In The Matter Of:

Reverend Stephen J. Walick v.
Michael S. Eisenstat, M.D., et al.

David L. Carr-Locke, M.D., F.R.C.P.
Vol. I, December 9, 1997

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STATE OF OHIO
COUNTY OF CUYAHOGA

REVEREND STEPHEN J. WALICK,
Plaintiff,

vs. : 307,479
: Judge
: Celebrezze

MICHAEL S. EISENSTAT, M.D., et al.,
Defendants.

DEPOSITION OF DAVID L. CARR-LOCKE, M.D., F.R.C.P., a witness called on behalf of the Defendant David L. Gottesman, M.D., taken pursuant to the Ohio Rules of Civil Procedure, before William J. Ellis, Registered Professional Reporter and Notary Public in and for the Commonwealth of Massachusetts, at The Endoscopy Center, Brigham and Women's Hospital, 75 Francis Street, Boston, Massachusetts, on Tuesday, December 9, 1997, commencing at 2:32 p.m.

PRESENT:

Linton & Hirshman
(by Tobias J. Hirshman. Esq.) Hoyt Block, Suite 300, 700 West St. Clair Avenue, Cleveland, OH 44113-1230, for the Plaintiif.

Jacobson, Maynard & Tuschman
(by Peter Voudouris, Esq.) 1001 Lakeside Avenue, Suite 1600, Cleveland, OH 44114-1192 for the Defendant David L. Gottesman, M.D.

(Continued on next page)

PRESENT (Continued):

Reminger & Reminger
(by James S. Casey, Esq.) The 113 St. Clair Building, Cleveland, OH 44114, for the Defendant Meridia Hillcrest Hospital

ALSO PRESENT: David L. Gottesman, M.D.

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PROCEEDINGS

DAVID L. CARR-LOCKE, M.D., F.R.C.P.
a witness called for examination by counsel for the Defendant David L. Gottesman, M.D., being first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION
BY MR. VOUDOURIS:

Q: Could you state your name **for** the record, please.

A: David Leslie Carr-Locke.

Q: Dr. Carr-Locke, my name is Peter Voudouris. I introduced myself to you a few moments ago. To my left, is Dr. Gottesman. We're here to take your deposition here today.

Have you ever been deposed before?

A: I have.

Q: Okay. I basically have just two ground rules. One, if I ask you a question and you don't understand it, you bring it to my attention so we can be on the same page.

A: I will.

Q: And, also, please answer everything verbally for the court reporter and myself because he can't take down nods of the head.

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A: Okay.

Q: And if you answer a question, I'm going to assume that you understood it. Is that fair enough?

A: Yes.

Q: You mentioned you've been deposed before?

A: Yes.

Q: Roughly how many times in your career have you given a deposition?

A: Four or five.

Q: Okay. Were those four or five occasions in a medical legal case such as this where you were testifying as an expert?

A: They were medical legal cases not always such as this.

Q: Okay. What do you mean by not always such as this?

A: Some were to do with credentialing privileges by a hospital of a physician.

Q: How many – before the five, what number of those involved medical malpractice and not credential?

A: *All* except one.

Q: Okay. And when did you begin reviewing medical legal cases?

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A: Approximately ten years ago.

Q: How many cases would you estimate you reviewed in your career?

A: More than twenty.

Q: More than thirty?

A: Possibly.

Q: More than forty?

A: No, probably not.

Q: Somewhere between thirty and forty?

A: Yes.

Q: Is that fair enough?

A: That's fair.

Q: Okay. The thirty to forty cases that you reviewed in medical legal cases, do you have an idea what percentage were on behalf of plaintiffs and what percentage were on behalf of defendant doctor or hospital?

A: Predominantly on behalf of the defendant. I would say 75 percent were on behalf of the defendant.

Q: Okay. And does that remain the same percentage throughout your career?

A: Yes.

Q: The four or five cases that you were

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deposed in, wese those all on behalf of the defendant doctor or hospital?

A: No.

Q: How many of those four or five were on behalf of the plaintiff?

A: One.

Q: What was the issue in that case?

THE WITNESS: Am I obliged to give that information?

MR. HIRSHMAN: He's allowed to ask you about that now. If you recall, you can answer it. And you don't have to give –

Q: You don't have to give patient names.

A: This was a case outside of this country anyway. It was a case where the patient had been injured during an endoscopic procedure, the result of which he required surgery, an esophageal perforation was the injury alleged; and the plaintiff won the case.

Q: And that was not in the United States?

A: It was not.

Q: Where was that?

A: It was in Ireland.

Q: The other three or four medical legal

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cases, were they in the United States?
A: No, not all of them.
Q: Okay. Where were some of the others?
A: In England, which is where I practiced until I came here.
Q: So one case was in Ireland, one was in England. Were the other *two* or three in the United States?
A: Two have been here, yes, in the U.S.
Q: Were they on behalf of the defendant doctor, those two cases in the United States?
A: One each. One defense, one plaintiff.
Q: Were they here in Massachusetts?
A: No.
Q: What state?
A: One was in Montana, and the other was in California.
Q: Do you remember the case in Montana when you were deposed for that?
A: That is still ongoing.
Q: Do you remember any of the attorneys' names involved in that?
A: I do not.
Q: Do you keep a list anywhere?

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A: I do keep records, yes.
Q: You do. How about the California case?
A: The California case is also ongoing; although my involvement in it may not be so. I hope. It's a case of a hospital against a physician whose privileges have been revoked. And I was called upon to be the expert witness on behalf of the hospital.
Q: The one in Montana, was that on behalf of a patient plaintiff?
A: That was on behalf of the defendant physician.
Q: I might be a bit confused. Have you ever testified in a case in the United States on behalf of a patient plaintiff?
A: No.
Q: Have you ever testified in court before?
A: Yes.
Q: In the United States?
A: No.
Q: Did the case in England and the case in Ireland go to trial?
A: Yes.
Q: And did you fly over to testify in those two cases?
A: In England, I was still there working. In the case of the Irish case, I flew over to testify.
Q: Do any of the cases that you've been involved in, the four or five medical legal cases, involve facts similar to this case?
A: No.
Q: Have you ever viewed cases for attorneys in northeast Ohio before?
A: Not that I recall.
Q: All right. Do you know how Mr. Hirshman got your name?
A: I do not.
Q: You've never reviewed a case for him before, have you?
A: I have not.
Q: Are you registered with any medical legal agency or society that provides referral service to plaintiffs' attorneys or defense attorneys?
A: Not that I'm aware of.
MR. HIRSHMAN: You know better than that to think that I'd do that.
Q: Have you ever?
A: No, not that I'm aware of.

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Q: I'm going to hand you what we'll mark as Exhibit 1.
MR. HIRSHMAN: Is that the copy that I just gave you?
MR. VOUDOURIS: Yes.
MR. HIRSHMAN: We'll get another set.
Q: Could you just identify that for the record.
(Witness reviews document)
A: This is a copy of my CV.
Q: You had an opportunity to quickly browse through it. Any major additions or deletions that are not on here?
A Some of the components are not completely up to date such as publications and abstracts and attendances at meetings.
Q: Do you have an up-to-date list that we could get from your office at a later time?
A: I would have to check to see if my current one is a little more up to date than this.
Q: Okay. Would you do that for us after the deposition?
A: Sure.
MR. HIRSHMAN: How did we mark that as,

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one?
MR. VOUDOURIS: Yes.
(Document marked as Carr-Locke Exhibit 1 for identification)
Q: Doctor, briefly looking at your CV, I understand that you were educated in England?
A: Correct.
Q: You want to basically tell me the difference between the educational system in England to become an M.D. as opposed to the United States.
A: The fundamentals are pretty much the same. The sequence may be a little different.
I chose one of the many pathways that one can take in medical education in the U.K. which was to go to a university first – Cambridge University – obtain my degree, and then go to medical school for a further three years, making the whole course six years in length.
An alternative is to go to medical school directly, in which case, it can be done in five years.
Q: So you didn't go directly?
A: I did not.
Q: Okay. What did you do in between the gap

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of the two universities that you attended?
A: No. It's continuous. There's no gap.
Q: Okay. I misunderstood you.
When did you come to the United States?
A 1989 permanently.
Q: Did you do what we call an internship in the states or in England?
A: I completed my internship and the equivalent of residency and fellowship training all in England other than one year which I spent in Boston in 1979.
Q: So when you came to the United States, were you required to take another one-year internship?
A: I was not.
Q: Okay. Were you required to take another residency?
A: I was not.
Q: What type of exam did you have to take to come to the United States?
A: None initially. But in order to obtain a permanent Massachusetts license, I took *the* flex exam in 1991.
Q: Okay. Did you pass that on the first try?
A: I did.

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Q: *All* right. Are you board certified in internal medicine?
A: I am not.
Q: Are you board certified in any medical specialty in the United States?
A: I am not.
Q: Did you complete a fellowship?
A: Yes. The equivalent of a fellowship, yes.
Q: In the United States?
A: No.
Q: What was your fellowship in England?
A: It would be described here as general medicine and gastroenterology.
Q: And how long was that?
A: Five years.
Q: The fellowship itself was five years?
A: I said, "Equivalent," because that term is not used in the United Kingdom. I was appointed as a lecturer in medicine with an interest in gastroenterology, which is, at the University of Leicester, the closest thing to a fellowship.
Q: I'm sorry. You might have told me. You came to the United States in what year?
A: 1989.

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Q: All right. So in 1984, where were you practicing?
A: At the University of Leicester in England.
Q: And what was your practice like in 1984? What did you do on a daily basis?
A: *Very* much what I do now except in a different health care system. I would be the equivalent of a faculty position here. They're termed a consultant physician working in the National Health Service but in an academic institution.
Q: So – I'm sorry. Go ahead.
A: Just to describe my – my work would be predominantly clinical practice with whatever research I could also fit into the time available.
Q: So in 1984, you were seeing patients?
A: *Yes.*
Q: Okay. On a daily basis?
A: *Yes.*
Q: Okay. What percentage of your work time – your professional time was devoted to seeing patients?
A: 100 percent.
Q: Did you have any teaching responsibilities

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then?
A: Yes, but that is considered part of the clinical work.
Q: Okay. What were your teaching responsibilities in '84?
A: I had trainee physicians on my team and residents and higher trainees that would come to endoscopic training.
Q: 1997. What's your average work week like now?
A: How would you like me to describe it?
Q: Tell me what you do on a weekly, monthly basis just so I get an idea of what your practice is like.
A: I work at least a twelve-hour day every day other than weekends. I'm a participant of the Brigham & Women's Hospital Gastroenterology Division faculty. My work is principally clinical. I spend really almost a hundred percent of my time in clinical practice.
I act as a director of endoscopy so I do have some administrative responsibility, but this is in a clinical area.
My teaching responsibilities are to the

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trainee fellows who are learning gastroenterology in our division. And I am training director for their endoscopy training.
Q: So there's a fellowship program here?
A: There is.
Q: Is that one year?
A: It's three years.
Q: It's three years.
A: And there is an additional year for advanced training, which is also attached to me.
Q: Is there also a residency program here in addition to a fellowship program?
A: There is in the hospital but not in gastroenterology. That is an elective topic.
Q: I see. So you only deal with fellows; correct?
A: Principally, yes.
Q: You're the director of The Endoscopy Center?
A: That's correct.
Q: What does it entail to be the director?
A: The Endoscopy Center at this hospital provides a facility for physicians to perform both gastrointestinal and pulmonary endoscopy. The unit

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currently sees over 8,000 patients a year. And I am responsible for running that unit and providing the facilities necessary for that to happen. That involves, obviously, a great many things which I could detail for you.
Q: How many physicians in the endoscopy group?
A: The Endoscopy Center has approximately fifty physicians that use the center. The Brigham & Women's GI faculty is – clinical faculty is six physicians. There is also an HMO that works with us, and that's another seven gastroenterologists.
Q: So in your office here, are you one of six physicians?
A: I'm one of six of our faculty, yes.
Q: Okay. Again, on a daily basis or a weekly basis, you mentioned you see patients the majority amount of your time. What type of procedures do you do?
A: I do two outpatient clinics a week. That probably adds up to forty patients a week from which a number of endoscopic procedures are required, plus the referrals that I receive for – specifically for endoscopy. And I both perform and train others in all of the gastrointestinal endoscopy procedures

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that are in practice.
Again, I can list them for you if you wish.
Q: Please do.
A: Gastroscopy, also known as EGD, which is both diagnostic and has many therapeutic components, which, again, we both perform and teach.
Colonoscopy, sigmoidoscopy and their therapeutic aspects. And then ERCP, which is what we're known for here, which is endoscopy of the biliary tract and pancreas, and, again, the therapeutic techniques that come with that.
Q: Judging from your CV, is that – would you call that your specially, ERCP?
A: Yes.
Q: How much of your practice is involved with performing ERCPs?
A: As a time component, probably 20 percent of my week is spent in that procedure.
Q: Okay. What about the other 80 percent? What do you do?
A: That's divided between the other endoscopic procedures, particularly colonoscopy, and our clinic work and the inpatient service.
Q: Can you give me an idea how many

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colonoscopies you did last year?
A: Approximately 400.
Q: And how long have you been doing *400* a year?
A: Twenty – about twenty-two years.
Q: So in *1984,* you were doing about *400* a year?
A: Probably more in 1984.
I should point out that in that time when I was in England, I was the only gastroenterologist for a population of a million people, which was busy.
Q: What type of equipment did you have in 1984 to perform colonoscopies?
A Fiber-optic endoscopy came in in the 1970s when I started performing it. And in the mid-1980s at the time that you're asking about, the equipment was not very different from the most recent fiber-optic instruments that we used until quite recently, and some people still use.
Of course in the last decade, they've given way to video endoscopes, which are what we use now.
Q: When did you start using video endoscopes?
A: About ten years ago.

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Q: And why did you make the switch?
A: It was the next technological development that was an advance on what we had before. The mechanics of the instruments did not change that much, but the way the image is displayed for a teaching situation was a huge advance for us.
Q: Can you give me an idea how the visual display was better with the new technology than with just the fiber-optic scope.
A: Optical instruments allow an operator or endoscopist to view through an eyepiece. If more than one person needs to view at the same time, it's possible to split the image by adding a piece to allow one person, and sometimes more than one person, to watch. Or one can attach a TV camera which is often what we did. The quality of that image, however, is not always ideal.
When video endoscopes came in, as they are now, the image is electronic and can be displayed on one or more television monitors either within the room or at a remote location such as the one we're sitting in.
Q: I'm sorry. When did you first start performing colonoscopies?

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A: In the mid-1970s.
Q: And toddy you mentioned your involvement with the fellows here at the Brigham. Do you have any teaching responsibilities in the classroom?
A: What do you mean by the classroom?
Q: In a medical school setting.
A: I have an appointment to Harvard Medical School, and I have taught undergraduates; but that is not my primary responsibility.
Q: Okay. When was the last time that you've taught at Harvard?
A: Well, I teach at Harvard every day here in the clinical setting.
Q: Right.
A: But in a preclinical setting, I have not been required to do that for the last four years.
Q: Your CV lists several publications, presentations, abstracts. Are there any that in particular you feel relate to this case?
A: No.
Q: Do you know when Mr. Hirshman first contacted you about this case?
A. I would have to check my file.
MR. CASEY: It looks like 3/26/96. I

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pulled that letter out.
Q: Did you get a phone call preceding the letter of March 26, 1996?
A: I think so. I'd have to check my file to see if –
Q: Please do.
A: – it told me so, but I have a recollection that I did receive a phone call.
(Witness reviews documents)
A: Yes, I did.
Q: What is it upon your review of your chart that makes you come to the conclusion that you got a phone call?
A: The letter from Mr. Hirshman dated March 26, 1996, refers to a telephone conversation that we had at some point prior to that date.
Q: Okay. From memory, do you have any idea when that conversation was, telephone?
A: I don't recall exactly. It must have been close to the date of this letter, however.
Q: Okay. Within a month, would you say?
A: I would guess so, yes.
Q: And you have no idea how Mr. Hirshman got your name?

