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IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

Doc. 463

DIANE M. CARRICK,
EXECUTRIX, etc.,

Plaintiff,

-vs-

JUDGE J. KILCOYNE
CASE NO. 185330

THE CLEVELAND CLINIC
FOUNDATION, et al.,

Defendants.

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Deposition of NAZIH M. ZEIN, M.D., taken as if upon cross-examination before Aneta I. Fine, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Nazih M. Zein, M.D., 14601 Detroit Avenue, Suite 590, Lakewood, Ohio, at 4:00 p.m. on Friday, March 15, 1991, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

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On behalf of the Defendant
Lakewood Hospital.

NAZIH M. ZEIN, M.D., of lawful age, called by the Plaintiff for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF NAZIH M. ZEIN, M.D.

BY MR. MELLINO:

Q. Would you state your full name, please?

A. Nazih Mohammad Bahaeddin Zein.

Q. And where do you live, Dr. Zein?

A. 17715 Edgewater Drive, Lakewood, Ohio.

Q. Okay. And what is the business address of where we are now?

A. 14601 Detroit.

Q. Okay. And that's in Lakewood also?

A. Lakewood.

Q. And you just handed me your CV which you said you would send me a copy of it after the deposition. I have your only copy in my hand and I'm just going to ask you questions off it. If you need to see it to answer one of the questions just let me know. We'll try and both look at it at the same time.

You were born in Syria?

A. Yes.
Q. And you went to?
A. College de Terre Sainte. This is like high school.
Q. Okay. And where is that?
A. Lattakia, Syria.
Q. And I'm sorry, you said that was like high school?
A. Yes. Yes.
Q. And then the next school, you graduated from there in 1966?
A. Damascus University College of Science.
Q. And that's like college?
A. Well, it is pre-med.
Q. Okay. How many years is that?
A. One year.
Q. Okay. How many years was the, what was it, it says college in your CV.

MR. GORE: You're chicken. Come on, pronounce it.

A. This is -- I went I guess about ten years to that college. It is called college but it's high school.
Q. Pronounce this for me again.
A. College de Terre Sainte.

Q. And you went there ten years?
A. About ten years, yes.
Q. And graduated in 1966?
A. Yes.
Q. Okay. So you would have been, let's see how good my math is, 18 when you would have graduated?
A. Yes.
Q. And then you went one year to Damascus University?
A. College of Science.
Q. Right. And then you went to the Damascus University School of medicine for six years?
A. Six and a half years, yes.
Q. Okay. Graduated in '73?
A. Yes.
Q. And did you get an M.D. degree from that university?
A. Yes.
Q. When did you come to this country?
A. July '73.
Q. Okay. To do a rotating internship at Lutheran Medical Center?
A. Yes.
Q. Okay. Did you have to take some sort of

examination or -- well, did you have to take some sort of examination to practice medicine in this country?

A. Yes.

Q. Okay. Where did you take that?

A. In Columbus.

Q. Ohio?

A. Yes.

Q. Okay. When did you take that?

A. It is here, 1977.

Q. Okay. That's?

A. February '77.

Q. State licensure?

A. Yes.

Q. That's just to get your license to practice medicine in the State of Ohio?

A. Yes.

Q. What is the --

A. This is ECFMG examination. I took it in American University in Beirut to be able to apply to hospitals here in this country.

Q. Okay. In 1972?

A. Yes.

Q. That was the only time you took it?

A. Yes.

Q. Okay. All right. And in passing the ECFMG enable you to come to this country and to do a rotating internship at Lutheran Medical Center?
A. Yes.
Q. And that was just a general internship?
A. Well, the first year it is called rotating but I did a straight medicine. They did not have a program called the straight medicine but they called it major medicine so I rotated 12 months in medicine.
Q. Okay. When you say medicine, you mean --
A. Internal medicine.
Q. Okay.
A. Yes.
Q. And then you did a three-year residency at Lutheran Medical Center?
A. Yes.
Q. Okay. So you did four years total of medicine at Lutheran --
A. Yes.
Q. -- Medical. All right. I guess I didn't understand what you were telling me about your internship. Did you ever rotate in those four years through other departments?
A. Like what?

Q. Well --
A. Surgery?
Q. Right.
A. No.
Q. Okay. Just straight medicine all four years?
A. Yes.
Q. Okay. And then what did you do, what further training did you undergo?
A. Two years in rheumatology at the Cleveland Metropolitan General Hospital.
Q. Okay. Your three year internship -- I guess we didn't cover this.
A. One year internship.
Q. Three years residency was combined with Cleveland Metropolitan General Hospital?
A. Yes.
Q. Okay. I didn't go over this when we started, but you have to wait till I finish asking the question before you answer it otherwise the record's not going to be clear, okay? Your answer is going to be interposed in the middle of my question and it might not be clear what I asked and what you answered.
A. Okay.
Q. Also if you don't understand any question that I

might ask you during the course of this deposition, just ask me to repeat it and rephrase it and I will be happy to do so, okay, and then any question that I ask you you have to answer verbally, okay?

A. Okay. I didn't realize that I interrupted you. I'm sorry.

Q. That's all right. Okay. Then you did a two year fellowship at Cleveland Metropolitan General Hospital in rheumatology?

