

THE STATE of OHIO,
COUNTY of CUYAHOGA.

IN THE COURT OF COMMON PLEAS

JACK J. MEEKS, executor,
 plaintiff,

vs. : Case No. 269426
:

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

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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11
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I N D E X

WITNESS: VINODKUMAR SUTARIA, M.D.

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(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,

1 Ohio 44130.

2 Q. Your business address?

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

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

7 A. No.

8 Q. Have you ever had your deposition taken
9 before?

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

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

21 Q. So you were called as a treating physician?

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

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

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

6 Q. Did you give any trial testimony?

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

9 Q. Yes.

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

16 Q. Did you do that in court --

17 A. No.

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

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

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

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

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

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

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

13 A. No.

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

16 A. No.

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

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

1 like that?

2 A. I understood the question.

3 During my Fellowship training one
4 more year I worked at the VA Hospital, there were
5 many protocol studies which were done with my
6 department, I was one of the persons taking care of
7 patients who are on the protocol and research.

8 When you were asking me about
9 research, I have not published anything on my
10 name.

11 Q. You said at the VA Hospital you were involved
12 in some research projects, where was the other
13 place?

14 A. Those two years of my Fellowship at
15 University Hospitals and VA, which is a combined
16 program, for three years I was involved in
17 protocols which included leukemia protocols also.

18 Q. Did any of those research projects involve
19 the subject matter of leukemia?

20 A. Yes.

21 Q. Did any of the research projects involve the
22 subject matter of acute promyelocytic leukemia?

23 A. Not in particular.

24 Q. Of the research projects that dealt with
25 leukemia, do you recall anything specific about an

1 individual research project as to whether the type
2 of research was being done related to leukemia?

3 A. I don't understand, can you repeat?

4 Q. The research projects that dealt with leukemia
5 at University Hospitals and VA Hospital, do you
6 recall what the research project was designed to
7 look for?

8 A. They were designed to look for comparison of
9 two types of drugs, which one does better than the
10 other.

11 Q. Do you recall the drugs that were involved in
12 that research or those research projects?

13 A. Right now I don't.

14 MISS TOSTI: Doctor, if you
15 need to answer that, go ahead.

16 THE WITNESS: That's fine.

17 Q. Have you ever had your hospital privileges
18 called into question or suspended or revoked by a
19 hospital?

20 A. No.

21 Q. Have you ever been declined or cancelled by a
22 professional negligence insurer?

23 A. No.

24 MISS TOSTI: Any time you
25 need to take a break, go ahead.

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(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

1 take down head nods or hand motions.

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

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

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

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

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

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

23 A. That is correct.

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

25 A. I am on permanent immigrant status, which is

1 like Green Card holder.

2 Q. You received all of your medical, your basic
3 medical education in India, correct?

4 A. Yes, the basic medical degree in India.

5 Q. Under the area marked certification, what
6 does the ECFMG certification stand for?

7 A. It's called Educational Counsel for Foreign
8 Medical Graduates.

9 Q. That was a test that you took when you
10 entered the country to practice medicine?

11 A. Yes, at that time that was an entrance test
12 for foreign graduates to enter United States.

13 Q. What does the certification FLEX stand for?

14 A. It is Federal License Examination, which is a
15 licensure examination taken in various states in
16 this country to practice medicine.

17 Q. You took that in the State of Illinois?

18 A. I took that, I wrote the test in Columbus,
19 Ohio, the test I was listed with the State of
20 Illinois because any person can list with another
21 state and write, it's the same examination given by
22 most of the states, but you can take for another
23 state anywhere in the country.

24 Q. Are you currently licensed in the State of
25 Ohio to practice medicine?

1 A. Yes, I am.

2 Q. When did you attain that licensure?

3 A. I got that licensure immediately after,
4 within six or eight weeks getting this license by
5 reciprocity. We applied to the Ohio State
6 certification, this is my training, they look at
7 all those things, send a license to practice in
8 Ohio which I got within six, eight weeks of
9 applying for this.

10 Q. Your Ohio license would date from
11 approximately 1973?

12 A. Approximately, yes.

13 Q. You indicate here that you're a Diplomat of
14 the American Board of Internal Medicine, what does
15 that designation mean?

16 A. After requisite training in internal
17 medicine, the physician person is allowed to write
18 an examination which is like a degree if you want
19 to call it, or certification in internal medicine.
20 Once you pass that examination you are called
21 Diplomat of American Board of Internal Medicine.

22 Q. Is this the same thing as being Board
23 certified in internal medicine?

24 A. Exactly.

25 Q. In regard to your Board certification in

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

3 A. No.

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

6 A. I passed the third time.

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

10 A. Yes.

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

15 A. Yes, that's correct.

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

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

1 a combined program.

2 Q. As far as the emphasis in that program, was
3 there any emphasis on oncology in your hematology
4 Fellowship?

5 A. Yes, there was emphasis on hematological
6 oncology in the program, it's a part of the
7 program.

8 Q. Would you be able to give me an approximate
9 percentage of the program that was spent in
10 oncology?

11 A. It's going simultaneous every day in
12 hematology and the oncology/hematology. Same
13 patient can have an overlap of the two. I cannot
14 give you an exact time. It involves a lot of
15 hematology/oncology.

16 Q. Under your practice and experience, the first
17 listing you have is with the Veterans'
18 Administration Hospital, you indicate that you were
19 a cancer chemotherapy physician, what were your
20 duties and responsibilities in that particular
21 position?

22 A. That was the staff position in the Department
23 of Hematology/Oncology, where I was involved in
24 taking care of hematologic/oncologic patients in
25 the hospital, teaching residents, teaching medical

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

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

8 A. Yes.

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

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

21 Q. Why did you leave the VA Hospital?

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

24 Q. Then you next went into private practice?

25 A. Yeah.

1 Q. Were you with any particular medical group in
2 private practice?

3 A. I was with an internist, he was a practicing
4 internist, I joined him.

5 Q. You had a medical association with him?

6 A. Right. He was having his practice, I joined
7 him.

8 Q. Who was that individual?

9 A. His name was Dr. Mohan Bafna.

10 Q. Spell that last name.

11 A. B like boy, A like American, F like French,
12 N like Nancy, A like American.

13 Q. Did you then leave that association?

14 A. Yes.

15 Q. Why did you decide to leave that association?

16 A. Well, Dr. Bafna was personal friend of mine,
17 from the time I joined we had an understanding that
18 I wanted to try private practice, plus he wanted to
19 go to India for three or four months, he wanted me
20 to cover his practice, I think that will be good
21 experience to know how the private practice is, in
22 the meantime, see whether I want to do something
23 else.

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

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

7 Q. You're still currently with Kaiser
8 Permanente?

9 A. Yes.

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

12 A. That's correct.

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

19 A. Are you asking like now?

20 Q. July of 1993 were there any other
21 hematologists?

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

24 Q. Who would that have been?

25 A. His name, you want his name?

1 Q. Yes.

2 A. Dr. Kenneth Weiss.

3 Q. Would you spell the last name?

4 A. W-e-i-s-s.

5 Q. In July of **1993** did you hold any type of
6 administrative position or responsibilities with
7 Ohio Permanente Medical Group or Kaiser Permanente?

8 A. No.

9 Q. Do you have hospital privileges any place
10 else besides Kaiser?

11 A. Yes.

12 Q. Where would that be?

13 A. Cleveland Clinic.

14 Q. When did you receive Cleveland Clinic
15 privileges?

16 A. January, **1994**.

17 Q. Was this part of an agreement that Kaiser had
18 with Cleveland Clinic?

19 A. Yes, but subject to the approval of their
20 selection committee looking at our certification
21 and everything.

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

1 committee or whatever.