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A: I did not ask him, and I'm not sure he ever told me. I do get calls frequently on many matters.
Q: What materials did you read before your report dated February 26, '97?
A: At that time, what was made available to me were copies of the hospital records from Hillcrest Hospital for admissions during 1984, 1987, and 1990 of Reverend Stephen Walick; the records from Lake Hospital for 1995; the Heather Hill Rehabilitation Hospital records; and copies of depositions from Dr. David Gottesman and Michael Eisenstat, Parts 1 and 2.
MR. HIRSHMAN: He also had the charts from their offices I believe your letter makes reference to.
THE WITNESS: Yes. I'm sorry.
A: Yes, office charts of the same physicians and Dr. Daniel Borison.
Q: I would imagine since February 26, 1997, that you've been provided with more materials?
A: I think the only additional materials I've seen are expert testimony from Frederick Slezak and Frederick Thomas dated December 2, 1997. I'm sorry. The letter is dated December 2. The

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testimony is dated October 2.
MR. HIRSHMAN: By "testimony," you mean their expert reports?
THE WITNESS: Their expert reports.
A: I think that's all.
Q: That's fine. Did you perform any independent medical research in reviewing this case?
A: No.
Q: Okay. Were you provided any medical literature or research by Mr. Hirshman?
A: No.
Q: Did you consult any other physician in reviewing this case?
A: No.
Q: This is your only report, February 26, '97?
A: It is.
Q: Okay. Did you produce any rough drafts?
A: If I did, I no longer own them.
Q: Okay. Is it your usual custom and practice to produce rough drafts in these types of cases?
A: I will often make notes from voluminous documents such as hospital reports. But once the final copy has been produced, I usually do not keep them.

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Q: Okay. Did you make notes in this case?
A: I probably did.
Q: And where are they?
A: I no longer have those.
Q: Are they still in existence?
A: No.
Q: Why did you throw them out?
A: I just do not have space to store all of this information, including hospital records [indicating].
Q: Did anyone help you in drafting this report of February 26, '97?
A: No.
Q: Did you talk to Mr. Hirshman before you drafted this report?
A: Only from the initial contact about the case. Of course, his request that I produce it.
Q: Okay. Did you review the contents of this report with Mr. Hirshman before you finalized it?
A: No. Only after I documented it.
Q: I notice you have a bill in there?
A: Yes.
Q: Could you briefly tell me what you're charging Mr. Hirshman for reviewing this case.

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A: In a letter dated July 2, 1996, I billed three hours at $250 per hour for review of all documents.
Q: Is that your usual rate, $250 an hour?
A: Yes.
Q: Do you charge more to produce a report?
A: No. That's part of the review process.
Q: To date, how much time have you spent on this file?
A: That's hard to say.
MR. CASEY: There's another bill in there, Doctor. That might help you.
THE WITNESS: Oh, is there?
(Witness reviews documents)
A: Oh, I'm sorry. There is a second bill of the same amount. I'm sorry. I forgot. It is ten months ago. So that would be a second three-hour period of time.
So other than those six hours, there obviously will be other periods of time that I haven't documented.
Q: Do you believe six hours is basically the total that you've spent prior to today?
A: That's the principal time in which I've

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been reviewing documents, yes, other than today.
Q: What do you charge an hour for your deposition?
A: I would probably charge the same amount.
Q: Do you have a different fee if you testify live in court?
A: Not particularly. As I've mentioned previously, most of my court appearances have been abroad. Sometimes there's no fee involved.
Q: Okay. Why is that?
A: Because the rules are different in different countries. Sometimes one doesn't expect a fee from court appearance.
Q: Would you get paid travel expenses over to those countries?
A: Yes.
Q: Here in America, have you had to travel anywhere for a deposition?
A: No.
Q: Have you had to give video testimony before?
A: Yes.
Q: Okay. That was used in court?
A: It has not been used yet.

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Q: Okay. And then was that 250 an hour?
A: Actually, I did not charge for that yet.
Q: Okay. The money that you charge to review cases, does that money go to you; or what happens with that money?
A: It goes to a divisional fund.
Q: Okay. Divisional fund, say, of all the doctors in your practice who provide expert testimony work?
A: No. It's a divisional fund that is under my name but is administered by the hospital and is used at my discretion for educational/research purposes, mainly to support the fellows.
Q: What I'm interested in is do you personally retain any of the funds that you charge for expert testifying?
A: I do not,
Q: It all goes into the fellowship program?
A: Correct. Other than my traveling expenses.
Q: Have you ever been sued for medical malpractice yourself?
A: I have not.
Q: All right. Doctor, do you have your own copy of your expert report in front of you?

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A: I do.
Q: Okay. Now, I've read your report; and – well, first of all, do you have any criticisms of Dr. Gottesman's care and treatment in this case?
A: Perhaps I should ask if we're – are we going to go through the chronology of this case step by step? In which case I can answer your question in that way; otherwise, I'm happy to do it now.
Q: I'm just asking you if you have any criticisms of Dr. Gottesman's care and treatment in this case.
A: My only concerns from the gastroenterologist's point of view concern the diagnosis of the colonic lesion in question – in other words, the polyp of the hepatic flexure – and the continuing responsibility to the patient once the referral was made to a surgical colleague.
I think that summarizes my concerns.
Q: I need to know in what ways you believe that Dr. Gottesman deviated from accepted standards of care for a gastroenterologist in 1984. You used the word "concern," but I need to know if you believe he deviated from accepted standards of care.

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A: I believe that a gastroenterologist's responsibility is to make – is to perform a procedure requested or that the gastroenterologist feels is appropriate, and I have no question with the procedures that were carried out here. They were very appropriate, the initial sigmoidoscopy and the subsequent colonoscopy.
The responsibility is also to make an accurate diagnosis and to provide treatment when appropriate. The sequence of events in this case are such that there was not sufficient time between the diagnostic procedure and the subsequent surgical treatment for that accurate diagnosis to be available and, as far as I can tell, discussed with the patient, keeping in mind that I'm going on the records that I mentioned that were available to me.
The second issue that I mentioned just now is that to me, the responsibility to the patient continues both before and after referral to a colleague. And if a course of treatment is advised by a colleague with which I disagreed, I would not only discuss that with the colleague but also with the patient.
So to answer your question, Dr. Gottesman

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may have been inadequate in maintaining – in providing an accurate diagnosis of that particular lesion at the hepatic flexure, which I'm sure we'll discuss because that's the basis of what was subsequently performed surgically, and the way that the patient was made aware of that diagnosis and the treatment that was offered by his surgical colleague, Dr. Eisenstat. I have not seen documented anywhere in the records made available to me that such a discussion ever took place with the patient prior to the surgery which was performed the day after the colonoscopy.

Q: Okay. Why don't I stop you right there because you used a phrase "may have been inadequate." I need to know do you have an opinion to a reasonable degree of medical certainty that Dr. Gottesman deviated from the accepted standards of care in this case?

A: You mention 1984. I think the timing probably doesn't make any difference because the same decisions would have to be made today as in *1984.* So, yes, I think that – those two elements I mentioned were below the standard of care of providing an accurate diagnosis which led to the

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patient's surgical treatment, which, as I'm sure we'll discuss shortly, was also inappropriate based on the documentation that I have.

Q: Okay. You use the word "think" in there. Again, I need to know if you have an opinion to a reasonable degree of medical certainty or probability –

A: I believe –

Q: – whether Dr. Gottesman deviated from accepted standards of care.

A: I believe that's what I just stated.

Q: So you do have an opinion to a reasonable degree of medical certainty that Dr. Gottesman deviated from accepted standards of care in this case?

A Yes, in those two elements that I mentioned.

Q: And one is providing – I don't want to put words in your mouth.

A: Well, I think I've stated it three times now. In providing an accurate diagnosis of a colonic lesion and a responsibility to the patient in treating that lesion.

Q: Okay. Could you explain for me why you

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believe providing an accurate diagnosis of a colonic lesion in this case, that there is a deviation in that regard.

A: The – the records show that this patient presented with at least two symptoms, one, rectal bleeding, and, secondly, diarrhea intermittent diarrhea. Although, that part of the history seems to vary from chart to chart depending on who took the history.

The rectal bleeding does not seem to be in question. This led Dr. Gottesman quite correctly to investigate the cause initially by sigmoidoscopy, which he performed in his office and again a colonoscopy which he performed at Hillcrest Hospital, both appropriate examinations.

At both examinations – both endoscopic examinations, he recorded the presence of up to six polyps throughout the colon, one of which caused him concern, namely, the lesion at the hepatic flexure because of its size and appearance, as he described. And that concern led him to the possibility of there being cancer in that lesion or that it might be precancerous.

Biopsies were taken of that lesion, and

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some of the other polyps were either biopsied or removed at the colonoscopy. And that was performed on November *6, 1984.*

Immediately following that examination, he consulted a surgical colleague, Dr. Eisenstat, who I understand was present at the time that the colonoscopic findings were described to the patient. So in other words, very shortly after the examination and long before any pathology report would be available.

During that conversation with the patient and the consultation that took place with the surgical colleagues, a decision was made to proceed to surgery. That surgery was decided preoperatively to be an extensive resection. In other words, a subtotal colonectomy as I think was stated in Dr. Eisenstat's chart.

The operation was performed the next day again, as far as I'm aware, before the availability of the pathology report which subsequently showed that this was not a premalignant lesion nor a malignant lesion. In fact, it was an inflammatory polyp.

So the importance of the decision to

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operate at all and what sort of surgery would be undertaken is totally dependent on the concerns about the lesion in question, about the other lesions that were present; and that is the responsibility of the diagnosing physician, who is Dr. Gottesman.

(Witness' pager sounds)

MR. HIRSHMAN: Do you have to get that?

THE WITNESS: Can I answer that, please?

MR. VOUDOURIS: You sure can,

(Recess taken)

BY MR. VOUDOURIS:

Q: All right. Doctor, we were talking about your first criticism, failure to provide an accurate diagnosis of the colonic lesion; correct?

A: Correct.

Q: All right. Briefly, what does that mean?

A I think it's pretty explicit what that means. It means that the suspicion that this was a cancerous lesion was not subsequently borne out by the biopsies, and yet decisions were taken and requested of a surgical colleague to perform a colonic resection which may not have been required at all.

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Q: Do me a favor and look at your report.

A Yes.

Q: On the second page, the second full paragraph, you say Father Walick was referred to Dr. Eisenstat for consideration of surgery which was performed on 11/7/84.

A: It does state that. Correct.

Q: In your opinion, then, does that mean that at that point in time, no judgment had been made as to surgery?

A: Quite the opposite. A judgment had been made.

Q: By whom?

A: That's why the request was made in the first place. If you want your patient to be considered for surgery, you ask a surgeon. If you don't want to consider that patient for surgery, you don't do that.

There's also the question of timing. If you think a level of urgency is required for something to take place, obviously, you ask your surgical colleague to see your patient more urgently than not. I could not see the reason for that in the charts.

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Q: Have you ever referred a patient to a surgeon before you had gotten pathology reports back?

A: Yes.

Q: Do you do that frequently?

A: Yes.

Q: Can you give me some occasions why you do that?

A: Usually for convenience, because the patient may have to come a second time to see a particular surgeon. And if the patient is already here with me, I can save time by getting the patient to see that surgeon if he is available. It doesn't mean I want the patient operated on immediately. It's usually a convenience for the patient so they doesn't have to travel again to come to the hospital.

But no decisions are taken until all the information is available. And, often, the biopsies alone may not be enough to make those decisions final. It doesn't mean we shouldn't discuss the options. And that's what I'm trying to imply here, that the options did not seem to be discussed with Father Walick at the time as far as I can tell.

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Q: So you've referred patients to general surgeons before you've gotten pathology back; correct?

A: I have done, yes.

Q: All right. Okay. And was that partly because you envision that surgery might be necessary for that patient?

A: That's correct.

Q: In all the times that you referred a patient to a general surgeon, have you known exactly the date and time when that general surgeon was going to perform surgery?

A: No.

Q: Is there any indication in any of the records, any of the materials that you reviewed that Dr. Gottesman was aware of when Dr. Eisenstat planned to do surgery?

MR. HIRSHMAN: Are you suggesting Eisenstat was a runaway surgeon here?

Q: Can you answer my question.

A: I do not recall seeing it documented that the date was - that knowledge of the date was made available to Dr. Gottesman. However, there is very little documentation of what was discussed following

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the colonoscopy other than I think what was stated by the – by Reverend Walick that the results were discussed in the presence of Dr. Eisenstat following the colonoscopy at which time surgery was discussed.
MR. CASEY: Wait. Wait. Wait. Just so I understand, when I wrote this down earlier, he didn't review Father Walick's deposition.
MR. HIRSHMAN: Sure he did.
MR. CASEY: I mean I did not get that on the list of things you reviewed.
MR. HIRSHMAN: I think it's on the list in one of the letters as a matter of fact.
MR. CASEY: I just didn't write it down, Toby. That's why I stopped it.
THE WITNESS: Sorry. I don't recall whether I mentioned it.
MR. HIRSHMAN: Whether it's in the letter or not – and I'm not sure it is – it's right here.
Q: So, Doctor, back to my original question. Do you find anything in the medical records that would indicate or support the fact that Dr. Gottesman was aware of the time – the exact time and date that Dr. Eisenstat planned to do the surgery?

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A: No, I do not.
Q: Okay. Do you believe that the standard of care requires that gastroenterologist to know when a general surgeon **is** going to perform surgery on one of his patients? And when **I** say "know," I mean the exact time of day.
A: It may not be the standard of care, but it's how our medical system works. If I ask a colleague to do something, **I** like **to** know when it's going to happen. If you were my patient, I'd certainly like that to be the case.
Q: **I** want to understand if you believe it's a standard of care for a gastroenterologist to be aware of the exact date and time when a general surgeon is going to perform surgery on one of his patients.
A: If you phrase the question like that, no. However, if the surgeon chose to operate the same day and, therefore, I did know the date and time and I disagreed, then it would become very important. Or the next day.
Q: Did that happen in this case?
A: It occurred the next day.
Q: It didn't happen the same day?

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A: No. But I'm asking you **a** hypothetical question with a hypothetical answer. In that case, it would be important to know the date and time.
Q: I'm asking you a factual question. Does anything in the records indicate to you that Dr. Gottesman was made aware by Dr. Eisenstat the exact time and date that surgery was going to be performed?
A: No. **I** see no documentation.
Q: And you just told me that the standard of care does not require a gastroenterologist to be aware of the exact date and time of when a general surgeon is going to perform surgery; correct?
A: That's correct.
Q: As a gastroenterologist, do you tell your patients the risks and benefits of certain surgical procedures?
A: If I am cognizant with them, then I do, yes.
Q: If you're not cognizant of them, you leave that to the general surgeon?
A: I do.
Q: Do you perform surgery yourself?
A: Not general surgery, no.

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Q: Have you ever performed general surgery?
A: During my training, I did, yes.
Q: Okay. How many years ago was that?
A: Of the type of surgery that you're asking me, and excluding endoscopic surgery, the **last** time was 1972.
Q: Okay.
A: I'm sorry. 1973.
Q: Do you think it's within the standard of care and reasonable for a gastroenterologist to defer questions on risks of procedures, specifically one that was done in this case in ***1984,*** to the general surgeon?
A: Which procedures are we referring to?
Q: To either some type of colon surgery, general surgery, open or laparotomy?
A: Well, that's not just one question, though. I think you have to be clear about what type of surgery we're discussing. You can discuss the risks and – risks and benefits of a laparotomy which you just mentioned; however, there are many types of colonic resection, each one carrying different types **of** risks.
Q: I understand. And you don't perform those

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types of surgery, do you?
A: No.
Q: And to the best of your knowledge, Dr. Gottesman doesn't perform those types of surgery?
A: To the best of my knowledge, he doesn't.
Q: And to the best of your knowledge, he didn't perform those in 1984, did he?
A: Not as far as I know.
Q: So it's reasonable for a gastroenterologist to defer questions on surgical risks, techniques, complications to the general surgeon who's doing the surgery; correct?
A: Yes.
Q: Have you ever in your career referred a patient to a general surgeon without getting pathology reports back based on what you visibly observed during a colonoscopy?
A. Yes. You asked me that just now.
Q: Okay. And why did you do that?
A: For the reason that if I'm suspicious that the patient has a cancer, which is often the reason for such a referral, I may ask for the surgeon to meet the patient when that patient is still here in

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the hospital, usually for convenience as I mentioned earlier. There are very few situations where it requires such a degree of urgency that it has to be done.
I want to make it clear it's for convenience, but decisions are often not taken at that point as to exactly what is required.
Q: Well, who makes the final decision as to surgery? The gastroenterologist or the general surgeon?
A: That's – in my practice, that's often a joint decision based on the nature of the case, the nature of the pathology, the patient's wishes, the nature of the disease. All those issues have to be taken into account.
Q: Okay.
A: Often, we change our minds. Surgery may not be the most appropriate treatment for someone even though it may be considered so initially.
Q: Do you think it's unreasonable that a general surgeon makes a final determination as to surgery?
A: In general, no, it's not unreasonable. It depends on the surgeon.

