephrectomy as a course of
17 treatment?

18 MR. KELLEY: Objection. You can
19 answer.

20 19:50 A. Once I have diagnosed a renal cancer, I do a
21 metastatic workup to see if there's been any spread of
22 tumor.

23 Q. Once you have drawn your conclusions regarding the
24 metastatic course that that cancer may have taken, let's
25 19:51 assume it's confined to stage 1 or stage 2 contained

1 19:11 somewhere in the kidney, do you recommend a nephrectomy?

2 A. Yes.

3 Q. And do you personally perform nephrectomies, or do you
4 refer that to an alternative specialist?

5 19:11 A. I personally perform nephrectomies.

6 Q. And in evaluating that patient as a candidate for a
7 nephrectomy, what does your metastatic workup consist of?

8 A. Now we're getting hypothetical and, of course, it
9 depends on the person's other clinical parameters again.

10 19:51 Q. Let's just assume an otherwise healthy individual.

11 A. Okay. Because obviously if a person has neurologic
12 signs or something, that would direct your focus towards
13 that area of the body as part of it. But if you have a
14 patient with a renal cancer and you're doing a metastatic
15 19:51 workup, the most common tests would be, in my experience, a
16 bone scan and CT scan of the chest. \ \ '

17 Q. Over your 23 years as a urologist, you have treated
18 — patients that have been stage 1 or stage 2 that have
19 undergone a nephrectomy; correct?

20 19:E2 A. Yes.

21 Q. And I want to ask you two separate questions about
22 that. The first is, based on your personal experience
23 treating these patients having had a nephrectomy in stage 1
24 or stage 2, in your practice, what is the five-year survival
25 19:52 percentage for those patients?

1 19:5 MR. KELLEY: Objection.

2 MR. SCHOBERT: Objection.

3 MR. KELLEY: What type of cancer?

4 MS. DIXON: Renal cell carcinoma.

5 19:5 MR. KELLEY: You say that like
6 there's only one type.

7 A. That's a difficult question to answer generally
8 because it really depends on the histology. Also, stage 1
9 or stage 2, are we talking again pathologic stage after you
10 19:5 have analyzed the tissue that you removed, or are we talking
11 clinical stage where that's all you see on the x-ray?

12 Q. Let's confine this question to a pathological stage 1
13 or stage 2. When the patient has undergone a nephrectomy,
14 what is your experience, the experience you have had in your
15 19:5 practice, with five-year survival in those patients?

16 MR. KELLEY: Objection. If you have
17 data. I don't want you to guess.

18 A. I don't have exact data on my -- I haven't written up
19 those patients in a series to be able to give you any kind
20 19:5 of a close percentage from my experience.

21 Q. Doctor, stepping out of the confines of your office,
22 you have told me early on that you have access to numerous
23 journals in the area of urology; correct?

24 A. That's correct.

25 19:5 Q. And, in fact, based on review of your CV, you serve as

1 19:E 3 an expert reviewer on several journals, as well; correct?

2 A. That is correct.¹

3 Q. I'm assuming you keep up with the literature within
4 your specialty; correct?

5 19:E 3 A. Generally I do.

6 Q. And as part of your review of the literature in a
7 current fashion, that oftentimes includes review of
8 statistics of different diseases, mortality and morbidity
9 rates, et cetera; correct?

10 19:54 A. That's contained in various journal articles at times.

11 Q. The efficacy of various treatments for different
12 diseases?

13 A. That's often included in the journals, too.

14 Q. Doctor, do you have an understanding based on
15 19:54 statistics generally available to you as a practitioner with
16 a patient who has been pathologically diagnosed as clear
17 cell nuclear grade 3 renal cell carcinoma in stage 1 or
18 stage 2 that undergoes a nephrectomy, what is that patient's
19 likelihood of a five-year survival statistically?

20 19:54 MR. KELLEY: Objection.

21 A. This is grade 3 on a 4 scale?

22 Q. Yes.

23 A. I would have to look up that statistic because I don't
24 know exactly.

25 19:54 Q. Is there a source that you would look to for that

1 19:5 statistic?

2 A. I would have to go through the urologic literature and
3 get some articles out to give you that approximate five-year
4 survival because I don't have that exact number in my head.

5 19:5 Q. In endeavoring --

6 MS. DIXON: Off the record.

7 (Thereupon, a recess was taken.)

8 BY MS. DIXON:

9 Q. Doctor, before we went off the record, we were talking
10 19:5 about some five-year survival statistics. I believe you
11 indicated that you would need to endeavor to review some
12 additional materials before answering that question;
13 correct?

14 A. I don't know the exact or even approximate statistics
15 19:5 without a guess and I would rather not guess.

16 Q. Certainly. Would that exploration of information
17 include reviewing statistics contained in various journals
18 that you subscribe to?