2 Q. On your vitae you indicate you were a
3 teaching Fellow at Case Western Reserve and
4 instructor in medicine at Case Western Reserve,
5 correct?

6 A. That's right.

7 Q. Can you tell me what your duties or
8 responsibilities were as an instructor in medicine
9 at Case Western Reserve?

10 A. Teaching medical students and teaching the
11 residents on the service.

12 Q. Did you give any type of formalized lectures
13 to students or were you a clinical instructor?

14 A. It was a clinical instructor.

15 Q. Did you do any classroom instruction?

16 A. No, no classroom instruction.

17 Q. Did you ever give any instruction on acute
18 promyelocytic leukemia to any of the students?

19 A. I'm pretty sure I did.

20 Q. Did you generate any notes or outlines from
21 those instructions or those lectures?

22 A. I do not understand your question.

23 Q. Did you have at the time that you did the
24 teaching, did you produce any type of notes related
25 to that lecture or any type of outline related to

1 that lecture?

2 A. I still do not understand what you are saying
3 prepare notes or outline. When we teach we prepare
4 sometimes some notes like the ones you want to
5 teach as a reference point to these students.

6 Q. That's what I'm getting at.

7 A. Most of the time I believe prepare and talk
8 to them without any notes.

9 Q. Do you currently have any notes, outlines,
10 dealing with acute promyelocytic leukemia you
11 utilized in lecturing students while you were an
12 instructor or teaching Fellow at Case Western
13 Reserve?

14 A. First tell me if I understood right, are you
15 asking me at present are there any notes or
16 outlines in my possession which I might have
17 prepared in the years which goes as far back as '81
18 with me right now, that's what you are asking me?

19 Q. That's going to be the first part of my
20 question.

21 Do you have any?

22 A. No.

23 Q. Did you generate any at the time you provided
24 that instruction to the students?

25 A. I do not understand what you are trying to

1 ask me by generate.

2 Q. Make, write, prepare?

3 A. I did say that most of the time I was talking
4 from what prepared. Sometimes I might have written
5 some notes on the blackboard like a part of the
6 lecture, sometimes I might have prepared on one
7 piece of paper, used it that time, threw it away,
8 to remember what I'm going to talk, but not as a
9 permanent piece of information for me.

10 Q. To your knowledge, do you know where any
11 notes or outlines from those lectures are, either
12 who might have them or where they might be?

13 A. I don't think -- I don't have any of those
14 notes.

15 Q. I asked you if you had knowledge of anyone
16 who did have those notes?

17 A. I have no knowledge of anybody who might have
18 those notes.

19 Q. Under medical societies you have listed down
20 here Ohio State Medical Board. Do you hold any
21 type of an office or position with the Ohio State
22 Medical Board?

23 A. No.

24 Q. What is that in reference to, in reference to
25 your license?

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

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

10 A. No.

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

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

15 Q. A long time?

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

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

25 A. No.

1 Q. Have you ever authored or co-authored any
2 medical journal or textbook chapters?

3 A. No.

4 Q. What have you reviewed for your deposition
5 today?

6 A. The useful textbooks in hematology, oncology,
7 some of the recent articles which I usually review
8 all the time, I might have reread them or things
9 like that.

10 Q. Could you tell me what books you referred to?

11 A. The Williams Textbook of Hematology I always
12 refer to, which I've used for all the years I was
13 in practice. Plus --

14 Q. Do you find Williams to be an authoritative
15 text?

16 A. Most of the things I find there very useful
17 in my practice.

18 Q. Would you consider it to be authoritative?

19 A. I do not understand what you mean by
20 authoritative.

21 Q. Is it the type of reference you rely on in
22 your practice?

23 A. Most of the problems, most of the times.

24 Q. Would you consider it to be an authority? In
25 other words, when you are looking for answers to a

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

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

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

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

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

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

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

22 A. All those textbooks and certain articles.

23 Q. What articles did you look at?

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

1 Q. Have you looked at the -- have you been
2 provided with depositions of Mr. Meeks, the
3 decedent's husband in this case?

4 A. Yes.

5 Q. How about the decedent's daughter's
6 deposition, have you looked at that?

7 A. Yes.

8 Q. Have you consulted with any other physicians
9 in preparation for this deposition?

10 A. No.

11 Q. Have you discussed this case with anyone else
12 other than with counsel at any time?

13 A. I do not understand what counsel meaning.

14 Q. Your attorney?

15 A. Yes, I talked to my lawyers only.

16 Q. Aside from what you discussed with your
17 attorney, have you talked with anyone else?

18 A. No.

19 Q. Have you ever made or written any personal
20 notes or kept a personal file on this case?

21 A. No.

22 Q. What medical journals do you currently
23 subscribe to?

24 A. I get American Society of Hematology journal
25 which is called Blood. I get also Annals of

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

5 Q. Anything else?

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

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

11 A. No.

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

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

21 Q. What was your usual work schedule?

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

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

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

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

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

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

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

1 A. I do not understand what you are trying to
2 ask.

3 Q. I'm trying to get down to what a differential
4 diagnosis is.

5 A. I understand what a differential diagnosis
6 is. The terminology that you are using, the
7 English that you are using, I'm not able to
8 understand what you mean so can you tell me in some
9 other words?

10 Q. I would like you to tell me what differential
11 diagnosis means to you, that might be easier.

12 A. Differential diagnosis is when you see a
13 patient, the possible diagnosis in this patient,
14 sometimes maybe three, sometimes five, maybe one
15 sometimes. You may not think what is going on, it
16 can be anything. Most of the time, yes, you think
17 of three, four, five different conditions which are
18 likely to be the cause of symptoms that the patient
19 is presenting.

20 Q. It's not uncommon then to have more than one
21 potential problem or disease within the
22 differential diagnosis, you might be thinking that
23 the cause of the patient's problems can be due to
24 either number one problem, number two problem or
25 number three problem?

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

4 A. Yes.

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

8 A. Say that again, what is question?

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

12 A. Yes, I have.

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

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

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

1 A. In most of the situations, yes.

2 Q. That's not uncommon to have several things
3 that might be causing a problem?

4 A. I'm saying of most situations it seems that
5 it is common to happen. I think if I understand
6 right, most of the time it's common, right.

7 Q. That is what I'm asking you, whether it is,
8 you've answered me.

9 A. I thought I answered your question.

10 Q. Can we agree that it's your responsibility,
11 your duty that when you form a differential
12 diagnosis that if you have a condition within the
13 differential diagnosis that is life threatening,
14 you would have the duty to immediately rule it
15 out? If one of the things within the differential
16 diagnosis is life threatening, you as a physician
17 have a duty to take the next step, immediately
18 check into it, try to rule it out if it's life
19 threatening?

20 A. I do not -- I will not agree with immediately
21 means what? Every possible idea has to be ruled
22 out in certain time. Means you can see how much
23 time you need to go to your next step.

24 Q. But if you've got a problem that may be life
25 threatening to the patient, isn't there a duty on

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

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

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

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

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

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

4 Q. I think you've answered it.

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

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

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

15 A. It is not an immediate life threatening
16 situation.

17 Q. Why not?

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

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

1 you are asking, next one hour if you are asking.

2 Q. Would you consider that a patient that has
3 acute promyelocytic leukemia, would you consider
4 them to be in an acute oncologic emergency?

