State of Ohio,
County of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

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William C. Tracek, Admr., Plaintiff	)	
vs.	)	Case No. 400269
Kaiser Permanente, et al., Defendants.	)	Judge Peggy Foley Jones

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DEPOSITION OF ARNOLD J.M. VOGTEN, M.D., Ph.D.

Monday, January 15, 2001

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The deposition of ARNOLD J.M. VOGTEN, M.D., Ph.D., a witness herein, called on behalf of the Plaintiff for examination under the Ohio Rules of Civil Procedure, taken before me, Kristin A. Beutler, a Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at Kaiser Permanente, 10 Severance Circle, Cleveland, Ohio, commencing at 4:00 p.m., on the day and date above set forth.

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APPEARANCES:

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ARNOLD J.M. VOGTEN, M.D., Ph.D.

the witness herein, called by counsel on behalf of the plaintiff for examination under the Rules, having been first duly sworn, as hereinafter certified, was deposed and said as follows:

EXAMINATION

BY MR. NORTON:

Q. Doctor, will you tell me your full name, please.

A. My name is Arnold Vogten, Arnold J. M. Vogten, V O G T E N .

Q. And you are a medical doctor?

A. That's correct.

Q. And you specialize in gastroenterology?

A. That's correct.

Q. Are you Board certified in the United States in gastroenterology?

A. I'm Board certified, not Board certified in the United States.

Q. Board certified in the Netherlands?

A. Yes, not in the United States.

Q. When did you become Board certified in gastroenterology in the Netherlands?

A. '77.

Q. 1977?

A. Yes.

Q. You're a member of the Ohio Permanente Medical Group?
A. That's correct.
Q. When did you become a member?
A. Since '91, February 1991.
Q. Do you have an employment contract with the Ohio --
A. That's correct.
Q. -- Permanente Medical Group?
A. Yes, that's correct.
Q. I think Steve will tell you that we're going to get along, so far as the court reporter is concerned, a lot better if you take a minute after I ask the question before you answer, otherwise we start racing and she can't pick it all up.
A. I'll do my best.
Q. Just relax.
Is that contract one that's renewable yearly?
A. Yes.
Q. And when each year is it renewable?
A. If nothing happens, it will --
Q. Automatically?
A. -- automatically be renewed, yes.
Q. And does that contract spell out your duties to some degree?
A. Yes.
Q. And those duties, more specifically, would be in the

area of patient care?
A. Patient care in the area of gastroenterology and liver diseases.
Q. Now, are you compensated for your services by the Ohio Permanente Medical Group?
A. That's correct.
Q. Are you on a salary, fixed salary?
A. Yes, that's correct.
Q. Is it a yearly salary?
A. It's a monthly salary.
Q. Monthly salary. Your income isn't dependent on the number of patients you care for?
A. In no way.
Q. And your income is reported on what, a W2?
A. W2, yes.
Q. Now, do you see any patients privately, or are all of your patients Kaiser patients?
A. All our patients are Kaiser patients, yes.
Q. Do you personally keep a record on the patients you treat?
A. I keep all the records on the consult patients that I see, yes, in the hospital.
Q. What --
A. Otherwise, I rely on the Kaiser medical records.
Q. What do you call the record that you keep on patients

you see on a consultant basis?
A. This is the example from one patient, lists very briefly when I have been called about a patient, what the diagnosis is, and what further workup should be done of this patient. Basically a reminder, if we see a patient one or two days later, I want to know what they had done before.
Q. Now, is this one page record that you referred to that's on the table in front of you, is that a record that you keep personally, that you have constructed for yourself, or is it one that Kaiser mandates that you keep on each patient?
A. It's a personal record, yes, that's correct.
Q. Except for your personal record, then, you rely exclusively on Kaiser records?
A. Yes, that's correct.
Q. For patients that you treat not only on a consultant basis, but I presume others that you see directly?
A. Correct, yes, yes.
Q. And when I say "see directly," they are Kaiser policy holders who come to you for gastroenterology service direct1y?
A. That's correct.
Q. As opposed to being referred by another Kaiser doctor?
A. I would say that most of our patients are referred by other Kaiser doctors, 95 percent at least.

Q. In terms of the kind of records that Kaiser keeps, are we talking about Kaiser Permanente Medical Group or Kaiser Foundation, or is there a difference?
A. Kaiser Foundation Health Plan is the insurance company that builds the building, has the computers and does everything. OPMG, Ohio Permanente Medical Group, is the group of medical doctors that have the medical care responsibilities, and they rely on Kaiser Foundation for their equipment, for the personnel, for their arrangements.
Q. And for their compensation?
A. Compensation is from OPMG, Ohio Permanente.
Q. But, I mean, OPMG gets its compensation from Kaiser Plan?
A. Yes, that's correct.
Q. So when we speak of patient records, those are records that, in terms of patient care, that OPMG maintains?
A. That's correct.
Q. And --
A. I should correct this. Kaiser Health Plan maintains it for OPMG.
Q. What do these records consist of?
A. We have, for all outpatients, we have computerized records.
Q. For outpatients?
A. For --

Q. Hospital patients?
A. Hospital patients. We have documentation, charts, a medical chart that's basically, the way we now work, that's given by the Clinic, they have the formality for the Cleveland Clinic charts and we use those charts.
Q. Would the Kaiser record, if referred to, also in addition to outpatient visits and treatments by Kaiser doctors, would it also reflect a given hospitalization?
A. Could you repeat the question?
Q. Let me back up on it. Is the record that Kaiser keeps on all outpatients, what you told me, is that some computerized record?
A. That's correct.
Q. And does the computerized record also contain a reference to those times when a Kaiser patient was hospitalized?
A. Yes, we have discharge notes and in the medical record are examples of that. We use discharge notes, they go directly into the medical record as soon as the patient comes back.
Q. Can you as a treating physician access a patient's computerized record?
A. Yes, I can, yes.
Q. Do you have to be at a given location to do that, or can you do it from the hospital?