A. Yes.

Q. Okay. All right. Before we went on the record, you told me that you no longer have privileges at Lutheran Medical Center?

A. That's correct.

Q. Okay. And you have associate privileges at Fairview General Hospital?

A. I reduced it to courtesy privilege.

Q. Okay. What are courtesy privileges?

A. That is category below associate.

Q. What does it allow you to do?

A. Allows me to admit patients and see consultations but I don't have to go to meetings and so on unless I want to.

Q. Okay. Do you currently admit patients at

Fairview Hospital?
A. I do, rarely.
Q. And you have active privileges at Lakewood Hospital?
A. Yes.
Q. And you are the chief of rheumatology there?
A. Yes.
Q. How many rheumatologists are on the staff of Lakewood Hospital?
A. There's currently another one.
Q. Okay. What is his or her name?
A. Carlos Vevallos.
Q. Could you spell his last name?
A. V E V A L L O S.
Q. Okay. And do you have any other publications besides the two that are listed on your CV?
A. No.
Q. Okay. What is the specialty of rheumatology?
A. Rheumatology is the specialty which deals with problems related to arthritis and to connective tissue diseases.
Q. And what are connective tissues?
A. Connective tissue is diseases also related to the joints and to certain other areas like muscle and certain skin diseases. Connective

tissues are tissues which are under the skin and in the joints, in the muscle. It is kind of really a vague term but it applies to certain kind of diseases we're dealing with.

Q. What I'd like to do is go over the consult note that you wrote in the Lakewood Hospital chart that's dated March 20th of 1989. I said March 20th. It was March 21st. Do you have that in front of you?

A. Yes.

Q. Okay. Is this the first time that you saw Mr. Carrick?

A. Yes.

Q. Okay. I had a hard time reading your writing so what I'd like you to do is just read the note for me.

A. Okay.

MR. FIFNER: Wait. Before you start. Do you want him to just read it through or sentence by sentence so you can ask him questions as he goes through?

MR. MELLINO: Well, I want him to start reading through it but I am not going to necessarily ask a question but I might stop him and ask a question.

MR. FIFNER: I understand.

A. 40-year-old white male at age 25 had acute attack of arthritis in one of his ankles. Was found to have elevated uric acid. Recurrent attacks since then, treated with Indocin and prophylactic Colchicine one a day. Joints involved, knees, ankles and wrists. In between attacks stiffness and achiness, mostly in legs.

A month ago, right shoulder pain, then left then right knee. No response to Indocin nor to high dose of prednisone. Progressive renal failure with one partially functioning or nonfunctioning kidney. Parentheses, (creatinine stable, around 5). Hypertensive. No kidney stones.

Admission workup March 20th, '89. Hemoglobin, 9.7. BUN, 174. Creatinine, 8.5. Alkaline phosphatase, 437. CPK, 1,612. Uric acid, 11.9. Urine, one plus protein. No history of recent fall. No history of urethritis, conjunctivitis, colitis.

Q. Let's just stop since we have come to the end of that page. How did you come to see Mr. Carrick? How was it that you saw him?

A. Dr. Riley asked me to see him.

Q. Was it verbal, his request that you see him?
A. I don't recall if he called himself or he wrote order in the chart and the nurse called me, I really don't recall.
Q. Did you talk to him at all before the consult?
A. I don't recall exactly if I did but I have the feeling that he did tell me that creatinine was stable around 5. I believe this is information from Riley.
Q. From Riley?
A. I am not really sure if it was from the chart or from him.
Q. Okay.
A. Just there might have been contact but I can't swear on it.
Q. All right. Keeping that in mind, that you're not sure about that particular thing, was it fair to say that other than that you didn't have any other information about the patient before you saw him?
A. These are the only information I had about the patient.
Q. When did you write this note?
A. The day I saw the patient.
Q. Okay. So my question was before you saw him,

did you have any other information about him?
A. No, unless Dr. Riley talked to me in person and gave me part of the story, that is, I mean it happened within that day, if I had any other information.
Q. Riley would have talked to you on the 21st?
A. He could have called me and told me that I want you to see this patient because I think he has gout, and I mean, this I can't tell you now with any certainty, but I did not know anything about this patient before that like a day before, two days before, three days before this.
Q. Okay. Just so we're clear, if you talked to Riley, it would have been on the 21st?
A. 21st or maybe the day before, could be, but I cannot swear on it.
Q. And you don't remember any specific conversation that you had with Riley?
A. No, I really don't.
Q. Okay. And as far as the information that's contained in at least the first page of your note that would have come from the chart, from Riley, anyplace else?
A. The patient.
Q. Okay. And as you sit here today, you can't tell

me, you know, what information came from what source?

A. At this point I can't tell you.

Q. Okay. Was Mr. Carrick on Indocin when you saw him?

A. I don't recall really.

Q. Okay. Because your note says no response to Indocin. But you don't know if he was on Indocin or not?

A. At that particular time, no, I am not sure.

Q. Okay. All right. Could you read the second page for me?

A. Objective, tenderness shoulders, right knee, right ankle. Subcutaneous nodules, left elbow. No definite joint effusion. No definite proximal weakness.

Impression, number one, the history is very suggestive of gout. The subcutaneous nodules, left elbow are probably tophi. Number two, the current joint pain, mainly shoulders, is probably unrelated to gout. It may represent a form of arthritis and periarthritis described in patients with a chronic renal failure. Number three, elevated CPK. Rule out myopathy.