5 A. Patient with acute promyelocytic leukemia
6 there are patients who may not be in emergency,
7 that there are patients who can wait, there are
8 patients in which you work in few hours, there are
9 all kinds of subsets of this patient. Every acute
10 promyelocytic leukemia is not an emergency. It
11 depends upon so many things in that patient. You
12 couldn't make a general statement for diseases like
13 this. It depends upon a lot of things.

14 MR. SWITZER: Doctor, you
15 answered the question.

16 Q. Doctor, I want to go through the signs and
17 symptoms, ask you if they would be consistent with
18 the diagnosis of acute promyelocytic leukemia.

19 How about ecchymosis and bruising,
20 are those consistent with acute promyelocytic
21 leukemia?

22 A. Ecchymosis can occur in many conditions. You
23 can bump yourself, have ecchymosis.

24 Q. I'm asking you specifically about acute
25 promyelocytic leukemia, do you see ecchymosis and

1 bruising in patients, is it consistent with that
2 diagnosis?

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

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

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

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

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

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

24 Q. We're focusing on acute promyelocytic
25 leukemia.

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

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

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

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

11 Q. One of the symptoms?

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

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

21 How about increased prothrombin
22 times?

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

25 Q. How about decreased platelets?

1 A. It is one of the things that can be present
2 in acute promyelocytic leukemia.

3 Q. What about bleeding such as nosebleed?

4 A. It can be one of the symptoms of acute
5 promyelocytic leukemia.

6 Q. Low hemoglobin and hematocrit?

7 A. It is commonly found in acute promyelocytic
8 leukemia.

9 Q. How about elevated temperature?

10 A. Low grade temperature is more common with any
11 leukemia and can be found in acute promyelocytic
12 leukemia.

13 Q. How about pallor or pale skin tone?

14 A. Pallor is also one of the symptoms of acute
15 promyelocytic leukemia.

16 Q. What about complaints of headache?

17 A. Patient can have headache because of anemia
18 which can be secondary to acute promyelocytic
19 leukemia.

20 Q. Doctor, the symptoms that I just mentioned to
21 you, would you agree these are all signs and
22 symptoms that Donna Meeks presented with when she
23 came into the hospital on July 19th of 1993?

24 A. Can you go one by one again, I will tell you
25 from my notes which ones she presented and which

1 ones she told things like that.

2 Q. I think what we'll do is I'm going to forget
3 that right now, we will be going through your notes
4 individually, get to that in a minute.

5 A. That will be fine.

6 Q. At the time of Donna Meeks' admission would
7 you agree acute promyelocytic leukemia should have
8 been within your differential diagnosis?

9 A. Diagnosis of acute leukemia was one of the
10 differential diagnoses.

11 Q. Was acute promyelocytic leukemia within your
12 differential diagnosis?

13 A. I said any type of acute leukemia was --
14 myeloleukemia there are six types, there is acute
15 myeloleukemia, that was one of them, myeloleukemia
16 which can happen was part of the diagnosis.

17 Q. You were considering that among several other
18 possible types of leukemia at the time of her
19 admission to the hospital?

20 A. Diagnosis of acute myeloleukemia was a strong
21 suspect on admission when I saw the patient, to
22 me. The subtype, it can be any of those subtypes
23 at that time, at six o'clock when I saw the
24 patient.

25 Q. In July of 1993, how were patients referred

1 to you from the emergency room at Kaiser Parma?

2 A. Most of the patients from the emergency room
3 are first referred to the internist on call. The
4 internist on the call will go and see the patient,
5 then admit the patient on his or her service, ask
6 for hematologic consult. If they have a question
7 the internist calls a hematologist for the answers
8 also, decide what to do.

9 Q. So that I understand you, you would not get a
10 direct referral from the emergency room physician,
11 that it would come through the internist on call;
12 is that correct?

13 A. That's correct. Let me specific my answer a
14 little more.

15 Emergency room there are so many
16 patients coming, as you know. If one of my
17 patients whom already taking ongoing care has come
18 for some minor problem, an emergency room physician
19 feels he can talk to me directly to resolve the
20 issue, he will call me. If the emergency room
21 physicians feels this would require extensive work
22 on admission, the internist on call will be called
23 first.

24 Q. I'm interested in referrals that come to you
25 generally

1 emergency room physician would see the patient,
2 then contact the internist on call, if he felt a
3 hematologist was needed he would make a referral?

4 A. That's correct.

5 Q. The referral does not come from the emergency
6 room doctor directly?

7 A. That's correct.

8 Q. Now were you on call for the emergency room
9 referrals, did you have any type of on call
10 schedule that you were following?

11 A. We had two hematologist/oncologists in the
12 Parma facility. By and large a hematologic
13 problem, hematology/oncology problem would be
14 referred to me, a non hematology/oncologic problem
15 referred to my colleague. Sometimes, depending
16 upon who is available, depending on the preference
17 of internist, they may call different people. Yes,
18 one of us will be contacted.

19 Q. You've just confused me. If something came
20 in that was a hematology/oncology problem, it would
21 come to you, if it wasn't it would go to your
22 colleague; what type of things would be referred to
23 your colleague, what type of doctor is your
24 colleague?

25 A. He's a hematologist/oncologist.

1 Q. What type of cases would he get?

2 A. It's a very broad answer to tell you how many
3 various cancers are there, what goes to him, what
4 goes to me. I do not understand what you are
5 trying to ask me actually. This is a very detailed
6 way we function at our place. I will answer that
7 but --

8 Q. Let me --

9 A. Honestly, it will take such a long time we
10 will be talking about --

11 Q. Let me clarify my question.

12 A. That's good.

13 Q. You are a hematologist, your colleague is a
14 hematologist, correct?

15 A. Yes.

16 Q. If I understand you correctly, you said that
17 things coming into the emergency room that were
18 hematology or oncology would come to you. I would
19 think if you are both hematologists you both would
20 take care of hematology problems, I'm confused as
21 to what your colleague does?

22 A. Hematology/oncology is, as you know, are two
23 subspecialties combined together.

24 Q. Are you saying hematology/oncology as being
25 one area then? I think I can understand.

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

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

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

10 A. More often referred to me.

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

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

16 Q. I think I understand now.

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

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

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

3 Q. Are you readily available if they need you?

4 A. That's correct.

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

8 A. Say to me again, I am sorry.

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

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

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

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

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

5 A. I don't understand your question.

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

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

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

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

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

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

1 diagnosed with acute leukemia, would it be the
2 usual process to then make a referral to Cleveland
3 Clinic, Cleveland Clinic would then manage the
4 chemotherapeutic regimen for the patient?

5 A. Yes.

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

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

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

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

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

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

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

16 Q. Thank you.

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

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

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

23 A. Patient may not have any symptoms.

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

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

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

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

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

24 A. They may come without an infection.

25 Q. I understand that, Doctor. When a patient

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

4 A. In general respiratory infections are common.

5 Q. Leukemia patient, in acute leukemia patients?

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

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

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

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

22 A. You say majority?

23 Q. Yes.

24 A. Majority will not have symptoms.

25 Q. Recognizable symptoms more than three months

1 before their diagnosis?

2 A. They have recognizable symptoms, some
3 patients ignore their symptoms, I don't know.

4 Q. Doctor, if they are ignoring them they are
5 not recognizing them, right?

6 A. I'm not able to understand what you are
7 trying to get. I don't know how to answer your
8 question.

9 Q. Can we agree that patients with acute
10 leukemia may not recognize symptoms of their acute
11 leukemia more than three months before they are
12 diagnosed?

13 A. Some patients will. Some patients will come
14 and either you're not doing anything for infection,
15 some people will say I'm tired because of this, so
16 what I'm trying to tell you is patients may ignore
17 the symptoms. Most of the patients have symptoms,
18 they ignore them.