A. I can do it in all the facilities, I can do it in the hospital. It excludes x-ray, CT scan, only is the written documentation about the patient, that's the only thing.
Q. It would report that there was an x-ray?
A. If there would be a report of an x-ray, this report of the x-ray would go into the documentation, that's correct, but not the x-ray itself.
Q. Is this record maintained in any particular record, is it chronological, or is it by illness?
A. It's by, yes, it's chronologically in all cases, yes.
Q. At what locations, Doctor, do you provide medical service to Kaiser patients?
A. Most of the time I work in this location, Cleveland Heights Medical Center, and approximately 25 percent of my time I spend in The Cleveland Clinic, where **I** see inpatients on a consultancy basis.
Q. Are you a member of any particular subgroup of Ohio Permanente Medical Group, subspecialty?
A. We have a department of gastroenterology, yes.
Q. Department?
A. Yes, that's correct.
Q. The department of gastroenterology?
A. That's correct.
Q. What locations does your department of gastroenterology cover besides 10 Severance Center?

A. We have two areas, Severance is one, this is the one, and the other one is Parma, Snow Road in Parma.
Q. How about The Cleveland Clinic?
A. For inpatients, yes, but I'm talking about outpatients. Then we have all the satellites, but in the other offices there are no gastroenterologists, so for any GI consultation a patient will go to one of these two locations.
Q. Snow or here?
A. Snow or here, yes.
Q. From time to time, do you go to the Snow Road facility?
A. No, I usually see patients from the east side, and in general patients will be seen by the west side gastroenterology if they live on the west side, except for emergencies, then we cross town, but --
Q. So you gon't go there on a routine basis, to Snow Road?
A. That's correct, I don't go.
Q. Now, is the Snow Road facility similar in its layout to this facility here at 10 Severance Center?
A. It's much nicer.
Q. Which is nicer?
A. This is much nicer. No, they are the same. We have offices, there's a specific area where there are two gastroenterologists that see the patients, there are exam rooms, and they have about four endoscopy suites, and that's basically the same here. But if you want to compare them on

a floor plan, it's different.

Q. Does the Snow Road facility have the capability of taking care of a patient overnight or over two or three nights?

A. Yes, we have a Clinical Decision Unit where we can admit patients in case of emergencies, and the limit is currently, I think, still 24 hours. Then we make up our mind or we have to decide whether the patients go to inpatient status in The Cleveland Clinic or whether they go home.

Q. Now, when a patient is admitted to the hospital, say a Kaiser doctor decides to admit a patient to the hospital, is there more than one hospital that he can choose, or do you have --

A. At this moment it's Cleveland Clinic. If people go for emergency reasons to another hospital in the city, then in general they will be transferred to the Clinic as quick as they are transferable.

Q. So in order for a patient to be admitted to Cleveland Clinic, a Kaiser patient, they would have to have an admitting order from a Kaiser doctor?

A. In general, yes.

Q. Unless they went through the emergency?

A. Unless through the emergency room, yes.

Q. And when a patient is so admitted on the order of a Kaiser doctor, then the patient is said to be on the service

of that doctor; is that correct?
A. No, not necessarily.
Q. What does that mean?
A. For all the subspecialties, patients are on service -- let's say the internists, subspecialties like cardiology, oncology, cancer treatment, and gastroenterology, they are on the internal medicine service. So a patient would be admitted for me as a treatment, then he or she would be admitted for internal medicine service, and they do the admission and the discharge and they ask me to consult on the patient.
Q. So your name wouldn't appear as the admitting doctor?
A. No, no.
Q. In that scenario, what type of doctor would be the admitting doctor?
A. One *of* the internists.
Q. And that doctor would sign the admitting order?
A. Sign the admitting order.
Q. What responsibility would that doctor have for a patient who's admitted to the hospital to be looked after on a consultation basis, say by gastroenterology?
A. Internal medicine has a general overview. They are responsible for diagnostic workup, they are responsible for general treatment, medical treatment, they're responsible for discharge. They're basically responsible for everything that

this patient needs in that specific time during admission.

If I do a consult, I explain through my reports, otherwise, what I found, my idea, what my conclusions were, then I give advice for treatment.

Q. To the internal medicine service?

A. To the internal medicine doctor. I would not write my own prescriptions in the Clinic, but I would advise for the internal medicine doctors to treat, or this, or this, or this.

Q. In that circumstance, say if you recommended a certain gastroenterology procedure, before you were authorized to do it you have to have the approval of the internal medicine?

A. No, it doesn't work that way.

Q. How does it work?

A. It works this way, they ask me, they have to have a specific problem or symptoms or laboratory abnormalities, and then they ask me for advice on diagnostic workup or treatment or both.

Q. And they accept your advice?

A. In general, yes. If they have good arguments to do it differently, then usually we communicate this. If there are other medications, for instance, then we communicate this.

