THE STATE of OHIO,
: SS:
COUNTY of CUYAHOGA.

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IN THE COURT OF COMMON PLEAS

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JACK J. MEEKS, executor,
plaintiff,

vs. : Case No. 269426

OHIO PERMANENTE MEDICAL
GROUP, INC., et al.,
defendants.

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Deposition of VINODKUMAR SUTARIA, M.D., a defendant herein, called by the plaintiff for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Constance Campbell, a Notary Public within and for the State of Ohio, at the offices of Weston, Hurd, Fallon, Paisley & Howley, 2500 Terminal Tower, Cleveland, Ohio on FRIDAY, FEBRUARY 24, 1995, commencing at 1:00 p.m. pursuant to agreement of counsel.

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I N D E X

WITNESS: **VINODKUMAR SUTARIA, M.D.**

PLAINTIFF'S EXHIBITS	MARKED
1 - progress notes 7-19-93	4
2 - doctor's orders 7-20-93	4
3 - laboratory report 7-21-93	4
4 - laboratory report 7-21-93	4
5 - laboratory report 7-28-93	4
6 - laboratory report 7-28-93	4

(FOR COMPLETE INDEX, SEE APPENDIX)

(Plaintiff's Exhibits 1 through 6 marked for identification.)

VINODKUMAR SUTARIA, M.D.

of lawful age, a defendant herein, called by the plaintiff for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, being first duly sworn, as hereinafter certified, was examined and testified as follows:

MISS TOSTI: Hello, Doctor, my name is Jeanne Tosti, I'm here representing the plaintiff in this case.

CROSS-EXAMINATION

BY MISS TOSTI:

Q. Would you please tell the court reporter your full name and spell your last name for her, please?

A. My full name is Vindokumar, last name is Sutaria, S like Sam, U, T like Tom, A like American, R like Robert, I like Indian, and A like American.

Q. Doctor, what is your home address?

A. 7645 Gerald Drive, Middleburg Heights,

Ohio 44130.

Q. Your business address?

A. Kaiser Permanente, 12301 Snow Road, Parma, Ohio 44130.

Q. Have you ever been named as a defendant in a medical negligence suit?

A. No.

Q. Have you ever had your deposition taken before?

A. Yes, about six, seven years before, probably a little more, there was a case on asbestosis claimed by one of the patients whom I had taken care of three years before for some medical problems.

There was the potential -- I was asked to come answer some questions about that patient, about his medical problems in the past. So they wanted to probably know what was the condition of that patient three years before when I was a doctor for that patient.

Q. So you were called as a treating physician?

A. I do not understand what you ask by treating physician.

Q. Just as a fact witness in regard to prior treatment?

A. Right, I think it was like a witness for that patient, for his prior treatment probably, I think they are asking doctor who took care of him in the past may help them, or something like that, information that can help.

Q. Did you give any trial testimony?

A. I do not know what trial testimony is. This was you are talking of same case?

Q. Yes.

A. If I understand it right, it was like a witness or expert, not expert, something they wanted to know about the patient's condition three years before. Whether he had any problems related to the asbestosis or not. I think that is what they wanted to know.

Q. Did you do that in court --

A. No.

Q. We can't talk at the same time. I'll try and allow you to finish your answer, you let me finish my question.

The testimony that you gave, was it in court or was it in a room similar to this?

A. The testimony was at Kaiser Permanente offices in a conference room like this. There were lawyers from both sides, both sides of the lawyers

asked me some questions about this patient's previous medical problem and treatment.

MR. SWITZER: I think it was out of state, attorneys from another state.

A. Yes. If 1 understand the lawsuit going on for a long time for asbestosis claims, one of the persons who was the claimant for some benefits was my patient three years before. They wanted to get information about his medical condition three years before everything happened.

Q. Doctor, have you been involved in any type of medical research in the past?

A. No.

Q. You haven't done any medical research in the area of leukemia?

A. No.

MR. SWITZER: Before you answer that, let's make sure you understand what she is saying. You are saying -- because obviously he's a hematologist, when you say medical research you and I could mean something different.

Q. I'm speaking of medical research which is set up under protocols where you have a subject selected according to the protocol criteria, have you been involved in any type of medical research

like that?
A. I understood the question.
During my Fellowship training one more year I worked at the VA Hospital, there were many protocol studies which were done with my department, I was one of the persons taking care of patients who are on the protocol and research.
When you were asking me about research, I have not published anything on my name.
Q. You said at the VA Hospital you were involved in some research projects, where was the other place?
A. Those two years of my Fellowship at University Hospitals and VA, which is a combined program, for three years I was involved in protocols which included leukemia protocols also.
Q. Did any of those research projects involve the subject matter of leukemia?
A. Yes.
Q. Did any of the research projects involve the subject matter of acute promyelocytic leukemia?
A. Not in particular.
Q. Of the research projects that dealt with leukemia, do you recall anything specific about an

individual research project as to whether the type of research was being done related to leukemia?
A. I don't understand, can you repeat?
Q. The research projecs that dealt with leukemia at University Hospitals and VA Hospital, do you recall what the research project was designed to look for?
A. They were designed to look for comparison of two types of drugs, which one does better than the other.
Q. Do you recall the drugs that were involved in that research or those research projects?
A. Right now I don't.
MISS TOSTI: Doctor, if you need to answer that, go ahead.
THE WITNESS: That's fine.
Q. Have you ever had your hospital privileges called into question or suspended or revoked by a hospital?
A. No.
Q. Have you ever been declined or cancelled by a professional negligence insurer?
A. No.
MISS TOSTI: Any time you need to take a break, go ahead.

(Brief recess had.)

BE' MISS TOSTI:

Q. Has your application to join a professional staff of an HMO, Health Maintenance Organization, ever been declined or rejected?

A. No.

Q. Have you yourself ever acted as an expert in a medical/legal proceeding? I'll explain that a little more in that did any attorney ever come to you, ask you to review a file, then act as an expert perhaps giving deposition testimony or trial testimony on a case?

A. No.

Q. I assume that your attorney explained to you this is a question and answer session under oath. It's important that you understand my questions, so if you don't understand it, if I phrase it inartfully, I'll be happy to repeat it or explain it.

Otherwise, I'm going to assume you understood what I've asked you, you are able to answer. I would also ask that you give all your answers verbally because our court reporter can't

take down head nods or hand motions.

Your attorney provided us with a copy of your curriculum vitae, this is the copy that I have, I would like you to take look at it, tell me if it's up to date.

A. Yes, it is up to date. If you need more information than what is there, you can ask me.

Q. Is there anything additional that is not included on here that maybe you've done or participated in since the time you prepared this curriculum vitae?

A. I would like to add one. I attended a conference of the American Society of Hematology every year since 1988, except one or two times I have not gone. 1 also attended the conference of American Society of Clinical Oncology every year except some of the years I may not have been able to go.

Q. I'm going to go through some of the things that you have on here.

You indicate that you were born in India; is that correct?

A. That is correct.

Q. Are you currently a U.S. citizen?

A. I am on permanent immigrant status, which is

like Green Card holder.
Q. You received all of your medical, your basic medical education in India, correct?
A. Yes, the basic medical degree in India.
Q. Under the area marked certification, what does the ECFMG certification stand for?
A. It's called Educational Counsel for Foreign Medical Graduates.
Q. That was a test that you took when you entered the country to practice medicine?
A. Yes, at that time that was an entrance test for foreign graduates to enter United States.
Q. What does the certification FLEX stand for?
A. It is Federal License Examination, which is a licensure examination taken in various states in this country to practice medicine.
Q. You took that in the State of Illinois?
A. I took that, 1 wrote the test in Columbus, Ohio, the test I was listed with the State of Illinois because any person can list with another state and write, it's the same examination given by most of the states, but you can take for another state anywhere in the country.
Q. Are you currently licensed in the State of Ohio to practice medicine?

A. Yes, I am.
Q. When did you attain that licensure?
A. I got that licensure immediately after, within six or eight weeks getting this license by reciprocity. We applied to the Ohio State certification, this is my training, they look at all those things, send a license to practice in Ohio which I got within six, eight weeks of applying for this.
Q. Your Ohio license would date from approximately 1973?
A. Approximately, yes.
Q. You indicate here that you're a Diplomat of the American Board of Internal Medicine, what does that designation mean?
A. After requisite training in internal medicine, the physician person is allowed to write an examination which is like a degree if you want to call it, or certification in internal medicine. Once you pass that examination you are called Diplomat of American Board of Internal Medicine.
Q. Is this the same thing as being Board certified in internal medicine?
A. Exactly.
Q. In regard to your Board certification in

internal medicine, did you pass that testing on the first attempt?

A. No.

Q. How many attempts did you make before you passed?

A. I passed the third time.

Q. In regard to the Board certification in hematology, did you pass that on your first attempt?

A. Yes.

Q. Under your training area you have a hematology Fellowship listed, you indicated that took place at University Hospitals and VA Hospitals; is that correct?

A. Yes, that's correct.

Q. Was that sequential, did you do the first part at University Hospitals and second part at VA or were they concurrent, both hospitals at one time?

A. It is a combined program at both hospitals, director is also the same. There is a director for the whole program who looks after both hospitals. All Fellows in the program rotate in the various departments at both hospitals. They are two institutions, the program is what we call -- is

a combined program.
Q. As far as the emphasis in that program, was there any emphasis on oncology in your hematology Fellowship?
A. Yes, there was emphasis on hematological oncology in the program, it's a part of the program.
Q. Would you be able to give me an approximate percentage of the program that was spent in oncology?
A. It's going simultaneous every day in hematology and the oncology/hematology. Same patient can have an overlap of the two. I cannot give you an exact time. It involves a lot of hematology/oncology.
Q. Under your practice and experience, the first listing you have is with the Veterans' Administration Hospital, you indicate that you were a cancer chemotherapy physician, what were your duties and responsibilities in that particular position?
A. That was the staff position in the Department of Hematology/Oncology, where I was involved in taking care of hematologic/oncologic patients in the hospital, teaching residents, teaching medical

students. We had a lung cancer protocol at **VA**, I was involved in the lung cancer protocol study, cancer chemotherapy of the lung. I did mention to you that I was taking care of patients also.

Q. In your position at the **VA** Hospital did you ever have the opportunity to diagnose a patient with acute promyelocytic leukemia?

A. Yes.

Q. How many times would you say you did that at the **VA** Hospital?

A. I couldn't tell you number of promyelocytic leukemia patients in that particular year, July, '75 to '76. We had a good number of leukemia patients being admitted and treated inpatient, new patients and patients in remission, patients coming to our clinic, sometimes I will see some patients, sometimes other doctors will see. It's very difficult to give you a certain number of that. Yes, leukemia patients we were seeing all the time during that one year.

Q. Why did you leave the **VA** Hospital?

A. **I** wanted to go into a community practice type of situation, that is why I left the **VA** Hospital.

Q. Then you next went into private practice?

A. Yeah.

Q. Were you with any particular medical group in private practice?
A. I was with an internist, he was a practicing internist, I joined him.
Q. You had a medical association with him?
A. Right. He was having his practice, I joined him.
Q. Who was that individual?
A. His name was Dr. Mohan Bafna.
Q. Spell that last name.
A. B like boy, A like American, F like French, N like Nancy, A like American.
Q. Did you then leave that association?
A. Yes.
Q. Why did you decide to leave that association?
A. Well, Dr. Bafna was personal friend of mine, from the time I joined we had an understanding that I wanted to try private practice, plus he wanted to go to India for three or four months, he wanted me to cover his practice, I think that will be good experience to know how the private practice is, in the meantime, see whether I want to do something else.

At that time I got an opportunity to join Kaiser Permanente more than -- I had more

hope of doing hematologic work back at the hospital and a laboratory available, which I thought was a better setup for my future, with a good understanding with Dr. Bafna. I decided that I would be joining Kaiser Permanente, which I joined in March of 1977.

Q. You're still currently with Kaiser Permanente?

A. Yes.

Q. Your employer is Ohio Permanente Medical Group; is that correct?

A. That's correct.

Q. Doctor, in regard to the position that you currently hold with Ohio Permanente Medical Group and Kaiser, as far as servicing the Parma facility, are there any other hematologists that practice out of the Parma facility or service the Parma facility?

A. Are you asking like now?

Q. July of 1993 were there any other hematologists?

A. Yes, there was another hematologist/oncologist at Parma in July of 1993.

Q. Who would that have been?

A. His name, you want his name?

Q. Yes.
A. Dr. Kenneth Weiss.
Q. Would you spell the last name?
A. W-e-i-s-s.
Q. In July of **1993** did you hold any type of administrative position or responsibilities with Ohio Permanente Medical Group or Kaiser Permanente?
A. No.
Q. Do you have hospital privileges any place else besides Kaiser?
A. Yes.
Q. Where would that be?
A. Cleveland Clinic.
Q. When did you receive Cleveland Clinic privileges?
A. January, **1994**.
Q. Was this part of an agreement that Kaiser had with Cleveland Clinic?
A. Yes, but subject to the approval of their selection committee looking at our certification and everything.

In other words, everybody doesn't automatically get privileges, they evaluate and give privileges. It was both part of an agreement and subject to approval of their selection

committee or whatever.
Q. On your vitae you indicate you were a teaching Fellow at Case Western Reserve and instructor in medicine at Case Western Reserve, correct?
A. That's right.
Q. Can you tell me what your duties or responsibilities were as an instructor in medicine at Case Western Reserve?
A. Teaching medical students and teaching the residents on the service.
Q. Did you give any type of formalized lectures to students or were you a clinical instructor?
A. It was a clinical instructor.
Q. Did you do any classroom instruction?
A. No, no classroom instruction.
Q. Did you ever give any instruction on acute promyelocytic leukemia to any of the students?
A. I'm pretty sure I did.
Q. Did you generate any notes or outlines from those instructions or those lectures?
A. I do not understand your question.
Q. Did you have at the time that you did the teaching, did you produce any type of notes related to that lecture or any type of outline related to

that lecture?
A. I still do not understand what you are saying prepare notes or outline. When we teach we prepare sometimes some notes like the ones you want to teach as a reference point to these students.
Q. That's what I'm getting at.
A. Most of the time I believe prepare and talk to them without any notes.
Q. Do you currently have any notes, outlines, dealing with acute promyelocytic leukemia you utilized in lecturing students while you were an instructor or teaching Fellow at Case Western Reserve?
A. First tell me if I understood right, are you asking me at present are there any notes or outlines in my possession which I might have prepared in the years which goes as far back as '81 with me right now, that's what you are asking me?
Q. That's going to be the first part of my question.

Do you have any?