19 Q. Doctor, how much, when you are taking a
20 history from the patient, they tell you how long
21 they have been having some of these problems they
22 are not recognizing, how long before you see them
23 do they tell you they have had the symptoms, one
24 month, two months, three months, six months -- we
25 can't talk at the same time.

1 A. Take your time. Take your own time.

2 Q. When you take the history and report these
3 symptoms that they are not recognizing as being
4 part of an illness, how long before you actually
5 diagnose them are you able to identify they were
6 having these symptoms?

7 A. There are all kinds of patients, all few days
8 before I see a patient with lump in neck which
9 was --

10 Q. I only want to talk about acute promyelocytic
11 leukemia.

12 A. In acute promyelocytic leukemia or any other
13 diagnosis there can be patients who are different.
14 I couldn't give you a generalized answer or
15 specific answer for the way you are asking me, I am
16 sorry. I think you have to ask more specifically.
17 You are asking me a nonspecific question, you want
18 a specific answer. I think we are not going to go
19 anywhere with that.

20 Q. I'm not asking you to give me an answer for
21 every patient you see. I'm asking you about the
22 majority of patients, do they report symptoms that
23 are occurring for more than three months before you
24 diagnose them?

25 A. Say to me again.

1 MISS TOSTI: Read it back.

2 -----

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

9 -----

10 A. This relates to acute promyelocytic
11 leukemia?

12 Q. Yes.

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

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

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

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

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

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

17 MR. SWITZER: I think he
18 understood the question.

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

22 -----

23 (Recess had.)

24 -----

25 MISS TOSTI: Back on the

1 record.

2 BY MISS TOSTI:

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

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

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

16 A. Right.

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

19 A. That is part of the complete blood count.

20 Q. Blood smear you mentioned?

21 A. Right.

22 Q. And bone marrow?

23 A. And bone marrow.

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

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

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

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

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

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

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

20 Q. It would be examined under a microscope?

21 A. Correct.

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

24 A. Yes.

25 Q. Do you do this frequently in your practice?

1 A. Very frequently.

2 Q. What is a bone marrow aspiration?

3 A. Bone marrow is a jelly-like substance inside
4 the bone, we try to go through the bone to suck
5 this marrow. It is usually done on the bones which
6 are very close to the skin. Mostly in the past it
7 was done on the sternum, now done on the hip bone
8 which is very close to skin.

9 We numb the skin, numb the bone,
10 put the needle through the bone, suck the marrow
11 which is a jelly-like substance, make the smear of
12 it. Then we take what is called a core biopsy.
13 Sometimes we collect special samples for the
14 chromosome or genetic studies.

15 Q. How long does it take to do the bone marrow
16 procedure part of it?

17 A. The procedure for the physician it takes
18 about 15 to 20 minutes, but explaining to the
19 patient, get the signature, then clean the skin,
20 numbing the skin, numbing the bone marrow, waiting
21 for Novicaine to act to numb it, take the specimen,
22 make sure to see that the patient after that is not
23 bleeding and put on dressing, everything together
24 will take one hour and 15 minutes.

25 Q. Do you have the knowledge and expertise to

1 perform a bone marrow?

2 A. Yes.

3 Q. In regard to the slides and the specimens
4 that are obtained from a bone marrow aspiration, do
5 you have the knowledge and expertise to read and
6 interpret those slides and those stains that are
7 done?

8 A. I have knowledge and expertise to read the
9 bone marrow smears which are done by stain. I
10 don't have experience to read the special stains.
11 We usually need a super specialist to read special
12 stains or sometimes some pathologists do that.
13 Chromosome studies are done in highly specialized
14 labs.

15 Q. In regard to the smears that are done from
16 bone marrow aspiration, is this something that you
17 frequently read in your practice as a physician?

18 A. I do it quite often.

19 Q. If you don't do it, is there somebody in the
20 lab that would do that for you?

21 A. The bone marrow procedure is done by a
22 physician, it is done by me or by my colleague who
23 is certified in hematology/oncology.

24 Q. I want to talk about just the general
25 procedure.

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

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

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

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

13 A. I am sorry?

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

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

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

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

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

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

25 Q. If it was in your clinical judgment an

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

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

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

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

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

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

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

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

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

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

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

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

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

10 A. That is what I was trying to say.

11 MR. SWITZER: Let her
12 finish.

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

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

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

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

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

7 A. Yes, I do.

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

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

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

17 A. In general.

18 MR. SWITZER: Let her finish.

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

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

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

25 A. Right.

1 Q. Are you able to diagnose acute leukemia from
2 the blood smear, is that possible?

3 A. We can strongly suspect them. In most -- in
4 cases, certain cases you see leukemic cells on the
5 blood smear, you suspect it, there are conditions
6 in which it may not be leukemia, you may have
7 premature cells or leukemic cells. Then there are
8 some special characteristics that sometimes present
9 from which you can strongly suspect from blood
10 only. Sometimes you need diagnosis from the bone
11 marrow supporting.

12 Q. You agree in some patients examination of
13 bone marrow aspirate would be necessary to make the
14 diagnosis of leukemia?

15 A. Yes.

16 Q. Is a bone marrow necessary to determine the
17 proper subclassification of leukemia?

18 A. Yes.

19 Q. Can you determine a subclassification from
20 the peripheral blood smear?

21 A. You can suspect that it can be one of those
22 types but you never final diagnosis unless you have
23 done bone marrow and most of the time special
24 stains and sometimes chromosome studies too.

25 Q. What is acute promyelocytic leukemia?

1 A. This is such a broad question.

2 Q. Can you give me a general definition?

3 A. In the bone marrow certain white cells start
4 becoming neoplastic, meaning thereby that they
5 become malignant. When they are malignant they are
6 premature cells which become malignant.

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

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

18 When there are more promyelocyte
19 cells in the marrow it is you say a promyelocytic
20 leukemia, plus there are some chromosome studies
21 which are going in favor of them. Of course the
22 special stains can differentiate various kinds of
23 white cells, there are different kinds of white
24 cells, as you probably know.

25 Q. How do you diagnose acute promyelocytic

1 leukemia?

2 A. I just told you.

3 Q. Well, you need a blood smear?

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

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

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

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

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

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

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

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

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

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

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

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

25 The subtype diagnosis going to the

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

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

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

11 A. That's right.

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

16 A. 10 to 15 percent.

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

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

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

3 Q. Correct.

4 A. That can lead to hemorrhage.

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

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

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

17 A. Can you repeat the question?

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

23 A. Correct.

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

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

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

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

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

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

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

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

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

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

4 A. Any patient in which a diagnosis of acute
5 promyelocytic leukemia is made, beyond doubt if the
6 prothrombin time is more than three seconds off or
7 four seconds off, or if the red count is less than
8 20,000, even if the patient does not have active
9 persistent bleeding, people will give transfusion,
10 platelets and plasma support.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 Q. What does the term disseminated intravascular
13 coagulopathy mean?

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

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

25 So what happens is, coagulation

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

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

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

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

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

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

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

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

21 Q. Would you see anything like ecchymosis?

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

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

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

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

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

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

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

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

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

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

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

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

25 When patients start hemorrhaging

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

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

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

17 A. Correct.

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

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

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

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

5 A. Yes.

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

9 A. Yes.

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

13 A. Yes.

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

16 A. Acute promyelocytic leukemia, basically DIC
17 is a symptom of acute promyelocytic leukemia.
18 Acute promyelocytic leukemia is treated with
19 chemotherapy, which is special therapy. If the
20 specific chemotherapy for acute promyelocytic
21 leukemia is given, the patient can have more DIC at
22 that time, more cells are killed, more
23 procoagulants are released. Sometimes while taking
24 the treatment for the acute promyelocytic leukemia
25 you may kill the patient of DIC and hemorrhage, so I

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

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

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

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

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

19 A. Yes.

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

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

1 Q. Your clinical judgment, if the patient has
2 DIC, would it require that you treat the patient?

3 A. If patient has DIC, with a criteria which I
4 said, with frank hemorrhage, clinical criteria,
5 prothrombin time off for more than three or four
6 seconds, PTT high, platelet count less than 20,000,
7 things like that, by this criteria.