Q. Now, can you tell me what records you reviewed in preparation for today's deposition?

A. I reviewed medical records of this patient.

Q. Which ones, though?
A. All medical records from The Cleveland Clinic and all medical records we have from our Kaiser system.
MR. HUPP: He actually pulled out the ones he wanted to keep and kept them, but he's seen pretty much everything in July and August, no nursing home records, and I don't believe he saw the final admission, but he did see the autopsy.
A. This second admission was in the Clinic record too, I believe, but anyway, I have seen the autopsy report.
Q. Were you generally aware of the computerized record on this patient?
A. In general, if I see a patient, then the computerized record, as far as relevant, will be printed out, yes.
Q. Did you review that in preparation for this deposition?
A. No, only the documentation that is in the medical records, paper.
Q. When you were in fact treating this patient, Alice Tracek, did you have some reference to the computerized record?
A. Yes.
MR. HUPP: To be complete, I also gave him Dr. Owen's deposition that he's --
Q. So in fact, then, you did come to care for Alice Tracek in July of 1998?

A. Yes, that's correct, three days.
Q. For three days?
A. Three days.
Q. And that was while she was at the Clinic, Cleveland Clinic?
A. That's correct.
Q. Did you see her at the CDU?
A. Not Snow Road, only at the Clinic,
Q. Cleveland Clinic?
A. I'm sorry.
Q. You have not been to Snow.
Do you know Paul Raykov, M.D.?
A. Dr. Raykov is one of the doctors that is in charge of the emergency room and the CDU.
Q. At Snow?
A. Both, I think they rotate.
Q. But at Snow Road?
A. Yes, he works on Snow Road, yes.
Q. How about Dr. Khalid Yaqoob, Y A Q O O B?
A. I don't remember that I have ever met him or spoke to him, but I don't deny it, but I don't remember.
Q. How about Dr. Ryder?
A. Dr. Ryder is one of the doctors that takes care of CDU patients, yes.
Q. In connection with your care and treatment of Alice

Tracek in July of '98, did you have any conversation with Dr. Raykov about her?

A. I vaguely remember, and from my notes that was substantiated, yes, she called me about the clinical information of this patient.

Q. What about Dr. Ryder?

A. I do not remember.

Q. You don't remember talking to him?

A. I don't remember.

Q. Now, Dr. Owens, do you know Bernard Owens?

A. I know Owens, yes, he's one of the surgeons.

Q. And where does he operate out of?

A. Both the centers, I think he's in the west side and the Cleveland Clinic.

Q. Did you discuss in July of '98 Alice Tracek's case with him?

A. We didn't discuss it in specific, but I think we have had a brief telephone conversation of this case, yes.

Q. There was a Cleveland Clinic resident in surgery by the name of Zakhary, do you recall him?

A. I don't recall him, this name, no.

Q. Do you know Dr. Milton Wong?

A. Yes, he's one of the internists.

Q. And where is he located?

A. I don't know, I see him only -- I know he's not in this

location, I think, but I don't know exactly. He recently joined Kaiser, I think.

Q. He's recently what?

A. Joined Kaiser fairly recently.

Q. Do you remember any conversation you had with him?

A. I don't remember.

Q. How about Susan Begeleman?

A. No.

Q. Don't recall her?

A. No, not at all.

Q. And a resident by the name of Faraq F A R A ***Q?***

A. I have never heard of that name, at least.

Q. Did you in fact examine Alice Tracek?

A. Yes.

Q. What kind of an examination did you perform?

A. I reviewed all the medical records in the CDU.

Q. Talking about the CDU, talking about July 26th or 27th, 1998?

A. July 28th. Before that I had only telephone conversatiocs.

MR. HUPP: No, I think the question is which CDU date.

A. Talking about CDU, Cleveland Clinic. I have never seen the patient in Parma.

Q. So there is a CDU unit of Kaiser in the Cleveland

Clinic?
A. Yes, correct, I'm sorry.
Q. I thought that was Snow Road.
A. We have two.
Q. You have two?
A. We have two.
Q. So the records that you reviewed before you examined her were the CDU records at The Cleveland Clinic?
A. Yes.
Q. And what is the date of that record?
A. When I reviewed it was the 28th. At that time I had the CDU record available, I had the emergency room records available, and I had the CDU Parma records.
Q. Can I briefly see what you're referring to?
A. Sure. This is the progress section of the medical records. The first time I physically was in touch with the patient, that's this date at 9:10 in the morning. Before that, they had contacted me by the phone, but it's standard if you go to a patient that you don't evaluate what's there.
Q. So your notes begin on July 28th?
A. That's correct.
Q. On a document, Cleveland Clinic Foundation Clinical Sheet?
A. That's correct. That's the same, we use those sheets in the CDU in the Cleveland Clinic, yes.

Q. And before you undertook to examine her, though, you reviewed other records generated at the CDU unit of The Cleveland Clinic?
A. Correct, but I also had some records available from the CDU of Parma. If a patient comes from Parma, it's transferred, then some of the record goes with the patient. And I had laboratory values available to me.
Q. What was the purpose -- first of all, what was the nature of your examination?
A. To review all the available information, and then I checked, did a physical exam of the patient, a limited physical exam, because it was already done before. And then I discussed the procedures that we were going to do.
Q. And you also took a history from her?
A. A brief history, yes.
Q. And was it consistent with what history was reported in the other records?
A. Yes, yes.
Q. And what did you tell her you were going to do?
A. I explained to her that we would do a EGD, upper endoscopy.
Q. Upper GI?
A. That's correct.
Q. And why were you doing that?
A. Because there was a drop of hemoglobin. Patient was

anemic, and the hemoglobin, the lab values of the blood were dropped.