A. No.
Q. Did you generate any at the time you provided that instruction to the students?
A. I do not understand what you are trying to

ask me by generate.
Q. Make, write, prepare?
A. I did say that most of the time I was talking from what prepared. Sometimes I might have written some notes on the blackboard like a part of the lecture, sometimes I might have prepared on one piece of paper, used it that time, threw it away, to remember what I'm going to talk, but not as a permanent piece of information for me.
Q. To your knowledge, do you know where any notes or outlines from those lectures are, either who might have them or where they might be?
A. I don't think -- I don't have any of those notes.
Q. I asked you if you had knowledge of anyone who did have those notes?
A. I have no knowledge of anybody who might have those notes.
Q. Under medical societies you have listed down here Ohio State Medical Board. Do you hold any type of an office or position with the Ohio State Medical Board?
A. No.
Q. What is that in reference to, in reference to your license?

A. No, we can become a member of the Academy of Medicine of Cleveland. If I understand right everybody who becomes a member of the Academy of Medicine of Cleveland becomes a member of the Ohio State Medical Board. You are a member of that, you pay in the fees, get the journals on information which are necessary for them to give us.

Q. Have you ever published anything on the topic of acute promyelocytic leukemia?

A. No.

Q. You've been out of the country for an extended period of time recently; is that correct?

A. I do not understand meaning of extended period of time.

Q. A long time?

A. I don't know what you say long time. Let me tell you I was out of this country from December 22nd to January 13th. Out of this country I was sometime in the end of June to middle of July of last year. When I say December 22nd, it's '94 to January 13, 1995.

Q. Since the time that you have been with Ohio Permanente have you been under any type of a disability, any medical problems?

A. No.

Q. Have you ever authored or co-authored any medical journal or textbook chapters?
A. No.
Q. What have you reviewed for your deposition today?
A. The useful textbooks in hematology, oncology, some of the recent articles which I usually review all the time, I might have reread them or things like that.
Q. Could you tell me what books you referred to?
A. The Williams Textbook of Hematology I always refer to, which I've used for all the years I was in practice. Plus --
Q. Do you find Williams to be an authoritative text?
A. Most of the things I find there very useful in my practice.
Q. Would you consider it to be authoritative?
A. I do not understand what you mean by authoritative.
Q. Is it the type of reference you rely on in your practice?
A. Most of the problems, most of the times.
Q. Would you consider it to be an authority? In other words, when you are looking for answers to a

question you would go to that book and follow what that book says?

A. If I do not find what I want to find there, in all the books. That book is not one complete book, I will go to another book. I will go to journals also, they have new information. Sometimes I go to another book published later, if that answers your question.

Q. What other books did you refer to for this deposition? You mentioned the one, were there other books you looked at you can recall?

A. There is textbooks, there is the Textbook of Internal Medicine which has sections on hematology/oncology. I refer to Edison's textbook, textbook written by Winthrope, another new textbook by Brink.

Q. These are all ones that you reviewed for your deposition today?

A. I have read them, various chapters in that.

Q. Doctor, I'm asking you what you reviewed in preparation for this deposition today?

A. All those textbooks and certain articles.

Q. What articles did you look at?

A. I can't tell you offhand those articles. There are quite a few, various.

Q. Have you looked at the -- have you been provided with depositions of Mr. Meeks, the decedent's husband in this case?
A. Yes.
Q. How about the decedent's daughter's deposition, have you looked at that?
A. Yes.
Q. Have you consulted with any other physicians in preparation for this deposition?
A. No.
Q. Have you discussed this case with anyone else other than with counsel at any time?
A. I do not understand what counsel meaning.
Q. Your attorney?
A. Yes, I talked to my lawyers only.
Q. Aside from what you discussed with your attorney, have you talked with anyone else?
A. No.
Q. Have you ever made or written any personal notes or kept a personal file on this case?
A. No.
Q. What medical journals do you currently subscribe to?
A. I get American Society of Hematology journal which is called Blood. I get also Annals of

Internal Medicine, I get Clinics of North America in Hematology/Oncology. These are the ones I subscribe to. That means I paid for that, I get it at my own place.

Q. Anything else?

A. These three I am getting at my own place at my own cost.

Q. Do you provide professional services to any other entity or medical group other than for Kaiser or Ohio Permanente?

A. No.

Q. In July of 1993 would you describe your duties and your responsibilities that you had with Ohio Permanente or Kaiser Permanente?

A. My practice was 100 percent hematology/oncology. I will see the patients mostly on a consultation basis, the new cases, I will follow the patients who are ongoing hematologic problems who require ongoing treatment.

Q. What was your usual work schedule?

A. My usual work schedule is that I start usually at 8:15, 8:30 in the morning, see my patients in the hospital, then 9:00, 9:15 I go in my office, see patients until 12:00, 12:15, again

go to -- because we have hospital premises, will go to the floor and see the patient or go to the lab and see the blood smears, bone marrows, discuss with colleagues if they have any patients during the lunch hour. Come to the office, see patients until five o'clock, again go to the hospital, talk with colleagues who have any questions, sometimes stay in the office, catch up on some errands, answering telephone calls, looking at blood smears in my own office, things like that.

Q. Did you work Monday through Friday or Monday through Saturday?

A. I worked Monday to Saturday in the office, certain Saturdays we don't work and certain Saturdays we work.

Q. Did you have a regular day off during the week at all?

A. There is no regular -- there is no one full day off. The time when I work on Saturday in the office, I will have half day of no office but at that time I am in the hospital doing something else.

Q. Doctor, I want to talk to you a little bit about general duties that you have as a physician, as a subspecialist in hematology.

A. I do not understand what you are trying to ask.
Q. I'm trying to get down to what a differential diagnosis is.
A. I understand what a differential diagnosis is. The terminology that you are using, the English that you are using, I'm not able to understand what you mean so can you tell me in some other words?
Q. I would like you to tell me what differential diagnosis means to you, that might be easier.
A. Differential diagnosis is when you see a patient, the possible diagnosis in this patient, sometimes maybe three, sometimes five, maybe one sometimes. You may not think what is going on, it can be anything. Most of the time, yes, you think of three, four, five different conditions which are likely to be the cause of symptoms that the patient is presenting.
Q. It's not uncommon then to have more than one potential problem or disease within the differential diagnosis, you might be thinking that the cause of the patient's problems can be due to either number one problem, number two problem or number three problem?

Can we agree first that you have a responsibility to your patients to render prudent and safe care?

A. Yes.

Q. Can we agree that when you assess a patient's problems you have a responsibility to form in your mind what we call a differential diagnosis?

A. Say that again, what is question?

Q. When you are assessing a patient you have a responsibility to formulate -- have you heard the term differential diagnosis before?

A. Yes, I have.

Q. When you are assessing a patient, can we agree that you have a responsibility to formulate a differential diagnosis for that particular patient?

A. In most of the situations, yes. Sometimes the diagnosis is very clear, you don't need a differential diagnosis. Sometimes you may think of things you still couldn't say in there is a differential diagnosis. In other words, you always think of what probably is in the particular patient when you see the patient.

Q. You have to formulate what the potential problems are, what the explanations for those problems might be?

A. In most of the situations, yes.
Q. That's not uncommon to have several things that might be causing a problem?
A. I'm saying of most situations it seems that it is common to happen. I think if I understand right, most of the time it's common, right.
Q. That is what I'm asking you, whether it is, you've answered me.
A. I thought I answered your question.
Q. Can we agree that it's your responsibility, your duty that when you form a differential diagnosis that if you have a condition within the differential diagnosis that is life threatening, you would have the duty to immediately rule it out? If one of the things within the differential diagnosis is life threatening, you as a physician have a duty to take the next step, immediately check into it, try to rule it out if it's life threatening?
A. I do not -- I will not agree with immediately means what? Every possible idea has to be ruled out in certain time. Means you can see how much time you need to go to your next step.
Q. But if you've got a problem that may be life threatening to the patient, isn't there a duty on

your part to look into that problem immediately and determine if there is something that you can do to reduce the threat to that person's life?

A. Certain situations can be spelled out in next few hours. When you say immediately, I do not know how I can agree. How can I answer your question?

I will say when we see a patient, when there are certain differential diagnoses, you can decide how much time the patient should be starting treatment, sometimes it can be two hours, sometimes immediately, sometimes 24 hours, sometimes 48 hours. It depends, it depends on various things.

Q. In some instances you would agree that it would be important for you to act immediately, maybe in other instances you would have more time, there wouldn't be any additional threat to the patient if you waited that extra time?

A. Those instances can be different. In some situations, yes, but in some situations you have a few hours, some situations a couple of days, some situations you have a few weeks, I'm not understanding what you are trying to get at. In some situations you just start the treatment in the first few minutes so I'm not exactly understanding,

I'm not try to not answer, I don't know what you are trying to ask me, I don't know how to answer your question.

Q. I think you've answered it.

Doctor, there are some situations that are critical, you have to act immediately, there are other situations that you have more time, you can take more time to react, would that be a fair answer?

A. Yes, depending on the situation the physician reacts, right.

Q. Doctor, in regard to acute promyelocytic leukemia, can we agree that this is an immediate life threatening condition?

A. It is not an immediate life threatening situation.

Q. Why not?

A. Because the treatment of acute leukemia particularly can be divided into symptomatic treatment and specific treatment.

The specific treatment can wait anywhere between 24 to 48 hours or even longer. Certain symptoms may require comparatively early treatment. I couldn't say immediate, something you do in the next 30 minutes or like that. If is what

you are asking, next one hour if you are asking.
Q. Would you consider that a patient that has acute promyelocytic leukemia, would you consider them to be in an acute oncologic emergency?
A. Patient with acute promyelocytic leukemia there are patients who may not be in emergency, that there are patients who can wait, there are patients in which you work in few hours, there are all kinds of subsets of this patient. Every acute promyelocytic leukemia is not an emergency. It depends upon so many things in that patient. You couldn't make a general statement for diseases like this. It depends upon a lot of things.
MR. SWITZER: Doctor, you answered the question.
Q. Doctor, I want to *go* through the signs and symptoms, ask you if they would be consistent with the diagnosis of acute promyelocytic leukemia.
How about ecchymosis and bruising, are those consistent with acute promyelocytic leukemia?
A. Ecchymosis can occur in many conditions. You can bump yourself, have ecchymosis.
Q. I'm asking you specifically about acute promyelocytic leukemia, do you see ecchymosis and

bruising in patients, is it consistent with that diagnosis?

A. Ecchymosis and bruising can occur in any condition. It can occur in almost all leukemias, it may not occur in certain leukemias.

Q. Doctor, I'm not asking you about -- please listen to my question. I'm asking you only about acute promyelocytic leukemia, whether this particular symptom that I'm going to be telling you is consistent with it. We're not going to talk right now about all other leukemias.

I understand what you are saying that it may show up in other types of leukemia. I want to know about acute promyelocytic leukemia, is ecchymosis and bruising consistent with the diagnosis of acute promyelocytic leukemia?

A. It's one of the symptoms of acute promyelocytic leukemia.

Q. How about complaints of fatigue, did you see that with acute promyelocytic leukemia, is it consistent with the diagnosis?

A. It's one of the symptoms of acute promyelocytic leukemia and any other leukemia.

Q. We're focusing on acute promyelocytic leukemia.

How about complaints of shortness of breath on exertion, that's consistent with acute promyelocytic leukemia?

A. If it is related to anemia patient, yes, some patients, not all.

Q. I'm asking you if it's consistent with the diagnosis?

A. One thing I do not want to use the word consistent. I would like to use one of the symptoms of this disease, okay?

Q. One of the symptoms?

A. Because shortness of breath is consistent with 10,000 things. I'm not able to understand when you say consistent, you are trying to say diagnostic of it. I hope you understand, if it is all right with you I will say yes, shortness of breath can be one of the symptoms of acute promyelocytic leukemia.

Q. That is the answer that I'm trying to get to, you can see this with that particular diagnosis.

How about increased prothrombin times?

A. It is one of the things present in acute promyelocytic leukemia.

Q. How about decreased platelets?

A. It is one of the things that can be present in acute promyelocytic leukemia.
Q. What about bleeding such as nosebleed?
A. It can be one of the symptoms of acute promyelocytic leukemia.
Q. Low hemoglobin and hematocrit?
A. It is commonly found in acute promyelocytic leukemia.
Q. How about elevated temperature?
A. Low grade temperature is more common with any leukemia and can be found in acute promyelocytic leukemia.
Q. How about pallor or pale skin tone?
A. Pallor is also one of the symptoms of acute promyelocytic leukemia.
Q. What about complaints of headache?
A. Patient can have headache because of anemia which can be secondary to acute promyelocytic leukemia.
Q. Doctor, the symptoms that I just mentioned to you, would you agree these are all signs and symptoms that Donna Meeks presented with when she came into the hospital on July 19th of 1993?
A. Can you go one by one again, I will tell you from my notes which ones she presented and which

ones she told things like that.
Q. I think what we'll do is I'm going to forget that right now, we will be going through your notes individually, get to that in a minute.
A. That will be fine.
Q. At the time of Donna Meeks' admission would you agree acute promyelocytic leukemia should have been within your differential diagnosis?
A. Diagnosis of acute leukemia was one of the differential diagnoses.
Q. Was acute promyelocytic leukemia within your differential diagnosis?
A. I said any type of acute leukemia was -- myeloleukemia there are six types, there is acute myeloleukemia, that was one of them, myeloleukemia which can happen was part of the diagnosis.
Q. You were considering that among several other possible types of leukemia at the time of her admission to the hospital?
A. Diagnosis of acute myeloleukemia was a strong suspect on admission when I saw the patient, to me. The subtype, it can be any of those subtypes at that time, at six o'clock when I saw the patient.
Q. In July of **1993**, how were patients referred

to you from the emergency room at Kaiser Parma?
A. Most of the patients from the emergency room are first referred to the internist on call. The internist on the call will go and see the patient, then admit the patient on his or her service, ask for hematologic consult. If they have a question the internist calls a hematologist for the answers also, decide what to do.
Q. *So* that I understand you, you would not get a direct referral from the emergency room physician, that it would come through the internist on call; is that correct?
A. That's correct. Let me specific my answer a little more.

Emergency room there are so many patients coming, as you know. If one of my patients whom already taking ongoing care has come for some minor problem, an emergency room physician feels he can talk to me directly to resolve the issue, he will call me. If the emergency room physicians feels this would require extensive work on admission, the internist on call will be called first.
Q. I'm interested in referrals that come to you generally

emergency room physician would see the patient, then contact the internist on call, if he felt a hematologist was needed he would make a referral?
A. That's correct.
Q. The referral does not come from the emergency room doctor directly?
A. That's correct.
Q. Now were you on call for the emergency room referrals, did you have any type of on call schedule that you were following?
A. We had two hematologist/oncologists in the Parma facility. By and large a hematologic problem, hematology/oncology problem would be referred to me, a non hematology/oncologic problem referred to my colleague. Sometimes, depending upon who is available, depending on the preference of internist, they may call different people. Yes, one of us will be contacted.
Q. You've just confused me. If something came in that was a hematology/oncology problem, it would come to you, if it wasn't it would go to your colleague; what type of things would be referred to your colleague, what type of doctor is your colleague?
A. He's a hematologist/oncologist.