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

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

17 Q. Do you know what, approximately what
18 percentage of patients with acute promyelocytic
19 leukemia untreated develop brain hemorrhages?

20 A. I know the general hemorrhages are 30 to 40
21 percent, which is all kinds of hemorrhages. Brain
22 hemorrhage is a very well known complication of
23 acute promyelocytic leukemia in general. Most of
24 the hematologists know that.

25 Q. When a coagulopathy is present, in a patient

1 with acute promyelocytic leukemia, would you agree
2 that initiation of treatment, including the
3 platelets, fresh frozen plasma, possibly Heparin,
4 can significantly reduce the risk for brain
5 hemorrhage?

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

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

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

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

1 platelet count of 20,000 or less?

2 A. Or is persistently bleeding.

3 Q. Or persistently bleeding?

4 A. Then clinical tells me more than what lab is
5 telling me. I say persistent acute bleeding,
6 ecchymosis is not considered that kind of
7 persistent bleeding, I wanted to qualify that
8 statement very well.

9 Q. That's fine.

10 So we would not consider ecchymosis
11 to be an acute bleeding situation, as far as the
12 criteria for when to give platelets or fresh frozen
13 plasma?

14 A. I do not consider ecchymosis as a criteria of
15 acute bleeding for flesh frozen plasma and
16 platelets, per se.

17 Q. Doctor, if you have an acute leukemia within
18 your differential diagnosis, would you agree that
19 appropriate diagnostic tests should be undertaken
20 immediately to determine the subtype of leukemia
21 that is present?

22 A. As I told you, that next step in this kind of
23 setup is to do bone marrow. The bone marrow can be
24 done because bone marrow is the one which involves
25 a lot of things, which I mentioned to you in the

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

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

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

14 A. No.

15 Q. Let me --

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

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

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

4 A. Yes.

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

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

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

18 A. Yes, in reasonable time.

19 Q. If you have --

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

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

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

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

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

17 A. Right.

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

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

1 also red cells, packed cells or blood, give
2 platelets and plasma. Now then you can use another
3 10 or 15 hours to find what type of leukemia it is;
4 does that answer your question?

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

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

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

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

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

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

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

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

25 In other words -- okay, go ahead, I

1 think I answered your question.

2 Q. You are doing fine, Doctor.

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

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

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

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

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

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

5 A. Are you asking me about the chemotherapy?

6 Q. Right, the names of the drugs.

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

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

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

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

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

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

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

15 Q. I'm speaking initial response rate.

16 A. That is a little more in general. A little
17 more of these are initially going into remission,
18 40 to 50 percent.

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

22 A. Correct.

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

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

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

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

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

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

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

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

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

1 no answer.

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

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

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

11 A. You are asking acute promyelocytic leukemia?

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

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

19 Q. For acute promyelocytic leukemia?

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

23 Q. Those statistics were for acute myelocytic
24 leukemia?

25 A. General.

1 Q. Not specifically to acute promyelocytic?

2 A. I don't know specifically acute promyelocytic
3 leukemia.

4 Q. Doctor, in your own clinical practice how
5 many cases, just approximately, would you say you
6 have seen that were acute promyelocytic leukemia?

7 A. They come so sporadically, sometimes you
8 don't get a case for eight, 10 months, sometimes
9 you get two. I maybe have seen roughly eight to 10
10 cases in the last years I can recollect. I'm sure
11 I have seen a few more in my training, they were
12 not my patients, I have seen them or something like
13 that.

14 Q. I think you may have answered this already,
15 after a diagnosis of leukemia is made, acute
16 leukemia, would it be your usual practice then to
17 refer this patient out to say Cleveland Clinic for
18 chemotherapeutic treatment?

19 A. Yes, to a tertiary center.

20 Q. Do you do any type of chemotherapy in your
21 own practice?

22 A. Yes.

23 Q. Could you tell me a little bit about that,
24 what type of patients are these patients with
25 leukemia?

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

3 Q. You would treatment patients with chronic
4 leukemia?

5 A. In my practice at my place.

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

8 A. Yes.

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

11 A. Yes.

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

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

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

21 A. No.

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

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

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

5 Q. Do you know what time he called you?

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

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

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

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

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

1 Q. She told you that Mrs. Meeks was stable at
2 the time she talked to you?

3 A. Yes, she said stable. Yes, she stated she is
4 stable, alert, well oriented.

5 Q. She didn't have the blood work available?

6 A. She told me prothrombin is this, blood count
7 is this.

8 Q. Had there been any blood smears done at the
9 time she talked to you?

10 A. She didn't mention blood smears. I did not
11 even ask because I knew I was going to see the
12 patient.

13 Q. At the time you talked to Dr. Narra did you
14 have a suspicion of any particular problem that
15 Mrs. Meeks might have?

16 A. I knew one thing with that kind of blood
17 count, I have to see the patient as soon as she
18 comes out from the CAT scan and other things, as
19 soon -- it was 4:15, usually I finish my office
20 5:00, 5:30 with that blood count, I told her -- she
21 was asking me if -- she was thinking giving her a
22 transfusion, checking with me. I said yes, give
23 the transfusion, I will see the patient.

24 Q. What was the purpose of the blood
25 transfusion?

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

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

7 A. Information I got from Dr. Narra.

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

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

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

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

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

17 A. Correct.

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

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

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

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

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

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

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

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

25 Q. What time did you arrive at the hospital then

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

3 A. I was in the hospital.

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

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

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

14 A. Yes.

15 Q. What was your evaluation of the blood smears?

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

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

1 A. No.

2 Q. What was the quality of the smears that you
3 looked at?

4 A. I think the smears were a little thick, I
5 could see the rods I was talking about.

6 /HAUR /SRER rods, I could see to my
7 satisfaction. I did not see any hour rods. For
8 hour rods I will say that quality was not good
9 overall. It did show the cells which were
10 premature.

11 Q. You had said you wanted additional smears
12 made; is that correct?

13 A. Yes, there is one thing which I wanted to do,
14 was to make a buffy coat. Do you know what a buffy
15 coat is.

16 Q. Why don't you tell me.

17 A. The buffy coat is -- see, leukemia patients
18 can present with many white cells, 100,000, 80,000,
19 at that time is very easy to see the cells in the
20 microscope because there are so many, get more
21 idea.

22 Leukemia patients can present with
23 a normal blood count or low count, could be at the
24 time you don't have enough to look at. You keep
25 the blood in a tube in which we draw the blood,

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

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

13 A. No, we can make smears from that.

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

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

20 Q. Were the smears then made at that time?

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

1 Q. Did they make more smears?

2 A. I did not go down immediately to see anymore
3 smears, whether they made some more smears or not
4 at this time I do not know, because patient died
5 next morning, as you know. Next morning she was
6 transferred. We had some more blood the next
7 morning, we had some smears from.