Q. Back up, what is that one word?

A. Hemoglobin.

Q. So you were concerned about her hemoglobin?

A. Yes.

Q. What was it about her hemoglobin that concerned you?

A. At that point it was dropping from about 12 to 10.1 or 10.2.

Q. Indicating a possibility of bleeding?

A. Indicating bleeding in the GI tract, yes.

Q. When you did the upper GI, was that specifically what you were looking for, the source of bleeding?

A. Yes, correct.

Q. Anything else?

A. At that moment, no. Well, I knew about the other problems, of course, but for that technique you don't do anything else.

Q. Did you find any bleeding in the upper GI?

A. I didn't find any bleeding, but I found two or three possible causes of bleeding.

Q. What were they?

A. One was a hiatal hernia; one was gastritis, inflammation of the stomach; and the third one was a scar in the duodenal bulb, suggesting a previous ulcer, and that's

well documented.
Q. Now, you say you knew of the other problems; what were the other problems?
A. There were abdominal problems.
Q. What specifically were they?
A. I knew that the patient had anorexia, she hadn't eaten for a long time. And I knew there was a possibility that there was a perforation, because the record from the Parma unit said that there was free air on one of the x-rays on the left side of the abdomen. I knew there was diverticulosis in the past, and I knew there was a question mark about appendix.
Q. In addition to the upper GI that you performed, had a colonoscopy been requested of you?
A. I had been asked to see the patient with the diagnosis, possible diagnosis, of pseudo-obstruction.
Q. Who asked you to do that?
A. One of the residents, I think.
Q. Well, did they specifically request a colonoscopy?
A. No.
Q. Did anybody?
A. No, it was mentioned in the workup, because it's a broad workup, but it wasn't specifically requested.
Q. Did you ever plan to do a colonoscopy?
A. Well, as soon as 1 knew that there was free air under

the diaphragm, that's considered absolute contraindication for doing a colonoscopy at that point. Secondly, there was a mentioning of ileus, and that's an obstruction of the bowel in one of the x-rays. That's a contraindication for doing colonoscopy also.

Q. Now, in fact, though, the finding of free air was ruled out later, correct?

A. It was not confirmed on the CT scans that subsequently are done. If you have free air, it may be absorbed, day two it may be gone. That doesn't mean that the cause of free air is also gone, doesn't mean.

Q. What information is obtainable during a colonoscopy?

A. You find polyps, you find strictures, you find cancers, you find inflammation, and you find active bleeding. You do not find motility problems, because you give the patient Demerol, Versed and Glucagon, so all the motility studies are not possible with colonoscopy.

Q. There was a note in the record that I came across, perhaps you saw it as well, that one of the residents reports that he was in communication with you and that you were instructed -- you instructed that the patient be given an enema in preparation for a colonoscopy, and if there was bleeding it would be done, but if not it would not be done. Do you recall that note?

A. I recall the note, but slightly different.

Q. How do you recall it?
A. There was a question of bleeding, we knew already, we had solved that with the EGD. And as far as the other problems, I requested to prepare the patient for colonoscopy. The regular preparing for colonoscopy is one gallon of liquid to clean up the bowel, because there was also a mentioning there was fecal material in the bowel, and to do a colonoscopy adequately you want to have a clean bowel.
Q. So you pass that information on to the resident?
A. That's correct.
Q. So at least at that point you were considering the possibility of a colonoscopy?
A. Yes.
Q. And then why was the colonoscopy not done in the hospital?
A. Colonoscopy was not in the hospital because we had already the explanation for bleeding and we had ruled out obstruction at that point, that's a negative reason. The positive reason, we had the finding of free air two days in advance, one day in advance, and that's an absolute contraindication to doing a colonoscopy at that point.
Q. You say you --
A. Can I finish? The third issue is that we do things not in the hospital, that doesn't mean the treatment stops.
What I advised was give the patient food, high fiber

diet, lots of liquids. If the patient can tolerate this, then the colon might move around better, might give better result and move on better. Then it's up to the local GI, in this case Dr. Pesh-Imam, who was seeing the patient, to decide what can be done, but I recommended to do colonoscopy or barium enema. And a full diet with high fiber and lots of liquids showed that she still had problems with passing her food through the bowel, and that's documented.

Q. This was something going to be done subsequently on an outpatient basis?

A. Yes, do it on a routine basis, two or three weeks later, yes. Kaiser is a close system, you don't lose the patient after the admission, the treatment is continuing.

Q. Now, did you, yourself, come to the conclusion that there was no bowel obstruction?

A. No mechanical obstruction, yes.

Q. You came to that conclusion?

A. Yes. At least we didn't document it.

Q. Pardon?

A. We didn't exclude it, but we didn't document it after all.

Q. And on what basis did you conclude that there was a mechanical obstruction of the bowel?

A. At that point there was no ileus. In the beginning there was a mentioning of air-fluid levels being a sign of

ileus, later on that cleared up.
Q. So basically you reached your conclusion based on a review of x-ray films?
A. Number one. And Number two, if we can give somebody colon prep without nausea and vomiting, that means the GI tract is open.
Q. so --
A. It was finally excluded by the colonoscopy a few weeks later.
Q. So you concluded that there was no mechanical obstruction. Did you believe there was a pseudo-obstruction?
A. Possibility, yes.
Q. In fact, you've read **Dr.** Owens' deposition, that was his conclusion?
A. I didn't document the conclusion, because any modalities --
Q. I'm asking, you read his deposition?
A. Yes, yes.
Q. And you read in his deposition where he says that it was his opinion that she had a pseudo-obstruction?
A. Yes, I read that, yes.
Q. Now, that's a diagnosis of exclusion, is it not?
A. Very broad term. Anybody who doesn't move his bowel for five days has a pseudo-obstruction, that means an obstruction-like syndrome without mechanical obstruction.