Plan, x-ray shoulders, left elbow,

question, calcifications. Number two, follow-up on muscle enzymes and alkaline phosphatase. Number three, will consider local injections. Thank you. Will follow.

Q. Okay. Under your impression the first paragraph, the history is very suggestive of gout, subcutaneous nodules, left elbow are probably, what is that word?

A. Tophi. T O P H I. Tophi.

Q. Will you spell that?

A. T O P H I.

Q. What does that mean?

A. Accumulation of uric acid in the subcutaneous tissues to form nodules.

Q. Why did Dr. Riley ask you to see the patient?

A. It was listed here, these are for consultation, severe gout.

Q. Do you know how long the patient had had gout?

A. He was -- he had first attack at age 25 which sounded like gout so I presumed he has, he had had it for 15 years.

Q. And to your knowledge had Dr. Riley been treating him for the gout for that period of time?

A. I don't have access to all his records, or to

any of his previous records so I am not sure for how long he has been treating him. I know that he has been treating him for a period or he had been treating him for a period of time but I'm not sure if it was 15 years or not.

Q. Okay. And I take it since he had asked you to do a consult that gout is something that a rheumatologist would treat?

A. Yes.

Q. Okay. Is that something that a nephrologist treats also?

A. Yes.

Q. What is the treatment for gout?

A. It depends on the circumstances.

Q. Well, what are the different circumstances?

A. Well, in certain situations we only treat the acute attack and we wait if patient will develop another attack or not so the treatment could be limited to only few days. In another circumstances we decide on a prophylactic treatment, and that prophylactic treatment could be with one medicine to prevent the attack or more than one medicine. One may consider adding medicine to lower uric acid level.

Q. Is that it?

A. Well, these are really the basic minimums for treating gout.
Q. Okay. Under what circumstances would you treat gout prophylactically?
A. If there are recurrent gouty attacks I would definitely in that case use a prophylactic treatment.
Q. And what medications specifically would you use to treat it prophylactically?
A. Colchicine to prevent the acute gouty attacks and it depends on the circumstances, I may use also medicine to lower uric acid level.
Q. And what would the circumstances be that you would use those?
A. I would recommend using them in younger patients below age 65, usually, I do recommend using medicine to lower uric acid level if the uric acid level is significantly elevated or if there are tophi or if there is history of kidney stone. Above age 65 I may be more conservative as far as using Allopurinol or Probenecid, another medicine to lower uric acid. Again, I would have to base it on the circumstances.
Q. What is the significantly elevated uric acid?
A. Well, it varies really from lab to lab a little

bit, but usually above 8 or 9 in most labs, that will be considered elevated uric acid.

Q. Okay. And what medication would you give to lower the uric acid?

A. I use one of two medications, one of them is Allopurinol, the other medicine is Probenecid. I tend to use Allopurinol rather more than Probenecid.

Q. Could you spell the second one for me?

A. P R O B E N E C I D.

Q. Okay. And what medication would you use to treat acute attacks?

A. Again, we have a choice. The most likely medicine I use is Indocin.

Q. What are some of the others you could use?

A. Another group of medication which Indocin is one of them is called nonsteroidal antiinflammatory medications and there are several of them in the market. I occasionally may use Colchicine intravenously or orally and occasionally I may use ACTH injection, and occasionally I may inject the joint with a steroid.

Q. Okay.

A. These are the usual choices. In certain patients I may use systemic steroids, in

patients who tend to be reluctant to other medications, or if there are contraindications with something like this, or something like this.

Q. What medications would you use in patients that have renal failure?

A. In patients with renal failure I would --

MR. GORE: Can I object for clarification? Do you mean patients just with renal failure or with renal failure and gout?

MR. FIFNER: I assumed it was both.

MR. MELLINO: He wouldn't be treating gout if they didn't have gout and renal failure.

MR. FIFNER: Just for clarification --

MR. GORE: With both.

MR. FIFNER: What would you use in a patient that had gout and renal failure?

Q. To treat gout?

A. My inclination nowadays is to use either ACTH or intra-articular injections if possible.

Q. Or intra what?

A. Intra-articular injections, injecting the joints.

Q. When you say nowadays, has that changed recently?
A. Yes, it did change to some extent. I used to use more nonsteroidal antiinflammatory medications including Indocin, and considering the different circumstances I may still consider using them but I do use them less than I used to before.
Q. When did you change?
A. Well, in the last few years, there has been more awareness of possible toxic effect of these medications on the kidneys. I cannot tell you exactly for how many years but basically gradually there has been kind of a little bit more at least in trend at least in my practice to use them less if there is alternative.
Q. Okay. Has that been -- well, can you give me a time frame as to when this came about?
A. To be honest with you, I honestly cannot tell you now any kind of accurate time frame.
Q. Has it been more?
A. Two years I would have acted different from the way I act today and certainly four years ago it was a little bit different. I can't tell you exactly time, really.

Q. Well, how did you learn about, or how did you become aware of the problem with nonsteroidal antiinflammatory agents?

A. Different studies indicated that they could have some kind of adverse effect in some patients on the kidney, and one of the articles, in fact, was within the last year, I recall about Motrin, an over-the-counter drug which was shown to have some adverse effect on the kidney, so basically the more we read about it, the more we are inclined really to use them less basically, if possible.