8 Q. So you don't know whether or not additional
9 smears were made?

10 A. I don't know whether or not additional smears
11 were made by the technician at that time or not.

12 Q. You did not go down and look at any
13 additional smears on the evening of July 18th?

14 A. Right.

15 Q. Did you do your own examination of
16 Donna Meeks when you went to the hospital, did you
17 do a physical examination of Donna Meeks?

18 A. Yes.

19 Q. What did you find when you did your physical
20 examination?

21 MR. SWITZER: You can refer
22 to the notes, not asking him if he remembers, are
23 you?

24 Q. No, please feel free to refer to the notes,
25 indicate to me which page you are looking at so I

1 can look at that same one.

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

4 A. It says 6:00 p.m.

5 Q. Looking at your progress note?

6 A. Right.

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

25 Q. Is this the sum total of your findings on

1 your evaluation?

2 A. Yes.

3 Q. Do you recall anything else about that
4 evaluation that isn't recorded here?

5 A. Patient was fully alert, oriented, talked to
6 me, there was no neurological deficit I could see,
7 gross neurological deficit I could see is what I
8 would like to add.

9 Q. Was there any indication consistent with a
10 brain bleed at the time you examined her?

11 A. When I saw, no.

12 Q. Do you have an opinion as to what caused her
13 lightheadedness or headache or her blurred vision?

14 A. I think anemia which was probably secondary
15 to leukemia, anemia which was secondary to leukemia
16 can give headaches and like that, I think that
17 might be the cause.

18 Q. How about I believe she had a nosebleed
19 earlier in the morning -- let me finish -- did you
20 have an opinion?

21 A. I wasn't talking, I was seeing this.

22 MR. SWITZER: Let her finish
23 the question. Better start over, I am sorry.

24 Q. In regard to the nosebleed she reported
25 earlier in the morning, do you have an opinion as

1 to what caused that nosebleed?

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

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

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

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

25 A. Okay. The ecchymosis can be present in any

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

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

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

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

16 A. That might be contributing to that.

17 Q. What else can be contributing to?

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

22 Q. But in her case?

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

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

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

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

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

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

17 Q. Acute leukemia?

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

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

22 A. At that time, no.

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

25 A. That was most likely the diagnosis at that

1 time.

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

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

6 THE WITNESS: I did finish.

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

9 MISS TOSTI: Read it back.

10 -----

11 (Question read.)

12 -----

13 A. Myelodysplasia, acute leukemia.

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

16 A. Acute leukemia.

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

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

21 MR. SWITZER: Off the record.

22 -----

23 (Recess had.)

24 -----

25 BY MISS TOSTI:

1 Q. Doctor, I'm going to hand you what has been
2 marked as Plaintiff's Exhibit 1, I would like you
3 to identify it, I believe it's a copy of the
4 progress notes you just read?

5 A. That's right, okay.

6 Q. You need to tell the court reporter if that
7 is indeed a copy of your progress report?

8 A. Yes, it is.

9 Q. From July 19th at 6:00 p.m.?

10 A. Yes.

11 Q. Doctor, after you examined Donna Meeks that
12 evening, did you believe her to be in any type of
13 an acute oncologic emergency?

14 A. No.

15 Q. The evening of the 19th when you examined
16 her, you were of the opinion that within your
17 differential diagnosis there was a high probability
18 for acute leukemia; is that correct?

19 A. Yes.

20 Q. You did not know what the subtype was the
21 evening of the 19th; is that correct?

22 A. Yes.

23 Q. Did you take any action whatsoever to
24 determine the subtype of the leukemia that night
25 on July 19th?

1 A. As I told you before, the plan was to do the
2 bone marrow next morning.

3 Q. Did you take any action the evening of the
4 19th to determine the subtype?

5 A. No.

6 Q. Doctor, the evening of the 19th when you came
7 in you said that you did look at the blood smears,
8 that you also reviewed the blood work that was
9 done, including the complete blood count and
10 differential; is that correct?

11 A. That's right.

12 Q. Do you know whether or not the blood smears
13 slides are still in existence or any type of a film
14 from those slides?

15 A. I couldn't answer that right now without
16 inquiring with them.

17 Q. Just generally do you know if Kaiser keeps
18 blood smears for any particular length of time
19 after they are produced?

20 A. I do not. The pathology department would
21 know that.

22 Q. Doctor, I'm going to hand you what is marked
23 as Plaintiff's Exhibit 3 and Plaintiff's Exhibit 4,
24 which are laboratory report sheets. Plaintiff's
25 Exhibit 3 has the date of 7-21-93 on the bottom, as

1 does Plaintiff's Exhibit 4.

2 MR. SWITZER: Did we have
3 a 2?

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

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

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

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

13 A. Yes.

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

17 A. Um-hum.

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

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

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

3 Q. Yes.

4 Did you not have the computer
5 printout to look at?

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

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

10 A. No.

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

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

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

22 A. I want to make a correction.

23 MR. SWITZER: Let her
24 finish.

25 A. I am sorry.

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

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

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

22 Q. Let me ask you about Exhibit 4 then.

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

1 the evening of July 19, 1993?

2 A. These printouts of Exhibit 4 were not
3 available to me at six o'clock on the day I
4 examined the patient.

5 Q. But you indicated you had read the smears
6 yourself?

7 A. Yes, I did indicate that I had looked at the
8 smears myself, which gave me the information I
9 wanted.

10 Q. Now if you will take a look at Exhibit 3 and
11 Exhibit 5, you will see under the differential that
12 Exhibit 3, which originally appeared on the chart
13 report that -- let me find mine.

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

19 Did either of these lab reports
20 have any impact at all on your diagnosis of
21 Mrs. Meeks, were they available to you at the time
22 you saw the patient?

23 A. As I said, Exhibit 3, 4 and Exhibit 5 was not
24 available to me at six o'clock on the day I
25 examined Mrs. Meeks.

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

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

8 Q. The amended report.

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

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

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

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

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

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

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

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

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

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

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

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

22 A. Differential by machine is done after the
23 blood is drawn, if marked stat in a half an hour,
24 40, 35 minutes available if stat. If it is
25 routine, comes from the medical offices, it will be

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

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

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

20 MR. SWITZER: What was the
21 question?

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

25 A. I was saying that the prothrombin time was

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

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

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

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

12 Q. Was there an indication of coagulopathy?

13 A. Coagulopathy is defined in such a way you
14 require some other thing before I will say it is
15 prolonged.

16 Q. That's the indication of coagulopathy?

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

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

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

1 that's an indication of coagulopathy or not.

2 Q. If you are unable to answer the question,
3 Doctor, it's fine to say that you are unable to
4 answer the question. I'm looking for a yes or no
5 or I don't know or I can't answer the question.

6 A. There is no yes or no answer. I cannot
7 answer the question start saying yes or no
8 coagulopathy. The PT is prolonged 2.6 seconds,
9 PTT normal, no gross evidence of thrombosis.
10 Coagulopathy is when there is bleeding. You are
11 using such a vague term, coagulopathy is a vague
12 term. A term which is used more is thrombosis used
13 for hemorrhage. Coagulation goes in both
14 directions which is a contradiction, you are using
15 the word coagulopathy as something in bleeding --
16 let me give you an example.

17 I don't need to go to the lab if
18 there is bleeding. I could see they are bleeding.
19 The terminology are you using is not something
20 which has yes or no answer. I couldn't answer your
21 question.

22 Q. Was the diagnosis of disseminated
23 intravascular coagulation within your differential
24 diagnosis on the evening of July 19, 1993?

25 A. It does suggest that some coagulation problem

1 was initiated.

2 Q. You would agree then that you needed to watch
3 Mrs. Meeks very carefully for signs of bleeding
4 disorders or other coagulation disorders?