Q. What type of cases would he get?
A. It's a very broad answer to tell you how many various cancers are there, what goes to him, what goes to me. I do not understand what you are trying to ask me actually. This is a very detailed way we function at our place. I will answer that but --
Q. Let me --
A. Honestly, it will take such a long time we will be talking about --
Q. Let me clarify my question.
A. That's good.
Q. You are a hematologist, your colleague is a hematologist, correct?
A. Yes.
Q. If I understand you correctly, you said that things coming into the emergency room that were hematology or oncology would come to you. I would think if you are both hematologists you both would take care of hematology problems, I'm confused as to what your colleague does?
A. Hematology/oncology is, as you know, are two subspecialties combined together.
Q. Are you saying hematology/oncology as being one area then? 1 think I can understand.

A. No, you need to be educated. I can tell you exactly what all these things -- it's going to take a long time. Hematology/oncology is two specialties they combine in one.

Q. I think you answered my question then. I think I understand what you are saying.

If you have an oncology problem involving the blood, those cases are referred to you?

A. More often referred to me.

Q. Other hematology cases that do not relate to oncology go to your colleague, non hematology/oncology go to your colleague.

A. I did tell you an internist may prefer to call one or the other because of various reasons.

Q. I think I understand now.

Did you carry any kind of beeper or did you have some type of a system for checking in with the emergency room, how would the internal medicine doctor on call contact you, how would they get in contact with you?

A. I carry a beeper plus it was office time when Mrs. Meeks came, usually most of the time Monday through Friday you are in office, most of my colleagues know that, they try my office first, no

answer in the office they beep me. We have both systems intact.

Q. Are you readily available if they need you?

A. That's correct.

Q. In July of 1993 did Kaiser Permanente have any formal agreement with Cleveland Clinic to accept Kaiser referrals?

A. Say to me again, I am sorry.

Q. In July of 1993 did Kaiser have any type of formalized agreement with Cleveland Clinic Foundation to accept referrals from Kaiser?

A. July, 1993, I don't know when the agreements changed. I can answer that we were referring our cases to the Cleveland Clinic. I don't know when the signed contract with Cleveland Clinic went on in administration. I'm not sure what date, which contract when. If you are asking me when we are assigning our patients to Cleveland Clinic, yes, we're assigning our patients to the Cleveland Clinic at that time.

Q. I'm only asking you what you do know. If you don't know it's fine to say you don't know.

A. Contract part, I don't know when the contract started. We were sending our patients to Cleveland Clinic at that time.

Q. In July of 1993 were you aware of any Ohio Permanente Medical Group policy or Kaiser policy that dealt with or referred to when a referral should be made to Cleveland Clinic?

A. I don't understand your question.

Q. Did you have any guidelines that were written out that said under these circumstances you should refer a patient to Cleveland Clinic? Did you ever see anything on paper that told you how or when you were supposed to refer a patient to Cleveland Clinic?

A. We have understanding with our patients waiting for bone marrow transplants for outside neurosurgical, refer outside.

Some patients, it's a wide range of patients with which we have a very good understanding through the chief of department and administration these patients we should be referred outside, which patients we should be treating.

Q. Did you refer any patients to Cleveland Clinic for chemotherapy for any leukemia, did you send any?

A. We were transferring acute leukemia to Cleveland Clinic tertiary care for that management.

Q. I want to clarify this. If a patient was

diagnosed with acute leukemia, would it be the usual process to then make a referral to Cleveland Clinic, Cleveland Clinic would then manage the chemotherapeutic regimine for the patient?

A. Yes.

Q. You would do initial diagnosis and then refer the patient to Cleveland Clinic?

A. Initial diagnosis, some basic workup, then we would transfer the patient, refer the patient to the Cleveland Clinic.

Q. In July of 1993, were you aware of any clinical trials which I'm speaking of research protocols, research studies being done at Cleveland Clinic involving the treatment of acute promyelocytic leukemia with the drug transretenoic acid?

A. I do not know specifically whether they were involved in the study or experiment. 1 do know there was a drug which was experimentally used by many teaching centers which was not available in the market, I think still not available in the market, it was not available to community hospitals, I don't know whether Cleveland Clinic had that thing over there available over there or not at that time. I have a general information

that certain teaching hospitals can get it on a compensate basis from NCI, I don't know whether they are available to get it from the manufacturer or not.

Q. Would that have been true in July of 1993, if you know?

A. In July, '93 I was telling you it was not available, that is what I was saying, it's not available to community, not available in the market, it was available on a compensate basis to the NCI to certain teaching institutions. I presume Cleveland Clinic can get it because they are a teaching hospital, there are many protocols, I did not know in particular at that time that a particular person will get it or will not get it.

Q. Thank you.

Could you tell me what leukemia is, just a general definition?

A. Leukemia is a neoplastic condition or tumor of white cells.

Q. What are some of the most common signs or symptoms that you see with acute leukemia?

A. Patient may not have any symptoms.

Q. When you do see signs or symptoms what are the things that you would be most likely to see?

A. Patient will most commonly -- patient will be tired, not feeling well, low grade temperature, sometimes they come with septic shock, infection first time they present, sometimes they present with hemorrhage, unconsciousness, heavy bleeding, they may present in various ways. As I told you, the patient may be completely healthy, can be diagnosed on routine examination. He can come for a rash, you diagnose acute leukemia. He might come for severe hemorrhage, you diagnose acute leukemia, there is a wide spectrum how patients present.

Q. Would you agree that probably the most common infection seen at the time of diagnosis are relatively minor upper respiratory tract infections that are frequently seen?

A. A number of patients may not have an infection when they present. Patients can have minor infections, can have pneumonia first time. Patient can have it, depends on what stage of leukemia the patient comes to you.

Q. The most common infections that are seen, would you agree with that, would be an upper respiratory infection?

A. They may come without an infection.

Q. I understand that, Doctor. When a patient

does have an infection would you agree that the most common infection is upper respiratory tract infection?

A. In general respiratory infections are common.

Q. Leukemia patient, in acute leukemia patients?

A. Number one if there is an infection, respiratory infection can be common, and skin infection can be common, rarely they have some infection also.

Q. Would you agree the majority of acute leukemia patients rarely have recognizable symptoms more than three months before they are actually diagnosed?

A. Some patients have symptoms, they don't recognize them. Patients can be tired and weak and they will say it's hard work. Many patients may have low grade fevers, may not know it.

Q. That was my question. Would you agree that the majority of acute leukemia patients rarely have recognizable symptoms more than three months before their diagnosis?

A. You say majority?

Q. Yes.

A. Majority will not have symptoms.

Q. Recognizable symptoms more than three months

before their diagnosis?
A. They have recognizable symptoms, some patients ignore their symptoms, I don't know.
Q. Doctor, if they are ignoring them they are not recognizing them, right?
A. I'm not able to understand what you are trying to get. I don't know how to answer your question.
Q. Can we agree that patients with acute leukemia may not recognize symptoms of their acute leukemia more than three months before they are diagnosed?
A. Some patients will. Some patients will come and either you're not doing anything for infection, some people will say I'm tired because of this, so what I'm trying to tell you is patients may ignore the symptoms. Most of the patients have symptoms, they ignore them.
Q. Doctor, how much, when you are taking a history from the patient, they tell you how long they have been having some of these problems they are not recognizing, how long before you see them do they tell you they have had the symptoms, one month, two months, three months, six months -- we can't talk at the same time.

A. Take your time. Take your own time.
Q. When you take the history and report these symptoms that they are not recognizing as being part of an illness, how long before you actually diagnose them are you able to identify they were having these symptoms?
A. There are all kinds of patients, all few days before I see a patient with lump in neck which was --
Q. I only want to talk about acute promyelocytic leukemia.
A. In acute promyelocytic leukemia or any other diagnosis there can be patients who are different. I couldn't give you a generalized answer or specific answer for the way you are asking me, I am sorry. I think you have to ask more specifically. You are asking me a nonspecific question, you want a specific answer. I think we are not going to go anywhere with that.
Q. I'm not asking you to give me an answer for every patient you see. I'm asking you about the majority of patients, do they report symptoms that are occurring for more than three months before you diagnose them?
A. Say to me again.

MISS TOSTI: Read it back.

(Question read as follows: I'm not asking you to give me an answer for every patient you see. I'm asking you about the majority of patients, do they report symptoms that are occurring for more than three months before you diagnose them?)

A. This relates to acute promyelocytic leukemia?

Q. Yes.

A. Do you know how many cases of acute promyelocytic leukemia are in the population that you are asking the majority of it? Listen to me, okay, now. In my practice which is 2,000 patients on both sides of the equator personalities, you will to listen to me now, that I have five or six acute leukemias. In that, we may diagnose acute promyelocytic leukemia one in three years' time, two. In there you want me to give answer for majority of cases.

Do you realize that acute leukemia is a relatively uncommon condition? You want answers, if you are asking me out of the majority

of patients are there. If you are going to tell me you're asking blood pressure, how many majority, I can answer you, or if you are asking textbooks, I can show you the textbooks how many come out, 40 percent come out, how many patients will come out -- you listen to me.

MR. SWITZER: Please slow down and speak clearly so the court reporter can record what are you saying.

A. Listen, you are trying to ask me something which I think you -- I may be misunderstanding, you are asking me specific answers for nonspecific questions, relatively uncommon condition in which there is a relatively uncommon subtype.

I want to break, I want to talk to my lawyer, then we'll again start.

MR. SWITZER: I think he understood the question.

MISS TOSTI: I think it would be good for him to take a few minutes. Off the record.

(Recess had.)

MISS TOSTI: Back on the

record.

BY MISS TOSTI:

Q. Doctor, how do you diagnose leukemia, what tests are important?

A. Most of the time for any patient we go in and examine the patient, ask the questions, various questions to diseases that we suspect during that time, then ask previous history, then try to ask in detail, sometimes they might have forgotten to mention. Examine the patient, look for certain things, then look at the blood count, laboratory tests, look at the blood smear, bone marrow is needed in most of the cases.

Q. Would a complete blood count and differential be one of the tests you order?

A. Right.

Q. How about the platelet count, is that one that is important?

A. That is part of the complete blood count.

Q. Blood smear you mentioned?

A. Right.

Q. And bone marrow?

A. And bone marrow.

Q. Would there be any other tests that would be important for you to order?

A. Yes, to know further details of the subtype on the bone marrow smears you have to do certain special stains, send it for chromosome studies. That tells you a lot about the subtype. The chromosome studies will be helpful in the further management, depending on the time of it will tell you the prognosis.

When anybody is trying to do a bone marrow in suspected case of leukemia they have to be very careful collecting specimens for anything like this.

Q. What is a peripheral blood smear, what is that?

A. Peripheral blood smear is a smear made from the blood taken from the vein that is prepared for a blood smear.

Q. Is the blood then put on a glass slide?

A. Right and it is smeared so it's called smeared, then you stain special stains.

Q. It would be examined under a microscope?

A. Correct.

Q. Do you have the knowledge and the expertise to do a peripheral blood smear and read it?

A. Yes.

Q. Do you do this frequently in your practice?

A. Very frequently.
Q. What is a bone marrow aspiration?
A. Bone marrow is a jelly-like substance inside the bone, we try to go through the bone to suck this marrow. It is usually done on the bones which are very close to the skin. Mostly in the past it was done on the sternum, now done on the hip bone which is very close to skin.

We numb the skin, numb the bone, put the needle through the bone, suck the marrow which is a jelly-like substance, make the smear of it. Then we take what is called a core biopsy. Sometimes we collect special samples for the chromosome or genetic studies.
Q. How long does it take to do the bone marrow procedure part of it?
A. The procedure for the physician it takes about 15 to 20 minutes, but explaining to the patient, get the signature, then clean the skin, numbing the skin, numbing the bone marrow, waiting for Novicaine to act to numb it, take the specimen, make sure to see that the patient after that is not bleeding and put on dressing, everything together will take one hour and 15 minutes.
Q. Do you have the knowledge and expertise to

perform a bone marrow?
A. Yes.
Q. In regard to the slides and the specimens that are obtained from a bone marrow aspiration, do you have the knowledge and expertise to read and interpret those slides and those stains that are done?
A. I have knowledge and expertise to read the bone marrow smears which are done by stain. I don't have experience to read the special stains. We usually need a super specialist to read special stains or sometimes some pathologists do that. Chromosome studies are done in highly specialized labs.
Q. In regard to the smears that are done from bone marrow aspiration, is this something that you frequently read in your practice as a physician?
A. I do it quite often.
Q. If you don't do it, is there somebody in the lab that would do that for you?
A. The bone marrow procedure is done by a physician, it is done by me or by my colleague who is certified in hematology/oncology.
Q. I want to talk about just the general procedure.

If you do do a bone marrow, generally are you responsible for reading the smears on your own bone marrows?

A. The smears are prepared by the technician, then I read them, our pathologist reads them later on. Depending upon the case we read it at the same time.

In general, most of the hematologic disease bone marrow is reviewed by me, read officially and reported by the pathologist.

Q. How long would it take, would you normally do that soon after you did the bone marrow?

A. I am sorry?

Q. When you read the slides, when did you do that?

A. If I have done a bone marrow, not talking acute promyelocytic leukemia, not talking of this patient, any bone marrow I do, if I'm expecting something to be taken action of immediately, then I will read it immediately; otherwise, I do it next day.

Sometimes we do the bone marrow on an outpatient procedure, which is a week of seeing the patient. Sometimes we do the bone marrow on admission of the patient, sometimes the next day,

depending on patient come in the evening, during the night, all of these procedures are highly specific procedures, if they are not handled right, the specimens are not right, you have to do the process again. It's very usual to do bone marrow in the patient in the morning, to do immediately because you can process it during the day time. The patient came five or six o'clock, do the next day because we want to do chromosome studies, special stain, so usually we do it on the next morning.

Q. If you are concerned about a patient, the patient's condition, in your clinical judgment you think that you need to find out the result of that bone marrow, would it be fair to say normally you would do the bone marrow and that soon after the bone marrow you would take a look at the slides?

A. Most of the time when the situation is, that I come across in my practice, that if the patient comes in in the morning I will do it and see them as soon as they are ready. If the patients are coming in the evening or in the night I will do the next morning and see them the next morning, if that answers your question.

Q. If it was in your clinical judgment an

emergency, you would normally immediately after you've done the bone marrow take a look at the smears?

A. Again I say it's emergency in which as I told you, the answer is not as straightforward as you want the answer. It depends upon what you are suspecting, what we are suspecting.

For example, if you are suspecting leukemia, there are two types of leukemia to be done immediately, the special treatment, chemotherapy which can always wait, you can do without the bone marrow, you can start treating the symptoms without doing the bone marrow.