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Q: Now, you said you've referred patients to surgeons without having pathology back when you've done a colonoscopy and seen polyps that to you were suspicious of cancer; correct?
A: Yes. I wouldn't say polyps, but certainly if I'm suspicious of cancer, yes.
Q: Well, what do you mean instead of polyps? Would there be something else other than polyps?
A: Well, a polyp and a cancer may not be the same thing.
Q: I understand.
A: Obviously, a polyp can be malignant, also.
Q: Right.
A: In general, we remove polyps. And some of those turn out to be cancerous. Some cancers are obvious from the beginning; and, yes, there are occasional cases where we're not absolutely sure whether it's cancerous at the time of the colonoscopic inspection. Of course, that's why biopsies are taken.
Q: But based on your experience, you've had 4 occasions where you've looked through a scope, seen a polyp or a mass that you thought was suspicious of cancer, made a referral to a general surgeon before

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a definitive diagnosis came back from pathology; correct?
A: That's correct.
Q: All right. And you mention you do that for convenience, but also in the back of your head is the fact that this person is going to need surgery or possibly surgery to have these cancerous be they mass, growth, section removed; correct?
A: Correct.
Q: Have you ever had a patient who underwent a colonoscopy and then underwent surgery within two days?
A: For any case? Or are you talking about cancer only?
Q: For any case. And then we'll talk about cancer.
A: Sure.
Q: Give me some ideas about those cases.
A: Patients with ischemic bowel disease where we're called upon to perform a colonoscopy as an emergency, a lot of those patients are operated on the same day. That's a very different situation from the one we're discussing here.
Q: I understand. How about with colon cancer?

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A: Within two days, I cannot recall a patient right now. The only situation where that might be relevant for a colon cancer is where the cancer is obstructing and an emergency procedure is required to decompress the colon. Although we have methods for treating that endoscopically also now so – in other words, those are emergency situations.
Q: Right. Earlier, you talked about one of the reasons you refer to a general surgeon before you get pathology back. But in instances where you've seen suspicious nodes or polyps is for convenience; right?
A It's not nodes. You did not see nodes.
Q: Polyps? Masses?
A: Yes.
Q: And it's for convenience sake; correct?
A: Yes.
Q: Convenience for the patient?
A: Yes.
Q: Okay How so?
A: In general, if you perform a colonoscopy and you're suspicious of cancer, if you wait for the biopsy to come back to be absolutely sure and then make the determination several days later, the

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patient then has to come to the institution again, meet the surgeon. A discussion has to take place and a decision made.
Often, I will put the patient in contact with the surgeon at the time if I think it's appropriate just so they at least meet.
But the patient is sedated so that's an absolute taboo for making any fiim decisions about anything. And that's why I say it's for convenience. It's not to make final decisions. It's really for no other reason than the two parties to meet each other.
I work particularly with one surgeon who is often in our endoscopy center, and I use him for that purpose.
Q: What's that surgeon's name?
A: David Brooks.
Q: What is involved in your patients prior to a colonoscopy? What do they have to do?
A: In what respect?
Q: Well, they have to clean out their bowel; correct?
A: Oh, preparation. Sure. Our traditional preparation – which has changed over the years –

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after a decision that a colonoscopy is required is the patient will be given written instructions referring to preparation. And they will take some sort of cleansing procedure, of which we have a range **of** different ones, prior to their attendance at The Endoscopy Center.
Q: Okay. They have to drink something –
A: Yes.
Q: – that basically flushes their system?
A. Correct.
Q: Do you know what that tastes like?
A: I do know what it tastes like, yes.
Q: What does it taste like?
A: There are three commercially available preparations that we use that are of the same electrolyte solution, and they are salty in taste. Some of them are flavored; some of them are not.
There's an additional type of preparation that's smaller in volume than the electrolyte solutions that is pretty tasteless but does the same job, and that's actually the one we use most often here.
Q: Do you know what Reverend Walick *drank* in 1984?

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A: I'd have to check. But as far as I recall, he received something called Go Lightly.
Q: Have you ever had patients take that before?
A: Yes.
Q: What did they tell you about it?
A: I can't **think** anybody would like it, and nobody would choose to *drink* a gallon or four liters of solution. But, surprisingly, most patients seem to manage to do it and tolerate it reasonably well.
Q: Obviously, colonoscopy is not a very pleasant experience?
A: Correct.
Q: I'm sure you've gotten patient complaints about colonoscopy and how it feels?
A: Yes.
Q: Okay. What are some of those complaints?
A: Most patients – remembering that they are – the majority are sedated, although not all, for colonoscopy – complain that it **is** uncomfortable, even painful at times; that it causes bloating because of the sensation of the air and inflation that we use in the colonoscopy and the stretching of the colon that takes place.

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Of course, they have already undergone a preparation which is also unpleasant. And they have to attend an unfamiliar place to undergo the examination, which carries its own anxieties.

So there are a number of reasons that patients might not like what they're about to undergo.

Q: Have you ever had a patient say to you after a colonoscopy, "I don't want to go through that again"?

A: Yes.

Q: Have you ever had a patient who underwent a colonoscopy who you wanted to come back for a repeat colonoscopy just not come back because of the pain or the misery associated with the colonoscopy?

A: Have I ever? There must be patients. I can't think of any right now. But having colonoscoped many thousands, yes, that must have happened.

Q: You believe that's happened?

A: Yes.

Q: Would one of the reasons for an immediate referral to a general surgeon – and we're talking about convenience – the fact that if surgery is to

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be done, that the patient has already been prepped, their bowel is pretty much clean, basically they don't have to go through the same thing twice for the surgery because they've just been through it for the colonoscopy?

A: What's your question? Is that a reason?

Q: For convenience.

A: There's a big difference between convenience of a bowel prep and having a colon resection the next day for convenience. I mean that's a big operation we're talking about.

If all of the answers are in place, and the decisions can be made, then, of course, it's very convenient for the patient not to have to undergo a bowel preparation all over again. However, that's not the reason to do it at that time.

Q: At the time in *1984*, I believe the Reverend Walick was *41* years old. So let's take a patient hypothetically of that age.

A: Yes.

Q: Okay. If you had a patient around that age who had one adenomatous polyp, do you have any idea what the chances are that he would have a second such polyp?

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A: What *size* is the first one?

Q: One centimeter.

A: We choose one centimeter for a good reason in that we know that polyps smaller than one centimeter when they're alone carry a very small risk of there being a second or more polyps elsewhere in the colon. Although that is still being studied even today.

As soon as the polyp is one centimeter or greater, the risk increases. And that's why our advice when we find a single polyp of that *size* on sigmoidoscopy is to perform a colonoscopy.

Q: Do you know what the risk is that there will be a second adenomatous polyp if you already found one that is one centimeter in size?

A: You want a percentage risk?

Q: Yes, based on your knowledge.

A Well, our knowledge may be changing from studies that we're doing here; but I think the general belief is that there is at least a 20 percent risk that there will be a second polyp somewhere else in the colon, and that risk is sufficient to look for it.

MR. HIRSHMAN: Synchronous? Or are we

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talking about –

THE WITNESS: Synchronous, I presume.

Q: Now, suppose you have two adenomatous polyps. What's the chance of having a third? Do you know?

A: Both are one centimeter or greater?

Q: Yes.

A: The chances are at least 20 percent and could be greater. The data are not accurate if you're going to ask me a series of questions about numbers of polyps.

Q: What about in 1984? Did you know what the data said in 1984?

A: There was obviously less data than there are today, but there was still quite a lot of evidence particularly from Saint Mark's Hospital where much of this work was performed in London from the late '70s and early '80s where the evidence was even more so than today that we would look for further polyps if you found one in the rectum or the sigmoid colon.

At that time, we did not have the information about size. So even small polyps were pursued more so than today.

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Now we have the confidence that smaller polyps are of less of a concern.
Q: I want to give you a hypothetical. I want you to assume that you have a patient roughly Mr. Walick's age, *41*, at the time who had two adenomatous polyps and a two and a half centimeter villus appearing polyp. Absent pathology, what would you think that third two and a half centimeter lesion would be?
A: Are we discussing Father Walick or something else?
Q: I just want to know if you have a patient roughly that age and you perform a colonoscopy –
A Yes.
Q: –you see two adenomatous polyps one centimeter in size –
MR. HIRSHMAN: I will object to that as being unrelated to the facts in this case.
Q: – and you see a two and a half centimeter villus appearing polyp, without getting anything back from pathology, what would you think would be the likely etiology of that **two** and a half centimeter polyp?
A: Well, I have to qualify your question

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because you called the first two adenomatous. Obviously, we don't know what they are.
Q: Okay.
A: Certainly, in the 1980s, we wouldn't have had the techniques available or the endoscopic appearances documented that you could tell just by looking what they were.
But that aside, polyps of that size somewhere in the distal colon and then a lesion of two and a half centimeters which you've called villus at the hepatic flexure would obviously cause concern because of its size.
Now, you've not told me anything else about the polyp so I can't really answer your question any more accurately. But those lesions could still all be benign.
Q: Why would it cause you concern?
A: Because we know that polyps, the larger they are, the more likely they are to harbor malignancy in general.
Q: In such a situation where you found two adenomatous polyps and another two and a half centimeter polyp that you thought might be villus and that you could not resect, would it be

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reasonable to refer that patient to a surgeon before you get pathology back?
MR. HIRSHMAN: Let me object to that question, too, unless you can tell me how you know that the two polyps are adenomatous and where you get your information that the villus polyp is one centimeter in size or greater.
With those exceptions, you're free to answer the question.
A: Well, as I stated in your previous hypothetical question, often one does not know they're adenomatous until they're removed and examined.
Q: And you've referred patients to a general surgeon just based on what your observation is, your suspicion; correct?
A: Of polyps?
Q: Correct.
A: No.
Q: Well, you have never referred a patient to a general surgeon after colonoscopy in which you observed polyps that you thought were suspicious for cancer?
A: Never, because that's not the question you

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asked me earlier.
Q: Okay. What's the difference?
A: If I think the patient has a cancer, for convenience, as I mentioned, I may refer the patient before pathology is back. However, if it's a polyp, and for some reason I can't remove it or I think it's unsafe to remove it, then I will wait for biopsies to tell me what it is **first** before I refer the patient because at that stage, I'm not sure what the appropriate treatment **is.**
Q: Do you think it's a deviation from the standard of care for a gastroenterologist to refer a person to a surgeon in that situation?
A: No, for an opinion.
Q: Exactly, for a surgical opinion –
A: Yes.
Q: – by the general surgeon.
A: Yes. That's not the same as referring for surgery. No, that's perfectly acceptable.
Q: Well, what's the difference?
A: Well, I'm not sure we're talking hypothetically or about this case now.
Q: Well, let's talk specifically about this case.

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A: Okay. This polyp, the one in question that's two and a half centimeters in diameter was not described as villus in Dr. Gottesman's report as far as I recall. He described it as multilobulated. The surgeon described it as villus many times even in correspondence to the primary care physician. At no time is the pathology described as **villus, and** I don't think Dr. Gottesman described it in that way.

So I think it's a little misleading to be discussing a **villus** lesion that may not have been present.

Q: Okay. Do you recall –

A: Just so that we're clear, villus architecture in a polyp does carry certain connotations. And we know that villus tumors – benign villus tumors carry a higher malignant potential than tubular adenomas. And sometimes you can tell the difference by examination of colonoscopy.

Q: Okay. You read the doctor's deposition, Dr. Gottesman's deposition?

A: **Yes.**

Q: Do you recall him ever in that deposition

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referring to the polyp that he cannot remove as appearing villus to him?

A. I don't recall. I'm basing it on what he originally described in his endoscopy report, which I think was – did not contain the word "villus," but I may be –

(Witness reviews documents)

A: I can quote from the endoscopy report of 11/6/84 that at the hepatic flexure or distal ascending colon, there was a multilobulated, flat, two and a half cm polyp with some satellite lesions which was biopsied. The word "villus" is not mentioned.

Q: Okay. I ask do you recall reading in Dr. Gottesman's deposition where he described that larger polyp that he could not remove as appearing villus?

A: I don't recall, but I do remember that the word "villus" was subsequently used by Dr. Eisenstat and Dr. Gottesman.

Q: Okay. What **does** severe architectural atypia mean to you?

A: Atypia is a pathological term used to describe appearances under the microscope

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principally of the nuclei of cells in certain contexts. The context in which it is seen is very important because the interpretation of atypia may be very different depending on that context.

When it's seen in an adenomatous tissue, atypia, which is a word used by some pathologists, or dysplasia, which is a similar term used by other pathologists, is used to denote a higher degree **of** abnormality, in other words, a tendency towards malignancy.

However, it's important to note that atypia when in the presence of inflammation may mean very little. So the context in which it is seen is very important.

Q: Well, can you have inflammation **and** atypia at the same time?

A: ***Yes.***

Q: Can you have inflammation **and** an adenomatous polyp at the same time?

A: **Yes,** it's possible.

Q: Just *so* I'm clear, do you believe it was unreasonable or below the standard of care for Dr. Gottesman in this case to refer this patient to a general surgeon before Dr. Gottesman got the

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pathology back?

A: No, that was not unreasonable.

Q: Going back to your report, Doctor, if I look under the opinion section, first paragraph, last line: In **1984,** colonoscopic surveillance would have been the management of choice.

All right. When you say "management of choice," does that mean that there are also at that time other reasonable treatment options?

A: For what?

Q: For this type of polyp or these polyps.

A: You didn't read the rest of the sentence.

Q: Okay. We can read it. I don't want to be unfair to you.

With or without treatment of co-existing inflammatory bowel disease if this was substantiated.