5 A. Yes.

6 Q. Did you, in your clinical judgment, believe
7 she required any treatment for coagulopathy, DIC or
8 any other clotting disorder on the evening of
9 July 19th?

10 A. At six o'clock in the evening when I saw the
11 patient I did not see any need for any treatment
12 for what you term as coagulopathy.

13 Q. When you got to the hospital after you had
14 done your evaluation and had looked at the blood
15 smears in the lab, did you discuss Mrs. Meeks with
16 anyone at the hospital, did you talk with Dr. Narra
17 or Dr. Blockstorf or Dr. Urso?

18 A. No.

19 Q. What is Dr. Urso's specialty?

20 A. Dr. Urso is a radiologist.

21 Q. Do you happen to know why Dr. Urso was
22 consulted by the emergency room doctor about
23 Mrs. Meeks' care?

24 A. I presume she must be the doctor that read
25 the scan that day or on duty or in charge or on

1 call, whatever you want to say.

2 Q. What was the significance of a platelet count
3 of 33,000?

4 A. It means that it is a low platelet count.

5 Q. If there is a low platelet count does that
6 increase the risk for bleeding?

7 A. Usually the normal platelet count is 150,000
8 to 300,000, usually no bleeding. When the platelet
9 count is 50,000 people can undergo major surgery,
10 with a platelet count of 75,000, with a 60,000
11 count patients can undergo major surgery. Patients
12 do not usually bleed of any kind when they are
13 50,000 or 60,000. If it is less than 40,000, they
14 may have black and blue marks or bruises, not
15 persistent bleeding. Less than 20,000 the chances
16 of bleeding persistently are more.

17 Q. Doctor, listen to my question: Does a low
18 platelet count in the range of 33,000 increase the
19 risk for bleeding as compared to a patient with a
20 normal platelet count?

21 A. At 33, yes, it increases the tendency for
22 bleeding as compared to a normal count.

23 Q. Does a patient who has a prolonged
24 prothrombin time as Mrs. Meeks had the evening of
25 July 19, 1993, does that -- was she at increased

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

3 A. Yes.

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

7 A. No.

8 Q. Why not?

9 A. Because that is the standard recommendation.

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

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

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

17 A. Yes.

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

21 A. Yes.

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

1 and a normal prothrombin time?

2 A. Yes.

3 Q. What was the purpose for ordering the blood
4 transfusion for Mrs. Meeks on the evening of
5 the 19th?

6 A. Because Mrs. Neeks was symptomatic from the
7 anemia, having headaches, she was light-headed, she
8 was not feeling well, she was weak for two months,
9 shortness of breath on activity, these are all
10 symptoms of anemia. Generally patients are
11 transfused with all the symptoms that -- hematocrit
12 is less than 25, her hematocrit on admission
13 was 70.9, that makes all standard criteria of blood
14 transfusion in this setup.

15 Q. Doctor, I'm handing you what has been marked
16 as Plaintiff's Exhibit 2, which has doctor's orders
17 written at the top for the date of July 18, 1993,
18 you may want to look at your original, it may be a
19 little clearer. That's not the original, this is a
20 COPY.

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

1 A. Yes.

2 Q. What is the purpose of giving Decadron in
3 this instance?

4 A. When we give a blood transfusion, in spite of
5 being crossmatched correctly there are some chances
6 of getting what we call reaction, putting into
7 coma, fever, chills, things like that, this can be
8 taken care of two ways; some patients are referred
9 to Benadryl before the blood transfusion, some
10 people do Decadron, a long acting Cardizem type
11 substance which can prevent these reactions. That
12 was the sole purpose of giving that Decadron before
13 transfusion, which is standard practice in our
14 transfusion site.

15 Q. Would Decadron have any effect of increasing
16 the risk for bleeding in a patient with acute
17 promyelocytic leukemia with a prolonged prothrombin
18 time and a low platelet count of 33,000?

19 A. Four milligrams of Decadron given once will
20 not have any effect of anything you have said.

21 Q. On the evening of July 19th did you speak to
22 any member of the Meeks family when you were at the
23 hospital?

24 A. Mo.

25 Q. Did you speak with Donna Meeks during the

1 time that you did your physical assessment of her?

2 A. Yes.

3 Q. The history that you recorded in your
4 progress note, was that given to you by
5 Donna Meeks?

6 A. Yes.

7 Q. Doctor, on the order sheet that you are
8 looking at, that is marked as Plaintiff's
9 Exhibit 2, on the top portion of the page, I would
10 like you to look at that. Do you recognize that as
11 Dr. Narra's writing?

12 A. Yes, these are in Dr. Narra's writing.

13 Q. Near the end of his entry it mentions
14 hematology consult with Dr. Sutaria, then it looks
15 like another consult with another doctor, are you
16 able to make out who the other doctor is?

17 A. That is Dr. Manning.

18 Q. Is that M-a-n-n-i-n-g?

19 A. I presume. I know there is one Dr. Manning.

20 Q. What type of doctor?

21 A. He's an eye specialist.

22 Q. Doctor, the orders at the bottom of the page
23 are in your handwriting; is that correct?

24 A. Um-hum.

25 Q. Would you read to me what you've written on

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

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

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

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

13 A. Thrombin time.

14 Q. F?

15 A. F is serum fibrin split product.

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

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

22 Q. Then under G?

23 A. G, urine fibrin split product.

24 Q. Why did you order those three tests?

25 A. I ordered those three tests because they are

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

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

9 A. That was my concern.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Q. Would there be any type of instance that you
2 would have considered transfer of Mrs. Meeks, any
3 particular complication or any other findings that
4 might have caused you to arrange a transfer the
5 evening of the 19th? Had she had a definite
6 coagulopathy would that have been an indication for
7 transfer on the 19th?

8 A. At that time I was seeing her there was no
9 indication for transferring her immediately.

10 Q. I'm asking what would be an indication for
11 transfer on the 19th?

12 A. For Mrs. Meeks at the time there was no
13 indication for transferring her immediately.

14 Q. I understand that is what your answer is.

15 If she had under your criteria a
16 definite DIC or coagulopathy would that be an
17 indication for transfer?

18 A. I did not have any criteria at that time,
19 blood count, prothrombin time.

20 Q. Doctor, I understand that. You had given me
21 a criteria before saying that if the platelet count
22 was below 20,000 or the prothrombin count was three
23 to four seconds elongated, this would be indication
24 of a coagulopathy. If those were present would
25 that be an indication to transfer the patient to

1 the Cleveland Clinic?

2 A. What you mention were the indications of
3 supporting therapy by platelets and plasma, that
4 would have been supporting therapy for that, that
5 was not present at that time, so supporting therapy
6 was not given. You can ask me.

7 MR. SWITZER: Hold on. I
8 think what she wants to know is with Mrs. Meeks,
9 give her an example what kind of condition or
10 symptom or signs or anything. I know it didn't
11 happen. Hypothetically if Mrs. Meeks had some
12 other type of symptom, what would it have to be in
13 order for you to have ordered a transfer of
14 Mrs. Meeks to the Cleveland Clinic the evening of
15 the 19th? I think that is what she wants to know.

16 A. What kind of situation are you thinking of
17 which you are asking me such a broad question? Let
18 me ask you, tell you this way: I can very easily
19 treat her with plasma and platelets. That would
20 not have been reason to transfer her.

21 Q. Okay.

22 A. We could do that. Not knowing what kind of
23 conditions are you thinking of which will make an
24 immediate transfer, can you tell me a couple of
25 things, then I can answer. That is a broad

1 question.