What I do in my practice is that if I'm suspecting a case of leukemia I will very much like to do the specialized study. Nobody wants to undergo bone marrow two times, it's not right to do it that way also. What I usually do, I tell the patient previous evening we are suspecting something like that, we need the bone marrow, important part of your diagnosis and management if you are suspecting leukemia. Most all of leukemia isn't assigned to us, I call those people, listen this is what we are suspecting, do you want me to do the bone marrow, send you all the special

stains, how many slides you want, what chromosome studies you want, I send it to you or do you want me to transfer the patient, you want to do that.

Most of the time in the later part of the day, evening or night, they will tell me why don't you give the symptomatic treatment to the patient, do the bone marrow in morning or send it or now, send the patient to us we'll do the bone marrow, we want special stains, don't forget the chromosomes, things like that.

Q. It sounds like you are talking about another person here. Who are you talking about sending the patient to for another bone marrow, would that be -- you lost me here.

A. You are right I was talking a little fast.

MR. SWITZER: You are talking too fast. Slow down.

A. What I'm trying to say is the bone marrow is -- let me do this way, start your question all over again, I can answer more specific.

MR. SWITZER: I heard what he said. He is talking about the tertiary care center.

Q. Let me see if I can clean this up a little bit.

If you are suspecting an acute leukemia, you said normally that patient would be treated at a tertiary care center such as Cleveland Clinic, that there may be indication for holding off doing a bone marrow because the tertiary care center may want to do additional tests on the bone marrow, you wouldn't want to have put the patient through it twice; does that summarize what you said?

A. That is what I was trying to say.

MR. SWITZER: Let her finish.

Q. We were talking about when you did a bone marrow there would be some instances you might read the slide right away, other instances you might wait, depending on what the condition was. You mentioned that there was a pathologist that would then read the slides after you look at them.

Is that pathologist there, is there a pathologist on call 24 hours a day, only there during the day, when might you expect to get a pathologist reading your slide?

A. There is a pathologist on call 24 hours a day, depending on how the pathologists will see in first 24 or see next morning, depending on the

urgency of the patient, urgency of reviewing, the pathologist will review it immediately or wait a couple hours or next day, depending upon urgency it is.

Q. Do you have the option to call in the pathologist --

A. Yes, I do.

Q. -- if it is at night I want you to come in, take a look at these slides?

A. If I'm going to change management of patient in next couple of hours I will. If I feel management is not going to change I will not unnecessarily call until in the morning, these are the things I want you to look at.

Q. When you say change management, you are talking about --

A. In general.

MR. SWITZER: Let her finish.

Q. -- referring a patient to Cleveland Clinic? What do you mean by change manaement?

A. Management if I'm going to do some more treatment.

Q. So in other words, if you were going to change whatever the therapeutic regimen was?

A. Right.

Q. Are you able to diagnose acute leukemia from the blood smear, is that possible?
A. We can strongly suspect them. In most -- in cases, certain cases you see leukemic cells on the blood smear, you suspect it, there are conditions in which it may not be leukemia, you may have premature cells or leukemic cells. Then there are some special characteristics that sometimes present from which you can strongly suspect from blood only. Sometimes you need diagnosis from the bone marrow supporting.
Q. You agree in some patients examination of bone marrow aspirate would be necessary to make the diagnosis of leukemia?
A. Yes.
Q. Is a bone marrow necessary to determine the proper subclassification of leukemia?
A. Yes.
Q. Can you determine a subclassification from the peripheral blood smear?
A. You can suspect that it can be one of those types but you never final diagnosis unless you have done bone marrow and most of the time special stains and sometimes chromosome studies too.
Q. What is acute promyelocytic leukemia?

A. This is such a broad question.
Q. Can you give me a general definition?
A. In the bone marrow certain white cells start becoming neoplastic, meaning thereby that they become malignant. When they are malignant they are premature cells which become malignant.

The white cells in the bone marrow start as a myeloblast first, promyelocyte which is second cell, then myelocyte. Normal white cell we find in the blood which fights infection.

If there is a clone of malignant cells which starts in the bone marrow, the myeloblast will start proliferating, they may come in the blood, or may not come in the blood. You may not find leukemic cells in the blood, you may find some. There are specific certain percentage of cells to be present to tell it is leukemia.

When there are more promyelocyte cells in the marrow it is you say a promyelocytic leukemia, plus there are some chromisome studies which are going in favor of them. Of course the special stains can differentiate various kinds of white cells, there are different kinds of white cells, as you probably know.
Q. How do you diagnose acute promyelocytic

leukemia?

A. I just told you.

Q. Well, you need a blood smear?

A. You do the blood smear and you see myeloblasts and promyelocytes, then you suspect leukemia. In the myeloblast there is a special cell, special finding we call Auer's, spelled A-u-e-r, they are the things, rod like structures in the myeloblast. If you see them in the peripheral blood, diagnosis of acute leukemia is almost certain; however, if you don't see them, it can be still leukemia, any other condition.

There is a condition which is called myelodysplasia, myelodysplasia which is the myeloblasts in the peripheral blood unless you see the Auer's you can't diagnosis 100 percent leukemia in the peripheral blood. That is the time you go to the bone marrow.

When you go to the bone marrow you see Auer's rods, you are certain it's leukemia, then you see how many promyelocyte cells are there, how many myeloblasts are there, then in the blasts there is another cell called a monoblast, it can be acute monoblastic leukemia cells, myeloblast and monos. There is acute myelomonoblastic leukemia

and the red cells can also be malignant in leukemia, which is myelocyte leukemia and erythrocyte leukemia. The practice is that you look at the myeloblasts -- I'm coming to what are you saying -- for those two stains I mentioned, five categories. There are six, I will not mention, it wouldn't help much here in the case you were talking.

What we do is we do certain special stains that tell us whether it is promyelocytic, then we follow-up with chromosome studies.

Q. Let me just summarize what I've heard that -- let me finish before you say anything.

You would do a peripheral blood smear and you might be able to pick up acute promyelocytic leukemia on the peripheral blood smear, maybe, maybe not. You need to do a bone marrow aspiration. In addition to that bone aspiration, slides as well as special stains, then also chromosomal studies possibly, that is the way you would make the diagnosis of acute promyelocytic leukemia?

A. Let me tell you this way, I do not want to confuse you but all the time there is one confusion which is coming up and coming up. I'm talking in

sometimes, most of the times, I'm talking acute myeloplastic leukemia in general, which is six subtypes. Most of the time you are mentioning acute promyelocytic leukemia. Maybe you are mentioning that is the diagnosis in front of you or maybe you are -- I do not understand why you are mentioning that all the time.

But, answer to the certain questions will be mixed up, what you mean in promyelocytic condition, what a myeloblast leukemia is is little different.

I can again tell this way: First thing you do when a patient comes to you in this kind of setup is by examining the patient seeing the blood count and their blood smear, you first suspect leukemia, then is the next stage of subtype of it.

Subtype can be suspected on a smear but you never, never, never can be sure of subtype on peripheral blood. You can be sure of a diagnosis of acute leukemia in general, any of six types if you see Auer's rods. But by seeing the myeloblast or promyelocytes you can distinguish subtype.

The subtype diagnosis going to the

bone marrow, finding certain special stains, the chromosome studies, if we talk in the future specifically I think I feel that I'm not -- you are not asking me a specific question, it is confusing you further. I don't want to confuse you.

MR. SWITZER: You answered the question. Let's go on to another one.

Q. Could we agree when you are trying to diagnose a subtype it's important to do a bone marrow?

A. That's right.

Q. Doctor, what percentage of newly diagnosed acute leukemia cases are acute promyelocytic leukemia, what is the incidence of acute promyelocytic leukemia?

A. 10 to 15 percent.

Q. In acute leukemia patients, what is the cause for bleeding when it occurs, what usually causes the bleeding problems that leukemia, acute leukemia patients have?

A. Platelet count below 20,000 is the one thing. Prothrombin time, the PTT deficiency of clotting factors. When the prothrombin time and PTT is very high, four or five seconds PTT also high, that means that there is a deficiency of the

clotting factors. These are the two reasons which can lead you to -- asking hemorrhage, right?

Q. Correct.

A. That can lead to hemorrhage.

Q. Would you agree that there is increased risk for bleeding in patients that have acute promyelocytic leukemia, increased risk as compared to say other types of leukemia?

A. If that prothrombin time is more than three seconds off. If the platelet count is more than -- less than 20,000, that is the time they are at risk of bleeding.

Q. Things that you mentioned before that would be the cause for the bleeding, that would also be a cause for bleeding in a patient that has acute promyelocytic leukemia?

A. Can you repeat the question?

Q. You just mentioned to me some of the causes for bleeding in an acute leukemia patient just a minute or two ago, would those also be the same things that would be going wrong in a patient that has acute promyelocytic leukemia?

A. Correct.

Q. How do you reduce the risk for bleeding in a patient with acute promyelocytic leukemia?

MR. SWITZER: Wait, before you answer that, does your question assume the diagnosis has been made?

Q. I'm going to assume you have a diagnosis, a patient with acute promyelocytic leukemia, that you have determined that this patient shows evidence of coagulopathy; how do you reduce the risk for bleeding in that type of patient?

A. Now at what time? You presume that I made a diagnosis of promyelocytic leukemia?

Q. When the patient presented to you you determined there is evidence of coagulopathy, how do you reduce the risk, what do you do for the patient, what is the treatment?

A. Number one you are presuming some things not right. At that time at six o'clock when I saw the patient --

MR. SWITZER: She's not talking about Mrs. Meeks.

Q. Not talking about Mrs. Meeks. Let me clean up my question.

If a patient presents to you, you have determined in your clinical judgment that the patient has coagulopathy, the patient also in your clinical judgment has acute promyelocytic leukemia,

how do you reduce the risk for bleeding, what do you do for that patient, what would be the appropriate intervention for that patient?

A. Any patient in which a diagnosis of acute promyelocytic leukemia is made, beyond doubt if the prothrombin time is more than three seconds off or four seconds off, or if the red count is less than 20,000, even if the patient does not have active persistent bleeding, people will give transfusion, platelets and plasma support.

The patient has platelet count of more than 20,000, prothrombin time less than three seconds, the patient has no active persistent bleeding, then we will watch that patient without plasma, or without platelet transfusion.

When an active persistent bleeding is going on, positive red blood in the stool, and persistent bleeding from a site or persistent nosebleed, meaning bleeding, bleeding, bleeding, something like that, then you can give the platelet and plasma support at a higher prothrombin time.

A patient who -- if the patient is not actively bleeding or persistently bleeding one should not give platelets. A platelet count is more than 20,000, one should not give platelets.

If prothrombin time is more than three seconds, you know the supporting substances, there is syphilis and AIDS and whatever.

Q. Any indication in that same type of patient for the use of Heparin?

A. The use of Heparin is debateable and disputed because it has more side effects. Heparin is usually used if you decide the patient is going to go for chemotherapy, people will give Heparin just before they want to start.

In the circumstances that 1 was talking, with prothrombin time less than three seconds, platelet count more than 20,000, one will not use Heparin.

Heparin, as I told you, is very debateable, difference of opinions. There are no double blind acceptable studies which have shown that.

Answering your question, I think Heparin is -- I will say I will use Heparin only before I'm going to treat an acute promyelocytic leukemia with chemotherapy. That is the time people may give Heparin.

Q. The values that you just cited, the 20,000 for the platelets and more than I believe you said

three or four seconds elongation of prothrombin time, where do you get those particular values from as a guidepost as to when platelets or plasma should be given, do you have a source for that?

A. Most of the textbooks will tell that, most of the literature will tell that.

Q. Any particular one that you utilize that would cite those particular values as being the guidelines for giving platelets and plasma?

A. Most of the textbooks and most of the articles on this will tell that.

Q. What does the term disseminated intravascular coagulopathy mean?

A. Disseminated intravascular coagulation means for some reason a coagulation cascade is initiated.

As you know there are several clotting factors in the body. There is a cell in the body which is called platelet which also releases substances which can initiate coagulation. In certain diseases, as in certain conditions say like septic shock, certain procoagulants are released, substances which can initiate coagulation.

So what happens is, coagulation

normally in the body, the blood is supposed to flow and not coagulate, the coagulation starts. It can start in a number of places because it is -- coagulation, it uses up the clotting factors and platelets so what happens is that eventually in this situation, we are talking in general terms, in this situation, the clotting factors will be consumed and platelets will be consumed.

When they are consumed it reverses, the patient starts bleeding, there is less clotting. It's a real paradox, very interesting thing in medicine that starts with clotting, ends up with bleeding because of the consumption of clotting factors and consumption of platelets which is important to clotting.

Q. What type of laboratory tests would reflect that DIC or disseminated intravascular coagulation was present?

A. Disseminated intravascular clotting, as I told you, can do a lot of things like this. One thing it does is that because of clotting around the blood cells can increase, decrease the lumen of the arteries. That is why when the red cells are passing through there, red cells can breakdown, the patient can be more anemic because of that, you see

the fragment of red cells because they are broken down. There are various things you can see. Given case you may see some, may not see others.

As far as, for example, you may see increased prothrombin time. You see increased prothrombin, PTT, prothrombin, prothrombin time, partial prothrombin time. You can see increase in thrombin time also. You can also see low platelets in a very late stage, fibrinogen can decrease. You look at the smear, you see the evidence of hemolysis on that. Means breakdown of red cells. There are various things you can find. You can say that it is disseminating intravascular process. That is why people say process, some of them you may not see all of them.

Q. Would you notice any clinical signs or symptoms aside from the lab tests, anything that you would see on examination of the patient?

A. One of the signs as we just mentioned is hemorrhage.

Q. Would you see anything like ecchymosis?

A. Okay, let me qualify this way: As you could see, we are saying a frank hemorrage is something which you get. That is frank hemorrhage in DIC is something which says very strongly that now things

are -- coagulations are consumed, platelets are consumed, patient is bleeding, ecchymosis can be part of DIC, yes.

Ecchymosis can be without DIC, without consumption of the clotting factors and platelets and everything. Ecchymosis can be because of bumping, ecchymosis can be because of bad blood vessels, ecchymosis can be one part of leukemia, ecchymosis can be part of DIC without any hemotologic problem, can be a vascular problem.

Q. In regard to the laboratory tests, are there any specific values or numbers that you look for when you are looking at the prothrombin or partial thrombin plastin time in order to diagnose DIC, there is a level of prothrombin time that below it you wouldn't consider DIC, above that point it's one of the things that would have to be in the differential diagnosis?

A. As I told you, DIC is a syndrome or complex of certain things. You may find some, you may not find some. You may say that DIC process is initiated but it is something in which you should immediately do something or not is a different question.

Q. No, I'm asking about the lab values, though

we talked about prothrombin, we talked about fibrinogen levels and we talked about PTT's.