Q. Would you agree with me that it's a diagnosis of exclusion?
A. It's a diagnosis of exclusion, yes.
Q. And when you have a diagnosis of exclusion, that means you have to rule out other more probable causes first?
MR. HUPP: Objection.
A. Yes, that's what we did.
Q. Now, you've indicated that on the basis of x-ray films and the fact that the patient took food later; is that right?
A. Uh-huh.
Q. You ruled that out, you ruled out mechanical obstruction?
A. Mechanical obstruction was less likely at that point.
Q. Is there any other way to rule out a mechanical obstruction other than the way you have just mentioned, which as I understand it was, one, the x-rays films that were reviewed, and two, I'm paraphrasing, and I may be wrong, she took -- she was able to pass fluid?
A. Yes. They are basically, one is the clinical observation that if you eat and you pass fluid or stool, then you have no obstruction. It may be still a small spasm or intermittent obstruction, but you have no full obstruction.
Diagnostic modalities are the CT scan, but it's bad because a lot of bowel movement is going on. Barium enema and colonoscopy, those are the diagnostic ways of excluding

or determining obstruction.
Q. I wonder, could you give me some examples, most common causes of mechanical obstruction?
A. Most mechnical obstructions we see is cancer.
Q. Pardon?
A. Most mechanical obstructions we see is cancer.
Q. Anything else?
A. Colon cancer. Diverticulosis with inflammation.
Q. Anything else?
A. Sometimes spasm, but that's temporary. But typical obstruction -- adhesions is the third one.
Q. Adhesions?
A. Yes, after surgery you see adhesions sometimes.
Q. Can you give me a common cause of, say, a pseudo-obstruction?
A. Pseudo-obstruction is basically everything that I mentioned before, but then it's an obstruction.
Q. What do you mean by everything that you mentioned?
A. The malignancy and stricture, the adhesions, gives pseudo-obstruction, but it's an obstruction.

Most common cause of pseudo-obstruction without real obstruction, mechanical obstruction, is peristalsis, lack of motility, lack of peristalsis. That can be postsurgery, after surgery you see that a lot, can be due to medication, can be due to anything else. If you don't eat for a longer

period you will possiblely have pseudo-obstruction, or if you don't drink enough for a period, yes.

Q. Will either type of obstruction, that is to say mechanical or pseudo-obstruction, impair a patient's ability to maintain nutritional status?

A. In general, it will.

Q. Now, a colonoscopy enables the doctor to visualize the lumen of the colon; is that correct?

A. Correct, correct.

Q. And I take it you have performed quite a few colonoscopies?

A. 13,000 procedures over the last 10 years, only for Kaiser.

Q. How many?

A. 13,000.

MR. HUPP: I think that was just colonoscopies.

A. That's divided by 50 percent, 7,000.

Q. 7,000 over the last 13 years?

A. Correct., last 10 years.

Q. I'd say you're qualified to perform a colonoscopy.

A. I think I have done enough to at least suggest that I'm qualified, yes. Maybe not in a legal term, but yes.

Q. Now, when you perform a colonoscopy, you're able to visualize the interior of the colon, you're looking for certain abnormalities, correct?

A. That's the purpose of doing colonoscopy, yes.
Q. And what kind of abnormalities are visual to the examiner?
A. Cancer, polyps, dilated phase, inflammation, bleeding.
Q. Anything else?
A. Those are the five majors, yes.
Q. If the colon is attenuated, would you be able to see that on colonoscopy?
A. Motility is not in the list that I gave you.
Q. Not motility, attenuated.
A. Possible, yes. The problem is, if you do colonoscopy you have to insufflate air into the bowel to pass curves, so it's very difficult to differentiate between attenuation or dilated, or whatever we call it, redundant colon.
Q. Would you be able to visualize a thinning of the bowel wall?
A. Unlikely. In rare case, yes.
Q. Would you be able to visualize a narrowing of the bowel?
A. In general, yes.
Q. Of the lumen?
A. In general, yes, unless it's spasm, because you give premedications, so spasm is relieved.
Q. Would you be able to visualize a stricture?
A. A mechanical stricture, yes, you would be able to, but

this patient didn't have that.
Q. You were aware that this patient had diverticulosis?
A. I was aware of that, yes.
Q. And from the chronological typewritten record, you knew that it was of longstanding duration, I'm sure?
A. Yes, that's correct.
Q. She had a number of -- two acute attacks?
A. It's possible.
Q. As a gastroenterologist, do you treat diverticulosis?
A. Yes.
Q. And how do you treat it, as a gastroenterologist?
A. As a gastroenterologist, we give high fiber diet, 45 grams or 50 grams of fibers a day, with about a gallon of liquid everyday. The high fiber diet and the liquid is known to prevent the next episode of diverticulitis, in some cases.
Q. Basically, this woman had diverticulosis, right?
A. Right.
Q. She did not have diverticulitis; is that what you're saying?
A. Yes, that's correct.
Q. Now, does diverticulosis -- first of all, in a colonoscopy, can you see the diverticular pouches?
A. Oh, yes, you see the openings.
Q. And in the colon adjacent to the diverticular pouches, are there sometimes changes in the bowel wall that are