A: You see we haven't really discussed the other interpretation of this lesion which, as you know, turned out to be inflammatory and not neoplastic at **all;** that this was inflammatory bowel disease. And you will recall at the beginning I mentioned that invariably, there had been documented in his history that he had suffered from diarrhea

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prior to presentation to Dr. Gottesman, raising the possibility that there may be inflammatory bowel disease as a cause of both the bleeding and the diarrhea. And that's why we come back to the whole issue of accurate diagnosis.
If the polyp is not adenomatous, then diagnosis may determine appropriate therapy which may not involve surgery. And the other polyps that were seen at the time of the colonoscopy could easily be removed endoscopically; and, indeed, most of them were.
So in that case, endoscopic surveillance or colon endoscopic surveillance would be the management of choice rather than removal of the colon.
Q: By your term "management of choice," I take that to mean that that's not the sole treatment that would have been within the standard of care. In other words, would a surgical consult and removal – partial removal of the colon been within the standard of care if the patient desired so?
A. It's possible that partial removal of a lesion that was suspicious for cancer or suspicious of a premalignant lesion that could not be removed

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through surgery could be resected, yes.
Q: And that would have been within the standard of care?
A: Of course.
Q: You mentioned inflainmatory bowel disease. What evidence do you have that in *1984* this gentleman had inflammatory bowel disease?
A: None prior to the colonoscopy which the biopsies from which documented that he had features of inflammatory bowel disease in that polyp at the hepatic flexure.
Q: Before the pathology came back, was there any indication that this guy had inflammatory bowel disease?
A: Not from what is documented, no.
Q: There's nothing in Dr. Gottesman's operative report of the colonoscopy that suggested inflammatory bowel disease, is there?
A: No.
Q: Is it fair to assume that a general surgeon would make himself or herself aware of all pathology results prior to performing surgery?
A: I would hope so.
Q: Okay. And as a gastroenterologist, you,

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yourself, would rely that a surgeon would do so?
A: Yes.
Q: I think – I believe you already told us that you don't know the exact surgery schedule, exact time, that a patient that you have referred is going to be operated on by a general surgeon; right?
A: I usually do, yes.
Q: But you don't know all of them, do you?
A: At the time that I refer the patient, no; but I always know subsequently.
Q: Okay. Prior to surgery?
A: Oh, yes.
Q: But do you believe that the standard of care requires the gastroenterologist to be aware of the exact time and date?
A: No.
Q: Do you agree with me that Dr. Gottesman had a right to rely on Dr. Eisenstat that Dr. Eisenstat would check the pathology before operating on this patient?
A: Yes, I think that's a reasonable expectation.
Q: You mentioned earlier that you had read the report of Dr. Gottesman's expert, Dr. Thomas; is

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that correct?
A: Yes.
Q: Do you know Dr. Thomas?
A: I do not.
Q: Have you ever heard of his name before?
A: I haven't.
Q: I want you to refer to the first page of his report. It's dated June 26, 1997.
A: Yes. I have that.
Q: Do you disagree with his second sentence? And I'll read it.
"It is quite common and certainly within the standard of practice for gastroenterologists to refer patients to surgery based on the gross appearance of a large sessile polyp, which cannot be removed with a colonoscopic snare polypectomy." Do you agree with that?
A: Where is that?
Q: Last paragraph, second sentence. Take your time.
MR. HIRSHMAN: Last paragraph of the report?
MR. VOUDOURIS: First page.
(Witness reviews document)

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A: That statement is true; however, no attempt was made to remove this polyp so we don't know that it's not removable. Nobody attempted it.
Q: Well, is there any reason for you to believe that Dr. Gottesman could have removed that polyp if he said he could not?
A: I don't know that he made the attempt. He was concerned about its appearance, which I accept, and did the appropriate thing, which was to biopsy it. However, if time had allowed that biopsy to be reviewed, maybe the sequence of events would have been different.
But it turned out not to be an adenomatous polyp so it would not be necessary to remove.
Q: Well, does the standard of care require you to remove that at that time not knowing what it was?
A No. I'm not saying that he should have.
Q: Have you had situations where you have seen a polyp that you have not attempted to remove?
A: Yes.
Q: And why was that?
A: Usually because of its size and extent, but I may have done so on a separate occasion once I knew the nature of the pathology or that it didn't

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require removal.
Q: Okay. And I believe you've already told me you agree with this, but let's just double-check.
The second page of Dr. Thomas' report, the first full sentence on the top of the page, "It is certainly appropriate, in my opinion, for Dr. Gottesman to have referred this patient to surgery."
Do you agree with that statement?
A: Not as it's worded, no.
Q: Why not?
A: I would accept that it's appropriate for him to consult with a surgical colleague for an opinion but not necessary to refer the patient to surgery, which suggests that the decision has already been made. That's how I read that statement.
Q: Is there anything – any fact that you're relying upon that Dr. Gottesman had said, 'You're going to have surgery," that it was solely Dr. Gottesman's call?
A: As I recall, in his very first endoscopy report, which I quoted in my report, polyps five and six were left alone because the patient would have

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to undergo a right hemicolectomy, which I believe were his words.
So it sounded like he had made the decision for surgery even during the colonoscopy.
Q: Then why would he even bother taking biopsies?
A: You'll have to ask him. I don't think it's appropriate for me to answer that question.
Q: Why not?
A: Because he took them. I can't tell you what his thinking was.
MR. HIRSHMAN: You're asking him to read Dr. Gottesman's mind.
Q: I'm asking you in your opinion why would a gastroenterologist bother to make biopsies if the decision for surgery had already been made? Don't you understand?
A: I do understand; and I would have taken biopsies, also. But I'm telling you that in his report, it sounds like he's made the decision for the patient to undergo surgery
Q: So you're basing your opinion solely on the impression from the report?
A: It's not an impression. It's a statement.

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The patient would have to undergo a right hemicolectomy.
Q: Okay. Did he undergo it?
A: No. He underwent something much more extensive.
Q: So he didn't undergo that procedure?
A: No, not by name.
Q: Let's go to the next paragraph in Dr. Thomas' report, Page 2. Again, we might already know the answer.
"I do not find fault with Dr. Gottesman's care of this patient, nor his referral to a surgeon after seeing the gross appearance of a large right sided colonic polyp."
Do you agree with that statement?
A: This is different wording. I can agree with that statement, yes. Referral to a surgeon.
Q: All right. Well, you've had an opportunity to look at the report of Dr. Thomas; correct?
A: Yes.
Q: Before today?
A: I saw it today.
Q: Okay. You had an opportunity to read it before the deposition?

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A: Yes.
Q: Any statements in here that you disagree with?
MR. HIRSHMAN: You know, if you want to ask him about a particular statement, do it. I'm not going to – I don't think that's a fair question. There's a lot of sentences in there. Why don't you just go through the report and pick out whatever you want him to opine about.
Q: I don't think it's that long, Doctor. Is there any statement in here that you've read that you disagree with, in Dr. Thomas' report?
MR. HIRSHMAN: Note my objection to the question.
A: Well, much of the large paragraph on Page 1 is factual –
Q: Correct.
A – is the chronology of the case. And I see no objection to that. It documents the colonoscopy. It documents the subsequent surgery. And it documents the pathology.
I would object to the statement that the large sessile polyp could not be removed as we discussed just now as no attempt was made to do

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that.
Q: What do you base that on, that no attempt was made to remove it?
A: Because there's no statement in the endoscopy report that an attempt was made.
Q: You told me that the standard of care didn't require it to be removed; correct?
A: No. But for something to be stated as not removable or that cannot be removed, there either should be a statement that an attempt was made and it's impossible or the reasons for that failure. I haven't seen that.
Q: If I understood you, though, you mentioned a little bit earlier that there have been occasions where you have not removed a polyp because you thought it was unsafe to do so; correct?
A: At the time.
Q: That's fine. Oh, please continue.
A: But as I say, it doesn't mention that in this report. The reason that it was not removed is that surgery would be required. I'm just reiterating what I read.
MR. HIRSHMAN: Let me stop you.

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If you want to ask him about specific statements, go ahead. I'm not going to ask him – I'm not going to let you ask him to opine about the report in general terms. If you want to go through it sentence by sentence, that's your prerogative. Go ahead. Be my guest.
Q: Doctor, we were at the last paragraph on the first page. You said you disagreed with the statement that the polyp could not be removed; correct?
A: Correct.
Q: All right. Keep reading. Tell me when you get to a statement that you disagree with.
(Witness reviews document)
A: Some of these statements are hypothetical such as the statement about a biopsy reported as showing no malignancy but there remaining a question whether or not a polyp could harbor malignancy. That's true but not strictly relevant to this patient.
We've already discussed the two statements about referral to surgery which Dr. Thomas expresses in two slightly different ways. Maybe he means the same on both occasions, but I would interpret them

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differently. Referring to surgery and referring to a surgeon are not necessarily the same thing. It may be a semantic distinction in his view.
I certainly don't object to taking biopsies from the polyp, as we've already discussed; and I think we've discussed everything else here.
Obviously, we disagree about the standard of care as, again, we've already discussed.
Q: Now, we talked mostly about your first criticism which was providing an adequate diagnosis of the colonic lesion. And then you had a second criticism dealing with the responsibility – the continued responsibility of the gastroenterologist once the referral is made?
A: Yes.
Q: What do you mean by that?
A: Well, in most clinical care situations, unless it's an emergency and completely outside the control of the initial physician, the responsibility for care continues. It doesn't stop the moment you ask somebody else to see your patient.
A referral for an opinion is exactly that. It does not mean that you pass on the care of that patient to another physician unless that's what you

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wish. And with two different specialties, that's usually not the case.

Now, if the care was being transferred to another physician – in this case, Dr. Eisenstat – I didn't see any documentation of that.

So if it were myself, I would still take responsibility for that patient's management up until the time that it no longer depended upon me. In this case, it would be the surgery. Although as we've already discussed, that was probably not warranted, particularly if I didn't agree with the opinion that I was seeking because I am the advocate for my patient. And if I disagree with the opinion that's been sought, even if it's a colleague that I trust and work with regularly, then it's my responsibility to tell the patient so. And that does happen from time to time.

Q: But you as a gastroenterologist obviously would have to be made aware of the opinion of the general surgeon and made aware of that opinion before surgery –

A: Correct.

Q: – to interject; correct?

A: Of course.

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Q: Okay. And you already said it was reasonable for Dr. Gottesman to refer this patient to the general surgeon even before **he** got results back from pathology; correct?

A: It was reasonable to seek that opinion. Sure.

Q: And it was also reasonable for Dr. Gottesman to rely on the fact that Dr. Eisenstat would look at the pathology before taking this patient to surgery; correct?

A: Yes.

Q: And you also told me there's nothing in the record that indicates that Dr. Eisenstat told Dr. Gottesman at exactly what time and when he was taking this patient to surgery?

A: Correct. That is not in the record. Unfortunately.

Q: Well, are you saying that Dr. Gottesman had a responsibility for making sure that this person did not go to surgery?

A: That's a slightly unusual question. I think it's the responsibility of the referring physician to ensure that his patient gets the best treatment. Now, let's speak hypothetically as we were just now.

If I refer a patient; and the surgeon says, "I'm going to operate tomorrow," and I think that that's not appropriate, then I will voice that opinion. And I might even document it in the chart. I will certainly tell the patient and discuss it with him or her.

Now, I have an opportunity to read Father Walick's statement; and I do not get that impression.

Q: I want you to assume that Dr. Gottesman, once a referral was made to Dr. Eisenstat, did not know when Dr. Eisenstat planned to take this gentleman to surgery; was never told by Dr. Eisenstat the time that this gentleman was going to be taken to surgery; that Dr. Gottesman was never made aware that Dr. Eisenstat, if the case be true, did not look at the pathology report before taking this gentleman to surgery, then how can you say that Dr. Gottesman deviated from the standard **of** care once the referral was made to Dr. Eisenstat?

A: Because it would be my responsibility if I were in that situation to know that all those things were taken care of. That's exactly my point is that

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once you ask for an opinion, it **does** not devolve you of responsibility to that patient. Otherwise, anybody can do anything they want and just not tell you. I don't think that's a reasonable standard of care.

Q: All right. But you have to be made aware of those facts before they happen to have any impact on the decision; correct?

A: Well, you can always ask the patient. If you have no other way of knowing, the patient usually knows when they sign a consent, when they're told things are going to happen to them. I mean that's **the** last source of information within an institution and shows that communications are not very good, which is perhaps a criticism of what happened here.

And perhaps Dr. Gottesman is in a very awkward position because of another colleague's actions, and that's what you're telling me happened. I don't think that completely removes responsibility, however, of the primary physician, who is the gastroenterologist in this case, to that patient.

If this situation happened to me in this

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hospital, the hospital would take action against me for not having controlled what was happening.
Q: You mean Dr. Gottesman has a duty to control the actions of the general surgeon, Dr. Eisenstat?
A: Well, maybe I can ask you a question. Why didn't he know? How was it possible for these things to take place?
(Knock at door)
THE WITNESS: Can you stop for a second?
MR. VOUDOURIS: Sure.
(Recess taken)
THE WITNESS: We were in the middle of something.
BY MR. VOUDOURIS:
Q: Do you want to have him read it back?
A: No. I think I've explained, you know, what I think about that.
MR. HIRSHMAN: Let me just make the record clear.
We had an interruption, and Dr. Carr-Locke is back now. And either we're going to go on with the same subject, or we're going to change subjects.
Q: Do you have anything to add to that last

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sentence? I want to be fair to you. I don't want to cut you off.
A: No.
Q: I want you to assume that Dr. Gottesman made the referral to Dr. Eisenstat on Wednesday afternoon. Dr. Gottesman does his other work, goes home, comes back to the hospital on Thursday at whatever time and finds out that the surgery has already been done. I want you to assume that.
A: All right. I shall assume that.
Q: Okay. Then do you believe that Dr. Gottesman deviated from an accepted standard of care in terms of following this patient once the referral was made?
A: It was – was the patient in the hospital at the time?
Q: Yes.
A: Then who saw the patient that evening? Does he have other staff! I mean I don't know the arrangements in the hospital. If he has junior staff to care for his patients, then obviously he can communicate with them.
Q: I want you to assume that it's a private hospital and he does not.

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A: Well, my response to that is obviously if what you tell me is the case, it's a very unfortunate state of affairs that a colleague has taken decisions without reference to the physician that referred the patient. However, if it's a private hospital and there are no other staff resident – when I was in private practice, I made the responsibility to see my patients every evening before I went home, particularly after a procedure. And it sounds like that did not take place if that is what you're telling me.
Q: I want to know given the hypothetical that I gave you, that after Dr. Gottesman was with this patient, he made the referral to Dr. Eisenstat sometime around the early afternoon of Wednesday, was not called by the referring surgeon that evening, was not called by the referring surgeon that morning, and that when the first time that Dr. Gottesman comes back to the hospital on Thursday, he learns that the patient has been taken to surgery, do you believe that Dr. Gottesman still deviated from accepted standards of care by not following up with this patient between that Wednesday visit and coming to the hospital that

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Thursday?
A: Yes, I do.
Q: Why is that?
A: Because the patient was admitted under his care, and he made the referral. Therefore, he took the responsibility of asking a colleague to take that action.
Q: Okay. I want you to assume that the patient was not admitted under Dr. Gottesman's care. Do you still hold that position?
A: Well, how was the admission arranged? I mean somebody has to take – if you're telling me it was Dr. Eisenstat, I'll have to accept that. And, therefore, his care was differed from if that's how things are done at Hillcrest Hospital.
MR. HIRSHMAN: I think the service was the internist if I'm not mistaken.
THE WITNESS: That's certainly not the way things are done here, or what I've been familiar with in the past.
Q: Well, I want you to assume that the responsibility of the patient was transferred from Dr. Gottesman to Dr. Eisenstat on Wednesday, early afternoon. Are you still critical of Dr. Gottesman

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for what transpired the next day?
A: I'm still critical of the way it happened, but I can then say it was not below the standard of care because he's then transferring care. It may be bad judgment and a bad way to perform medicine; but, again, I cannot criticize him.
Q: You can't say that was a deviation?
A: No. In that situation, no.
Maybe I can just add something.
I do appreciate that colleagues can put us in very awkward positions. And if that's the way things happened, then I'm sorry that Dr. Gottesman was put in that position. Hopefully, it hasn't happened ever again.
But from the outside, I have to view what happened to that individual patient in a 24-hour period.
Q: Doctor, I probably have some questions; but I am going to let Mr. Casey ask you some questions now. Okay?
A Very well.
MR. HIRSHMAN: Mr. Casey is here, and he's going to be asking you questions presumably on behalf of the hospital and on behalf of

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Dr. Eisenstat.
MR. CASEY: Since you're trying to hold the hospital for Dr. Eisenstat's care, I guess I would have to.
MR. HIRSHMAN: I just want him to know who's asking the questions.
MR. CASEY: I'll be asking the questions.

CROSS EXAMINATION
BY MR. CASEY:

Q: Doctor, in 1984, were you licensed to practice medicine in any state of the United States?
A: No.
Q: At any time prior to *1984*, had you been licensed to practice medicine in any state of the United States?
A: Yes.
Q: For one year, from *'78* to '79?
A: That's correct.
Q: And you had provisional privileges –
A: *Yes.*
Q: – for a fellowship?
A: Yes.
Q: But at the time the procedures in this case took place, you were not licensed to practice

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medicine in any state of the United States?
A: That's correct.
Q: Upon what do you base your belief or your knowledge base on the standard of care for physicians within the United States during the year 1984?
A: I base that on my knowledge of having worked in this country now for eight years and being very much a part of the professional organizations that help establish the standards of care for the practice of endoscopy and gastroenterology; having also been very much involved in similar circumstances in the United Kingdom prior to 1989, keeping in mind that the standard of care is very similar in the two countries.
Q: Are you saying that the standards of care for physicians in the United States in *1984* were the same as the standards of care for physicians in the U.K. in 1984?
A: Well, that's a very big question. There are many similarities, particularly within gastroenterology, which is a well-defined field with similar levels of development in the two countries at that time and even today.