In regard to the diagnosis of DIC is there any -- there may not be, you can tell me -- is there any particular level that you look at where you say this is normal, this is abnormal, may be DIC?

A. You can always say abnormal may be DIC, yes.

Q. In regard -- let's take a look at the prothrombin. Is there a particular value where your level of suspicion of DIC would be raised?

A. Prothrombin time and PTT, as you can see, is a test which has a range. If you are seeing the report, to give you an example, I don't know what, every lab is different thing, what was in this case, let me put in general prothrombin time normal is 12 to 15, which is a range. Now, if 16 is an abnormal PTT, doesn't make diagnosis, okay.

In the same vein, for PTT it is again a range. Fibrinogen is normal range, then you get anything a little higher than the normal range, you may start suspecting it, but you will make a diagnosis of DIC with clinical symptoms also.

When patients start hemorrhaging

that is the time you say so much clotting has occurred in the whole vascular system, clotting factors are consumed, now is a trained person's hemorrhage diagnosis of DIC is a complex, it's not a particular value which tells it is now DIC, not DIC. You can suspect it has -- you have accurately put your words. Certainly you can say that it may be DIC, you understand.

Plus there is another thing, there are many situations in which this test will, as we started talking earlier, we come to a differntial diagnosis, DIC can be one of the differential diagnoses of that abnormal PT or PTT.

Q. Would it be fair to say you have to look at all the lab values, you have to look at the patient?

A. Correct.

Q. There is no particular number in those lab values that needs to be there in order to make the diagnosis?

A. Right. Or as you say, we'll look at all the lab tests, if you find abnormal liver test we'll say that all this PT and PTT increased because of abnormal liver function test. Some people we say that advanced liver disease is a chronic DIC

process. So you can see how the things are all overlapping with each other.

Q. Would you agree that DIC can be a complication in acute promyelocytic leukemia?

A. Yes.

Q. Would you agree that patients with acute promyelocytic leukemia are at increased risk for DIC, as compared to most other types of leukemia?

A. Yes.

Q. Would you agree that DIC is something that you have to watch for carefully in a patient with acute promyelocytic leukemia?

A. Yes.

Q. Would you agree that DIC is a treatable condition in acute promyelocytic leukemia?

A. Acute promyelocytic leukemia, basically DIC is a symptom of acute promyelocytic leukemia. Acute promyelocytic leukemia is treated with chemotherapy, which is special therapy. If the specific chemotherapy for acute promyelocytic leukemia is given, the patient can have more DIC at that time, more cells are killed, more procoagulants are released. Sometimes while taking the treatment for the acute promyelocytic leukemia you may kill the patient of DIC and hemorrage, so I

can't answer specifically whether DIC is preventable in this.

When you start, when there is a frank DIC --

Q. Doctor, I didn't ask you if it was preventable. Is it treatable, is DIC treatable in acute promyelocytic leukemia when it's present?

A. DIC when it is -- there are certain criteria of treatment. As I was telling you before, that if you -- if the patient has a frank hemorrhage you may try giving platelets, coagulants.

MR. SWITZER: Hold on a minute. The question she asked you was whether a patient with that type of leukemia, has DIC, whether the DIC is treatable. She didn't ask you whether you can cure it or stop the DIC or prevent it, she asked you whether you can prescribe treatment for it?

A. Yes.

Q. If DIC is present in acute promyelocytic leukemia, does it require immediate treatment?

A. I told you the criteria of treatment. If the criteria of treatment are there, as I told you a couple times before, the patient should get platelets and plasma support.

Q. Your clinical judgment, if the patient has DIC, would it require that you treat the patient?
A. If patient has DIC, with a criteria which I said, with frank hemorrhage, clinical criteria, prothrombin time off for more than three or four seconds, PTT high, platelet count less than 20,000, things like that, by this criteria.

In other words, it should be treated by criteria of lab tests rather than every DIC you start as soon as the patient comes in, DIC you start treating because of the potential side effects. Certain things are not even debateable whether it should be done in the particular case or not.

Answering your question, every case has to be judged and treated.

Q. Do you know what, approximately what percentage of patients with acute promyelocytic leukemia untreated develop brain hemorrhages?
A. I know the general hemorrhages are 30 to 40 percent, which is all kinds of hemorrhages. Brain hemorrhage is a very well known complication of acute promyelocytic leukemia in general. Most of the hematologists know that.
Q. When a coagulopathy is present, in a patient

with acute promyelocytic leukemia, would you agree that initiation of treatment, including the platelets, fresh frozen plasma, possibly Heparin, can significantly reduce the risk for brain hemorrage?

A. I told you with the criteria, if there are criteria of treatment it can decrease the chances of hemorrhage elsewhere, particularly platelets, fresh frozen plasma. I'm not sure of Heparin because it's very debateable. Some people will not use. Some people Heparin it's not an issue to the best of my knowledge.

Q. The administration of platelets and fresh frozen plasma can reduce the incidence of brain hemorrhage in a patient that has acute promyelocytic leukemia and a coagulopathy?

A. And prothrombin time more than three seconds or four seconds and platelet count less than 20,000 or persistent acute bleeding, you don't go by lab, you give it.

Q. So that I'm understanding what you are saying, the criteria that you would utilize for the administration of platelets or fresh frozen plasma would require that the patient have a prothrombin time that is elongated by three or four seconds and

platelet count of 20,000 or less?
A. Or is persistently bleeding.
Q. Or persistently bleeding?
A. Then clinical tells me more than what lab is telling me. I say persistent acute bleeding, ecchymosis is not considered that kind of persistent bleeding, I wanted to qualify that statement very well.
Q. That's fine.

So we would not consider ecchymosis to be an acute bleeding situation, as far as the criteria for when to give platelets or fresh frozen plasma?
A. I do not consider ecchymosis as a criteria of acute bleeding for flesh frozen plasma and platelets, per se.
Q. Doctor, if you have an acute leukemia within your differential diagnosis, would you agree that appropriate diagnostic tests should be undertaken immediately to determine the subtype of leukemia that is present?
A. As I told you, that next step in this kind of setup is to do bone marrow. The bone marrow can be done because bone marrow is the one which involves a lot of things, which I mentioned to you in the

past. I personally will take any patient in which I suspect a leukemia, say after six o'clock during the night, I will do the bone marrow next morning.

You are using the word immediately, I would say in that six to eight, ten hours, the setup for doing the tests is better, is the time we should be doing it. That is the way I practice. That is the way I'm doing that. I think that is the right way of doing it. You are using the word immediately, I have to qualify my statement the way I did.

Q. Immediately to me means soon within probably an hour after you have --

A. No.

Q. Let me --

MR. SWITZER: She is telling you what immediately means to her, you don't have to agree with her definition.

Q. Immediately means to me once you have established within your differential diagnosis acute leukemia, that you would then take the next step down, a bone marrow soon after that, I would say within the hour. You are telling me that that isn't necessarily true, that with a diagnosis of acute leukemia that was made say in the evening, in

your clinical practice you could wait until the next morning to do the bone marrow; that's a fair statement of what you said?

A. Yes.

Q. Would you agree that the determination of the type of leukemia and the subtype of leukemia is necessary before you can determine the appropriate treatment?

A. As 1 told you before, subtype has to be determined because it tells you -- say for example acute promyelocytic leukemia, if you start giving chemotherapy right away you are going to kill the patient, because they start bleeding. So, yes, answer to question is yes.

Q. It is important for you to know the subtype in order to determine what the therapy is going to be?

A. Yes, in reasonable time.

Q. If you have --

A. Let me make one statement. Sorry for stopping you.

By and large active leukemia patients can start treatment between 24 to 48 hours, this is accepted time in any of the standard textbooks, standard teachers, standard medical

schools and journals, any patient of acute leukemia comes, you don't have to jump on him immediately. You have 24 to 48 hours. You don't have a week or two weeks, you have 24 to 48 hours to find out that your diagnosis is correct, it is not myelodysplasia, you don't treat it as leukemia.

First thing you decide leukemia, subtype and certain basic information which would be very usefull in total management of the patient, by and large you have 24 to 48 hours to do that. There is a general statement if that answers most of your questions probably of management.

Q. When we are talking about treatment, we are talking about chemotherapeutic treatment, the cancer curing drugs, that can be started 24 hours or so after you first diagnose the patient?

A. Right.

Q. How about a patient that comes in with evidence of coagulopathy, can you start treatment for the coagulopathy without knowing what the subtype of leukemia is?

A. The certain criteria we discussed a few minutes before, if those criteria are present, you have to go ahead and start by giving blood because they have anemia and coagulopathy in the anemia,

also red cells, packed cells or blood, give platelets and plasma. Now then you can use another 10 or 15 hours to find what type of leukemia it is; does that answer your question?

Q. You are able to treat the coagulopathy without having to know specifically the subtype you are dealing with?

A. Now you are getting it in acute leukemia, there are two things, specific treatment and symptomatic treatment. Symptomatic treatment for anemia, symptomatic DIC is plasma and platelets, other support you should start if it's indicated.

The specific treatment, which is chemotherapy, you have 24 to 48 hours to start that, so you plan your bone marrow in such a way that you can plan that.

Q. Doctor, just a few minutes ago you told me that with acute promyelocytic leukemia there is increased risk for hemorrage, as compared to other types of leukemia. Wouldn't it be important to know the subtype so that you could be watching carefully for signs that this patient was beginning to develop a coagulopathy, could begin treating it early since we know that with this particular type of leukemia, acute promyelocytic leukemia, there is

a high incidence of hemorrage, wouldn't that be important to identify that early on to nip in the bud any signs of a coagulopathy that is beginning to develop?

A. I told you it meant after preventing hemorrhage or possible hemorrhage you can go by the criteria and start. You don't need to know what type of leukemia it is, if prothrombin time four, five seconds, platelet count 5,000, you don't need to now give the platelets, whether it's not promyelocytic leukemia.

If patient comes to you who you suspect leukemia and platelet count of 5,000, prothrombin time seven seconds, you don't have to do bone marrow. What you have to do is give plasma in next couple of hours, give platelets in four to six hours when available from the Red Cross.

What I'm trying to tell you is the symptomatic treatment of possible hemorrhage or continued hemorrhage right now can be started and the criteria I gave you for doing bone marrow in the next one hour is not going to tell you about your patient, laboratories are telling you more than the subtype at that time.

In other words -- okay, go ahead, I

think I answered your question.

Q. You are doing fine, Doctor.

If you know the patient has acute promyelocytic leukemia, you've made that diagnosis, by whatever, bone marrow, whatever, would you wait to give plasma and fresh frozen -- I am sorry, platelets and fresh frozen plasma until you hit the criteria of pro time elongated by four seconds or platelets that had dropped to the level of 20,000, knowing that this patient had acute promyelocytic leukemia, would you wait to hit those benchmarks?

A. Knowing the patient has acute promyelocytic leukemia, if patient is not having persistent bleeding I will not give plasma or platelets to patient whose prothrombin time is less than three seconds, platelet count is more than 20,000.

Q. We've said that bruising or ecchymosis is not evidence of hemorrhage or bleeding?

A. No, I did not say ecchymosis and bruises is not the sign of hemorrhage. I said ecchymosis is not considered a criteria of active persistent bleeding on which you base your decision of treating by plasma and platelets.

Q. In July of 1993 what was the standard of care for treatment of acute promyelocytic leukemia? I'm

talking about the drug therapy, the chemo drug therapy utilized to treat acute promyelocytic leukemia, what type of drugs would be started for a patient?

A. Are you asking me about the chemotherapy?

Q. Right, the names of the drugs.

A. I will call upon my statement that after stabilizing the patient for leukemia, getting a red cell count, the patient has -- we are talking in general criteria for giving plasma and platelets and other things, with that support, after that patient should start with chemotherapy. The most common is induction therapy, means the therapy to control leukemia in the initial phase, induction phase is Daunorubicin and Cytarabine is the long names.

Q. How long a course of therapy, just generally, would a patient have?

A. There are various protocols various physicians are using as mentioned before, most of all leukemia, all of acute leukemia at tertiary care centers, every treatment center, every hematologist has his own type of protocol and Daunorubicin and Cytarabine for five to seven days, then everything depends on the response and side

effects and the general condition of the patient and complications and blood count among other various factors.

Q. Do you know what percentage of newly diagnosed acute promyelocytic leukemia patients achieve complete remission with therapy, if you know?

A. The general -- it varies from center to center, number one. Number two, 30 to 50 percent acute leukemia, all subtypes will have a complete remission.

In acute promyelocytic leukemia there are two types, granular and hypogranular. One of them initial response rate --

Q. I'm speaking initial response rate.

A. That is a little more in general. A little more of these are initially going into remission, 40 to 50 percent.

Q. So for first time remission it would be a little more than 50 percent for one type of acute promyelocytic leukemia?

A. Correct.

Q. How about the other types, lower, higher?

A. I do not know the numbers, it's low, that I know.

Q. Do you know what the life expectency is in general for a person who has acute promyelocytic leukemia, achieves complete remission after therapy?

MR. SWITZER: Before you answer the question, do you want to add any qualifiers such as age?

MISS TOSTI: There may be statistics out there that speak to general life expectency of a person in number of years who has achieved complete remission after therapy.

MR. SWITZER: Are you asking five year survival rates?

MISS TOSTI: There is a difference between remission and cure. I'm speaking of people that have gone into a remission, if the doctor knows, if there is a life expectency of a person who achieves complete remission after therapy.

MR. SWITZER: I'm asking are you talking a 20 year old versus a 60 year old?

MISS TOSTI: I think the statistics are for acute promyelocytic leukemia in general, on first remission. If the doctor has no answer then he can say it's a bad question, I have

no answer.

MR. SWITZER: Do you know what she is asking? Maybe you do, I understand life expectancy in a different manner, go ahead.

A. I understand the question. I don't know what part, what are you trying to ask me, as Don asked you, whether you are asking about total cure rate, life expectancy or --

Q. I'm talking about of the patients who achieve a complete remission?

A. You are asking acute promyelocytic leukemia?

Q. In acute promyelocytic leukemia, if you know, what is the life expectency for that patient?

A. I can tell you in general acute promyelocytic leukemia, if that help us, do you want to know that? I will say 10 to 15 percent people will have five year survival. 10 to 20 percent five year survival.

Q. For acute promyelocytic leukemia?

A. Acute promyelocytic leukemia, again, we have the breakdown from the age, how presented, various other things.

Q. Those statistics were for acute myelocytic leukemia?

A. General.

Q. Not specifically to acute promyelocytic?
A. I don't know specifically acute promyelocytic leukemia.
Q. Doctor, in your own clinical practice how many cases, just approximately, would you say you have seen that were acute promyelocytic leukemia?
A. They come so sporadically, sometimes you don't get a case for eight, 10 months, sometimes you get two. I maybe have seen roughly eight to 10 cases in the last years I can recollect. I'm sure I have seen a few more in my training, they were not my patients, I have seen them or something like that.
Q. I think you may have answered this already, after a diagnosis of leukemia is made, acute leukemia, would it be your usual practice then to refer this patient out to say Cleveland Clinic for chemotherapeutic treatment?
A. Yes, to a tertiary center.
Q. Do you do any type of chemotherapy in your own practice?
A. Yes.
Q. Could you tell me a little bit about that, what type of patients are these patients with 1eukemia?