Q. What about Indocin specifically, I mean how long have you been aware that that is a toxin to the kidney?

MR. FIFNER: Objection to the form. Go ahead.

A. When I am talking about Motrin and other nonsteroidal antiinflammatory medications I include Indocin. I don't think Indocin is any different so I am talking about the last several years without really being able to pinpoint to any particular time. It did not happen that one day I decided that Indocin and Motrin and this group of medication cannot be used. It was kind

of a trend, really to use them less, and to use certain agents more. For example, ACTH was not at all popular for treating gout several years ago. Now there are certain articles which I believe published within the last couple of years maybe indicated that it is as effective, so I tend to use it more.

Q. All right. With the body of medical knowledge as it exists today, is it inappropriate to use or to prescribe Indocin to a patient that has gout and renal failure?

MR. FIFNER: Objection. Go ahead.

A. Well, I really would not consider the word inappropriate. I would say that medicine like Indocin is not invariably going to cause trouble to the kidney. We are talking about maybe small percentage of patients who are running really to problem from using Indocin and this group of medications, so it depends on the circumstances. One may use it really in patients with renal failure.

Q. Okay. But if you do use it you'd have to monitor the effects of the drug closely. Would you agree with that?

A. Well, I would tend to monitor that. Nowadays in

particular when I have to use it I would tend to monitor the kidney function.

Q. What about in '89?

A. I can't really tell you exactly how was my practice two years ago or three years ago, but I know that I was not as strict in monitoring this problem as now. There's just much more awareness now of this problem as a potential problem, and I know now that I tend to do that more, much more. 1989 in particular, I can't tell you. I really can't, honestly. I can't swear on it that this change or this happened in this particular month or year.

Q. Can you cite to me any particular articles that you read that would have brought about this change in your thinking?

A. No, I can't.

Q. Okay.

A. I can't.

Q. Well, could you tell me generally what periodicals they would be in?

A. The article about Motrin, Ibuprofen was, I believe, within a year in Annals of Internal Medicine. I think it was within a year. As far as previous articles, I just cannot tell you now

which medicals are now published.

Q. What journals do you subscribe to?

A. I review many journals in the library. I used to subscribe to many journals but nowadays I subscribe mostly to arthritis related journal, Arthritis and Rheumatism and Clinics on Rheumatic Diseases. I review several other journals in the library, Lancet, a British medical journal, Annals on Rheumatic Diseases, Annals on Internal Medicine, New England Journal of Medicine.

Q. But you can't cite for me any specific journals that these articles appeared in?

A. At this point I can't, no.

Q. Did you talk to Dr. Riley after your consult?

A. I would think I did. Now, I can't be positive when did I talk to him and what did I tell him and what I did not tell him for sure I didn't talk to him.

Q. What is the significance of the elevated CPK?

A. Well, it was not very clear to me at that point what really its significance was. CPK could come from the muscle as a general rule and it could come from the heart, during heart attacks. For one reason or another, I don't

believe there was any reason to suspect heart attack in that patient so we presume it was coming from the muscle.

Q. Okay. So you --

A. One condition I suspected was polymyositis. I mean that is one of the common causes of elevated CPK.

Q. And what is polymyositis?

A. Polymyositis is one of these connective tissue diseases I talked about which involve mainly the muscle, the proximal muscle and result in inflammation in the muscles as well as some damage to the muscle tissue and some regeneration of the muscle tissue cause muscle weakness mostly and sometimes could cause some other manifestations as well.

Q. Okay. Whose idea was it to have Mr. Carrick undergo the muscle biopsy?

A. That was my idea.

Q. Okay. And did you see him again before the muscle biopsy?

A. From my note here I saw him on March 23rd and on March 25th.

Q. All right. Why don't you read the March 23rd note?

A. I don't have it here. I don't have it here.

MR. MELLINO: Can you get him a copy?

MR. FIFNER: Yes. I will give him mine.

Do you have it right there, George?

MR. GORE: Yes.

MR. FIFNER: There you go.

A. Rheumatology. Shoulder x-ray reviewed. Severe periarticular muscular calcifications. Clinically same. CPK is elevated, about 1200. Impression, consider polymyositis with muscular calcifications. B, hydroxyapatite crystal deposition disease. Plan, bone survey, injection shoulders, muscle biopsy. Will discuss with Dr. Riley.

Q. Okay. Under impression B, what is that?

A. Hydroxyapatite crystal deposition disease is a condition described in a patient with chronic renal failure. It is certain kind of calcium deposit which deposits around the joints.

Q. Okay. So your impression changed then between the 21st and the 23rd?

A. No, it did not change in the way that I -- you don't keep repeating that, all the impressions,

so my impression about gout did not change the second impression I felt it could have been clarified further. I'm talking about that current joint pains, mainly shoulder, I wrote in my first note that it is probably unrelated to gout.

It may represent a form of arthritis and periarthritis described in patients with chronic renal failure, and that is what I meant with my note on March 23rd about hydroxyapatite crystal deposition disease. That will end to be the same thing.