visible?
A. Most of the time, yes.
Q. Are you familiar with a diverticular stricture?
A. Yes.
Q. You've seen them on colonoscopies?
A. Yes.
Q. Would a diverticular stricture be competent to cause some degree of colonic obstruction?
A. Possible, yes.
Q. Would that be classified as mechanical or pseudo?
A. It would be mechanical, but this patient didn't have an obstruction as appeared in the colonoscopy done by Dr. Pesh-Imam.
Q. That was done in August, though?
A. Yes.
Q. That will be the subject of another inquiry, what he thought?
A. She.
Q. Or she, I'm sorry.
What was your final diagnosis on this patient?
A. My final diagnosis was pseudo-obstruction of the colon with diverticulosis and a spastic colon, as mentioned in this chart summary here. I forget completely what the diagnosis was.
Q. Then did you, after you made your final diagnosis, then

turn her back over to the medical service?
A. Yes.
Q. And what did you expect they were going to do for her?
A. They would do a colonoscopy and they would follow her up, follow up with Kaiser gastroenterologist specialist in two to three weeks. That was the recommendation in the hospital discharge summary.
MR. NORTON: Now, I wonder if we could have this marked as Plaintiff's Deposition Exhibit 1.
MR. HUPP: Okay, Plaintiff's Exhibit 1.
(Plaintiff's Exhibit 1 was marked.)
Q. I'm handing you what has been marked as Plaintiff's Deposition Exhibit 1. First of all, tell us what it is.
A. It's a brief summary of my involvement with Mrs. Alice Tracek in the period of July 26 to 28.
Q. Is it entirely in your handwriting?
A. It's entirely in my handwriting, yes, except for the sticker.
Q. Is it the type of private document that you said you prepare and keep on patients you see in consultation?
A. That's correct.
Q. And when was that writing made?
A. This writing was made, part of it was made July 27, part of it was made July 28th, and one note was made July 29.
Q. And why do you maintain a private record?

A. I maintain the private records to keep track on what's happening during the admissions of the patients in the Clinic.

Q. Now, can I see it just briefly? I wonder if you would take it word by word and read it slowly so that the court reporter can get it down. Do you mind if I come over there and look over your shoulder while you read it?

A. That's fine.

IC stands for intercollegial consult by telephone. Another colleague asked me to do something as a consult. Not a procedure, but a consult, by telephone, 7/27, 1998, 1:40 F.M.

The patient name, Alice Tracek, Clinic No. 60471363.

birthdate, date of birth is 6/4/1937.

And our Kaiser medical record is 406281.

Q. Pointing.

A. Just a number, because I list them by number.

This is CDU bed 10. That's the first time I saw the patient, and this is H80.06.

Q. That's in the Cleveland Clinic?

A. That means that the patient transferred first time I saw her, next time she was here.

Admission, the reason for that was abdominal pain/nausea/vomiting/obesity.

Q. That was the reason for the admission?

A. Usually, yes, in very brief summary, doesn't list in the -- urinary tract infection.
Q. Parma CDU, they found free air under the diaphragm?
A. Repeat XKUB at the CCF ER. No free air.
NG tube was given, was positive, means for blood.
Questionable subvolvulus, V O L V U L U S.
Q. What does that mean?
A. That's the bowel rotates.
Q. In other words, sub --
A. That's --
Q. That's the prefix, sub, to volvulus?
A. It's not a real volvulus.
Dilated right colon, 15 centimeters.
CT pending.
Laboratory, white blood cell count 15, that's 15,000, that's elevated. Hemoglobin stable, 10 point something. I need above 10 to do endoscopy.
7/27, CT scan, no volvulus, no perforation.
7/28, advise colon prep. NG tube positive. Hemoglobin dropped. EGD, that's the procedure I did.
Q. That's what you were planning on doing?
A. Planning on doing.
7/28, EGD, give Versed. I won't change anything. Nosebleeds. I'm sorry. Hiatal hernia, HH, gastric erosion. Duodenal bulb deformation, what's causing this, I didn't know

at this time. Endoscopy, only to explain what you found, you get an endoscopy.

7/29, colonoscopy on hold unless active bleeding.

Q. Is that your signature?

A. Yes, Dr. Owens.

Q. No, "Dr. Owens" that says.

A. That's my name, I wrote the name Dr. Owens.

Q. Why did you write "Dr. Owens"?

A. Because he was involved in this patient, I knew he was involved in the treatment of this patient.

Q. I thought that was your writing.

A. I wrote it, the whole sheet I wrote, yes.

Q. Fine, thank you.

Now, you note in there that, Plaintiff's Exhibit 1, that the cecum was dilated 15 centimeters. That's a pretty good, significant dilation?

A. Yes.

Q. In fact, anything over 10, the patient's possibility of rupture is presented, correct?

A. Depends how you make the x-ray. If a patient's bowel is close to the x-ray tube, then it projects huge. In case patients are obese, the bowel can move in the abdomen up and down. So it depends on how you made the x-ray. If the patient sits on the back and the colon is further from the-- the tube is under the patient, colon is further from the

tube, okay, and it gets smaller on the x-ray. If it's closer to the tube, it gets big, so it's too wide. But you usually see a few -- all the information we have, CT scan, free air, the dilation, we have to see in the perspective of the follow-up, it is repeated everyday to see what's happening.

Q. Now, when you perform a colonoscopy, the scope is introduced into the colon through the rectum?

A. That's correct.

Q. And it passes through the sigmoid, correct?

A. That's correct.

Q. Is that the descending colon?

A. Descending colon, transverse colon, ascending colon and cecum.

Q. So you can see the cecum?

A. Most of the time, yes.

Q. In a colonoscopy?

A. Yes.

Q. So if you are doing a colonoscopy and visualizing the cecum and you see one that's 15 centimeters dilated, you know that it's some sort of abnormality?