A. They are patients with chronic leukemia which I do.

Q. You would treatment patients with chronic leukemia?

A. In my practice at my place.

Q. Do you refer out the majority of your acute leukemia patients?

A. Yes.

Q. Back in 1993 you would make those referrals to Cleveland Clinic?

A. Yes.

Q. Doctor, do you have any independent recall of Donna Meeks; do you remember her at all or treating hex?

A. Yes, I remember the way I saw her in the room so I have a recollection of the patient there, things like that. Go ahead.

Q. Prior to July 19 of '93, which is the date she was admitted to the Parma facility of Kaiser, had you ever met Donna Meeks before?

A. No.

Q. On July 19th of '93, how were you contacted about Donna Meeks, who contacted you?

A. Dr. Narra called me in my office, told me that there is a patient in the emergency room that

he is seeing right now, who he is going to admit with anemia and thrombocytopenia, low blood count, and she told me the story of the patient, told me that 5he will need to be seen by me.

Q. Do you know what time he called you?

A. I think it was around four o'clock, 4:15 or so. Dr. Narra is she, not he.

Q. I am sorry, did you talk with the emergency room doctor at all, Dr. Blockstorf?

A. No, not anybody but Dr. Narra from the emergency room.

Q. What did Dr. Narra tell you, other than this patient had anemia and thrombocytopenia, did Dr. Narra go through any history and physical with you?

A. She did tell me the patient in the emergency room was not feeling well for the last two months, has some ecchymosis, comes to the emergency room with low grade temperature, otherwise stable, very well oriented. She was also complaining of some lightheadedness, in the process of doing a CAT scan or done the CAT scan, these are the blood counts, I need to see her. Initially that is all I knew on the telephone at that time when she called me in my office.

Q. She told you that Mrs. Meeks was stable at the time she talked to you?
A. Yes, she said stable. Yes, she stated she is stable, alert, well oriented.
Q. She didn't have the blood work available?
A. She told me prothrombin is this, blood count is this.
Q. Had there been any blood smears done at the time she talked to you?
A. She didn't mention blood smears. I did not even ask because I knew I was going to see the patient.
Q. At the time you talked to Dr. Narra did you have a suspicion of any particular problem that Mrs. Meeks might have?
A. I knew one thing with that kind of blood count, I have to see the patient as soon as she comes out from the CAT scan and other things, as soon -- it was 4:15, usually I finish my office 5:00, 5:30 with that blood count, I told her -- she was asking me if -- she was thinking giving her a transfusion, checking with me. I said yes, give the transfusion, I will see the patient.
Q. What was the purpose of the blood transfusion?

A. 16.8 was hemoglobin. Any patient the hemoglobin is less than 25 first time, feeling weak, tired, sick, blood transfusion is indicated in any situation.

Q. So you were in agreement with the blood transfusion, based on the information --

A. Information I got from Dr. Narra.

Q. We can't talk at the same time.

A. I am sorry. I'm not doing on purpose, it happens.

Q. It's difficult for her to take it down.

A. I'm not experienced in that way, you will pardon me for that.

Q. You were in agreement with the blood transfusion based on the information that Dr. Narra gave you about the patient?

A. Correct.

Q. Did you feel that from the information that you heard and with regard to the lab tests, that Mrs. Meeks sounded stable to you?

A. Well, again, now the word stable, the word stable when we talk, physicians talk to each other, by stable we mean blood pressure is normal, patient is well oriented, alert, by and large patient is not going to drop in a few minutes, normally at

rest, pulse rate is acceptable in the sense of 72 to 90, that's what we consider stable. In the language that we understand doctors with each other, yes, she was stable.

Q. So, at the time that you talked with Dr. Narra, in your clinical judgment did you believe that Mrs. Meeks needed to be seen immediately or could wait an hour or two?

A. Number one is that she was already telling me she is in the process of doing a CAT scan, CAT scan is being done when she called. I think they are going to do chest x-rays at that time, I don't recollect exactly.

Yes, my seeing her at 5:30 was reasonable when I finished. Dr. Narra is very competent doctor, if there is something happening she can again call me in two minutes. I told you stable, this is happening, come.

Q. How long does it take you to get from your office to the hospital?

A. Four or five minutes, three minutes probably. We are in the same building, by the way. The offices and hospital is in the same building.

Q. What time did you arrive at the hospital then

to see Mrs. Meeks, what time did you actually get --

A. I was in the hospital.

Q. What time did you actually see Mrs. Meeks and evaluate her chart on the patient?

A. At 5:30 I went down first to the lab, looked at the smear. I saw Mrs. Meeks at six o'clock, around six o'clock, I think a little before six o'clock, I saw her at six o'clock, I wrote down the notes. 5:30 to 6:00 I saw the blood smears in the lab, then went up, saw Mrs. Meeks.

Q. You went to the lab first, you looked at the blood smears?

A. Yes.

Q. What was your evaluation of the blood smears?

A. The blood smear showed certain cells which were premature, which was giving me the most important suspicion of this being a leukemia. I wanted some more smears to be made which can be seen in more detail later on, Get red cell count and other things. I thought there is a chance, good chance this patient can have leukemia because of the cells which I saw on the smear.

Q. Based on those smears that you looked at, could you determine what the type of leukemia was?

A. No.
Q. What was the quality of the smears that you looked at?
A. I think the smears were a little thick, I could see the rods I was talking about.
/HAUR /SRER rods, I could see to my satisfaction. I did not see any hour rods. For hour rods I will say that quality was not good overall. It did show the cells which were premature.
Q. You had said you wanted additional smears made; is that correct?
A. Yes, there is one thing which I wanted to do, was to make a buffy coat. Do you know what a buffy coat is.
Q. Why don't you tell me.
A. The buffy coat is -- see, leukemia patients can present with many white cells, 100,000, 80,000, at that time is very easy to see the cells in the microscope because there are so many, get more idea.
Leukemia patients can present with a normal blood count or low count, could be at the time you don't have enough to look at. You keep the blood in a tube in which we draw the blood,

keep it for some time, sometimes few hours, sometimes overnight, then plasma and cells separate. The cells go down, the red cells, plasma goes up, at the junction there are plenty of white cells. We take a smear and do it. So, artificially we are making concentrate smear of white cells to have more to look at.

Q. And apart from the buffy coats was there still blood in the lab you could do new smears from or was this something you had to have a redraw of the blood in order to get additional smears? I'm speaking of the buffy coats?

A. No, we can make smears from that.

Q. At the time you went down there, you said these particular smears were not of good quality or too thick, did you then go ahead and make new smears at that time?

A. I told the technicians to make a number more smears.

Q. Were the smears then made at that time?

A. The technician was in the process of making them, there were some other smears also, we told them -- let me see, yeah, to stain them. I told them this, I remember, if the smears you can stain them, otherwise make some more smears.

Q. Did they make more smears?
A. I did not go down immediately to see anymore smears, whether they made some more smears or not at this time I do not know, because patient died next morning, as you know. Next morning she was transferred. We had some more blood the next morning, we had some smears from.
Q. So you don't know whether or not additional smears were made?
A. I don't know whether or not additional smears were made by the technician at that time or not.
Q. You did not go down and look at any additional smears on the evening of July 18th?
A. Right.
Q. Did you do your own examination of Donna Meeks when you went to the hospital, did you do a physical examination of Donna Meeks?
A. Yes.
Q. What did you find when you did your physical examination?
MR. SWITZER: You can refer to the notes, not asking him if he remembers, are you?
Q. No, please feel free to refer to the notes, indicate to me which page you are looking at so I

can look at that same one.

MR. SWITZER: I assume he's going to look at his physical exam.

A. It says 6:00 p.m.

Q. Looking at your progress note?

A. Right.

Q. Two months history of feeling not well, decrease in energy level, black and blue marks but no eye, nose, GI or GU bleed. Appetite good, weight stable, no fever by history, works in the meat department, uses some chemicals to clean. No medicines except antibiotics one or two months before, no alcohol. Old ecchymosis on limbs and trunk, no new bleeds. Obese, no nodes, liver, spleen. MCV 97.7, hematocrit 17.6, hemoglobin 6.8, platelets 3,000, PT 2.6 seconds off. PTT okay, LDH 300 plus. BUN, creatinine within normal limits. Blood smear not good quality, shows no hemolysis, premature myelocytic cells. Do more smears and buffy coat. Rule out leukemia, see orders for agree with BT, blood transfusion tonight, will watch platelet count without transfusion of platelets. Bone marrow tomorrow a.m.

Q. Is this the sum total of your findings on

your evaluation?
A. Yes.
Q. Do you recall anything else about that evaluation that isn't recorded here?
A. Patient was fully alert, oriented, talked to me, there was no neurological deficit I could see, gross neurological deficit I could see is what I would like to add.
Q. Was there any indication consistent with a brain bleed at the time you examined her?
A. When I saw, no.
Q. Do you have an opinion as to what caused her lightheadedness or headache or her blurred vision?
A. I think anemia which was probably secondary to leukemia, anemia which was secondary to leukemia can give headaches and like that, I think that might be the cause.
Q. How about I believe she had a nosebleed earlier in the morning -- let me finish -- did you have an opinion?
A. I wasn't talking, I was seeing this.
MR. SWITZER: Let her finish the question. Better start over, I am sorry.
Q. In regard to the nosebleed she reported earlier in the morning, do you have an opinion as

to what caused that nosebleed?
A. Number one she did not tell me about the nosebleed. She may have told other people, it was not there at that time to me. She did have a nosebleed. I saw in the notes of ER she had a nosebleed, I think she had a nosebleed which must have stopped. The nosebleed can be secondary to the same process which gives ecchymosis. In the nose any irritation can give a nosebleed.

In other words, there was no persistent bleeding in the nose, that is all. I did read about the nosebleeds in the other notes. What I wanted to know at that time was there any persistent bleeding from the nose. No bleeding from irritation, dry weather or because of some local vascular problem in the nose or anything. Nosebleeds can be because of a number of things, I don't know the cause of the nosebleed which totally stopped when I was seeing her.

Q. Doctor, you noted in your note that there were a few old ecchymoses on the limbs and the trunk.

Do you have an opinion as to what the cause of those ecchymoses were?

A. Okay. The ecchymosis can be present in any

patients with leukemia, can be a manifestation of leukemia, one of the symptoms of leukemia. Can be precipitated by bumping herself, she was working in the meat department, maybe she bumped herself, that can make more ecchymosis. I thought it is part of the leukemic process she might have at that time.

Q. Is that an indication of a blood clotting problem, ecchymosis over the limbs and the trunk?

A. That can be when contributing factors are low platelets, it can be a problem of -- blood problem, yes.

Q. In Mrs. Meeks' case, I don't want to misinterpret what you are saying, do you think that the ecchymosis that she had was because of her low platelets?

A. That might be contributing to that.

Q. What else can be contributing to?

A. Bumping yourself. Her blood vessels, the small capillaries in the trunk and skin can be fragile, that can precipitate ecchymosis by and large found in many other conditions.

Q. But in her case?

A. In her case I told you exactly it can be her vasculature is fragile, the low platelets can contribute to that, trauma might have contributed

to that. Some people get bumping and trauma without realizing, especially arm and trunk. Ecchymosis can be a combination of various things.

Q. Do you have an opinion what was causing her elevated temperature?

A. It was a low grade temperature, I've had that it is secondary to whatever hematologic process she has, which is one of the strong suspicions was leukemia, related to that. That is how I will assess that, it was a low grade, 100 or something. I had seen that in the chart, it was 100.

Q. After you had looked at the blood smears, you had examined the patient, what was within your differential diagnosis?

A. One of the strong suspicions, as you know, as I told you, was leukemia.

Q. Acute leukemia?

A. Yes. With history and everything combined together, acute leukemia was the strong suspicion.

Q. Were you able to determine any type of a subgrouping or subtype of that leukemia?

A. At that time, no.

Q. Was there anything else within your differential diagnosis at that time?

A. That was most likely the diagnosis at that

time.

Q. Any others that rose to the level of suspicion?

MR. SWITZER: Let her finish. Go ahead, now you can answer.

THE WITNESS: I did finish.

MR. SWITZER: She was still talking while you were talking.

MISS TOSTI: Read it back.

(Question read.)

A. Myelodysplasia, acute leukemia.

Q. Of the two, which one at this time was more probable in your mind?

A. Acute leukemia.

Q. Was that based on what you saw on the blood smear slides, as well as what you saw clinically?

A. That was based on the entire picture of the patient.

MR. SWITZER: Off the record.

(Recess had.)

BY MISS TOSTI:

Q. Doctor, I'm going to hand you what has been marked as Plaintiff's Exhibit 1, I would like you to identify it, I believe it's a copy of the progress notes you just read?
A. That's right, okay.
Q. You need to tell the court reporter if that is indeed a copy of your progress report?
A. Yes, it is.
Q. From July 19th at 6:00 p.m.?
A. Yes.
Q. Doctor, after you examined Donna Meeks that evening, did you believe her to be in any type of an acute oncologic emergency?
A. No.
Q. The evening of the 19th when you examined her, you were of the opinion that within your differential diagnosis there was a high probability for acute leukemia; is that correct?
A. Yes.
Q. You did not know what the subtype was the evening of the 19th; is that correct?
A. Yes.
Q. Did you take any action whatsoever to determine the subtype of the leukemia that night on July 19th?

A. As I told you before, the plan was to do the bone marrow next morning.
Q. Did you take any action the evening of the 19th to determine the subtype?
A. No.
Q. Doctor, the evening of the 19th when you came in you said that you did look at the blood smears, that you also reviewed the blood work that was done, including the complete blood count and differential; is that correct?
A. That's right.
Q. Do you know whether or not the blood smears slides are still in existence or any type of a film from those slides?
A. I couldn't answer that right now without inquiring with them.
Q. Just generally do you know if Kaiser keeps blood smears for any particular length of time after they are produced?
A. I do not. The pathology department would know that.
Q. Doctor, I'm going to hand you what is marked as Plaintiff's Exhibit 3 and Plaintiff's Exhibit 4, which are laboratory report sheets. Plaintiff's Exhibit 3 has the date of 7-21-93 on the bottom, as

does Plaintiff's Exhibit 4.

MR. SWITZER: Did we have a 2?

MISS TOSTI: No. We haven't got to that one yet. I premarked them.

MR. SWITZER: I wanted to make sure I didn't miss something.

MISS TOSTI: I premarked the exhibits, I'm using them out of order.