On my initial note, my third impression was elevated CPK, rule out myopathy. I clarified it further on March 23rd by indicating that we should consider polymyositis with muscular calcification because on occasion polymyositis per se can cause muscular calcifications.

Q. Okay. Did you discuss the muscle biopsy with Riley?

A. Yes.

Q. When?

A. I cannot say the date really.

Q. Okay. Well, tell me what the discussion was?

A. Well, I have to presume really that basically I

told him that muscle enzyme is high and it will be good idea to do a muscle biopsy to see if he has polymyositis or not. And he apparently asked, I recall he asked the surgeon to see the patient for that procedure.

Q. Okay. Let's go to your March 25th note.

A. March 25th, '89, rheumatology. Each shoulder injected with 0.5 cc. Aristospan plus 055 ccs. Xylocaine. Naprosyn times two days to prevent steroid induced synovitis.

Q. Okay. What were the injections in the shoulder for?

A. For the patient was having shoulder pain and at that point my presumption was it was probably hydroxyapatite crystal disease. I felt gout was less likely and the injection, the purpose of them was to treat the shoulder pain.

Q. Okay. Why did you feel that gout was less likely?

A. Usually when we have attack of gout there's usually swelling, effusion, and redness of the joint. The presentation is kind of more dramatic, that is number one, and number two, patients with gout as a general rule, they do respond to Indocin. He did not respond. And

they usually respond to high dose of Prednisone. He did not respond.

Q. Okay. What is uremia?

A. I'm sorry?

Q. What is uremia?

A. Uremia is a term used for really elevated blood, urea nitrogen basically or substance called urea. The important part of it or the way it is tested, it is tested by testing BUN. It is something we find usually in patients with renal failure, but it could be found also in other problems sometimes.

Q. Does uremia cause anything?

A. In patients who have very high level of uremia, they could have certain complication like pericarditis, for example, anemia, but these are usually manifestation of kidney failure anyway.

Q. I'm sorry, what were the symptoms they could have again?

A. Well, uremia, I like to use it in basically if we're talking about uremia resulting from renal failure, there are several manifestations to that.

Q. Okay. What other kinds of uremia are there?

A. You could have sometimes what we call a

pre-renal azotemia which could be elevated urea without having necessarily renal failure, severe dehydration could lead to that.

Q. Okay. Any other forms of uremia?

A. If you have gastrointestinal bleeding you may have some elevation of uremia.

Q. Did Mr. Carrick have uremia?

A. Yes.

Q. And what in your opinion did it result from?

A. Renal failure.

Q. And what was the cause of his renal failure?

A. I don't know. I can't say.

Q. How do you know he had uremia?

A. Well, his BUN was very high.

Q. What was it?

A. On my consult note I put the figure here, 174.

Q. Okay. And what is normal?

A. Depends on the lab but usually less than 20.

Q. And how do you treat uremia?

A. Well, I am really not a nephrologist, I am not an expert on treating uremia.

Q. That's fine. Any time you can't answer one of my questions you can just say I don't know, that would be fine.

A. Okay.

Q. Okay. Do you have any other notes in the chart?
A. I don't recall if there is any more really that is --

MR. FIFNER: Progress notes I don't think so. He may have an order but I don't think there are any other progress notes. You want to take a quick scan through the orders, doctor, see if you have any in there? Go ahead.

A. On March 21st I ordered x-ray of both shoulders and right elbow. CPK with isoenzymes, sed. rate ra latex with titer, ANA, GGT, and discontinue Naprosyn.
Q. Those were your only other notes?
A. No. This is my order on the 21st. Now, on, was it March --

MR. GORE: It was July but it's March.

A. March 12th, '89. Bone survey. Please bring Aristospan at least 2 ml. from pharmacy. I will inject shoulders tomorrow. On March 25th, '89 I ordered Naprosyn, 250 milligrams p.o. t.i.d. times two days. That was it.
Q. Okay. Was it your expectation that the muscle biopsy would confirm your impressions of

polymyositis and --

A. Can I see this?

Q. And your other impression you have listed under B for the March 23rd note?

A. Well, muscle biopsy could be positive if patient had polymyositis. I mean that was a condition I indicated that it should be considered.

Q. Well, what was the reason you wanted the muscle biopsy done?

A. Well, because if a patient did have polymyositis that is very definite treatment for that. Patient will have to stay on prednisone over a long period of time.

Q. Okay. So the muscle biopsy would tell you if he had polymyositis?

A. In a large number of patients.

Q. Okay. And I'm sorry, tell me again what that word is about?

A. Hydroxyapatite crystal deposition disease.

MR. FIFNER: Doctor, you are probably going to save yourself a phone call if you would say it very slowly and spell it, because I'm certain the --

A. H Y D R O X Y, A P A T I T E, crystal disease.

Q. And would that show up on a muscle biopsy?

A. I don't think so.
Q. Okay. How do you test for that?
A. You have to take part of this deposits and send it for electron microscopy and it needs really sophisticated testing.
Q. Is there treatment for that?
A. It will be by using something like injection and it will be symptomatic treatment.
Q. Did you test the crystals?
A. No. There was no fluid obtained from the shoulders to be tested. I mean that was not -- the muscle biopsy, it really meant basically for the polymyositis so I did not request a special testing for hydroxyapatite.
Q. Okay. But there's a test you can do to determine the presence of that but you didn't do it?
A. Well, as a general rule what I am really aware of is that if the fluid is obtained or if one has done synovial biopsy there's possibility that this could be tested but we don't do it routinely. I mean it is mostly really a research kind of thing. I mean from a practical standpoint you don't need to prove this diagnosis, so even if I aspirated the fluid from

the joint, I don't believe I would have sent it for electron microscopy testing. It is done in certain universities, in certain research centers. We don't do it routinely.