19 A. It would involve reviewing journals and articles
20 19:5 published in textbooks and various other sources to get
21 essentially a median analysis to give me the best picture.

22 Q. Are there certain journals that you find more reliable
23 or you're more comfortable relying upon?

24 MR. KELLEY: Objection.

25 20:0 A. There's a lot of variability to journals. I really

1 20:01 prefer to see what the exact study is and the individual
2 group that's done the study, what the patient population is
3 that they're reviewing and so forth. I can't say
4 specifically that a journal is necessarily reliable by
5 20:01 itself. It depends on the article.

6 Q. I see by virtue of your CV that you're an expert
7 reviewer for both -- for "Urology," "Journal of Urology" and
8 "Cancer"; correct?

9 A. I have done reviews for all three journals; that's
10 20:01 correct.

11 Q. Do you find any and/or all of those journals reliable?

12 MR. KELLEY: Objection. He just
13 answered.

14 A. That's --

15 20:01 MR. KELLEY: You can answer again.

16 A. It's a speculative question. I think sometimes they
17 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
20 20:02 you ever reviewed an article that included survival
21 statistics related to renal cell carcinoma?

22 A. I have reviewed such an article.

23 Q. As an expert reviewer?

24 A. I can't recall. It's possible.

25 20:02 Q. Do you keep any notes or records that would reflect

1 20:02 the projects in which you have been -- you have served on as
2 an expert reviewer for any of those three journals?

3 A. No. I don't keep any notes about that.

4 Q. And are those assignments given to you through the
5 20:02 general administrative offices of each of those journals or
6 periodicals?

7 A. They are. They send an article to me and ask my
8 opinion and I put comments, and I don't even know if my
9 opinion is even registered or if they pick two out of the
10 20:02 three reviewers they send them to. I have no idea how they
11 do it each time.

12 Q. I just have a few clean-up questions and then I will
13 be through.

14 You indicated very early on you currently have one
15 20:03 unpublished article that you expect to go into publication
16 the summer of 2000; correct? \ \ \

17 A. We're submitting it in June of the year 2000.

18 Q. Are there co-authors on that article?

19 A. I haven't turned it in, so I can't say which people
20 20:03 will be co-authors. I expect there will probably be one or
21 two co-authors.

22 Q. And is that article currently a format that is
23 prepared to go to publish?

24 A. No. It's not quite ready.

25 20:03 Q. Was there research conducted in conjunction with

1 20:03 preparation of that article?

2 A. There was. We reviewed cases at the University of
3 Kansas back when I was at that facility.

4 Q. Can you identify some of the doctors who worked in
5 20:03 conjunction with you on that article, whether or not they
6 will be ultimately named as a co-author?

7 MR. KELLEY: My only objection is are
8 you allowed to disclose anything about the article before
9 it's published?

10 20:03 THE WITNESS: I was going to ask that.
11 I don't think that ethically I'm supposed to because it's
12 not any kind of an authoritative record until it's accepted
13 at least for publication.

14 A. It's basically an article that is still in preparation
15 20:0 stage. It's not completed, and who will be the final
16 authors included on the manuscript hasn't been finalized
17 yet.

18 Q. Separate and apart from Nancy Farkas' chart which you
19 currently have on your lap, have you made and/or kept any
20 20:0 notes regarding her care and treatment --

21 A. No.

22 Q. -- that aren't contained in the chart?

23 A. No.

24 Q. You directed my attention to the red ink demarcation
25 20:0 of 1/15/99, 1:30 p.m. appointment for Nancy.

1 20:04 A. That is correct.

2 Q. Is there anywhere¹ else in that chart where an
3 appointment for Miss Farkas is noted in that type of a
4 fashion?

5 20:05 A. You mean in red ink?

6 Q. No. Actually, just in the margin indicating when the
patient will return.

8 A. There's the one for the surgery scheduling where the
9 date is fixed and it's in the morning. We never get the
10 20:05 exact time of that until the day before.

11 Q. Let me clarify my question. It related exclusively to
12 office visits.

13 A. Okay. The form was a different kind of form when I
14 saw her on October 26th, 1998. It was about that time that
15 20:06 the form was changed to the one that you see for
16 November 16th and November 23rd, is it, or November -- or
17 January 15th return and the November 16th surgery dated
18 11/12.

19 On the 26th, we were not using that type of form and
20 20:06 so it wasn't specifically noted as to time, for example,
21 like the 11/12 visit because we didn't have that form back
22 on 10/26. Pardon me.

23 Q. But, actually, it was not a blank on the form that the
24 1/15/99 date was entered. It was simply a marginal note;
25 20:07 correct?

1 20 MR. KELLEY: I object. It's right
2 next to the note saying return to office.