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Q: Does the U.K. even recognize a concept that we know as standard of care?
A: It does today. Maybe in the mid-1980s the concept was different. However, I was very much aware of the situation here traveling to the United States many times prior to my move here.
Q: So in *1984* when you were practicing in the U.K., that country did not even recognize the same legal terminology in terms of standard of care medicine?
A: It did. And even to this day, it probably uses different terminology. That's correct.
Q: The system for bringing lawsuits and for prosecuting those suits is much different in the two countries; correct?
A: Yes.
Q: Medicine in the U.K. is socialized; correct?
A There are a number of different ways patients can be treated. There is a socialized system. It's not the only one.
Q: Were you operating in the socialized system in 1984?
A: I was salaried in the National Health

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Service which is the socialized system you're referring to. I was also performing private practice.
Q: So if I understand your testimony, your basis for what the standard of care required of gastroenterologists in 1984 is based mostly on your experience in the United States since 1989; is that fair?
A: That's partly fair. I mean I did have colleagues who were here in the 1980s before I moved. So I wasn't completely unaware of the situation in the United States at that time.
Q: And you feel comfortable commenting on what the standard of care required for a gastroenterologist in 1984 for Dr. Gottesman in Cleveland, Ohio?
A: Yes. I've been asked to do that, and I'm comfortable doing so.
Q: And even though you were practicing nearly 4,000 or 5,000 miles away?
A: Yes. Actually, 4,000.
Q: You have told us that you have but for a limited surgical experience during your early training not done any general surgery since about

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1972; is that fair?
A: That's correct.
Q: Do you feel qualified to comment on the standard of care for a surgeon in Cleveland, Ohio, in 1984 when Dr. Eisenstat was contemplating taking this patient to surgery?
A: Yes, because throughout my professional career from 1974 onwards, I've worked almost exclusively with general surgeons both on inpatient and outpatient bases and during the developments of endoscopy. And I do to this day.
Q: So even though you have never done colorectal surgery, you can and will give opinions in this case regarding the standard of care for Dr. Eisenstat?
A: I'm prepared to give opinions on the decisions as to whether surgery is appropriate. Obviously, I cannot give an opinion about the technique – technical aspects of surgery which I have not performed for a long time.
Q: I think I understand your criticisms regarding whether or not surgery was appropriate in this case. And let me see if I can paraphrase it and whether you agree.

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Your criticism of both Dr. Eisenstat and what I have been hearing about Dr. Gottesman is that this patient was taken to surgery presumably before the results of the histopathology were back?
A: That's correct.
Q: If the results of the histopathology were back and had been communicated both to Dr. Eisenstat and to the patient, and the patient was given the option of continued colonoscopies or surgery, do you have any criticisms of either Dr. Gottesman or Dr. Eisenstat?
A. You're limiting your options. Those may not have been the only two options, and you have to define for me what you mean by continuing colonoscopies.
Q: Well, surveillance colonoscopies. We will repeat the colonoscopies if you so wish, and we will continue to monitor this lesion that we can't get to. Or –
A: I would disagree with that statement.
Q: Well, do you have anything in the records that would suggest to you that this lesion at the hepatic flexure was resectable?
A: You're assuming that it required

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resection. It's not a neoplasm.
Q: I understand that that is what we know now in retrospect. But we didn't know that on November 6, did we, of 1984?
A: No. That's exactly my point.
Q: And even when the biopsy results came back on November 7 of 1984, we still didn't know for sure that that was not a neoplasm; isn't that fair?
A: First of all, we don't know that the biopsies came back on November the 7th.
Q: Well, we know that the report was dictated and typed on November 7, don't we?
A: It was dated November 7. I do not know when it was made available to the medical staff.
Q: I understand. But you and I can agree that the report is typed and dated November 7; correct?
A: But I disagree with the other half of your statement, that we still don't know that there is a – whether this is a – I forget what term you used.
Q: A neoplasm.
A: Yes.
Q: So you do not give any credence to the fact that this biopsy may have been sampling error?

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MR. HIRSHMAN: To the fact or to the assertion?
Q: Well, on November 7, before we had taken it out and before the pathologist had looked at it and before. We know today that it wasn't.
A: Well, that's precisely my point. It's because we didn't know that he should not have proceeded to surgery as there was no hurry to do so.
Q: My question is: On November 7 of 1984 when the biopsy results came back and were made available – let's assume just for a moment that they were made available before the surgery.
A: Okay.
MR. HIRSHMAN: To whom? To Dr. Eisenstat?
MR. CASEY: To Dr. Eisenstat because Dr. Gottesman has said that he does not ever recall hearing those before the surgery.
Q: Assuming that those results had come back and been communicated, knowing how Dr. Gottesman had described the lesion, and knowing that two other polyps within that same colon had come back adenomatous, would that give you any cause for concern that this biopsy may have been in fact sampling error?

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A: I would be concerned that that lesion seemed to be different from the others, and one interpretation can be sampling error. Another interpretation could be it's a completely different lesion and, therefore, further information is required.
So I can partly agree with you, yes.
Q: Okay. And even in doing a repeat colonoscopy and a repeat biopsy of that lesion, without excision, without the ability to resect the entire lesion, could the doctors be certain in assuring Father Walick that there was no adenomatous portion to the inflamed tissue at the hepatic flexure?
A: Well, we have to define exactly what you mean by excision. You can take very large biopsies from the colon which increases the accuracy of the diagnosis. We do this all the time.
If your question is do we always need to remove every single piece of tissue to be absolutely sure, no, we don't. If we are convinced that a lesion is inflammatory, as this lesion turned out to be, then, clearly, we do not need to resect it because resection is not the appropriate treatment.

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It is the appropriate treatment for a neoplasm.
Obviously, I agree with that approach.
Q: So in a repeat biopsy, how much of the tissue would have had to have been gotten to make sure that this lesion was not an adenoma – did not have a portion of adenoma in it?
A: Well, I can't give you a percentage. And it's unfortunate that the photographs of lesion which Dr. Gottesman took are not reproduced in an interpretable way in the charts. That would have helped enormously.
But a large proportion of a lesion such as this can be removed for what we call excision biopsy. And it's the same technique that we use for polypectomy, and it certainly was available in 1984.
Do we have to remove a hundred percent of it? No, we don't. If you remove 50 percent and it all shows the same inflammatory tissue, one can make a reasonably confident diagnosis that the lesion is not adenomatous.
The question was raised earlier whether inflammatory tissue and adenomatous tissue can coexist; and, of course, it can. And that's why we

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take large biopsies, to ensure that sampling error is excluded.
Q: So regardless of how many biopsies we did, the possibility of sampling error can never be eliminated; is that fair?
A: No, that's not fair. Because the more biopsies you take, and the larger biopsies you take, the less likely the sampling error is going to be present.
Q: If you were the doctor who's talking with Father Walick on November 7 of 1984 after the results of this pathology come back, could you guarantee Father Walick that the polyp at the hepatic flexure was not in any way precancerous?
A: On that day, I can't guarantee it, no; but I would make my job one to ensure that was or went on a subsequent occasion.
Q: So you would recommend to Father Walick a repeat colonoscopy.
A: I –
Q: Do we know or do you have an opinion as to what Father Walick's individual fear of cancer was in regard to the average patient? Would you say it was higher or lower?

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A: I have no knowledge of that.
Q: So in reading his deposition, you formed no opinion as to whether his phobia of this potential disease was higher than the normal –
MR. HIRSHMAN: Object to the word "phobia" because there isn't any evidence in the record that there was a phobia.
Q: You made no opinion regarding that?
A: I recall that cancer was discussed, and I think he was asked about people that he knew with cancer and what treatments they had undergone. So, clearly, he was familiar with the concept of malignancy and how it's treated; but I did not form an opinion that he was somehow phobic of the disease in a psychiatric sense.
Q: Will you agree with me that a patient's concerns regarding the potential for cancer in his colon – in Father Walick's case – would be real if he had those concerns?
MR. HIRSHMAN: Objection.
A I'm not sure I understand that question.
Q: In *1984,* on November 7, after these adenomatous polyps were discovered or even before these adenomatous polyps were discovered on

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November 6 when they were resected and they looked to be adenomatous or villus adenomatous and that was communicated to Father Walick, his fear of a potential for cancer in the future would be real; correct?
A: Well, not – we come back to how things are discussed and how things are explained.
Q: Do you have any information in this case as to what was discussed?
MR. HIRSHMAN: Let him answer the question before you ask the next one. That's a rule we can all live with.
I don't think you're done answering the question. Go ahead.
A: You can remove a large polyp, which I probably do every day. You can say to a patient, "This is a neoplastic lesion. It's a tumor. I've removed it. Pathology, we'll wait for tliat." And that discussion takes place. You tell the patient that they're cured of that lesion, and we will undertake further colonoscopy as required. That's one way.
You can tell the patient they've got cancer. That's a very different way of explaining

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he same pathology.
So in answer to your question about what he patient felt, of course I can't tell you how he felt. I wasn't there. But if a particular Explanation is given, of course that can engender anxiety; and it's our job not to do that.
Q: Is there any information that you have in this case from depositions, from the records, from anywhere that either Dr. Gottesman or Dr. Eisenstat ever told Father Walick that he had cancer?
A: Well, the word "precancer" was used many times.
Q: You and I can agree that precancer is not cancer; correct?
A: Well, I know that. But I'm not sure Father Walick knows that. I've never talked to him.
Patients interpret what you say in many different ways, particularly when they're anxious and particularly when they may be a little sedated from a procedure, which is apparently when this conversation took place.
You're asking me to answer questions that are very difficult because I wasn't there.
Q: Let me ask it this way: If Father Walick

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was told that lesions had been removed from his colon that were indeed precancerous, would that have been an inaccurate statement?
A: It's not inaccurate. It's not a very genteel way of doing something.
Q: Would that have been an accurate statement?
A: If that's the way you want to describe it, that's an accurate statement. But if I said that to my patients every day, I wouldn't have any patients.
Q: The telling of – and I understand that you may do things differently. What I want to understand is if Dr. Eisenstat or Dr. Gottesman had told Father Walick that he had a situation in his colon that was precancerous, would they have been deviating from acceptable medical standards in communicating that information to Father Walick?
A: That's a different question from what you just asked me. Let me clarify it first so that you know what I understand from your questions.
You asked me if he had been told that precancerous lesions had been removed. I said that would be accurate but not a very pleasant way to describe it.
Remember, we're talking about small polyps

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that Dr. *Gottesman* removed. They were five millimeters, five millimeters, eight millimeters, fifteen millimeters – which was a little larger – but they were all removed. And only two of those were adenomatous. In fact, the small ones, one was normal tissue.

So I'm talking about two lesions that were previous to adenomatous which were removed in their entirety, which is standard colonoscopic practice.

We don't tell patients that they're going to get cancer having removed them. That's why we remove them.

Q: To tell Father Walick that those polyps were indeed precancerous, would that be a deviation from the standard of care by –

A: No.

Q: – either –

MR. HIRSHMAN: Which polyps are we talking about now?

MR. CASEY: The two that came back adenomatous.

A: No, that would not – that would be an accurate statement.

Q: So if the doctors indeed told Father Walick

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on the 7th of November that there was a situation in his colon that was precancerous or that had been precancerous, they would not be deviating from acceptable standards of care?

MR. HIRSHMAN: Objection. The conversation didn't take place on the 7th. It took place on the 6th.

MR. CASEY: I understand that –

MR. HIRSHMAN: There's a big difference in this case between the 6th and the 7th.

MR. CASEY: I understand that's your position, Toby; and I don't know that that's going to turn out to be the factual situation at trial. That's what I want to explore with the doctor.

MR. HIRSHMAN: Okay. **Go** ahead.

A: There are two questions you just asked me. Yes, I would agree that it was not a great way; but if they stated that the patient had had precancerous lesions removed, they had been present, I would accept that.

If they told him that he still remained in a situation where the precancerous lesions were present in the colon, I would not accept that.

You asked both questions.

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Q: *All* right. So we know on the 7th that the pathology report came back and said that the – that the hepatic flexure lesion, the biopsy that was taken, turned out to be inflammatory; is that fair?

A: That's correct.

MR. HIRSHMAN: Printed on the 7th I think is what he indicated.

MR. CASEY: Right. Printed on the 7th.

Q: We don't know what time that came back?

MR. HIRSHMAN: Came back is ambiguous. Came back implies that a doctor had it in his hand and read it.

MR. CASEY: I understand. Let's deal with that right now.

Q: The information that you get from pathology, can you get that in an oral form over the phone?

A: Yes, of course.

Q: Is it within the standard of care to receive that information from a pathologist over the phone?

A: That's very much dependent on the institution arrangements. We would expect it here if it showed malignancy. However, if it did not

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show malignancy, we would not expect it to be called unless we'd asked it to be done so.

Q: My point is if Dr. Eisenstat got the information over the phone from a pathologist –

A: ***Yes.***

Q: – on November 7 before he took the patient to surgery, would that be adequate to meet the standard of care in your mind?

A: Of assuring that he had the pathology, yes.

Q: Now, what he did with it is another matter. But at least in getting the pathology results, he could have gotten that in one of two ways, either the written report that we see here, or he could have gotten a verbal report from the pathologist. Fair?

A. That's fair.

Q: Now, assuming he got this information that the biopsy came back as inflammatory, and that information was communicated to the patient before he was taken to surgery, would it be a deviation from the standard of care to offer that patient, Father Walick, a surgical option at that point in time?

A: You have to define what you mean by that.

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Q: Surgery of the colon, a partial colectomy, a right hemicolectomy, or a subtotal colectomy depending upon his surgical judgment when he went in.
A: Firstly, I do not think that's appropriate because no resection was indicated. And I seem to recall that Father Walick was asked to sign a consent form on the 6th and not on the 7th.
Q: And I understand that. But my question to you is: Assuming that the results of the pathology had come back, were known by Dr. Eisenstat and were communicated to the patient, do you believe it was a deviation from the standard of care for Dr. Eisenstat to offer Father Walick the option of surgery at that point in time?
A: With those assumptions, I think that was inappropriate.
Q: So even to give him the option of surgery would be deviating from the standard of care in your mind?
A: For an inflammatory polyp, yes.
Q: And taking into consideration everything that this patient had had, the multiple polyps, the –

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A: Two.
Q: – the multiple polyps within the colon –
A: Two. Two adenomatous polyps.
Q: There were six polyps in the colon.
A: But there were only two adenomatous.
Q: I understand. But there were **six** polyps in the colon.
A. That's correct.
Q: Two of those turned out to be adenomtous; correct?
A: Correct.
Q: And by your indication, there was in that pathology report some suggestion that the patient may have inflammatory bowel disease; **is** that fair?
A: Correct.
Q: So a patient that had two adenomatous polyps, six polyps total, and inflammatory bowel disease, your opinion **is** that it's not within the standard of care to offer that patient surgery?
A: That's correct.
Q: Then why is it appropriate to ask a surgeon to come in and consult?
A: Because at the time that that question was raised, which was the day before the one that you're

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telling me about, the pathology was not available; **and** nobody knew what that lesion was that worried Dr. Gottesman at the time of the colonoscopy.
Q: I think you said earlier in your deposition something to the effect of – and I wrote it down. And **I** don't want to misquote you – if you want the patient to be considered for surgery, you can ask a surgeon. If you don't, you don't.
Does that sound about what you might have said?
A: It sounds like it.
Q: So you think that on the 6th, it was okay to ask a surgeon to consider surgery; but on the 7th, once the pathology came back, it was no longer within the standard of care for that surgeon to consider going forward with the surgery?
A: That's absolutely correct. You defined it exactly.
Q: And you say that despite the fact that you are not a surgeon?
A: I'm not sure of the relevance of that question.
Q: What caused the cecal lesion at the hepatic flexure?