Q. When you are talking about aspirating fluid from the shoulder, are you talking about something you do or --

A. When we do the injection, we try to aspirate if there is any fluid there.

Q. And you tried that and there was no fluid?

A. Yes. I automatically do.

Q. Okay. That was on the 25th that you did the injection?

A. Yes.

Q. And the attempted aspiration?

A. Yes.

Q. Did you see the patient after the 25th?

A. I don't believe so. If I saw him I could have stopped by to see how he was doing really. How many days I stayed after that? Three days.

Q. Were you aware of the results of the muscle biopsy?

A. I was aware of it after he went to Cleveland Clinic.

Q. How did you become aware of it?

A. I could have asked Dr. Riley or I could have contacted pathology. I'm not sure, really.
Q. Okay. The muscle biopsy was negative, right?
A. Yes, from what I see here.
Q. What impact would that have on your impressions of the patient?
A. Well, at that point it made polymyositis less likely, and -- yes? You want to ask me something?
Q. No. Are you done with your answer?
A. Yes.
Q. Okay. Well, your impressions when you first saw him on the 21st were number one, that he had gout?
A. Yes.
Q. But you felt that that was less likely, you told me?
A. Less likely to be causing his shoulder pain.
Q. Okay.
A. Not every pain in a patient with gout is from gout so --
Q. Well, on the 23rd when you saw him did you still think he had gout?
A. Yes, I did think that he did have gout. That particular impression did not change.

Q. Okay.
A. I usually like to -- I wrote in my impression the history is very suggestive of gout. I could not be absolutely certain, not 100 percent because myself to make the diagnosis of gout I prefer either to take fluid from the joint and find the crystals or at least find the patient during definitely acute episode and try to verify that. But the history was very suggestive of gout.
Q. Okay. Your second impression on the 21st was that he had polymyositis?
A. No. The second impression was -- which day we're talking here about?
Q. 21st.
A. The second impression, I read it again. The current joint pain, mainly shoulders, is probably unrelated to gout. It may represent a form of arthritis and periarthritis described in patients with a chronic renal failure.
Q. Okay. Did that impression change at all?
A. No.
Q. Or would it change knowing the results of the muscle biopsy?
A. No.

Q. Okay. And what about the elevated CPK?
A. I wrote elevated CPK, rule out myopathy.
Q. Right.
A. I was not very specific here. When I saw him next time I repeated CPK was again elevated. I thought that polymyositis should be a consideration, and muscle biopsy should be done. It did not show it. That would not 100 percent exclude polymyositis but it made it less likely.
Q. All right. You felt that the elevated CPK was as a result of the polymyositis?
A. I was not -- no, I did not have definite diagnosis.
Q. No. That was your impression though?
A. I thought that should be a consideration. That should be a consideration.
Q. Since the muscle biopsy was negative what do you think was the cause of the elevated CPK?
A. Well, now, at this point I will have only to sit and speculate really. I have not seen the patient after that. I have not seen the patient after he had the muscle biopsy, and --
Q. Well, let me ask it a little different way. If he didn't have polymyositis, or, if he didn't

have that, just assume that he didn't, what could be the other causes of an elevated CPK other than the myocardial infarction or something from the heart?

A. Well, now in certain situation if there was trauma to the muscle it could elevate the CPK. If there was low potassium it could elevate the CPK. I was not really sure of if renal failure per se could cause elevated CPK, I was not aware of it and I am not aware of it now either.

I do see sometimes in practice patients with high CPK without explanation. I tend in these cases to follow the patient for a while and see what will happen without committing them to long term treatment.

So basically if I had the chance to follow the patient after that, I probably would have repeated the CPK subsequently in two weeks or three weeks and really to find out what was it and then proceeding from there. It will be hard to determine. It will be hard to determine.

Q. All right. As we sit here today, you don't know what the cause of the elevated CPK was?

A. No, I don't know at this point.

Q. Why did you stop seeing Mr. Carrick?

A. What do you mean with that?
Q. Well --
MR. FIFNER: That's an objection to the form.
MR. MELLINO: Is that what that is?
MR. FIFNER: I think so. What was the reason that you didn't see Mr. Carrick after the 25th of March?
A. Consultant is not supposed to see the patient every day. You give certain treatment, you don't have to have result the next day and you don't need to see the patient every day as a consultant. And my interest was mostly to see what the muscle biopsy will show, and muscle biopsy result was available, I believe, after he went home, after he went to Cleveland Clinic.
So even if I stopped to see him, I could have stopped to see him to say hi and if he had any improvement so far with the injection or not, and I didn't feel that I should record it in the chart at the time I see him and to charge money for it. That is exactly the truth. I mean --
Q. I understand that. I think you're reading more

into my question than maybe I intended. I just want to know if you stopped seeing him because he transferred to the Cleveland Clinic or if you felt you were done treating him or if Dr. Riley asked you to stop seeing him or --

A. No. Dr. Riley did not ask me to stop seeing him. Knowing the patient went to Cleveland Clinic he was in the hands of somebody else.