Q. Plaintiff's Exhibit 3 is a report of the complete blood count; is that correct, from July 19, '93?

A. Yes.

Q. There is a differential report at the bottom, on the bottom half of that page for July 19th of '93?

A. Um-hum.

Q. Are these the lab results that you had available to you the night of the 19th?

A. The lab results which were available to me were handwritten at that time, six o'clock were handwritten by Dr. Narra in her notes and this computer printout, this computer printout was not ready at that time, was not even available on a computer the printout was not delivered to me at

that time, at six o'clock. Does that answer your question?

Q. Yes.

Did you not have the computer printout to look at?

A. This printout at six o'clock was not available to me.

Q. Did you have a report of a differential at six o'clock in handwritten form?

A. No.

Q. Would that have been something that would have been helpful to you in making a diagnosis of the patient?

A. I looked at a smear myself so I knew what cells were there, looking at the smear was so useful to me that I did not need this, I did not go and look for it.

Q. I'm going to ask you a question which you may have already answered. As I look at this next set of Plaintiff's Exhibit Number 5 and Number 6, which are additional laboratory reports --

A. I want to make a correction.

MR. SWITZER: Let her finish.

A. I am sorry.

Q. I'm going to hand you Plaintiff's Exhibit 5 and 6 which are apparently corrected copies of the lab report for July 19, 1993, showing the complete blood count and differential and I would like you to take a look at the differential and note the change that was made by the lab.

What I am wondering is if the report of the lab had any impact or significance to you in regard to your diagnosis? You told me you read the blood smears yourself; therefore, the differential was not of any consequence to you as reported on these two sheets. I would like to know if the discrepancy in these reports made any difference in your diagnosis?

A. Before I answer your question I want to say that earlier asking me about Exhibit 3 and Exhibit 4, what I said was about Exhibit 3, that this was not available to me at that time at six o'clock. I don't know if there is a misunderstanding, a correction, I did not say anything about Exhibit 4.

Q. Let me ask you about Exhibit 4 then.

Were the results that are noted on Exhibit 4 under the pathologist's review and under the WBC morphology on Exhibit 4 available to you on

the evening of July 19, 1993?
A. These printouts of Exhibit 4 were not available to me at six o'clock on the day I examined the patient.
Q. But you indicated you had read the smears yourself?
A. Yes, I did indicate that I had looked at the smears myself, which gave me the information I wanted.
Q. Now if you will take a look at Exhibit 3 and Exhibit 5, you will see under the differential that Exhibit 3, which originally appeared on the chart report that -- let me find mine.

There were three corrections, 97 lymphs and zero monos. Then the report was corrected on July 27th, the report was corrected to read 1 seg, 28 promyelocytes, 61 blasts, 8 lymphs, 2 monos.

Did either of these lab reports have any impact at all on your diagnosis of Mrs. Meeks, were they available to you at the time you saw the patient?
A. As I said, Exhibit 3, 4 and Exhibit 5 was not available to me at six o'clock on the day I examined Mrs. Meeks.

Q. I want to know if the incorrect report misled you at all. From what you are telling me you did your own reading of the slides, your diagnosis was based on your diagnosis of the slides?

MR. SWITZER: Let me note you referred to it as incorrect, you are talking about an amendment unless I was misreading it.

Q. The amended report.

A. Exhibit 3, Exhibit 4, Exhibit 5 were not available or were not seen by me at six o'clock of the day I examined Mrs. Meeks, which was July 19th.

Q. That would also be true of Exhibit Number 6, because that was also revised, I believe , much after the 19th?

A. I think. Exhibit 6 also was not available to me at that time.

Q. How long does it take after blood work is drawn for this type of a computer copy to be available on the floor to the physicians when they come in?

A. Inpatient, next morning usually they are on the floor.

Q. Does the lab usually call up a report to the floor or call the specific doctor?

A. If it is ordered stat, lab will call. Lab has some standard rules of panic, if it falls into that they invariably call the doctor.

Q. Does the lab routinely do a differential on the evening shift and report it to the doctor or do they only do the complete blood count?

A. The differential is done by machine. There is a machine available that does the differential. If differential is ordered especially by a technician, the technician will do it. If it falls into the certain criteria, the white cell is this or that, then the technician will do it.

Q. In the evening would you be able to get a differential from the lab?

A. Any time any doctor wants a differential, any time will be available if he wants by machine, by a technician, as I told you, if doctor wants it, it's always available.

Q. How long does it take them to run that test once it's drawn, how long would it take before you can get results back?

A. Differential by machine is done after the blood is drawn, if marked stat in a half an hour, 40, 35 minutes available if stat. If it is routine, comes from the medical offices, it will be

available next day. This is inpatient, available in 45 minutes if anybody wants it.

Q. Doctor, when you reviewed the blood work of the patient, I believe you said that you had some handwritten notes from Dr. Narra, you may refer to your own progress note, did you note any indication of coagulopathy on the evening of July 19, 1993 in Donna Meeks?

A. As I mentioned in my notes, prothrombin time was 2.6 seconds off. Prothrombin time, which I must have gotten at that time from the lab, I went to the lab, I might have asked the technician prothrombin time or had gotten the handwritten copy at the station or the nursing station from which at that time I found out it was 2.6 seconds different from the prothrombin time. There is a printed report here which says prothrombin time right here. This print copy was not available to me at that time.

MR. SWITZER: What was the question?

Q. I asked him if he found any indication of coagulopathy at the time you saw Mrs. Meeks on the evening of July 19, 1993; is your answer yes or no?

A. I was saying that the prothrombin time was

off 2.6 seconds, that means it is a little increased.

What you want to say by coagulopathy is what I'm not telling you. I'm telling you it was prolonged by 2.6 seconds, the prothrombin time was prolonged by 2.6 seconds, which was increased over normal.

Q. In your clinical judgment was there any indication of a coagulopathy in Mrs. Meeks?

A. There is indication that prothrombin time was prolonged in numbers.

Q. Was there an indication of coagulopathy?

A. Coagulopathy is defined in such a way you require some other thing before 1 will say it is prolonged.

Q. That's the indication of coagulopathy?

A. All I can say is it was prolonged by 2.6 seconds.

MR. SWITZER: Wait a minute. Did you or did you not find evidence? I am sorry.

MISS TOSTI: I just asked if he found any evidence of coagulopathy in Donna Meeks the evening of July 19, 1993. He is indicating that he found a prolongation of the prothrombin time. He has not told me whether

that's an indication of coagulopathy or not.
Q. If you are unable to answer the question, Doctor, it's fine to say that you are unable to answer the question. I'm looking for a yes or no or I don't know or I can't answer the question.
A. There is no yes or no answer. I cannot answer the question start saying yes or no coagulopathy. The PT is prolonged 2.6 seconds, PTT normal, no gross evidence of thrombosis. Coagulopathy is when there is bleeding. You are using such a vague term, coagulopathy is a vague term. A term which is used more is thrombosis used for hemorrhage. Coagulation goes in both directions which is a contradiction, you are using the word coagulopathy as something in bleeding -- let me give you an example.

I don't need to go to the lab if there is bleeding. I could see they are bleeding. The terminology are you using is not something which has yes or no answer. I couldn't answer your question.
Q. Was the diagnosis of disseminated intravascular coagulation within your differential diagnosis on the evening of July 19, 1993?
A. It does suggest that some coagulation problem

was initiated.
Q. You would agree then that you needed to watch Mrs. Meeks very carefully for signs of bleeding disorders or other coagulation disorders?
A. Yes.
Q. Did you, in your clinical judgment, believe she required any treatment for coagulopathy, DIC or any other clotting disorder on the evening of July 19th?
A. At six o'clock in the evening when I saw the patient I did not see any need for any treatment for what you term as coagulopathy.
Q. When you got to the hospital after you had done your evaluation and had looked at the blood smears in the lab, did you discuss Mrs. Meeks with anyone at the hospital, did you talk with Dr. Narra or Dr. Blockstorf or Dr. Urso?
A. No.
Q. What is Dr. Urso's specialty?
A. Dr. Urso is a radiologist.
Q. Do you happen to know why Dr. Urso was consulted by the emergency room doctor about Mrs. Meeks' care?
A. I presume she must be the doctor that read the scan that day or on duty or in charge or on

call, whatever you want to say.
Q. What was the significance of a platelet count of 33,000?
A. It means that it is a low platelet count.
Q. If there is a low platelet count does that increase the risk for bleeding?
A. Usually the normal platelet count is 150,000 to 300,000, usually no bleeding. When the platelet count is 50,000 people can undergo major surgery, with a platelet count of 75,000, with a 60,000 count patients can undergo major surgery. Patients do not usually bleed of any kind when they are 50,000 or 60,000. If it is less than 40,000, they may have black and blue marks or bruises, not persistent bleeding. Less than 20,000 the chances of bleeding persistently are more.
Q. Doctor, listen to my question: Does a low platelet count in the range of 33,000 increase the risk for bleeding as compared to a patient with a normal platelet count?
A. At 33, yes, it increases the tendency for bleeding as compared to a normal count.
Q. Does a patient who has a prolonged prothrombin time as Mrs. Meeks had the evening of July 19, 1993, does that -- was she at increased

risk for bleeding as compared to a person with normal prothrombin time?

A. Yes.

Q. With a platelet count of 33,000 was there indication for the administration of platelets in this patient?

A. No.

Q. Why not?

A. Because that is the standard recommendation.

Q. At what level would platelets be indicated, if any?

A. Less than 20,000 or definite evidence of active persistent bleeding.

Q. Did you agree with the orders to transfuse two units of packed red blood cells on the evening of July 19th?

A. Yes.

Q. Would you agree that the administration of packed red blood cells would not correct the low platelets or the prolonged prothrombin time?

A. Yes.

Q. Therefore, even with the administration of packed red blood cells, Mrs. Meeks would still be at increased risk for bleeding as compared to a patient that had normal blood levels of platelets

and a normal prothrombin time?
A. Yes.
Q. What was the purpose for ordering the blood transfusion for Mrs. Meeks on the evening of the 19th?
A. Because Mrs. Neeks was symptomatic from the anemia, having headaches, she was light-headed, she was not feeling well, she was weak for two months, shortness of breath on activity, these are all symptoms of anemia. Generally patients are transfused with all the symptoms that -- hematocrit is less than 25, her hematocrit on admission was 70.9, that makes all standard criteria of blood transfusion in this setup.
Q. Doctor, I'm handing you what has been marked as Plaintiff's Exhibit 2, which has doctor's orders written at the top for the date of July 18, 1993, you may want to look at your original, it may be a little clearer. That's not the original, this is a COPY.

I would like to ask you in regard to the bottom of the page, there is an indication about the blood transfusion, I believe there is an order there for Decadron four milligrams IV, do you see that?

A. Yes.
Q. What is the purpose of giving Decadron in this instance?
A. When we give a blood transfusion, in spite of being crossmatched correctly there are some chances of getting what we call reaction, putting into coma, fever, chills, things like that, this can be taken care of two ways; some patients are referred to Benadryl before the blood transfusion, some people do Decadron, a long acting Cardizem type substance which can prevent these reactions. That was the sole purpose of giving that Decadron before transfusion, which is standard practice in our transfusion site.
Q. Would Decadron have any effect of increasing the risk for bleeding in a patient with acute promyelocytic leukemia with a prolonged prothrombin time and a low platelet count of 33,000?
A. Four milligrams of Decadron given once will not have any effect of anything you have said.
Q. On the evening of July 19th did you speak to any member of the Meeks family when you were at the hospital?
A. Mo.
Q. Did you speak with Donna Meeks during the

time that you did your physical assessment of her?
A. Yes.
Q. The history that you recorded in your progress note, was that given to you by Donna Meeks?
A. Yes.
Q. Doctor, on the order sheet that you are looking at, that is marked as Plaintiff's Exhibit 2, on the top portion of the page, I would like you to look at that. Do you recognize that as Dr. Narra's writing?
A. Yes, these are in Dr. Narra's writing.
Q. Near the end of his entry it mentions hematology consult with Dr. Sutaria, then it looks like another consult with another doctor, are you able to make out who the other doctor is?
A. That is Dr. Manning.
Q. Is that M-a-n-n-i-n-g?
A. I presume. I know there is one Dr. Manning.
Q. What type of doctor?
A. He's an eye specialist.
Q. Doctor, the orders at the bottom of the page are in your handwriting; is that correct?
A. Um-hum.
Q. Would you read to me what you've written on

the first line of your notation on the doctor's orders for the evening of the 19th?

A. 7-19-93, number one, tomorrow a.m. urine routine and microscopic. In front of routine you will find a question mark. That question mark is not my handwriting. I presume that the nurse who was taking up those orders had some problem reading that, she put a question mark.

Then B says CBC, differential platelet to tell you more than that.

Q. I'm going to ask you to skip down here, down to E, would you read me that?

A. Thrombin time.

Q. F?

A. F is serum fibrin split product.

Q. Of those two things that you just read to me, what is the purpose of those two tests?

A. Fibrin time is the clotting, one of the tests for clotting or coagulation. Same with serum fibrin products, one of the tests done in the clotting disorders in certain situations.

Q. Then under G?

A. G, urine fibrin split product.

Q. Why did you order those three tests?

A. I ordered those three tests because they are

the ones which will tell me there is any further clotting problems coming up. All the tests can be done in the next morning so they were ordered for the next morning.

Q. Would it be fair to say you had some concerns that she might develop a problem with blood clotting, this was to assess her to see if she indeed was having a problem with blood clotting?

A. That was my concern.

Q. Doctor, why weren't those ordered the evening she came in?

A. Thrombin time is not done as a special test, it's not done as a stat test. They are done always in a certain time of the day, in the first shift only. That test could not have been done. The other test, two tests, were done to know about this clotting mechanism, which I can know more about that for the next morning. Same evening the PTT and platelet count was enough for me to make my decisions.

Q. Doctor, wouldn't the fibrin split product be something you want to know the evening she came in -- let me finish, please -- with the prolonged prothrombin time and patient who has ecchymosis on a number of areas of the body and the platelet

count of 33,000, wouldn't this be a patient that you would want to see the fibrin split products on that evening to determine whether or not you had a coagulopathy?

A. It would not have made any change in my management of the patient.

Q. After you had evaluated Donna Meeks, what was your plan then of care for her?

A. My plan was to do a -- my plan was to talk to in the morning to evaluate all the tests I ordered, see what is changing, get the whole progress of the patient during the night and see the patient next morning, see anything immediate I need to do by that time.

Then call the super specialist at the tertiary center, there is a patient I have, this is the story, this is what I find in her blood, I have looked at smears which I ordered, called them, said this is what I had. Most likely diagnosis of leukemia, we need next thing to do is a bone marrow before we can initiate further treatment.