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What caused the lesion at the hepatic flexure? Sorry.
A: What caused it?
Q: Yes.
A: I can't tell you what caused it. **I** can tell you its pathology, which has many features suggesting Crohn's disease.
Q: Did he have early Crohn's disease?
A: **I** can't tell you. I've not been involved in his care. But the pathology of that lesion is very suggestive, and Crohn's disease can affect segments of the bowel without affecting other parts. So it **is** certainly compatible with what was seen.
Q: Do you know what the pathology of the lesion in the cecum was?
A: Well, **I** searched for that **in** the pathology report; and it was really not made clear what that was.
Q: So we don't know **if** it was adenomatous or if it was inflammatory?
A: We know that it was not. There was a statement in the pathology report that I think says there **is** no adenomatous tissue in the resected

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colon.
Q: But we don't know – you looking through the pathology report couldn't figure out what the pathology was for that lesion itself?
A: Well, remember, this was described as a six millimeter sessile polyp in the cecum, Polyp No. 6. And if the pathologist says there's no adenomatous tissue, then I have to assume that it's something else. It either means that it's hyperplastic, it's normal, or it's inflammatory.
Q: Do you know Dr. Thomas Gouge?
A: I do not.
Q: Do you know of him?
A. No.
Q: If I told you that he was the director of the residency program for surgery at the NYU Medical Center, would you suspect that he's a competent surgeon?
A: I would suspect that, yes.
Q: NYU is a competent and credible facility?
DR. GOTTESMAN: Better than competent.
A: Yes.
DR. GOTTESMAN: It's my alma mater.
Q: In regard to whether a physician – a

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surgeon was within the standard of care in offering a surgical option to this patient, once the pathology results had come back, would you defer to someone like Dr. Gouge for that opinion?
A I don't know Dr. Gouge, but I would certainly respect his opinion and read it and discuss it with him.
Q: I mean would – if his opinion differed from yours under the same set of circumstances, would you defer your opinion to his?
MR. HIRSHMAN: On the issue of the indications for proceeding with –
MR. CASEY: On this indication.
MR. HIRSHMAN: – procedure as opposed to another?
MR. CASEY: No. Let me explain.
Q: My understanding of what Dr. Gouge has testified to –
MR. HIRSHMAN: He doesn't know what Dr. Gouge has testified to.
Q: Well, I'm going to give it to you right now.
My understanding of what Dr. Gouge has testified to – and I may be wrong when the

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transcript is printed up.
But my understanding is that Dr. Gouge has testified that if the pathology had come back, and if that pathology had been communicated to the patient, then offering the patient a surgical option was within the standard of care on the 7th.
Now, assuming that to be true, would you defer your opinion that it was outside the standard of care to Dr. Gouge?
A: Okay. There are *two* things you haven't told me. One, what the pathology was that was communicated to the patient.
Q: What was in the report.
A: Okay. So you're asking me if the patient is told that the polyp is inflammatory and, therefore, has no cancer risk, based on that knowledge, you're asking me if the surgical option is appropriate?
Q: And Dr. Gouge has opined that it was an option if the patient was fully informed.
A: And what surgical option was he suggesting was appropriate?
Q: He was not critical of the decision to do a subtotal colectomy in this case. He said that would

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be a matter of medical judgment.
MR. HIRSHMAN: Why don't you put this in a hypothetical if you're going to ask him a question. I mean, you're sitting here talking about what somebody else testified to a few days ago.
Q: Well, what I really want to know, Doctor, is if I give you a hypothetical, the same hypothetical that Dr. Gouge is given, and Dr. Gouge opines one way for the standard of care for a surgeon in ***1984,*** and you opine a different way, to whom should the jury look and believe?
A That's hard for me to answer. I have my view, and I've expressed it many times this afternoon.
Q: But you would not defer your opinion to his, him being the head of the residency program and surgery program at NYU?
A: Well, I haven't seen this testimony that Dr. Gouge, who I don't know, has given; and I haven't heard of him until just now. And I'm not sure who he's testified for and who requested it so there are many things that I am not aware of.
But I could find surgeons that I work with now who might give quite a different opinion.

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Q: So that you understand, Dr. Thomas Gouge –
A: Oh, I know who he is. You told me.
Q: – is the head of the residency program at NYU. He's been identified to us as the plaintiff's surgery expert in this case.
We took his deposition last week in New York, and my recollection in that testimony is that he opined that if the pathology results that are contained in the report dated November 7 had come back and had been communicated to the patient, and the patient elected to go forward with surgery under those circumstances, it would not be a departure from the standard of care for the surgeon to take the patient to surgery at that time.
MR. HIRSHMAN: He didn't ask him the follow-up question, though.
A: I have to ask you one more thing. What other options were offered to the patient at this time?
Q: Repeat colonoscopy.
A: That's all? No medical treatment? No clarification of the diagnosis? No discussion of Crohn's disease?
Q: That's the hypothetical that was posed to

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Dr. Gouge.
A: I don't think that's a fair question. If you don't give all the options, how can you expect me to give you a fair answer?
Q: My question to you is: Is surgery one of the options that can be given to the patient among all of the other ones that you're talking about?
A: Obviously, I understand what you're asking me. But you're not – if it's hypothetical, then I think we should cover all of the options; and, clearly, you're not doing that in your questions –
MR. HIRSHMAN: Nor did you in your questions to Dr. Gouge.
A: – so that I think that's an unfair question. And I must make that clear.
Then, yes, there might be a surgical option for removing a suspicious polyp that there is concern about. A local resection might be one of the many options. But that's not the situation that existed. So that's not strictly relevant to this case.
Q: The other opinion that Dr. Gouge gave last week –
MR. HIRSHMAN: What are we doing here? Are

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you reciting the deposition of Dr. Gouge, or do you want to ask this gentleman a question?
MR. CASEY: I want him to hear all of the testimony in this case.
MR. HIRSHMAN: It doesn't matter what the testimony is. You're asking him for his testimony. Ask him a question about his opinions.
MR. CASEY: Toby, I'll take my deposition. You take your deposition.
MR. HIRSHMAN: It's ridiculous.
MR. CASEY: And we'll go from there.
MR. HIRSHMAN: I think you're asking a ridiculous question, as well as an inaccurate question.
MR. CASEY: This physician has a right to understand all of the testimony in this case. That testimony includes the testimony of Dr. Gouge.
MR. HIRSHMAN: All right. Tell him what the testimony is if you have such a specific and accurate recollection of it.
MR. CASEY: I have my notes right here. I've gone through them for the last hour.
THE WITNESS: I have not seen this testimony.

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MR. CASEY: I understand that you haven't, and I appreciate that. And perhaps we will furnish you with that deposition before we get to trial.
MR. HIRSHMAN: You won't furnish him with anything.
Q: Well, I want you to have all of the information that is available in this case before you make your opinions to the jury in this case. And my recollection of Dr. Gouge's testimony was that in considering the options for surgery for Father Walick and assuming that the pathology report had come back and had been communicated to Father Walick, the issue of what procedure to do, be it a right hemicolectomy, a segmental colectomy, or a subtotal colectomy, would be a matter within the medical judgment of the surgeon and would not deviate from the standard of care in doing any one of those three surgeries.
Would you agree or disagree with that statement?
A: I disagree because those are not all of the options.
Q: But would you agree that they are options that could be pursued by a surgeon and still be

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within the standard of care for Father **Walick?**
A: But that's not a realistic question. I'm sorry. It's like saying you have five ways you can turn, but you can only take these two. That's not fair. That's not a realistic hypothetical situation.
I would not face my patient and say, "Look. You've only got these options. I'm not going to tell you about the others."
Q: I'm not asking you to assume that those were all of the options that were available –
A: Then I can't answer that question.
Q: My question is: Would those options – subtotal colectomy, right hemicolectomy or segmental colectomy – be within the options that would be available to a surgeon for use on Father Walick on November 7 after he had the pathology report?
A: And for what condition are those options the treatment?
Q: For Father Walick's condition.
A: What is the disease that you are treating? You tell me, and then I'll answer your question.
Q: Father Walick's condition as he was found on November 7, 1984, including all of the polyps

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that had been removed, the adenomatous nature of the two polyps, the fact that there was still a polyp in there that couldn't be taken out, the biopsy had come back and said it was inflammatory, and we still didn't know what the biopsy of the cecum would say –
A: Then I disagree.
Q: – under those circumstances, would it be appropriate to offer Father Walick among the various options the ability to go to surgery and to have a subtotal colectomy?
A: Well, you started to change your question. You said, "Among the various options."
Q: And that's what I'm asking. Among those various options –
A: That's not what you asked me just now.
Q: That's what I'm – it's my fault, then, because I'm not asking good questions.
Among the various options that could be given to Father Walick and be within the standard **of** care, would those options include an operation that would be a subtotal colectomy?
A: No.
Q: Okay. Then you disagree with Dr. Gouge if

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that's what he says?
A: Then I disagree.
MR. HIRSHMAN: You just can't restrain yourself from bringing Dr. Gouge into it. You just can't restrain yourself.
A: You changed your question about three times. I thought I was going to be able to agree with you because you included a lesser procedure which might be one of the many options. But if you make the only option a subtotal colectomy, then, no.
Q: For purposes of my questions, just so that you and I are communicating, I am not asking you to assume that the subtotal colectomy was the only option given. What I'm asking you to opine on is whether giving that option among all of the other options was within the standard of care.
A: No, I disagree with that based on what was known.
Q: Can you and I agree that Father Walick's wound infection, his ileus, and his subsequent development of a hernia were postoperative complications?
A: We can agree on that.
Q: There was no deviation from the standard of

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care in the causation of those items themselves if the jury believes that the first surgery was warranted?
A: That's true. If the first surgery was warranted, then the others were a direct consequence, yes.
Q: Can you **and** I agree that all of Father Walick's complications from ***1984*** until now are complications and not deviations from accepted medical standards if the jury believes the first surgery was warranted?
A: I can't comment on all of the treatments that he's had subsequently; but I can agree with you that they are consequences of his first operation, yes.
Q: And if the jury believes that the first surgery was warranted, you would not be of the opinion that any of those subsequent injuries or subsequent damages that he suffered were caused by a deviation from any doctorate from acceptable medical standards?
A: Well, there's one issue that perhaps I'm not qualified to give expert testimony on, and that's the use of the mesh in the repair of his

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incisional hernia, which I know there might be some controversy about.
Q: So in that respect, you do not feel qualified to render an opinion?
A: Not about that. But I agree with you that they are all consequences of his original surgery.
Q: How about the 1995 surgeries for the small bowel obstruction? Do you feel qualified to render opinions as to the adequacy of those surgeries by that surgeon?
A: Can you give me a name.
Q: Dr. Borison at Lake Hospital.
A: I believe that was appropriately based on what information I was given.
Q: Did you understand that Dr. Borison took the patient back to surgery within thirteen days of the first surgery for the small bowel obstruction?
A: I was aware of that.
Q: So you do not have any criticisms as to the timing of that surgery?
A: There are a number of different ways that small bowel obstruction can be treated. Some conservative, some surgical.
In the very complex situation that Father

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Walick was in at that time – and it's hard for me to know how ill he was – but on the basis that he was pretty ill so soon after an operation, I believe that some surgeons would have treated that conservatively in the hope that it would resolve and avoid another operation.
Q: Can you and I agree that in retrospect, that would have been a better way to manage that problem?
A: It's possible.
Q: Can you and I agree that but for the second surgery in 1995 to repair the small bowel obstruction, Father Walick never would have developed a fistula?
A: I'm not aware of a fistula.
Q: So you were not aware that Father Walick had developed a fistula post the second 1995 surgery?
A: Can you define what type of fistula it is.
I'm not aware of it.
Q: I don't have the records here in front of me.
A: My records stop in 1995.
Q: I believe it was an enterocutaneous.

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A: I don't think I was aware of that.
Q: Assuming that he did develop the fistula after this second surgery in 1995, can you and I agree that in all probability, had that surgery not occurred, Father Walick probably would not have developed that fistula?
A: I can't answer that.
Q: Because you don't have the information?
A: I can't tell you that it would not have developed.
Q: You will not be rendering any opinions at trial as to the causation of that fistula; is that fair?
A: That's fair.
Q: How about the cholecystectomy? Do you believe that the cholecystectomy was proximately related to the surgery which was performed in 1984?
A: It's certainly possible because we know that resection of the ileum increases your chances of developing gallstones.
Q: As to the trial, do you have an opinion which you base to a reasonable degree of medical probability whether the cholecystectomy is related to the surgery which was performed in 1984? What
Q: You still could have billiary tract disease that required the removal of the gallbladder?
A: That's true.
Q: But in Father Walick's case, we know that he had it removed because he had gallstones; is that fair?
A: That's correct.
Q: So do you have an opinion which you base to a reasonable degree of medical probability – that is, 51 percent – that if Father Walick had not had surgery in 1984, he would not have subsequently developed those gallstones and would not have subsequently needed that cholecystectomy?
A: No, I cannot prove that.
Q: You agree with me that pancreatitis and small bowel obstruction are known complications of cholecystectomy?
A: That's correct. Well, complication of

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gallstones and cholecystectomy. You have to distinguish the two.

Q: Will you be rendering an opinion in this case as to whether Father Walick's subsequent pancreatitis after cholecystectomy is proximately related to the surgery which occurred in 1984?

A: I cannot prove that, either.

Q: And the same question as to the small bowel obstruction.

A: I would have to review the operative details of the two laparotomies as to the cause of the small bowel obstruction, which I assume was adhesions and their site. But my recollection is that they are almost certainly related to the primary operation.

Q: So it is your opinion that the small bowel obstruction which occurred in *1995* would not have occurred but for the operation which took place in 1984?

A: Correct.

MR. VOUDOURIS: Which one in '84? Which surgery in '84?

MR. CASEY: Well, there was only one surgery in *'84*.

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Q: There was a second surgery in '87; correct?

A: Yes.

Q: What is your understanding of Father Walick's limitations as a result of the damages that he has suffered resultant to the *1984* surgery?

A: As of today, you mean?

Q: Yes.

MR. VOUDOURIS: Objection. But go ahead.

A: I'm not sure I've been made aware of what you're asking.

Q: What are his limitations?

A: And where is that stated?

Q: That's what I want to know from you is when you come into trial and you're asked, "Doctor, what injuries and damages or limitations does Father Walick now have as a result of the surgery which took place in *1984*," what will your answer be?

A. Well, I've never met Father Walick; and, of course, his medical records stop in *1995*. Up until that time, many symptoms are documented, principally diarrhea and the consequences of urgency in diarrhea that he seems to have suffered ever since 1984.

I've never interviewed **him** personally so I can't answer that question directly. I did read his own statement which also documents profuse diarrhea I think up to thirteen or fourteen times a day from which he still suffers. I'm aware that he was investigated subsequent to many of the surgeries that we've discussed for other causes of diarrhea. And other diagnoses were suggested but not substantiated. And I can, therefore, only assume that his diarrhea is a consequence of his subtotal colectomy and ileorectal anastomosis.

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Q: So other than **this** persistent diarrhea that you have just discussed, are you aware of any other injuries and damages which Father Walick suffered as a direct and proximate result of the ***1984*** surgery?

A: Well, he has suffered small bowel obstruction, which you just asked me about, at which time he was considerably ill from that episode and requiring him to have two operations. And you tell me that he's been left with an enterocutaneous fistula which for most patients is a considerable embarrassment and problem. I don't know how severe it is.

Q: Assuming that the fistula has closed, do you have any opinion as to the permanency of that situation?

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A: Which situation?

Q: The enterocutaneous fistula, assuming it's closed.

A: What is your question?

Q: Do you have any opinion as to the permanency of that condition or the problems that it will cause Father Walick in the future?

A: Well, I don't have the details of how that's been investigated; but often when they are closed, they remain closed.

Q: So you will be rendering no opinions regarding what Father Walick can expect in the future as it relates to this fistula?

A: I don't have that information available to me.

Q: Okay. How about as to the diarrhea? Will you be rendering opinions as to what Father Walick can expect in the future?

A: I can give you an opinion about that, yes.

Q: And what **will** your opinion be?

A: Well, based on the fact that for the last thirteen years he has diarrhea that seems to have been relatively unchanged since his first operation, it's likely to continue.