Q. Okay. So you stopped seeing him because he went to the Cleveland Clinic?

A. That's correct.

Q. Okay. And I guess what you're telling me is you may have seen him after the 25th but you didn't necessarily write a note?

A. Unofficially I could have. I could have seen him.

Q. You didn't render any treatment?

A. That's correct.

Q. Okay. Dr. Riley asked you to do a consult because the patient had gout, is that right?

A. Well, yes, he indicated the reason for consult, severe gout.

Q. Where is that, by the way?

A. On the top of the consult.

Q. Okay. So the patient had had gout for a number

of years before this, correct?
A. Yes.
Q. Do you know why Dr. Riley was asking for a consult at this point in time?
A. I will have only to speculate, really, that.
MR. FIFNER: Well, don't do that. I mean if you know you have to tell him, if you don't know just say you don't know.
A. I can't say for sure what was in the mind of Dr. Riley, no.
Q. Okay. Do you know if Mr. Carrick had ever seen a rheumatologist before this point in time?
A. I don't know.
Q. Is a rheumatologist more qualified to treat gout than a nephrologist?
A. Gouty arthritis, yes. I should really -- could I make a statement about this?
MR. FIFNER: Go ahead. We talked about this before. Go ahead.
A. Rheumatologists are probably the most qualified people to treat gout, but most gouty patients are treated by general internists, including nephrologists. Not every patient with gout is in this community as far as I know is referred to rheumatologists. The majority are not.

Q. Okay.
A. But rheumatologists probably, they have more experience treating gout than anybody else in the community.
Q. Okay. So if a general practitioner or a nephrologist is having a problem controlling somebody's gout or treating that gout then it would be appropriate for them to refer that patient to a rheumatologist?
A. Yes.
Q. And did you consult with the purpose in mind of treating Mr. Carrick's gout?
A. Repeat that question, please.
Q. Did you do this consult with the purpose in mind of establishing a treatment for Mr. Carrick's gout?
A. Yes.
Q. Okay. And what treatments did you establish?
A. Well, now, here I should state that that was the purpose of the consult, but when I find something else which I feel could belong to my specialty, I will make comments about it. So basically in this particular case, I felt that the patient did have gout, but I did not feel that the current problem this patient had was

caused by gout.
Q. Okay.
A. So I had to pursue that other point of view also.
Q. Okay. So you were asked to consult with him because he had severe gout so you examined the patient, took a history from the chart.
Q. You believe that his history was suggestive of gout but you also felt that his problems were more probably related to polymyositis. Would that be fair?
A. I'll read it again. The current joints pain, mainly shoulder, is probably unrelated to gout. It may represent a form of arthritis and periarthritis described in patient with a chronic renal failure, and then I found the elevated CPK and I felt this should be pursued further.
Q. Okay. I guess where we keep -- where I guess I'm getting confused is you are telling me there's no connection between your impression number two and the polymyositis?
A. That's correct.
Q. The arthritis and periarthritis?
A. Yes. Yes.

Q. So did you establish any treatment program for the arthritis and periarthritis?
A. I injected his shoulders.
Q. Okay.
A. My job I felt was to try to establish some kind of more definite diagnosis, and on that basis I did request additional x-ray, and I wanted to have the CPK repeated to just verify that it is definitely elevated, it was not lab error or anything like this, which we did, and I consider further workup to include muscle biopsy, I recommended that was done, and I did inject his shoulders in an attempt to relieve his pain.
Q. Okay. So would it be fair to say then you felt that even though he may have had gout, that his problems were most probably caused by the arthritis and periarthritis?
A. I felt that his pain at that time was probably more related to arthritis, periarthritis related to the renal failure maybe rather than to the gout. That was my impression at that time.
Q. Okay. What is the cause of gout?
A. Are you talking in general or about this patient?
Q. Let's talk in general first.

A. Well, the cause of gout is elevated uric acid. As a general rule, because of certain error in metabolism which makes certain people have elevated uric acid, certain percentage of these people who have elevated uric acid for reasons which we don't understand, they develop gout as a result of deposition of uric acid in the joints, and in certain other areas in the body. When you have a lot of deposition of uric acid in the joints, this may lead to acute gouty attacks.

Q. Okay. And what was the cause of this patient --

A. This patient, I can't tell. Most of the time we don't know exactly what is the exact cause. I am presuming if he is at age 25 had high uric acid that probably had enough deposition in his joints to cause the flares of gout.

Q. And you didn't, you weren't able or did you attempt to determine the cause of his gout?

A. I mean, by the way, if I could answer the other question also, add a few things?

Q. Which question are you answering, doctor?

A. What caused gout.

Q. Oh, okay. Go ahead.

A. I talked about some error in metabolism leading some people to have high uric acid and so on. Sometimes high uric acid could come as a result of other things like renal failure can cause elevated uric acid, like certain medications used for high blood pressure, in particular, diuretics, can lead to high uric acid and over the years this could lead to gout also. So just to make my answer before complete, okay? Now, what was your second question?