I'm going to transfer the patient, ask them depending upon who is on call, they have five, seven, eight, ten specialists there,

everybody has a different way of handling things, speak to him, say there is this most likely leukemia, as you well know, I know we have to do bone marrow special studies, those studies can be done at your center and chromosomes and other things, but if you want me to go ahead and do it, I will do them, send all those things to you the way you want that done, transport the patient, I will transport the patient, you carry on further treatment.

So this was my plan. I did mention to Mrs. Meeks also that bone marrow is something we are going to do tomorrow.

Q. Could you have transferred Mrs. Meeks to the Cleveland Clinic on the evening of the 19th?

A. I did not see any immediate need of doing that. I thought the evening we are already decided to stabilize her red cell count, watch her until next morning, transfer her the next morning.

Most of the tertiary center consultants usually prefer the patient come in in the morning so they can start working on that faster. You talk to them, things like that. It works out better in my practice patient is transferred next morning.

Q. Would there be any type of instance that you would have considered transfer of Mrs. Meeks, any particular complication or any other findings that might have caused you to arrange a transfer the evening of the 19th? Had she had a definite coagulopathy would that have been an indication for transfer on the 19th?
A. At that time I was seeing her there was no indication for transferring her immediately.
Q. I'm asking what would be an indication for transfer on the 19th?
A. For Mrs. Meeks at the time there was no indication for transferring her immediately.
Q. I understand that is what your answer is.
If she had under your criteria a definite DIC or coagulopathy would that be an indication for transfer?
A. I did not have any criteria at that time, blood count, prothrombin time.
Q. Doctor, I understand that. You had given me a criteria before saying that if the platelet count was below 20,000 or the prothrombin count was three to four seconds elongated, this would be indication of a coagulopathy. If those were present would that be an indication to transfer the patient to

the Cleveland Clinic?
A. What you mention were the indications of supporting therapy by platelets and plasma, that would have been supporting therapy for that, that was not present at that time, so supporting therapy was not given. You can ask me.
MR. SWITZER: Hold on. I think what she wants to know is with Mrs. Meeks, give her an example what kind of condition or symptom or signs or anything. I know it didn't happen. Hypothetically if Mrs. Meeks had some other type of symptom, what would it have to be in order for you to have ordered a transfer of Mrs. Meeks to the Cleveland Clinic the evening of the 19th? I think that is what she wants to know.
A. What kind of situation are you thinking of which you are asking me such a broad question? Let me ask you, tell you this way: I can very easily treat her with plasma and platelets. That would not have been reason to transfer her.
Q. Okay.
A. We could do that. Not knowing what kind of conditions are you thinking of which will make an immediate transfer, can you tell me a couple of things, then I can answer. That is a broad

question.

Q. Doctor, would it be fair to say that you are unaware of any indication that would have prompted you to transfer this patient to Cleveland Clinic, that there is no complication or any other clinical situation that would have caused a transfer to the Cleveland Clinic the evening of July 19th?

All I'm trying to identify is what situation would have arisen that you would have transferred the patient to the Cleveland Clinic on the 19th; if there were none, if you would keep that patient there regardless, then tell me that, I'm looking for an answer here.

A. Depending on what complications come up, whether they were handled there or not, when it comes, how it came up, whether the patient is stable at that time or not. I think you are asking me a very broad question, I have no answer for that.

Q. What complication would you not be able to handle that would be likely to arise in acute promyelocytic leukemia patients at Kaiser Parma?

MR. SWITZER: How about an intracerebral hemorrhage?

A. There is none that is emergency we had to

transfer the patient.
Q. Is that one instance where you would transfer the patient?
A. We transferred the patient with that complication. I was not able to understand what you are trying to ask me. I think you are knowing the patient was transferred to the Cleveland Clinic for intracerebral hemorrhage.
Q. Doctor, I'm aware the patient was transferred, I don't know what the indications for the transfer were, that is why we're here taking your deposition.
A. Okay.
Q. On the evening of July 19th did you give any particular instructions to the nursing staff to monitor for any particular complications in the case of Donna Meeks?
A. They usually take certain vital signs on a routine basis, which are the classic --
Q. I'm asking did you give any specific instructions to the nursing staff to monitor this patient?
A. No, other than the usual instructions which are to the nurses for any patient.
Q. After you finished your examination of

Donna Meeks and writing orders, what did you do?
A. After finishing?
Q. After the examination, after writing orders, what is the next thing you did?
A. Let me ask you one thing.
Whether you are asking me I did talk to Donna Meeks is what you want to know?
Q. You told me you talked with her when you examined her?
A. Okay, after I finished examination with her I talked to her, then I came down and wrote down the orders.
Q. Then after you finished the orders what did you do?
A. After finishing the orders I went back to my office, did certain work which I had to finish for the day, then I left.
Q. Approximately what time did you leave the area where Donna Meeks was the patient?
A. I was there at six o'clock, I started writing orders, I think I was there through approximately 6:25, 6:30.
Q. Would it be correct to say at the time you left the hospital you had not identified the subtype of leukemia that Donna Meeks had?

A. Yes, I had not identified.

MR. SWITZER: You answered the question. You don't need to go on.

Q. At the time you left the hospital, had you determined that she had an acute leukemia?

A. That was the most likely suspicion in my mind.

Q. When, if at all, were you next contacted regarding Donna Meek's condition change?

A. Can you repeat the question?

Q. Yes. After you left the hospital, when if at all were you contacted again about Donna Meeks?

A. I was not contacted.

Q. Were you aware at all of her condition change between four and six o'clock in the morning, did anyone call from the hospital?

A. No.

Q. Did any doctor contact you later on the 20th to tell you what had happened to Donna Meeks?

A. No.

Q. Did Dr. Narra ever inform you as to what happened with Mrs. Meeks?

A. No.

Q. When did you find out that there was a condition change and she was transferred?

MR. SWITZER: Let her finish.

A. I came in around 8:30, I don't know the time, 8:25 or 8:35, went to the floor, found that she was transferred.

Q. At the time that you were called in on consultation were you managing her care or was Dr. Narra still managing her care?

A. The setup we have is consultants are usually called by the internist if they need help. If anything happens to the patient, the internist is called first.

Q. So technically Dr. Narra was managing the case, you were called in as a consultant, you were not a managing physician in her care?

A. It does not mean that I was not managing the care. Dr. Narra will call me, I will be managing the case. That is a technical thing I think.

Q. When she started to develop a headache and vomiting at four o'clock in the morning, would that have been something that you would want to have been notified about?

A. I will leave it to the internist. Most of our internists are competent enough to know when to call me.

Q. Would you agree headache and vomiting are signs frequently associated with brain hemorrage?

A. Headache and vomiting are associated with brain hemorrhage, yes.

Q. Do you have an opinion as to whether Donna's headache and emesis was an indication of a brain hemorrhage in this instance?

A. She had a headache when she came in, I don't think that headache was an additional indication, at that time was suggestive that something else might be happening, vomiting. I think that's the time they called the house doctor or whoever was to be first informed.

Q. Do you have an opinion as to what point in time Donna Meeks' condition was irreversible?

A. Say to me again.

MR. SWITZER: Which condition are you talking about?

MISS TOSTI: Her brain hemorrhage and ultimate death.

Q. Do you have an opinion as to what point in time Donna Meeks' condition was irreversible?

A. As you know very well that I was not informed, not knowing about this, I know at 8:30 I did not have the chance to see her or see the scan

or anything. I'm not a person who will tell that but I know that the doctors at Cleveland Clinic when they saw her, after initially in evaluation, told her she had massive hemorrhage or something like that. Answering your question, no.

Q. You don't have an opinion to a particular point in time that her condition was irreversible?

A. I couldn't.

Q. Do you know who made the decision to transfer Donna to the Cleveland Clinic?

MR. SWITZER: Wait a minute. You want to look?

MISS TOSTI: I'm asking him if he knows, if he doesn't know that is fine.

A. I can answer your question by looking at my notes, notes of other people. I personally do not remember anything offhand.

Do you want me to look at the notes and --

Q. No, that's okay.

Were you consulted about the transfer prior to transfer?

A. No.

Q. Do you know what the reason was for the transfer, did anyone indicate to you why they had

to transfer her to the Cleveland Clinic?
A. Let me tell you, you know very well I was not here.
Q. I'm wondering if any doctor --
MR. SWITZER: Subsequently?
A. Subsequently I know that patient had vomiting and headache, she went down for CAT scan, CAT scan was read as hemorrhage. I know the doctor, the neurologist saw the CAT scan, was the one who got the report or read the CAT scan or somebody else read for her. From there, later on, I knew that along with viewing the CAT scan, Dr. Kamenar, the doctor on call, must have decided to transfer the patient. I think mostly must be Dr. Kamenar suggested to actually transfer the patient or transferred the -- I can't tell you exactly.
Q. What is Dr. Kamenar's specialty?
A. Neurology.
Q. Did you ever speak to any of the Cleveland Clinic physicians regarding Donna Meeks?
A. After the transfer, yes.
Q. When did you do that?
A. I called when I came in, 8:30 I knew she was already transferred, taken care of, I went to my office, saw some patients, around 9:30, 9:45, I

couldn't tell you the time, maybe later to 10:00 I put a call to neurology where she was transferred.

I talked to a doctor, most probably remember that it was Dr. Frank or one of the senior persons or at least Fellow or faculty member, mostly same doctor who took care of her. I told them that this patient had these hematologic problems which I identified, if he has anymore questions regarding this you may ask me. I did suggest you should consult hematology on this case.

Q. Other than that phone call, did you make any other phone calls to Cleveland Clinic prior to that?

A. Prior to that?

Q. In regard to Mrs. Meeks' care?

A. I tried the hematology department and tell them that there is a patient, they may consult you. I do not know I called them after that, during the same time. I also called the hematology/oncology department, told there is a patient like this who is consulted, who is transported, they will consult you or something like that.

Q. I want to clarify this. On the evening of

the 19th did you call Cleveland Clinic at all?
A. I'm --
Q. I'm going to ask you to tell me yes or no, did you call on the evening of the 19th?
A. On the evening of the 19th I did not call the Cleveland Clinic.
Q. On the morning of the 20th, after you came in, you called Cleveland Clinic, you talked to the neurology department?
A. Um-hum.
Q. Did you you also that morning make a call to the hematology department?
A. Hematology/oncology department.
Q. Your two calls to the Cleveland Clinic were both made on the 20th?
A. After the patient was transferred and already there.
Q. Do you have an opinion as to what caused Donna Meeks' leukemia?
A. I don't.
Q. Are you aware of any history, family history of leukemia that was evidenced in the history that you took?
A. I don't remember asking detail about the family history at that time.

Q. You don't remember whether you inquired?
A. I don't remember whether I asked in that detail or not at that time family history of leukemia, I do not remember.
Q. Do you have an opinion as to whether or not Donna Meeks' brain bleed was preventable?
A. Say to me again.
Q. Do you have an opinion as to whether or not Donna Meeks' brain bleed was preventable?
A. I don't think it was preventable.
Q. What is the basis for that opinion?
A. Because this can happen to these patients any time. I would not -- nobody would have given her anything to prevent that at that time. This can happen in patients. There are patients who come in bleeding, an intracerebral hemorrhage, there are patients bleeding when they are transported, patients who are bleeding after the transport, there are patients who have cerebral hemorrhage after the chemotherapy. This can happen at any time. This can happen for reasons other than the coagulopathy because we don't know what is wrong in the brain. We don't have the post mortem.

I personally feel it was not preventable, it just happened as a part of the

process.

Q. Do you have an opinion as to whether or not the administration of platelets or fresh frozen plasma would have prevented Donna Meeks' brain hemorrhage?

A. Might have given more problems also. I couldn't comment on that. Nobody can anticipate what will happen with that and if we do that. I personally feel that there is no way you can know, patient has hemorrhage, you want to given plasma and platelets to. I don't think I can answer your question. It is unpredictable is the answer to that question.

Q. Do you have any opinion as to Donna Meeks' life expectency if she had not suffered a brain bleed on July 19, 1993?

A. I don't think I can kind of guess that because let me -- philosophically I seen patients going down the road -- anyway, let me tell you this, I don't think I can answer that.

Anything can happen to anybody at any time. People can die. If you want to see the life expectency of people you can reproduce the table, you will know who can live how long in the United States.

Q. Are you critical of anyone that rendered care to Donna Meeks at Kaiser or Cleveland Clinic?
A. No.
Q. Have you covered all of the opinions you presently hold relative to Donna Meeks' care and treatment?
MR. SWITZER: Wait a minute. I don't think he needs to -- that is kind of an open-ended question. He may have other opinions down the road when I talk to him some more.
MISS TOSTI: 1 asked whether he presently holds.
MR. SWITZER: You can answer yes or no. She covered everything pretty thoroughly in this deposition.
A. I do not understand. Actually I do not understand what are you trying to tell me? Can you tell me again the question, tell me what comment Don made?

(Record read.)

MR. SWITZER: Say ***yes*** or no, whatever the answer is.
A. I really do not understand the question. I

do not understand the question.

Q. If you should arrive at any new opinions that we haven't discussed, I would appreciate it if you would tell counsel so that counsel can let us know, that we would continue your deposition relative to those new opinions that you might form between now and the time of trial.

MR. SWITZER: I'll just say yes.

MISS TOSTI: I think we're done, Doctor. Thank you for your time.

(Deposition concluded; signature not waived.)

ERRATA SHEET

PAGE LINE

I have read the foregoing transcript and the same is true and accurate.

_____

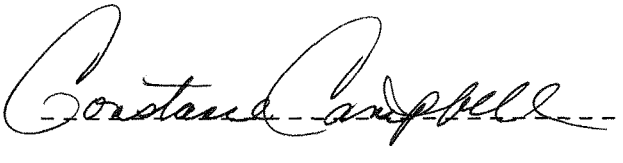
VINODKUMAR SUTARIA, M.D.

The State of Ohio,
County of Cuyahoga. CERTIFICATE:

I, Constance Campbell, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, VINODKUMAR SUTARIA, M.D. was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 3rd day of March, 1995.



Constance Campbell, Stenographic Reporter,
Notary Public/State of Ohio.
Commission expiration: January 14, 1998.

Look-See Concordance Report

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UNIQUE WORDS: **1,771**
TOTAL OCCURRENCES: **8,601**
NOISE WORDS: **385**
TOTAL WORDS IN FILE: **25,895**

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SINGLE FILE CONCORDANCE

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CASE SENSITIVE

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PHRASE WORD LIST(S):

- - -

NOISE WORD LIST(S): **NOISE.NOI**

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COVER PAGES = 4

- - -

INCLUDES ONLY TEXT OF:
QUESTIONS
ANSWERS
COLLOQUY
PARENTHETICALS
EXHIBITS

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- - -

INCLUDES PURE NUMBERS

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POSSESSIVE FORMS **ON**

- -

MAXIMUM TRACKED OCCURRENCE THRESHOLD: **50**

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NUMBER **OF** WORDS SURPASSING OCCURRENCE THRESHOLD: **13**

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