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Q: Do you have an opinion as to whether or not Father Walick would have developed this type of diarrhea regardless of whether he would have had surgery in 1984?
A: I think it's extremely unlikely as I don't have all of the investigations that were done for the diarrhea subsequent to his surgery. But based on what I know, I think it's extremely likely that it's a direct consequence of his original operation.
MR. HIRSHMAN: You think that it's highly unlikely? That it is or is not?
THE WITNESS: That it is.
Q: Do you have any information in this case as to the disabling nature of that diarrhea on Father Walick?
A: Directly, no, because I have not interviewed him. But even in the medical record as far as I can recall, many times it's documented that he's been severely incapacitated by it. And I know from experience of patients having twelve or thirteen loose bowel movements a day, particularly with little control, that that's a severely incapacitating problem.
Q: Do you have any idea whether or not his

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career or his chosen profession has been hindered in any way because of this limitation?
A: I'm not directly aware of what effect that has had.
Q: Do you have any opinion as to whether or not his life expectancy has been affected by this condition?
A: That's very hard to answer. Clearly, he has been through a great deal in the last thirteen years. He has already developed some complications of his original surgery. Whether he will develop further complications, I cannot predict. But all of those can have an effect on life expectancy.
Q: You were asked earlier about if a person has one polyp, what's the likelihood they're going to have a second adenomatous polyp. What I want to know is if a person – Father Walick in this case we know had two adenomatous polyps in his colon; correct?
A: Correct.
Q: One was nine millimeters, almost one centimeter, and the other was I think six millimeters or five millimeters, something like that. With those polyps removed, was Father Walick

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at an increased risk for developing adenomatous polyps in the future?
A: Increased above what?
Q: The general population.
A: Yes, but at decreased risk of cancer.
Q: Because those adenomatous polyps had been removed and could not cause him cancer?
A: Correct.
Q: We know that cancer can develop spontaneously in the colon; is that fair? It doesn't have to come through a polyp?
A: It's controversial. It's thought to be possible. It's probably very rare.
Q: You have told me that offering Father Walick a subtotal colectomy after the results of the pathology came back was outside of the standard of care. My question now is: Would offering Father Walick a right hemicolectomy under those circumstances be outside the standard of care?
A: For what condition?
Q: For the condition that Father Walick had on November 7 as diagnosed by pathology.
A: Yes. At that stage, I think that was inappropriate, also.

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Q: Inappropriate?
A: Yes.
Q: Can you and I agree that if a right hemicolectomy had been done in this case – and I understand that you think it would have been inappropriate to recommend or to give that as an option – but if that had been done in this case, can you and I agree that the consequences for Father Walick most likely would have been the same?
MR. HIRSHMAN: As a subtotal?
MR. CASEY: As a subtotal.
A: Can you specify –
Q: The complications that he has suffered, being the diarrhea, the wound infection, the subsequent hernia, incisional hernia, those probably all would have been the same if he had been given a right hemicolectomy?
A: I can't answer that.
Q: The incision would have been the same; correct?
A: The incision would be similar. It may not be exactly the same; but, yes, they would – it would be almost the same.
Q: So do you have an opinion in all

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probability whether his course would have been the same or not?
MR. HIRSHMAN: As to the incisional injuries or –
A. As to everything?
Q: As to his subsequent course of conduct, that being his wound infection, his incisional hernia, the subsequent repair, and the diarrhea which he suffered.
A: No. I think it would have been different.
Q: Upon what do you base your opinion that his course would have been different if he had been given a right hemicolectomy as opposed to a subtotal colectomy?
A: Because they're very different operations. If you look at the surgical literature, you'll find that the complication rates are very different. The leakage rate of the anastomosis is different. The wound infection rate is different. The incidence of diarrhea is different.
Q: Well, in Father Walick – with all due respect, Doctor – he had either a 100 percent chance of developing wound infection or a zero percent chance; is that fair?

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A: No, it's not fair.
Q: In that individual patient, that's not a fair statement?
A: You mean –
Q: Either he does or he doesn't.
MR. HIRSHMAN: Well, it's after the fact not before the fact.
MR. CASEY: I understand.
Q: But we know that he did develop a wound infection after the surgery.
A: He developed – a wound infection is a spectrum of problems.
Q: And he developed that in all probability because of the nature of his abdomen; is that fair?
A: That is one element in the causation of wound infections, yes.
Q: As to his diarrhea, if he had undergone a right hemicolectomy as opposed to a subtotal colectomy, could we expect the results experienced by Father Walick to have been relatively the same?
A: No. We would have expected them to be very different.
Q: And less?
A: Less or no diarrhea.

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Q: So the fact that the ileocecal valve would be removed in a right hemicolectomy would have no effect on the subsequent diarrhea in this patient?
A: I didn't say it would have no effect, I said the ultimate outcome might be different. There are many patients who have right hemicolectomies for cancer who do not have diarrhea thirteen years later.
Q: In fairness, Father Walick was either going to develop diarrhea or not develop diarrhea after this surgery; is that true?
MR. HIRSHMAN: Which surgery?
MR. CASEY: Whatever surgery he underwent on November 7 –
MR. HIRSHMAN: Objection.
MR. CASEY: – be it a right hemicolectomy or a subtotal colectomy.
A: Yes, I suppose. It's on odd question; but, yes.
Q: And whether he underwent a subtotal colectomy or a right hemicolectomy, he was still at risk for developing diarrhea?
A: Yes, hypothetically; but not if he had no surgery.

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Q: Do a patient's wishes regarding surgery play a role in the decision whether to offer surgery to that patient?
A: Yes. In general, yes.
Q: Would Father Walick's wishes concerning whether he wanted to have surgery or not have been a proper consideration for Dr. Eisenstat and Dr. Gottesman in this case?
A: Provided he had the information available to him to allow him to make a rational decision.
Q: And I'm asking you to assume that he was given the information regarding the pathology report before he was taken to surgery. Would his wishes regarding whether he wanted to go forward with the surgery or have repeat colonoscopies have been important to consider?
A: But as we discussed previously, I have to be sure that he's been told all the options and why before I can answer your question. You're only giving me half of the options.
Q: What options in your opinion needed to be discussed with Father Walick prior to taking him to surgery on November 7 of *1984* for it to have been proper to take him?

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A: I think by now you should have gathered that I did not think the surgery was appropriate at all.

Q: I understand that. But what facts or what options – what informed consent needed to be given to Father Walick in order to take him to that surgery?

MR. HIRSHMAN: I think he's telling you that he doesn't think he should have been taken, period.

THE WITNESS: No.

Q: So the father's wishes or his desires regarding whether he wanted to have this surgery would play no effect in the doctor's decision? He should not have offered surgery; is that your opinion?

A: That's correct.

Q: So the fact that the father may have said, "I don't want to go through a repeat colonoscopy. I want to have surgery. I want to get this thing out of me," should have played no effect and been given no consideration by Dr. Eisenstat?

MR. HIRSHMAN: That is a hypothetical I take it?

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MR. CASEY: I understand.

MR. HIRSHMAN: Well, where are you getting those facts from? Is that from some deposition somewhere? Put it as a hypothetical. That's what it is.

Q: If that happened, Doctor, if the father had been given the information and he spoke to the doctor and said, "I do not want to undergo repeat colonoscopies. I don't like these procedures. I want to get this thing out of me, and I want to have surgery," you're telling me that the doctor should not have considered that under those circumstances and never should have offered the option of surgery?

A: We're now talking about a totally different situation as to what this thing in me is.

But you're suggesting to me that a patient has been told that there is something in the colon that has to be removed. Now, of course, if you tell somebody that, they're going to elect to have it removed.

Q: I'm suggesting to you that he had been told that the pathologic diagnosis had come back as inflammatory; that the doctors had seen it, thought it was villous, a villus adenoma; that the pathology

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came back and said it wasn't; that an option to him was given for a repeat biopsy; and that the father advised the physician that he did not want to have a repeat biopsy; that he did not want to have repeat colonoscopies; and that he wanted to have surgery; he wanted to get this lesion out of him.

Is it your testimony that such a wish by the patient would be given no weight by the physician in deciding whether to offer an option of surgery?

A: Under the circumstance you just described, of course it would not be given weight; but I would not follow it. I would not take the patient's advice for his own operation, no, under that circumstance.

Q: Surveillance colonoscopies have risks; is that fair?

A: That's fair.

Q: What are those risks?

A: Surveillance for polyps or for colitis or –

Q: How often should repeat colonoscopies have been done on Father Walick in 1984?

MR. VOUDOURIS: Assuming?

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MR. CASEY: Assuming the situation as it was found on November 7 and he didn't go to surgery.

A: I'll have to start again.

Q: Let me start the question again.

A: No. I understand your question, but what I need to convey is that this patient has two conditions. Let's make it hypothetical if you wish.

He has two polyps, two relatively small polyps, which Dr. Gottesman successfully removed completely. And, as I just mentioned, that reduces his risk of cancer like any other patient with colonic polyps that we treat daily and have been doing so for a long time.

In addition, another lesion was detected which initially was concerned and was thought to be neoplastic, subsequently found to be not so. The next step should be the clarification of that lesion.

Now, the options for treatment will be based on what that lesion represents. If it's Crohn's disease, the treatment might be purely medical. It might never involve surgery. That

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lesion may not require repeated colonoscopies over a long period of time, may not require surveillance.
If you're asking about surveillance colonoscopies for polyps, at that time, in *1984*, it was being offered on an annual basis. Today, we do it differently because we have further information.
Q: Would the size of the polyp at the hepatic flexure of two and a half centimeters have influenced that decision on whether to have repeat colonoscopies?
A: For diagnosis, yes, of course. I already mentioned that.
Q: So the size alone –
A. But not surveillance. That's a different question.
Q: Well, that's what I'm asking. Would the size alone have required surveillance?
A. That's a different issue here. The term "surveillance" is used for something quite different,
Q: Would it have required repeat colonoscopies to check its size and to continue to biopsy it?
A: Well, you don't need to continue to biopsy it. You need to make an accurate diagnosis, which

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I've already gone into that. Once you know what it is, it does not require any further endoscopic treatment or biopsy. You don't keep doing it for that reason. So this lesion might have healed on medical treatment.
Q: Medical treatment being what?
A: Let's assume if it was Crohn's disease, maybe steroids would have been appropriate. I don't know because that diagnosis was never made.
Q: Well, the diagnosis that was made was that it was an inflammatory polyp; correct?
A: Correct, but it had certain features that were a little bit different from other inflammatory polyps. It had a granuloma. It had crypt abscessus, features of inflammatory bowel disease.
Q: We didn't know that on the superficial biopsy, did we?
A: We knew about crypt abscessus, yes. It was mentioned in the biopsy report. Granuloma was mentioned in the resection.
Q: So if FatherWalick never goes to surgery in *1984*, my question to you is: In your opinion, what would have been his course? What would have happened to FatherWalick? Where would he be today,

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and what would have happened?
A: Well, at – I can give you a spectrum of answers because you're asking me to guess.
Q: Well, I want to know your opinion to a reasonable degree of medical certainty because that's the question that you'll be asked at trial.
A: *All* right. Then at the best end of the spectrum, he would have been healthy. He would have had clarification of the inflammatory polyp and perhaps medical treatment for it. He would have had biopsies taken from the remainder of his colon not affected by polyps, which was not done. And he would have had at that time an annual colonoscopy for the follow-up of his polyps.
Subsequently, the data has shown that annual visits are not required. We do it every three years. So that would have changed.
Q: It would have changed when?
A: When the data became available, which is about five years ago.
Q: So in 1992, he would have then changed to every three years?
A: Yes.
Q: So from *1984* until 1992, FatherWalick

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would have undergone eight –
A: Yes, like thousands –
Q: – eight colonoscopies?
A: – and thousands of other patients, which was standard practice.
Q: And then he would have had one in '92 and one in '95 and again one in '98?
A: Possibly.
Q: By the time this case comes to trial, FatherWalick would have undergone eleven colonoscopies?
A: Just as you would if you had polyps or I would if I have polyps. That's no way different from any other patient.
Q: And each of those colonoscopies would have risks to those procedures; correct?
A: Yes, small. But, yes, there is always a risk for any procedure.
Q: And what are those risks?
A: The principal risk of diagnostic colonoscopy with or without biopsy is perforation. That's the principal risk. And the risk that's published is something like one in 10,000 procedures.

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Q: And are there any other risks?
A: There are always potential risks of the sedation, of the preparation. All of which are extremely rare.
Q: Were there risks to Father Walick subsequent to *1984* for the development of cancer, colon cancer?
A: Subsequent to 1984?
Q: Yes. He never has the surgery, and he continues to go on with his life. Is there anything in his life or in his history that suggests to you that he was at an increased risk for the development of colon cancer?
A: His only risk was the finding of the two adenomatous polyps. I don't know of any family history. I don't know of any other conditions that he or his family had that would increase his risk if that's what you're asking.
Q: In **1985,** were you aware that his father underwent colon cancer surgery?
A: I was not aware of that.
Q: Assuming that that happened, can you and I agree that Father Walick would have been at even a higher risk for the development of colon cancer?

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trial in this case?
A: Yes.
Q: There's nothing standing in the way of you coming in to testify live? Because I noticed a letter in your file that talked about a problem that you might have.
A: Only about dates.
Q: Okay.
A: Depends when it is.
Q: So if it's in January, your plan is to be there?
A: Is that definite?
MR. HIRSHMAN: No, it's not definite.
Q: I mean if we go in January, there's nothing standing in your way?
A: That depends on the date.
MR. HIRSHMAN: Hold on a minute. There's someone in back of you.
(Pause)
Q: When you were asked about the chance of a second polyp and a third polyp regarding the colonoscopy which was performed in *1984*, you used the word "synchronous." What does that mean?
A: There are two types of lesion that we

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A: He does have an increased risk, but he's already had his first colonoscopy the year before that you just mentioned. And we do know that the first colonoscopy is the most valuable one and, in fact, reduces your cancer risk by the removal of polyps which Dr. Gottesman had done successfully.
Q: Can you say in all probability that had Father Walick undergone these repeat colonoscopies as you suggest, given the fact that we know he subsequently developed a family history and he had two adenomatous polyps removed, that he would not have developed cancer up **until** today?
A: Can I say that? No, of course I can't say that. He might get a cancer of some other organ. I can't say that, either. That's not a fair question.
(Pause)
THE REPORTER: When you come to a convenient breaking point, could we take a very short break, please?
MR. CASEY: We're at a convenient breaking point.
(Recess taken)
BY MR. CASEY:
Q: Doctor, do you have plans to come to the

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describe both with respect to polyps and cancers when they occur at the same time. In other words, when you find one lesion when you do a procedure and within a few days you find another lesion, we call that synchronous.
When you find one lesion and then sometimes weeks or months or sometimes years later you find another one, we call that metachronous. In other words, at another time.
Q: Metachronous?
A: Yes.
Q: In Father Walick's case, with the fact that he had developed these two adenomatous polyps, do you have an opinion which you base to a reasonable degree of medical probability as to his chances for metachronous development of adenomatous lesions?
A: I can't give you a percentage. We know that patients who have adenomatous polyps are at risk of developing polyps subsequently, and that's why we keep them under surveillance. What the recent data has shown us, as I suggested just now, is that that risk is rather less than we used to think and takes longer so that the interval between colonoscopies can now be extended to longer

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intervals.
Q: So to tell a patient – specifically to tell Father Walick in *1984* that because he has two adenomatous polyps that have been removed, he is at an increased risk for the development of further polyps and potential cancer in future would not have been a deviation from the standard of care?
A: No. That's correct.
Q: You were also asked about and you tried to make a distinction in the colonoscopy report between the way Dr. Gottesman had described the lesion at the hepatic flexure as being multilobulated and having satellite lesions and you somehow distinguished that from a villus lesion. Is there a distinction between those terms?
A: Yes. They're different descriptions.
Q: In what way? What do you perceive Dr. Gottesman's words to have meant as he described those lesions in his colonoscopy report?
MR. HIRSHMAN: Do you wish to look at the report, again?
THE WITNESS: No, no.
A: Well, as I mentioned, a picture is worth a thousand words; and it's such a shame that those two

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photographs did not reproduce when they were copied.
But I take Dr. Gottesman's description to mean an area that is raised above the level of the surrounding tissue, which makes it a polyp; and that instead of being one continuous lump of tissue, it has a number of different areas. In other words, it's a lumpy appearance; and that's what multilobulated means. That is the description that's in his report.
Q: And when he says, "Satellite lesions"?
A: Satellite means there are separate lesions apart from that main body of *2.5* centimeters that are distinct from it and usually are a lot smaller, and he does not say what size.
Q: And distinguish for me in your mind the difference between that and villus.
A: Villus is a description that means fingerlike. It's Latin for fingers. So that a lesion that has protrusions that are thin and look like – just like small fingers gives the description villus. And sometimes we can see that in colonoscopy if it's obvious enough, or the pathologist tells us that it's a villus lesion

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because it's also a pathological term. It's used in two different contexts.
Q: Did you read in Dr. Gottesman's deposition where in addition to how he described it in the colonoscopy report, he believed the lesion to be villus?
A: Yes. And that's different from saying it looks villus. I think he's probably thinking in pathological terms, and that increased the risk of concern, of course. That was my interpretation of what he said.
Q: The Lesion No. *2* that was removed from the colon, the nine millimeter adenomtous polyp, was described by the pathologist as having severe architectural atypia. What is the significance of that, if any?
A: I think we discussed this earlier this afternoon, but No. *2* was five millimeters. Number *3* was nine.
Q: Okay.
A: But it doesn't really matter. The presence of atypia implies a further stage of neoplasia compared to when it's not present. In other words, another stage towards

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malignancy.
Q: So in Father Walick at that time, he was another stage towards malignancy on that lesion?
A: Yes, which was removed. And that's not an uncommon finding.
Q: Would that increase – the fact that it had gotten to that level, would that increase his risk for subsequent development of adenomatous polyps?
A: No.
Q: So the fact that a particular lesion had reached the point where it had severe dysplasia or severe atypia or the fact that it had progressed to the point where it is now a villus adenoma, those things, if they are removed, do not increase the risk of future adenomas in and of themselves if they are removed; is that correct?
MR. HIRSHMAN: Are you trying to equate villus adenomas with atypia?
MR. CASEY: No.
Q: These things have stages; correct? I take it that a villus adenoma would be over and above an adenoma with severe atypia?
A: No. We're talking about different things here.