Q. Did you attempt to determine the cause of Mr. Carrick's gout?

A. No.

Q. Okay. Do you need to determine the cause to treat it?

A. No.

Q. The injections that you gave, I think you said before that that was symptomatic treatment?

A. That's correct.

Q. Okay. How long would that last?

A. Well, if the injection was successful, it may last for weeks or months.

Q. Okay. Do you know how long it lasted here?

A. I am not sure even that was successful. I don't know. I did not have follow-up.

Q. Okay. I take it based upon what we talked about before as far as this you believe change in medical knowledge over the last few years which you weren't able to quantify the number of years for me, you don't have an opinion as to whether it would have been below the standard of care to give Indocin to a patient with gout and chronic renal failure?

MR. FIFNER: Objection.

Q. You can answer the question.

MR. FIFNER: Yes. Go ahead.

A. I could not really make that statement.

Q. You don't have an opinion one way or the other?

A. Well, I cannot make the statement that every time Indocin is given in patients with gout who has renal failure will be deviation from the standard of practice.

Q. Well, what about in Mr. Carrick?

MR. FIFNER: Objection.

A. I don't know even how was he given Indocin. I don't know. I never reviewed his record prior to his hospitalization.

MR. FIFNER: Let me tell you, Chris, that if there comes a point in time where he addresses any of those standard of

care issues at trial I will certainly --

MR. MELLINO: Well, I'd like to know now as long as we're here.

MR. FIFNER: I don't think he has any opinions.

MR. MELLINO: That's what I'm trying to find out.

MR. FIFNER: If he ever does intend to express any I will go ahead and reproduce him. I mean I think he's made pretty clear the only documents he's seen in connection with the case are his consult.

MR. MELLINO: Let me just ask one more question on this and I will be done.

Q. Do you have an opinion as to whether or not it would have been below the standard of care to give Mr. Carrick Indocin?

A. Repeat the question.

Q. Do you have an opinion whether it would have been below the standard of care to give Mr. Carrick Indocin, given the fact that he had chronic renal failure?

A. I am sorry, I thought I answered this question. It will not be invariably below the standard of

care to give Indocin to a patient with gout and renal failure.

Q. Right. You answered it that way before, you were talking general terms. I'm talking specifically.

MR. FIFNER: In this specific case? Do you know enough about the facts to say --

A. I said that I don't have really access to previous records. From what I can see in my note, to try Indocin for an attack of gout in a patient with gout and renal failure is not absolutely contraindicated, it could be done. It is not deviation from the standard of care as far as I'm concerned.

Q. Okay. But I'm talking about specifically under the facts of this case?

A. This one, I'm talking about specifically, based on the information I have on my consult sheet.

Q. Okay. And you don't know --

A. I don't know how much he was given. I don't know for how long. I really just don't know. I don't know that information.

Q. Okay. Can I take a look at your chart?

MR. MELLINO: Can I get a copy of

this?

MR. FIFNER: Sure.

MR. GORE: May I see it, please?

Q. Do you treat renal failure?

A. Usually not.

Q. Okay. Did you make any recommendations about dialysis in this case?

A. No.

Q. Do you have any opinion about whether or not Mr. Carrick should have been put on dialysis?

A. I don't know if he was put on dialysis or not.

Q. No. Do you have an opinion as to whether he should have been?

A. I don't have opinion really.

Q. Okay. Do you treat hypoparathyroidism?

A. Not as a general rule. This kind of situation I get usually help from other specialists.

Q. Okay. What specialists would you get help from?

A. Well, for renal failure, nephrologist, for hypoparathyroidism, endocrinologist.

Q. Did you consider hypoparathyroidism as a cause of Mr. Carrick's problems when you saw him?

A. Which problem you are talking about?

Q. His joint pain?

A. No.

Q. What about now in retrospect?

MR. FIFNER: Objection.

A. I am sorry. I have to answer the question again basically. We did consider that hypoparathyroidism could have been contributing to the calcium deposit.

Q. Okay. You didn't write that in the chart, though?

A. No.

Q. And you didn't do any tests or anything to determine if that was the cause?

A. No, I did not.

Q. And in retrospect now, do you believe that might have been the cause of joint pain?

MR. FIFNER: Objection.

A. I believe the joint pain is probably related to what I mentioned as far as hydroxyapatite crystal disease, his shoulder pain, okay. Now, the calcium deposit, they could have something to do with hypoparathyroidism.

Q. Did he have steroid myopathy?

A. No.

Q. If a person has urea can that be treated with dialysis?

A. Yes.

Q. Okay. And I think you answered this question already, but you didn't prescribe any treatment for his gout, is that true?

A. Repeat to me the question, please.

Q. You didn't prescribe any treatment for Mr. Carrick's gout?

A. No.

MR. MELLINO: Okay. I think that's all the questions I have.

MR. FIFNER: Do you guys have any?

MR. GORE: I have no questions, doctor.

MS. HENRY: No questions.

MR. FIFNER: Why don't we -- we'll not waive it.

NAZIH M. ZEIN, M.D.

C E R T I F I C A T E

The State of Ohio,) SS:
County of Cuyahoga.)

I, Aneta I. Fine, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named NAZIH M. ZEIN, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this _____ day of _____, A.D. 19 __.

_____
Aneta I. Fine, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires February 27, 1996

W I T N E S S I N D E X