A. No, if you do endoscopy, given same three medications, you don't know whether that's the real width or not. Second issue is, if you know already it's dilated, you had better not do colonoscopy, because you need more air to go all the way and take all the turns of the colon, colon is not

straight, so rounding all the curves you have to inflate more air.

Q. I just want to back up and ask you this question: Are you suggesting that the medicine that's given precolonoscopy examination could cause a dilation of the cecum?

A. Could, yes.

Q. Which medicine?

A. We use Demerol, Versed and Glucagon, they all three are.

Q. Demerol is a painkiller?

A. If you take a painkiller, you get constipated, everybody does, so by giving those medications you get rid of the peristaltic movement of the colon.

Q. And Versed is a sedative?

A. A sedative.

Q. Works on the central nervous system?

A. Works directly through the colon, yes.

Q. What's that other?

A. Glucagon, G L U C A G Θ N. It's medication to decrease the bowel motility.

Q. Is there another name for it, is that a generic name?

A. Yes.

Q. Is that a trade name?

A. Same, it's used as Glucagon.

Q. Now, I think you have previously told me that a

colonoscopist could see a stricture?
A. Yes.
Q. And that you're familiar with diverticular strictures?
A. Yes.
Q. And you knew this patient had diverticulosis?
A. Yes.
Q. Counsel has indicated that in connection with this deposition you have reviewed the autopsy?
A. Yes, correct.
Q. Did you review the gross description of the gastrointestinal tract?
A. Yes.
Q. In reviewing the gross description of the gastrointestinal tract, did you find that the examiner noted that the bowel prior to the sigmoid was dilated 27 centimeters?
A. Yes.
Q. But to that the sigmoid -- the lumen was dilated only five centimeters?
A. There was five centimeters lumen left, yes.
Q. And that the examiner found at that point a sigmoid stricture?
A. Five centimeters is not a stricture.
Q. But he described it as such?
A. Oh, yes, but we knew from the previous colonoscopy --

Q. I'm just asking you if you found that the examiner on gross examination reported a sigmoid stricture?

MR. HUPP: The question is what's on the autopsy.

A. Sigmoid colon diverticulitis with stricture and marked dilation of the proximal colon, no evidence of perforation.

Q. Also at the sigmoid the muscularis propria was significantly thickened?

A. Yes, that's correct.

Q. And again, that's a finding that's consistent with the longstanding history of diverticulosis, correct?

A. Yes, it's the thought without spasm you can have diverticulitis.

Q. Do you have an opinion as to whether or not the diverticular stricture -- or strike that -- the stricture that the examiner found on autopsy at the proximal sigmoid was the cause of this woman's bowel obstruction?

A. There was no bowel obstruction, there was a pseudo-obstruction during the clinical.

Q. Did she have any bowel obstruction at all?

A. No.

Q. Never?

A. Five centimeters was enough to pass fluids and foods, I think.

Q. Why was --

A. Total obstruction she didn't have.
Q. Why was the cecum dilated 15 centimeters when she presented to the Cleveland Clinic in July of '98?
A. Multiple possibilities.
Q. What are they?
A. Number one, you swallow air, total, about gallon, or 8 or 10 a day; number two, all the food contains air; number three, some people swallow more air, they only swallow air without food; and a lot of bacteria may produce air in the colon or in the small bowel.
Q. In the average person, the cecum is dilated 5 to 6?
A. Anything between 10 and 12 centimeters would be still an average normal cecum.
Q. Now, could I have briefly a glance at the records that you have marked?

Doctor, in looking at these records that you have just delivered to me, I find a page that is a duplicate of Plaintiff's Exhibit 1, except that it has a further note on it on the bottom.

A. That's correct.
Q. I'll ask you to --

MR. HUPP: Go ahead, he wrote that letter.

MR. NORTON: I know he did, I'm going to have it marked first.

(Plaintiff's Exhibit 2 marked.)

Q. Handing you what's been marked Plaintiff's Exhibit 2, Deposition Exhibit 2, that's a duplicate of the top part of Plaintiff's Exhibit 1?
A. Yes.
Q. It contains a subsequently entered note?
A. Yes.
Q. What's the date of the subsequent note?
A. August 20, '98.
Q. May I come over?
A. Well, I don't know, the note relates to August 28, 1998.
Q. Mind if I come over and look at it?
A. Sure, sure.
Q. Read it, please.
A. August 20, 1998, colon, Parma, diverticulosis, otherwise negative. Lots of stool, chronic constipation.
Q. Can you tell me when you made that particular note?
A. I don't recollect, but that's recent.
Q. Pardon?
A. That's recently added.
Q. Was it added after this claim was made, or after you were asked to be --
A. After the patient was discharged, but it was done after the colonoscopy in Parma, so it's about a few weeks later.
Q. The August 20th note refers to the colonoscopy that Dr.