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

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

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

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

23 MR. SWITZER: How about an
24 intracerebral hemorrhage?

25 A. There is none that is emergency we had to

1 transfer the patient.

2 Q. Is that one instance where you would transfer
3 the patient?

4 A. We transferred the patient with that
5 complication. I was not able to understand what
6 you are trying to ask me. I think you are knowing
7 the patient was transferred to the Cleveland Clinic
8 for intracerebral hemorrhage.

9 Q. Doctor, I'm aware the patient was
10 transferred, I don't know what the indications for
11 the transfer were, that is why we're here taking
12 your deposition.

13 A. Okay.

14 Q. On the evening of July 19th did you give any
15 particular instructions to the nursing staff to
16 monitor for any particular complications in the
17 case of Donna Meeks?

18 A. They usually take certain vital signs on a
19 routine basis, which are the classic --

20 Q. I'm asking did you give any specific
21 instructions to the nursing staff to monitor this
22 patient?

23 A. No, other than the usual instructions which
24 are to the nurses for any patient.

25 Q. After you finished your examination of

1 Donna Meeks and writing orders, what did you do?

2 A. After finishing?

3 Q. After the examination, after writing orders,
4 what is the next thing you did?

5 A. Let me ask you one thing.

6 Whether you are asking me I did
7 talk to Donna Meeks is what you want to know?

8 Q. You told me you talked with her when you
9 examined her?

10 A. Okay, after I finished examination with her I
11 talked to her, then I came down and wrote down the
12 orders.

13 Q. Then after you finished the orders what did
14 you do?

15 A. After finishing the orders I went back to my
16 office, did certain work which I had to finish for
17 the day, then I left.

18 Q. Approximately what time did you leave the
19 area where Donna Meeks was the patient?

20 A. I was there at six o'clock, I started writing
21 orders, I think I was there through approximately
22 6:25, 6:30.

23 Q. Would it be correct to say at the time you
24 left the hospital you had not identified the
25 subtype of leukemia that Donna Meeks had?

1 A. Yes, I had not identified.

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

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

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

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

10 A. Can you repeat the question?

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

13 A. I was not contacted.

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

17 A. No.

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

20 A. No.

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

23 A. No.

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

1 MR. SWITZER: Let her
2 finish.

3 A. I came in around 8:30, I don't know the time,
4 8:25 or 8:35, went to the floor, found that she was
5 transferred.

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

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

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

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

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

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

1 Q. Would you agree headache and vomiting are
2 signs frequently associated with brain hemorrhage?

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

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

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

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

16 A. Say to me again.

17 MR. SWITZER: Which condition
18 are you talking about?

19 MISS TOSTI: Her brain
20 hemorrhage and ultimate death.

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

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

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

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

8 A. I couldn't.

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

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

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

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

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

20 Q. No, that's okay.

21 Were you consulted about the
22 transfer prior to transfer?

23 A. No.

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

1 to transfer her to the Cleveland Clinic?

2 A. Let me tell you, you know very well I was not
3 here.

4 Q. I'm wondering if any doctor --

5 MR. SWITZER: Subsequently?

6 A. Subsequently I know that patient had vomiting
7 and headache, she went down for CAT scan, CAT scan
8 was read as hemorrhage. I know the doctor, the
9 neurologist saw the CAT scan, was the one who got
10 the report or read the CAT scan or somebody else
11 read for her. From there, later on, I knew that
12 along with viewing the CAT scan, Dr. Kamenar, the
13 doctor on call, must have decided to transfer the
14 patient. I think mostly must be Dr. Kamenar
15 suggested to actually transfer the patient or
16 transferred the -- I can't tell you exactly.

17 Q. What is Dr. Kamenar's specialty?

18 A. Neurology.

19 Q. Did you ever speak to any of the Cleveland
20 Clinic physicians regarding Donna Meeks?

21 A. After the transfer, yes.

22 Q. When did you do that?

23 A. I called when I came in, 8:30 I knew she was
24 already transferred, taken care of, I went to my
25 office, saw some patients, around 9:30, 9:45, I

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

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

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

15 A. Prior to that?

16 Q. In regard to Mrs. Meeks' care?

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

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

1 the 19th did you call Cleveland Clinic at all?

2 A. I'm --

3 Q. I'm going to ask you to tell me yes or no,
4 did you call on the evening of the 19th?

5 A. On the evening of the 19th I did not call the
6 Cleveland Clinic.

7 Q. On the morning of the 20th, after you came
8 in, you called Cleveland Clinic, you talked to the
9 neurology department?

10 A. Um-hum.

11 Q. Did you you also that morning make a call to
12 the hematology department?

13 A. Hematology/oncology department.

14 Q. Your two calls to the Cleveland Clinic were
15 both made on the 20th?

16 A. After the patient was transferred and already
17 there.

18 Q. Do you have an opinion as to what caused
19 Donna Meeks' leukemia?

20 A. I don't.

21 Q. Are you aware of any history, family history
22 of leukemia that was evidenced in the history that
23 you took?

24 A. I don't remember asking detail about the
25 family history at that time.

1 Q. You don't remember whether you inquired?

2 A. I don't remember whether I asked in that
3 detail or not at that time family history of
4 leukemia, I do not remember.

5 Q. Do you have an opinion as to whether or not
6 Donna Meeks' brain bleed was preventable?

7 A. Say to me again.

8 Q. Do you have an opinion as to whether or not
9 Donna Meeks' brain bleed was preventable?

10 A. I don't think it was preventable.

11 Q. What is the basis for that opinion?

12 A. Because this can happen to these patients any
13 time. I would not -- nobody would have given her
14 anything to prevent that at that time. This can
15 happen in patients. There are patients who come in
16 bleeding, an intracerebral hemorrhage, there are
17 patients bleeding when they are transported,
18 patients who are bleeding after the transport,
19 there are patients who have cerebral hemorrhage
20 after the chemotherapy. This can happen at any
21 time. This can happen for reasons other than the
22 coagulopathy because we don't know what is wrong in
23 the brain. We don't have the post mortem.

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

1 process.

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

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

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

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

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

1 Q. Are you critical of anyone that rendered care
2 to Donna Meeks at Kaiser or Cleveland Clinic?

3 A. No.

4 Q. Have you covered all of the opinions you
5 presently hold relative to Donna Meeks' care and
6 treatment?

7 MR. SWITZER: Wait a minute.
8 I don't think he needs to -- that is kind of an
9 open-ended question. He may have other opinions
10 down the road when I talk to him some more.

11 MISS TOSTI: I asked whether
12 he presently holds.

13 MR. SWITZER: You can answer
14 yes or no. She covered everything pretty
15 thoroughly in this deposition.

16 A. I do not understand. Actually I do not
17 understand what are you trying to tell me? Can you
18 tell me again the question, tell me what comment
19 Don made?

20 -----

21 (Record read.)

22 -----

23 MR. SWITZER: Say **yes** or no,
24 whatever the answer is.

25 A. I really do not understand the question. I

1 do not understand the question.

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

8 MR. SWITZER: I'll just say
9 yes.

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

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15 (Deposition concluded; signature not waived.)

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ERRATA SHEET

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LINE

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

VINODKUMAR SUTARIA, M.D.

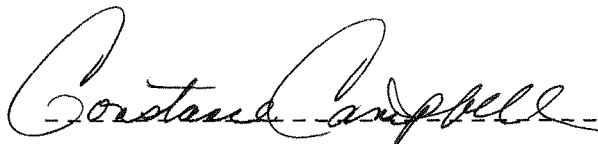
1 The State of Ohio,
2 County of Cuyahoga.

CERTIFICATE:

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

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

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

21 
22 -----

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

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