3 A. The secretary put that there.

4 Q. And which secretary's handwriting is that?

5 20: A. That's -- I'm not positive, but I think it may have
6 been -- I'm not for certain whose handwriting that is. Back
7 then we had several secretaries back then. At least one or
8 more aren't working in the office now.

9 Q. Doctor, you indicated in your previous answers that
10 20: you have not only diagnosed renal cell carcinoma, you have
11 personally performed nephrectomies on some of those
12 patients; correct?

13 A. That is correct.

14 Q. What is your standard time frame from diagnosis of
15 20: renal cell and performing a nephrectomy in the patients you
16 deem it's appropriate for?

17 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
20 20: three to six weeks you would like to get the nephrectomy
21 done from the time you have found the problem.

22 But, of course, it depends upon the clinical status.
23 If the patient has got chest pains that are non-specific,
24 you may have to get a cardiac evaluation and they may need a
25 20: heart cath. or other tests, so those things may delay it.

1 20:08 Q. Doctor, based on your experience in the area of
2 urology and treating patients with renal cell carcinoma, can
3 a nine to ten-month delay in diagnosis of renal cell impact
4 that patient's chances of survival?

5 20:08 MR. KELLEY: Objection to the form of
6 the question as being overbroad. You can answer if
7 possible. Don't guess if it's not specific.

8 A. I don't know if there are published data in terms of
9 any reported studies that could give an answer to what that
10 20:09 impact would be. On a theoretical note, if there's a delay
11 of that period of time, you know, naturally one would expect
12 that it might affect, but I don't have any specific data to
13 answer that with statistics for you.

14 Q. And other than your own personal practice, are you
15 20: aware of any written protocol or standard in a urological
16 text or journal that states that a CT scan is part of a
17 metabolic workup?

18 A. Well, it's not in itself a metabolic test, but, again,
19 I would have to look in the literature. I'm sure that in
20 20: some of the articles I have written about stones before we
21 went to CT scans as a lot of the diagnostic testing for
22 stones, I'm sure that there was some reference to up-to-date
23 imaging being performed as part of the stone treatment and
24 follow-up.

25 20: MS. DIXON: I don't have anything

1 20: 0 further. Thank you for your time.

2 MR. MURPHY: I do have a few
3 questions, doctor. I know it's getting late at night.

4 - - -

5 CROSS-EXAMINATION OF MARK NOBLE, M.D.

6 BY MR. MURPHY:

7 Q. You talked before about the inquiry Miss Farkas made
8 concerning the necessity for this 24-hour urine test. Do
9 you recall that discussion?

10 20:10 A. Yes.

11 Q. You were asked whether or not there was a form in your
12 chart to check off, yes, she received the phone call. You
13 said there's no form, per se; is that correct?

14 A. I don't believe we have a separate form. We just have
15 20:1 a practice if the patient isn't reached, the secretary tells
16 me, could not convey this message, patient can't be reached.
17 That way I can write a letter.

18 Q. And there is no such letter. So based on your normal
19 routine, office practice, that would tell you, as you review
20 20:1 this chart, that Miss Farkas was reached with that
21 information about the test?

22 A. That's the ordinary practice; yes.

23 Q. I know you said your plan was to finish the metabolic
24 workup prior to doing the CT scan and I know you have tried
25 20:1 to explain. I have tried to listen. Can you give me

1 20:11 further explanation as to why that was the sequence you
2 wanted to do it in?

3 A. I felt that IVP wasn't a very good test. It was with
4 an unprepped bowel in an emergency room setting.

5 20:11 When you have a blocked kidney, there is often
6 inflammation associated with and around the kidney and there
7 was a small calcification you could barely see in the left
8 kidney.

9 When I don't have complete information, I want to get
10 20:11 a complete picture of the stones in that patient when I'm
11 going to try to prevent more, so I had intended to
12 coordinate being meticulous about the findings on the IVP
13 with that final determination at the completion of the
14 metabolic testing phase and I thought it would be within a
15 20:12 few weeks.

16 Q. I saw a note some place in here, -- it was dated
17 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 20:12 x-ray machinery had been working earlier during that day for
21 other cases but was not working at the time of her scheduled
22 case.

23 Do you recall that situation or not?

24 A. I would have to go back and look at that chart to see
25 20:12 that note, and I don't have it, but I seem to recall that I

1 20:12 may have written something to that effect.

2 Q. From the standpoint that that test was delayed for one
3 week, from the 16th to the 23rd of November, in your
4 opinion, did that have any impact on your workup of Nancy
5 20:12 Farkas?

6 A. I don't think that one week would make a difference
7 unless you had an out and out emergency, and, to my
8 knowledge, she didn't.

9 Q. You were asked whether or not, I think, your office
10 20:13 notes actually detailed your plan for, first, a retrograde
11 pyelogram, then a metabolic workup and then a CT scan, and
12 you testified that, per se, you don't have such terminology
13 in your notes basically?