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I agree with your first statement or your first question that a tubular adenoma – let's distinguish the pathology.
Adenomas come in basically two sources, tubular and villus; and sometimes they're mixed.
We're always more concerned about villus because we know the malignance potential is greater size for size. But we know that *size* is probably the most important determinant, and that's why Dr. Gottesman was worried in the first place about that lesion in the hepatic flexure, because of its she.
Tubular adenomas and villus adenomas have the potential of getting larger with time, and that's the progression towards cancer that we know exists in most patients. They do go through different stages, and sometimes we can detect that when we take out the polyp; and atypia or dysplasia is used to describe the grade of severity of that change. That's usually with respect to tubular adenomas.
Villus adenomas are not quite so easy to characterize because the pathology is a little different. We often see dysplasia in villus

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adenomas, whatever stage they're at. And that's presumably why they have this greater malignance potential. But there's two distinct types of polyps.
Q: But assuming each one is resected and removed completely from the colon, do either one have the propensity to increase Father Walick's risk of developing future adenomas?
A: No.
Q: That is increased **simply** because of the fact that he has had multiple adenomas in his colon?
A: Yes. Two is multiple I suppose.
Q: When you talked about Dr. Gottesman consulting with Dr. Eisenstat, do you understand the difference between a situation where a physician asks another to consult and advise versus consult and co-manage or consult and take over the care of the patient?
A: Yes, I recognize all those differences.
Q: And those are terms that are familiar to you?
A: Yes.
Q: Do you have any opinion as to what the situation was in this case? What was being asked

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for?
A: I was not **until** I was informed during this afternoon because it was not documented.
Q: So nowhere in the records do you have any opinion as to what the situation was between Dr. Eisenstat and Dr. Gottesman regarding whether he was to consult and advise, consult and co-manage, or consult and take over the care of the patient?
A: No. As I just stated, that is not documented in the record.
Q: Assuming a lack of documentation, would you by default go to one **of** the three?
A: I'm sorry. Could you repeat that.
Q: Assuming a lack of documentation in the file, would you by default go to one of the three?
A: I can't. How can I guess what he was asking?
Q: Okay. I mean I don't know if it's regular medical practice here that if you don't say one way or the other, you're to assume that you want co-management or you just want advice or the like. I mean is that your practice?
A: No. I don't think one can make that assumption.

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Q: Okay.
A: Each situation is different.
Q: Do you have any opinion as to whether or not Dr. Eisenstat had the pathology results before he took the patient to surgery?
A: I have no way of knowing.
Q: So if Dr. Eisenstat testifies at trial that he did have those results, you would not be in a position to disagree?
A: Except that his deposition says that he can't remember.
Q: I understand. But if he testifies that he did have those results at trial, would you be in a position to disagree?
A: Well, how can I if that's what he states?
Q: Okay. So you **will** not be coming in and telling the jury that based on X, Y, and Z, I don't think that he had those results?
A: Well, you're asking me an impossible question.
MR. **HIRSHMAN:** If you want to give him X, Y, and Z –
A: If he says that's what he had, then that's what he had.

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MR. GASEY: That's all I have.
MR. VOUDOURIS: Doctor, I just have a few brief questions for you.

REDIRECT EXAMINATION
BY MR. VOUDOURIS:

Q: As I understand – and correct me if I'm wrong – you have two criticisms of Dr. Gottesman in this case. And the first is Dr. Gottesman – based on the statement in his colonoscopy operative note on November 6, it's your opinion that Dr. Gottesman had already made up his mind that this patient required surgery; correct?
A: That was my impression, yes.
Q: And that's the first criticism that you have; correct?
A: No. It's not what we discussed earlier today.
Q: What's your first criticism?
A: Remember I made two criticisms. One was the accuracy of the diagnosis, and the other was the continuation of care.
Q: Okay. What's accuracy of diagnosis again?
A: You want to go through this again?
Q: Yes, I do.

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A: You will recall that the colonoscopy revealed six lesions in different parts of the colon, some of which were removed, some were biopsied. The two polyps turned out to be adenomas we've discussed many times. The lesion in the cecum was not biopsied, and we don't know what that was. One of the polyps turned out to be normal tissue. Another polyp was hyperplastic.

The lesion of concern at the hepatic flexure was interpreted by its appearance to be a possible malignant or premalignant lesion. It was described in the ways that we've discussed. It was interpreted by the physicians concerned – Dr. Gottesman and Dr. Eisenstat – as a possible villus adenoma.

It was biopsied. The biopsy subsequently showed this to be inflammatory, and it happens to be confirmed by the resection specimen which also showed it to be inflammatory with no adenomatous tissue.

So the accuracy of diagnosis of that lesion, which is the one lesion that really led to all the decision making, is very critical to Father Walick's care. And my criticism was that although

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the appearance may have been a concern, the true diagnosis was that this was a benign inflammatory lesion that did not require surgery.
Q: You only know that in retrospect; correct?
A: Well, we know it from the biopsies.
Q: Exactly. Which was retrospect; correct?
A: No. How can that be retrospect?
Q: The pathology that came from the biopsy.
A: Well, one usually waits for those. That's why we do them.
Q: Exactly. But then I gave you the hypothetical that Dr. Gottesman referred this patient to Dr. Eisenstat, which you said was in the – which was acceptable and reasonable –
A: For an opinion, yes.
Q: Right – and surgical consult, and that he had a right to rely on – that Dr. Eisenstat would check the pathology before he went ahead with surgery; correct?
A: Yes. That's what you asked me previously, and I agreed with that. I could also ask or could pose the situation why ask for surgery at all at that point? What's the hurry? Why go ahead at such a short time frame? That I didn't understand.

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Q: Well, Dr. Gottesman referred this patient for Dr. Eisenstat to make that decision.
A: Okay. Well, you told me that's what happened; and I have to accept that.
Q: That being the case, then I do not understand your first criticism of how he deviated from the standard of care in terms of accuracy of diagnosis.
A: Well, did Dr. Gottesman – was he aware of the result of the pathology before the patient had surgery?
Q: Assume that Dr. Gottesman was not made aware of – by Dr. Eisenstat or pathology – what the results of the biopsies were.
A: But, you know, we take responsibility for what we do. We can't say, 'Well, pathology didn't tell me," or "The surgeon didn't tell me."

If you generate tissue, you generate – you ask people to get involved, you have to take some responsibility for the consequences. You either follow up something that you want the answer to, you either ask your colleague what his decision was. That I don't understand, either.

I mean we haven't discussed these issues,

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but - they're not in the chart, but you've told me that Dr. Eisenstat made all these decisions so I have to accept them. But why didn't Dr. Gottesman know about them?

I presume these two physicians worked together regularly in the same hospital, and I can't believe that that's how they manage all their cases together.

You know, if Dr. Gottesman is in this very awkward position because of Dr. Eisenstat's actions, that's unfortunate; but that's what happened.

Q: Well, within **less** than a 24-hour period, if Dr. Gottesman was never made aware of the pathology report by either pathology or Dr. Eisenstat, and unbeknownst to Dr. Gottesman, Dr. Eisenstat takes this gentleman to surgery, then what is your criticism of Dr. Gottesman in this case?

A: Well, but you've only revealed that to me this afternoon. I did not know that from the medical record; and, therefore, my criticisms were based on what I was shown.

Q: Okay.

A: Now, I accept what you're telling me is m e , although it's not documented anywhere.

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Q: I want you to accept what I just told you is true. If you accept those facts to be **true,** do you have any criticisms in this case of Dr. Gottesman?

A: I still have criticism that no follow-up was made the same day for a patient who was in the hospital. That's not - it may not fall below the standard of care because the patient was not critically ill. Yet decisions were being taken, albeit without his knowledge as you tell me.

But if I accept what you tell me, that it was taken out of his hands for some reason, and decisions were not made by Dr. Gottesman on any of these accounts, then he's presumably not responsible for them. Although he's still responsible for that patient's care. That's hard to reconcile with what happened to him.

I would feel terrible if I was in that situation and the patient has treatment that I know nothing about, even though I may have initiated the sequence of events.

Q: All right. Based on the facts that I want you to assume earlier, that Dr. Gottesman, on that afternoon of the 6th, had sought a referral with

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Dr. Eisenstat - you already said that was reasonable based on what he found visually from the colonoscopy -

A: Yes.

Q: - that Dr. Gottesman was not made aware of the pathology reports that evening, the biopsy, the results of the biopsy; that he was not made aware of them in the morning, the following morning; that Dr. Eisenstat took this patient to surgery and did not inform Dr. Gottesman that he was taking this patient to surgery, do you still believe that Dr. Gottesman deviated from the standard of care?

A: If what you tell me is true, then I have to say no. I don't think it's very good judgment, and I don't think it's very good clinical care; and maybe that's a hospital problem.

Q: But you don't believe given the facts that I asked you to assume that Dr. Gottesman deviated from the standard of care?

A: That's correct. I have to accept that.

MR. VOUDOURIS: Thank you. That's all I have.

MR. CASEY: Now I have to ask you another question because of your last statement.

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RECROSS EXAMINATION
BY MR. CASEY:

Q: If the factual scenario as Mr. Voudouris has just given you does turn out to be true at trial, do you have criticisms of the hospital itself in the fact that you've never seen any of the policies and procedures - you've never seen any of that stuff - of the hospital itself for that situation occurring?

A: Well, my criticisms -

Q: Wait. My caveat to it **is** that it's not a situation **like** you have here where you are employed by the hospital. These are independent medical practitioners who are given privileges to operate at the hospital.

A: I'm not employed by the hospital, either.

Q: Okay.

A: My criticisms will almost entirely revolve around communications because that's what we're discussing, communication **of** - principally from the surgeon to anyone else except the operating room.

Q: And that doesn't involve the hospital personnel itself? That involves the two physicians

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in question; fair?
A: Well, it may involve more. I'd have to give that some thought because certain arrangements have to be made for a patient to go to the operating room, a consent has to be obtained which was obtained the previous day, on the same day that he had a procedure involving sedation. So that has to be questioned. Who obtained that consent? Who explained the surgery to him? I don't think it was Dr. Eisenstat.
So those are hospital issues. So it may be more than just a communication between two physicians. It may be hospital policies.
Q: Do you have any facts from which you will render an opinion that any of the hospital personnel deviated from acceptable standards of care in this case? Have you seen anything or are you in a position to render that opinion at this time?
A: No. Other than Dr. Eisenstat, no, I have no evidence of that.
Q: Do you have an opinion that Dr. Eisenstat was hospital personnel? Have you seen anything to indicate that?
A: I have no idea who employs him or how his

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contract is written. How would I know that?
Q: Now, if you review any subsequent materials or if you come to any further opinions in this case that you may be expressing at trial, will you please let Mr. Hirshman know so that we can understand that which you will be basing your opinion on and the opinions that you have; is that fair?
A: Sure.
Q: And have you ever been involved in a case or heard of a case here at your hospital where a gastroenterologist has been accused of failing to diagnose a cancer?
A: You mean in any organ?
Q: In the colon.
A: Have I been involved in such a case? No.
Q: Have you heard of those cases here at the hospital?
A: Not while I've been here, no.
Q: So none of the gastroenterologists here that you know of has ever been accused of failing to catch something that was in the colon that turned out to be a malignant neoplasm?
A: Not that I'm aware of, and I think that I would be aware of that.

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Q: And you probably sit on a lot of the committees here?
A: I do.
Q: And you haven't heard of any of that through your involvement in those committees?
A: That's correct.
MR. CASEY: Okay.

FURTHER REDIRECT EXAMINATION
BY MR. VOUDOURIS:

Q: Doctor, just a few housecleaning things. Can you – we'll mark it as Exhibit 2 your folder in this case. And if you could do me a favor? Make a copy of everything in that folder. I take it nothing has been removed; correct?
A: Correct.
Q: So we'll mark that as No. 2; and you can just send a copy of that to Toby, and he'll pass it along.
MR. HIRSHMAN: Yes.
Q: I also need an updated copy of your CV. If you could also give that to Toby, and he'll pass it along to us.
You said you keep a list of the cases that you serve as a medical legal expert?

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A: I do not keep a list, no.
MR. HIRSHMAN: And if you want to go to the court for that, you can.
A: I keep documents that I'm currently working on, of course.
Q: The materials that you were sent?
A: Yes.
Q: Okay. You don't keep a list of the cases that you've served as a medical legal expert?
A: I do not, no.
Q: I just want to make sure of one thing, too. You're not going to be giving an opinion to the reasonable degree of medical certainty as to life expectancy of Mr. Walick at this trial, are YOU?
A: I can't do that.
MR. VOUDOURIS: That's all I have.
MR. HIRSHMAN: It's up to you. Do you want to read this three and a half hour deposition? It's up to you. You have the right to read and file – not to read and file.
You have the right to read this and make corrections to it, or you can waive that right. It's your decision.

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I don't know this gentleman so I can't tell you how reliable his transcript is so it's your decision.

THE WITNESS: Would it be sent to me, or do I have to go -

MR. HIRSHMAN: You'll make him a copy so he doesn't have to -

THE REPORTER: May we go **off** the record so I can talk?

MR. HIRSHMAN: Yes.

(Discussion off the record)

MR. HIRSHMAN: He's reading and signing. I'm going to get a copy. He'll use the copy to read and sign.

(Folder marked as Carr-Locke Exhibit *2* for identification)

(Whereupon the deposition was adjourned at 5:56 p.m.)

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CERTIFICATE

I, DAVID L. CARR-LOCKE, M.D., F.R.C.P., do hereby certify that I have read the foregoing transcript of my testimony, and further certify that said transcript (with/without) suggested corrections is a true and accurate record of said testimony.

Dated at ___, this ____ day of _____, 19____.

Sworn and subscribed to before me this day of _____, 19____.

Notary Public
My commission expires:

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COMMONWEALTH OF MASSACHUSETTS)
SUFFOLK, SS.)

I, William J. Ellis, Registered Professional Reporter and Notary Public in and for the Commonwealth of Massachusetts, do hereby certify that there came before me on the 9th day of Dec., 1997, at 2:32 p.m., the person hereinbefore named, who was by me duly sworn to testify to the truth and nothing but the truth of his knowledge touching and concerning the matters in controversy in this cause; that he was thereupon examined upon his oath, and his examination reduced to typewriting under my direction; and that the deposition is a true record of the testimony given by the witness.

I further certify that I am neither attorney or counsel for, nor related to or employed by, any attorney or counsel employed by the parties hereto or financially interested in the action.

In witness whereof, I have hereunto set my hand and affixed my notarial seal this ____ day of December, 1997.

Notary Public
My commission expires: 1/17/03

Lawyer's Notes

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