Pesh-Imam did August 18th or 19th?
A. Correct.
Q. In Parma?
A. In Parma, yes.
Q. Now, you saw that colonoscopy report?
A. Yes.
Q. Were you aware when you read this colonoscopy report that she had attempted to perform a colonoscopy one day earlier, were you aware of that?
A. No, I wasn't.
Q. Were you aware that she was unable to perform the colonoscopy because of difficulty in passing the scope?
A. It's possible.
Q. Were you aware of the fact that when she in fact did the colonoscopy, the one you're referring to, she had to use a pediatric scope?
A. That's common practice. Yes.
Q. And that she had to use a pediatric scope because she had difficulty advancing the scope through the sigmoid?
A. Uh-huh.
Q. Are you aware of that?
A. I saw this in her report, yes, but I think it was the same day she used the two scopes, it was not two different days.
Q. And is the colonoscopy that Dr. Pesh-Imam did in August

of '98 the one that you anticipated would be done on an outpatient basis when you signed off on the patient in July?
A. That's correct, that's correct.
Q. At any time, did you discuss the patient with Dr. Nahra?
A. No.
Q. Do you know --
A. I don't remember that.
Q. Do you know Dr. Nahra?
A. Yes, I know she's an OPMG doctor.
MR. HUPP: Female physician.
A. Yes.
Q. Is she the doctor that cares for the OPMG patients at ManorCare?
A. Yes.
Q. Doctor, I think at the very beginning of the deposition when you explained that you were aware of some of her records and you were aware of the labs, you were aware then that her albumin was 2?
A. That's correct.
Q. And that level of albumin would have been consistent with someone who reported inability to eat for 14 days?
A. It's low. Whether it's consistent or inconsistent, that depends on the rest, because if you have an infection it will get lower, if you have a liver problem it will get

lower, but part of it is if you eat low albumin.
Q. When the calcium level is also correspondingly out of line with the albumin level, that's an indicator of malnutrition?
A. No, it doesn't mean anything. Calcium is bound to albumin, so if you measure more albumin you will measure more calcium. If you measure low albumin, you will have lower calcium.
Q. This patient when she presented to the Clinic had an abnormal calcium level?
A. Of course, and she had a lower albumin, of course. Again, there is, the calcium is not measured, so you only measure what's bound to albumin.
Q. By the way, Doctor, just handing you this Parma Medical Center CDU note of July 27, '98, the signature on the second page, do you recognize it?
A. No.
Q. It's not yours, though?
A. No, it's not my handwriting, no. The yellow pieces are mine.
Q. Not your writing?
A. No.
Q. They refer to you.
MR. NORTON: I wonder if we couldn't just have all these, Steve, marked.

MR. HUPP: Yes.

(Plaintiff's Exhibits 3 through 14 marked.)

Q. Doctor, just briefly, handing you what has been marked for identification Plaintiff's Deposition Exhibits 3 through 14, those are copies of all the documents that you had available to you and reviewed and brought personally to this deposition?

A. Yes, that's correct.

Q. And you regard these documents to contain pertinent information as far as you're concerned?

A. That's correct.

Q. And right there at that document, which is Plaintiff's Exhibit what --

MR. HUPP: 11.

Q. -- 11, that shows a calcium level of 7 point?

A. Yes.

Q. That's abnormal, isn't it?

A. Again, that's related to the low albumin.

Q. Fine.

A. So for this albumin, this calcium level is not abnormal.

(Plaintiff's Exhibit 15 marked.)

Q. Doctor, finally, plaintiffs' Deposition Exhibit 15 is your CV; is that correct?

A. Yes.

MR. NORTON: Thank you, Doctor, I don't have any further questions. Thank you very much.

EXAMINATION

BY MR. KWARCIANY:

Q. Doctor, I'm Attorney Dale Kwarciany, I represent ManorCare. I just want to talk to you a little bit about Dr. Nahra.

Did I understand you correctly that you had a conversation with Dr. Nahra?

A. No.

Q. You did not?

A. No.

Q. Her first name is Margie?

A. Yes, I guess.

Q. What is her medical specialty?

A. I don't know, ask her, please.

Q. But you indicated that she is the OPMG doctor who takes care of Kaiser patients at Manorcare?

A. No, I was asked whether she was an OPMG doctor, and I know that she is from Ohio Permanente Medical Group. What she did and what her role was with this patient, I honestly don't know. I'm not denying this, but I don't know.

Q. Do you know a Kaiser physician assistant by the name of Uva Costia (phonetic)?

A. The first time I will hear.

MR. KWARCIANY: I don't have any other questions. Thank you, Doctor.

MR. CONWAY: I don't have any questions.

MR. HUPP: We're going to read the deposition if it's ordered.

(Deposition concluded at 5:10 p.m.)

- - -

_____

ARNOLD J.M. VOGTEN, M.D., Ph.D.

CERTIFICATE

- - -

State of Ohio,)
)
County of Cuyahoga.)

I, Kristin A. Beutler, RPR, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, ARNOLD J.M. VOGTEN, M.D., Ph.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth, in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified, and was completed without adjournment.

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio on this 18th day of January, 2001.

Kristin A. Beutler, RPR, Notary Public in and for the State of Ohio. My commission expires September 26, 2001

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January 17, 2001

Steven J. Hupp, Esq.
Bonezzi, Switzer, Murphy & Polito
Leader Building, Suite 1400
Cleveland, Ohio 44114

In re: William C. Tracek, Admr. v. Kaiser Permanente, et al., Case No. 400269.

Dear Mr. Hupp:

Enclosed please find the transcript of the deposition of Dr. Vogten which you have ordered.

Please have the witness read the deposition, making any corrections on the enclosed blue errata sheets, and to sign at the end of the transcript. When this has been accomplished, please return said pages to me.

Please advise the witness that pursuant to the Ohio Rules of Civil Procedure, if the transcript is not signed within seven days of receipt of this letter, unless otherwise stipulated by counsel, it may be filed without signature.

Very truly yours,

Kristin A. Beutler, RPR

Kristin A. Beutler, RPR

cc: J. Norton, Esq.
D. Kwarciany, Esq.
M. Groedel, Esq.