14 A. Well, I initialed the report that was in the chart and
15 20:13 I went over that report and the findings as well as the
16 x-rays themselves with the patient and her sister. No, I
17 did not rewrite it again in a separate place in my notes.

18 Q. I was going to follow up with a question. As you do
19 write your progress notes, do you try to summarize in a
20 20:13 brief manner what you are doing with a patient, what you are
21 talking to the patient about so that you will have a record
22 of what was discussed later on when you look back?

23 A. It depends on what we're talking about. Generally the
24 notes are to indicate what I have done so far.

25 09 E2 Q. Looking at your November 12, 1998 note, you state in

1 09:52 part, "I think they have a good understanding of the
2 situation and after a long discussion, we elected to proceed
3 with those procedures."

4 When you talk about t.he "situation" and the "long
5 09:52 discussion," is that your notation manner of indicating you
6 have gone over the findings of the IVP, you have talked to
7 her about the cyst versus mass issue and what your plan is
8 to work all of this up?

9 A. Yes.

10 09:52 Q. I believe your office chart contains the IVP report
11 from the 10/20/98 ER visit but not any other ER records; is
12 that correct?

13 A. That's correct. I didn't see any ER records contained
14 in there.

15 20:15 Q. You said your custom would normally be to request the
16 complete ER chart and try to get it? \. \.

17 A. It's possible when I was performing the patient's
18 retrograde, it was in the main chart and I looked at it
19 there, but I don't have a copy of that right now to
20 20:15 demonstrate it.

21 Q. Whether or not you had reviewed the complete ER chart
22 completely, which is kind of redundant, do you believe
23 there's anything contained in there which in any way would
24 have changed or altered your workup and plan given the
25 20:15 results of the actual IVP films?

1 20:15 P Was~~er~~ on my knowl~~ed~~g~~e~~, no

2 W~~ere~~ the fil~~m~~s the~~m~~s~~e~~l~~v~~e~~s~~ the key w~~it~~ne~~s~~s of information
3 for you to try to as~~s~~e~~s~~s her com~~p~~la~~i~~nts and r~~e~~ the up to
4 determine the etiology of her complaints?

5 20:16 A. Well, the films w~~il~~l~~l~~us her clinical history
6 w~~as~~ certainly And when you loo~~k~~ed at the films, w~~as~~ you
7 actually go to the ho~~s~~pital and look at the original films?

8 A. I ha~~v~~e the films w~~it~~ch~~ed~~ up and bro~~u~~ght to the offic~~e~~,
9 and I too~~k~~ the original fil~~m~~s and put them on the w~~it~~ne~~s~~s box
10 20:16 with the pa~~t~~ient and her sister, be~~ca~~use I always try to
11 show the films to the patient if I think they can
12 understand, you know, what the films show.

13 Q. Do you recall doing that in this case, showing them
14 the films actually whil~~e~~ you w~~er~~e talking to them about the
15 20:16 situation?

16 A. Yes.

17 Q. You indicat~~e~~d that at all tim~~e~~s you were managing
18 Nancy Farkas w~~ho~~ w~~er~~e an emp~~l~~oy~~e~~e of the Cle~~ve~~land Clinic
19 Foundation?

20 20:17 A. That is correct.

21 Q. You were not employ~~e~~d at all Sy Elyria Memorial
22 Hospital during that time frame?

23 A. No; I was not.

24 Q. You have never been employed Sy them, ha~~v~~e you?

25 20:17 A. No.

1 20:17 Q. And serving periodically as an on-call urologist for
2 the emergency room is part of your staff privilege
3 relationship with Elyria Memorial to admit patients there?

4 A. That is correct.

5 20:17 MR. MURPHY: Thanks for your time.

6 - - -

7 CROSS-EXAMINATION OF MARK NOBLE, M.D.

8 BY MR. CULLEN:

9 Q. Doctor, from the time that you reviewed the IVP report
10 20:19 of Dr. O'Campo, it was your plan to work this mass or cyst
11 up within three months time; correct?

12 A. That is correct.

13 Q. You don't think that a CT was required at the
14 emergency room or within 24 hours of her visit?

15 20:19 A. No; I don't think so.

16 MR. CULLEN: Thanks.

17 MR. SCHOBERT: No questions.

18 MS. DIXON: Nothing else.

19 MR. KELLEY: He will read it.

20 - - -

21

22 (Thereupon, the deposition was concluded
23 at 8:25 p.m. and signature was not waived.)

24

25

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:

[illegible]

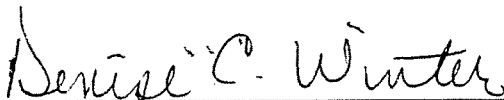
State of Ohio) SS.
County of Cuyahoga) ,

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.

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